Utah Developmental Disabilities Council

Direct Support Professionals

Issue Brief

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The Problem: DSP Workforce Crisis

Under the Olmstead Act, "states have a legal obligation to provide supports and services to individuals with intellectual and developmental disabilities (I/DD)"[1] to live in their homes and communities. Direct support professionals (DSPs) provide much of this labor. DSPs are a specific group of professionals within the direct care workforce that provides supports to individuals with I/DD in home and community-based settings (HCBS). These supports may include: habilitation services, employment assistance, medication administration, assistance with personal care and daily living activities, life skills training, behavioral support, medical monitoring, crisis intervention, etc.

Both nationally and in Utah, there is a significant shortage of DSPs and a lack of adequate support for the existing DSP workforce. This shortage is due to a variety of issues with retaining current workers and recruiting new workers. The shortage presents many harmful consequences for DSPs, people with disabilities and their families, provider agencies, the state, and the industry as a whole.

- In Utah in 2022, the average DSP turnover rate was 49%.[3]
- In 2021, the estimated cost of DSP turnover nationally was ~ $2.3 billion.[1]
- In Utah in 2021, 34% of people with I/DD in waiver services were unable to access services they were funded for, due to a shortage of DSPs. After a significant wage increase for DSPs in Utah in 2022, this number was reduced to 18% just 6 months later.[4]

Causes of the Workforce Crisis

Insufficient compensation for DSPs. Rates are determined by state legislature, and often are not increased from year to year. Even when wages are increased, they don't keep up with inflation or market trends for similar jobs or other entry-level jobs.[2] In addition, most provider agencies in Utah do not offer DSP employees health insurance, paid time off, or retirement options. Many DSPs end up leaving the profession to work in industries such as fast food or retail, which offer more competitive wages and better benefits.[3]

Lack of professionalization of the field. DSPs also do not have a specific federal standard occupational classification (SOC), and so they may hold a variety of job titles that may get classified within a larger category of direct care workers (DCWs), or within another industry altogether. Lack of a

Percent (%) of provider agencies in Utah in 2022 that offered *at least some* of their DSP employees:[3]

Health insurance	36.7%
Paid sick leave	45%
Retirement benefits	22.2%

Causes (continued)

federal SOC presents many issues, including a lack of formal or consistent training and licensing across states and the country, as well as challenges with research and data collection. Official federal and state data collection systems do not collect the information on this specific labor population that is necessary to drive effective system-wide policy change. The lack of consistent job classification can also present challenges for non-governmental organizations that are trying to gather comprehensive data on DSPs.[5]

Most common current training for DSPs in Utah	Training that DSPs in Utah report they would like to receive*
Crisis intervention & behavioral support	Communication
Agency policies & procedures	Person- or disability-specific
CPR	Seizures
Facilitation of services	Behavioral support plans
Vocational, educational & career	Customized employment
Medication administration	Disability law
Assessing medical conditions	Interagency coordination

Note: Items are listed in descending order of how frequently they were identified.[6]

*DSPs also indicated they would like more training on topics already covered.

Inconsistent training and lack of career growth opportunities. In 2022 in Utah, only 49% of provider agencies reported providing any job-specific training to DSPs, and only 24% had career advancement opportunities.[3] According to a recent study by the Institute for Disability Research, Policy & Practice (IDRPP) at Utah State University, "only 83% of participating [DSPs] had received training for their positions. Of those… 100% felt that these trainings were insufficient."[7] Although many DSPs in Utah desire further training, they don't have the necessary time, resources, access to opportunities, or employer assistance to obtain such training.

Inadequate training leads to higher rates of DSP turnover and intent to quit. However, increased training without increasing wages can also lead to turnover, as higher skilled workers become more competitive in the job market, and may leave to work somewhere else where they will be adequately paid for their skills. Therefore, not only is it necessary to provide funding and resources required for DSPs to gain additional training, but also to tie increased skill development with increased compensation. Together, these strategies can significantly reduce job-related stress and turnover.[6] However, it is important that policy makers account for the necessary costs and resources associated when considering imposing additional training requirements.[7]

Undervaluing of DSP work. Although DSP labor is essential, and the demand for the long term services and supports (LTSS) that they provide is expected to continue growing, many still undervalue their labor. Legislative underinvestment and lack of funding, the wage barrier most frequently mentioned by experts,[2] contributes to high turnover rates and poses critical risks to the quality of care[1] and the

Causes (continued)

stability of the entire LTSS system. Public undervaluing of DSP work, in addition to the lack of competitive compensation and career growth opportunities, makes recruitment efforts challenging.[2]

Some experts pose that discrimination[5] could also be a factor contributing to the stagnant wages, as most DSPs nationally are women of color. Societal undervaluing of not only care work, but also of the individuals performing the work, may present a barrier to increased recognition and compensation in the profession.[2]

Effects of the Workforce Crisis

On DSPs

- About 45% of direct care workers live below 200% of the federal poverty guidelines; and about 47% of direct care workers rely on public assistance to get by (e.g. Medicaid, food stamps, housing assistance, etc.).[9]
- Inadequate compensation for DSPs also leads to higher levels of burnout and lower job satisfaction.[1]
- Inadequate training for DSPs leads to increased risk of injury[2] as well as higher levels of job-related stress and burnout;[7] among DSPs in Utah, over 50% report experiencing burnout.[8]

On people with I/DD

- Many are unable to access care, even after they get off the waitlist and are receiving funding for Medicaid HCBS waiver services.[1]
- Some have to relocate to access services.[11]
- For those who are able to access care, many experience frequent disruptions in services from frequent staff turnover, leading to lower quality of care.[1]

Support DSPs in Utah report they would like from their employers.[8]

Interpersonal	Concrete
More communication/staff check-ins	Insurance and retirement benefits
Wellness activities & events	More paid time off (sick and/or personal)
Active promotion of work-life balance	Wages (higher salary, and option for working more than part-time)
Environment supportive of self-care and mutual support	Increased staff (to support the increase of clients)
Flexibility (both with time off & clients they work with)	Access to affordable or free mental health support/therapy
Appreciation (explicit, verbal)	Educational support (more than just CEUs)

Percent (%) of clients in DSPD waiver services in Utah in 2022* who:[4]

Were unable to access services they were funded for	34%
Had to relocate to access services	12%
Had to wait more than 90 days for a service they needed	13%

*As reported in a DSPD survey in January 2022.[4]

Effects (continued)

- Poorer quality of life (physical and mental health, safety and overall well-being).[4]
- Decreased or no access to job supports, which leads to less people with disabilities employed and less financial stability.[1]
- Decreased ability for people with disabilities to access and participate in the community how they would like, and less choice and self-determination.[4]
- Increased reliance on unaffordable emergency services.[1]
- If they are unable to get their needs met by HCBS, some people with disabilities may be forced to live in an institution.[11]

On families of people with I/DD

- Many caregivers are forced to quit or reduce hours at their job to provide full-time caregiving services, losing health insurance coverage and lowering family income, impacting financial stability.[1]
- Less access to services includes less access to respite care; this impacts caregivers' ability to take care of their own health needs, seek treatment for health issues, or participate in their own interests, hobbies, and communities.[12]
- High rates of burnout.
- Poorer physical and mental health outcomes,[13] overall well-being and quality of life.[1]

There are systemic issues that, until they are addressed, will continue to destabilize the DSP workforce and may eventually lead to a complete system collapse,[11] both nationally and in Utah.

On provider agencies

- Low Medicaid reimbursement rates mean that providers are unable to adequately train or compensate employees, leading to high turnover rates.[2]
- Financial losses due to time and resources required to constantly recruit, hire and onboard new employees (meaning there is less money available to spend on actually providing services).[1]
- Financial losses due to uncollected funds (e.g. federal matches).[1]
- In 2022, 63% of provider agencies nationally were forced to discontinue programs and/or services and 83% were forced to turn away new referrals due to staff shortages.[11]
- If things do not improve, many agencies report they may have to discharge current clients or, in some cases, may be forced to close completely.[11]

Effects (continued)

On the State and the industry

- When people with disabilities are unable to access adequate HCBS services, they are often forced to utilize institutional and/or emergency services, which are much more costly to the state.[1]
- These services may include: emergency department visits and hospital care; nursing homes; intermediate care facilities (ICFs) or other institutional settings; police services; homeless services/shelters; jails; regional centers; etc.[1]
- This puts more strain on the healthcare industry as a whole, particularly those working in emergency medical and mental health services.[1]
- As stated previously, many DSPs, as well as family caregivers who are unable to continue working while providing care to their loved one with a disability, may also have to rely on public assistance and resources to get by, including: Medicaid, food stamps, housing assistance, utility payment assistance, emergency mental and physical health services, etc.; which puts more strain on the state's budget.[1]
- The loss of people with disabilities and their family caregivers from the workforce also means the state is suffering losses in revenue via income taxes; so not only is the state paying more in social services, but they are also losing potential revenue due to unemployment of these populations.[1]
- State residents (people with disabilities, family members, DSPs) experience a decrease in quality of life and physical and mental health outcomes.
- The DSP workforce shortage also means states struggle to meet federal standards of inclusion and service access and quality, which could put the state in non-compliance with the Americans with Disabilities Act (ADA).[11]
- If the DSP workforce continues to destabilize, the state could eventually face a complete disability service system collapse.[11]

Conclusion

There are systemic issues that, until they are addressed, will continue to destabilize the DSP workforce and may eventually lead to a complete system collapse. To overcome this problem, prompt and meaningful policy and implementation changes are needed to address the root causes perpetuating the DSP workforce crisis.

References

1. Goss & Associates, Economic Solutions. (2024). *Fueling prosperity: The positive economic ripple effects of increasing wages for Nebraska's direct care workforce.* Nebraska Association of Service Providers. https://www.neserviceproviders.org/vimages/shared/vnews/stories/65aa9bc779e90/Final_HCBS_EconStudy.pdf

2. Office of the Assistant Secretary for Planning and Evaluation & RTI International. (2024). *State efforts to improve direct care workforce wages: Final report.* (Contract No. HHSP233201500039I). U.S. Department of Health & Human Services. https://aspe.hhs.gov/sites/default/files/documents/e88ca623469819d2444d07fe9564fb67/state-efforts-improve-dcw-wages-final.pdf

3. National Core Indicators Intellectual and Developmental Disabilities. (2023). *National Core Indicators Intellectual and Developmental Disabilities State of the Workforce in 2022 Survey report.* https://idd.nationalcoreindicators.org/wp-content/uploads/2024/02/ACCESSIBLE_2022NCI-IDDStateoftheWorkforceReport.pdf

4. Division of Services for People with Disabilities. (2022). *Direct Support Provider Survey Report.* Utah Department of Health & Human Services. https://dspd.utah.gov/wp-content/uploads/2023/01/DSP-survey_August_2022.pdf

5. National Center on Leadership for the Employment and Economic Advancement of People with Disabilities (LEAD Center). (2022). *Valuing Women's Direct Care Work.* U.S. Department of Labor, Office of Disability Employment Policy. https://www.dol.gov/sites/dolgov/files/ODEP/pdf/dsp-recommended-actions-and-report.pdf

6. Juhasz, A. C., Culter, S., Wappett, M. (2024). *Research brief: Impacts on Utah DSP Retention: Training*. Logan, Utah: Utah State University, Institute for Disability Research, Policy & Practice. https://idrpp.usu.edu/cei/publications/research-briefs/rb-dsp-retention-june2024.pdf

7. Culter, S., Juhasz, A. C., Wappett, M. (2024). *Research brief: Training and Burnout: What Direct Support Professionals in Utah Say About the Top Two Predictors of Turnover.* Logan, Utah: Utah State University, Institute for Disability Research, Policy & Practice. https://idrpp.usu.edu/cei/publications/research-briefs/rb-dsp-qualatative-june2024.pdf

8. Juhasz, A. C., Cutler, S., Wappett, M. (2023). *Research brief: Impacts on Utah DSP Retention: Burnout & Well-Being.* Logan, Utah: Utah State University, Institute for Disability Research, Policy & Practice. https://idrpp.usu.edu/cei/files/research-briefs/dsp-burnout.pdf

9. Scales, K. (2021). It is time to resolve the direct care workforce crisis in long-term care. *The Gerontologist, 61*(4), 497–504. https://doi.org/10.1093/geront/gnaa116

10. North Carolina Area Health Education Centers Program. (2023). *Recommendations for HCBS worker certification.* North Carolina Department of Health and Human Services. (Contract No. 30-2023-007-DHB, Section D). https://www.ncdhhs.gov/nc-ahec-recommendations-dcw-hcbs-worker-certification/download?attachment

11. American Network of Community Options and Resources (ANCOR). (2022). *The state of America's direct support workforce crisis 2022.* https://www.ancor.org/wp-content/uploads/2022/10/The-State-of-Americas-Direct-Support-Workforce-Crisis-2022.pdf

12. Family Caregiver Alliance. (2006). *Caregiver health.* https://www.caregiver.org/resource/caregiver-health/

13. Hogue, M. (2022). *Utah's Invisible Workforce: The Economic Contributions and Health Impacts of Family Caregiving.* Kem C. Gardner Policy Institute, University of Utah. https://ucoa.utah.edu/_resources/documents/Utahs%20Invisible%20Workforce.pdf