



PCPA Overview

Human Services/Disability System Financial and Employment Issues 2007

The Pennsylvania Community Providers Association (PCPA) membership is comprised of provider agencies, advocacy groups, county mental health and mental retardation offices, managed care organizations, and businesses concerned about and involved in community-based services for children and adults in need of supports in mental health, mental retardation, and drug and alcohol. The association has over 200 members that serve approximately one million Pennsylvanians each year.

Each year PCPA advocates with legislators and state officials on behalf of its members for financial stability of state funding. Financial resources available to service providers and their ability to retain competent and trained staff have a direct correlation to the health and safety of individuals relying on community supports.

An "Agency Turnover and Vacancy Survey" was completed in 2006 to gather data on provider issues and recommendations regarding high levels of staff turnover and vacancy in human services. State and federal agencies have also completed surveys and reports over the past few years to seek answers and determine issues related to employment, especially for direct care workers. This paper combines that information to review findings and share statistics and recommendations from members who deal daily with staff turnover while providing quality services and supports to individuals with disabilities.

System Funding

The disabilities fields served by PCPA members rely heavily on state and federal funding; Medical Assistance (Medicaid) is the main funding source for most service providers. These dollars are distributed either by direct billing to Medicaid or through federally approved waivers. The waivers consist of a combination of state dollars matched with federal monies based on a federal financial participation percentage.

Mental Retardation

Agencies serving persons with mental retardation are funded through the Department of Public Welfare's Office of Developmental Programs (the office name changed in January 2007 from the Office of Mental Retardation). The majority of funding for these services is through two waivers, the Consolidated Mental Retardation waiver and the Person/Family Directed Support waiver. There is a limited amount of "base-dollars" which comes from counties. Service and funding guidelines were addressed in the Mental Health and Mental Retardation (MH/MR) Act of 1966.

Mental Health

The majority of mental health services provided by PCPA members are reimbursed through Medical Assistance funding by behavioral health managed care organizations in HealthChoices or by the Office of Medical Assistance Programs through the Fee-For-Service Program. Behavioral

HealthChoices is in its final development phase and will be operational in all Pennsylvania counties in July 2007. Funding also flows through counties for community mental health services. County Mental Health/Mental Retardation offices contract with provider agencies to deliver services. The MH/MR Act of 1966 require counties to provide community mental health services to include inpatient treatment, partial hospitalization, outpatient services, emergency services, specialized rehabilitation, vocational rehabilitation, and residential services.

Children's

Meeting the service needs of special populations of children and adolescents is the work of several systems that rely on a range of funding streams. The primary child serving systems and related funding streams are listed below.

- Early Intervention Services for children ages zero to three programs and services are supported through state and county dollars administered by the state's joint Departments of Public Welfare and Education through the Office of Child Development and Early Learning (OCDEL). At the county level these programs and related funding is supervised by the county office of mental retardation. There is an increased effort to shift more services to funding through Medicaid.
- Early Intervention Services for children three to five years of age are administered through OCDEL and local school districts and Intermediate Units. Funding for these special education services comes from state education funding and local taxes for educational services.
- Child and adolescent mental health and substance abuse services are provided predominately through Medicaid (MA) funding. A small amount of funding is provided on a county-by-county basis through state and federal block grant funding. Some funding comes through HealthChoices reinvestment for certain services not covered by MA. Recently the Department of Education has increased the use of school-based ACCESS Medicaid funding for behavioral health clients and has committed limited funding for a small number of school-based mental health pilot programs.
- The vast majority of child and adolescent autism services are provided through MA and, in particular, through Behavioral Health Rehabilitation Services (BHRS). The past two years have seen a limited but increasing allocation of state dollars for the development of model and pilot programs. In addition to MA funding, special education funds are also used for services for children on the autism spectrum.
- Historically, counties had committed limited numbers of child welfare and juvenile justice dollars to behavioral health services. This was not consistent with the requirements and funding guidelines of Title IV-E of the Social Security Act and Pennsylvania Act 148. In the past two years this practice has been greatly curtailed through the MA Realignment initiative. This initiative has decreased county child welfare funding for behavioral health services and increased the level of Medicaid behavioral health services and funding for many child welfare and juvenile justice provider agencies, especially those providing residential services.

Drug and Alcohol

A large percentage of funding for drug and alcohol services is provided through Medicaid. In addition, special funding is provided by both the Departments of Public Welfare and Health. The Department of Public Welfare provides Behavioral Health Special Initiative (BHSI) and ACT 152 funding and over sees Intergovernmental Transfer (IGT) funds. The Department of Health provides Drug and Alcohol Block Grant Funding.

Minimum Wage Act

Service providers have indicated concerns regarding financial stability and the ability to retain staff due to several issues including the state's implementation of a new minimum wage law, Act 112 of 2006. Governor Rendell signed legislation raising the state's minimum wage from \$5.15 to \$7.15 per hour by July 1, 2007. This is projected to impact over 420,000 workers. For a copy of the legislation access www.legis.state.pa.us and insert SB1090 of 2006 in the Bill Search feature.

Details of the act are noted below.

- 1) A minimum wage increase to \$6.25 per hour by January 1, 2007;
- 2) A second increase to \$7.15 per hour by July 1, 2007;
- 3) Employers with 10 or fewer full-time employees may phase in the new rate by increasing to \$5.65 per hour by January 1, 2007; \$6.65 per hour by July 1, 2007; and \$7.15 per hour by July 1, 2008;
- 4) A 60-day training wage is allowed at \$5.15 per hour for employees under the age of 20, but this rate must increase to the new minimum wage after the individual is employed for 60 calendar days; and
- 5) An exception to minimum wage increases for employees whose earning capacity is impaired by physical or mental deficiency/injury may be granted if a license with this information is obtained from the Secretary of Labor or a federal certificate is obtained under the Fair Labor Standards Act, Section 14(C).

Cost of Living Allowance

Another significant financial concern for providers is Pennsylvania's state budget, which over the past eight years has trended toward minimal or no increases for community-based mental health, mental retardation, and drug and alcohol services. This is occurring at a time when the state is closing and downsizing state-run institutional care for individuals and moving them into community-based services. In addition, the commonwealth is making an effort to expand drug and mental health courts in an effort to reduce unnecessary incarceration and provide needed treatment as an alternative to incarceration. The cost-of-living adjustments have also been limited by legislative budget language that allows any increases to be applied only to direct care worker salary line-items. This continued lack of addressing actual increases in the cost of doing business for community agencies has created a financially fragile system that will reach a breaking point in the next few budget cycles if the administration and legislature do not take steps to correct this oversight.

Statistics show the following funding increases for community mental health, mental retardation and drug and alcohol services:

- 1999/00: Two percent
- 2000/01: Zero percent mental health and drug and alcohol; two percent mental retardation
- 2001-02: Two percent
- 2002/03: None
- 2003/04: None
- 2004/05: Two percent; mental retardation services provided by county staff received no increase
- 2005/06: Two percent for direct care workers only, none for drug and alcohol
- 2006/07: Two percent for direct care workers only, none for drug and alcohol.

The eight year average increase for the mental health community system was 1.25 percent; 1.5 percent for mental retardation community-based services and three-quarters of one percent for drug and alcohol services. During the same time period the managed care organizations in the

state received cost-of-living adjustments (COLAs) ranging from two percent to 10.7 percent, averaging 6.18 percent. Hospitals received COLAs ranging from one to four percent, averaging 3.05 percent and nursing homes received from 2.8 to 7.1 percent, averaging 5.09 percent. Intermediate Care Facilities for Persons with Mental Retardation are required by law to receive a two percent annual increase.

Options for system financial stability in community-based mental health, mental retardation, and drug and alcohol services should include annual cost-of-living adjustments equal to other parts of the health care system. Legislation should not include any limiting language in the annual increases such as has been done in the past with tying increases to direct care salaries. It is understandable that this was done to try to assure that direct care staff received annual increases in an effort to address staff turnover and vacancy issues. However, these funds have not always been distributed to provider agencies. Many times counties, which negotiate providers' budgets and rates, need to retain some or all of these monies to address emergency and unexpected expenses. COLAs need to be allocated for all components and business expenses of the community system which includes county departments and service providers. Consistent funding and anticipation of subsequent years' increases are needed to allow providers to adequately anticipate and develop budgets and services.

During the 2005/06 legislative session PCPA and other associations worked diligently to try to resolve the lack of annual COLAs by promoting passage of House Bill 1813. This legislation provided for the use of the federally-determined Home Health Market Basket Index cost-of-living adjustment as an annual minimum for mental health and mental retardation system provider increases. While passed by the Pennsylvania Senate and House of Representatives, the proposed legislation was vetoed by the governor.

Drug and Alcohol Legislation

PCPA introduced and advocated for the passage of a bill that would provide a more secure source of funding for drug and alcohol services. The problems of addiction permeate many other systems such as education, health care, law enforcement/criminal justice, welfare, domestic violence, child abuse services, foster care, and health and car insurance. These problems result in unnecessary costs and significant cost shifting. Given the constraints on funding, resources cannot simply be taken from other systems to fund drug and alcohol services. A source of secure funds to invest that will result in significant savings in these other systems is needed. Approximately 65 percent of Pennsylvania citizens drink alcohol, and of those, 20 percent of drinkers consume 80 percent of the alcohol. The state is working hard to make wine and liquor more accessible through Sunday sales and expanding sales within grocery stores, border stores, and super stores. This increased accessibility to alcohol must bring with it a commitment to treatment and prevention.

There exists a tax on wine and spirits often referred to as the *Johnstown Flood Tax* or the *Emergency Tax*. This tax is 18 percent and generates over \$200 million each year. There has been discussion about the commonwealth eliminating this tax or dedicating it to other purposes. Legislation was introduced that would eliminate this tax. PCPA believes that this tax should not be eliminated, but instead be dedicated to existing state-funded drug and alcohol treatment and prevention services.

Employment/Staff Issues

The lack of consistent annual funding increases is a major factor affecting community providers' ability to recruit and retain staff, especially direct care professionals. The staffing issues addressed in this section are based on several state and federal surveys as well as PCPA's member survey to determine issues and possible solutions.

Report to Congress

According to a 2006 report to Congress, it is estimated nationally that about 19,000 additional direct support professionals will be needed on average each year to meet growing demand. This does not include the additional persons to be recruited to replace those leaving employment for other jobs. National turnover rates averages are approximately 50 percent. Retention is a key component to meeting the increased demand. Staff turnover has negative effects on the lives of persons being served. Staff vacancies also have a negative impact on the direct support staff that remains through increased workload and pressures. This causes frustration and job burnout, further contributing to retention issues. The increased need for direct support professionals is occurring at a time when the labor force is expected to grow much more slowly than in the past. There will be increased competition for people to work not only in the disability field but as health and aging long-term care workers.

The Report to Congress 2006: Supply of Direct Support Professionals Serving Individuals with Intellectual Disabilities and Other Developmental Disabilities was developed for the US Department of Health and Human Services and presented to Congress. According to the report an estimated 4.3 million Americans of all ages with developmental disabilities live in residential settings, their own homes, or with family members. Ensuring access to quality direct support professionals is extremely important to quality of life.

As of June 2003 there were an estimated 874,000 full-time direct support professionals providing assistance. By 2020, the estimate is for an increase of 37 percent, to 1.2 million staff needed. Competition for direct support workers means compensation, working conditions, career opportunities, and job design will play key roles in recruitment and retention. Assuring lifelong supports includes sufficient numbers of paid professionals, including full and part-time residential support providers, day training and vocational support workers, home health assistants, respite care providers, job coaches, and personal care attendants. According to the National Alliance for Direct Support Professionals, who developed the report, conditions leading to high staff turnover include poor wages, insufficient training, and limited educational and career opportunities. For a copy of the report access <http://aspe.hhs.gov/daltcp/reports/2006/DSPsupply.htm>.

ODP System Capacity Report

In 2004 the Office of Mental Retardation (OMR), now the Office of Developmental Programs (ODP), established the System Capacity and Capability standing subcommittee to the Quality Improvement Council. In cooperation with OMR's Planning Advisory Committee it was recommended that a baseline be established regarding turnover and vacancy rates for direct support professionals in the provider system. The University of Minnesota designed a survey to collect statewide data regarding workforce stability during the 2005 calendar year.

Responses were received from 151 providers of whom 90 percent provided residential 24-hour support, 56 percent provided less than 24-hour residential, 64 percent offered in-home support, 70 percent provided job/vocational/day support, and 17 percent offered school/education support. The average respondent employed 160 direct support professionals and 17 frontline supervisors.

Wages averaged \$9.49 per hour for direct support workers and \$13.15 per hour for supervisors. Highlights of results include:

- High overall vacancy rates,
- The need to address recruitment and retention together,
- Turnover is higher in agencies that provide in-home support, and
- Multi-service providers struggle more with early direct support professionals leaving and frontline supervisor turnover and vacancies.

Recommendations include technical assistance and training/support models need to continue to be developed and implemented, there is a need to share promising and emerging practices in direct support workforce outcomes, and tenure turnover and vacancy measures should be imbedded in quality management efforts.

OMHSAS Survey

In January 2007 the Office of Mental Health and Substance Abuse Services (OMHSAS) released results of their compensation survey of 140 programs, 132 which provide Therapeutic Staff Support Services (TSS). Responses are summarized in the following categories.

Hiring and Retention of Staff

- Over 100 providers reported difficulty with recruitment and retention at least occasionally. Seventy-seven providers report current staffing difficulty.
- Common recruitment and retention challenges reported include part-time versus full-time employment, low pay, limited benefits, limited long-term growth, weekend and evening hours, and scheduling difficulties.

Employment Models

- Over 120 providers employ TSS workers as agency staff rather than contract staff. Reported annual wage based compensation ranged from \$20,000 – 40,000.
- Hourly rates range from \$8.50 – \$21 per hour with most rates falling in the mid-teens.

Benefits

- Ninety-eight of 132 providers offer some benefits.
- Fifty-one do not provide health benefits.
- Sixty-four do not provide paid vacation.
- Seventy-two do not provide paid sick leave.
- Sixty-nine do not provide any "other benefits."
- "Other benefits" listed by 63 providers included retirement, holidays, life and disability insurance, and 401k plans.
- Thirty-four of the 132 providers do not provide any benefits to TSS workers.

NeATTC

The Northeast Addiction Technology Transfer Center (NeATTC) has taken the lead and hosted task force meetings, designed a workforce development survey, and prepared a number of tools to address the issue of addictions workforce development. A number of workforce development products are available on the product page of the NeATTC web site (www.ireta.org/store/customer). All products are free to download. Some of them include:

In 2005 the NeATTC held its second workforce summit where leaders from New York, New Jersey, and Pennsylvania gathered to share updates on their workforce development programs, discuss challenges to implementation, and discuss new directions for workforce development. The *Workforce Development Monograph 2006* was developed and serves both as a summary

of ideas discussed and as a model for the substance use disorder treatment workforce. It describes the strategies used, the outcome of those strategies when available, and next steps that the region and member states are either considering or were suggested.

Imagine Who You Could Save, an addictions workforce recruitment video was designed to promote career opportunities in the addictions field while breaking down the stereotypes typically associated with the addiction/substance use disorder field. In the video, a diverse cast of addictions professionals contrast the toll addiction takes on the lives of substance users with the hope that addictions professionals provide for individuals and families affected by this disease. The video portrays the richness of the field, the personal satisfaction inherent in helping others, and the positive impact that addictions professionals have on individuals, families, and communities.

PCPA Survey

In October 2006 PCPA surveyed members to determine employment issues regarding staff turnover, staff vacancies, opinions on the reasons for staff turnover, and suggestions to reduce turnover and vacancy rates. The populations served by the respondents included mental health, mental retardation, juvenile justice, drug and alcohol, autism, physical and sensory disabilities, co-occurring drug and alcohol and mental health issues, and dually diagnosed mental health and mental retardation disabilities. Types of services offered included treatment, supported living, residential, family living, early intervention, crisis intervention, geriatric services, day services, acute care, case management, and sheltered and supported employment.

Statistics from the respondents were:

- 40 percent reported annual turnover rates between 11– 20 percent,
- 60 percent reported annual turnover rates between 21– 50 percent,
- 40 percent reported annual staff vacancies between 0– 10 percent,
- 20 percent reported annual staff vacancies of 11– 20 percent, and
- 10 percent reported annual staff vacancies of 21– 50 percent.

All respondents conducted exit interviews with staff and indicated the following reasons and statistics for leaving employment:

- 80 percent reported pay as the initial reason,
- 15 percent reported job advancement as the initial reason,
- 25 percent reported benefits as the secondary reason,
- 40 percent reported job advancement as the secondary reason, and
- 10 percent reported need for job flexibility as the second reason.
- Other secondary reasons include relocation, job burnout, and furthering educations.

Employer perceptions of the reasons for staff turnover include:

- 70 percent indicated pay,
- 15 percent indicated benefits, and
- Other options were difficult clients, high caseloads, and job advancement.

Agencies have implemented a variety of efforts to reduce turnover and vacancy rates. These have included mentoring programs, employee recognition, comprehensive benefits package, pay scale revision, flex-time, tuition reimbursement, training options, rehire welcome programs, and employee referral programs. Agencies surveyed gave the number one suggestion to reduce turnover and vacancy as salary increases. Following this are better benefit packages, career

ladders, reduced caseloads, flexible schedules, reduced paperwork/licensing/monitoring requirements, and management interaction with employees for retention suggestions.

Resources

PCPA has developed two reports which provide overviews on the Supreme Court *Olmstead* decision and the Pennsylvania Governor's Office of Health Care Reform grants and projects. These issues have some relevance to financial stability and employment issues being addressed by service providers. The association's monthly newsletter, *Provider News*, often includes articles related to staffing issues. Past issues may be accessed at www.paproviders.org.

Olmstead and Office of Health Care Reform

The 1999 US Supreme Court decision in *Olmstead v. L.C.* requires mental health programs to be administered in the "most integrated setting appropriate to the needs of qualified individuals with disabilities". This requires states to move services for persons with disabilities away from institutional care to integrated community-based settings. Each state was to develop an Olmstead Plan to implement these changes. With the state moving away from mental health and mental retardation state-center care where the state covered all costs to maintain the facility and residents, Pennsylvania was able to apply for Medicaid waiver funding to supplement state dollars used for these services.

Nationally some of the main barriers to Olmstead implementation have been state budget shortfalls or lack of increases to providers which have led to hiring freezes and higher rates of staff turnover. Many community service providers rely on Medicaid funding to implement programs and provide supports to individuals with disabilities. A more extensive overview of Pennsylvania's Olmstead efforts is available at www.paproviders.org.

The next step in implementing the Olmstead decision was the 2001 President's New Freedom Initiative aimed at promoting full access to community life for individuals residing in institutional programs. Executive Order 13217 directed federal agencies to work together to remove barriers to community living for the elderly and persons with disabilities. Eight states, including Pennsylvania, volunteered to be part of a research study directed by the Centers for Medicare and Medicaid Services to examine the effects of management techniques and system changes that states would have to implement to rebalance their Medicaid long-term care and long-term support programs.

Pennsylvania began to address these issues through the development of the Governor's Office of Health Care Reform. This office coordinates a variety of federal grants which are addressing system changes including Aging and Disability Resource Centers, Cash and Counseling, and Money Follows the Person. A more extensive overview of these efforts is also available at www.paproviders.org.

Benchmarking Project

PCPA, through a grant from the Office of Mental Health and Substance Abuse Services, has implemented a benchmarking project designed to enable the state's behavioral healthcare system to analyze best practices, organizational and system financing and fiscal health, as well as compiling performance data to assist in personnel development. Staffing benchmarks look at open positions, staffing patterns and retention, and staff-to-client ratios. Financial benchmarks measure debt ratio, operating revenue, and cost per client/unit.

Better Jobs Better Care

Better Jobs, Better Care is a four-year \$15.5 million research and demonstration program funded by the Robert Wood Johnson Foundation and the Atlantic Philanthropies. The program seeks to achieve changes in long-term care policy and practice that help to reduce high vacancy and turnover rates among direct care staff across the spectrum of long-term care settings and contribute to improved workforce quality. The lead agency for Pennsylvania's demonstration project is the Center for Advocacy for the Rights and Interests of the Elderly in Philadelphia. This project has developed a universal core curriculum for new direct care workers that is portable across all long-term care settings. For details access www.bjbc-pa.org.

Direct Care Workforce Clearinghouse

The National Clearinghouse on the Direct Care Workforce is an online library for those searching for solutions to the direct care staffing crisis in long-term care. The clearinghouse includes government and research reports, news, fact sheets and other information on topics such as recruitment, career advancement, supervision, workplace culture, and caregiving practices. A free biweekly online newsletter, *Quality Jobs/Quality Care*, is available. For details access www.directcareclearinghouse.org.

Annapolis Coalition

The Substance Abuse and Mental Health Services Administration commissioned the Annapolis Coalition on the Behavioral Health Workforce to develop a national action plan on workforce development that encompasses the breadth of the field. There are significant concerns about the capability of the current workforce to provide quality care. Problems include difficulties in recruiting and retaining staff, the absence of career ladders for employees, marginal wages and benefits, and limited access to relevant and effective training and financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources. This report was released in March 2007 and is available at www.annapoliscoalition.org.

Conclusion

The majority of mental health, mental retardation, children's, and drug and alcohol services are state and federally funded. It is the responsibility of these government entities to adequately fund service for persons with disabilities. National and state policymakers and funders need to ask these important questions:

- What will happen to persons with disabilities when the current community-based service system cannot hire enough workers to provide individual's with their necessary daily living supports?
- Will the system have no choice but to return to large, congregate, institutional warehouses which are segregated, civil rights limiting, isolating, and ultimately more expensive than the community system?

PCPA will monitor relevant legislation that will assist in providing financial stability and enhance workforce development, as well as seeking member input regarding recommendations to address the continuation of quality supports and services to persons with disabilities. An example of legislation that will be assessed and supported include initiatives have been reintroduced during the 2007 fiscal year. Their passage would have an impact on to the ability of service providers to employ necessary direct care staff. These include:

- Federal House Resolution 1279 to amend Title XIX of the Social Security Act to provide funds to states to enable them to increase wages paid to targeted direct support

professionals in providing services to individuals with disabilities under Medicaid. Entitled *Direct Support Professionals Fairness and Security Act of 2007*, wage enhancement incentive percentages would allow increases in funding to cover this effort.

- Pennsylvania Senate Bill 583 would establish a minimum annual wage for certain full-time direct care employees of publicly funded mental health and mental retardation programs. Entitled *Mental Health and Mental Retardation Direct Care Workers' Minimum Salary Act*, minimum hour wages would be set at \$8.65 per hour or an \$18,000 annual salary.