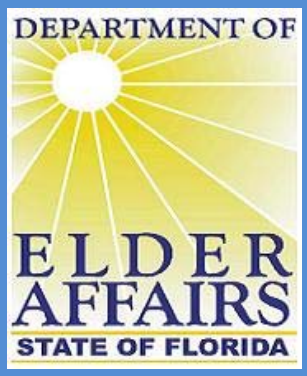



RICK SCOTT
*GOVERNOR*

CHARLES T. CORLEY
*SECRETARY*

# 2012 Direct Service Workforce Study

*elderaffairs.state.fl.us*

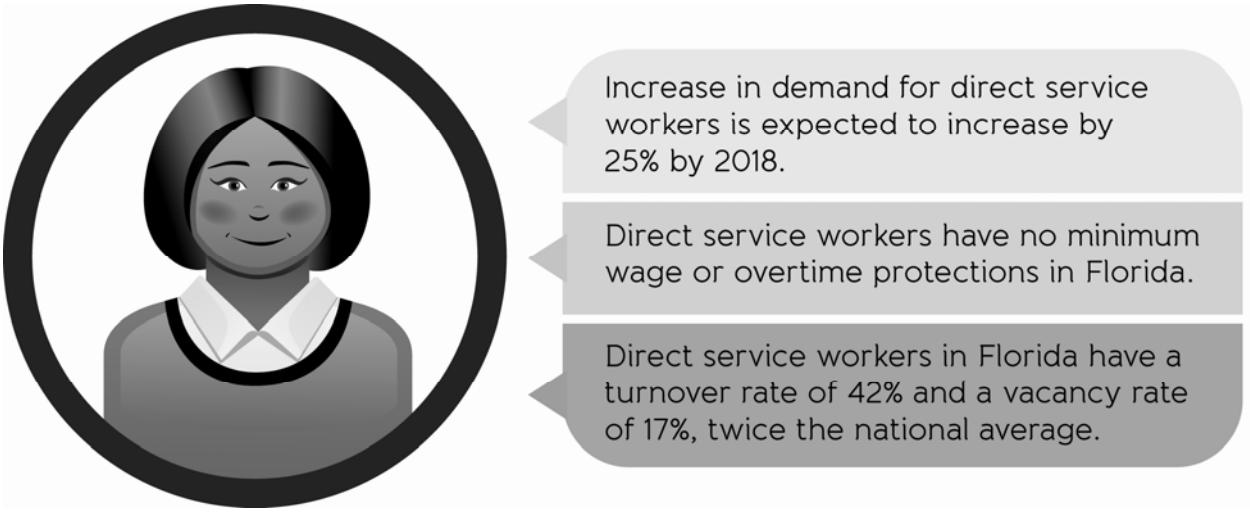
*Bureau of Planning & Evaluation, April 2013*

## Table of Contents

## Executive Summary

By 2016, the U.S. Department of Health and Human Services predicts that there will be demand for one million additional direct service worker (DSW) positions nationwide. However, one million of these workers are currently consigned to near-poverty because of the structure of their employment.[1] In Florida, the direct service workforce is made up of approximately 130,000 workers, with an expected 25 percent increase in demand over the next decade.[2] The Direct Service Workforce Resource Center estimates Florida's turnover rate of DSWs at 42 percent and its vacancy rate at 17 percent. There are serious consequences of this workforce instability, including diminished quality of care, compromised access to services, and greater unmet need among the full population that could benefit from in-home supports and services.[3]

As a participant in a multi-state grant funded by the Centers for Medicare & Medicaid Services (CMS), the Florida Department of Elder Affairs (DOEA) conducted a statewide survey of the direct service workforce. The DSW survey was designed to establish a baseline for future efforts in improving the field of direct service work and to establish Florida's formal inquiry into the need that is being forecasted nationwide by leading organizations like the Robert Wood Johnson Foundation, CMS, and AARP. The survey was sent to 10,640 employer organizations and individual licensed providers of direct care services to elders and individuals with disabilities, with 1,001 respondents. Survey results indicate that employers of DSWs pay an average hourly wage of approximately $9, do not provide health insurance or paid leave, have a worker-to-client ratio of approximately one to three, and have an average of two vacancies.




[1] HHS, 2011.

[2] PHI State Data Center, 2011.

[3] Seavey and Marquand, 2011.

This paper discusses the findings of this survey, as well as the problems experienced in other states and how they are attempting to remedy these problems. Many of these efforts have only recently been implemented or are still in the development stage and thus data are not yet available on the outcomes of these initiatives. Because it is too soon to determine which initiatives will be effective in improving the state of the direct service workforce at this time, and how well they would apply to Florida, more monitoring over the next few years will be necessary. That effort should include regular examination of the needs of the direct service workforce and DSW employers, as well as additional surveys and other methods of monitoring to identify trends in key areas such as wages and benefits, staffing needs and turnover rates, training needs and skill development, and consumer outcomes.

## Introduction

DOEA was a recipient of a multi-state grant called the State Profile Tool from CMS, which enabled participants to assess their respective long-term support systems for elder and disabled populations. The Direct Service Workforce Survey is a deliverable of this five-year grant.

In conjunction with The Lewin Group and the University of Florida, DOEA conducted surveys of a census of 8,034 employer organizations (EO) and 2,606 individual licensed providers (IP) of services to elders or disabled adults and children across the state.[4] For the purposes of the IP survey, individual providers were considered to be those who were working or had worked, in the past 12 months, to support a person who is older or has a disability and whose support/care enables the person to live in his/her own home through the Consumer-Directed Care (CDC+) program. The surveys sought to measure characteristics of the long-term care direct service workforce, including volume (i.e., how many workers, hours, populations, and care recipients), stability (i.e., turnover rates and vacancies), and compensation (i.e., wages, training, sick leave, and health insurance).

**The demand for direct service workers is expected to increase by 35% over the next decade. However, recruiting workers to the field has proven to be a daunting task for many states.**

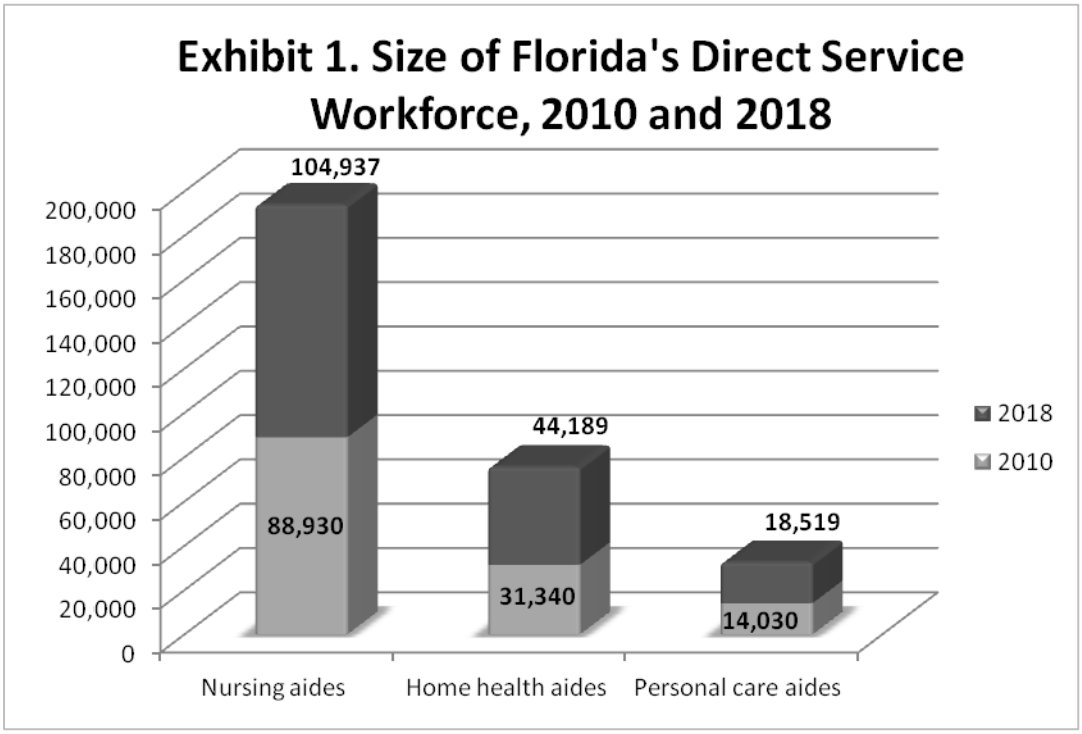
Direct service work is one of the fastest growing occupations nationwide, with demand for these workers expected to increase by 35 percent over the next decade. Information collected through the surveys will enable state and federal policymakers to create a baseline against which the progress of workforce improvement initiatives can be measured, as well as compare Florida's progress, challenges, and innovations to the efforts of other states.

For the purposes of this data collection, direct service workers were defined as those who provide hands-on care to elders and individuals with disabilities, including services such as preparation of meals, medication assistance, bathing, dressing, mobility, and transportation. The workforce has an array of titles that all describe similar responsibilities, these include personal and home care aides, home health aides, direct support professionals, certified nursing assistants, homemakers, and personal attendants, as well as other workers in similar roles.

[4] Surveys were administered to a sample population of 10,640 employer organizations and individual providers through the state licensure database by mail, telephone, and the internet. Surveys were available in both English and Spanish.

## Expected Growth

According to the Paraprofessional Health Institute (PHI), Florida's direct service workforce is made up of more than 130,000 workers, who fall into three main categories: nursing aides (86,980), home health aides (29,170), and personal care aides (15,750). It is projected that between 2010 and 2018 there will be a 25 percent increase in demand for these workers in Florida, while overall jobs in the state are expected to grow by only 14 percent.[5]




Data sources: Bureau of Labor Statistics and Paraprofessional Health Institute.

For example, there are currently approximately 30,000 home health aides in the state, and there is expected to be a 41 percent increase in demand for these workers. Thus, 12,000 people will need to become home health aides over an eight-year period to avoid worker shortages. The current size of the workforce, as well as the predicted size of each worker category, is displayed in Exhibit 1.

[5] The Paraprofessional Health Institute predicts that between 2010 and 2018 there will be the following increases in demand for these workers: personal care aides (32%), nursing aides (18%), and home health aides (41%) (PHI, 2011).

Of 1,001 completed surveys, roughly half were employer organizations (EO) and half were independent providers (IP). However, of the 527 surveys returned for the IP survey, only nine percent of respondents indicated that they currently provide care to elders. Since independent providers caring for developmentally disabled clients were the primary respondents, the IP survey data are not included in the analysis addressed by this report. The data were provided to the Agency for Persons with Disabilities.

Conversely, the employer organization respondents provided services to a broader array of clients, including 83 percent to those 65 and older, so DOEA chose to analyze the EO survey data exclusively. Though there was wide variability in employer responses, the average respondent to the EO survey was an independent entity (as opposed to a chain or government organization), employed 33 direct service workers, had two vacancies, paid a median hourly wage of $9.07, and provided care to 104 clients who have a disability or are aging (a ratio of approximately one worker for every three clients).

## Wages

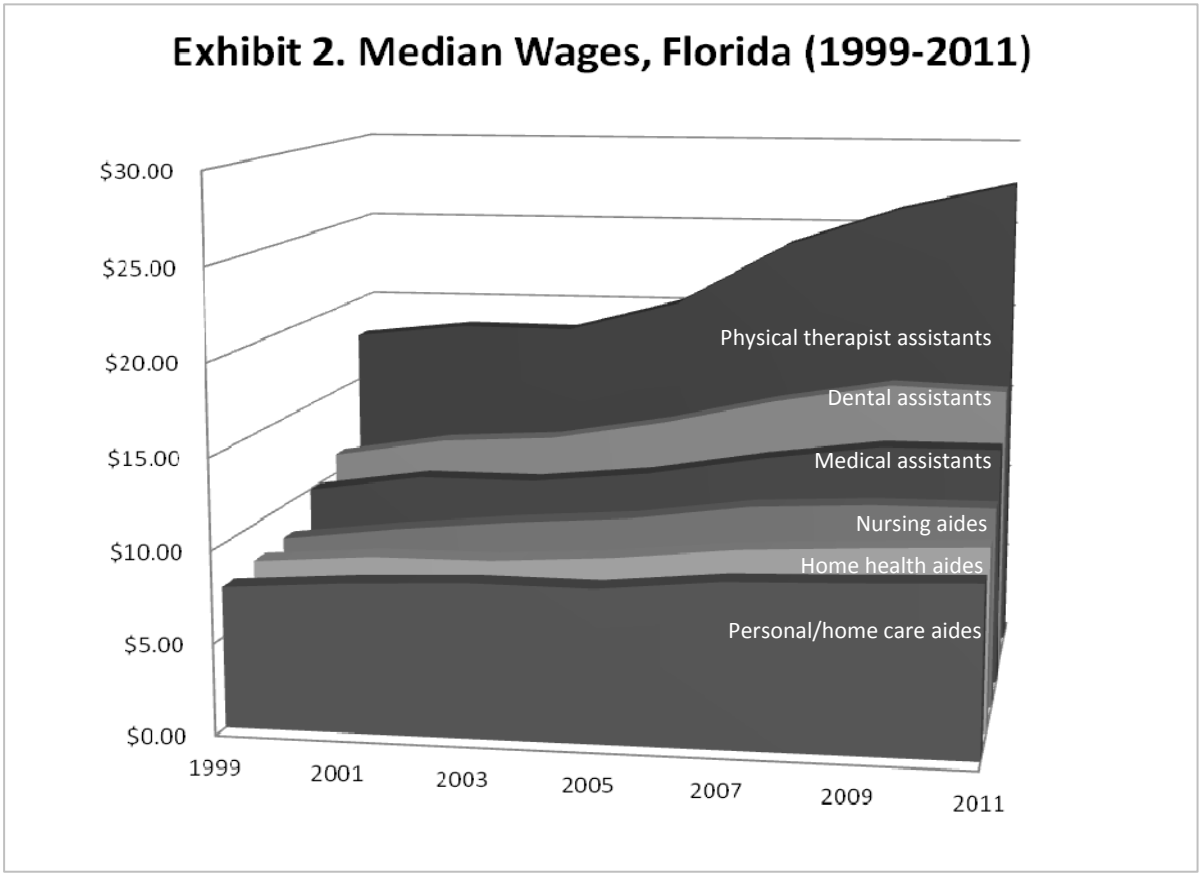
It may be difficult to fill projected gaps in DSWs, as they earn significantly less than the statewide average across occupations ($14.79/hour), and that trend has worsened in recent years. Over the last decade, the real median wage for personal care aides in Florida fell by over 10 percent.[6]

Exhibit 2 shows the median wages over the past 12 years for DSWs, as well as other comparable professions.[7] This exhibit shows the higher rate paid to such workers as physical therapist assistants and dental assistants, as well as the faster rate of wage increases seen in these fields. While the following exhibit may show wages increasing slightly for direct care workers (and thus contradicting the decrease in real median wages), this increase does not account for inflation.

**Despite the variability in tasks, settings, and skill required of direct service workers, the wages across all types are very similar, and the average wage is significantly lower than the statewide average of all occupations.**

[6] State Chart Book on Wages for Personal Care Aides, 2000-2010 (PHI, 2011).

[7] According to the Bureau of Labor Statistics, the median hourly wages for direct service workers are as follows personal care aides ($9.39), home health aides ($10.13), and nursing aides ($11.19), while the median hourly wages for these comparable workers are as follows medical assistants ($13.50), dental assistants ($15.99), and physical therapist assistants ($27.59), all of which are above the statewide average.




Data source: Bureau of Labor Statistics, 1999-2011

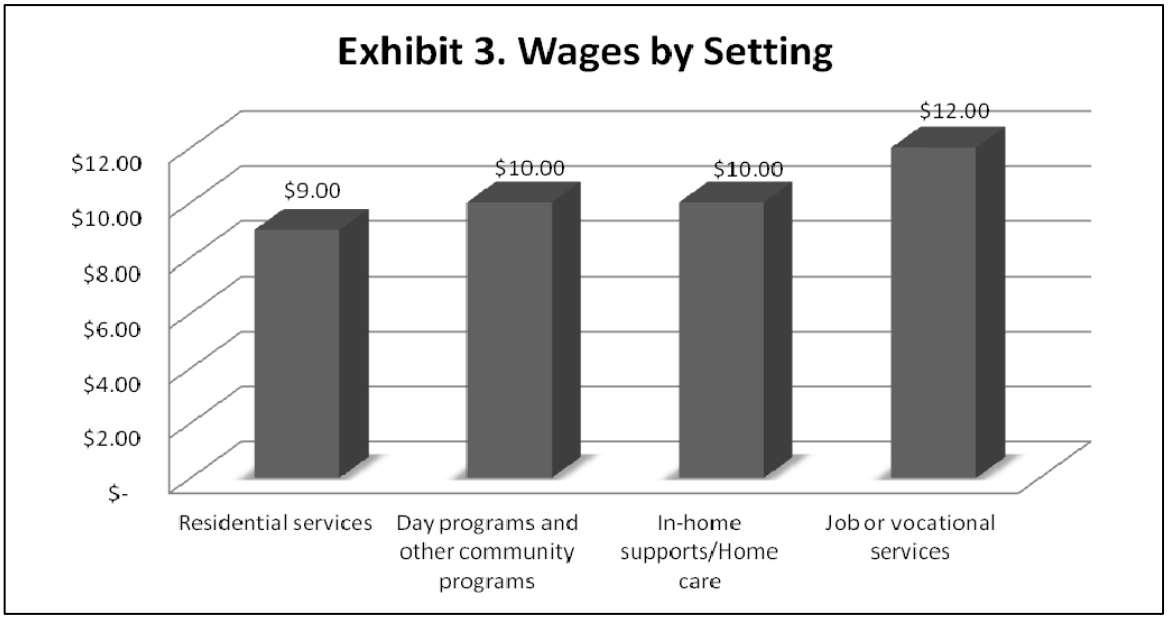
Furthermore, average wages in Florida for personal care aides ($9.39/hour) and home health aides ($10.13/hour) currently fall below 200 percent of the 2010 federal poverty line for a single individual working full-time ($10.42/hour), which is low enough to qualify for several state and federal assistance programs. In fact, from 2008 to 2010, 37 percent of DSW households in Florida relied on some form of means-tested public assistance (27 percent were enrolled in Medicaid and 23 percent received support from food or nutrition programs).[8] The need for public support by DSWs is so common that PHI posits that raising worker wages modestly could result in an overall state cost savings via reductions in Medicaid and other programs.[9] As state budget makers are looking for new ways to decrease reliance on public assistance, improving the wages of DSWs and other working poor may be an opportunity to reduce the financial burden of welfare programs on state budgets.

In the DSW survey results, the median starting hourly wage across service types was consistent with previous studies and other measures of direct service workforce pay, at $9 an hour. Direct service workers who provide services in congregate residential settings also earn a median wage

[8] PHI State Data Center, 2011.

[9] Seavey and Marquand, 2011.

of $9 an hour, with slightly higher rates for those who provide services in adult day care or community programs and in-home care ($10/hour). Job and vocational service workers reported the highest median hourly wage of $12 (see Exhibit 3). Although this is an improvement over other personal care workers, it is still significantly lower than the statewide median across occupations. Moreover, it appears that additional years of experience do not translate into substantially higher wages for these workers. The practical consequence of this fact is that there is little incentive for workers to stay in this field without the expectation of advancement or increase in compensation.




Data source: 2012 Direct Service Workforce Survey

## Health Insurance

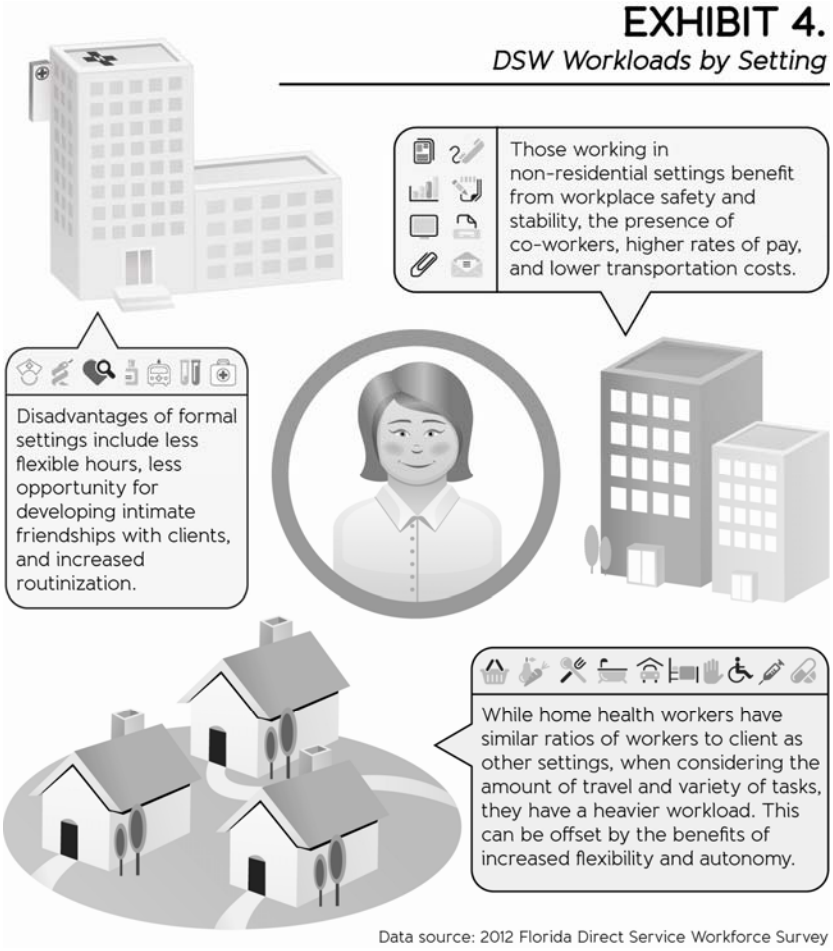
Wages are not the only way in which employers can compensate workers. Health insurance is an important component of compensation and a common reason workers stay with an employer. Research shows that Florida's direct service workforce has lower rates of employer-provided health insurance compared to the national workforce. While 52 percent of direct care workers in Florida are covered by employer-sponsored health insurance, 68 percent of workers nationwide receive such coverage. The other half of Florida's direct service workforce either receives Medicaid or is uninsured.[10]

[10] PHI State Data Center, 2011 (using Census Current Population Survey data).

In the DSW survey results, less than one-quarter of employers (23 percent) provide insurance to any direct service worker.[11] Of these, health insurance is provided to an average of 16 employees. In looking at coverage eligibility by worker type, 39 percent of respondents provide coverage to full-time employees, while only six percent consider part-time workers eligible for health insurance. The full-time/part-time eligibility discrepancy is particularly problematic for DSWs, due to the episodic nature of their work. An additional explanation for so few employers offering coverage may be the size of the organizations that responded. Only 44 respondents employ more than 50 workers, which is the size at which Fair Labor Standards begin to apply.

## Workloads

By looking at client/worker ratios, we can gain a better idea of typical DSW workloads. Employer respondents provided the following average ratios by setting: job or vocational services (3:1), day programs and rehabilitative or medical supports (6:1), in-home supports and home care (4:1), and congregate settings (2:1). Though the workload for home care workers is not the highest ratio (at 4:1), it is unique in its lack of support that is generally available in more formal workplace settings, such as co-workers and protocols guaranteeing a certain degree of safety and support. In-home care workers go to a diverse array of residential settings and incur a much higher risk of personal danger (i.e., travel hazards, pets, firearms, and infrastructure problems). Additionally, in-home workers perform a wider array of services than those in more structured settings.




[11] This significantly lower rate (compared to the 50 percent estimate) can most likely be attributed to the spousal coverage picked up by the Census Current Population Survey, but not by the DSW survey from the employer's perspective. Because the EO survey only asked about coverage by DSW employers, it is a more accurate depiction of the rate of coverage offered to these workers.

## Cultural Competence

As clients become more diverse, the workforce serving them needs to become more diverse as well. According to the 2010 Census, Florida has the fourth largest minority population (7.9 million), after California, Texas, and New York. Therefore, Florida needs to address diversity and cultural competency issues. CMS defines cultural competency broadly to include "behaviors, attitudes, and policies that enable professionals to work effectively in cross-cultural situations." Because Florida is so culturally complex, individual flexibility and accommodation, being sensitive to care recipients' experiences (i.e., those who have experienced war or other type of trauma), in addition to meeting specific cultural, religious, or language requirements, is often emphasized.

While speaking a language and being able to provide services in that language are generally considered to be the minimum level of competency necessary, it is important for workers to be trained to anticipate differences in clients and to change the way they provide services based on those differences. In a setting where communication about personal matters of grooming, eating habits, personal care, and health maintenance tasks is commonly expected between workers and clients, education about different languages and cultural requirements will help workers to avoid frustration, misinformation, and offending or failing to assist clients. Currently, cultural competence in practical applications requires staff to be flexible with individual preferences and backgrounds and to accommodate these preferences wherever possible, but stops far short of educating staff about other cultures.

**Florida has diverse profiles for both clients and workers. This means employers often have to conduct significant amounts of training to ensure workers have the language proficiency and cultural sensitivity appropriate for service delivery.**

In order to assess respondents' levels of cultural competence, the survey asked six questions regarding such aspects as translation services, written policies, and training on cultural competence. Approximately 46 percent of respondents said their staff receives training in this area, and 62 percent said that interpreters with knowledge in health care terminology are available when needed.[12]

## Training

It has been argued by worker advocates and other national organizations, such as the Joint Commission on Accreditation of Healthcare Organizations, that an impediment to increasing the preparation of the direct service workforce is workers' inability to cover the cost of personally-secured education and training. This passes the cost of developing this class of

[12] We expect that this rate would have been higher if respondents were asked simply about translation services, without the caveat of interpreters needing to be "knowledgeable in health care terminology."

professionals on to the employing businesses. According to the National Home Health Aide Survey, the only training 70 percent of certified nursing assistants received was provided by their employer. Subsequently, only 66 percent of CNAs reported that they were well-prepared for their work in a nursing facility.[13]

**Although important, the increased cost of recruiting and training new workers - and paying for the mistakes that inexperienced workers make- is overshadowed by the costs of delivering lower quality care to clients.**

High turnover rates result in increased costs for employers. These costs are incurred not only in continuously recruiting, hiring, and training, but also in absorbing the cost of the mistakes made by new workers. For example, in a recent study by the Joint Commission on Accreditation of Healthcare Organizations, hospitals with high turnover rates (21 percent or more) had a 36 percent higher cost per discharge than hospitals with low turnover rates.[14] The U.S. Department of Health and Human Services has also identified inadequate training as a contributing cause of poor job performance and diminished quality of care. They have also suggested that training can mitigate poor job satisfaction and high turnover rates.

Additionally, a lack of training has been linked to an increased likelihood of injury and absenteeism among direct care workers. According to a national survey in 2010, home health aides took twice as many days off work due to injuries (median of 12) than nursing home staff (median of six) and more than workers across all occupations (median of eight). In one-third of direct care worker injury-related absences, workers were away from work for 31 days or more. This time away from work suggests the injuries were quite severe, and not only resulted in lost income for the workers but also adversely impacted the continuity, and by extension the quality, of care for the clients they serve.[15] An additional explanation for the severity of injuries experienced by DSWs in residential settings is delayed treatment and reporting. "When workers are unable to comfortably report incidents like injuries and other issues in home care environments, not only are occupational stress and job dissatisfaction increased, but also, unaddressed injuries on the part of aides can worsen through continued overexertion and physical and emotional stress, ultimately worsening the quality of care delivered to clients."[16]

[13] HHS, 2011.

[14] Joint Commission on Accreditation of Healthcare Organizations, 2003.

[15] Seavey and Marquand, 2011.

[16] Ibid.

In the EO survey, respondents were asked about required training topics at their organizations. The areas of training coverage included basic interpersonal skills as well as more position-specific skills related to treating client medical needs, handling the administrative aspects of the business, and performing core competencies of personal care duties.

The following are the array of training topics mentioned in the EO survey. All were identified by at least 87 percent of respondents.

*Core competencies*

- Problem solving
- Safety and emergency training
- Household management
- Providing services based on needs of individual
- Cultural competence
- Personal care
- Behavior management
- CPR
- Transferring or lifting

*Interpersonal skills*

- Stress management/personal safety and wellness
- Interpersonal relationship skills
- Communication
- Teamwork
- Conflict resolution
- Assessing consumer needs
- Customer empowerment

*Medical skills*

- Infection control
- Administering medications
- Health and wellness
- Nutritional support
- Crisis prevention and intervention
- Assisting with wound care, dialysis, catheter, and/or ostomy care

*Organization/administration skills*

- Documentation
- Consumer confidentiality
- Consumer rights
- Ethics
- Direct service professionalism
- Vocational, educational, and career support
- Facilitation of services
- Advocacy
- Participant-directed service planning and implementation
- Organizational participation

This list exemplifies what a wide array of training topics employers have become responsible for providing. By the size of this list, employers clearly recognize the need to develop more sophisticated skills in the workers they are able to recruit to meet their staffing needs and have identified areas where workers need more education to properly address the needs of the clients they serve. As one can see from these topics, training is a care quality issue for elders, a liability and efficiency issue for employers, and a job safety issue for workers.

### Consumer Preference

According to a recent report published by the National Consumer Voice for Quality Long-Term Care, consumers believe their home care workers should have better quality jobs. This report shows that many surveyed respondents (87 percent of whom were age 51 and older) reported that their workers made a positive impact in their lives, and they consider them to be part of the family. Consumers expressed worry over low wages not only because they care about their workers but also because of the high turnover rates they have experienced. They believe that much of the turnover rate could be mitigated by higher wages. Respondents also expressed concern over organizations encouraging workers not to bond with clients. Many feel that a close bond results in better care.[17]

## The Future of the Direct Service Workforce

With low wages and low rates of health care coverage among workers, direct service workers have little incentive to stay with an employer, or to even stay in the field. As a result, many employers are short-staffed. Compounding this problem is that DSWs constitute one of the largest and fastest growing sectors of the workforce. There is a documented shortage of these workers throughout the country – a shortage that is projected to grow as the population ages. This is of particular importance in Florida where the vacancy rate for DSWs is double the national average and aging residents are a large proportion of the state's population.[18] Currently, more than 1.7 million residents in Florida are age 75 and older – with 85-100 year olds being the fastest growing age group by percentage.[19] The need for paid care workers for those 75 and older is the highest of all age groups.

One of the primary barriers to improving the conditions of this field, and in turn, the quality of the workforce, is the Companionship Exemption in the Fair Labor Standards Act (FLSA). This exemption, commonly referred to as the "babysitter exemption," makes home care workers exempt from the federal minimum wage, as well as overtime protections. As of 2011, 21 states and the District of Columbia have extended their minimum wage laws to these workers (with 16 of those states also providing overtime pay at time and a half to home care workers who work over 40 hours in a week).[20] Florida does not provide either of these protections to DSWs.

[17] National Consumer Voice for Quality Long-Term Care, 2012.

[18] CMS, 2012.

[19] DOEA Fact Sheet, 2012.

[20] States that provide minimum wage and overtime coverage to home care workers: Colorado, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New York, Pennsylvania, Washington, Wisconsin. States that provide minimum wage but no overtime coverage to home care workers: Arizona, California, District of Columbia, Nebraska, North Dakota, Ohio, South Dakota (PHI, 2012).

## Worker Turnover

There are serious consequences of this workforce instability, including diminished quality of care, compromised access to services, and greater unmet need among the full population that could benefit from in-home supports and services.[21]

The Paraprofessional Health Institute's analysis of the 2007 National Home Health Aide Survey indicates that nationally 35 percent of home health aides who were working for home care agencies planned to leave their job within the following year. According to the 2011 report *Caring in America*, various studies have found that "wages play a critical role in determining the adequacy and stability of the homecare workforce." Lower wages and fewer hours are associated with higher turnover, which has a strong negative correlation with care quality. The Direct Service Workforce Resource Center estimates Florida's turnover rate of DSWs at 42 percent and its vacancy rate at 17 percent.[22] "Staff instability and turnover can also result in major financial burdens for both agency-based long-term care providers, and the state and federal agencies that foot a large part of the bill for these services."[23]

**With the added costs of new employee recruitment, training and errors, failing to retain experienced direct service workers may increase overall costs more than improving wages and benefits to existing workers would.**

A 2004 report investigating these costs concluded that "turnover among frontline workers is a critical cost driver for the long-term care industry," and that "the costs of turnover to the public sector are tantamount to an implicit tax on reimbursement rates paid to public-financed providers—a hidden tax which ultimately is paid by taxpayers for high industry turnover costs." Several additional studies have also found the correlation between high turnover and diminished quality of care in nursing care facilities. Increases in nursing aide and LPN turnover were found to be associated with decreases in quality of care, as measured by rates of physical restraint use, catheter use, contractures, pressure ulcers, psychoactive drug use, and certification survey quality-of-care deficiencies.[24] In Michigan, a $1 per hour wage increase reduced the odds that a paraprofessional worker would leave by 15 percent and for nursing home workers, in particular, by 27 percent. Similar results were also seen in California, Wyoming, Maine, and Illinois.[25]

[21] Seavey and Marquand, 2011.

[22] CMS, 2012.

[23] Seavey and Marquand, 2011.

[24] Ibid.

[25] Ibid.

## Training

According to the Institute of Medicine (IOM), "Poor training contributes to poor quality care, abuse and neglect, decline in resident health and functioning, and institutionalization."[26] Therefore, it is important to identify variations in training requirements across states as well as among worker type. The largest discrepancies in training requirements for personal care aides among states are between those workers who are consumer-directed and those who are employed by an agency. Often under consumer-directed care models, consumers are responsible for training their workers, and thus many workers receive no training at all. "The isolated nature of home care work and the generally poor state of training and supervisory support for these workers provides few opportunities for workers to learn safe workplace practices either before they begin employment or on-the-job."[27]

IOM recommends that "Federal requirements for the minimum training of certified nursing assistants (CNAs) and home health aides should be raised to at least 120 hours and should include demonstration of competence in the care of older adults as a criterion for certification." Currently, home health aides and CNAs are required to complete 75 hours if working under Medicare (including 12 hours of continuing education each year). Additionally, IOM recommends establishing minimum training requirements for personal care assistants, as currently there is no training required under federal law for these workers. In an effort to reduce the variation in training requirements, in 2010 the New Mexico legislature adopted a bill requesting the establishment of a task force to examine a strategy for consolidating and coordinating training programs for direct support professionals across disability programs. The task force is designed to examine the economic savings associated with consolidated training requirements and to research direct care training initiatives in other states. Additionally, Washington's Home and Community-Based Long-Term Care Workforce Development Workgroup has called for 75 hours of mandatory training and certification testing for all long-term care workers.[28]

**Developing formal certifications for defined skills and tiers of credentials has been linked to increasing a personal sense of vocation, and may help retain direct service workers in the field.**

In an effort to prevent worker shortage and attract future direct service workers, the U.S. Departments of Labor and Health and Human Services are working together to improve the quality and stability of the direct service workforce. They have begun this effort by helping workers to acquire the necessary skills and credentials and by working with employers to create more sustainable health care jobs that offer advancement in the field. The Affordable Care Act

[26] CMS, 2009.

[27] Seavey and Marquand, 2011.

[28] Ibid.

(ACA) authorizes $10 million over three years to establish advanced training opportunities for new and incumbent DSWs. Once training is complete, trainees must work in the field of geriatrics, long-term care, or chronic care management for at least two years.

The ACA also provides $85 million per year in mandatory funding for three years to conduct a Medicaid demonstration in up to six states for development of training programs for personal and home care aides. Under this provision, the U.S. Department of Health and Human Services' Health Resources and Services Administration created the "Personal and Home Care Aide State Training Program." This program will fund a three-year (2011-2013) demonstration project for six states (California, Iowa, Maine, Massachusetts, Michigan, and North Carolina) to develop core competencies, pilot training curricula, and develop certification programs for personal care and home health aides. It is expected that these states will train over 5,100 personal care aides by 2013.[29] Further, the ACA establishes a panel of long-term care workforce experts to develop core competencies for these training programs and to make recommendations on how such training could be provided (2010-2014).

The U.S. Department of Labor has also created DSW apprenticeship programs for direct support specialists and home health aides. Designed to support employers in recruiting and retaining skilled employees, these programs provide opportunities for training and learning while working and for career advancement. [30]

In 2007, Pennsylvania's Direct Care Workforce Workgroup issued a report recommending the development of a statewide training system to certify direct care workers using a set of core competencies including both "hands-on" and "soft" skills. In 2008, a 77-hour entry-level competency-based PCA curriculum, developed by the Pennsylvania Department of Labor and Industry under a contract with PHI, was introduced for field testing. This pilot training program will train over 300 PCAs in southwestern Pennsylvania.[31] Arizona also developed a model training curriculum for PCAs, as well as competencies and standards for DSWs, including a standardized competency evaluation. Throughout 2011, Arizona's Medicaid department has implemented the new training and testing requirements for DSWs who work in home care settings.[32]

Many states have also implemented "peer specialist programs," where experienced workers serve as role models and teachers, and are being utilized as a way to train workers and orient them to the field. "Through enhanced training in health education and system navigation, these aides can improve the health experience and outcomes of consumers."[33]

[29] PHI, 2012.

[30] Dawson, 2012.

[31] Seavey and Marquand, 2011.

[32] Ibid.

[33] CMS, 2012.

It has been proposed that setting standards for certification of DSWs would help ensure that workers come into the workforce with a baseline of skills and training. Workers would receive government-funded education from traditional sources such as schools, technical programs, and colleges. By increasing the amount of personally-secured training and lowering the need for employer-provided training, business overhead costs would decrease. These savings could result in increased wages and benefits which would aid in the recruitment and retention of better trained workers. Although generally DSWs do not currently personally secure training, many other fields do (i.e., the aforementioned medical and physical therapist assistants), and as a result they are, on average, paid better. Particularly in light of many of these training programs being in whole or in part provided at little or no cost by the government, expecting workers to secure this training is a reasonable expectation.

### Minimum Benchmarks

In order to improve the workforce and ensure higher job quality, the National Direct Service Workforce Resource Center recommends states alter contracts with Medicaid providers to require better treatment of workers. One suggested strategy is to modify contracting and procurement standards to establish minimum benchmarks for providers. In some instances, this is done by providing incentive awards or enhanced rates to providers who meet higher wage, insurance, or promotion rates.[34] In return, states expect that better quality jobs for workers will result in a more attractive and viable career to recruit DSWs. Some of the experts suggest that the implementation of living wage laws or indexing the state minimum wage to inflation would also result in higher wages for workers and less turnover. In Minnesota, 2009 legislation mandated that personal care aide provider agencies must use 72.5 percent of PCA revenue toward PCA salaries and benefits, and all PCAs must complete the state's online training program (the nine-part training program is available in six languages).[35]

**The state needs to form a partnership with direct service employers to achieve the goal of expanding insurance to the workforce; for employers control many of the central issues. For example, insuring part-time workers, offering paid sick leave to workers, and contributing to health plans are all within the employer's control.**

Besides wages and credentials, there are also other strategies for increasing retention of workers. Providing health insurance has been an identified opportunity of improvement for direct care workforce conditions. The rate of insured DSWs could be increased by expanding Medicaid to

[34] Ibid.

[35] Seavey and Marquand, 2011.

a greater number of workers, creating purchasing pools, allocating public funds to subsidize the employer or employee share of premiums, building insurance costs into Medicaid reimbursement, and providing workers with assistance for their health care expenses (i.e., prescription discount cards, health saving accounts, or health reimbursement accounts).[36]

## Additional Initiatives

Additional initiatives have been suggested to expand improvements to workers in rural service areas, including online training programs, reimbursement for gas and other transportation costs, scheduling based on geographic proximates, carpooling, and the use of teletechnology for corresponding with clients in order to decrease the amount of trips workers must make. Teletechnology is particularly important when put in the context of the amount of traveling required of direct service workers. A 2008 study conducted by the National Association for Home Care and Hospice found that home care nurses, aides, and therapists travel close to five billion miles each year.[37] Governments can help in these efforts by encouraging urban agencies to create branches that serve rural clients or to make accommodations for urban workers to commute. As one example, in New York, Medicare "add-ons" were used to reimburse gas and auto expenses to offset costs for urban-based workers traveling to rural areas. Other pilot tests have funded telehealth equipment and established and facilitated consumer-directed care programs that allow clients to control their own care plans and hire relatives, neighbors, and friends. These initiatives are particularly important in areas where worker shortages are forecasted.[38]

In attracting new people to the field of direct service work, some states are targeting specific demographics of workers, including men, immigrants, older people, volunteers, those with disabilities, and family caregivers, as potential DSWs. Many states have also developed marketing materials in multiple languages and are partnering with churches and community service organizations to gain access to new sources of potential workers.[39]

Additionally, some workers have organized to create DSW cooperatives as worker-owned or worker-operated businesses. These enterprises have been successful in increasing wages and decreasing turnover among workers. The DSW co-ops provide consistent hours, consolidate resources, create consistent billing policies, coordinate travel, and improve the quality of home care services. These results are consistent with research that shows that increased involvement in decision-making is linked to increased job satisfaction and greater job stability.[40]

[36] CMS, 2012.

[37] Seavey and Marquand, 2011.

[38] Brown, et. al., 2011.

[39] CMS, 2012.

[40] Wright, 2011.

Studies have found that the perceived lack of opportunity for advancement was significantly related to intent to leave.[41] One suggested solution is the creation of a career ladder for DSWs, particularly a rung between home health aide and LPN. This role could include assisting with training, peer mentoring, or having a role on a care coordination team. An additional approach could be to create "a range of specialized roles," including dementia aides, medication aides, or aides specializing in end-of-life care.[42] A 2008 report from the Iowa Direct Care Worker Task Force recommended the stratification of DSWs based on function; drafted a basis for a core curriculum; and developed in-service requirements, standards for instructors, and outreach and educational strategies. Additionally, in 2012 the Iowa Legislature established a board of directors to report on the size of the workforce and any pilot results and launched an independent statewide association of DSWs for education and outreach. In Maine, 2010 legislation called for the Commissioner of Health and Human Services to establish a workgroup to report on establishing a statewide job classification system of direct care job titles and develop logical sequences of employment tiers and training links between these tiers.[43]

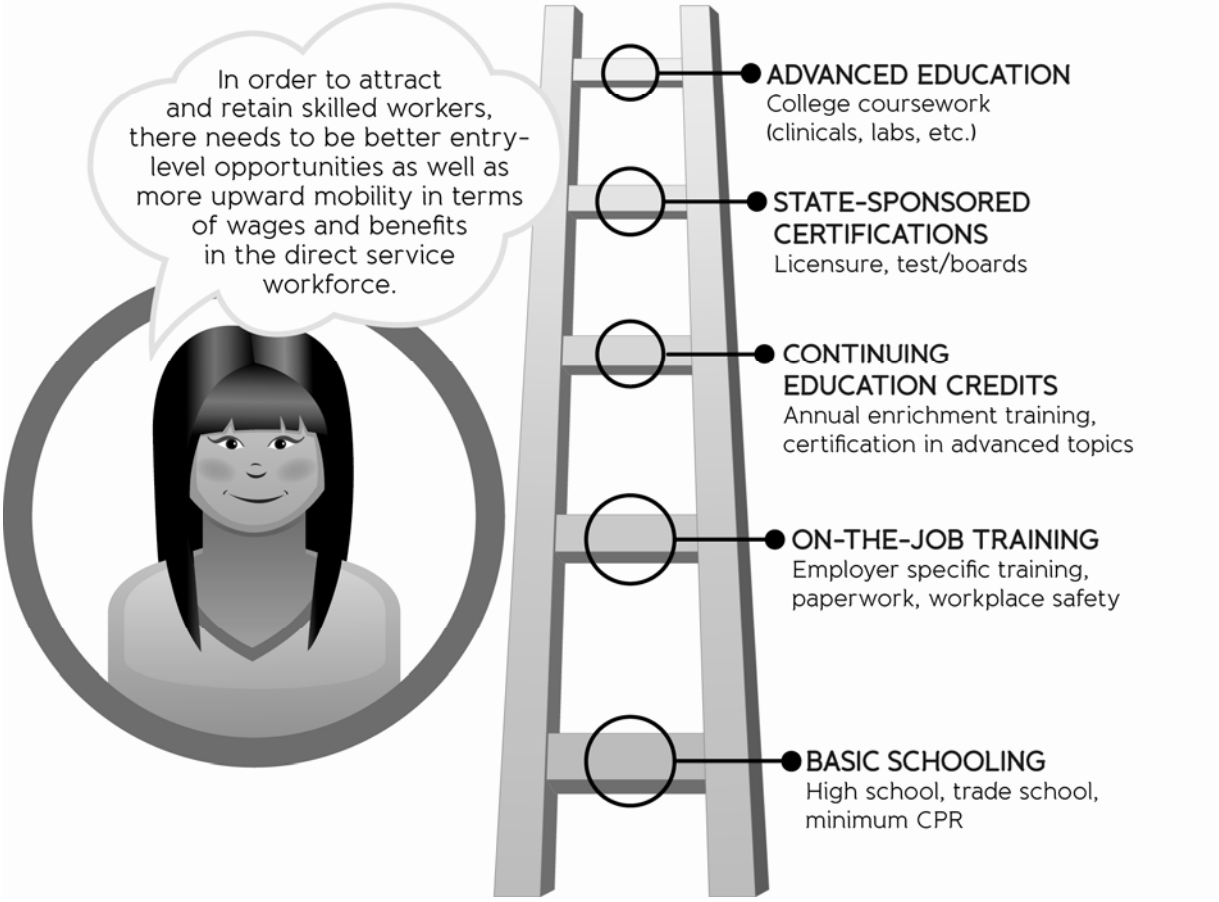
[41] Seavey and Marquand, 2011.

[42] Dawson, 2012.

[43] Seavey and Marquand, 2011.

# EXHIBIT 5.

*Proposed DSW Educational Career Ladder*




An additional area of future initiatives could be federal and state or private sector partnerships with universities, community colleges, and vocational programs to assist in the identification of skills and the development of training and curriculum in geriatric direct service work. Other avenues for partnerships could target worker shortfall areas identified by employers, as well as developing programs or curriculum that result in various levels of professional certification for DSWs. States need to proactively work to solve these problems, as PHI predicts that at the federal level there will be minimal changes, such as reauthorizing the Older Americans Act and the Workforce Investment Act. Even with new federal Affordable Care Act resources, eldercare and disability service systems vary from state to state and are uniquely shaped by each state's Medicaid policy. As such, direct state attention to these matters is expected to be necessary.[44]

[44] Dawson, 2011.

Governments, providers, and families need to be prepared for the growing number of people in the state who will need care, as well as the growing medical complexity of those care needs. The population of Americans over the age of 65 is growing at three times the rate of the population of family members available to care for them.[45] This affects the amount of non-family caregivers who are available as well. "Today's demographics are strikingly different from the labor supply conditions that existed from the 1960s to the early 1990s when increasing numbers of females were entering the labor force. Service delivery systems for in-home services and supports in the United States can no longer continue to rely on a steady supply of women with few other employment opportunities."[46] While the overall demand for direct service workers nationwide is projected to increase by 35 percent over the next decade, adding one million new openings by 2018, the number of women aged 25-54 – the main labor pool from which these workers are generally drawn – is projected to increase by less than two percent, down from over 14 percent just two decades ago.[47]

Federal and state governments have begun to implement a wide array of initiatives with the goal of improving the direct service workforce. In order for these initiatives to have widespread impact, they should be incorporated by both federal and state governments, as well as by provider organizations themselves. If they succeed, these initiatives (including training, certification, higher wages, the expansion of health care coverage, etc.) are expected to improve the field of jobs, expand quality care options for long-term care populations, promote economic recovery, and expand the middle class.[48]

[45] Seavey and Marquand, 2011.

[46] Ibid.

[47] Ibid.

[48] HHS, 2011.

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# Appendix: Florida Direct Service Workforce Employer Survey

## Survey Instructions

### Purpose of the Survey:

You received this survey because your organization receives funding to deliver Florida Medicaid HCBS supports and services to older adults and/or people of all ages with physical or intellectual/developmental disabilities. We are interested in information about all your employees who provide hands-on, direct services and support.

The Centers for Medicare and Medicaid Services has asked the Florida Department of Elder Affairs to gather and report basic information about the volume, stability, wages, and compensation of direct service workers (DSW). This information will allow state and federal policymakers to:

- Identify and set priorities for long-term support and services reform and systems change.
- Inform policy development regarding direct services workforce improvement initiatives.
- Promote integrated planning and coordinated approaches for long-term supports and services.
- Create a baseline against which the progress of workforce improvement initiatives can be measured.
- Compare workforce outcomes for various programs and populations to better evaluate the impact of policy initiatives.
- Compare state progress with the progress of other states and with overall national performance (where data from other states are available).

Information from this survey will help the federal and state governments develop ways to attract more workers into these jobs and keep workers in these jobs longer. The information from this survey can also assist organizations like yours understand how you compare to other organizations in your state, and how organizations in your state compare to those in other states (where data from other states are available). Your organization will be given the opportunity to see the results from Florida.

### Notice of Privacy:

Filling out this survey is voluntary. Your answers to these questions will be kept private under the guidelines of the Privacy Act and will not affect your status as a Medicaid HCBS waiver provider in Florida. Information will be kept private under the guidelines of the Privacy Act. This survey has been assigned a Survey ID number that appears at the bottom of every page. This number is the only way your organization will be identified; it will be kept separate from your responses and used only for the purpose of tracking which organizations complete the survey, so that we can follow up with organizations that do not fill it out to encourage a higher response rate and send you the survey results from Florida. Results of this survey will be reported only in the aggregate; your organization will not be identified in any way.

If you have any questions or concerns about the survey, please contact the DSW Resource Center at 1-877-822-2647.

*CMS-10404 (exp. Date 2/28/15)*

### Directions:

We encourage you to complete your survey online at:

https://www.research.net/s/Florida-Employer-Org

If you complete your survey online, please enter ‹‹123456›› when it asks for your Survey ID number. Alternatively, you may complete the paper survey enclosed and return your completed survey to *[address to be determined]* by mail using the stamped return envelope enclosed by *[date to be determined]*.

The survey will take approximately one hour to complete and will require access to your organization's personnel data. Please answer each question as accurately as possible. If you do not know the answer to one or more of the questions, please ask the person in your organization who would be able to provide an accurate answer. This survey should be completed by the person or group in your organization responsible for maintaining direct services worker records including wages, benefits, hiring, training, and tenure with your organization. If your organization is part of a larger national or state organization, please send the survey to your organization's headquarters, or contact them for answers to any questions that you do not know. Please complete this survey for all locations and workers employed by or contracted with across your entire organization in the categories listed below.

We encourage you to keep a copy of your answers to this survey as a baseline for your own organization so that you can monitor your progress in addressing staff recruitment, retention and training challenges over time and compare your organization's experiences to those of other organizations in Florida. You can learn more about effective recruitment and retention strategies at the Direct Service Workforce Resource Center *(www.dswresourcecenter.org)*.

Please refer to the following definitions as you complete this survey.

## Definitions: Types of Workers

**This survey is about people employed or contracted to be direct service workers. Direct service workers** may work in one or more type of service settings and with one or more populations. This includes all paid workers whose primary job responsibility is direct service work. The direct service workforce includes the following job titles and those in similar roles:

- Personal and home care aides
- Home health aides
- Direct support professionals
- Certified nursing assistants
- Homemakers
- Personal attendants

**Please include in your responses:**

- All people whose primary job responsibility is to provide support, training, supervision, and personal assistance to older adults and/or people of all ages with physical and/or intellectual disabilities with support needs.
- All part-time, full-time, intermittent and on-call direct service workers.
- All direct service workers from all branches, divisions, or offices.
- Contract or subcontracted workers who are not employed by your organization directly.

- All paid staff members who spend at least 50% of their hours doing direct service tasks. These people may do some supervisory tasks, but their primary job responsibility and more than 50% of their hours are spent doing direct service work.

**Only include** supervisors if more than 50% of their hours are spent doing direct service tasks.

**Do not include** licensed health care staff (nurses, social workers, psychologists, etc.), case managers, administrative staff, or full time managers or directors, unless they spend 50% or more of their hours providing direct, hands-on support and personal assistance or supervision to individuals with disabilities or older adults.

## Definitions: Workplace settings / services

This survey refers to the following services in Florida:

- Community living supports
- Personal care
- Home maker/ home chore
- Adult day services
- Respite
- Ongoing supported employment services

**Please include in your responses** direct service workers in the following settings:

a) **Residential services**—Supports provided to a person living in a community home with two or more people of any age with disabilities or who are aging (e.g., group home, Assisted Living Facility).

b) **In-home supports/Home care**—Supports provided to a person in their own home or in the home of a family member in which they reside.

c) **Day programs and rehabilitative or medical supports**—Supports provided outside an individual's home such as adult day services, rehabilitative services, day training and habilitation services, and disability specific non-school based services to children and youth with disabilities (e.g., respite, drop in centers).

d) **Job or vocational services**—Supports to help individuals to locate, acquire, and keep a job for which they are paid. This includes services such as job coaching, supported employment, work crews, sheltered workshops, and job training.

Do not include employees in the following settings:

- **People who work only in institutional settings** such as ICF-MRs, Skilled Nursing Facilities, Nursing Homes, Hospitals, or Rehabilitation Facilities. However, employees of institutional settings should be included if they work with people living in home and community settings.
- **People who are hired directly by the person or the person's family** for whom your organization's role is limited to being a fiscal intermediary/employer of record.
- People working only in school settings for children through 12$^{th}$ grade.
- **People working in child care facilities** unless they specifically support children with disabilities.
- **People providing therapy services** such as occupational therapists.

## Survey Questions

1. **Which of the following services does your organization currently provide? (check all that apply)**
   - ☐ Community living supports
   - ☐ Personal care
   - ☐ Home maker/home chore
   - ☐ Adult day services
   - ☐ Respite
   - ☐ Ongoing supported employment services
   - ☐ Other _____ (please indicate)

2. **Which of the following populations does your organization serve with Medicaid funds in home and community based settings in Florida? (check all that apply)**
   - ☐ People 65 years or older
   - ☐ People with physical disabilities
   - ☐ People with developmental disabilities / intellectual disabilities
   - ☐ People with mental health conditions / psychiatric disabilities
   - ☐ People with chemical dependency related support needs
   - ☐ People with chronic illnesses (including HIV/AIDS)
   - ☐ People with a traumatic brain injury

3. **To which of the following age groups does your organization provide home and community based supports? (check all that apply)**
   - ☐ Birth to 5 years
   - ☐ 6 to 18 years
   - ☐ 19 to 21 years
   - ☐ 22 to 40 years
   - ☐ 41 to 64 years
   - ☐ 65 to 74 years
   - ☐ 75 to 84 years
   - ☐ 85 or older

**4. In which county(ies) in Florida does your organization provide services?**

- ☐ ALACHUA
- ☐ BAKER
- ☐ BAY
- ☐ BRADFORD
- ☐ BREVARD
- ☐ BROWARD
- ☐ CALHOUN
- ☐ CHARLOTTE
- ☐ CITRUS
- ☐ CLAY
- ☐ COLLIER
- ☐ COLUMBIA
- ☐ MIAMI-DADE
- ☐ DESOTO
- ☐ DIXIE
- ☐ DUVAL
- ☐ ESCAMBIA
- ☐ FLAGLER
- ☐ FRANKLIN
- ☐ GADSDEN
- ☐ GILCHRIST
- ☐ GLADES
- ☐ GULF
- ☐ HAMILTON
- ☐ HARDEE
- ☐ HENDRY
- ☐ HERNANDO
- ☐ HIGHLANDS
- ☐ HILLSBOROUGH
- ☐ HOLMES
- ☐ INDIAN RIVER
- ☐ JACKSON
- ☐ JEFFERSON
- ☐ LAFAYETTE
- ☐ LAKE
- ☐ LEE
- ☐ LEON
- ☐ LEVY
- ☐ LIBERTY
- ☐ MADISON
- ☐ MANATEE
- ☐ MARION
- ☐ MARTIN
- ☐ MONROE
- ☐ NASSAU
- ☐ OKALOOSA
- ☐ OKEECHOBEE
- ☐ ORANGE
- ☐ OSCEOLA
- ☐ PALM BEACH
- ☐ PASCO
- ☐ PINELLAS
- ☐ POLK
- ☐ PUTNAM
- ☐ SANTA ROSA
- ☐ SARASOTA
- ☐ SEMINOLE
- ☐ ST. JOHNS
- ☐ ST. LUCIE
- ☐ SUMTER
- ☐ SUWANNEE
- ☐ TAYLOR
- ☐ UNION
- ☐ VOLUSIA
- ☐ WAKULLA
- ☐ WALTON
- ☐ WASHINGTON
- ☐ I am not sure/don't know

**5. Is your organization… (check only one answer)**

- ☐ Independent entity (i.e., not part of a chain or larger organization)
- ☐ Part of a chain, system or multi-organization structure (either within Florida or nationally)
- ☐ Government operated
- ☐ I'm not sure/don't know

**6. If your organization is part of a chain, please confirm that you will complete this survey for your local site only. (check only one answer)**

- ☐ Yes, I will provide data from this branch, division, or office only (a single service setting that is part of a larger organization)
- ☐ No, I will provide data for all the branches in Florida

**7. Excluding services provided to people in their own or a family member's home, how many different service locations [e.g. agency offices, residential group homes, supported employment sites, adult day centers, day programs] does your organization operate in Florida?**

☐ Total number of locations

☐ I am not sure/don't know

## Workforce Volume

The following questions are related to the number and assignments of the direct services workers your organization employs or contracts with to provide the services listed in Question #1.

**8. How many hours per week (not per pay period) do direct service workers have to work to be considered full-time employees at your organization?**

☐ Number of hours per week

☐ I am not sure/don't know

**9.** Does your organization contract with direct services workers who are not employees of your organization to provide the services listed in Question #1?

- ☐ Yes
- ☐ No
- ☐ I am not sure/don't know

**10.** How many total direct service workers did your organization employ or contract with on February 29, 2012? (check box below if using a different date)

_____ A) Number who work 36 or more hours per week

_____ B) Number who work 1 to 35 hours per week

_____ **Total** number of direct service workers (the sum of A plus B)

- ☐ Used date other than last day of past month_____ (please indicate)
- ☐ I am not sure/don't know

**11.** How many employed or contracted direct service workers work primarily in each of these types of settings? (please count each employee once, in the setting he or she works the most hours)

_____ A) Residential services

_____ B) In-home supports/Home care

_____ C) Day programs and rehabilitative or medical supports

_____ D) Job or vocational services

_____ **Total** number of direct service workers (the sum of A-D)

- ☐ I am not sure/don't know

**12.** How many people with a disability or who are aging does your organization currently support?

_____ **Total** number of people supported

- ☐ I am not sure/don't know

**13.** How many people does your organization currently support in each of the following settings? Individuals should be counted in more than one category if they receive services in more than one setting.

_____ A) Residential services

_____ B) In-home supports/Home care

_____ C) Day programs and rehabilitative or medical supports

_____ D) Job or vocational services

- ☐ I am not sure/don't know

## Workforce Stability

The following information will be used to calculate the turnover and vacancy rates for direct service workers that your organization employs or contracts with to provide the services listed in Question #1.

**14.** **How many direct service workers do you need to hire this week? Please include all full-time and part-time, on-call contract, and intermittent positions that are currently funded but have no specific person assigned. You might be using overtime or substitutes to cover these positions.**

☐ Number of new workers needed

☐ I am not sure/don't know

**15.** **In the last 12 months, how many direct service workers (including full-time, part-time, on-call, contract, or intermittent) left employment or stopped contracting with your organization for any reason (voluntary or involuntary)?**

☐ Total direct service workers who left the organization

☐ I am not sure/don't know

## Worker Compensation and Benefits

The following information will be used to determine the average wage rates and benefit levels for direct service workers your organization employs or contracts with to provide the services listed in Question #1. **Please use your organization's definition of full-time and part-time for this section. Please report average amounts across your organization.**

**16.** **What was the average starting hourly wage paid to full-time, part-time, on-call, or intermittent direct service workers who were hired in your organization over the last 12 months?**

$___.__ (per hour)

☐ I am not sure/don't know

**17.** **What is the current average hourly wage paid to all full-time, part-time, on-call, or intermittent direct service workers in each of the following types of services or settings?**

$___.__ (per hour) Residential services
$___.__ (per hour) In-home supports/Home care
$___.__ (per hour) Day programs and rehabilitative or medical supports
$___.__ (per hour) Job or vocational services
$___.__ (per hour) **Current average hourly wage across all services and settings**

☐ I am not sure/don't know

**18.** **Which of the following direct service workers are eligible to earn and use vacation or paid time off (excluding sick time) at your organization? (check all that apply)**

- ❑ Full-time direct service workers
- ❑ Part-time direct service workers
- ❑ On call or intermittent direct service workers
- ❑ Contracted full-time direct service workers
- ❑ No direct service workers are eligible for paid vacation or paid time off
- ❑ No paid vacation time or paid time off offered
- ❑ I am not sure/don't know

**19.** **Which of the following direct service workers are eligible to earn and use paid sick time? (check all that apply)**

- ❑ Full-time direct service workers
- ❑ Part-time direct service workers
- ❑ On call or intermittent direct service workers
- ❑ Contracted full-time direct service workers
- ❑ No direct service workers are eligible for paid sick time
- ❑ Paid sick time is not offered
- ❑ I am not sure/don't know

**20.** **Which of the following direct service worker groups are eligible for individual health insurance coverage through your organization? (check all that apply)**

- ❑ Full-time direct service workers
- ❑ Part-time direct service workers
- ❑ On call or intermittent direct service workers
- ❑ Contracted full-time direct service workers
- ❑ No direct service workers are eligible for health insurance coverage
- ❑ No health insurance coverage is offered
- ❑ I am not sure/don't know

**21.** **How many direct service workers (including full-time, part-time, on-call, contract, or intermittent) currently receive individual health insurance coverage through your organization?**

_____ Number of direct service workers receiving health insurance coverage through your organization

- ❑ I am not sure/don't know

## Training

**22.** For each topic listed below, please check the boxes next to the topics that your organization requires in-service or on-the-job training on (check all that apply).

| | *Yes, we require training on this topic.* |
|---|---|
| Advocacy | ❑ |
| Administering medications | ❑ |
| Assessing consumer needs | ❑ |
| Assisting with wound care, dialysis, catheter and/or ostomy care | ❑ |
| Behavior management | ❑ |
| Cariopulminary resuscitation (CPR) | ❑ |
| Communication | ❑ |
| Consumer confidentiality | ❑ |
| Conflict resolution | ❑ |
| Consumer empowerment | ❑ |
| Consumer rights | ❑ |
| Crisis prevention and intervention | ❑ |
| Cultural competence | ❑ |
| Direct service professionalism | ❑ |
| Documentation | ❑ |
| Ethics | ❑ |
| Facilitation of services (e.g., finding and getting services for the individual) | ❑ |
| Health and wellness | ❑ |
| Household management | ❑ |
| Infection control | ❑ |
| Interpersonal relationship skills | ❑ |
| Nutritional support | ❑ |
| Organizational participation | ❑ |
| Participant-directed service planning and implementation | ❑ |
| Personal care | ❑ |
| Problem solving | ❑ |
| Providing services based on needs of individual | ❑ |
| Safety and emergency training | ❑ |
| Stress management/personal safety and wellness | ❑ |
| Teamwork | ❑ |
| Transferring or lifting | ❑ |
| Vocational, educational and career support | ❑ |
| I am not sure/don't know | ❑ |

**23.** Check the boxes next to the topics you would identify as a critical training need for direct service workers in your organization (check at least three and all that apply).

| | *Yes, this is a critical* |
|---|---|

| | *training need for direct service workers in my organization.* |
|---|---|
| Advocacy | ❑ |
| Administering medications | ❑ |
| Assessing consumer needs | ❑ |
| Assisting with wound care, dialysis, catheter and/or ostomy care | ❑ |
| Behavior management | ❑ |
| Cariopulminary resuscitation (CPR) | ❑ |
| Communication | ❑ |
| Consumer confidentiality | ❑ |
| Conflict resolution | ❑ |
| Consumer empowerment | ❑ |
| Consumer rights | ❑ |
| Crisis prevention and intervention | ❑ |
| Cultural competence | ❑ |
| Direct service professionalism | ❑ |
| Documentation | ❑ |
| Ethics | ❑ |
| Facilitation of services (e.g., finding and getting services for the individual) | ❑ |
| Health and wellness | ❑ |
| Household management | ❑ |
| Infection control | ❑ |
| Interpersonal relationship skills | ❑ |
| Nutritional support | ❑ |
| Organizational participation | ❑ |
| Participant-directed service planning and implementation | ❑ |
| Personal care | ❑ |
| Problem solving | ❑ |
| Providing services based on needs of individual | ❑ |
| Safety and emergency training | ❑ |
| Stress management/personal safety and wellness | ❑ |
| Teamwork | ❑ |
| Transferring or lifting | ❑ |
| Vocational, educational and career support | ❑ |
| I am not sure/don't know | ❑ |

## Organizational cultural competence

Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations.[49]

**24.** Does your organization have a written plan for recruiting, retaining, and promoting staff who are representative of populations served?

- ❑ Yes
- ❑ No
- ❑ I am not sure/don't know

**25.** Are interpreters available if needed who are knowledgeable about healthcare terminology and can translate and/or interpret information to diverse populations?

- ❑ Yes
- ❑ No
- ❑ I am not sure/don't know

**26.** Does your organization have a written policy concerning cultural competence?

- ❑ Yes
- ❑ No
- ❑ I am not sure/don't know

**27.** If yes, which of the following populations are included in cultural competency training, plan, or policy at your organization? (check all that apply)

- ❑ Racial/ethnic minorities
- ❑ Language minorities
- ❑ Lesbian/gay/bisexual/transgender population
- ❑ Specific religious groups or faith-based affiliations
- ❑ AIDS/HIV status
- ❑ Disability status
- ❑ I am not sure/don't know

**28.** Do staff at your organization receive training in cultural competence?

- ❑ Yes
- ❑ No
- ❑ I am not sure/don't know

**29.** Does your training address key cultural related knowledge, skills, and attitudes of the populations served by your organization?

- ❑ Yes
- ❑ No
- ❑ I am not sure/don't know

Thank you for completing this survey.

[49] Five essential elements contribute to a system's institution's, or agency's ability to become more culturally competent, which include: 1) Valuing diversity, 2) Having the capacity for cultural self-assessment, 3) Being conscious of the dynamics inherent when cultures interact, 4) Having institutionalized culture knowledge, and 5) Having developed adaptations to service delivery reflecting an understanding of cultural diversity. For more information, visit the National Center for Cultural Competence at: http://www.nccccurricula.info/culturalcompetence.html

For paper surveys:

Please return it to *[address to be determined]* in the postage paid envelope provided.

**PRA Disclosure Statement**

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