North Carolina Commission for Mental Health, Developmental Disabilities, and Substance Abuse

Direct Support Professional Work Group Report

November 2007

Prepared by:

Amy Hewitt, MSW, PhD, Senior Research Associate, Research and Training Center on Community Living, University of Minnesota

Steve Edelstein, JD, National Policy Director, Paraprofessional Healthcare Institute

Dorie Seavey, Director of Policy Research, Paraprofessional Healthcare Institute

John Morris, MSW, Executive Director, The Annapolis Coalition on Behavioral Health Workforce

Michael Hoge, PhD, Senior Science and Policy Advisor, The Annapolis Coalition on Behavioral Health Workforce

The information gathering and development of this report was funded by the North Carolina Council of Community Programs through a grant from North Carolina Council on Developmental Disabilities. Additional support was provided form the National Resource Center on Direct Support Workforce through a grant from the Centers for Medicare and Medicaid (CMS).

Thank you Realistic Reflections for the photos used in this document.

Overview

The quality of support provided by Direct Support Professionals (DSPs) to individuals with developmental disabilities, who also have mental health challenges and substance abuse issues, has a profound influence their satisfaction with services and supports paid for by the State of North Carolina. Additional factors that can have a significant impact on the quality of life for these individuals include the competence, stability, and satisfaction of DSPs, as well as direct service organizations with higher rates of turnover and more DSP vacancies. Quality of life outcomes include health, community integration, and participation in activities of their choice (Hewitt, Larson, Lakin 2000).

Several challenges are seriously undermining the ability of the state of North Carolina to develop a high-quality, direct support service system, as well as expand current service capacity to consumers and families. Challenges include —

- Retaining existing DSPs.
- Meeting a significant increase in the demand for DSPs in the face of employee shortages.
- Addressing a high turnover rate that compromises care for consumers, adds to provider costs, and increases the demand for replacement workers.
- Low wages and extremely limited access to health care insurance and other benefits for DSPs: direct support workers are paid near poverty level wages and make less than the federal poverty level for a family of four; many do not have health insurance or depend on Medicaid.
- Meeting the need for comprehensive training of DSPs to ensure knowledge, skills, and competence in provision of care to consumers and families.

These barriers produce significant challenges to ensuring the capacity of the DSP workforce to provide essential services and supports to individuals North Carolina. Serious attention must be given to enhancing the quality of the direct support workforce in order to provide quality services that align with and meet the Centers for Medicaid and Medicare (CMS) Quality Framework.

Table 1 provides an overview of the relationship between CMS expectations for quality service provision and the competence of the direct support workforce. In the area of Provider Capacity and Capabilities, the CMS standards require sufficient numbers of qualified providers to meet the needs of service recipients (CMS, 2004).Current national turnover rates for DSPs indicate by the year 2020,, 600,000 new DSPs will need to be recruited and trained each year in order to replace those who have left the field (USDHHS, 2006). North Carolina currently faces an extreme challenge in this regard.

Table 1. CMS Quality Framework

Focus Area	Outcome
Participant Access	Individuals have access to home and community-based services and supports in their communities.
Participant-Centered Service Planning and Delivery	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community
Provider Capacity and Capabilities	There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
Participant Rights and Responsibilities	Participants receive support to exercise their rights and in accepting personal responsibilities.
Participant Outcomes and Satisfaction	Participants are satisfied with their services and achieve desired outcomes.
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.

* CMS website (2004)

This report includes research on evidence-based strategies and interventions to improve DSP retention and competence, as well as an overview of the DSP issues faced by the state of North Carolina. The report also includes a review of North Carolina's efforts to address these issues through a statewide collaborative charged with identifying and implementing effective DSP workforce strategies.

Workforce Innovations Statewide Initiative

The North Carolina Council on Developmental Disabilities (NCCDD) provided a grant to the North Carolina Council of Community Programs to address the need for workforce interventions in regard to DSP turnover, vacancies, retention, and competence. A stakeholder group was established to meet and reach consensus on recommendations in this regard. Between July 2006 and October 2007, this group met to learn about the challenges faced by the direct support workforce, as well as to review innovative projects and activities in North Carolina and throughout the United States. Table 2 provides information about the members of this group and their affiliations

A nominal group process was used to identify possible, evidence-based solutions as well as to select those that were identified as most critical. In collaboration with the North Carolina Commission on Mental Health, Developmental Disabilities, and Substance Abuse, a series of "listening sessions" were conducted with DSPs, supervisors, individuals with disabilities, and families. The purpose of these sessions was to learn about the challenges being faced as well as to work together to identify possible solutions. .

Table 2. Stakeholder Participants in the Innovations in Workforce Development

Name	Agency
Leica Anzaldo	Autism Society of North Carolina
John Biggers	Southern Regional Area Health Education Center
Marta Hester	Division of Mental Health/Developmental Disabilities/Substance Abuse
Linda Guzman	Arc of North Carolina
Sandy Spillman	North Carolina Direct Care Workers Association
Regina Dickens	RSD Consulting
Pheon Beal	Department of Health and Human Services
Laurie Coker	Mental Health/Developmental Disabilities/Substance Abuse Commission
Michael Owen	North Carolina Council on Community Programs
Scott Keller	Residential Services, Inc.
Michael Helgason	Residential Services, Inc.
Adam Robinson	Wake AHEC
Jill Hinton Keel	Autism Society of North Carolina
Chris Egan	Developmental Disabilities Training Institute
Yvonne Copeland	North Carolina Council on Community Programs
Diane Steinbeiser	North Carolina Community College System
Marvin Swartz	Mental Health/Developmental Disabilities/Substance Abuse Commission
Michelle Edelen	Division of Mental Health/Developmental Disabilities/Substance Abuse
Mary Roughton	Easter Seals UCP North Carolina
Cathi Drinkard	Community Partnerships, Inc.
Karen Ferguson	Division of Child Development
Steve Hairston	Division of Mental Health/Developmental Disabilities/Substance Abuse
Jill Rushing	North Carolina Council on Developmental Disabilities
Marc Roth and Robin Baker	Arc of Orange County
Keisha Lee	North Carolina Council on Developmental Disabilities
Amy Hewitt	University of Minnesota, Research and Training Center on Community Living
Jason Laws	North Carolina Council on Developmental Disabilities
Larry Swabe	North Carolina Council on Developmental Disabilities
Holly Riddle	North Carolina Council on Developmental Disabilities

Overview of Direct Support Workforce Issues and Challenges

Who are Direct Support Professionals?

Direct Support Professionals (DSPs) play a vital role in the lives of individuals with developmental disabilities who also have mental health needs and substance abuse challenges. DSPs provide support and assist individuals with a wide range of daily living activities including such things as home maintenance, healthcare coordination, social activities with friends, employment, healthcare and physical care, skill development, and much more. DSPs facilitate connections to people, resources, and experiences necessary for individuals and their families to live a full and safe life.

DSPs work in a wide variety of service settings including group homes, sheltered workshops, supported employment programs, day centers, community mental health programs, residential institutions, developmental centers (ICFs/MR), nursing homes, and within people's homes. DSPs also work across the lifespan, from birth to elder care.

In North Carolina, DSPs have a wide variety of occupational titles including: direct care worker, facilitator, life skills trainer, counselor, residential assistant, job coach, intake worker, psychiatric aide, technician, psychiatric attendant, and more. Within aging services, DSPs are often called nursing aides, personal care assistants, home health aides, and in-home workers. However, in the field of developmental disabilities, the occupational title of Direct Support Professional (DSP) is becoming widely accepted. This may be due to the adoption of this professional title by the National Alliance for Direct Support Professionals, a professional association for direct support workers in community human services.

Services provided by DSPs are funded through a number of programs in North Carolina including those offered through various Medicaid Waivers (e.g CAP-MR/DD, CAP-DA, CAP-C, CAP-AIDS), Medicaid State Plan services, and other long-term care programs funded by the North Carolina DHHS.

While professional titles vary and funding sources differ, a common thread that ties DSPs to one another is their provision of daily support to individuals who receive health and human services. DSPs share the life space of individuals receiving supports and services, and often know the service recipient better than other paid staff. DSPs are responsible for ensuring that individual support plans, care plans, treatments, and interventions are correctly and competently implemented and that the intended outcomes of service are achieved.

Demand for New Workers and Recruitment

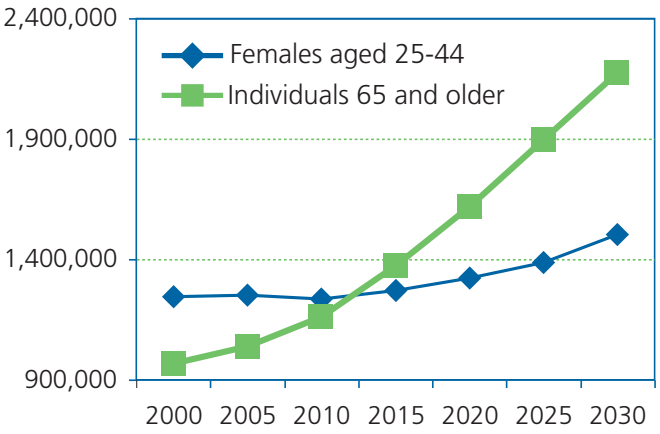
In North Carolina, as in the rest of the nation, the demand for DSPs is growing rapidly. Several factors are responsible for this trend: a) growth in and changing demographics of the U.S. population, b) increased demand for services, and c) high rates of turnover among existing DSPs. From 2004 to 2014, the Employment Security Commission of North Carolina projects several DSP occupations to be among the top ten fastest growing occupations in the state. Jobs for Home Health Aides are expected to increase by 48.3% over this period; Nursing Aides, Orderlies and Attendants by 27.8%; and Personal and Home Care Aides by 49.5%. Over the next decade, these three occupations are expected to create a total of just under 40,000 job openings (Employment Security Commission of North Carolina).

An increase in demand for services by individuals with developmental disabilities is anticipated at 37%, or a total number of 8,394 additional service recipients by the year 2020. This growth will require another 10,912 new direct support positions between now and 2020 (Assistant Secretary Planning and Evaluation, US DHHS, 2006). At current turnover rates, an additional 14,329 DSPs, or 1023 per year, will need to be hired between now and 2020 and unfilled

positions are estimated to require another 3,539 DSPs. Approximately 18,780 new DSPs will be required just to support service recipients in the developmental disabilities service system between now and 2020.

Figure 1 illustrates that while the population of people over the age of 65 in North Carolina is growing at a rapid pace, workers that traditionally provide direct care to older Americans (women aged 25–44) is expected to increase only slightly over the same period. This relationship is sometimes referred to as North Carolina's "care gap." As baby boomers begin to age, and as demand for care increases, community human services will be in intense competition with other service sector employers, as well as those within the community human services industry, to recruit and retain a qualified workforce that is competent to provide services.

Figure 1. North Carolina's Care Gap



Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005

While there is a dedicated core of employees who remain committed to direct support work over many years, current conditions do not offer wage advancement or career opportunities that recognize this commitment. Moreover, the ongoing practice of hiring new, inexperienced DSPs who often leave within a relatively short period of time places additional strain on experienced DSPs. In addition to improving the quality of the existing workforce, it is critical to find ways of attracting and comprehensively training new recruits to the field.

Staff Turnover

Data regarding comprehensive staff turnover across all settings and by type of DSP is not available for the state of North Carolina. The last statewide turnover study of DSPs in the area of developmental disability, substance abuse, and mental health services was conducted in 1999 and found a staff turnover rate of 41% (Test, Solomon and Flowers, 1999). However, methodological issues were present in this study which indicate uncertainty as to whether only DSP data were included in the final report. Recently, the Office of Long-Term Care of the North Carolina Department of Health and Human Services commissioned a statewide study that was then conducted by the North Carolina Institute on Aging (Konrad, 2003). Six hundred and two long-term care facilities/agencies were surveyed regarding estimated annual turnover rates for 2002. The results were as follows: Nursing homes (94.8%), Adult Care Homes (115.1%), Home Care, Home Health, and Hospice Agencies (37.2%).

In the field of developmental disabilities, the national DSP turnover rate averages 50% (Hewitt and Larson, 2007). This mirrors reports within the field of mental health and substance abuse disorders, where DPSs constitute about one quarter of the workforce (Ben-Dror, 1994; Morris and Stuart, 2002).

Table 3. Occupational Wages for Selected DSP Occupations, 2007

Occupational Title	Estimated Employment	Estimated Entry Wage	Estimated Average Wage	Estimated Experienced Wage
Home health aides	61,150	$7.42	$8.97	$9.74
Personal and home care aides	17,880	$7.18	$8.54	$9.22
Nursing aides, orderlies and attendants	28,940	$8.18	$10.26	$11.29

Source: NC Employment Security Commission, 2007 Release Wage Rates, Available at: http://eslmi23.esc.state.nc.us/oeswage/

Numerous factors are known to influence turnover rates, including —

- Employee characteristics: age, education, gender, culture;
- Employee attitudes: job expectations, job satisfaction, organizational commitment, intent to leave;
- Job experience: tenure. job performance, ongoing professional development;
- Job characteristics: number of employees, organizational structure, wages, benefits, supervisor, job duties.
- Employment context: unemployment rate, economic conditions. (USDHHS, 2006).

Studies have shown that turnover is costly. Estimates of the average cost of turnover per DSP range form $2,400 to 3,800 (Seavey, 2004). At a cost of $3,500 per hire, the current annual cost of DSP staff turnover for North Carolina for DSPs in developmental disability services alone is estimated at $42 million. However, this figure does not reflect the annual growth previously mentioned. These fiscal costs are insignificant in comparison to the emotional toll and the impact on quality of life for those who need daily support. Many individuals with disabilities find it impossible to focus on significant life goals because they are engaged in a daily struggle to find the support essential to meet their basic health, safety, and daily care needs.

Wages and Benefits

Accurate data reflecting wage ranges of DSPs by service type and population are currently not available for North Carolina. In 1999 (Test et. al.), a study of DSPs in North Carolina indicated an average wage of $9.30 for public employees and $9.24 for combined public and private DSPs. However, there were several methodological issues this study, including categorization of wages in relation to services provided and DSP title or role.

Ideally, hourly wage data would be available on entry level, average, and experienced DSPs in relation to setting, service type, and population served. Broad data is available from the U.S. Bureau of Labor Statistics regarding direct support positions, but is generally focused on the aging industry rather than across the life span. These data sources are not typically inclusive of direct care workers in the developmental disabilities, mental health, and substance abuse fields. This data is presented in Table 3.

It is widely known that the wages for people in direct support work are on the low end of the spectrum and that employees that work for public sector employers earn more than those working in the private sector. Average wages for DSPs in private sector community services for persons with developmental disabilities range from $7.30 to $15.18, with a mean of $8.68 (Larson, Hewitt & Knobloch, 2005). National studies have also looked at the disparity between public and private sector wages. In a recent study the average DSP hourly wage in a public sector direct support position was

$12.53 (Larson, Byun, Coucouvanis & Prouty, 2005). For comparison, the Bureau of Labor Statistics wage data are provided for the three job classifications tracked. Wages for all workers in behavioral health tend to trail comparably with prepared workers, and the direct care workers are the lowest paid of all in the field (Thompson, Merrick, Reif & Horgan, 2007). While precise data on wages for this sector of the workforce is unavailable, the low level of compensation has been repeatedly cited by program managers as a major cause of turnover in behavioral health (Hoge, Morris, Stuart, Daniels, Huey, Adams, (2007).

Chronic low wages often result in DSPs having to work multiple jobs in order to maintain their quality of life, creating high levels of stress and leading to burnout. This can contribute to increased incidents of abuse and neglect, resulting in low quality job performance that can be harmful to recipients of service.

Studies show that many DSPs in community settings, especially those who work part-time, are not eligible for health care benefits. Even when benefits are available, many DSPs cannot afford to purchase them (BDO Seidman, 2002). For example, a DSP earning under $10 per hour, which amounts to $400 per week before FICA and Social Security, is hard pressed to afford the typical monthly family health care premium of $300. Studies have shown that while only 41% of workers who earn under $10 per hour have access to health care, among workers who earn $10-$15, 72% are eligible. When workers have an hourly wage of $15 or more, 88% of these workers are eligible for healthcare benefits (Collins, Davis, Doty & Ho, 2004). The lack of access to affordable health care for employed DSPs is an important factor influencing successful recruitment and long-term retention.

Occupational Status and Awareness

While DSPs provide the overwhelming majority of services and support to individuals with developmental disabilities, substance abuse challenges, and serious and persistent mental health issues, they have little professional recognition. Most citizens of North Carolina do not know who DSPs are, nor do they understand the value DSPs contribute to North Carolina communities. Organizations often view DSPs as entry level employees and provide few opportunities for growth and development. Connecting DSPs to systems of secondary and post secondary education, as well as statewide labor initiatives, does not occur. This may be due to a general belief by policy makers and communities that the position of DSP is not a high level job, worthy of investment.

Training and Development

Applicants for direct support positions are typically required to have a high school diploma or its equivalent, a driver's license, and must pass a criminal background review. While North Carolina rules require that supervision be available from a qualified professional, there are no pre-service training requirements for DSPs. Training requirements during employment are focused on service rules and on mastering service definitions. Certain types of service provision require DSPs to have CPR and first aid training and the amount of in-service training provided to DSPs varies by agency. Most employer-based training meets minimal regulatory requirements, with substantial portions focused on regulatory procedures rather than the person-centered knowledge and skills identified as key professional competencies that lead to positive outcomes (Taylor, Warren and Bradley, 1996).

Currently, DSP training does not result in a certificate or diploma. Few post-secondary programs are designed to reach entry-level community human services personnel. In addition, many trainers within human service organizations are not well-versed in instructional design methods and effective adult learning methods. This results in

training that is inconsistent, does little to enhance employee motivation and long-term commitment. The end result is that North Carolina's current system fails to create a pattern of linked steps that increase professional knowledge and lead to continued career advancement for the majority of DSPs.

Due to systemic factors as well as problems inherent to the DSP workforce, it becomes difficult to provide effective training to this workforce. While employers do offer the required introductory training to their new employees, few offer extensive or additional professional development training in the evenings, on weekends, or in formats that would provide flexibility and access to DSPs, such as Internet-based learning. Incentives for DSPs to complete additional training vary widely. Graduated pay levels based on levels of responsibility and training/certification do not exist in North Carolina and are not built into provider rate structures and contracts for direct support work.

It is important to recognize that the professional development needs of DSPs vary based on the services provided and the needs of the recipients of service. While there are a number of common competencies that are relevant across all three

Table 4. Comparison of Core Competencies for Direct Support Workers

Substance Abuse/ Behavioral Health	Community Human Services (Developmental Disabilities and Mental Health - 167 competencies)	Aging (88 competencies)
Professional and ethical responsibilities, professional role competencies	Participant empowerment	Consumer rights, ethics and confidentiality
Client, family and community education	Community living skills and support	Personal care skills according to consumer preference and service plan
Counseling, interpersonal	Crisis intervention	Safety and Emergencies
Treatment planning, planning and outcomes, interventions	Facilitation of services	Self care
Diversity	Organizational participation	Role of direct care worker
Documentation	Documentation	Infection control
Service coordination	Community and service networking	In-home and nutritional support
Referral, community resources	Providing person-centered supports	Apply knowledge to the needs of specific consumers
Clinical evaluation, assessment	Assessment	
	Communication	Communication, problem-solving and relationship skills
	Supporting health and wellness	Health related tasks according to consumer preference and service plan
	Building and maintaining friendships	
	Advocacy	
	Education, training and self-development	
	Vocational, educational and career support	

service types (community human services, long-term care/aging, and substance abuse), there are many differences as well. The Community Support Skill Standards (CSSS) are a comprehensive job analysis conducted by U.S. Department of Labor (Taylor, Warren and Bradley, 1996). The CSSS identifies 12 competency areas and 144 skills required of entry-level community human service practitioners. The National Alliance for Direct Support Professionals has also articulated competencies and skills required of DSPs. Their standards identify 15 broad competency areas and 167 specific skills (NADSP, 2007). Direct support careers in long-term services for the elderly include 10 competency areas and 88 specific skills. Table 4 identifies these competency areas across populations.

In the field of substance abuse, a nationally recognized set of competencies have been identified in the federally-funded Technical Assistance Publication (TAP-21), titled *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (Center for Substance Abuse Treatment, 2006). This document has been used to define the content of multiple addiction counselor training programs and have been translated into various languages. It contains 123 competencies that are organized into four "foundations": understanding addiction; treatment knowledge; application to practice; and professional readiness. It also includes eight "practice dimensions, " including: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities.

While there are no nationally or universally recognized competencies for mental health practice, the United States Psychiatric Rehabilitation Association (USPRA) does certify psychiatric rehabilitation practitioners using competencies identified through a Role Delineation Study (IAPSRS, 2001). A total of 75 competencies, labeled *tasks,* are organized into seven domains, which include: interpersonal competencies; professional role competencies; community resources; assessment, planning, and outcomes; system competencies; interventions; and diversity. While many DSPs in the mental health field are not certified, these competencies have influenced the focus of training for many of these direct care providers.

In addition to differences in broad competencies and skills, there are also vast differences in ideology and philosophical approach to services. Within the developmental disabilities field, a community support model is the dominant philosophical orientation. This model is based on the premise

that individuals with disabilities should have lives that are rich with friendship, inclusion in all aspects of community life and are self-determined. Community supports are delivered by teams of individuals who are closest to the person receiving services and are directed by that person or their family. Services focus on strengths, abilities, and support needs and are less reliant on medical or mental health diagnoses and treatments. Service providers, recipients, or advocates in the field of developmental disabilities increasingly reject the medical support model.

Historically, mental health and long-term care services have been characterized by an over reliance on institutionally-based service delivery, dominated by and entrenched in a medical model where physicians and other licensed healthcare personnel make decisions about treatment plans and interventions. However, efforts are underway to move toward both a more community-focused service delivery system, as well as to provide services that are more responsive to individual needs and preferences. Efforts that support responsiveness to individual needs include consumer direction, in home and community based services, and a culture change movement in facility-based services. The field of substance abuse disorders has long-recognized the importance of an individual's acknowledgement of his or her disorder and taking an active role in managing the recovery process. There is increasing attention to issues of recovery and resilience in mental health, which has a robust consumer movement.

Listening Sessions

In May and June 2007 the MH/DD/SAS Commission's ad hoc group on Direct Support Professional Workforce Development conducted a series of listening sessions. The purpose of these sessions was to hear what North Carolinians were experiencing regarding direct support workforce challenges and to identify ideas about effective strategies and interventions. A total of 6 sessions were conducted that included 44 participants. The voices of DSPs, service recipients, and family members were heard. The results of these listening sessions are summarized in Table 5 and have been used to inform the recommendations provided in this report.

Table 5. Direct Support Workforce Development in North Carolina: Report from Listening Sessions Conducted 5/07–6/07

Recruitment

Question: *What are the best ways/places to recruit direct support staff?*

Mental Health/Substance Abuse

- Very difficult to recruit due to specificity of service definition and required roles
- Collaboration among providers to raise awareness of available jobs (job fairs), rather than the more traditional, competitive approach
- Recruit through NAMI, Mental Health Association
- Little response to newspaper advertisement
- LME matching provider contributions to recruitment efforts have been effective
- Rural areas difficult to recruit to (particularly for positions requiring extensive experience/ credentials), have demonstrated some success in using natural beauty of area as recruitment tool.
- Schools of Social Work and SA credentialing programs have been fertile recruiting grounds —
  - » Get on university resource lists
  - » Participate in school job fairs
  - » Build personal relationships with school faculty/administrators as means of recruitment
  - » Offering internships that can turn into FT employment after graduation
- Offering credentialing programs has proven effective in recruiting
- Higher pay
- Offer opportunities for staff to earn their provisional licensure while getting paid

Developmental Disabilities

- Find staff through colleges/universities – market through PT, OT, nursing, Psychology, Social Work programs
- Accessing list-serves
- Word of mouth
- Engagement of Employee Security Commission in recruiting efforts (holding job fairs on site at the ESC)
- Conduct job fairs/expos within health care settings
- Develop relationships with professionals in health care settings
- Staff referrals (with bonus to referring staff) are effective as a recruiting tool
- Approaching guidance counselor offices within high schools
- Use current DSPs as recruiters (all staff carry applications/brochures with them)
- Consumer participation in recruiting/ interviewing process
- Public awareness campaigns (billboards, PSAs, TV, etc.) to bring exposure to the field, also reduces anxieties many people have about disabilities
- Engage the business community in recruitment efforts
- Recruit people participating in TANF (Welfare to Work programs)
- Work with Better Business Bureaus to market organizations
- Flyers in community gathering areas
- Children with disabilities in inclusive school models would increase awareness and help recruitment to the field
- Avoid acronyms and use general language to describe jobs (no jargon)

Table 5. Direct Support Workforce Development in North Carolina: Report from Listening Sessions Conducted 5/07–6/07

Retention

Question: *Why do Direct Support Professionals leave their jobs?*

Mental Health/Substance Abuse

- Decisions surrounding licensure often made around what is best within urban areas (i.e. Raleigh) rather than more rural areas
- Constantly changing regulations/paperwork requirements
- People swamped with paperwork rather than actually providing services
- No investment in the area of service (people working in native communities more likely to stay)

Developmental Disabilities

- Low ceiling, no room to advance
- Poor supervision
- No recognition
- Pay not commensurate with difficulty of job
- Too large a caseload
- Little opportunity for continuing education
- Lack of benefits
- Little job security (constantly in fear of losing their job)
- No clear job descriptions
- Stress/burnout
- Family obligations do not match with demands of the job
- Cost of gas (given scattered nature of service sites)

Question: *How can agencies reduce staff turnover?*

Mental Health/Substance Abuse

- Reduce the amount of paperwork through more efficient use of documentation (less repetition of information)
- Less frequent change of requirements/ regulations (people get trained to do something, then it changes)
- More effective systems change (rather than quick fix mentality)
- Create regulations appropriate to population served rather than blanket regulations (i.e. PCP process not appropriate for someone who needs immediate service such as SA consumer)
- Offer more comprehensive benefits (i.e. health insurance, etc.)
- Up front guidelines about expectations, clear job expectations to reduce surprises
- Job shadowing programs
- Greater utilization of technology to reduce paperwork and keep up with employees in community settings
- Improved supervision practices (more investment in supervision training)

Developmental Disabilities

- Higher pay
- Provide better benefits to employees (health insurance, reliable vacation planning, etc.)
- Greater career paths/benchmarks for success and experience
- Improved training
- Realistic job descriptions/expectations
- More training about disability specific issues to increase staff understanding
- Standardized training/credentialing program
- More full time job opportunities
- Better supervisors (more supervisor training regarding role modeling and effective leadership), supervisors with more "real-life" experience
- Better screening processes for incoming staff
- Greater usage of family members as DSPs
- More investment in "take care of the caregiver"
- Peer to peer support programs, access to support resources
- Greater reimbursement for expenses (mileage, meals, etc.)

Table 5. Direct Support Workforce Development in North Carolina: Report from Listening Sessions Conducted 5/07–6/07

Training and Support

Question: *What skills are needed by the workforce?*

Mental Health/Substance Abuse

- Familiarity with Medicaid rules/structures
- Strong communication (verbal and written) and observation skills
- Logical, analytical, decision-making skills
- Background in content area (via academic/ school-based training)

Developmental Disabilities

- Must understand the "Golden Rule" (Do unto others as you would have them do unto you)
- Understanding of the weight/responsibility of caring for another human
- Understanding of Person Centered Planning/ Thinking, willingness to get to know consumers on an individual level
- Good communication skills (verbal & written)
- Strong decision-making and problem-solving skills
- Awareness of community activities/opportunities for greater participation and integration
- Ability to recognize consumer talents/creativity
- Basic computer skills
- Basic math/reading/writing skills

Question: *What kind of training does direct support staff need?*

Mental Health/Substance Abuse

- Communication training
- On-the-job training/job shadowing
- Crisis recognition and response training

Developmental Disabilities

- Healthcare/medication administration/CPR
- Basic overview of disability issues/diagnostic information
- Individualized training (people are different, no template for services)
- Training that is engaging and held frequently (quarterly?)
- Understanding of emergency resources
- Portable training that can be taken from job to job (more standardized)
- Greater inclusion of disability material in school/ college curricula
- Total immersion and cross training across work sites to help staff become more well rounded
- Put people in the role of receiving services to experience consumer perspective
- Leadership and management training for DSPs who hope to someday get promoted

Table 5. Direct Support Workforce Development in North Carolina: Report from Listening Sessions Conducted 5/07–6/07

Training and Support

Question: *What kind of things can employers do to better support DSPs in their jobs?*

Mental Health/Substance Abuse

- Encourage participation in trainings/conferences external to agency (increases recognition and investment)
- Opportunity to be listened to regarding organizational direction and activities
- Offer a living wage (without having to work 60 hr/wk)
- Safe/secure organizational culture (people scared for their jobs will not be effective workers)
- Rewards/incentives for good work done

Developmental Disabilities

- Greater recognition for work performance
- Reduce paperwork requirements to allow people to concentrate on actual service provision
- Value input from DSPs, create team approach to services
- Provide positive feedback
- Rewards/incentives for good work (specific acts, not just "good job")
- Focus put on staff rights/needs as well as consumers' rights/needs
- Accessibility of supervisors and administrators for DSP concerns and suggestions
- Opportunities for new challenges
- Less bureaucratic approach to dealing with DSPs (more personal relationships)
- Offer higher-level trainings to DSPs (rather than only supervisors, admin.)
- Education of human resource/personnel departments surrounding issues pertinent to DSPs

Evidenced-Based Interventions and Strategies

A number of researched-based interventions have been identified as effective in improving direct support worker retention and competence. These strategies include —

- Finding and hiring
- Socializing and training
- Motivating, and supporting.

Demonstrations involving one or more of these interventions have been shown to be effective in reducing direct support turnover in a number of organizations and states, in both human services and long-term care aging services. Brief descriptions of these interventions are identified in the following sections of this report.

Recruitment

Recruitment is part of the organizational entry process and involves letting people know about positions that are currently available. Studies indicate the most common method of advertisement for positions in this field are advertising in the newspaper and using existing employees to find new employees (Test, Solow & Flowers, 1999; NYSARC, 2000). Unlike other industries, the community human services and long-term care industries rarely rely on radio and television ads, referral agencies, or job fairs. In a review of best practices conducted by the Centers for Medicare and Medicaid Services, a number of successful marketing strategies were identified. These include Web-based registries that match people with positions and the use of community sponsored events such as job fairs (CMS, 2007).

Using inside recruitment sources is another effective strategy to increase the probability that workers hired will make a long-term commitment to their position. Inside sources provide information not typically known by persons outside the company (Wanous, 1992). Examples of inside sources are rehires, referrals, and in-house job postings that target current employees, volunteers, and friends of staff members. Research indicates the number of months a new hire stays in an organization is approximately 24% higher when inside sources are used (Wanous, 1992).

Realistic Job Previewing

Realistic job previews give potential new hires with an accurate picture of the job for which they are interviewing. This preview is provided before a job offer is made. Using realistic job previews provides applicants with an opportunity to make an informed decision regarding whether they are a good match for the job and want to accept a job offer, if made. A realistic job preview includes both positive and negative information about the various aspects of the job and is conveyed by people who do the work.

Ensuring applicants have a good understanding of the job for which they are applying supports better retention. Research indicates that when new employees have unmet expectations about a job, it can result in lower job satisfaction, causing newcomers to leave their positions more rapidly. In a study conducted at the University of Minnesota, new hires in residential direct support jobs that had fewer unmet expectations were significantly less likely to quit in the first 12 months after hire than those who had greater unmet expectations (Larson, Lakin & Bruininks, 1998). Realistic job previews can reduce the likelihood that newly hired employees will leave their positions due to unmet expectations about the job.

Orientation, Socialization, Networking and Professionalism

When new workers are hired, they often come to the position with little or no experience and a variety of supports may be needed for the individual to experience success in their new job. Assistance in understanding the informal aspects of the job — "how things are done"— and information and training on how to do the specific tasks and duties of the job, are critical. New employees report that one of the greatest challenges in starting a new job is to understand the characteristics, routines, likes, dislikes of and getting to know the people they work with on a daily basis. Learning their job duties and getting to know their co-workers is an additional challenge. These barriers contribute to a stressful start for most new DSPs (Larson, Lakin and Bruininks, 1998).

One effective strategy to address this challenge is enabling DSPs to learn from one another. In 1994, a study of newly hired DSPs found that when they were supported by their coworkers, DSPs were more likely to stay on with their positions than those who did not have this support (Bachelder & Braddock, 1994). In this study there were several components of co-worker support that were deemed important, including existing direct support workers are personally supportive of the new staff person; existing staff with experience see one aspect of their job as training newcomers; existing staff give newcomers advice and guidance on how to do their job; and the training provided by the organization builds on experience of the new staff person. Another study found that coworkers are the most available source of socialization information (Louis, Posner & Powell, 1983).

Supervisors also play an important role in the orientation and socialization of new employees. Research suggests that the information provided by supervisors about the tasks and roles of new employees is an important factor in socialization satisfaction, commitment, and feelings of adjustment (Ostroff & Kozlowski, 1992; Louis, Posner & Powell, 1983).

Competency-Based Training

Competency-based training is training that focuses not on rules and regulations, but instead on the knowledge, skills, and attitudes required of new employees to be effective at direct support. Competency-based training programs are focused on work performance and results. They are based on specific, precisely stated outcomes, known as competencies or tasks, which are viewed as essential for successful employment in the given occupation. These competencies describe exactly what the learner should be able to do upon completion of the training program. Competency-based training programs give learners time to master one task before moving on to the next and require each learner to perform each task in the work environment before receiving credit for attaining each task. These training programs typically avoid dictating the method of instruction, allowing for more flexibility within organizations and educational institutions (Fiorelli et al., 1982).

For some DSPs, national job analyses have been conducted in order to identify the necessary competencies required of people who work in direct support (Table 4). Competency based training programs are effective at teaching workers the skills they need to do their jobs and are more effective than dictating the number of hours of required training or focusing training on specific rules and service definitions. In North Carolina, all training required of direct support workers is hours-based and not competency-based.

Mentoring

Four out of five CEOs of Fortune 500 companies attributed a significant proportion of their success to having had a mentor (Bell, 2002). Mentoring programs were one of many interventions used in community living services that successfully resulted in turnover reductions by as much as 18% (McCulloh, Larson, Hewitt, 2007). Table 6 provides an overview of benefits of effective mentoring programs.

Table 6: Benefits of a Mentorship Program

Key People	Benefits to those Key People
Organization	Low cost method to communicate vision/mission/best practice
	Better quality supports
	Fosters development of employees
	Strengthens retention and reduces turnover
	Stronger employee commitment
New Hires	Tap into accumulated knowledge and experience of mentor
	Safe opportunity for feedback
	Place to bring anxiety and concerns
	Connect socially with others
	Decrease feelings of isolation
	Gain access to information
	Guidance on norms
Mentors	Recognition for skills and abilities
	Opportunities to develop new skills and advancement
	Renewed interest in job
	Raises, bonuses, and rewards
Consumers	Better services
	Less turnover
	Positive long-term relationships

(Taylor, Sauer, Hewitt, O'Nell, & Larson, 2001)

Supporting and Training Supervisors to Support a Diverse Workforce

Supervisors are critical to effective hiring, training, and retention of DSPs (Cohen, 2000; Hewitt, Larson, & Lakin, 2000; Lakin, Bruininks, Hill, & Hauber, 1982; Larson, Lakin, & Hewitt, 2002). Organizations that have new or ineffective supervisors have higher DSP turnover rates (Larson, Lakin, & Bruininks, 1998). DSPs often leave their positions for reasons in which the supervisor pays a critical role, such as difficulties in getting along with co-workers and conflicts with supervisors (Larson, Lakin, et al., 1998).

Many supervisors are promoted to their position because they were good at performing direct care. However, they are often thrown in to a supervisory position with little training and support and learn through trial and error. Supervisors reported that they like having opportunities for networking, practicing the information they learned, and attending training provided outside the organization (Larson, Sauer, et al., 1998). In a recent national report on the behavioral health workforce (Hoge, Morris, Stuart, Daniels, Huey & Adams, 2007), increased attention to supervision was cited as a key strategy in improving the quality of the workforce. Previous demonstration and evaluation projects conducted by the NIDRR funded Research and Training Center on Community Living and the Centers for Medicare and Medicaid have shown that when organizations implement the training supervisors as one of several evidence based workforce interventions, they can reduce their turnover rates y 4% to 15% on average.

There are a number of identified competencies required of effective supervisors in community human services. These competencies include enhancing staff relations; providing and modeling direct support; facilitating and supporting consumer support networks; planning and monitoring programs; managing personnel; leading training and staff development activities; promoting public relations; maintaining homes, vehicles, and property; protecting health and safety; managing finances; maintaining staff schedules and payroll; coordinating vocational supports; coordinating policies, procedures, and rule compliance; and performing general office work (Larson, Doljanac, Nord, Salmi, Hewitt, & O'Nell, 2007) .

Recommendations

The North Carolina Commission's ad hoc group on direct support workforce development prioritized recommended interventions and strategies for the State of North Carolina to address issues of compensation recruitment, retention, and training. Through a nominal process, the top ten most highly recommended strategies were identified. The leading recommendations are as follows —

1. Create a Permanent Structure and State-Wide Advisory Capacity

The state Department of Health and Human Services (DHHS) should convene and support a statewide advisory group. This group would have the responsibility for gathering data and information to inform policy makers, advocates, and service recipients about the status of the North Carolina direct support workforce. Data elements of focus for this advisory group should include: 1) identifying the number of DSPs working in MH, SA, and DD services, as well as those in long-term care aging service; 2) gathering annual DSP turnover rate;, 3) gathering annual DSP vacancy rates; 4) identifying entry, median and the range for direct support wage;, and 5) identifying eligibility and election of offered health care benefits. In addition to data collection and trend analyses, this stakeholder group would have the responsibility for making decisions about the implementation and outcomes of strategies to address the direct support workforce challenges. Membership should include representatives from many areas of state government and should be comprised of people in

decision-making roles. This Department of Health and Human Services initiative should be led by DHHS, in full collaboration and partnership with the Departments of Labor, Public Instruction, and Post -Secondary Education. In addition to state level policy members, the advisory group should include members of the community that represent the many key stakeholder groups. See Table 7 for a list of recommended participants.

Table 7. Recommended Membership of Statewide Advisory Group on Direct Support Workforce Development

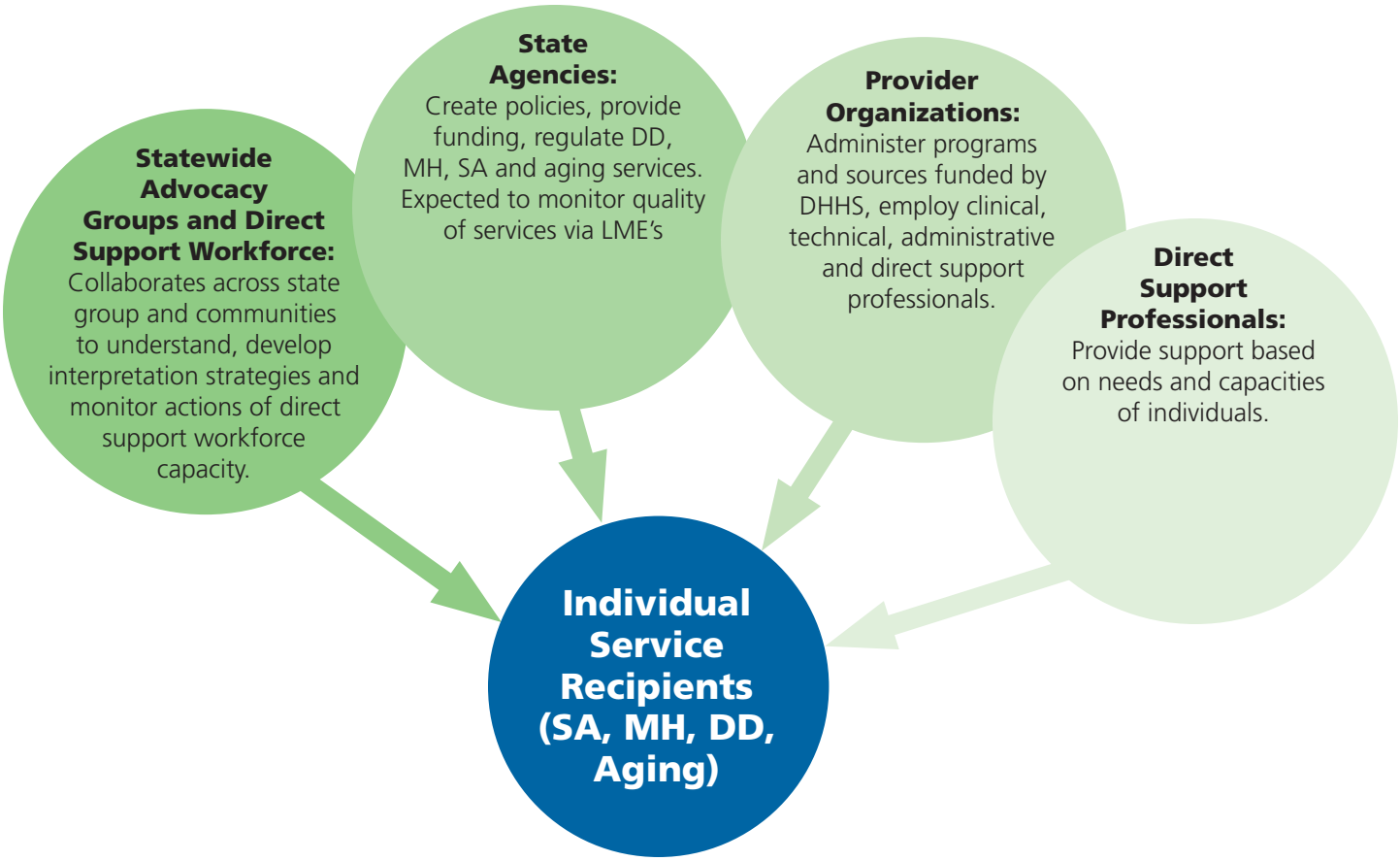
Department	Division Directors
Health and Human Services	DMH/D/DSAS, DMA, Aging and Adult Services, Vocational Rehabilitation, Social Services
Labor	Apprenticeship, Workforce Commission
Public Instruction	K-12
Post-Secondary Education	Public Universities, Community Colleges
Community Stakeholders	**Representation/Membership**
Direct Support Professionals	Mental Health, Substance Abuse and Developmental Disabilities, Aging
Community Providers	Mental Health, Substance Abuse and Developmental Disabilities, Aging
Local Management Entities	Each region
AHEC	Each region
Council on Community Programs	Executive Director
Council on Community Providers	Executive Director
Family members	Mental Health, Substance Abuse and Developmental Disabilities, Aging
Service recipients	Mental Health, Substance Abuse and Developmental Disabilities, Aging
North Carolina Council on Developmental Disabilities	Executive Director
University Center on Excellence in Developmental Disabilities	Executive Director or Training Director
Protection and Advocacy organization	Executive Director
Legislator	Key HHS or Labor Committee Chair
Direct Support Worker Professional Association(s)	Board members who are direct support workers

It is important that the statewide advisory group on direct support workforce understand their relationship to improving quality within the system. Figure 2 provides a visual representation of the roles and responsibilities of various stakeholders. In this Figure, the service recipient is at the center. It is important to note that direct support workers are represented next and are closest to the center circle of service recipients. Provider organizations are the next circle and state agencies are farther removed. The direct support workforce advisory group has the daunting, yet critical task of ensuring that the resources, support and recognition for excellence in service provision across mental health, substance abuse, and developmental disabilities are targeted as close to the service recipient as possible. The closer committed resources are to the service recipient, the greater their impact on the overall quality of service and quality of life experienced by that service recipient.

2. Create a Certificate or Credentialing Program for DSPs

In collaboration with Providers and the State Medicaid Office, the DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse should assume a lead role in creating an education and training program that recognizes DSP skills and competence through a certificate or credentialing program and offers a multi-level career path for these workers. An on-line, competency-based training opportunity for DSPs should also be made available throughout North Carolina communities. This program should be accessible to direct support workers, meet national credentialing requirements as appropriate, and be based on the philosophical and best practice orientation for each industry (mental health, substance abuse, developmental disabilities, and aging). Incentives should be created for DSPs to

Figure 2. Role of Statewide Direct Support Workforce Advisory Group.



complete the education/training program, and should include, such things as job promotions, increased wages, and/ or student loan relief for DSPs who agree to remain on the job at an organization after completion. Individuals with disabilities and families should be included as active instructors in any certificate or credentialing program that evolves in any of the industries.

3. Increase the Wages of Direct Support Workers

The State Department of Medicaid Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse should work together to provide wage increases to all direct support workers in North Carolina, in order to ensure workers earn a livable wage. In addition, create a budgeting mechanism in North Carolina that ensures an annualized cost of living wage increase for direct support workers. A statewide wage incentive program should be created that ties wage increases to demonstration of competence and a comprehensive, statewide, competency-based training program.

4. Create a Marketing and Public Awareness Campaign

The provider organizations and associations, in collaboration with the advisory group, should create a well-designed and comprehensive statewide marketing and public relations campaign that results in North Carolinians knowing who direct support workers are and what contributions they make to their communities. This campaign should create a consistent occupational title for direct support workers. Marketing materials and resources such as fliers, videos, and Web sites should be created for use by providers to recruit specific target groups into direct support work, including but not limited to retirees, students, and displaced workers. These materials should be used within the workforce development center, K-12 education, and other community resources where individuals seek stable, professional careers.

5. Provide Systematic Training, Technical Assistance and Incentives to All Community Providers in North Carolina on Effective Recruitment, Retention and Training Practices

The provider organizations and associations, in collaboration with other training entities in North Carolina, should provide training to organization and service providers on evidence-based practices for direct support worker recruitment, retention, and training. This training should be developed and disseminated throughout the state and target providers of MH, DD, SA and aging services. Interventions taught in this training should include marketing and recruitment strategies; selection; orientation/socialization; supervisor training; organizational cultural change; competency-based training and motivation and recognition. Organizations in North Carolina that —

- Effectively implement these workforce strategies and successfully reduce their direct support turnover and vacancy rates; and
- Improve DSP competence by increasing the percentage of workers that have achieved credential or certification
- Should be given incentive-based increases in their rates to offset their increased investment in their workforce.

6. Provide System-Wide Training to Supervisors and Managers on Effective Supervision

The provider organizations and associations, in collaboration with other training entities in North Carolina, should provide system- wide training to supervisors on effective supervision practices to increase the ability to retain employees. This training should include topics such as the role of a supervisor, professional relationship building, understanding leadership, supervising a diverse workforce, communication, teamwork, performance coaching, conflict resolution, competency-based training, employee development, and employee motivation and recognition.

7. Provide Opportunities to Empower DSPs

All state agencies involved in community human services should ensure that DSPs are at the table when public policy is discussed regarding persons receiving mental health, substance abuse, developmental disabilities or aging services. DSPs must be viewed as key stakeholders within the system and financial support must be provided for their participation. The DCWA of North Carolina should provide statewide and local access to professional association(s) for DSPs with national affiliations, as appropriate. Opportunities should be provided for DSPs to network across organizations through sponsoring such events as a statewide conference for DSPs.

8. Create New Service Options for Consumer Directed Services for Individuals with Disabilities and, as Appropriate, Their Families

The State Medicaid Office and the Division of Mental Health, Developmental Disabilities, and Substance Abuse should create a self-direction option for service delivery under the Home and Community Based Waiver programs in North Carolina. Self-direction will provide the opportunity for individuals and families to find, choose, guide, and direct their own direct support workers without reliance on provider organizations. All individuals and families who choose a self-directed service option should be trained on how to find, choose, and keep DSPs. Individuals and families that choose self-direction should be provided with training and support regarding finding and being matched with potential DSPs through the use of a Web-based registry program for direct support workers.

9. Provide Access to Affordable Health Insurance Benefits

The North Carolina legislature, State Medicaid Office, the Division of Mental Health, Developmental Disabilities, and Substance Abuse departments should create a means to organize access to health, dental, and life insurance pooled benefits across multiple provider organizations. This may include providing opportunities for DSPs to access the State employees' health insurance program.

10. Create Selection Tools to Assist Providers in Reducing Early Turnover

The North Carolina Council on Developmental Disabilities in collaboration with the departments of Mental Health, Developmental Disabilities, and Substance Abuse, should create a realistic job preview video that crosses disability groups, as well as age, that describes the role and responsibilities of DSPs from the perspective of the worker, and highlights both the positive and challenging aspects of the work being provided. Training to organizations must be provided regarding how to use the realistic job preview as a component of their selection process. This video should be made available to all providers of developmental disability, mental health, substance abuse, and aging services in North Carolina.

References

Bachelder, L. & Braddock, D. (1994). *Socialization practices and staff turnover in community homes for people with developmental disabilities.* Chicago: University of Illinois at Chicago, Institute on Disability and Human Development, College of Associated Health Professions.

Ben-Dror, R. (1994). Employee turnover in community mental health organization: A developmental stages study. *Community Mental Health Journal, 30*(3), 243-257.

BDO Seidman (2002). *On the growing crisis in recruiting and retaining the direct support workforce.* American Network of Community Options and resources. Retrieved July 31, 2006. http://www.ancor.org

Center for Substance Abuse Treatment (2006). *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.* Technical Assistance Publication (TAP) Series 21. DHHS Publication No. (SMA) 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Centers for Medicare and Medicaid Services (February, 2004). *CMS correspondence from Glenn Stanton, Acting Director of the Disabled and Elderly Health Programs Group to State Medicaid Directors, State Directors for Agencies Administering the HCBS Waivers, CMS Regional Administrators, CMS Associate Regional Administrators, CMS Regional Offices, and the HCBS Inventory Group.* Downloaded September 15, 2007 from http://www.cms.hhs.gov/HCBS/downloads/qc3_020904.pdf.

Collins, S.R., Davis, K., Doty, M.M., & Ho, A. (2004). Wages, health benefits, and worker's health. *Task force on the future of health insurance Issue Brief #788.* New York: The Commonwealth Fund. (www.cmwf.org)

Hewitt, A. Larson, S.A. (2007). The Direct Support Workforce in Community Supports to Individuals with Developmental Disabilities: Issues, Implications and Promising Practices. Mental retardation and Developmental Disabilities research review. John Wiley & Sons

Hewitt, A., Larson, S., Lakin, K.C., (2000). *An independent evaluation of the quality of services and system performance of Minnesota's Home and Community Based Services for persons with mental retardation and related conditions.* Minneapolis: University of Minnesota, Research and Training Center on Community Living.

Hoge, M.A., Morris, J.A., Stuart, G.W., Daniels, A.S., Huey, L.Y., Adamns, N. (2007) *An Action Plan for Behavioral Health Workforce Development,* The Annapolis Coalition on the Behavioral Health Workforce, Cincinnati, OH

Konrad, Thomas (2003). *Descriptive results from the annual short turnover surveys conducted for the Office of Long-Term Care of the NC Department of Health and Human Services.* North Carolina Institute on Aging. Available at: http://www.aging.unc.edu/research/winastepup/reports/ShortTurnoverReport2003.pdf

International Association of Psychosocial Rehabilitation Services (2001). *Role delineation report of the psychosocial rehabilitation practitioner.* Morrisville, NC. Columbia Assessment Services.

Larson, S.A., Byun, S.Y., Coucouvanis, K., & Prouty, R.W. (2005). Staffing patterns, characteristics and outcomes in large state residential facilities in 2004. In R.W. Prouty, G. Smith, and K.C. Lakin (Eds.), *Residential services for persons with developmental disabilities: Status and trends through 2004.* Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

Larson, S.A., Doljanac, R., Nord, D. K., Salmi, P., Hewitt, A.S. & O'Nell, S. (2007*). National Validation Study of Competencies for Front Line Supervisors and Direct Support Professionals: Final Report.* Minneapolis, MN: University of Minnesota, Research and Training Center on Community Integration.

Larson, S.A., Lakin, K.C., & Bruininks, R.H. (1998). *Staff recruitment and retention: Study results and intervention strategies.* Washington, DC: American Association on Mental Retardation.

Larson, S.A., Hewitt, A.S., & Knobloch, B. (2005). Recruitment, retention and training challenges in community human services. In S.A. Larson & A.S. Hewitt (Eds.). *Staff recruitment, retention and training strategies for community human services organizations.* (pp. 1-20). Baltimore: Paul H. Brookes Publishing, Co.

Louis, M.R., Posner, B.Z., & Powell, G.N. (1983). "The availability and helpfulness of socialization practices." *Personnel Psychology, 36,* 857-866.

Morris, J.A., Stuart, G.W. (2002). "Training and education needs of consumers, families, and front-line staff in behavioral health practice." *Administration and Policy in Mental Health, 29,* 37-402.

NADSP, 2007. http://www.nadsp.org/credential - retrieved 9.22.07.

North Carolina Employment Security Commission, Labor Market Information Division, *Statewide Occupational Projections 2004-2014,* Available at: http://www.ncesc.com/lmi/occupational/Occupational_Projections_NC_2004_2014.pdf.

Ostroff, C., & Kozlowski, S.W.J. (1992). "Organizational socialization as a learning process: The role of information acquisition." *Personnel Psychology, 45,* 849-874.

Paraprofessional Healthcare Institute. (2007). Definitions of core competencies for entry-level direct-care workers. Paraprofessional Healthcare Institute, NY.

Seavey, Dorie (2004) The Cost of Frontline Turnover in Long-Term Care, Better Jobs Better Care Practice and Policy Report. Washington, DC: BJBC, IFAS/AAHSA. Available at: http://www.bjbc.org/content/docs/TOCostReport.pdf.

Taylor, M., Bradley, V., & Warren, R. Jr. (1996). *The community support skill standards: Tools for managing change and achieving outcomes.* Cambridge, MA: Human Services Research Institute.

Test, D., Solow, J. & Flowers, C. (1999). *North Carolina direct support professionals study: Final report.* Charlotte: University of North Carolina at Charlotte.

Thompkins, C.P., Merrick, E.L., Reif, S., & Horgan, C.M. (2007) Financing issues in the behavioral health workforce. In Hoge, M.A., Morris, J.A., Stuart, G.W., Daniels, A.S., Huey, L.Y., Adamns, N. (2007) *An Action Plan for Behavioral Health Workforce Development.* The Annapolis Coalition on the Behavioral Health Workforce. Cincinnati, OH.

U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long Term Care Policy (2006). *The supply of direct support professionals serving individuals with intellectual and developmental disabilities: Report to Congress.* U.S. Department of Health and Human Services, Washington, D.C.

Labor Market Information Division, Employment Security Commission of North Carolina - http://eslmi23.esc.state.nc.us/projections/EmploymentOutlook.asp?version=aopengd&AreaType=01&Area=000037&PeriodID=07 (retrieved 9, 2007).

U.S. Census Bureau, Population Division, Interim State Population Projections, 2005 http://www.census.gov/population/www/projections/projectionsagesex.html (retrieved 9, 2007)

Wanous, J.P. (1992). *Organizational entry: Recruitment, selection, orientation and socialization of newcomers.* (2nd Ed.). New York: Addison Wesley