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The Human Services Workforce Crisis: Moving Forward with Intention in Massachusetts

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Abstract

The human services field is growing rapidly in Massachusetts as it is across the country, and the Commonwealth does not have enough qualified staff to fill vacancies. The workforce shortage has risen to crisis levels due to high turnover, insufficient training, low wages, and a lack of recognition and appreciation for direct support professionals. The individuals receiving services in Massachusetts deserve quality and stability. The state budget – strained by inefficient service models and reactive fixes – also demands systemic change.

The human services workforce crisis impacts a variety of stakeholders. Individuals served are directly affected, as are the direct support employees. Additionally, provider organizations and state funding departments constantly bear the burden of this problem. Families of individuals served are substantially impacted, as is the overall community (including taxpayers). The costs of the crisis are reflected in service quality, in relationships, and in dollars.

This paper explores the literature on factors contributing to this workforce crisis and its effects. My focus is on intellectual and developmental disability services, but relevant research from other human service areas is considered. Information from various academic journals and industry studies at both state and federal levels is included. Public policy is an important consideration. Based on my research and experience, I will propose additional solutions to the problem, particularly around wages, training, technology, and employee recognition.

Overview of Human Services

The Massachusetts Executive Office of Health and Human Services (EOHHS) focuses on the "health, resilience, and independence of the one in four residents of the Commonwealth we serve" (EOHHS website). This expansive mission makes EOHHS the largest secretariat in state government, reaching every community and every age group. Massachusetts EOHHS is comprised of twelve agencies, two soldiers' homes, and the MassHealth program:

Board of Registration in Medicine

Department of Children & Families

Department of Developmental Services

Executive Office of Elder Affairs

Department of Mental Health

Department of Public Health

Department of Transitional Assistance

Department of Veterans' Services

Department of Youth Services

Massachusetts Commission for the Blind

Massachusetts Rehabilitation Commission

Massachusetts Commission for the Deaf and Hard of Hearing

MassHealth

Office for Refugees and Immigrants

Soldiers' Home in Chelsea

Soldiers' Home in Holyoke

Throughout this paper, I use “human services” to refer to the field encompassing this array of services. Intellectual and developmental disability services is my key focus; however, to limit the scope of my literature review would ignore important research on generalized human services and/or other types of service. I use the term “disability services” or refer to the Department of Developmental Services (DDS) to clarify when my subject is more specifically focused.

This paper centers on the direct support professional (DSP) workforce – those frontline staff who work directly with individuals with disabilities, promoting learning and independence, facilitating health needs, and supporting household or occupational tasks. I will use the terms “direct support professional,” “DSP,” and “direct support staff” interchangeably to indicate members of this workforce. Some relevant literature on other roles (e.g., social workers and nursing assistants) is included because of the overlap in factors and experiences. However, I will focus the discussion on DSPs to provide actionable recommendations. With over twenty years’ experience in nonprofit human services, from direct support to organizational leadership, I can offer a professional perspective to complement the academic perspective. I have spent the majority of my career in intellectual/developmental disability services, and I specialize in staff learning and development, program licensing, and quality improvement.

Investigation: Factors in the Workforce Crisis

Growth of the Field

The 21st century has seen unprecedented rapid growth in human services. Employment in the field grew six percent between 2003 and 2004 in Massachusetts, compared to less than one percent overall employment growth in the state. This six percent Massachusetts human services growth was more than double the 2.3 percent national increase from 2003 to 2004 (Citino et al., 2006). Over the following years, as leaders in human services and public policy considered incremental improvements, industry employment grew explosively. Human services employment increased by 58 percent between 2004 and 2014, to approximately 164,000 jobs (Schoenberg, 2019), exceeding all projections. Around 25,000 new health care and social assistance jobs – particularly low-paying aide jobs – are expected between 2014 and 2024 (Schoenberg, 2019).

Numerous social, policy, and health factors are central to this industry growth. The 21st century trend toward community-based, person-centered services and away from facility-based services has increased the staffing ratios required. Life expectancy of individuals with intellectual disability has improved and now – with some exceptions – is approaching that of the general population (Waldman et al., 2020, p.16). Also, the prevalence of autism spectrum disorder has continued to grow; the Autism and Developmental Disabilities Monitoring Network found that one in 54 eight-year-olds had ASD in 2016 (Centers for Disease Control and Prevention [CDC], 2016). In addition, the overall aging of the United States population contributes to increasing human service needs. An estimated 72 million people will be age 65 or older by 2030 – over 20% of the U.S. population (University of Massachusetts Boston Gerontology Institute, 2018, p. 6). In a field already plagued by vacancies, this rate of growth is alarming.

Vacancy and Turnover

Research from P.C. Light (2003) explored the health of the human service workforce based on seven organizational factors. With a 25-minute telephone survey of 1213 human service workers, Light diagnosed each factor as *healthy*, *at risk*, or *in critical condition*. Out of seven organizational factors:

One factor was rated as "healthy":

The motivation to improve the lives of people they serve.

Three factors were rated "at risk":

Training and talent of the workforce.

Having sufficient resources to succeed.

Perceiving respect and confidence from those served.

Three factors were deemed "in critical condition":

Being asked to do the possible.

Recruiting and retaining talented workers.

Rewarding employees for a job well done.

The average annual turnover rate for direct support professionals in the United States is a staggering 45% (President's Committee for People with Intellectual Disabilities [PCPID], 2017). This is in comparison to an average of about 18% turnover across industries, before the impact of the COVID-19 pandemic (Society for Human Resource Management, 2017, p. 13). Many factors contribute to this high turnover in direct support, fostering a vicious cycle in which vacancies beget more vacancies. Unfilled shifts leave more tasks for the remaining staff to complete. Temporary and agency staff are not familiar with the documentation and approaches needed, leaving the burden on the remaining staff. Exhausted employees working multiple jobs perform

poorly, making the environment more stressful for those trying to do a good job. Relationships with individuals served are inconsistent, resulting in more challenging behaviors. In short, the existence of high turnover makes the work environment frustrating – leading to even higher turnover. To stop this cycle, we must create a stable, positive environment by filling vacancies and improving conditions.

A study published in the Journal of Social Work highlighted key forces behind direct support staff turnover (Thaden et al., 2010). Stress and burnout were at the forefront. 81% of human service workers strongly agreed that it was easy to burn out in their line of work. Interpersonal stress is entwined in the support services they provide, even discounting the stress of inadequate human resources. Critical incidents are regular occurrences, and depending on the service sector, a health emergency or behavioral crisis might be a daily event. These are accompanied by emotional fallout and, often, extensive documentation requirements.

The overall workload also contributes to turnover. In the 2010 study by Thaden et al., 70% reported always having too much work to do. The job description of direct support staff is incredibly diverse, encompassing everything from health care to community coaching, writing, cleaning, counseling, safety and compliance work, and more. Human service organizations, typically operating on government contracts and limited fundraising, tend to be under-resourced. This trickles down to the direct support staff, who often fill multiple roles and have insufficient technology and equipment.

The heavy workload relates to another finding of Thaden et al. (2010) indicating that employees leave because the reality of the job is far from their expectation. A direct support professional may have been attracted to the field by the desire to connect with humans and make a difference. If this was their motivation to overlook the low pay, they may leave quickly when

they realize the amount of administrative documentation required, and do not see visible outcomes to their clients. Also discouraging was the finding of Thaden et al. (2010) that the most talented employees turned over quickly, with recent college graduates indicating little interest in a long-term human services career.

In fact, approximately 35 percent of direct support professionals leave their positions in less than six months, and 22 percent leave within six to twelve months (PCPID, 2017, p 20). The President's Committee for People with Intellectual Disabilities, in their 2017 report, cited numerous studies confirming the high turnover rate in the DSP workforce. They estimated the annual cost of replacing United States DSPs to be a staggering $2,338,716,600 in 2015 (p. 20). In their research on turnover in human services, Wine et al. (2020) outlined the financial strain in addition to the service delivery impact and loss of expertise. Typical financial considerations include overtime costs, temporary staffing, additional human resource time for termination procedures, training and material costs for the replacement employee, and trainer time.

At current turnover rates, the field requires 574,200 new DSPs in the United States every year (PCPID, 2017). Amplified by the rapid growth in the human services field, the turnover and vacancy problem will become insurmountable without major improvements.

Training

Thaden et al. (2010) surveyed 132 former employees of a social service organization who rated their experiences on a seven-point Likert scale. Only 44.7% *agreed* or *strongly agreed* with the statement "I received appropriate training on joining the department to enable me to do my job," with another 21.2% *slightly agreeing* (p. 415). Employees varied widely in the amount of time they reported spending in training and the quality of the training. They referenced

complicating factors such as being pulled from training to perform direct service work or receiving training that did not reflect the reality of their work (p. 420-421).

As Light concluded back in 2003, the training and talent of the human services workforce is at risk. Today, organizations struggle to recruit enough applicants for their direct support vacancies. This can result in hiring staff without relevant experience or education. Amidst the scarcity, organizations may also drop their requirements for important skills such as written and verbal communication, a driver's license, and health and safety certifications. Some staff do enter the field with specific credentials, such as Certified Nursing Assistant (CNA) or Home Health Aide (HHA). But individuals hoping to validate and professionalize their training can find themselves frustrated by the fact that direct support professionals are *not* just health care workers. They are teachers, community navigators, and human rights advocates. They are cooks, cleaning coaches, and drivers. They are behavior supporters and data trackers. CNAs and HHAs identifying solely as nursing staff will be disappointed by the dilution necessitated by the broad job description of a DSP.

Training for direct support staff is limited by a number of factors. The President's Committee for People with Intellectual Disabilities (2017) noted the lack of federal pre-service and in-service requirements for DSPs. Their report also highlighted four key challenges in thoroughly training DSPs before they start work:

(1) reimbursement rates that cover little more than personnel costs;

(2) the dispersal of DSPs across many work sites and the centralized location of training;

(3) the widely varying hours worked by DSPs and the difficulty of finding convenient times for training; and

(4) the high rate of DSP position vacancies, making it difficult to cover work shifts while DSPs attend training (p. 17).

These realities impact the quality of DSP training. New staff may need to be hurried through a checklist of compliance requirements, sometimes training themselves via packets of materials or online slides. Interactive virtual training is a useful tool in accommodating these challenges but does not replace the need for fully-engaged learning on the job. A 2016 article from the American Network of Community Options and Resources (ANCOR) points out that many frontline staff report discrepancies in the training they received before starting work. This predisposes them to dissatisfaction and introduces unnecessary risk. Frontline staff need a structured and accurate training curriculum that includes continuing education (Gause, 2016).

The need for higher-quality, more extensive training is more intuitive than the possibility that direct support staff receive *too much* training at orientation. New hires are bombarded with material to meet licensing and certification requirements. In the space of a few days, a Massachusetts direct support professional working in a group home funded by DDS might be trained in human resource requirements, health and safety protocols, behavior management, causes of disability, documentation and reporting, nutrition, human rights, equipment, written communication, nursing skills, community inclusion, details of the individuals in the residence, and a multitude of policies. See Table 1 for a sample orientation training schedule based on DDS regulations and training requirements from the DDS Learning website.

Certainly, this abundance of training is rooted in the right priority – the need to support all facets of an individual's life. The DSP's job description is highly diverse, so the training must be diverse as well. However, in a frenzy to meet licensing requirements and check off needs before deploying the new hire, the DSP receives too much information too quickly. The issue is

exacerbated by the reality that 18.9% of Massachusetts human service workers are foreign-born and have higher instances of both disability and English language barriers than the overall workforce (University of Massachusetts Donahue Institute, 2018, p. 8). The deluge of information is too much – yet not enough. DSPs would be better served by a limited orientation, followed by structured, ongoing in-service training. Materials could be absorbed gradually on the job, with learning solidified by real-life examples.

Unfortunately, human service organizations tend to operate with limited training resources. Providing a continuous program of site visits with individual-specific learning is not feasible for most at current Massachusetts funding levels. Further complicating the issue are state licensing standards that require staff to complete numerous training modules *before* working a shift. The standards are well-intentioned, often inspired by a critical incident that occurred in the past and the desire to prevent similar incidents. But reactive pre-employment standards leave organizations with two undesirable choices: either delay the start dates of in-demand new DSPs, or rush them through a checklist of requirements and hope they retain most of it. Remarkably, many of the DSPs have already completed a similar training series through another job. Because Massachusetts has the same training requirements for each category of licensing, but does not have a centralized learning registry, staff who work multiple jobs will repeat the mandatory modules. Perhaps this is useful for reinforcing core learning, but it is certainly not an efficient use of resources.

Training improvement is not an issue limited to direct support staff; their supervisors need it too. Frontline managers in human services often stumble into their promotions rather than following a structured career path. Their supervisory skills (or lack thereof) become another factor in the job satisfaction of DSPs. A 2019 Relias Learning survey of DSPs found that they

were frustrated by the preferential treatment and work politics exhibited by their supervisors. Staff called for better supervisory training in avoiding these pitfalls, showing appreciation, and providing clear and consistent communication (Kunst, 2019). Improved training for frontline managers is one element of the overall need for learning paths and career growth opportunities in human services.

Wages

The human services field – particularly its direct support roles – is notorious for low wages. In 2007, the University of Massachusetts Donahue Institute and the Massachusetts Council of Human Service Providers collaborated for their second study of the workforce crisis: "Help Wanted 2: Recruiting and Retaining the Next Generation of Human Services Workers in Massachusetts." The human service provider organizations surveyed perceived wages as a substantial driver of the problems:

- Nearly 85 percent agreed that the low human service salaries contributed to staff turnover.
- Nearly 80 percent agreed that low salaries contributed to recruitment difficulties and extended vacancies.

The salary study by the Donahue Institute and Providers' Council reinforced these perceptions. At the time, median earnings among human services workers were approximately $9,000 less than workers in health care and other industries. The gap is even more substantial between direct service workers in human services and health care, with the health care workers earning almost $15,000 more.

Another study from the Donahue Institute and Providers' Council (2018) showed that the median wages of human service workers were substantially lower than both healthcare workers and the Massachusetts average across industries. The average human service worker earned only $27,376, compared to the average healthcare worker who earned $45,626 (University of Massachusetts Donahue Institute, 2018, p. 11). See Table 2 for an illustration of salary discrepancies.

In 2008, the Commonwealth of Massachusetts enacted Chapter 257, An Act Relative to Rates for Human and Social Service Programs (Massachusetts Legislature, 2008). The Legislature passed Chapter 257 unanimously to address years of underfunding, as human service rates had not been adjusted statewide from 1987 to 2007. The rates in place did not cover actual operating costs for programs once factors like salary, benefits, and utilities were factored in (Association for Behavioral Healthcare, 2014). EOHHS leaders acknowledged that the reimbursement rates were not standardized, transparent, or aligned with market realities. Under Chapter 257, the Secretary of EOHHS would be responsible for setting reimbursement rates after receiving testimony at a public hearing on each proposed rate.

The act mandated a four year timeline for rate-setting with the deadline originally set for 2012. The Legislature extended the timeline to require progress milestones, with 100% of contracts with social service providers subject to the new process by January 1, 2014. As of that date, only 37.3% of providers were being paid the new rates (Association for Behavioral Healthcare, 2014). The Providers' Council, along with some individual human service providers, filed suit later in 2014. The Superior Court ruled in January 2015 that EOHHS had 90 days to establish payment rates for all covered providers. In May 2015, EOHHS reached a settlement with providers requiring one-time payments to compensate for delayed rate reviews, and a three-

tier rate rollout by 2017; these deadlines were met (Office of the State Auditor, 2019). Today, EOHHS continues to conduct the Chapter 257 rate-setting process every two years.

Chapter 257 funds were certainly a step in the right direction toward improving compensation for human service workers. Communication and collaboration around this issue has also improved. For example, in a Providers' Council article about a rate review impacting funding for FY 2020-21, the tone was hopeful:

> The Association for Behavioral Healthcare (ABH), the Association of Developmental Disabilities Providers (ADDP), the Providers' Council and the Children's League of Massachusetts (CLM) have been working closely since the beginning of the year with EOHHS Secretary Marylou Sudders and members of her senior leadership team to devise strategies to help human service organizations confront the growing workforce crisis in our industry. These meetings were inspired, in part, by the commitment made by Gov. Charlie Baker at the Providers' Council convention last September to address workforce shortages in the human services industry. The projected rate increases are a direct result of these discussions. Additionally, EOHHS has committed to implementing similar investments in rates for other services scheduled for review later in state Fiscal Year 2020 and Fiscal Year 2021. The organizations have been meeting productively with EOHHS on a weekly basis since January to begin addressing the human services workforce issues (Providers' Council, 2019).

However, reimbursement rates are still not adequate to offer direct support staff a competitive wage. With many programs requiring high staff-to-client ratios and 24-hour coverage, payroll consumes the bulk of a provider's budget. Even with creative fundraising efforts, providers

struggle to pay direct support staff more than fast food workers. The 2006 study by the Donahue Institute and Providers' Council (p. 27) found that human services represented 3.3 percent of the state's workforce yet represented only 1.6 percent of the total payroll. The low share of state payroll illustrates the low wages paid to many human service workers.

DDS provider organizations have an unexpected competitor with respect to paying attractive wages to direct support staff: the DDS itself. Direct support workers employed directly by the state are paid substantially higher wages than community-based providers can afford based on current contract rates. The difference may be up to 30% (Providers Council, 2021). This adds yet another obstacle for provider organizations trying to recruit and retain staff. Massachusetts bills such as An Act Relative to Fair Pay for Comparable Work (2019-21) have targeted this problem, but the issue persists. During the COVID-19 pandemic, the discrepancy became even more pronounced as the employees' union for state-operated programs negotiated a hazard pay raise that was not extended to community-based providers.

Several human service advocacy organizations have performed salary studies and proposed solutions. The Arc of Massachusetts, with its 18 chapters across the state and extensive budget advocacy, lists the Workforce Shortage Crisis as one of two key items on its legislative agenda. The Arc has proposed a minimum $17/hour prevailing wage for entry level direct support staff. They request a market adjustment every two years with a target of $24/hour by 2025. They propose additional considerations for frontline supervisors' wages to promote an overall stable, qualified DSP and managerial workforce (The Arc of Massachusetts, n.d., Workforce Crisis).

Appreciation and Recognition

Direct support workers lack a strong professional identity; the average citizen has little concept that this job exists. There is not a great deal of standardization in titles or career paths. Combined with the low professional visibility is the perception of low prestige in this work, especially when value is equated with salary. To recruit and retain quality DSPs, two types of recognition are essential: recognition in the greater community of the role and value of the DSP, and recognition within the provider organization.

The Caring Force, the Providers' Councils grassroots advocacy initiative, is addressing both of these factors. The Caring Force – which promotes an agenda that supports vulnerable citizens and human service workers – launched the Essential Human Service Workers Campaign during the COVID-19 pandemic. It began as a way to thank DSPs for their commitment and courage but developed into a public awareness campaign. Yard signs, media coverage, and billboards expressed appreciation for essential human service workers and provided informational links. Governor Charlie Baker and EOHHS Secretary Marylou Sudders produced public service announcements. The campaign has enhanced awareness and recognition of human service careers, while offering appreciation to the workers themselves and showing support for legislation that benefits them.

Advocacy from initiatives like the Caring Force can help build professional identity and attract workers from the community. But until DSPs feel recognized within their own organizations, high turnover is inevitable. Light (2003) found that 51 percent of workers surveyed reported their work was "unappreciated." If an organization's culture does not value the contributions of DSPs, there is little hope for long-term retention of high-performing staff.

Relias Learning, a major provider of training for health and human service employees, produced a whitepaper to illustrate the results of its 2019 DSP Survey. Lack of appreciation was a common theme in the staff feedback, with DSPs complaining about condescending tones from management and acknowledgments with no substance. In fact, the top two factors DSPs named in retention were both related to recognition. When asked "Besides increasing your pay or benefits, what is the most important thing your employer could do to make sure you stay with them for the next five years?" the leading selections were:

"Show more appreciation for my work" – 25.91%

"Show more respect for my experience" – 18.91% (2019, p. 24)

Another Relias Learning whitepaper (Hess, 2019) recommends that provider organizations create a culture of respect to recognize and retain DSPs. They suggest asking DSPs for input on organizational policies, communicating about changes, increasing transparency, investing in training and development, and creating a peer mentoring program. The United States has celebrated DSP Recognition Week in September for over a decade now. While this is an excellent opportunity for bold gestures of gratitude, it is not sufficient to change the status quo unless an overall culture of recognition is adopted.

Costs to Stakeholders

The workforce crisis affects stakeholders across Massachusetts – the Executive Office of Health and Human Services and its array of departments, the provider organizations, and the taxpayers. It has a tremendous impact on the employees themselves, as well as the Service Employees International Union and other advocates. But the most affected, by far, are the individuals served by Massachusetts human service programs.

Maintaining high quality standards is next to impossible with 45% turnover and disengaged employees. Individuals served are sharing their most personal needs, from counseling to personal hygiene. They are also vulnerable to abuse and manipulation. Asking them to form trusting relationships with support staff who may be gone in six months is wishful thinking – or even dangerous.

Gilburt et al. (2008) researched the impact of patient-caregiver relationships on the experience of psychiatric hospitalization. The majority of themes that patients used to frame their experience were related to relationships, not treatment. Factors that were important to them, such as trust, communication, safety, and culture, are prominent across human services. Without consistent, trusting relationships, quality of care will inevitably suffer and feed into the cycle of staff turnover. Gilburt et al. took a deeper look at the drivers of these factors, but the overall application for human services is clear: therapeutic relationships are even more important than the physical environment in a care setting.

The quality and safety of services is threatened by the high turnover and vacancy rates. DSPs who do not have strong relationships with the individuals they support are less likely to recognize signs and symptoms of illness, and less likely to efficiently de-escalate a behavioral

crisis. DSPs exhausted from overtime or multiple jobs could make medication errors, judgment errors, or be generally less pleasant to work with.

The Report of the President's Committee (PCPID, 2017, p. 20-26) outlines additional effects of the workforce crisis, including those on families of individuals served. They cite the National Health Interview Survey Disability Supplement of 1994–1995, in which 53 percent of parents interviewed reported major career concessions (e.g., not taking a job, working fewer hours, dropping out of the workforce, turning down a promotion) related to having a child with intellectual/developmental disability (IDD). Family members also spend time and energy building relationships with DSPs, and communicating the needs of their loved one, only to have the DSP leave the job sooner than expected.

The human service workforce crisis impacts the greater community and economy as well. The Report of the President's Committee (PCPID, 2017) illustrates that when the number and/or quality of direct support staff is inadequate, the people they support use more of the community's police, ambulance, firefighter, emergency department, acute care, and other resources. Experienced, well-trained DSPs and high-quality services can reduce this cost to communities. The report further explains that nearly half of all DSPs use some form of government-funded, means-tested public assistance, so taxpayers carry the burden of income replacement support for food, housing, health care and other necessities. Ultimately, the extensive need for human services in Massachusetts is not going to disappear. We can support these citizens efficiently through well-resourced programs and an appropriately funded workforce, or we can pass the buck through an expensive, high-risk, patchwork of reactive activity.

Solutions

With an increasing demand for human services in Massachusetts and an increasing shortage of staff to support them, we are overdue for meaningful action. Several groups have studied the current crisis and proposed solutions. Some overlap with my own recommendations, while others are beyond the scope of this paper. In their 2017 report, the President's Committee for People with Intellectual Disabilities offers comprehensive recommendations from a centralized federal viewpoint (summarized in Table 3). In *Who Will Care? The Workforce Crisis in Human Services,* the University of Massachusetts Donahue Institute and Providers' Council (Citino & Goodman, 2017) focus their recommendations on expanding the pool of available workers. They advocate for targeted strategies to recruit millennials, foreign-born workers, and individuals with barriers to employment. This crisis requires action from multiple angles – public policy at the federal and state levels, and changes within provider organizations.

Wages

Wages must be adjusted – and not just enough to track the increasing Massachusetts minimum wage. DSP pay must be sufficient to attract and retain a quality workforce in sufficient numbers. By now, the details have been well-studied by the Providers' Council, Donahue Institute, Arc of Massachusetts, and other researchers; funding the adequate rates is the only step left for the state. As discussed earlier, any illusion of savings from underfunding human services is quickly dispelled when other state program budgets are burdened by the fallout. Numerous advocates have come to the same conclusion: DSP pay must improve before the workforce crisis will improve.

The President's Committee for People with Intellectual Disabilities, in their 2017 report, recommends prioritizing a federal review to ensure that states "include sufficient Direct Support Professional wages and compensation packages in their rate-setting methodologies for long-term services and supports to people with intellectual and developmental disabilities" (p.40). The Arc of Massachusetts 2021-2022 Legislative Platform includes both *An Act Relative to Fair Pay for Comparable Work* and *An Act Establishing an Education Loan Repayment Program for Human Service Workers*. The Providers' Council 2021-2022 Legislative Agenda lists the same two acts as their top priorities. This legislation complements Chapter 257 and other rate-setting advocacy. The former act addresses the inequities between pay rates for workers in state-operated programs and those in community-based programs. The latter recognizes the reality that student loan debt can make it impossible to work in a lower-paying field, and also encourages continuing education to promote career progression within human services. Improving DSP salaries creates positive ripples that improve other issues simultaneously – professional identity increases, perceived recognition and appreciation increases, and turnover decreases.

Training

Staff learning and development is another solution that can create positive ripples. Not only does it enhance skills and promote quality services; it has the potential to improve professional identity and sense of career growth. Training, if integrated correctly into organizational culture, can also demonstrate much-needed appreciation and respect. However, my years of experience training DSPs have made it evident that the issue of rushing to complete mandatory training is all too real. Compliance may be achieved at the expense of learning retention.

Two straightforward changes from the state could greatly improve this situation. First, DDS should revise licensing standards to allow more discretion from provider agencies. Certain training modules could be encouraged rather than required, allowing a provider agency to manage the risk themselves without putting their license in jeopardy. For example, if they knew certain DSPs would not be working alone, they could introduce the material on an ongoing basis, allowing for more natural learning opportunities and minimizing the information overload at orientation. If DSPs could start working without certain training, then the courses could be staggered throughout the year to allow for continuous learning and review. The second straightforward change is for DDS to increase the budgets to allow for more learning and development staff. In addition to providing a living wage for DSPs, the state should fund enough administrative depth to allow for on-the-job training and skill development. Continuous coaching promotes far better learning than a hurried orientation.

For more comprehensive reform in training, I contend that the best option is a centralized registry of staff qualifications. This does not exist for Massachusetts DDS-funded programs, except for some specific certifications such as Medication Administration Program (MAP). Centralizing training records would be highly efficient:

- DSPs working in DDS-funded programs have very similar training requirements from one organization to another;
- DDS could create the tracking system in alignment with licensing standards, and use this to facilitate audits;
- It is common for a DSP to work for more than one provider organization (either simultaneously or in succession), repeating the training modules at each job;

- Experienced DSPs hired for a new position could focus their learning on the specific needs of the individuals served, rather than repeating general training modules;
- Provider organizations (and therefore the state) would save money by only needing to provide training in material that was due for review, rather than everything;
- It would increase DSP employment mobility between state programs and community-based provider programs;
- Provider organizations using a staffing agency would have instant access to the qualifications of their temporary staff;
- The need for copying, scanning, and sharing certificates would be greatly reduced;
- DSP requirements other than training (background checks, testing for COVID-19, driving record, etc.) could be tracked in the registry as well for further efficiency;
- DDS could implement one statewide learning management system, with provider organizations receiving access privileges;
- The system would professionalize and standardize DSP skills and knowledge, creating the opportunity for credentialing programs and tiered salary rates.

Centralized tracking is the key change here. The training itself could continue to be offered through a combination of provider agency staff and other certification programs. For even further standardization and efficiency, DSP training could be centralized to the DDS regional training offices that already exist. DDS could offer a comprehensive DSP training program to new staff – similar to a credential like CNA – which would also serve as a recruiting and placement tool for the field. DDS would require more resources to provide this program, but the needs in the provider organizations would be greatly reduced, yielding higher overall efficiency. Centralizing the tracking *and* the training allows for more layers of quality

improvement, including ongoing updating and assessment of the curriculum. Evaluation tools such as the Human Services Training Effectiveness Postcard (Curry & Chandler, 1999) could be used to explore the factors that influence staff training and how it impacts the services provided.

An alternative but similar approach would be to centralize DSP credentialing and tracking through a private organization. The current leader in this area, the National Alliance for Direct Support Professionals (NADSP), is doing great work and would be a leading contender for the job. However, DDS would need to adopt the program statewide and align regulations to match, or there would not be a meaningful difference in efficiency. Whether implemented by state agencies or a private provider, a comprehensive program for DSP credentialing and tracking would ease the training burden on provider organizations, while saving money overall for the state and improving curriculum resources. It also offers the much-needed side effect of recognition and professionalism for the DSP career.

Technology

Human services has never been a field known for cutting-edge technology. Organizational budgets for new technology resources are typically limited, and many employees attracted to the "human" aspect of human services lack technical expertise. As our world has evolved with the information age, though, the field has gradually moved in the same direction. Features such as the web-based Home and Community Services Information System (HCSIS), mandatory for DDS providers, have nudged organizations into embracing technology.

Technology is an essential solution in narrowing the gap in human service workforce capacity. First came the simpler changes – most staff became comfortable with email and smartphones to expand communication options. Tablets were popularized for assistive

technology applications or simple data tracking. Electronic health records and learning management systems both gained popularity in human service organizations. Then the COVID-19 pandemic pushed providers out of their comfort zones and into telehealth, remote programming, online learning, and virtual meetings. With the capacity developed during the pandemic, new possibilities have emerged for inclusive service planning meetings, virtual licensing surveys, and improved connections with individuals' family and friends.

Human services is ready for the next level of technology, which offers unique solutions to the workforce crisis. Although compassionate communication and human connection will always be integral to the services, technology can reduce the number of staff needed or make their work more efficient. Deloitte Consulting summarized recent developments in its article "AI-augmented Human Services: Using Cognitive Technologies to Transform Program Delivery" (Fishman & Eggers, 2019). Some of the progress has been in streamlining the administration of human services – for example, using machine learning to flag case notes for risks, or implementing virtual assistants to assess eligibility. Other developments affect DSPs more directly, such as artificial intelligence (AI) assistants for recording progress notes, or voice-activation devices that help individuals become more independent. The report from the PCPID (2017) urges government support for efficiencies such as remote monitoring, sensors, robotics, and smart homes, which also support independence and community living for people with intellectual disabilities.

I can easily visualize the usefulness of AI in securing and dispensing medication in group homes. It is not difficult to imagine in-home open telehealth screens; this would promote independent living for those in semi-independent apartments, or even group homes. Individuals or staff could check in with state-funded health care providers whenever they felt the need. After

all, the current system has the state funding 911 dispatch, ambulance, ER visits and the accompanying staffing or case worker calls each time a health concern arises. With open minds and quality controls, technology can offer amazing efficiencies.

Appreciation and Recognition

This issue has been intertwined with the other topics discussed throughout this paper – compensation, professional identity, turnover, training, and more. The solutions were evident from the research explored earlier: DSPs want respect for their experience and appreciation for their work. They want a stable work environment, a manageable workload, and a livable wage. Some of this can be facilitated by the state (through the rate-setting and legislative processes) and through advocacy groups (as with the public identity campaign from the Caring Force). But much of the work happens within organizations.

DSPs should not feel isolated from their upper management. Open channels of communication, shared projects and committee work are all means to this end. A culture of respect for direct care work must start with the leadership, with frontline managers trained to exemplify the culture. Light (2003) found that most of the variation in job satisfaction among human services workers could be explained by eight questions asked in his survey. Satisfaction increased when workers:

1. Said their co-workers were more qualified for their jobs.
2. Strongly rejected the notion that their job is a dead end with no future.
3. Strongly agreed that the work they do is fun.
4. More frequently trusted their workplaces to do the right thing.
5. Strongly agreed that they felt valued in the work they did.

6. Said they had more than adequate training to do their jobs.

7. Said their organizations did a very good job at helping people.

8. Strongly agreed that they accomplished something worthwhile at work.

These are simple, wholesome themes that should be obvious priorities in an organization providing person-centered services.

Conclusion

Fatigued by overtime, multiple jobs, low wages, and a lack of appreciation, our human services workforce is ready for rejuvenation. To maintain an adequate workforce of well-qualified staff in Massachusetts, leaders will need to implement changes at the state level as well as the organizational level. I have discussed some specific possibilities for improvement, and I hope they will complement the excellent recommendations in the existing body of research. We also need to be cognizant of the many creative approaches already being tested in Massachusetts and beyond; identifying and scaling best practices is a critical component.

As priorities change in service delivery and public policy, the challenges of the human service workforce will evolve. This is not an insurmountable crisis, however. With attention to policy, compensation, training, recognition, and technology, the future is bright for this fast-growing industry. It can serve the interests of citizens in search of a rewarding career as well as those in need of skillful, compassionate support.

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Tables

Table 1

Sample Orientation Training for DSP in a DDS-funded Residential Program

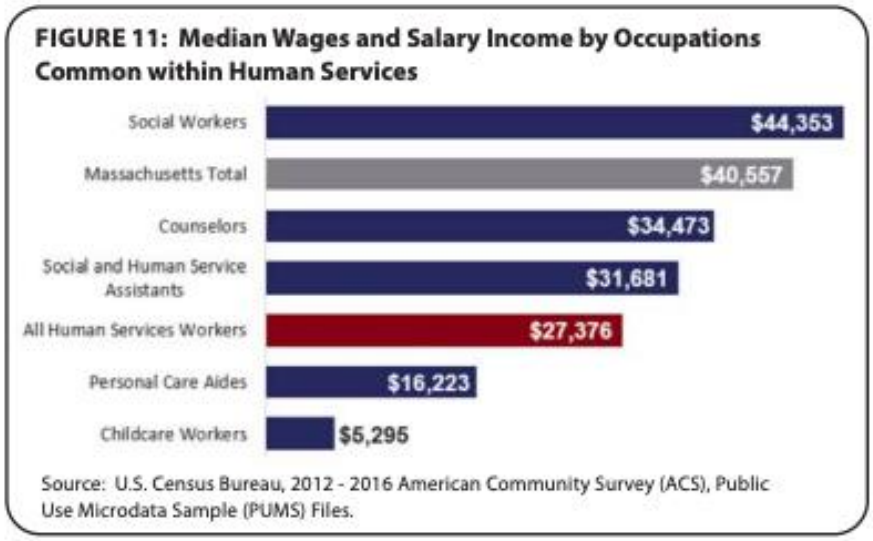
Training Typically Completed Before Working First Shift (Some Within 30 Days)
Organization-specific Human Resources, Policy, and Mission Orientation
Cultural Competency
Sexual Harassment
Universal Precautions
Human Service Worker Safety
Transmission Prevention of Communicable Specific Diseases (Infection Prevention and Control) – COVID-19 series
First Aid Certification
CPR Certification
MAP Certification (for all administering medication)
Signs and Symptoms of Illness
Executive Order 509 Food Standards
Vital Signs
Basic Human Rights
DDS Mandated Reporter
Positive Behavior Supports/ Universal Supports
Crisis Intervention Certification, including Emergency Restraint Training and Authorizer's Training
Basic Fire Safety
Site Safety Plan and Evacuation

Site Scheduling and Responsibility Checklist
Defensive Driving
Safe Lifting and Transfers
Incident Management
Documentation and Data Collection
Relationships and Sexuality
Community Inclusion
Use and Maintenance of Equipment and Assistive Technology
Support Needs of Individuals; Individualized Plans and Protocols:
Epi-Pen for Individual A
Diabetes for Individual B
Seizure Protocol for Individual C
Special Diet Plans for Individuals B & C
Behavior Support Plans for Individuals A, B & C
Risk Plans for Individuals A & C
Supports and Health Related Protections for Individuals A, B & C
Restrictive Interventions/Practices for Individuals A & C

Note. Adapted from Massachusetts DDS licensing/certification standards and *Provider Mandatory Training 1/2021* at http://www.ddslearning.com.

Table 2

Wages by Industry



Note. p. 11 in University of Massachusetts Donahue Institute. (2018). *The Face of the Human Services Sector: Our Caring Workforce.* https://providers.org/report/the-face-of-the-human-services-sector/

Table 3

Summary of Recommendations from President's Committee for People with Intellectual Disabilities

The U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services should ensure through review of Home and Community-Based Services Waivers or regulation that states include sufficient Direct Support Professional wages and compensation packages in their rate-setting methodologies for long-term services and supports to people with intellectual and developmental disabilities.	The U.S. Department of Health and Human Services, Administration for Community Living should provide technical assistance and financial or programmatic incentives to states to promote the use of technology solutions in long-term services and supports, such as remote monitoring, sensors, robotics, and smart homes, to create efficiencies, reduce costs and support community living for people with intellectual disabilities.
The U.S. Department of Health and Human Services, Administration for Community Living should provide funding to states through grants and contracts to develop, implement and evaluate comprehensive programs designed to provide training and technical assistance to employers that focus on improving business acumen to reduce Direct Support Professional vacancy rates, improve retention and promote efficient, high-quality long-term services and supports for people with intellectual and developmental disabilities.	The U.S. Departments of Education, Health and Human Services, and Labor should create grant programs and financial incentives for states to expand the pool of Direct Support Professionals through recognition programs, grassroots campaigns and training efforts designed to expand awareness about the profession and encourage greater participation by people with disabilities, men, retirees, and young adults across diverse racial, ethnic and cultural groups.
The U.S. Department of Health and Human Services should work with states to expand utilization of self-direction in long-term services and supports so that family, friends and neighbors can be hired as Direct Support Professionals.	The U.S. Department of Labor through the Bureau of Labor Statistics should investigate ways to recognize "Direct Support Professional" as a distinct occupation title and provide routine labor statistical reporting on this occupation.

The U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) should ensure through regulation and review of Home and Community-Based Services Waivers that states identify provider qualifications that recognize Direct Support Professionals as skilled practitioners who are community navigators, facilitating greater community and economic involvement for people with intellectual and developmental disabilities. Additionally, CMS and states should ensure that compensation rates are aligned with appropriate status, value, respect, a living wage and benefits.	The U.S. Department of Health and Human Services, Administration for Community Living and Centers for Medicare & Medicaid Services should develop federal standards and work with the Department of Labor to implement specialized credentials and professional development opportunities for Direct Support Professionals, ensuring: (a) that people with intellectual disabilities are trainers and mentors, (b) that programs are focused on competencies specifically identified for DSPs, (c) that completion of training to meet standards is voluntary and occurs post-hire, and (d) that the credentials result in increased wages and access to benefits for DSPs.
The U.S. Department of Labor should engage the broader American workforce system to find solutions to this crisis by using community colleges and American job centers to develop and invest in career training and credentialing for Direct Support Professionals.	The U.S. Department of Health and Human Services and the U.S. Department of Labor should engage the business community and provide grants and other incentives to states to develop online matching registry services and other creative options to match people with intellectual disabilities and their families who need help finding available DSPs.

Note. p. 40 in President's Committee for People with Intellectual Disabilities. (2017). *America's Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy*. https://acl.gov/sites/default/files/programs/2018-02/2017%20PCPID%20Full%20Report_0.PDF

Appendix A

Glossary

Artificial Intelligence (AI): Ability of a computer or computer-controlled machine to perform tasks associated with intelligent beings. These could include reasoning, discovering meaning, generalization, or learning from past experience.

Certified Nursing Assistant (CNA): Certification for staff providing health-related and personal care under the supervision of a registered nurse. A CNA provides personal assistance similar to that of a HHA, with additional training in health promotion such as wheelchair transfers, vital signs checks, body positioning, and recording symptoms and observations.

Department of Developmental Services (DDS): In Massachusetts, the agency providing supports for adults and children with intellectual and developmental disabilities, including Autism Spectrum Disorder. DDS offers educational services, family support, employment and day program supports, and community living and other residential services.

Direct Support Professional (DSP): Human service employee who works directly with people with I/DD to facilitate participation in their communities. A DSP provides a variety of support, including medication administration; assistance with activities of daily living (e.g. personal care, feeding, cooking, and cleaning); transportation to appointments and activities; connections with friends, employers, and other community members; and support with individual goals.

Executive Office of Health and Human Services (EOHHS): The largest secretariat in Massachusetts government; EOHHS encompasses 12 agencies, two soldiers' homes and the MassHealth program and focuses on the health, resilience, and independence of individuals served.

Home Health Aide (HHA): Certification for staff providing health-related and personal care under the supervision of a registered nurse. Tasks might include meal preparation, medication reminders, light housekeeping, bathing, dressing, and/or shopping.

Human Services: Field encompassing a broad range of essential services, especially for those who are disadvantaged, vulnerable, or unable to help themselves. Human services promote functioning in the major domains of living and are provided in diverse settings such as group homes, correctional centers, community mental health centers, intellectual disability agencies, family and youth service agencies, and programs addressing alcoholism, drug abuse, family violence, and/or aging.

Intellectual/Developmental Disabilities (I/DD): Disorders that are usually present at birth and that negatively affect an individual's physical, intellectual, and/or emotional development. Intellectual disability starts any time before a child turns 18 and is characterized by problems with both intellectual functioning and adaptive behavior. Developmental disability is a broader category of (often lifelong) disability that can be intellectual, physical, or both.

President's Committee for People with Intellectual Disabilities (PCPID): Federal advisory committee, including representatives from federal agencies and citizen members, which

promotes policies and initiatives that support independence and lifelong inclusion of people with intellectual disabilities in their communities.