Texas Direct Support Workforce Stability Survey

Status of the Direct Support Workforce Employed by Home and Community-Based Long-Term Services and Supports and Intermediate Care Facility Providers in Texas

Texas Department of Aging and Disability Services
Center for Policy and Innovation
Quality Assurance and Improvement

September 2010

Prepared by:
Elyse L. Luke, MSPH
Janie P. Eubanks, Ph.D.

Table of Contents

Acronyms 4
Executive Summary 5
Introduction 6
Methods 6
Key Findings 8
Workforce Statistics among All Direct Support Workers (HCBS and ICFs/MR) *8*
Workforce Statistics by Setting (HCBS or ICFs/MR) *12*
Percentage of Employers that Offered Benefits or Incentives *12*
Effect of Benefits or Incentives on Workforce Statistics *13*
How Findings fit with what is known about the Direct Support Workforce 18
State-Level Workforce Activities 18
National Health Care Workforce Commission 18
Implication of Findings 19
Technical Notes 21
Calculations of Percent Vacancies, Turnover, Longevity, and Stability *21*
References 22

Appendix A. Direct Support Staff Turnover Survey for Providers of Community and ICFs/MR Programs 24
Appendix B. Continuum of Long-Term Care (Hewitt et al., 2008) 32
Appendix C. Percentage of Employers that Offered Benefit or Incentive by Discipline (%) 33
Appendix D. Direct Support Workforce Statistics for Large State Residential Facilities in 2008 34
Appendix E. State-Level Workforce Activities 36
Appendix F. National Health Care Workforce Commission: Purpose and Definition of Health Care Workforce Commission 38

Table of Figures

Figure 1. Minimum Hours Worked per Week to Attain Full-time Status by Discipline 8
Figure 2. Employment Status by Discipline 9
Figure 3. Average Hourly Wage by Experience-Level and Discipline 9
Figure 4. Percent Vacancies by Employment Status and Discipline 10
Figure 5. Percent Turnover by Discipline 10
Figure 6. Length of Time Continuously Employed (Longevity) by Discipline 11
Figure 7. Length of Time Continuously Employed at Separation (Stability) by Discipline 11

Acronyms

CNA	Certified Nurse Aid
DADS	Texas Department of Aging and Disability Services
DSW	Direct Service Workforce
HCBS	Home and Community-Based Services
HHSC	Texas Health and Human Services Commission
ICF/MR	Intermediate Care Facility for Persons with MR
PIAC	Promoting Independence Advisory Committee
QMRP	Qualified Mental Retardation Professional
UNT	University of North Texas

Executive Summary

Introduction and Background

In June 2008, the Texas Department of Aging and Disability Services (DADS) undertook an exploratory study to examine the stability of the direct support workforce that provides long-term services and supports to people in home and community-based settings (HCBS) or intermediate care facilities for persons with MR (ICFs/MR). The purpose of the study was to (a) examine workforce indicators including, vacancies, turnover, longevity, and stability; (b) examine whether workforce statistics differed by setting (HCBS vs. ICFs/MR); and (c) explore whether benefits or incentives influenced workforce statistics.

Methods

Service providers were asked to voluntarily supply aggregate staff-related data for calendar year 2007 that included information about hire dates, separation dates, wages, hours worked, time continuously employed, and the number of staff that separated during 2007 for the following disciplines: case managers, certified nurse aid (CNAs), direct care staff, nurses, personal attendants, qualified mental retardation professionals (QMRPs), service coordinators, and therapists. Four-thousand four-hundred fifty-five surveys were distributed, and 1,025 were returned.

Key Findings

- Statistically significant differences in hourly wages, turnover, longevity, and stability statistics were observed between HCBS and ICFs/MR settings.
- The top five benefits sorted by the percentage of employers that offered the benefit were: paid vacation or paid holiday, paid sick leave, life insurance, paid personal leave or retirement/pension/401k plan, and partial health insurance for the employee.
- The top five incentives sorted by the percentage of employers that offered the incentive were: bonus or paid time off, in-house continuing education, gift cards or “give-aways,” reimbursement for workshops or conferences, and employee recognition.
- Benefits and incentives offered in specific combinations improved workforce stability statistics; combinations of benefits and incentives that improved workforce stability differed by discipline.
- Examination of individual benefits and incentives, not controlled for the effect of other benefits or incentives, suggest that insurance, paid time off, recruitment bonus, and a retirement, pension, or 401k plan improves workforce stability across multiple disciplines.

Significance of Study

Study findings provide information about (a) turnover, vacancy, longevity, and stability statistics of the state’s workforce; (b) differences in workforce statistics by setting (HCBS vs. ICFs/MR); (c) the frequency of employer-offered benefits or incentives; and (d) the influence of benefits or incentives on workforce statistics. While these findings shed light on the workforce at a single point-in-time, routine collection of data is needed to inform workforce policy and priorities, coordination of state workforce initiatives, and creation of state-level data that are comparable to national workforce statistics (National Direct Service Workforce Resource Center, 2009).

Introduction

Background

In June 2008, the Quality Assurance and Improvement unit in the Center for Policy and Innovation at DADS contracted the Survey Research Center at the University of North Texas (UNT) to distribute a survey to service providers of HCBS waiver programs and ICFs/MR to examine the stability of the direct support workforce in the state. DADS and UNT adapted a survey created by the Texas Center for Nursing Workforce Studies (Texas Department of State Health Services, 2008, *Study Design & Methods*) for the study. The "Direct Support Staff Turnover Survey for Providers of Community and ICF/MR Programs" (Appendix A) invited providers to voluntarily supply information about employees whose primary duties include hands-on, face-to-face contact with people who receive services including: personal attendants, case managers, service coordinators, direct care staff, QMRPs, therapists, CNAs, and nurses."

Purpose of Study

The purpose of the study was to:

1. Examine workforce statistics including the percentages of vacancies, turnover, length of time continuously employed (i.e., longevity), and length of time continuously employed at separation (i.e., stability).
2. Examine whether workforce statistics differed between HCBS and ICFs/MR settings.
3. Explore whether benefits or incentives influenced workforce statistics.

Methods

Data Collection

Data collection was done by asking providers for information about the following workforce statistics:

- ***Vacancy*** Vacancy was calculated as the number of vacant positions by the total number of direct support staff positions at the end of 2007.
- ***Turnover*** Turnover was calculated as the number of direct support staff that separated during the 2007 calendar year divided by the total number of direct support staff on the employer's payroll at the end of 2007.
- ***Longevity*** Longevity was determined by totaling the number of months of continuous employment (<6 months, between 6 and 12 months, and >12 months) at the end of 2007.
- ***Stability*** Stability was determined by totaling the number of months of continuous employment (<6 months, between 6 and 12 months, between 12 months and 5 years, and >5 years) for staff that separated during the 2007 calendar year.

Survey Instrument

The study survey, "Direct Support Staff Turnover Survey for Providers of Community and ICF/MR Programs" (Appendix A) asked service providers to supply information about direct support workers that were on the providers' payroll from January 1, 2007 to December 31, 2007. Providers were asked to voluntarily supply: (a) dates of hire or termination, (b) information about entry-level and maximum experienced-level wages, (c) hours worked, (d) time continuously employed, (e) number of staff that separated in 2007, and (f) benefits and incentives offered to direct support staff.

Survey Distribution to Service Providers and Response Rate

Surveys were mailed to providers between July and September 2008. The response rate was 23%; of 4,455 surveys distributed, 1,025 were returned. The response rate for providers with one to four contracts was 24.5%. The response rate for providers with five or more contracts was 19.7%. Of the surveys completed and returned, 670 (65.3% of all surveys returned) were validated (e.g., numerator data from various statistics added up to the relevant denominator by provider) and included in data analyses.

Data Analysis

Descriptive Data Analysis

Reported findings represent average figures across all providers that responded to the survey and supplied numerator and denominator data for each statistic (e.g., hourly wages, hours worked per week, vacancies, turnover, longevity, and stability). Detailed information about how vacancies, turnover, longevity, and stability statistics were calculated is provided in the Technical Notes section of this report.

Effects of Benefits or Incentives on Vacancy, Turnover, Longevity, or Stability

Statistical analyses to explore whether the 32 benefits or incentives (17 benefits and 15 incentives) employers could potentially offer employees had an effect on vacancies, turnover, longevity, or stability were done in two steps. First, factor analyses were done to reduce the 32 benefits and incentives down to only those factors that largely or entirely explained the influence of benefits or incentives on workforce statistics by discipline. Each factor provided information about (a) benefits and incentives that tended to be offered together and (b) benefits and incentives that tended not to be offered when other benefits or incentives were offered. An example of a factor is (a) the combined offer of long-term care insurance, shift differential, and a sign-on bonus and (b) the absence of reimbursement for professional license renewal fees and full dental insurance when long-term care insurance, shift differential, and a sign-on bonus were offered to case managers.

After factors were identified, regression analyses were performed on the factors to examine the influence of each factor on vacancies, turnover, longevity, or stability. Regression analyses were done on combined factors (like the example provided above) and individual factors (i.e., individual benefits or incentives). When reviewing the findings, readers should note that regression analyses done on combined factors supercede regression analyses done on individual factors because

combined factors account for the possibility that employers offered a combination of benefits or incentives rather than a single benefit or incentive.

The effect of combined or individual factors on workforce statistics were analyzed by combining staff employed in HCBS and ICFs/MR settings. Small sample sizes precluded comparisons between settings. Only statistically significant findings ($p<.05$ or $p<.01$) are presented in the report.

Examining the Direct Support Workforce by Setting

Data analyses were done by setting to examine whether workforce statistics differed by setting. The study sample included providers that employed people in residential rehabilitation settings (i.e., ICFs) and HCBS (i.e., community residential, supports to individuals and families, and non-residential community supports) (Appendix B). Even though the effects of benefits or incentives on workforce statistics could not be conducted by setting because of small sample sizes, other analyses were possible by setting (ICFs/MR vs. HCBS).

Key Findings

Workforce Statistics among All Direct Support Workers (HCBS and ICFs/MR)

Figure 1. Minimum Hours Worked per Week to Attain Full-time Status by Discipline

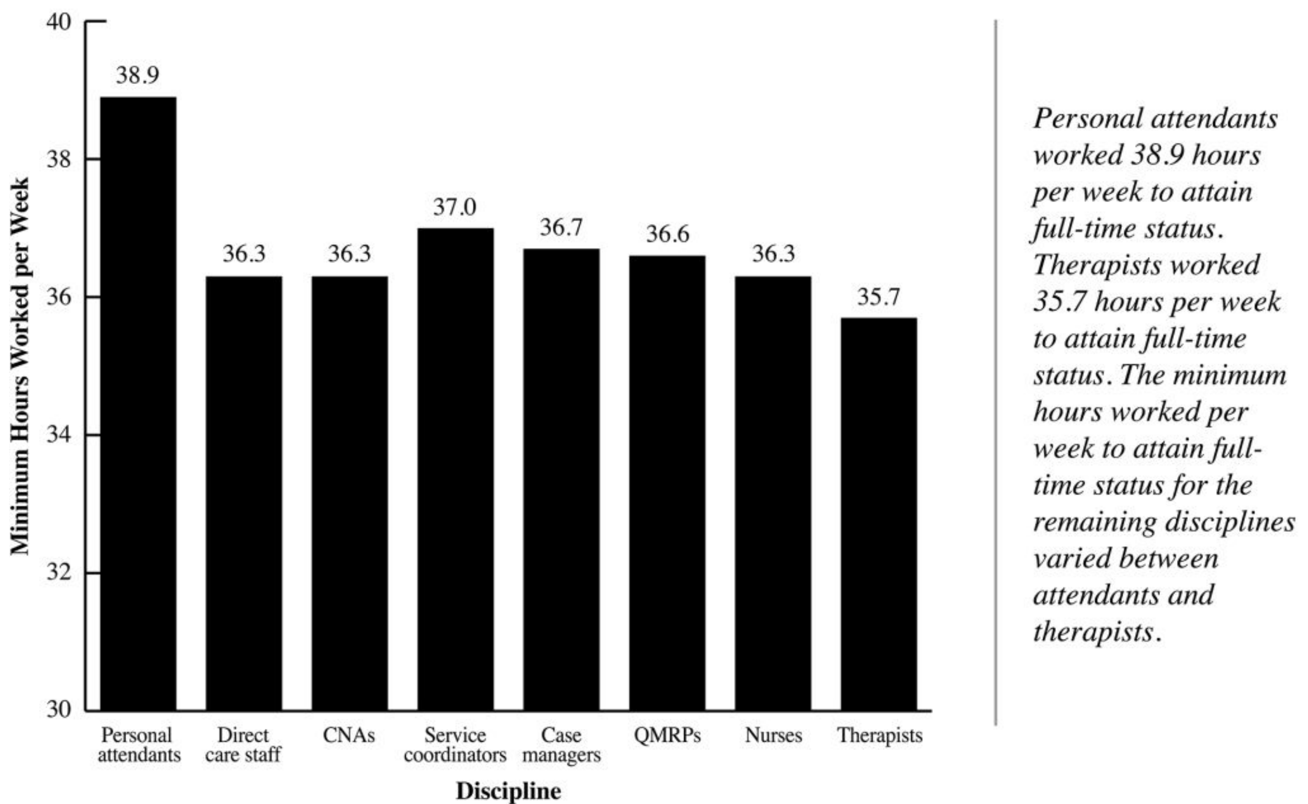
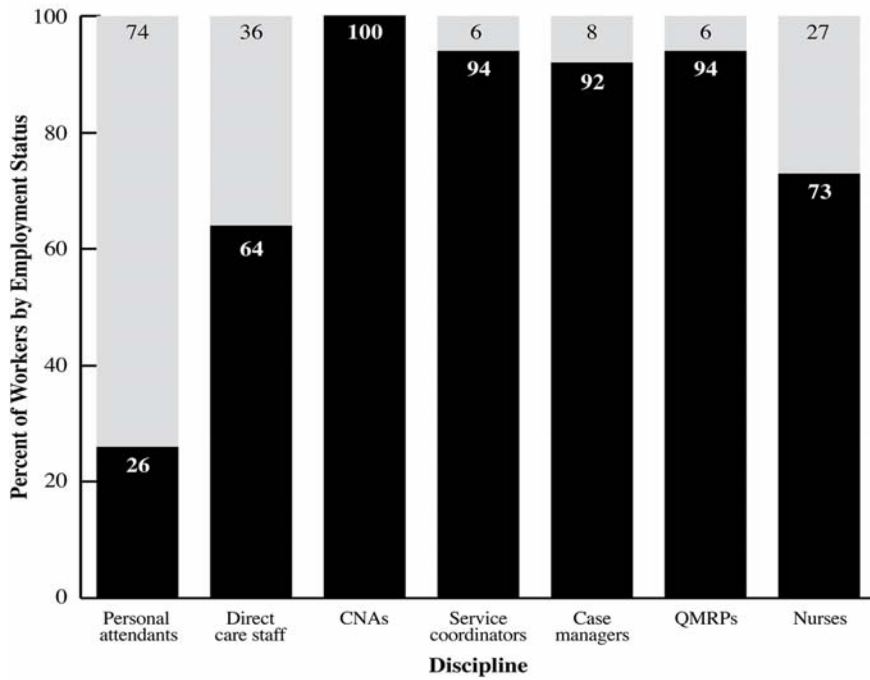
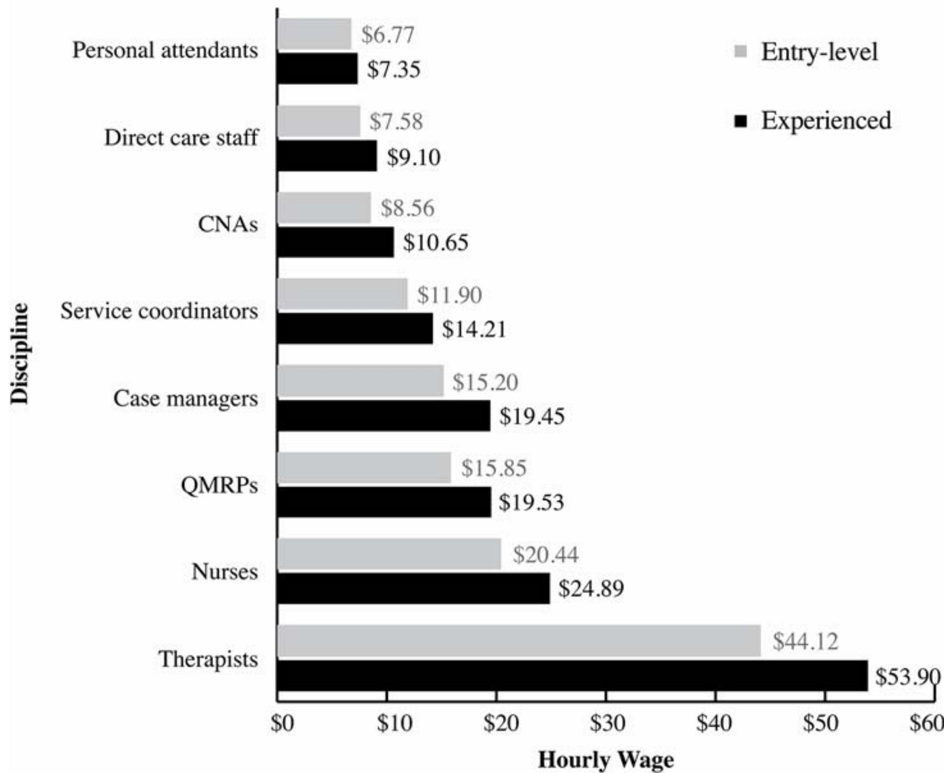


Figure 2. Employment Status by Discipline



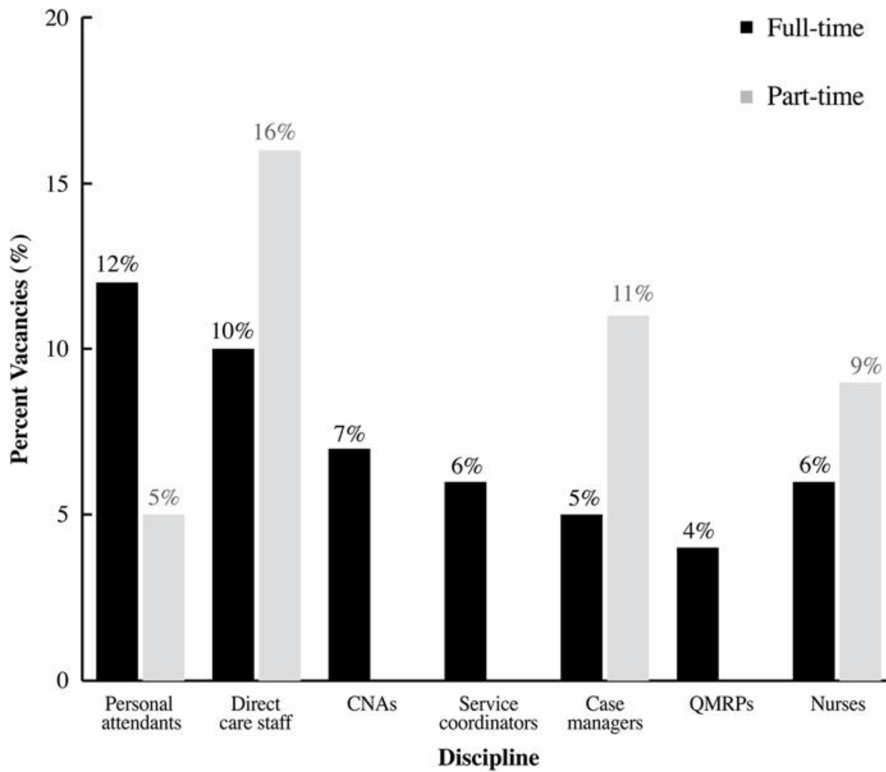
One-hundred percent of CNAs were employed full-time. More than 90% of service coordinators, case managers, and QMRPs were employed full-time. Seventy-three percent of nurses and 64% of direct care staff were employed full-time. The majority of personal attendants were employed part-time.

Figure 3. Average Hourly Wage by Experience-Level and Discipline



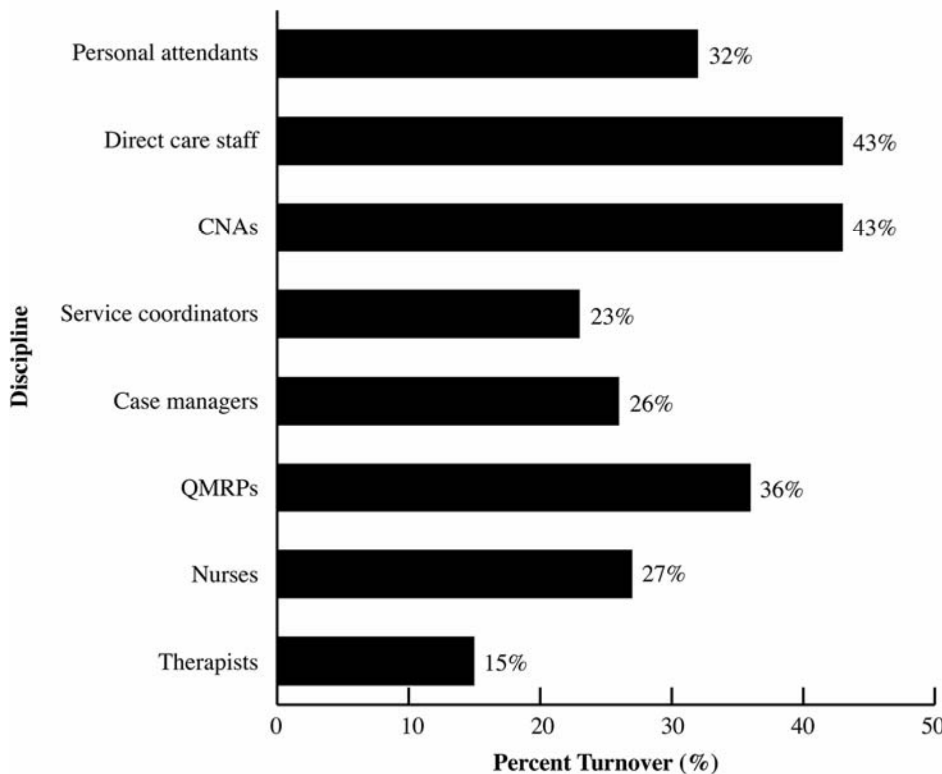
Professionals earned higher wages than paraprofessional direct support staff. Experienced workers earned more than entry-level workers in each discipline.

Figure 4. Percent Vacancies by Employment Status and Discipline



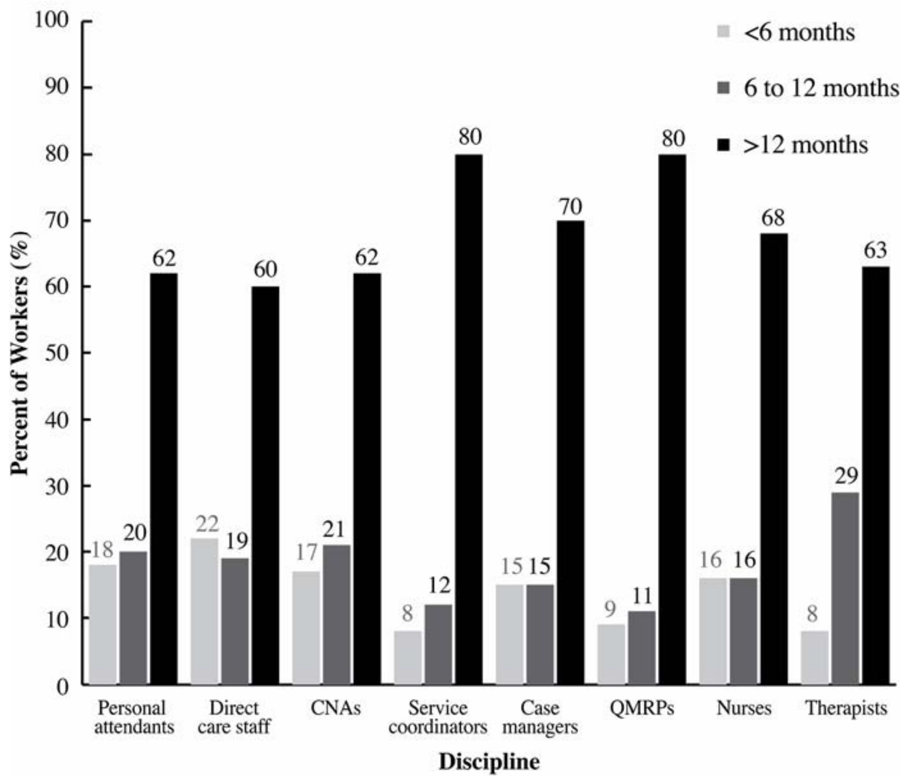
The percentage of part-time position vacancies was higher than full-time positions among direct care staff, case managers, and nurses. Among personal attendants, the percentage of full-time vacancies was higher than part-time vacancies.

Figure 5. Percent Turnover by Discipline



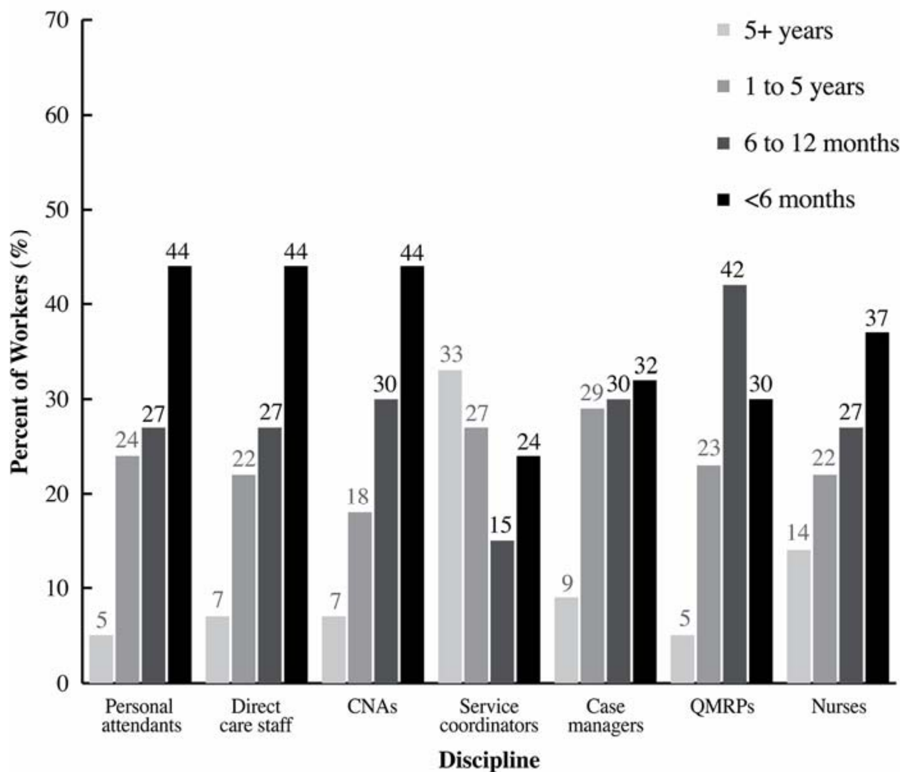
At 43%, CNAs and direct care staff had the highest turnover, followed by QMRPs, personal attendants, nurses, case managers and service coordinators. Turnover was lowest among therapists.

Figure 6. Length of Time Continuously Employed (Longevity) by Discipline



Between 60%-62% of personal attendants, direct care staff, and CNAs were continuously employed for more than 12 months. Twenty-two percent of direct care staff were employed for less than 6 months, followed by personal attendants (18%), and CNAs (17%). Eighty percent of service coordinators and QMRPs were continuously employed for more than 12 months.

Figure 7. Length of Time Continuously Employed at Separation (Stability) by Discipline



Thirty-three percent of service coordinators worked for 5 years or more at separation. Fourteen percent of nurses worked for 5 years or more at separation. With 44% working less than 6 months at separation, stability was lower among personal attendants, direct care staff, and CNAs.

Workforce Statistics by Setting (HCBS or ICFs/MR)
Only direct care staff, nurses, and service coordinators were included in analyses by setting because these were the only disciplines with a sufficient number of observations to conduct statistical analyses by setting. Statistically significant differences between settings included the following:

Hourly wage
- Entry-level wages were higher among direct care staff employed in ICFs/MR ($7.76) than HCBS ($7.47) settings in 2007 ($p<.01$).
- Entry-level wages were higher among nurses employed in HCBS ($21.01) than ICFs/MR settings ($18.97) in 2007 ($p<.01$).
- Maximum wages for experienced nurses were higher in HCBS ($25.58) than ICFs/MR ($22.96) settings in 2007 ($p<.01$).

Turnover
- Among direct care staff, turnover was higher in ICFs/MR (51%) than HCBS settings (38%) in 2007 ($p<.05$).

Longevity
- Longevity was higher among nurses employed in ICFs/MR than HCBS settings (78% were employed more than 1 year at separation vs. 65% in HCBS settings; $p<.01$).
- Longevity was higher among direct care staff employed in ICFs/MR than HCBS settings (66% were employed more than 1 year at separation vs. 56% in HCBS settings; $p<.01$)

Stability
- Separation after less than 6 months on the job was higher among direct care staff employed in ICFs/MR (14%) than HCBS settings (11%) ($p<.05$).
- Stability was higher among nurses employed in HCBS than ICFs/MR settings. Three percent of nurses employed in HCBS settings were employed more than 5 years at separation compared to 1% of nurses employed in ICFs/MR ($p<.01$).

Percentage of Employers that Offered Benefits or Incentives (Sample Average of all Disciplines)[1]
The five most frequently offered ***benefits*** were (percentage of employers that offered benefit):
1. Paid vacation or paid holiday (62%)
2. Paid sick leave (50%)
3. Life insurance (40%)
4. Paid personal leave (39%) or retirement/pension/401k plan (39 %)
5. Partial health insurance for employee (35%)

The five most frequently offered ***incentives*** were (percentage of employers that offered incentive):
1. Bonus or paid time off (42%)
2. In-house continuing education (31%)
3. Gift cards or "give-aways" (28%)
4. Reimbursement for workshops or conferences (28%)
5. Employee recognition (27%)

[1] The complete list of benefits or incentives employers offered is presented in Appendix C.

Effect of Benefits or Incentives on Workforce Statistics

The findings suggest combinations of employer-offered benefits and incentives reduced vacancies or turnover, or increased longevity or stability among personal attendants, direct care staff, CNAs, case managers, QMRPs, and nurses (Table 1). An interpretation of the effect of each combination of benefits and incentives by discipline follow Table 1. Incentives are presented in italics and benefits are not italicized.

Table 1. Summary of Effect of Combined Benefits or Incentives on Workforce Statistics by Discipline

Discipline	Effect of Combined Benefits or Incentives
Personal Attendant	Increased Longevity
Direct Care Staff	Increased Longevity
CNAs	Reduced Vacancies
Case Managers	Reduced Turnover Increased Longevity Increased Stability
QMRPs	Reduced Turnover Increased Stability
Nurses	Reduced Turnover Increased Stability

Personal Attendants

Benefits and Incentives Increased Longevity:
The more *bonus/paid time off, flex schedule/job share, gift cards or "give ways," in-house continuing education, perfect attendance rewards, a recruitment bonus, reimbursement for workshops/conferences,* and *shift differential* was offered in the absence of life insurance, long-term care insurance, partial dental insurance, partial health insurance for the employee and his or her family, partial vision insurance, and retirement/pension/401k plan, the higher the percentage of personal attendants that stayed on the job for at least 1 year.

Direct Care Staff

Benefits and Incentives Increased Longevity:
The more *career ladder positions, payback for unused sick/vacation time, shift differential* and *a sign-on bonus* was offered in the absence of full dental insurance and retirement/pension/401k plan, the higher the percentage of direct care staff that stayed on the job between 6 and 12 months.

CNAs

Benefits and Incentives Reduced Vacancies:
The more paid sick leave, paid personal leave, paid vacation/holiday leave, and some other benefit was offered in the absence of *reimbursement for workshops/conferences*, the lower the percentage vacancies among CNAs.

Case Managers

Benefits and Incentives Reduced Turnover:
The more *bonus/paid time off*, full dental insurance, full health insurance for the employee, and *in-house continuing education* was offered in the absence of partial paid dental insurance, partial health insurance for the employee, a

recruitment bonus, or some other benefit, the lower the percentage turnover among case managers.

Benefits and Incentives Increased Longevity:
The more *flex schedules/job share*, full health insurance for the employee and his or her family, partial vision insurance, *payback for unused sick/vacation time, reimbursement for professional license renewal fees,* and *tuition reimbursement* was offered in the absence of full dental insurance, the greater the percentage of case managers that stayed on the job between 6 and 12 months.

Benefits and Incentives Increased Stability:
The more *bonus/paid time off*, full dental insurance, full health insurance for the employee, and *in-house continuing education* was offered in the absence of partial paid dental insurance, partial health insurance for the employee, a *recruitment bonus*, or some other benefit, the smaller the percentage of case managers that separated after less than 6 months on-the-job or between 6 and 12 months on-the-job.

Also, the more full health insurance for the employee and full health insurance for the employee and his or her family was offered in the absence of *reimbursement for professional license renewal fees*, the smaller the percentage of case managers that separated after being on the job between 6 and 12 months.

In addition, the more long-term care insurance, *shift differential, and a sign-on bonus* was offered in the absence of *reimbursement for professional license renewal fees*, and full dental insurance, the smaller the percentage of case managers that separated between 6 and 12 months on the job and the greater the percentage of case managers that separated after at least 5 years on the job.

QMRPs

Benefits and Incentives Reduced Turnover:
The more *career ladder positions*, full health insurance for the employee and his or her family, full vision insurance, long-term care insurance, *reimbursement for professional license renewal fees*, and *tuition reimbursement* was offered in the absence of partial health insurance for the employee, and a *recruitment bonus*, the lower the turnover among QMRPs.

Benefits and Incentives Increased Stability:
The more *career ladder positions*, full health insurance for the employee and his or her family, full vision insurance, long-term care insurance, *reimbursement for professional license renewal fees*, and *tuition reimbursement* was offered in the absence of partial health insurance for the employee, and a *recruitment bonus*, the smaller the percentage of QMRPs that separated after working less than 6 months or between 6 and 12 months.

Also, the more full vision insurance, *a recruitment bonus*, *reimbursement for professional license renewal fees* or some other benefit was offered in the

absence of full health insurance for employee, and paid personal leave, the greater the percentage of QMRPs that worked between 1 and 5 years at separation.

Nurses	Benefits and Incentives Reduced Turnover: The more full dental insurance, full health insurance for the employee, full health insurance for the employee and his or her family, and full vision insurance was offered in the absence of *career ladder positions*, *a recruitment bonus, sign-on bonus*, or some other benefit, the lower the percentage turnover among nurses.
	Benefits and Incentives Increased Stability: The more full dental insurance, full health insurance for the employee, full health insurance for the employee and his or her family, and full vision insurance was offered in the absence of *career ladder positions*, *a recruitment bonus, sign-on bonus*, or some other benefit, the smaller the percentage of nurses that separated after working between 6 and 12 months.

Table 2 summarizes the effect of individual benefits or incentives on workforce statistics.

Table 2. Effect of Individual Benefits or Incentives on Workforce Statistics

Discipline	Benefit or Incentive[2]	Reduced Turnover	Reduced Vacancies	Increased Longevity[3]	Increased Stability	
					1-5 years	>5 years
Case Managers	Life insurance			√		
	Other incentive				√	
	Shift differential					√
CNAs	Long-term care insurance					√
	Paid personal leave					√
	Paid sick leave		√			
	Paid vacation/holiday		√			
	Payback for unused sick/vacation time					√
	Retirement/pension/401k plan		√			
	Tuition reimbursement	√				
Direct Care Staff	Full health insurance for employee	√				
	Full vision insurance					√
	Life insurance					√
	Other benefit				√	
	Retirement/pension/401k plan					√
Nurses	Full health insurance for employee	√				√
	Full health insurance for family			√		
	Paid personal leave		√		√	
	Paid sick leave				√	
	Paid vacation/holiday				√	√
	Partial dental insurance				√	
	Partial health insurance for employee				√	
	Partial health insurance for family				√	
	Retirement/pension/401k plan				√	
	Tuition reimbursement				√	
Personal Attendants	Partial vision insurance				√	
	Retirement/pension/401k plan				√	
QMRPs	*Bonus/paid time off*		√			
	Employee recognition				√	
	Flex schedule/job share				√	
	Full health insurance for employee	√				
	Life insurance		√			
	Long-term care insurance				√	
	Other benefit				√	
	Other incentive				√	
	Paid vacation/holiday		√			
	Partial dental insurance				√	
	Payback for unused sick/vacation time	√		√		
	Recruitment bonus				√	√
	Retirement/pension/401k plan		√			
Service Coordinators	Full health insurance for employee			√		
	In-house continuing education			√		
	Long-term care insurance					√
	Paid vacation/holiday	√				
	Partial dental insurance					√
	Partial vision insurance					√
	Recruitment bonus					√

[2] Effect of benefit or incentive on workforce statistics ($p<.05$); incentives are italicized, benefits are not.
[3] Longevity is defined as staying on-the-job for 12 months or more

The effect individual benefits or incentives had on workforce statistics across multiple disciplines are summarized below:

- Insurance
  - **Full health insurance** for the employee (a) reduced turnover among direct care staff, QMRPs, and nurses, (b) increased longevity among service coordinators, and (c) increased stability among nurses.
  - **Life insurance** (a) reduced vacancies among QMRPs, (b) increased longevity among case managers, and (c) increased stability among direct care staff.
  - **Long-term care insurance** increased stability among QMRPs, CNAs, and service coordinators.
  - **Partial dental insurance** increased stability among QMRPs, nurses, and service coordinators.
  - **Partial vision insurance** increased stability among personal attendants and service coordinators.

- Paid time off
  - **Paid personal leave** reduced vacancies and improved stability among nurses and improved stability among CNAs.
  - **Paid sick leave** reduced vacancies among CNAs and increased stability among nurses.
  - **Paid vacation or paid holidays** (a) reduced turnover among service coordinators, (b) reduced vacancies among CNAs and QMRPs, and (c) increased stability among nurses.
  - **Payback for unused sick or vacation time** reduced turnover and increased longevity among QMRPs and increased stability among CNAs.

- **Recruitment bonus** increased stability among QMRPs and service coordinators.

- **Retirement, pension, or a 401k plan** (a) reduced turnover among direct care staff, (b) reduced vacancies among CNAs and QMRPs, and (c) increased stability among personal attendants, nurses, and direct care staff.

How Findings fit with what is known about the Direct Support Workforce

Fitting in what was learned from this study to what is known about the direct support workforce is limited to direct service workers (i.e., personal attendants, direct care staff, and CNAs) and service coordinators because data about workforce indicators are most frequently reported on these disciplines. With respect to employment status, results from the study support PHI's report that, "A significant proportion of the direct-care workforce is employed part-time" (PHI, 2010, February, p. 2). A review of wages showed that the average hourly entry-level wage for direct care staff in ICFs/MR settings was $7.76 compared to $11.35 for direct support staff employed in large state residential facilities in the United States in 2008 (Lakin et al., 2009; Appendix D, Table D2). Lakin et al. (2009) suggest that lower starting wages for direct support professionals was one of three variables correlated with higher turnover ($r = 0.49$, $p<.0001$). Direct service worker turnover was comparable to turnover reported in home health settings in various states or regions (Hewitt et al., 2008, p. 11) (43% vs. 40-60%). At 23%, turnover among service coordinators was comparable with a 20% turnover rate reported by the NYS Office of Mental Retardation and Developmental Disabilities (2007) and a 19.7% national turnover rate reported by the Bureau of Labor Statistics (2005, as cited in NYS Office of Mental Retardation and Developmental Disabilities, 2007). With respect to health insurance, the data suggest health insurance coverage in Texas is lower than the reported 53% of direct-care workers that have employer-based coverage across the United States (PHI, 2010, February, p. 3). Finally, at 12%, the vacancy rate for personal attendants was the same as the average vacancy rate published by Engberg et al. (2009) who evaluated 10 programs in various states aimed at improving recruitment and retention of direct service workers.

State-Level Workforce Activities

Workforce activities at the state-level include but may not be limited to: (a) an HCBS workforce advisory council, (b) a realistic job preview activity targeted toward improving retention by recruiting people who have a realistic expectation about what direct support work entails, (c) stakeholder workforce recommendations supported by the Promoting Independence Advisory Committee (PIAC), and (d) nursing workforce studies conducted on people employed in nursing facilities. Detailed information about each of these activities is provided in Appendix E.

National Health Care Workforce Commission

The Patient Protection and Affordable Care Act of 2010 mandated creation of a National Health Care Workforce Commission to address health care workforce issues. One of the aims of the Commission is to evaluate whether the demand for health care workers is being met. The Commission will serve as a national resource for congress, the president of the United States, states, and communities. The 15-member commission is expected to be selected from nominee applications

in September 2010. Additional information about the purpose of the National Health Care Workforce Commission and the definition of the "health care workforce" is provided in Appendix F.

Implication of Findings

Significance of the Study

The study is significant because:

- The study provides state-specific workforce data of professional and paraprofessional direct support staff that provide hands-on, face-to-face contact with people who receive long-term services and supports.
- The study suggests workforce statistics differ by setting (HCBS vs. ICFs/MR).
- The study also suggests the influence of benefits or incentives on workforce statistics vary by discipline.
- The study further suggests that benefits or incentives related to insurance, paid time off, recruitment bonus, or retirement/pension/401k plan, in particular, reduces vacancies or turnover, or improves longevity or stability statistics across the direct support workforce.

Limitations of the Study

Limitations of the study include the following:

- Generalizability of findings is limited to service providers that responded to the survey because a non-probability sampling method (i.e., a convenience sample) was utilized.
- The report only presented benefits or incentives found to be associated with favorable outcomes (e.g., reduced vacancies or turnover, or improved longevity or stability). However, since the survey did not ask providers to supply reasons for offering a benefit or incentive, it is not possible to determine if a benefit or incentive was offered in response to an unfavorable outcome (e.g., increased vacancies or turnover, or reduced longevity or stability) or if the benefit or incentive consistently resulted in a favorable outcome. In addition, it is possible that benefits or incentives associated with unfavorable outcomes were beneficial but not reported because not enough time passed to determine if the benefit or incentive would have resulted in a favorable outcome.
- Comparison by setting (HCBS vs. ICFs/MR) was possible but comparison between disciplines was not because different disciplines were employed by providers.
- Since the tool was modified from the Texas Center for Nursing Workforce Studies survey, the tool was assumed to have face validity but the tool did not undergo formal validity testing prior to use.
- Estimates of workforce statistics may be imprecise because discipline types were not defined beforehand. The issue is particularly important for direct service workers because there is no consensus about workforce terminology (direct care staff vs. direct service staff vs. direct support professional). The survey assumed all providers define personal attendants and direct care staff in the same way but if providers defined these workers differently then imprecise workforce statistics were obtained.

- Some analyses could not be conducted because there were too few observations. For example, data regarding staff terminated due to results of a background check could not be done because too few staff were terminated due to the outcome of criminal background checks.

Recommendations for Future Workforce Activities

Findings from the study suggest the need to monitor the direct support workforce to prioritize strategies that have the greatest potential to improve workforce stability. Specific monitoring should include regular collection of basic workforce information to systematically monitor workforce initiatives, inform workforce policy, set priorities for long-term services and supports, promote coordinated workforce approaches, and compare state to national workforce data (National Direct Service Workforce Resource Center, 2009).

Technical Notes

Calculations of Percent Vacancies, Turnover, Longevity, and Stability

Vacancies

Vacancy rates were calculated using the same method for each discipline. For full-time vacancy positions, the numerator included the number of full-time positions for each discipline that were vacant at the end of 2007 (question 11 on the "Direct Support Staff Turnover Survey" used for the study). The denominator was the sum of the number of full-time positions that were vacant at the end of 2007 (question 11, *total*, on survey) plus the number of staff for each discipline that were employed full-time (question 10, *total*, on survey). Vacancy rates were calculated by dividing the numerator by the denominator and multiplying the result by 100.

Turnover

Turnover was calculated using the same method for each discipline. The numerator included the number of direct support staff that separated from an employer during the 2007 calendar year (question 6 on survey). The denominator included the number of 2007 year-end staff for each discipline (question 4 on survey). Turnover rates were calculated by dividing the numerator by the denominator and multiplying the result by 100.

Longevity

Longevity was calculated using responses to question 5 on the survey. The numerator was being continuously employed for less than 6 months (g), between 6 and 12 months (h), or over 12 months (i) at the end of 2007. The denominator is the sum of these responses ([(g) + (h) + (i)]). The percent staff continuously employed for each discipline was calculated by dividing the numerator (either (g), (h), or (i)) by the denominator ([(g) + (h) + (i)]) and multiplying the result by 100.

Stability

The length of time direct support staff were continuously employed at the time of separation was obtained from responses to question 7 on the survey. The numerator was being continuously employed for less than 6 months (k), between 6 and 12 months (l), between 12 months and 5 years (m), or 5 or more years (n) at the time of separation. The denominator is the sum of these responses ([(k) + (l) + (m) + (n)]). The percent staff separated for each discipline was calculated by dividing the numerator (either (k), (l), (m), or (n)) by the denominator ([(k) + (l) + (m) + (n)]) and multiplying the result by 100.

References

Engberg, J., Castle, N. G., Hunter, S. B., Steighner, L. A., & Maggio, E. (2009). *National evaluation of the demonstration to improve the recruitment and retention of the direct service community workforce* (Technical Report). Retrieved from http://www.rand.org/pubs/technical_reports/2009/RAND_TR699.pdf

Hewitt, A., Larson, S., Edelstein, S., Seavey, D., Hoge, M. A., & Morris, J. (2008). *A synthesis of direct service workforce demographics and challenges across intellectual/developmental disabilities, aging, physical disabilities, and behavioral health.*. Retrieved from http://rtc.umn.edu/docs/Cross-DisabilitySynthesisWhitePaperFinal.pdf

Lakin, K. C., Larson, S. A., Salmi, P. & Scott, N. (2009). *Residential services for persons with developmental disabilities: Status and trends through 2008*. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

Luke, E. (2008). *Stakeholder recommendations to improve recruitment, retention, and the perceived status of paraprofessional direct service workers in Texas*. Retrieved from Texas Department of Aging and Disability Services website: http://www.dads.state.tx.us/news_info/publications/studies/DSW-june2008.pdf

National Direct Service Workforce Resource Center (2009). *The need for monitoring the long-term care direct service workforce and recommendations for data collection.* Retrieved from National Direct Service Workforce Resource Center website: http://www.dswresourcecenter.org/tiki-index.php?page=Data+Collection

National Health Care Workforce Commission (2010, May 7). *Notices*, *75*(88), 25259. Retrieved from http://phinational.org/wp-content/uploads/2010/05/may-7-fed-reg-NHCW-Commisssion.pdf

NYS Office of Mental Retardation and Developmental Disabilities (2007). *Medicaid Service Coordination Retention Survey: Identifying best practices*. Retrieved from http://www.omr.state.ny.us/wt/images/wt_msc_retention_survey.pdf

PHI (2009). *State chart book on wages for personal and home care aides, 1999-2008*. Retrieved from http://phinational.org/policy/wp-content/uploads/phi_state_chartbook_phca_wages_99-08.pdf

PHI (2010, February). *Facts No. 3: Who are direct-care workers?* Retrieved from http://www.directcareclearinghouse.org/download/NCDCW%20Fact%20Sheet-1.pdf

PHI (2010, May 13). *Administration working to set up health care workforce commission*. Retrieved from PHI website: http://phinational.org/archives/administration-working-to-set-up-health-care-workforce-commission/

Promoting Independence Advisory Committee (2005, December). *Promoting Independence Advisory Committee 2005 stakeholder report*. Retrieved from http://www.dads.state.tx.us/providers/pi/piac_reports/piac_2005.pdf

Promoting Independence Advisory Committee (2006, October). *Promoting Independence Advisory Committee 2006 stakeholder report*. Retrieved from http://www.dads.state.tx.us/providers/pi/piac_reports/PIAC_2006.pdf

Promoting Independence Advisory Committee (2008, February). *Promoting Independence Advisory Committee 2007 stakeholder report*. Retrieved from http://www.dads.state.tx.us/providers/pi/piac_reports/PIAC-2007.pdf

Promoting Independence Advisory Committee (2008, October). *Promoting Independence Advisory Committee 2008 stakeholder report*. Retrieved from http://www.dads.state.tx.us/providers/pi/piac_reports/PIAC-2008.pdf

Promoting Independence Advisory Committee (2009, December). *Promoting Independence Advisory Committee stakeholder report*. Retrieved from http://www.dads.state.tx.us/providers/pi/piac_reports/PIAC-2009.pdf

Promoting Independence Advisory Committee (2010, March). *Interim 2010 Promoting Independence Advisory Committee stakeholder report: Recommendations for the 2010 Promoting Independence Plan and for agency legislative appropriations request*. Retrieved from http://www.dads.state.tx.us/providers/pi/piac_reports/piac-2010-interim.pdf

Texas Department of Aging and Disability Services, Texas Health and Human Services Commission (2010). Home and Community-Based Services Workforce Advisory Council: Preliminary Workforce Recommendations. Retrieved from http://www.dads.state.tx.us/hcbscouncil/HCBS-WAC-report-5%2020-10.pdf

Texas Department of State Health Services, Texas Center for Nursing Workforce Studies (2008, September). *2008 Long Term Care Nurse Staffing Survey: Highlights, conclusions and recommendations*. Retrieved from http://www.dshs.state.tx.us/chs/cnws/2008_LTC_highlights.pdf

Texas Department of State Health Services, Texas Center for Nursing Workforce Studies (2008, September). *2008 Long Term Care Nurse Staffing Study (LTC NSS): Study design & methods.* Retrieved from http://www.dshs.state.tx.us/chs/cnws/2008_LTC_design.pdf

The Patient Protection and Affordable Care Act of 2010, H.R. 3590, 111 Cong. (2010). Retrieved from http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf

Direct Support Staff Turnover Survey
For Providers of Community and ICF/MR Programs

All information will be kept confidential and only aggregate data
will be published or made available for analysis.

IMPORTANT INSTRUCTIONS

All data provided should be limited to information related to the contract shown on Question 1. The questionnaire collects data on direct support staff only and does not address administrative or supervisory staff.

To fill out this survey, you need to have the following information for all direct support staff who were on the payroll of the listed contract during the period from **January 1, 2007 - December 31, 2007**:

- Date of hire
- Date of termination (if applicable)
- Whether they are **current** staff or **separated** staff
- Whether they work **full-time** or **part-time** (current staff only)
- Hourly wage information and employment benefits provided

If you provide services to both adults AND children, you can still include all staff, even those who just work with children.

DEFINITIONS

For the purposes of this survey, use the following definitions:

Direct support staff: Employees whose primary duties include hands-on, face-to-face contact with people who receive services.

Includes: personal attendants, case managers, service coordinators, direct care staff, QMRP, therapists, CNA, and nurses.

Excludes: any of these positions whose responsibilities are primarily supervisory in nature.

2007 Year-end staff: Direct support staff (both full-time and part-time) that were on your payroll as of **December 31, 2007.**

Separated staff: Direct support staff that left your agency for any reason during the period of **January 1, 2007 - December 31, 2007**. Do not include workers who were promoted or transferred within the agency.

CONTRACT DETAILS

1)	All your responses should be based on the contract number that appears to the right		(a)
2)	Does your agency provide **residential** supports to adults or children on this contract?	☐1 YES ☐2 NO	(b)
	If yes, to how many individuals did this contract provide residential supports between January 1, 2007 and December 31, 2007?		(c)
3)	Do employees of your agency provide **day** supports on this contract (such as day habilitation, adult day care, employment or vocational services)?	☐1 YES ☐2 NO	(d)
	If yes, to how many individuals did this contract provide day supports between January 1, 2007 and December 31, 2007?		(e)

2007 YEAR-END DIRECT SUPPORT STAFFING

4) In the boxes below please write the number of **2007 year-end** direct support staff on this contract for each profession.

Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	Quality Mental Retardation Professional (QMRP)	Therapist	Certified Nurse Aid (CNA)	Total (f)

5) For the staff counts presented in question 4, detail the numbers that were **continuously employed** in a direct support capacity for each of the time ranges listed below.

	Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	Quality Mental Retardation Professional (QMRP)	Therapist	Certified Nurse Aid (CNA)	Totals
Less than 6 months									(g)
Between 6 and 12 months									(h)
Over 12 months									(i)

Note: lines (g) + (h) + (i) = (f). If totals do not agree, please re-check.

SEPARATED DIRECT SUPPORT STAFF

6) In the boxes below please write the number of direct support staff for each profession that left your agency during the 2007 calendar year (January 1, 2007 - December 31, 2007).

Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	Quality Mental Retardation Professional (QMRP)	Therapist	Certified Nurse Aid (CNA)	Total (j)

7) For the separated direct support staff counts presented in question 6, detail how long each had been **continuously employed** in a direct support capacity at the time they left the agency.

	Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	Quality Mental Retardation Professional (QMRP)	Therapist	Certified Nurse Aid (CNA)	Totals
Less than 6 months									(k)
Between 6 and 12 months									(l)
Between 12 months and 5 years									(m)
Over 5 years									(n)

Note: lines (k) + (l) + (m) + (n) = (j). If totals do not agree, please re-check.

FULL-TIME/PART TIME DISTINCTIONS

8) Does your agency distinguish between full-time and part-time direct support staff positions? ☐1 YES ☐2 NO (o)

If YES, answer questions 9 through 15.

If NO, skip to question 16 on page 6.

9) How is a **full-time** position defined? (**enter minimum number of hours per week**)

Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	Quality Mental Retardation Professional (QMRP)	Therapist	Certified Nurse Aid (CNA)	Total (p)

10) How many of your 2007 year-end direct support staff (from question 4) were considered **full-time** employees?

Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	Quality Mental Retardation Professional (QMRP)	Therapist	Certified Nurse Aid (CNA)	Total (q)

11) Enter the number of **full-time** direct support staff positions in each profession that were vacant at the end of 2007.

Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	Quality Mental Retardation Professional (QMRP)	Therapist	Certified Nurse Aid (CNA)	Total (r)

12) Add lines (q) + (r). Enter result in the box to the right. This figure represents your **total number of full-time direct support positions**. ☐ (s)

13) How many of your 2007 year-end direct support staff (from question 4) were considered **part-time** employees?

Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	Quality Mental Retardation Professional (QMRP)	Therapist	Certified Nurse Aid (CNA)	Total (t)

Note: lines (q) + (t) = (f). If totals do not agree, please re-check.

14) Enter the number of **part-time** direct support staff positions in each profession that were vacant at the end of 2007.

Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	Quality Mental Retardation Professional (QMRP)	Therapist	Certified Nurse Aid (CNA)	Totals (u)

15) Add lines (t) + (u). Enter result in the box to the right. This number represents your **total number of part-time positions**. [ ] (v)

STAFF COMPENSATION

16) Indicate the incentives that were offered to the full-time direct support professionals on this contract during the 2007 calendar year. (Circle all that apply)

		Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	QMRP	Therapist	Cert. Nurse Aid
0	None								
1	Employee recognition programs								
2	Reimbursement for workshops/conferences								
3	Reimbursement for professional license renewal fees								
4	Sign-on bonus								
5	Recruitment bonus								
6	Career ladder positions								
7	In-house continuing education classes								
8	Flexible scheduling or job sharing								
9	Shift differential								
10	Tuition reimbursement								
11	Perfect attendance rewards								
12	Bonus/paid time off								
13	Payback for unused sick / vacation time								
14	Gift cards or give-aways								
15	Other (specify)								

17) Indicate the benefits that were offered to the full-time direct support professionals on this contract during the 2007 calendar year. (Circle all that apply)

		Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	QMRP	Therapist	Cert. Nurse Aid
0	None								
1	Fully paid health insurance plan for employee								
2	Fully paid health insurance plan for employee spouse/dependents								
3	Partially paid health insurance plan for employee								
4	Partially paid health insurance plan for employee spouse/dependents								
5	Fully paid dental insurance								
6	Fully paid vision care insurance								
7	Partially paid dental insurance								
8	Partially paid vision care insurance								
9	Life Insurance								
10	Long Term Care Insurance								
11	Retirement / pension / 401k plans								
12	Paid vacation / holidays								
13	Paid sick days								
14	Transportation Allowance								
15	Daycare (child)								
16	Paid time off for “other/personal” reasons								
17	Other (specify)								

18) **If hired today**, what would be the hourly entry level and maximum experienced-level hourly wages of the direct support professionals related to this contract?

	Entry Level HOURLY Wages	**Maximum Experienced-Level HOURLY Wages**
Nurse	$_______._______	$_______._______
Personal Attendant	$_______._______	$_______._______
Case Manager	$_______._______	$_______._______
Service Coordinator	$_______._______	$_______._______
Direct Care Staff	$_______._______	$_______._______
Qualified Mental Retardation Professional (QMRP)	$_______._______	$_______._______
Therapist	$_______._______	$_______._______
Certified Nurse Aid (CNA)	$_______._______	$_______._______

19) For the full year 2007, what is the number of direct support staff working on this contract that were later terminated due to the results of criminal background checks? (*Enter the number in the box below for each profession*).

Nurse	Personal Attendant	Case Manager	Service Coordinator	Direct Care Staff	Quality Mental Retardation Professional (QMRP)	Therapist	Certified Nurse Aid (CNA)	Total

Thank you very much for taking the time to complete this survey.

Send the completed questionnaire in the business reply envelope to:

Survey Research Center
University of North Texas
P.O. BOX 310619
Denton, TX 76203-0619

Appendix B. Continuum of Long-Term Care (Hewitt et al., 2008)

Institutional Settings		Home and Community-Based Settings		
		Community Residential	**Supports to Individuals and Families**	**Non-Residential Community Supports**
• Nursing facility & residential rehabilitation *(e.g., SNFs, ICFs)*	• State operated institutions & large private institutions *(e.g., ICF/MR, residencies with 16 or more people, residential rehabilitation, psychiatric hospitals, VA hospitals, residential schools/ colleges)*	• 24-hr residential supports & services *(e.g., group home, supported living, arrangement, supervised living facility, assisted living, residential treatment)* • Less than 24-hr residential supports and services *(e.g., semi-independent living services, home-based/family preservation)*	• Home health care services • Personal care services (agency-directed) • Personal care services (consumer directed)	• Day programs & rehabilitative or medical supports *(e.g., day services for seniors, MH day services, adult day programs, rehabilitation for working age adults, outpatient treatment, detoxification programs, methadone treatment, homeless shelters)* • Job or vocational services (e.g., supported employment, work crews, sheltered workshops, job training)

Appendix C. Percentage of Employers that Offered Benefit or Incentive by Discipline (%)

Benefit or *incentive*[4]	Personal attendants	Direct care staff	CNAs	Service coordinators	Case managers	QMRPs	Nurses	Therapists	Sample Average
Paid vacation/holiday	26	72	50	69	73	92	61	49	62
Paid sick leave	19	54	44	56	60	75	50	41	50
Bonus/paid time off	*22*	*49*	*33*	*46*	*52*	*67*	*43*	*25*	*42*
Life insurance	13	45	29	39	50	68	39	39	40
Paid personal leave	17	41	32	37	44	59	39	46	39
Retirement/pension/401k plan	19	44	25	35	45	70	34	37	39
Partial health insurance for employee	10	43	25	30	47	65	34	29	35
In-house continuing education	*21*	*39*	*31*	*29*	*38*	*36*	*31*	*22*	*31*
Gift cards or "give-aways"	*25*	*37*	*24*	*25*	*31*	*33*	*29*	*19*	*28*
Reimbursement for workshops/conferences	*7*	*20*	*14*	*30*	*46*	*47*	*36*	*20*	*28*
Employee recognition	*19*	*35*	*26*	*19*	*29*	*38*	*27*	*24*	*27*
Flex schedule/job share	*17*	*28*	*21*	*25*	*35*	*23*	*27*	*29*	*26*
Transportation allowance	6	21	19	24	39	33	26	20	24
Partial dental insurance	8	22	12	18	24	39	21	25	21
Partial health insurance for family	4	19	11	11	18	28	18	22	16
Payback for unused sick/vacation time	*11*	*19*	*10*	*16*	*13*	*24*	*16*	*10*	*15*
Partial vision insurance	7	17	9	14	11	30	14	12	14
Full health insurance for employee	4	13	8	17	15	20	15	7	12
Long-term care insurance	4	13	8	10	13	23	11	14	12
Full dental insurance	2	12	9	8	12	22	11	8	11
Tuition reimbursement	*4*	*11*	*10*	*8*	*11*	*16*	*10*	*7*	*10*
Career ladder position	*1*	*14*	*4*	*6*	*16*	*16*	*7*	*5*	*9*
Other benefit	4	7	5	7	13	2	7	0	6
Recruitment bonus	*1*	*8*	*4*	*1*	*14*	*8*	*6*	*5*	*6*
Other incentive	*3*	*9*	*5*	*6*	*6*	*8*	*6*	*2*	*6*
Reimbursement for professional license renewal fees	*2*	*4*	*2*	*3*	*8*	*6*	*12*	*8*	*6*
Full vision insurance	0	4	2	4	4	4	3	0	3
Full health insurance for family	1	2	3	3	2	4	2	3	3
Shift differential	*3*	*8*	*6*	*2*	*2*	*1*	*3*	*0*	*3*
Perfect attendance rewards	*4*	*4*	*3*	*3*	*4*	*0*	*2*	*3*	*3*
Sign-on bonus	*0*	*2*	*2*	*0*	*2*	*0*	*5*	*3*	*2*
Childcare	0	1	0	1	0	1	0	0	0

[4] Benefits are not italicized; *incentives are italicized*.

Appendix D. Direct Support Workforce Statistics for Large State Residential Facilities in 2008

Lakin, Larson, Salmi, and Scott (2009) surveyed administrators of large (16 or more residents) state intellectual and/or developmental disabilities residential facilities or units operating on June 30, 2008 and found that Texas reported the largest number of direct support staff with 5,381 full-time equivalent (FTE) (Table D1).

Table D1. Number and Percentage of FTE Staff by Discipline in Large State Facilities on June 30, 2008 (Lakin et al., 2009)

	Texas		Total Reported U.S.[5]		Estimated Totals in U.S.	
Discipline	Number	Percent	Number	Percent	Number	Percent
Physicians	38	0.4%	330	0.5%	430	0.5%
Nurses	1,128	11.7%	6,054	8.4%	7,901	8.8%
Teachers/Aides	181	1.9%	1,500	2.1%	1,958	2.2%
Psychologists	140	1.4%	722	1.0%	943	1.1%
OT/PT	78	0.8%	534	0.7%	696	0.8%
Speech	35	0.4%	353	0.5%	461	0.5%
Other QMRP	182	1.9%	1,498	2.1%	1,955	2.2%
Direct Support (Aides)	5,381	55.6%	38,357	53.2%	50,059	55.8%
Other Direct Service	275	2.8%	3,433	4.8%	4,481	5.0%
Administration/Management	421	4.4%	5,100	7.1%	5,321	5.9%
Support Personnel	1,816	18.8%	14,282	19.8%	15,439	17.2%
Total	9,676	100%	72,163	100%	89,643	100%

In 2008, Texas was one of six states reporting turnover rates exceeding 50%: Georgia (100.9%), Nebraska (66.3%), Alabama (59.7%), Louisiana (59.3%), Texas (56.2%), and Mississippi (55.5%) (Table 20). When asked about common workforce concerns, 56% of large state facility administrators ranked direct support professional turnover as their biggest concern. Other concerns included "finding qualified direct support professionals (47%), new hires quitting during their first six months of employment (33%), and direct support wages and benefits (31%)" (Lakin et al., 2009, p. 58).

[5] 50 states and Washington, D. C.

Table D2. Wage, Turnover, and Vacancy Statistics for Direct Support Staff (e.g., Aides) in June 2000, 2002, 2004, 2006, 2008 (Lakin et al., 2009, pp. 56-57)

	Texas				National			
Year	Mean Starting Wage ($)	Average Wage ($)	Turnover (%)	Vacancies (%)	Mean Starting Wage ($)	Average Wage ($)	Turnover (%)	Vacancies (%)
2000	7.79	8.56	40.0	8.1	9.19	11.57	27.0	7.7
2002	7.97	9.27	39.5	5.8	9.62	12.33	28.0	5.6
2004	8.10	8.83	38.4	4.9	10.12	12.53	28.5	5.8
2006	8.44	9.44	37.6	6.2	11.06	13.17	27.3	6.7
2008	9.58	10.24	56.2	7.7	11.35	14.13	29.6	6.9

In 2008, Pearson correlation coefficient analyses showed that three variables were significantly correlated with higher direct support professional turnover rates: lower daily per diem ($r=-0.22$, $p<.05$), facilities with lower starting wages for direct support professionals ($r=-0.49$, $p<.0001$), and facilities located in the South Census Region ($r=0.52$, $p<.0001$). Multiple regression analyses showed that direct support professionals wage ($p<.05$) and In South Census Region ($p<.05$) helped account for 28.5% of the variability of direct support turnover rates at facilities participating in the survey (Lakin et al., 2009, pp. 62-63).

Appendix E. State-Level Workforce Activities

Home and Community-Based Services Workforce Advisory Council

Senate Bill 1850 (81st Legislature, Regular Session, 2009) would have created an HCBS Workforce Advisory Council (Council) to address issues of recruitment and retention within the direct service workforce (DSW), but did not pass. In August 2009, Texas Health and Human Services Commission (HHSC) Executive Commissioner Thomas M. Suehs directed HHSC and DADS to establish a council modeled after Senate Bill 1850. The Council was charged with analyzing current and anticipated funding needs and developing policy and funding recommendations related to the HCBS workforce. The Council used stakeholder recommendations reported in, "Stakeholder Recommendations to Improve Recruitment, Retention, and the Perceived Status of Paraprofessional Direct Service Workers in Texas" (Luke, 2008) as its starting point. The Council's preliminary report of recommendations was completed in May 2010 (DADS, HHSC, 2010). A final report detailing the Council's recommendations to address direct support workforce issues in HCBS settings is expected to be delivered to Executive Commissioner Suehs in November 2010.

Realistic Job Previews: Reduces Turnover due to Unrealistic Expectations

In September 2005, the RAND Corporation, with assistance from the University of Pittsburgh Graduate School of Public Health and the American Institutes for Research, initiated a national evaluation of each of ten demonstration grants made by the Centers for Medicare and Medicaid Services to improve recruitment and retention of direct service workers. Key findings from the "National Evaluation of the Demonstration to Improve the Recruitment and Retention of the Direct Service Community Workforce" report included, "that the realistic job preview initiative was well received by participants, and the outcome evaluation showed that it had a positive association with outcomes, suggesting that increased information about the nature of the job will reduce turnover due to unrealistic expectations" (Engberg, Castle, Hunter, Steighner, & Maggio, 2009, Summary, p. xv). Engberg et al. (2009) suggest that of the strategies piloted, in addition to making workers feel valued by promoting the occupation of direct care work, recognizing long-serving and high-performing workers, and offering health coverage benefits, even though not tailored to the workers' needs, a realistic job preview provided by job preview videos was positively associated with recruitment, retention, and job satisfaction (p. xiv).

In June 2009, DADS began work on two 15-20 minute realistic job preview videos that will be made available to service provider agencies and individuals hiring direct support workers. The first video was completed in early 2010 and targets applicants seeking to work with people who have a developmental disability. The second video is expected to be completed in late 2010 and will target applicants seeking to work with people who are older and/or have a physical disability. Like the realistic job preview videos evaluated by RAND (Engberg et al., 2009), these videos will increase awareness about direct support work, including its rewards and challenges, so direct support applicants can decide if they are a good fit with direct support work.

Workforce Issues: A Priority of PIAC Stakeholders

PIAC identified workforce issues as a priority in each of six PIAC stakeholder reports (PIAC, 2005, 2006, 2007, 2008, 2009; PIAC, 2010, Interim Report). The Committee states, "an available and competent workforce must exist…in order to ensure that institutional transition to the community is successful" (PIAC, 2005, p. 28) and that workforce issues must be addressed "if community-based services are to be an option of every individual" (PIAC, 2007, p. 25). In November 2006, PIAC appointed a workforce subcommittee--the Direct Service Workforce (DSW) Advisory Committee--to advise development and implementation of an intensive technical assistance award the Texas HHSC received from the Centers for Medicare and Medicaid Services National DSW Resource Center. HHSC delegated daily management and completion of the DSW Initiative to DADS. The Workforce Subcommittee advised DADS to hold a DSW forum in Austin, TX, followed by a series of four smaller focus groups-one each in El Paso, Houston, Progresso, and San Angelo-to obtain stakeholder input on workforce issues. In June 2008, stakeholder input collected from these stakeholder activities were reported in, "Stakeholder Recommendations to Improve Recruitment, Retention, and the Perceived Status of Paraprofessional Direct Service Workers in Texas" (Luke, 2008). The stakeholder report was used as the starting point for workforce activities initiated by the HCBS Workforce Advisory Council (described above) in August 2009. The report concluded that improving recruitment, retention, and the perceived status of paraprofessional direct service workers in Texas called for compensation, opportunity, and support of direct service workers.

Texas Center for Nursing Workforce Studies

The Texas Center for Nursing Workforce Studies is a unit within the Center for Health Statistics at the Texas Department of State Health Services. In 2008, the Statewide Health Coordinating Council and the Council's Texas Center for Nursing Workforce Studies Advisory Committee published the "2008 Long Term Care Nurse Staffing Survey" (HHSC, 2008, *Highlights, Conclusions, and Recommendations*). The report summarizes turnover rates, vacancy rates, and the effects of compensation and benefits on nursing staff longevity for nurses employed in nursing facilities.

Appendix F. National Health Care Workforce Commission: Purpose and Definition of Health Care Workforce Commission

On May 7, 2010, a notice was published in the *Federal Register* soliciting letters of nomination for a 15-member National Health Care Workforce Commission (National Health Care Workforce Commission, 2010). The Government Accountability Office's Comptroller General of the U.S. will review nominee applications and will appoint members to the Workforce Commission. The Workforce Commission "is one of many provisions to take effect during the first year of the health reform law's passage; appointments are to be made no later than September 30, 2010" (PHI, 2010, May 13).

The purpose of the National Health Care Workforce Commission is to (The Patient Protection and Affordable Care Act of 2010, 2010, p. 474):

- Serves as a national resource for Congress, the President, States, and localities;
- Communicates and coordinates with the Departments of Health and Human Sevices, Labor, Veterans Affairs, Homeland Security, and Education on related activities administered by one or more of such Departments;
- Develops and commission evaluations of education and training activities to determine whether the demand for health care workers is being met;
- Identifies barriers to improved coordination at the Federal, State, and local levels and recommend ways to address such barriers; and
- Encourages innovations to address population needs, constant changes in technology, and other environmental factors.

The definition of the health care workforce follows:

> The term "health care workforce" includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, opthamologists, physician assistants, pharmacists, dentists, dental hygenists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate (The Patient Protection and Affordable Care Act of 2010, 2010, p. 480).