Vermont Health Care Innovation Project

Health Care Workforce Workgroup

Subcommittee on Long Term Care

Direct Care Workforce

October 10, 2014

EXECUTIVE SUMMARY

Vermont's population is aging and will continue to age over the next 20 years. According to Census information, the number of Vermonters age 75-79 will increase by 156% from 15,960 Vermonters in 2010 to 40,910 by 2030. Census information also shows that 13% of the population (83,148 Vermonters) had disabilities in 2010 and will likely grow as a similar percentage of the total population in 2030 as it is in 2010.[i]

Ages	**2010 Census**	**2020 estimate (% change from 2010)**	**2030 estimate (% change from 2010)**
65-69	29,390	47,672 (62.2%)	50,168 (70.7%)
70-74	20,148	38,677 (92.0%)	50,579 (151.0%)
75-79	15,960	24,908 (56.1%)	40,910 (156.3%)
80-84	12,783	14,802 (15.8%)	28,701 (124.5%)
85+	12,797	16,157 (26.3%)	23,707 (85.3%)

Total population – State of Vermont	**619,928**
Total with a disability	83,148 (13.4%)
Total population under 18	123,563
Total population under 18 with a disability	6,820 (5.5%)
Total population age 18 to 64	401,075
Total population age 18 to 64 with a disability	46,401 (11.6%)
Total population age 65 and older	95,290
Total population age 65 and older with a disability	29,927 (31.4%)

Direct Care Workers (DCWs) play an important role in caring for older Vermonters and Vermonters with disabilities. As the population of older Vermonters and Vermonters with disabilities continues to increase, the demand for direct care workers will also increase.

This subcommittee of the Vermont Health Care Innovation Project's Healthcare Workforce Committee was formed in part as an alternative to Vermont House Bill 301, which was introduced in the 2013-2014 legislative session. H. 301 proposed to establish a task force that would assess whether the need to train and license DCWs exists. H.301 defined direct care worker "*as an individual who is reimbursed by the State to assist adults residing in community settings not licensed by the State with activities of daily living and instrumental activities of daily living.*[ii]" ADLS as defined by Vermont's Choices for Care 1115 Medicaid Long Term Care regulations include dressing and undressing, bathing, personal hygiene, bed

mobility, toilet use, transferring, mobility in and around the home, and eating.[iii] Direct Care Workers also provide assistance with companion and respite services as well as assistance with instrumental activities of daily living (IADLs). IADLs are defined by Vermont's Choices for Care 1115 Medicaid Long Term Care regulations to include meal preparation, medication management, phone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment.[iv] The H. 301 definition of DCWs will be used in this report. This **does not** include individuals who work for providers/facilities that are licensed by the state; Assisted Living Residences, Home for the Terminally Ill, Nursing Homes, Residential Care Homes or Therapeutic Community Residences.[v] However, some recommendations may also impact or be applied to these workers as well. The recommendation for micro-simulation demand modeling applies to all DCWs.

Vermont has been fortunate to have had many grant funded efforts over the last 10-15 years to study and make improvements in the Long Term Care Direct Care Workforce environment. The key findings and recommendations of these studies will be summarized in this paper. Overall, these studies found that training and reasonable wages are key to an effective direct care workforce because they promote recruitment and retention of direct care workers. This subcommittee endorses these findings. The subcommittee also finds that while there has been some progress in Vermont to address wages and benefits for DCWs, there continues to be a need for comprehensive, standardized, accessible training for these workers.

Many of the recommendations listed below are also included in the work of the Vermont Self Determination Alliance. This group met earlier in 2014, as the Vermont Agency of Human Services was negotiating a collective bargaining agreement with Vermont Homecare United/American Federation of State, County and Municipal Employees, (AFSCME), to discuss recommendations for DCWs which they referred to as Independent Direct Support Providers. Please see Appendix E for the full list of VT Self Determination Alliance recommendations.

Findings

1. As Vermont's population ages, there will be an increased need for DCWs.

2. Consumers in Vermont want their DCWs to have access to training that meets their specialized needs and preferences.

3. Training and reasonable wages are key to an effective direct care workforce.

4. Accessible training has a positive impact on recruiting and retaining DCWs.

5. Existing DCW training varies considerably, and as such, there is a need in Vermont to establish standardized accessible training for DCWs.

Recommendations

State and key stakeholders shall consider Fair Labor Standards Act obligations imposed by the United States Department of Labor "Home Care" Rule when evaluating and implementing these recommendations.[vi]

1. Explore licensure and/or certification for DCWs as a way to create minimum, standard training requirements for DCWs.

2. Explore options to pay for training, such as Medicaid billing or Workforce Education and Training (WET) funds from the Department of Labor or other funding sources.

3. Develop a comprehensive, standardized direct care worker training curriculum that reflects the preferences of the people receiving the services from direct care workers, meets the needs of specialized populations, and work toward statewide implementation. If possible, resolve any Fair Labor Standard Act implementation challenges when planning for direct care worker training

4. Identify existing promising practices in DCW training and ways to expand those practices.

5. Include DCWs in any workforce demand micro-simulation model developed by the State and have this subcommittee work with state staff and the micro-simulation contractor to provide context and content to help the vendor better understand the current and future demand for DCWs in Vermont.

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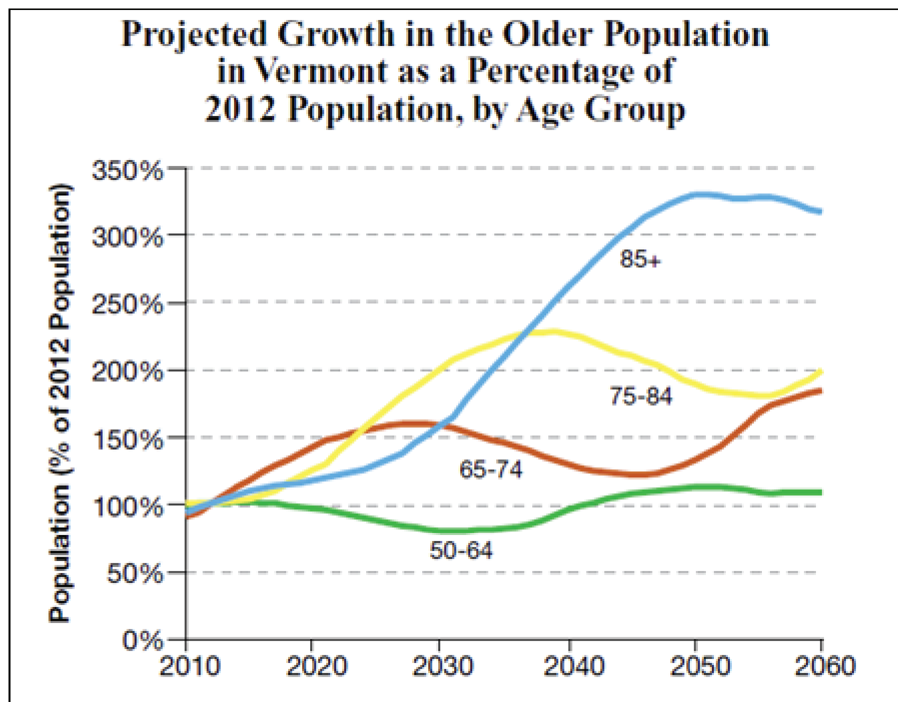
1. BACKGROUND

Analyses of, evaluations of and recommendations for the long term care direct care workforce have occurred over many years both in Vermont and nationally. This report will focus on direct care workers as defined in Vermont House Bill 301 Section 2 (a) (2) *"Direct care worker" shall mean an individual who is reimbursed by the State to assist adults residing in community settings not licensed by the State with activities of daily living and instrumental activities of daily living.*[vii] There are other DCWs who work for institutional providers or who work for private pay home care organizations such as Home Instead Senior Care[viii] or Armistead Caregiver Services.[ix] While they are not the focus, the recommendations and next steps could have a positive impact on the entire direct care workforce. This report is not going to address Community Health Workers as defined by federal statute.[x]

The following section of the report, Section 2 Summary of Prior Direct Care Workforce Efforts in Vermont, will review some programs conducted and information collected both in Vermont and nationally to help provide history and context to our recommendations.

2. DEMAND FOR LTC DIRECT CARE WORKFORCE IN VT

Vermonters are living longer and the population as a whole is aging, therefore the demand for DCWs in Vermont is going to dramatically increase. [xi]



The charts below show data from the United States Census about the growing population of older Vermonters. Growth in the number of individuals who are ages 75-79, from 2010 Census data and projections in 2030 show an increase of 156.3% in that population. This information further demonstrates the need for more DCWs in the future.

VT Population Projections by Age and County, 2020, 2030 – Scenario A[xii]

Ages	2010 Census	2020 estimate (% change from 2010)	2030 estimate (% change from 2010)
65-69	29,390	47,672 (62.2%)	50,168 (70.7%)
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Disability data for Vermont from United States Census Bureau[xiii]

Total population	**619,928**
Total with a disability	83,148 (13.4%)
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2a. Projected need for additional direct care workers in the future

Census data projects large increases in older Vermonters and increases in the number of Vermonters with disabilities. In addition, with the shift from nursing facility to community-based care, there is increased demand for services in a home and community based setting. Together these factors indicate a demand for additional direct care workers in Vermont. The Workforce Workgroup has discussed including the need for direct care in the micro simulation modeling of health care demand, which is under development to support the efforts of the Workforce Workgroup. This subcommittee on LTC Direct Care Workforce should be consulted for input on data sources for this work.[xiv] We recommend that the analysis go beyond demand for direct care workers who work in community based settings and also include the demand for direct care workers in institutional settings. It is common for direct care workers to serve multiple clients in various settings.

3. SUMMARY OF PRIOR DIRECT CARE WORKFORCE EFFORTS IN VERMONT

Significant work has occurred in the last 10-15 years to study the impact of Direct Care Workforce both in Vermont and nationally. The summary information below highlights some of the research that has already been conducted as a frame of reference for the current efforts occurring in Vermont in 2014.

3a. Report of LTC DCW from the Vermont Department of Disabilities, Aging and Independent Living- 2008

This report defined DCWs as those who provide the most direct care and support at the lowest end of compensation[xv]

Using the above described criteria the list of direct care and support workers described in the study included: licensed nursing assistants (LNA), personal care attendants (PCAs), direct support professionals and community support workers, developmental home providers, resident assistants and aides, homemakers, Shahbaz (caregivers in the Greenhouse model of nursing homes), geriatric aides, privately paid professional caregivers, respite aides, and hospice support workers [xvi]

The Vermont Department of Disabilities, Aging and Independent Living (DAIL), through assistance from Flint Springs Consulting, developed the 2008 Legislative Study of the Direct Care Workforce in Vermont[xvii] and made the following eight substantive recommendations:

- increase direct care worker wages;
- increase access to health insurance through group health plans;
- create accessible and affordable orientation, training, and professional development for direct care workers and their employers;
- recruit direct care workers from new sources;
- continue support for the development and full implementation of the Direct Care Worker Registry;
- promote recruitment and retention through the use of evidence-based tools and promising approaches;
- create standardized and portable career ladders for direct care workers; and,
- establish a workgroup responsible for developing protocols and methods for collecting needed direct care workforce data.

3b. Robert Wood Johnson Foundation funded Better Jobs Better Care project

From 2008-2011, Vermont was one of five states that participated in the Robert Wood Johnson Foundation's Better Jobs Better Care project. Through Better Jobs Better Care, The Community of Vermont Elders (COVE) was chosen as the host sponsor for this project.

Better Jobs Better Care defined a direct care worker as "*an individual who provides hands-on personal care (e.g., assistance with bathing, dressing, transferring and feeding) as a significant part of their job at a nursing facility, home health agency, assisted living organization, adult day center or other personal care organization.*"[xviii]

Vermont built a multi-stakeholder coalition that included policy-makers, professional organizations, educators and other stakeholders with vested interests in long-term care.[xix] Some key findings from this work include:

- Workers who perceive their organization as culturally competent reported higher levels of job satisfaction.
- Good frontline supervision is a key factor influencing the commitment of nursing assistants to their jobs.
- Commitment to the consumer, flexibility and competitive wages and benefits are critical to attract and retain home-care workers.
- Turnover rates among direct-care workers were lower at sites that employed a retention specialists trained to systematically address low job satisfaction and turnover.
- Mature workers (55+) are interested in direct-care work but need training and support to overcome barriers, such as the lack of technological knowledge and age-related functional limitations.
- Individuals who have provided care to family members and friends could add significantly to the pool of caregivers, but more outreach and targeted information is needed to recruit them.
- Managers, supervisors and nursing assistants who used a 33-hour curriculum focused on clinical and interpersonal skills reported a positive impact on job satisfaction, morale and quality of care.
- Tailored, ongoing training can improve job satisfaction while personal and job-related stressors are the most powerful predictors of dissatisfaction.[xx]

3c. Vermont Association of Professional Care Providers

Through Better Jobs Better Care funding, the Vermont Association of Professional Care Providers (VAPCP) was created as a subsidiary of COVE but as its own separate 501(c) 3 organization. VAPCP was instrumental in assisting with developing trainings for DCWs and in the development of the online direct care workforce registry Rewarding Work.[xxi] While VAPCP closed in 2010, Rewarding Work continues and allows both consumers in need of a DCW and

DCWs in need of work to search and connect. Over 1000 individual consumers/employers have registered and over 1600 direct care worker employees have registered.

3d. Alliance for Health Reform Direct Care Worker Report – 2012

This report discusses direct care workers using larger groups of workers including nurses aides, home health aides, personal care aides, direct support professionals and psychiatric aides[xxii]

This national report developed in 2012 included many findings. The most relevant findings from the report were:

- DCWs provide a variety of services to clients, such as help with eating, bathing, dressing, toileting, food preparation, medication management and light housekeeping.[xxiii]
- The majority of DCWs are employed in home & community based settings rather than in large institutions such as nursing homes or hospitals.[xxiv]
- In 2011, nationally, the direct care workforce totaled about 4 million workers, including an estimated 800,000 providers employed directly by consumers.[xxv] In Vermont in June of 2014, 6850 DCWs were directly employed by consumers.[xxvi]
- Turnover tends to be high among DCWs, in part because of low pay. The median pay nationally for home health and personal care aides in 2010 was $9.70 per hour, or $20,170 per year.[xxvii]

3e. Consumer Perspectives on Quality Home Care – National Consumer Voice for Quality Long Term Care – 2012[xxviii]

The National Consumer Voice for Quality Long Term Care produced a report called Consumer Perspectives on Quality Home Care – National Consumer Voice for Quality Long Term Care in September 2012.[xxix] Consumer Voice used to be called the National Citizens Coalition for Nursing Home Reform or NCCNHR. This project was supported by grants from the SCAN foundation and the Atlantic Philanthropies. The project had a State “Consumers for Quality Care No Matter Where” project advisory council in 5 states: California, New Mexico, Ohio, Vermont and Virginia.

Key findings from this project included:

- Consumers have a voice and want to be heard. Consumers should be involved in policymaking and program development.

- There is a different power dynamic at home. Consumers feel more in charge when they receive services at home rather than in institutional settings.
- Consumers often feel grateful to get any home and community-based services, and don't focus on quality of care or quantity of services being provided.
- Home is viewed as better than a nursing home. Consumers from this report perceive care at home as being better than nursing home care.[xxx]

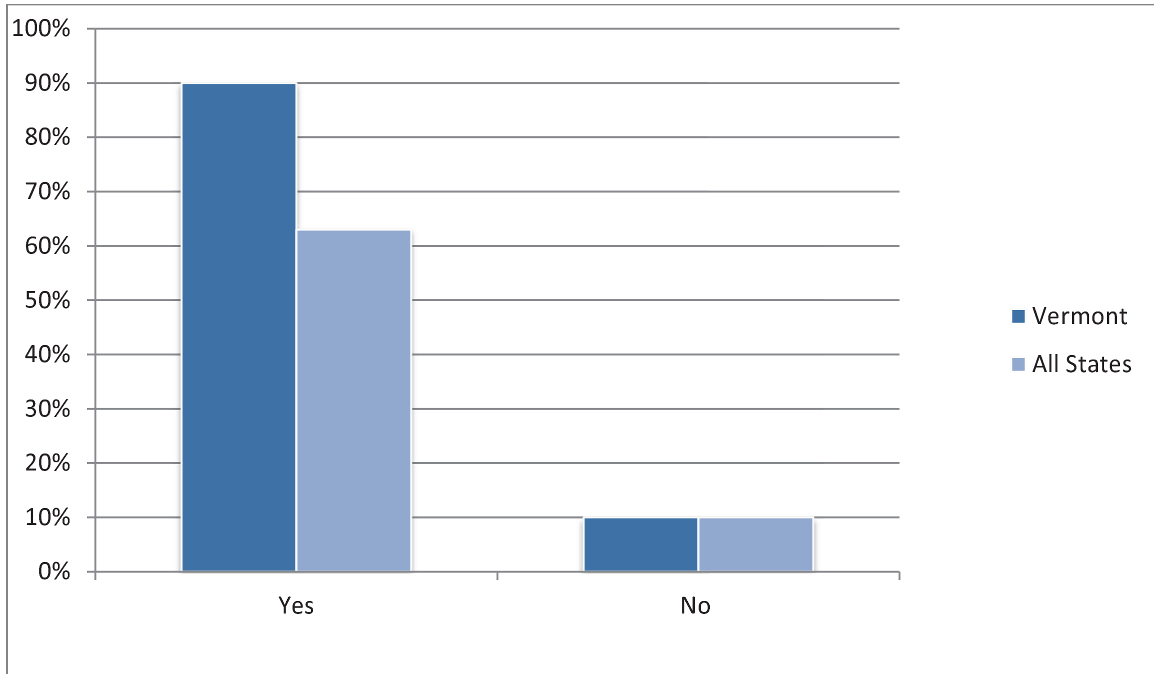
The policy recommendations that came out of this research included:

- Ensure adequate, continued funding of critical programs like Medicare and Medicaid.
- Make home and community-based services a mandated Medicaid service.
- Enact policies that increase training, wages and benefits for home care workers.
- Require that consumers have the right to choose their workers and schedules for care and service.
- Carry out background checks on all home health workers.
- Support home care ombudsman demonstrations.[xxxi]

The project surveyed consumers who received home based care in 14 states including Vermont. In Vermont, of the 300 contacted, 212 were eligible to respond. To be eligible, consumers needed to reside in their own home, receive paid care services, and receive additional services other than home delivered meals. Out of the 163 consumers who participated in one-on-one interviews and the online survey, 40 were from Vermont, giving Vermont the highest response rate.

When asked whether home care workers should receive additional training, 90% of the 40 Vermont respondents indicated yes while only 60% of 123 respondents from other states thought home care workers should receive additional training. Training is very important to consumers as shown by the results of this survey.

Should Home Care Workers Receive Additional Training?[xxxii]



4. PROGRESS TO DATE ON IMPROVEMENTS FOR DIRECT CARE WORKERS

4a. Wages

History of independent direct support provider wages for the programs listed below[xxxiii]

	Department of Disabilities, Aging and Independent Living Program/service			
	Choices for Care Consumer/ Surrogate - directed personal care	Choices for Care Consumer/ Surrogate -directed respite/ companion	Attendant Services Program Medicaid Participant Directed Attendant Care (first six months)	Attendant Services Program Medicaid Participant Directed Attendant Care (after six months)
Base (as of July 2009)	$10.14	$8.62	$9.00	$9.50
8/5/2012	$10.53	$8.97	$9.15	$9.65
1/6/2013	$10.68	$9.12	$9.30	$9.80
11/10/2013	$11.00	$9.40	$9.56	$10.12
July 2014	$11.28	$10.80	$10.80	$10.80

Direct Care Workers have seen wage increases under the collective bargaining agreement (CBA) reached between the Vermont Agency of Human Services and Vermont Homecare United/American Federation of State, County and Municipal Employees, Council 93, Local 4802. In July 2014 the minimum hourly

wage for all covered services was increased to $10.80. All providers who were paid a "fixed wage" (i.e., one established by the State), as reflected in the chart above, received an increase to $10.80 per hour or 2.5%, whichever was greater. In "flexible wage" programs (i.e., Choices for Care 'Flexible Choices', Choices for Care Adult Family Care Respite, Children's Personal Care Services, and Developmental Services), providers received a minimum of $10.80 per hour and $150.00 per day (for daily respite services). In these "flexible wage" programs, additional increases above these minimums may be made at the discretion of the employer. [xxxiv]

The subcommittee discussed the hope that wages for direct care workers could be raised to be in alignment with livable wages. The 2012 Vermont Livable Wage is $12.48 per hour (this is the average of the urban and rural rate for Two Adults with No Children).[xxxv] However, any increase to wages for DCWs has a direct impact on the State budget, making it difficult to further increase wages.

4b. Health Insurance

Through the Affordable Care Act individuals who work as DCWs can purchase health insurance as an individual and, depending on their household income, may qualify for subsidies towards the purchase of that coverage.[xxxvi] In addition, some DCWs, depending upon how many hours they work and other qualifying factors, also may qualify for Medicaid coverage if their household income is under 138% of the FPL ($16,100 for an individual or $32,900 for a family of four).

4c. Career Ladders

Efforts continue to improve career ladder options for direct care workers. Career ladders allow an opportunity for a direct care worker to be employed as a personal care attendant (PCA) and with additional education and experience move up the career ladder to become a licensed nursing assistant or a registered nurse over time. Additional career ladder opportunities exist by increasing responsibility without additional formal education. For example, a DCW may become more specialized over time and work with specific populations such as individuals being served through hospice or through the developmental services program.

This career ladder process exists currently through some home health agencies, where employees could start as a Personal Care Attendant 1, (PCA 1) and with additional training and experience move to a PCA 2 or a PCA 3, which are more specialized positions.

5. SUMMARY OF FINDINGS AND RECOMMENDATIONS BASED ON WORKGROUP DISCUSSIONS AND DATA COLLECTION EFFORTS

5a Training general information

Initial and ongoing training for Direct Care Workers will help with both recruitment and retention of Direct Care Workers. The subcommittee recommends having standards for training. The subcommittee discussed and did not reach agreement on Direct Care Workers being paid to attend initial and ongoing trainings to obtain and refine DCW skills, such as how to cook properly for someone else or how to bathe someone safely. Training should also include soft skills such as writing notes in a care plan, being a professional, and dealing with conflict.

There is a significant challenge with the State's involvement in setting extensive qualifications for DCWs, such as fulfilling comprehensive, state-administered training requirements (beyond those required for relevant licenses) as this might trigger the State's status as a joint employer of the DCW and, therefore, require the State to comply with minimum wage, overtime and paid travel time requirements of the Fair Labor Standards Act (FLSA). This could potentially be a significant unanticipated cost to the state of Vermont.

Vermont has a workforce and training fund through the Department of Labor. The Workforce Education and Training Fund (WETF) receives approximately $1.2M from the Next Generation Fund, and supports workforce training, internships, regional workforce initiatives, adult technical education centers, and other initiatives. [xxxvii] Organizations that have offered DCW trainings have had some access to these funds in the past and should continue to access these funds in the future.

Consider licensure and/or certification for Direct Care Workers (DCWs). The fees for licensure cover the costs of regulating individuals who are licensed; acupuncturists pay a $100 fee and cosmetologists pay a $110 fee. The licensure or certification process could allow for minimum standards for all DCWs. The professions currently licensed by the State of Vermont vary greatly but include: Acupuncturists, Barbers/Cosmetologists and Tattoo Artists/Body Piercers among other professions. This subcommittee believes that consideration should be given to licensure and/or certification of direct care workers. The full list is included as an attachment to this report. If licensure or certification occurs it needs to be sensitive to the needs of subpopulations of consumers and also sensitive to work performed by family caregivers that is unpaid direct care work or limited to paid work for just a family member. By creating minimum

standards and providing training to satisfy those minimum standards as a baseline, this may help to guarantee increases in quality of care provided by direct care workers.

Little or no training is provided for DCWs who work directly for consumers and whose payroll is processed by ARIS.[xxxviii] However some DCWs who work directly for consumers have previous job experience providing direct care work for a provider such as home health agency or a designated agency.

Significantly more training exists for DCWs who work for agencies and institutional providers; however it varies in amount and scope. Subsection *5b* includes some examples of training amounts, scope and costs but they are not inclusive of all direct care workers or all providers.

CMS, through the National Direct Service Workforce Resource Center has created a DSW core competency set, which created evidence-based practices for training and employment across LTSS sectors.[xxxix]

The following DSW core competency set lists out best practice information including the core competencies and skills needed to most effectively work as a DCW.

Core Competency Area	**# of skill statements**
1. Communication	4
2. Facilitation and Individualized Services	9
3. Evaluation and Observation	4
4. Participant Crisis Prevention and Intervention	6
5. Safety	5
6. Professionalism and Ethics	8
7. Participant Empowerment	4
8. Advocacy	4
9. Supporting Health and Wellness	9
10. Community Living Skills and Supports	5
11. Interpersonal and Family Relationships	6
12. Community and Service Networking	4
13. Cultural Competency	5
14. Education, Training and Self-Development	4
Total	77

Although, CMS has developed these training best practices, payment for training is not something that can automatically be included in provider rates according to information from CMS.

Medicaid statute and regulations (section 1902 of the Social Security Act and 42 Code of Federal Regulations 430 and 447) allow reimbursement for covered services delivered by a qualified provider to an eligible beneficiary. Costs associated with requirements that are prerequisite to being a qualified Medicaid provider are not reimbursable by Medicaid. However, costs associated with maintaining status as a qualified provider may be included in determining the rate for services. Specifically, if as part of its provider qualification requirements, a State requires a provider to acquire a certain minimum number of hours of specified types of continuing education (CE) each period (annually or quarterly, for example), the State may recognize such CE expenses as a cost to the provider of doing business and may consider such costs in developing the rate paid for the service. The cost of CE may only be included as part of the rate paid for the service and may not be claimed separately by the Medicaid agency as an administrative expense.[xl]

To be able to include training within the DCW rate, first, DCWs would need to be licensed and regulated by the state. Second, Medicaid would need to recognize the CE expenses as a Medicaid expense and add that into the Medicaid rate process which would need to be approved by CMS. Finally, rate increases to incorporate training would need to be implemented through the Medicaid budget process.

An additional challenge for this whole process is 3rd party employer status issues the State of Vermont and other states might have with respect to Fair Labor Standards Act changes. Setting wages, rates and licensure might inadvertently put the State of Vermont in a role of being an employer and some direct care workers would be employees of the state of Vermont. The state is currently reviewing interpretations of the federal definition of employee under the Fair Labor Standards Act, as recently affirmed by the U.S. Department of Labor, when deciding how to provide and pay for training for DCWs. The issue is whether Direct Care Workers who are not employed by an agency or a provider, but rather are directly employed by consumers and whose payroll goes through ARIS are considered employees of the state, if the state were to, require, provide, and/or pay for training directly or indirectly through providers.

5b. Training information from existing programs

i. VNA of Chittenden and Grand Isle Counties – additional information can be found in Appendix D

Since 2012, the VNA of Chittenden and Grand Isle Counties has trained and tested more than 500 new PCAs and incumbent PCA workers using their PCA (Personal Care Attendant) Ladders Training Program.

Traditional PCA 1 Classroom Style Training with Exam: This traditional classroom style of training includes the use of an Adult Learning Model with documented Return Demonstration teaching the Six Area of PCA 1 Knowledge (12 Students per class) with 1 Health Care Educator and 4 Educator Assistants.

1	Type of Training	Personal Care Attendant (PCA 1)	
2	# of Participants	12	Direct Care Workers
3	Hours of Training	40	per class
4	Estimated Training Costs	$875.00	per student based on a full class size

ii. Vermont Council for Developmental and Mental Health Services – Northwestern Counseling & Support Services Inc. – additional information can be found in Appendix D

Trainings Census for - **DIRECT CARE SUPPORT STAFF*** – for **New Staff** and **Existing Staff Ongoing** - September, 2014

Reporting Time Period: **July 2013 through June 2014**[xli] **ee = employees**

	A*	**B**	**C**	**D**	**E**
Type of Training **(for Direct Care Support Staff ONLY)**	**# of New ee's trained in each category**	**# of Existing ee's trained in each category**	**Average Training Hrs of Existing ee's**	**Average Training cost *per* Existing ee*** **	**TOTAL Estimated Training Cost by Type** (ee wages w/fringe - receiving training only)****
New Employee Orientation (classroom)	**69**	**n/a**	**0**	**0**	**4899.00/0**
Safety Related	**56**	**320**	**54.5**	**1072.00**	**43,008/343,040**
Administration	**66**	**108**	**2.75**	**54.00**	**7,062/5832**
Professionalism	**69**	**319**	**3**	**59.00**	**2484/18,821**
Professional Development	**34**	**105**	**8**	**157.00**	**4318/16485**
Totals **Columns A & D – total non-duplicated ee's only;**	**69**	**320**	**68.25 hours**	**$1342.00(ee time only – without agency costs)**	**61,771/384,178** **<u>$445,949</u>**

iii. Vermont Health Care Association[xlii]

LNAs hired in nursing facilities receive a general orientation; this is often followed by several weeks of one on one mentoring with a skilled peer and a skills checklist for competency. The number of hours of training for a new hire ranges from 80 to 210 hours or more in the first year. Range of training costs for the first year can be $5,000 or more. The hours and costs do not include the education and training required for a person to obtain their LNA license.

Ongoing training includes mandatory in-service training, online training as well as one on one education. Topics include but are not limited to dementia, challenging behaviors, infection control, incontinence care, oral hygiene, nutrition and hydration, customer service, restorative nursing, blood-borne pathogens, fire safety, confidentiality, HIPAA, stress management, body mechanics, transfer skills, range of motion and positioning. Ongoing training hours is from 12 - 36 hours per year and higher.

iv. Vermont Center for Independent Living (VCIL)

VCIL offers an online toolkit for training.[xliii] This toolkit includes the following:

- Introduction
- Origins of VCIL's Toolkit
- Why a Toolkit and How to Use it
- Aging and Independent Living
- The Independent Living Movement and Disability Rights
- Three Methods of Personal Assistance Services PAS Training
- List of Available Self Training Options
- Bibliography of VCIL (PAS) Training Toolkit and Reference Grid
- Other Resources
- Attendant Services Program (ASP) Options
- More Facts/Tips About Attendant Care in Vermont
- Thanks and Acknowledgements
- The "Quickstart" Guide

vi. Association of Africans Living in Vermont[xliv]

This information reflects the September 30, 2012 – February 28, 2014 period –over the course of the WETF grant from the Department of Labor

1. Type of training: Both new employee and incumbent training
2. # of participants: 52 completions
3. Hours of training: 88 hours (total) – 4 hours of instruction, 2 hours of homework and studies, 2 hours of work (a week/per person).
4. Estimated training costs: $65,000 which is equal to $1,250 per person. (This course is free of charge to participants).

5c. Recruitment

In recruiting DCWs, it is important to develop a multi-pronged strategy to attract potential employees. Subcommittee members indicated that they have seen some success in using internet-based recruitment strategies, including Craigslist, care.com, and rewardingwork.org. Organizations that pay higher salaries and offer benefits to their DCWs are likely to be more successful in recruitment and less likely to have high employee turnover. In addition, based on previous studies, it appears that organizations that offer training and provide career ladders are better positioned to recruit direct care workers.

It is important that DCWs have a full understanding of the job responsibilities prior to starting work. Some organizations conduct a pre-hire orientation which includes the opportunity to work directly with consumers and assist with activities of daily living such as; eating, bathing, dressing, toileting and transfer. When recruiting to serve an individual with specific needs, it is important to be clear about any specific skills required as part of the job-posting.

Based on our discussions at several subcommittee meetings, the subcommittee believes that the best way to recruit DCWs falls squarely along generational boundaries. If a DCW is being recruited through a local paper or ad in a regional paper that individual is likely to be an older worker. However to recruit younger individuals to work as a DCW, social media is an easier and more effective approach. In recruiting, it is important to reach out through multiple areas.

Some organizations and some consumers themselves are hiring mature workers or workers with disabilities as direct care workers. VT Associates for Training &Development (VATD) offers training and job assistance for mature workers who are looking for work.[xlv] VATD gets funding from a national program known as the Senior Community Service Employment program.[xlvi] This program provides job training for low income seniors.

Low rates of pay and lack of benefits can be a barrier to recruitment. Other challenges include how to reach out and include new Americans.

A bigger barrier to recruitment may be that the work of a DCW is not always a day shift/ 9-5 type of job. Individual consumers who need assistance often need assistance during the evening or on weekends. However, it may also be an incentive for those who want to work nights and weekends.

In addition, it may not be possible to provide job shadowing options for direct care workers given confidentiality concerns unless a client consents to the job shadow.

In addition to recruiting for positions through advertisements, as with any job, recruitment may be most successful through word of mouth. Individuals can provide either paid or unpaid direct care for a family member. After the family member dies, these individuals might provide direct care for someone else and it could provide a new job opportunity for that individual and a new way to recruit more people.

5d Retention

The subcommittee talked from experience about best practices that include: setting clear expectations with DCWs, having a positive work environment, empowering the DCW to be part of a care team, having DCWs involved in decision making or at least having input into decision making. Also, having a varied work schedule is positive for those who want to have flexibility.

Increases in wages and benefits have a direct impact on retention of DCWs. Wages and benefits were discussed previously in this report. Given the recent Union contract between Vermont's Agency of Human Services and the Vermont Homecare United/American Federation of State, County and Municipal Employees, (AFSCME) wages have seen a significant increase. [xlvii]

According to AFSCME: *The contract allowed for a new floor for homecare workers of $10.80 an hour and a 2.5 percent raise for those currently making over that amount. This represented a 49 percent increase for the lowest paid hourly homecare workers. Respite providers currently earning $116 per day will earn $150 per day, nearly a 30 percent increase over current daily minimums and a 2.5 percent raise for those currently earning above that rate.*[xlviii]

The lack of opportunities for job shadowing is a barrier to retention because of confidentiality. Ongoing training can be an important tool in retaining a DCW. Training can be expensive; however, lack of training can be a source of frustration for both the direct care worker and the consumer. Barriers to retention include evening and weekend shifts, emotionally and physically demanding work and lack of vacation and sick time. To address these barriers, additional access to training, shift options, and other supports will need to be provided.

6. FINDINGS AND RECOMMENDATIONS

Many of the findings in the section below are included in the findings and recommendations of the Vermont Self Determination Alliance. This group met earlier in 2014, as the Vermont Agency of Human Services was negotiating a collective bargaining agreement with Vermont Homecare United/American

Federation of State, County and Municipal Employees, (AFSCME), to discuss recommendations for DCWs which they referred to as Independent Support Professionals. Please see appendix E for the entire list of VT Self Determination Alliance recommendations

Findings

1. As Vermont's population ages, there will be an increased need for direct care workers.

2. Consumers in Vermont want their direct care workers to have access to training that meets their specialized needs and preferences.

3. Training and reasonable wages are key to an effective direct care workforce.

4. Accessible training has a positive impact on recruiting and retaining direct care workers.

5. Existing Direct Care Worker training varies considerably; there is a need in Vermont to establish standardized accessible training for direct care workers

Recommendations

State and key stakeholders shall consider Fair Labor Standards Act obligations imposed by the United States Department of Labor "Home Care" Rule when evaluating and implementing these recommendations.

1. Explore licensure and/or certification for DCWs as a way to create minimum, standard training requirements for DCWs.

2. Explore options to pay for training, such as Medicaid billing or Workforce Education and Training (WET) funds from the Department of Labor or other funding sources.

3. Develop a comprehensive, standardized direct care worker training curriculum that reflects the preferences of the people receiving the services from direct care workers, meets the needs of specialized populations, and work toward statewide implementation. If possible, resolve any Fair Labor Standard Act implementation challenges when planning for direct care worker training

4. Identify existing promising practices in DCW training and ways to expand those practices.

5. Include DCWs in any workforce demand micro-simulation model developed by the State and have this subcommittee work with state staff and the micro-simulation contractor to provide context and content to help the vendor better understand the current and future demand for DCWs in Vermont.

APPENDICES

Appendix A. ***VT House Bill 301–An act relating to a task force on direct care workers***

http://www.leg.state.vt.us/docs/2014/bills/Intro/H-301.pdf

Appendix B. Subcommittee membership list

Amanda Ciecior	Department of Vermont Health Access
Amy Coonradt	Department of Vermont Health Access
Angel Means	Visiting Nurse Association
Anthony Treanor	Northwestern Counseling & Support Services
Audra Rondeau	VT Homecare United
Betty Milizia	Parent of an individual with I/DD
Brendan Hogan	Bailit Health Purchasing
Charles MacLean	University of Vermont
Denise Lamoureux	State of Vermont Agency of Human Services
Devon Green	State of Vermont Agency of Administration
Georgia Maheras	State of Vermont Agency of Administration
Gini Milkey	Community of Vermont Elders
Greg Stewart	Bayada
Jackie Majoros	Vermont Legal Aid
Jacob Bogre	Association for Africans Living in Vermont
Janelle Blake	Home Instead Senior Care
Jean Danis-Gilmond	Northwestern Counseling & Support Services
Jen Woodard	VT Dept of Disabilities, Aging & Ind. Living
Jim Durkin	AFSCME 93 council
John Barbour	Champlain Valley Agency on Aging
Julie Tessler	VT Council
Kara Artus	Transition II, Inc
Laura Pelosi	Vermont Health Care Association
Lorraine Jenne	Howard Center
Mark Bernard	AFSCME93 council
Marlys Waller	VT Council
Martha Richardson	VT Alzheimer's Association
Mary Val Palumbo	University of Vermont
Matthew Matthew	AFSCME93 council
Nicole LaPointe	Northeastern Vermont Area Health Ed Center
Nicole LeBlanc	Green Mountain Self Advocates
Pat Glynn	AFSCME 93 Council
Penne Ciaraldi	Community College of Vermont
Peter Cobb	VNAs of Vermont
Phul Pokhrel	CVAA
Robin Lunge	State of Vermont Agency of Administration
Rosemary Dale	University of Vermont
Sarah Launderville,	Vermont Center for Independent Living
Sherry Callahan	Vermont Health Care Association
Stuart Schurr	VT Dept of Disabilities, Aging & Ind. Living
Susan Anderson-Brown	Visiting Nurse Association

Appendix C. List of professions currently licensed by the State of Vermont Office of Professional Regulation

- Accountancy
- Acupuncturists
- Allied Mental Health
- Architects
- Athletic Trainers
- Auctioneers
- Barbers & Cosmetologists
- Boxing Control Board
- Chiropractic
- Dental Examiners
- Dietitians
- Electrologists
- Engineering
- Funeral Service
- Hearing Aid Dispensers
- Land Surveyors
- Landscape Architects
- Midwives
- Motor Vehicle Racing Commission
- Naturopathic Physicians
- Nursing
- Nursing Home Administrators
- Occupational Therapy
- Opticians
- Optometry
- Osteopathic Physicians
- Pharmacy
- Physical Therapists
- Private Investigative & Security Services
- Property Inspectors
- Psychoanalysts
- Psychological Examiners
- Radiologic Technology
- Real Estate Appraisers
- Real Estate Commission
- Respiratory Care Practitioners
- Social Workers
- Tattooists & Body Piercers
- Veterinary Medicine

Appendix D. Additional training information from the Visiting Nurse Association of Chittenden and Grand Isle Counties and Northwestern Counseling and Support Services – the Designated Agency for Mental Health, Substance Abuse and Developmental Services in Northwestern Vermont.

VNA of Chittenden and Grand Isle County additional training information:

The ladder training program has three levels PCA 1, PCA 2, & PCA 3. These levels each have a specific curriculum based on the level of care, knowledge, and skill required to effectively care for clients with specific diagnoses. Within the first year, the program successfully reduced the PCA turn-over rate from 53% to 32.6% and improved client satisfaction by almost 10%.

The VNA received generous support from the Vermont Department of Labor in 2012 to launch the PCA Career Ladder Program and again in 2014 for continued PCA Ladders trainings. As in the first grant the VNA continues to work in partnership with the Community College of Vermont (CCV) for the PCA 1 training program with CCV providing 20 hours of classroom instruction and the VNA providing an additional 40 hours of classroom and lab instruction.

The complexity of the care, knowledge, and skill increases as the students move up the ladder. When a PCA 3 reaches the top of the ladder they are then eligible to be considered for LNA training. The VNA's main goal in developing and providing the PCA Career Ladder program was to strengthen and expand the PCA program so that they could continue to improve their PCA retention rate, increase client satisfaction, and provide better quality care.

E-Hub and Spoke Rural Healthcare Training for direct care worker using an interactive delivery network could be used in the future

Hub and Spoke Classroom Style Training with Exam: use of an Adult Learning Model with documented Return Demonstration teaching the Six Area of PCA 1 Knowledge (up to 10 remote sites with 100 Students per class) taught by 1 Health Care Educator and 15 remotely located Educator Assistants.

1	Type of Training	Personal Care Attendant (PCA 1)	
2	# of Participants	100	Direct Care Workers
3	Hours of Training	40	per class
4	Estimated Training Costs	$ 400.00	per student based on a full class size

The VNA is happy to support the need for quality and consistent training of Vermont's direct care workers.

Notes to explain chart from Northwestern Counseling and Support Services

1. New Employee Orientation (likely touches on all training categories below it (categories 2-5) - which are typically dedicated trainings covered in more depth, otherwise)
2. Safety Related (e.g. CPR, First Aid, Defensive Driving, Emergency Procedures, Interventions, OSHA Blood Borne Pathogens, Sexual Harassment, Medications, Safety Data Sheets, etc.)
3. Administrative (e.g. payroll, expense, EMR, incident reporting software, myLearningPointe, etc.)
4. Professionalism (e.g. Ethics, confidentiality, HIPAA, Diversity, Corporate Compliance, HITECH, Red Flags, etc.)
5. Professional Development – clinical content based, would include Agency in-house trainings ONLY.

**This is an ESTIMATE to include employee wages with fringe spent in MANDATORY (baseline) trainings. It DOES NOT include fixed costs – e.g. software, hardware, apportioned space, and NCSS trainer time (wages, fringe, fees) – or the expense of outside trainers hired.

In addition to MANDATORY Trainings – staff participate in significant ELECTIVE professional development trainings on an ongoing basis. These trainings include in-house, on-line, and outside trainings and are not reflected in this compilation.

Definition of New Employee: First time recipient of baseline trainings, including New Employee Orientation.

*Definition of Direct Care Support Staff:

*As with the previously completed Direct Care Support Staff Census (May, 2014) - the focus of this request is also on non-licensed/non-certified long term care, direct care workers in positions that DO NOT require a license (even though the worker may have one). There are also some workers who are registered or rostered with the state but are not licensed.

*DATA do not include: Managers (directors, program managers, team leaders), administrative staff, licensed clinical staff (therapists, drug & alcohol, docs, nurses), teachers, special educators, facilities staff, transportation staff.

Note: *** Average Wage for New Employees = $12.00 per hour + fringe of 32% = $15.84 per hour; Average wage for Existing Employees = $14.90 per hour + fringe of 32% = $19.67 per hour

Appendix E –VERMONT SELF DETERMINATION ALLIANCE RECOMMENDATIONS

The Vermont Self Determination Alliance is an advisory body established by Vermont Act 48 Relating to Independent Direct Support Providers

1. "PRESERVE PROGRAM CHARACTERISTICS MOST VALUED BY PEOPLE WHO MANAGE THEIR SERVICES." Whether by "choice" or "necessity", these programs provide greater flexibility, creativity, and autonomy for people who manage their supports.

Recommendation: Ensure program policies protect the "self-determination" of people with disabilities who self-direct or self-manage their support, which recognizes that all people have inborn tendencies to grow and develop psychologically, to strive to master challenges in the environment, and to integrate experience into self-concept.

Recommendation: Ensure that services continue to be "person-centered" by assisting individuals with disabilities with identifying their unique skills, goals and dreams in order to plan for their future.

Recommendation: Maintain and protect existing funds allocated for these programs from being considered in any way to address the additional costs of increasing wages or providing any other benefits. The funding allocated to each individual's budget is almost exclusively limited to the amount of wage and hours authorized for direct services with little or no indirect funds for program infrastructure.

Recommendation: Protect the ability of independent employers to determine job descriptions; schedules and work environment, while ensuring employers adhere to state and federal laws regarding the role of employers.

2. "INCREASE DIRECT CARE WORKER WAGES." It is often difficult for individuals and families who self-direct or self & family manage their supports, to recruit and retain workers due to low wages. A number of these programs allow for some flexibility in the rate paid to independent direct support providers and employers often supplement the hourly 'base" wage set by the program, in order to maintain competent workers and household stability. Across the various programs, independent direct support providers perform different tasks that often require different skills. In other circumstances, tasks are uniquely tailored to the individual receiving services, making it difficult to compare the tasks to traditional job descriptions.

Recommendation: Wages should be set at no less than what is generally recognized as a "livable wage" for Vermonters, which is a higher level than current "minimum wage" allows.

Recommendation: Wages should correspond to the technical expertise or skills required for a specific job.

Recommendation: The wage level agreed upon through the collective bargaining process should be set as a minimum, allowing employers the flexibility to increase wages when they deem it appropriate and necessary.

3. "INCREASE ACCESS TO HEALTH INSURANCE THROUGH GROUP HEALTH PLANS." Every Vermonter has a right to access quality health plans. No Vermonter should be prevented from receiving appropriate and adequate healthcare.

Recommendation: Independent direct care providers should have access to a group health plan as part of an overall compensation package.

Recommendation: Health insurance benefits should be calculated based on the cumulative hours worked, due to the fact that many independent direct support providers are employed by multiple employers to maintain their financial independence. Their efforts must be recognized and supported.

4. "CREATE ACCESSIBLE AND AFFORDABLE ORIENTATION, TRAINING AND PROFESSIONAL DEVELOPMENT FOR DIRECT CARE WORKERS AND THEIR EMPLOYERS." There is a need for better access to quality training and development of competencies for independent direct support providers. Independent direct support providers develop many skills while employed by individuals with disabilities and families.

Recommendation: Ensure independent direct support providers receive training on laws and regulations such as: working with vulnerable populations; reporting abuse; global safety and first aid; HIPPA, rules and regulations related to working under Medicaid funded programs, etc.

Recommendation: Ensure independent direct support providers receive training on "Self Determination" and "Person-Centered Planning".

Recommendation: Develop an inventory of and provide access to already existing training, such as: "licensed nursing assistant" or "personal care attendant" training; "supported employment" job coaches; "facilitated communication", etc.

Recommendation: Provide compensation for time spent in training that is required by a particular position, including webinars and workshops. Some programs already allow employers to pay independent direct support workers for time spent in trainings, however this requires them to sacrifice time they would receive supports to ensure employees are trained.

Recommendation: Ensure access to training offered by both professionals and employers on the use of medical or adaptive equipment, in the person's home, when appropriate.

Recommendation: Provide flexibility for employers to determine what training is relevant for the position an independent direct support provider is employed.

Recommendation: Provide and encourage opportunities for employees to mentor one another.

Recommendation: Provide training for employers on: Labor laws; developing job descriptions; recruiting, hiring, supervising, and terminating employees.

5. "RECRUIT DIRECT CARE WORKERS FROM NEW SOURCES." Recruiting workers is very difficult for individuals and families. Employers compete with one another and with agencies for the limited workers available.

Recommendation: Improve current procedures and timeframes to conduct national and state background checks and establish reasonable timelines for the completion of background checks and ensure that they are met.

Recommendation: Investigate whether there are federal funding opportunities to improve/coordinate/streamline all of the background checks.

Recommendation: Collaborate with colleges and technical centers to promote direct care work.

Recommendation: Develop a stronger partnership with Department of Labor.

Recommendation: Disseminate information on strategies used by some employers, such as: individual networking.

Recommendation: Develop access to available workers when an employee takes a "sick day" or no longer works for an individual or family.

6. "CONTINUE THE SUPPORT FOR DEVELOPMENT AND FULL IMPLEMENTATION OF THE DIRECT CARE WORKER REGISTRY" The rewardingwork.org registry provides a list of people in Vermont who are ready to provide direct care, but it is not widely known or used.

Recommendation: Increase and improve public awareness of the registry through media outreach, integrate information about the registry for employees working with the programs referenced above, and increase the frequency of notice of the registry to independent direct support workers disseminated through ARIS.

Recommendation: Resolve issues, regarding logistics and state and federal background checks for hiring workers from the registry that prevent timely responses for initiating access to potential workers. How can background checks remain "current" for workers on the registry to allow for hiring substitute or new workers in an "emergency"?

Recommendation: Prevent any requirement that employers must only hire from"rewardingwork.org" or any other registry that may be created. Many people prefer to recruit their own workers through personal networks and other resources.

7. CREATE STANDARDIZED AND PORTABLE CAREER LADDERS FOR DIRECT CARE WORKERS. Some direct care workers are interested in advancing their education and training.

Recommendation: Collaborate with relevant institutions to develop programs for increasing the number of people who may choose to be independent direct support providers.

Recommendation: Procedures and evaluation tools should be developed enabling employers to validate the competencies already acquired by individuals they employ to satisfy any pre-requisites necessary for their entrance into an education or training program and any life experience evaluations that may be offered.

Recommendation: Review federal and state mandates that prevent the development of alternatives to "traditional" qualifications for specific positions. Example: "Endorsement process" for "Independent Qualified Developmental Disabilities Professionals", achieved through a waiver to a specific Medicaid

requirement." Any alternative positions created need to include a "review" or "recertification" process.

8. ENSURE THE SELF DETERMINATION ALLIANCE CONTINUES TO PARTICIPATE IN THE IMPLEMENTION AND MONITORING OF PROGRESS ON THE STATED RECOMMENDATIONS. The Self Determination Alliance is mandated to advise the State on the stabilization of the independent direct provider workforce and on improving the quality of services.

Recommendation: The Self Determination Alliance should receive a report from the Secretary of Human Services on the status and results of the State's collective bargaining process with Vermont Homecare United.

Recommendation: The Self Determination Alliance should be available for consultation if needed, during collective bargaining.

Recommendation: The Self Determination Alliance should continue to fulfill its role in advising the Secretary of Human Services on the progress of the activities outlined in S.59.

Recommendation: As a committee appointed to represent individuals and families who self-direct or self and family manage their supports, the Self Determination Alliance should participate in any future initiatives or entities created for the purposes of implementing the recommendations outlined in this document.

Endnotes/citations

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[x] *a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.*
A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy
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[xxx] Ibid

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