OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

Definitions and Occupational Characteristics of Direct Support Professionals: Environmental Scan and State Interview Findings Report

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by
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Office of the Assistant Secretary for Planning and Evaluation

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DEFINITIONS AND OCCUPATIONAL CHARACTERISTICS OF DIRECT SUPPORT PROFESSIONALS:

ENVIRONMENTAL SCAN AND STATE INTERVIEW FINDINGS REPORT

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EXECUTIVE SUMMARY

Many states face challenges in recruiting and retaining Direct Support Professionals (DSPs), a crucial professional group that plays a vital role in assisting children and adults with disabilities with the acquisition, retention or improvement of skills, activities of daily living, community inclusion, transportation, adult education, employment and social and leisure skill development, implementing prescribed therapies, and fostering the independence of individuals with disabilities in their homes and communities. These services are sometimes referred to as habilitation services. Despite the significant need for information about this workforce, DSPs remain difficult to identify distinctly in workforce data collection efforts.

The largest and most comprehensive federal data collection on workforce characteristics is the Occupational Employment and Wage Statistics (OEWS). However, it is not possible to identify the DSP workforce in the OEWS because the Occupational Handbook does not have a distinct Standard Occupational Classification (SOC) code for DSPs. Instead, DSPs are categorized under other direct care workforce classifications, most often Personal Care Aides (PCAs) (SOC #31-1122) and Home Health Aides (HHAs) (SOC #31-1121). To improve future workforce data collections for DSPs and to further inform workforce development, program planning, and the development of workforce policies, including the calculation of Medicaid payments, a standardized, detailed definition of DSPs that clearly distinguishes these workers from other direct care workforce occupations is needed. It could also be used to inform the consideration of a new DSP SOC code.

To further understand current DSP occupational characteristics and identify information states need on the DSP workforce to address policy and workforce planning activities, we reviewed the literature and state workforce policies related to DSP roles and responsibilities and gathered information from expert state developmental disability officials familiar with the issues impacting the DSP workforce in five states. Overall, we found the definition of DSPs has evolved over time with DSPs today assuming more responsibilities and a broader set of competencies to effectively serve several populations, including persons with disabilities and the elderly, in a variety of settings. Specifically, the role of DSPs has expanded beyond basic support, to include fostering community engagement supporting social inclusion, and advocating for the independence of individuals with disabilities. Recently, Congress has made several attempts to formally define the role of DSPs, recognizing their growing importance in supporting individuals with disabilities.[1,2] State officials interviewed for this study highlighted the unique scope of DSP duties to include social integration, skill development, and fostering independence--distinguishing their duties from HHAs and PCAs.

To address workforce shortages, states need detailed demographic data on DSPs, including age, geographic distribution, and information on the characteristics of their work environments. This information is vital for pinpointing regions or populations experiencing acute shortages. Understanding the causes of high turnover is key to developing retention strategies. States also require insights into DSP wages compared to competing industries and how wage increases tied to training or certification impact recruitment. Understanding the effectiveness of training programs and the influence of Medicaid policies on wages is essential. Finally, improved data collection tools are needed to capture regional and demographic variations in the DSP workforce, enabling states to craft informed strategies for improving recruitment and retention.

BACKGROUND

DSPs work primarily in community settings including individual and family homes, residential settings, and supporting people activities and events in the community. DSPs assist with daily living activities, employment, and social participation. They play a crucial role in connecting individuals to essential resources and support networks, enabling them to live fulfilling lives within their communities.

In 2003, Congress defined DSPs as *individuals who provide a wide range of supportive services to individuals with mental retardation [sic] or other developmental disabilities on a day-to-day basis, including habilitation, health needs, personal care and hygiene, employment, transportation, recreation, and housekeeping and other home management-related supports and services so that these individuals can live and work in their communities and lead self-directed, community and social lives*.[3]

In a 2006 U.S. Department of Health and Human Services "Report to Congress: Support Professionals Serving Individuals with Intellectual Disabilities and Other Developmental Disabilities," DSPs for persons with intellectual disabilities and other developmental disabilities were defined in a manner consistent with the Congressional definition contained in the 2003 Direct Support Professional Recognition Resolution (S. Con. Res. 21/H. Con. Res. 94). Specifically, "*DSPs are individuals who receive monetary compensation to provide a wide range of supportive services to individuals with intellectual and developmental disabilities on a day-to-day basis, including habilitation, health needs, personal care and hygiene, employment, transportation, recreation, and housekeeping and other home management-related supports and services so that these individuals can live and work in their communities and lead self-directed, community and social lives (Congressional Record, November 4, 2003, p. H10301). DSPs for individuals with ID/DD work in a range of settings, including family homes, intermediate care facilities, small community residential settings, vocational and day training programs and others. They include full and part-time employees*."[a]

The need for a clear DSP definition and SOC code was recognized by Congress in 2019-2020 (H.R. 6045) and 2023-2024 (H.R. 2941), where members of congress introduced bills that attempt to further define DSPs and establish a Bureau of Labor Statistics (BLS) SOC code for this profession.[1,2]

Because of their critical role and the growing population of people with disabilities, the demand for DSPs is outpacing the available supply, and states are struggling to keep up with the demand due to high vacancy rates and turnover. One frequently cited explanation for the high rates of vacancies and turnover is the combination of low wages, limited benefits, and career opportunities for DSPs.[4] Yet, efforts to highlight the challenges faced by the DSP workforce are hampered by a lack of comprehensive data.[5]

Despite the need for information on this workforce, it continues to be difficult to discretely identify DSPs in workforce data collection efforts. The largest and most comprehensive federal data collection on workforce characteristics is the Occupational Employment and Wage Statistics (OEWS). Occupations are classified based on work performed and, in some cases, on the skills, education and/or training needed to perform the work. The BLS Occupational Handbook does not list DSPs as a distinct Standard Occupational Classification (SOC). DSPs are aggregated into related direct care workforce occupations, most often Personal Care Aides (SOC #31-1122) and Home Health Aides (SOC #31-1121) (***Appendix A***).

Exhibit 1 provides an overview of Direct Care Workforce 2018 Standard Occupational Classifications as they exist today:

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[a] Support Professionals Serving Individuals with Intellectual Disabilities and Other Developmental Disabilities. (2006). U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Washington, DC.

Exhibit 1. Direct Care Workforce 2018 Standard Occupational Classifications				
Title	**DSPs[4]**	**PCAs[5]**	**HHAs[5]**	**Nursing Assistants[4]**
SOC #	(none)	31-1122	31-1121	31-1131
Responsibilities	(Needed)	Provide personalized assistance to individuals with disabilities or illness who require help with personal care and activities of daily living support (e.g., feeding, bathing, dressing, grooming, toileting, and ambulation). May also provide help with tasks such as preparing meals, doing light housekeeping, and doing laundry. Work is performed in various settings depending on the needs of the care recipient and may include locations such as their home, place of work, out in the community, or at a daytime nonresidential facility.	Monitor the health status of an individual with disabilities or illness, and address their health-related needs, such as changing bandages, dressing wounds, or administering medication. Work is performed under the direction of offsite or intermittent onsite licensed nursing staff. Provide assistance with routine health care tasks or activities of daily living, such as feeding, bathing, toileting, or ambulation. May also help with tasks such as preparing meals, doing light housekeeping, and doing laundry depending on the patient's abilities.	Provide or assist with basic care or support under the direction of onsite licensed nursing staff. Perform duties such as monitoring of health status, feeding, bathing, dressing, grooming, toileting, or ambulation of patients in a health or nursing facility. May include medication administration and other health-related tasks. Includes nursing care attendants, nursing aides, and nursing attendants. Excludes "Home Health Aides" (31-1121), "Personal Care Aides" (31-1122), "Orderlies" (31-1132), and "Psychiatric Aides" (31-1133).
Note: Retrieved from: 2018 SOC Manual (Entire Manual) (bls.gov).[6]				
DSP = Direct Support Professionals; PCA = Personal Care Aide; HHA = Home Health Aide; SOC = Standard Occupational Classification.				

Changes to the occupational classification system are periodically considered to recognize the growth and decline of occupations to provide data users the greatest detail. In 2018, BLS and the U.S. Census Bureau considered a new detailed occupational category for DSPs (Docket Number 2-0120.03) and recommended no change--indicating that job titles and job duties of DSPs do not allow discrete classification of workers between occupations, depending on actual work performed.[7]

An emerging body of evidence, however, recommends the establishment of an SOC code for DSPs. In 2022, the U.S. Department of Labor (DOL), Office of Disability Employment Policy hosted a *Direct Support Professionals Think Tank*,[8] and one recommendation from this meeting was to "differentiate and standardize occupational categories that are similar to and/or overlap with direct support professional work to improve data quality." Further, a 2023 Bipartisan Policy Center Report, *Addressing the Direct Care Workforce Shortages: A Call to Action* recommended that "The Office of Management and Budget should update the 2018 Standard Occupational Classification Manual to create an independent Standard Occupational Classification (SOC) code for direct support professionals that can be utilized by states and federal agencies."[9] Because the OEWS is the main source of occupation data, having a SOC code for DSPs is crucial for effective data collection, workforce analysis, and planning to inform policy decisions and resource allocations.[10]

A standard definition of DSPs may support a wide range of activities, including establishing competencies and required qualifications, workforce development initiatives, improved data collection, program planning, and the calculation of Medicaid payment rates. State rate models are structured to address the cost of providing a service including the wages and benefit paid to personnel. Within these models, "the wages and benefits paid to direct support professionals (DSPs) comprise the largest component".[11] Consequently, due to the substantial influence of DSP compensation on overall rate determination, the lack of a systematic mechanism to gather employment and wage data specifically for DSPs may affect the accuracy of rate calculations. This study explores duties and activities that distinguish the DSP occupation from other direct care workforce occupations to inform workforce data collection efforts including the consideration of a DSP SOC code. This study also identifies information that states need on the DSP workforce to address policy and workforce planning activities.

METHODS

We conducted an environmental scan of peer-reviewed and gray literature (***Appendix A***) and interviews with state experts to address two key research questions (RQs):

1. What are the distinct occupational characteristics of DSPs from other long-term services and supports workforce occupational categories?
2. What information on the DSP workforce do states need to address policy and workforce planning activities?

Interviews were conducted with experts in five states: Georgia, New York, Pennsylvania, Rhode Island, and Tennessee. State selection prioritized sustained commitment to DSP recruitment and retention, strong agency leadership, size of the population served by the state intellectual/developmental disabilities (IDD) agency and adoption of National Alliance for Direct Support Professionals (NADSP) certification standards. Within each state, state developmental disability experts who were familiar with the issues impacting the DSP workforce were interviewed.

LITERATURE REVIEW RESULTS

Unique Occupational Characteristics of Direct Support Professionals

This section provides an overview of the literature on the unique occupational characteristics of DSPs. Peer-reviewed articles illustrate the skillsets and competencies required of DSPs. Results from the gray literature reveal major frameworks of DSP competency that have historically shaped the profession.

Exhibit 2 presents an overview of select peer-reviewed articles to illustrate the skillsets and competencies required of DSPs:

Exhibit 2. Skills and Competencies of DSPs Found in the Peer-Reviewed Literature, 2015-2024

Author(s), Year	Skills	Competencies
Bogenschutz, Nord, & Hewitt (2015)[12]	"… the segment of the labor force responsible for providing direct personal service and support to people in need of [ADL] tasks, personal care, household upkeep, relationship building, and community participation." (pg. 183)	• Describe self-determination and explain why it is a best practice • Identify strengths, interests, and preferences of their clients and establishes community-based opportunities • Explain how social services and supports can impede a client's ability to exercise their rights • Assist and support clients to make informed decisions about their health care • Maintain positive relationships with clients • Identify three primary factors that may affect a client's personal care needs
Caler (2023)[13]	"Their work requires many skills, which may include needing to understand complex health conditions, conflict mediation and de-escalation, emergency preparedness and response, positive behavioral support, teaching and reinforcement strategies around ADLs, transportation, and community engagement." (pg. 87)	• Cites the 15 competencies as outlined by the NADSP (see ***Exhibit 3*** for details)
Ejaz et al. (2015)[14]	"Activities of daily living: bathing, toileting, dressing, grooming, feeding; Instrumental activities of daily living: meal preparation, housekeeping, medication reminders, transportation." (pg. 146, Table 2)	Not provided
Friedman (2019)[15]	"DSPs must utilize a complex balance of skills… such as assistance with personal care, transportation, financial duties, education, household tasks, and self-determination." (pg. 1)	• Support clients deciding where to live • Identify and establish services for clients based on their needs and wants
Hewitt et al. (2021)[16]	No specific skills mentioned.	• Identify and establish services for clients based on their authorizations

Exhibit 2 (*continued*)		
Author(s), Year	**Skills**	**Competencies**
Houseworth et al., (2020)[17]	"DSPs provide support to people with IDD that enables them to live, work, and participate in their communities." (pg. 192)	• Support for health and hygiene • Identify and provide person-centered services according to clients' goals • Supporting self-determination • Supporting full and active community participation
Johnson et al. (2021)[18]	DSP skills include "providing high quality supports and promoting person-centered services" (pg. 204)	Not provided
Johnson et al. (2022)[19]	"The role of the DSP… includes promoting the person's self-determination, community belonging, and civil rights…. [DSPs] are primary facilitators of community access and integration, as well as a primary deterrent to institutionalization for the people they support." (pg. 200)	• Basic health and safety training • Promote and understand civil rights, self-determination, and person-centeredness
Laws & Hewitt (2020)[20]	"DSPs are staff who are employed to 'provide a wide range of supportive services to individuals with [IDD] on a day-to-day basis, including habilitation, health needs, personal care and hygiene, employment, transportation, recreation, housekeeping, and other home management-related supports, so that these individuals can live and work in their communities and lead self-directed, community and social lives'." (pg. 189)	• Teach clients new skills • Dispense medications, administer treatments, document care, and communicate with medical professionals • Assess needs, implement specific treatment plans, and document progress • Connect clients to community resources and benefits • Listen, reflect, and offer suggestions to clients
Laws et al. (2024)[21]	"[DSPs] spend time developing… effective strategies to help people develop new skills and enrich current ones… connect people with IDD and families to resources and benefits… dispense medications, administer treatments, document care provided, coordinate with various medical teams, and implement plans of care." (pg. 176)	• Cites the 15 competencies as outlined by the NADSP (see ***Exhibit 3*** for details)
Mir et al. (2024)[22]	"DSPs support people with IDD by providing one-on-one individualized personal assistance, enabling people to live, work, and participate in their communities." (pg. 14)	• Take person-centered approach • Build and maintain positive relationships • Demonstrate professionalism • Support good health and safety • Establish an appropriate home setting • Support being active and productive in society
Pettingell et al. (2022)[23]	"[A DSP] is an employee with the primary job responsibility of providing training, support, personal assistance, and supervision to adults with [IDD]." (pg. 114)	• Cites the 15 competencies as outlined by the NADSP (see ***Exhibit 3*** for details)

Exhibit 2 (*continued*)		
Author(s), Year	**Skills**	**Competencies**
Pettingell et al. (2023)[24]	"DSPs provide various supports that include meeting individual needs related to health, social connections, employment and other aspects of community living." (pg. 197)	• Cites the 15 competencies as outlined by the NADSP (see ***Exhibit 3*** for details)

ADL = activity of daily living; DSP = Direct Service Professional; IDD = intellectual and developmental disability; NADSP = The National Alliance for Direct Service Professionals.

The NADSP framework[25] has become a key foundation in the field, evolving to meet the expanding demands of habilitation services and the increased focus on person-centered principles and serving as a valuable benchmark for essential DSP skills and competencies: participant empowerment, communication, assessment, community services and networking, facilitation of services, community living skills and supports, self-development, advocacy; vocation, education and career support; crisis prevention and intervention, documentation, building and maintaining friendships, providing person-centered supports, and supporting health and wellness. Each NADSP competency has corresponding skill statements which describe the knowledge and skills DSPs must have to demonstrate competency in each area.

Exhibit 3 provides an overview of the competencies and skills as outlined in the NADSP framework.

Exhibit 3. NADSP Competency Areas and Skills	
Competency Area	**Skills**
Participant empowerment	Assists participant with strategizing, decision-making, and responsibility fulfillment
Communication	Utilizes effective communication methods to maximize participant understanding
Assessment	Initiates assessments to determine participant's needs and capabilities and provides recommendations
Community Services & Networking	Identifies community supports and resources that are relevant to the participant's needs
Facilitation of Services	Implements individualized support plans for the participant and collaborates with all support team members
Community Living Skills & Supports	Assists participant with physical (hygiene, toileting, eating) and emotional (relationships, sexual wellness) needs. Secures durable medical equipment, if needed
Education, Training, & Self-Development	Keeps up with current information through training
Advocacy	Understands laws, services, and community resources to secure services for the participant
Vocational, Educational, & Career Support	Assists participant with identifying vocational interests and aptitudes and prepares participant for entry into the workforce
Crisis Prevention & Intervention	Identifies crises, defuses emergency situations, and determines appropriate course of action
Organizational Participation	Contributes to program evaluations and maintains standards set by quality control
Documentation	Submits accurate records in a timely fashion and maintains confidentiality and ethical record keeping practices
Building & Maintaining Friendships & Relationships	Assists participant with scheduling activities and interacting with community members

Exhibit 3 (*continued*)	
Competency Area	**Skills**
Provide Person-Centered Supports	Identifies what is important to the participant and ensures all supports and interventions take a person-centered approach
Supporting Health and Wellness	Administers medication, assists with scheduling and following through with health appointments
Note: The Skill Statements have been summarized by RTI. For the complete list, see https://nadsp.org/resources/the-nadsp-competency-areas/.	

Some states have opted to develop their own competency standards in this field. For example, Florida,[4] Illinois,[5] and South Carolina[7] consider a comprehensive understanding of individuals' rights, including human rights violations, signs of abuse, and Health Insurance Portability and Accountability Act laws a core competency. This is comparable to the NADSP competency areas of Advocacy, Education, Training & Self-Development, and Documentation. Illinois, Florida, and Virginia[4] also highlight community integration as a core competency, similar to the NADSP competency area of Building & Maintaining Friendships & Relationships. In some cases, states' competency areas do not have an analogous NADSP counterpart. For example, South Carolina specifically notes cardiopulmonary resuscitation (CPR) and first aid certification as a core competency for DSPs. Additionally, South Carolina requires basic cyber security training, Occupational Safety and Health Administration training, and a demonstrated knowledge of fire safety and disaster planning.

Competencies in DSP Training Requirements

Despite the complex responsibilities that DSPs need to fulfill, there are no formal higher education requirements to become a DSP. However, most employers require a high school diploma (or equivalent) at a minimum to become a DSP, a valid driver's license, and no criminal history.[13] Approximately one-third of the DSP workforce possess at least some college education.[20]

There are no federal training requirements for DSPs. DSP training requirements vary by state and employer, with some states requiring DSPs to complete a specific training program. In contrast, the federal training requirement for HHAs and Certified Nursing Assistants (CNAs) is a minimum 75-hour training course requirement prior to working with clients.[4,26] In the absence of federal requirements, national organizations have developed skill standards, certification programs and competency models for DSPs. State governments and providers have used these resources to support their workforce development.

Direct Support Professional Training

The National Alliance for Direct Support Professions (NADSP) training (described above) has developed a tiered DSP certification program. This certification requires at minimum of 50 hours of training initially and 20 hours of continued education every two years.

Community Support Skill Standards include 12 main competency areas: participant empowerment, communication, assessment, community and service networking, facilitation of services, community living skills and supports, education, training and self-development, advocacy, vocational, educational and career support, crisis prevention and intervention, organizational participation, and documentation.[27]

Registered Apprenticeships are industry-vetted and approved and validated by the U.S. Department of Labor or a State Apprenticeship Agency.[28] The goal of the DSP Apprenticeship Model is to create a structured training pathway for DSPs working in long-term care.[28] The DSP Registered Apprenticeship Model teaches DSPs to help people with disabilities achieve increased independence, productivity, and inclusion in the

community competencies. DSP Registered Apprenticeship programs include training on community living skills and supports, communication, documentation, participant empowerment, assessment, community and service networking, advocacy, crisis prevention intervention, building and maintaining friendships and relationships, providing person-centered supports, and supporting health and wellness.

State Policy Approaches

In examining selected state workforce policies related to definitions of DSP roles and responsibilities and efforts to enhance data collection for informing policy decisions and workforce planning, this study found the delineation of DSP roles and functions at the state level is most apparent in two key areas: payment policy and training and apprenticeship programs. This section provides examples of these approaches from select states.

Medicaid Payment Policies

A clear definition of DSP roles and responsibilities is crucial for determining Medicaid reimbursement rates. In the absence of a DSP SOC code states have had to identify and average other occupations. A study conducted by Health Management Associates across 26 states revealed a prevalent trend in Medicaid rate setting: the utilization of rate models structured around provider expenses.[11] These models, essential for determining overall reimbursement rates, identified DSP wages and benefits as the most substantial cost component. Given the significant impact of DSP compensation on rate calculations, a standardized system provides an opportunity to improve the accuracy of rate setting. The study further highlighted variation of methodologies for establishing DSP wage assumptions among states. While 20 out of 26 states relied on BLS data, three states employed minimum wage benchmarks, two states predetermined wage assumptions, and two used provider survey results.[b]

Georgia recently conducted a comprehensive evaluation of its rate-setting methodology for IDD waiver programs. The state used an assumed wage of $15.18 per hour for its DSPs. This was determined with 2021 BLS data using a blend of 50 percent PCA/HHA, 20 percent social/human services assistant, 10 percent weight for three other BLS classifications: community health workers, psychiatric aides, and recreation workers.[29]

Wyoming utilized HHAs and PCAs as occupational benchmarks to establish hourly wage rates for staff providing various IDD waiver services.[30]

Hawaii based wage assumptions for several IDD waiver services by referencing BLS data for HHA/PCAs, psychiatric technicians, and recreation workers. To determine the relative weight of each occupation in representing DSP roles, a weighted average was applied.[28,31]

Training Policies

Many states have training and apprenticeship programs in place to recruit and retain DSPs. These programs provide a blend of paid on-the-job training and classroom instruction in various community-based settings. The training requirements provide valuable insight into the skills and competencies that states expect and require from their DSP workforce. These requirements highlight the specific abilities and knowledge areas that are deemed essential for DSPs to effectively support individuals with IDD. This section highlights examples of select states' training programs and required competencies.

Alaska has collaborated with the University of Alaska Anchorage, Center for Human Development to create an enriched training and professional development curriculum for DSPs. The training for DSPs emphasizes

[b] One state adopted a hybrid approach, utilizing two distinct methods for rate determination.

collaboration, effective communication, and relationship-building while maintaining boundaries. DSPs assess client strengths and needs. They support decision-making, implement care plans, ensuring safety, and provide emotional and physical support. DSPs also teach, resolve conflicts, prevent crises, promote wellness, connect individuals to resources, and tailor care to individual needs. They maintain professionalism by fulfilling responsibilities, adhering to regulations, and managing stress, while also focusing on professional development through skill enhancement and feedback.[32]

Missouri Talent Pathways Certified Direct Support Professional (CDSP) apprenticeship is a registered apprenticeship through DOL, and trains DSPs in 15 core competencies and 69 skills aligned with NADSP. The training covers areas such as communication, crisis prevention, person-centered supports, health and wellness, advocacy, relationship-building, assessment, service facilitation, education, documentation, and community living skills. Participants ultimately earn a certificate as a CDSP. As the apprenticeship credentials are issued by DOL's Office of Apprenticeship, participants may be eligible for additional financial assistance through local workforce development programs and/or the GI Bill.

The **Tennessee** Quality Improvement in Long Term Services and Supports (QuILTSS) DSP Apprenticeship Program is a work-based learning model.[33] The program is designed to align training with industry-recognized competencies, providing participants with the essential skills needed to support to individuals with IDD through practical, hands-on experience. The competencies for DSPs encompass person-centered practices which prioritize personalized communication, advocacy, professionalism, and adherence to ethical standards, including confidentiality and decision-making. Additionally, they involve assessing and observing individual goals to ensure alignment with evaluations, fostering community living skills to encourage participation and inclusion, and empowering individuals by removing obstacles. Health and wellness competencies focus on addressing medical needs, while cultural competency enhances the ability to respect and incorporate individual preferences. Training in crisis prevention emphasizes risk assessment and planning, while safety skills ensure preparedness for various situations.[34]

In **Illinois**, DSP trainings must cover six core competencies including understanding agency values, distinguishing between ID and mental illnesses, and applying ethical standards and confidentiality practices. DSPs must also be knowledgeable about human rights, civil and legal protections, the role of Human Rights Committees, advocacy principles, and preventing and recognizing abuse and neglect. They are trained in effective communication techniques, including active listening and assistive technologies, to build rapport and ensure consistent information sharing, and in service plan development which involves engaging in person-centered planning, supporting individuals' goals, and utilizing community resources. Furthermore, DSPs are equipped with basic health and safety knowledge, such as injury prevention, emergency procedures, infection control, food safety, and personal care, enabling them to provide comprehensive support and advocacy for individuals with developmental disabilities.[35]

FINDINGS FROM STATE INTERVIEWS

We conducted interviews with experts in five states: Georgia, New York, Pennsylvania, Rhode Island, and Tennessee. State selection prioritized sustained commitment to DSP recruitment and retention, strong agency leadership, size of the population served by the state IDD agency, and adoption of NADSP certification standards. Within each state, state developmental disability experts who were familiar with the issues impacting the DSP workforce were interviewed. Within each state, we interviewed state developmental disability officials familiar with the issues impacting the DSP workforce. In summary, state officials defined the responsibilities and functions of DSPs, as follow:

- Facilitating community integration.
- Skill-building.
- Implementing behavioral support and diagnosis-specific therapy plans.
- Adhering to trauma-informed practice.
- Providing independence support.
- Performing unsupervised health care tasks (e.g., administering medications, managing feeding tubes, providing diabetes care, handling colostomy).
- Learning and using communication modalities specific to each individual.
- Providing direct assistance in self-help, socialization, and adaptive skills training.
- Ensuring retention and improvement in self-help and adaptive skills.
- Delivering personal care, protective oversight, and supervision.
- Assisting with training in independent community living skills.
- Supporting individuals in achieving their goals as outlined in their support plans.
- Promoting informed decision-making, understanding risks, and exercising rights and choices.
- Supporting individuals throughout their entire life journey, adapting to clients' evolving needs from childhood to adulthood.
- Promoting independence, ensuring safety, and enhancing overall quality of life.
- Fostering and maintaining personal relationships for clients.
- Supporting social interactions and helping clients build meaningful relationships.
- Setting goals and participating in goal achievement for clients.

Exhibit 4 provides a summary of differences between DSPs, HHAs and PCAs, qualifications and requirements, payment policies, and data collection by each state interviewed for this study (for a detailed description by state, see ***Appendix C***).

Exhibit 4. Summary of State Interview Findings					
State	Differences Between DSPs from HHAs and PCAs	Qualifications and Requirements	Credentialing and DOL Apprenticeship	Payment Policies	Data Collection
Georgia (GA)	DSPs take a person-centered approach to support; HHAs and PCAs take a task-oriented approach. DSPs have training in socialization, adaptive skills development, and implement behavioral support plans.	Aged 18+; High school diploma or equivalent; Passing score on the Test of Functional Health Literacy in Adults; Valid driver's license; CPR and first aid certification; Completion of initial and annual trainings.	Currently provides 3 programs for credentialing: GA DOL's Certified DSP Apprenticeship program, DSP Training and Assessment Program; NADSP E-Badge Academy.	GA's DOL requires DSPs be paid a minimum salary before starting an apprenticeship. Upon completion of the apprenticeship, DSPs are expected to receive a salary increase. Currently, the base wage is $14/hr.	GA primarily utilizes the NCI State of the Workforce Survey for data collection. The state also contracts with an external entity to conduct annual quality reviews, consisting of interviews with DSP service beneficiaries and a review of the current care delivery system. GA also distributes quarterly surveys to DSP service coordinators.
New York (NY)	DSPs are involved in goal setting and participating in goal achievement, which are not responsibilities of HHAs and PCAs. Unlike HHAs and PCAs, DSPs provide person-centered support.	High school diploma, equivalent, or NADSP certification; Valid driver's license; Passing of state background check; DSPs employed by the state are required to complete trainings.	Currently provides a DOL apprenticeship program for DSPs through a collaboration with the SUNY system.	State minimum wage is $15/hr. NY provides bonuses to state-employed DSPs through the American Rescue Plan Act. Organizations may offer hourly pay increases for DSPs that obtain certifications.	NY asks DSPs to complete the NCI survey, but it is not required.
Pennsylvania (PA)	DSPs assist individuals in every activity, relationship, and decision made by helping clients understand and exercise their rights; HHAs and PCAs do not provide this support.	Aged 18+; 4-year degree; Completion of initial and annual trainings.	In addition to the NADSP requirements, PA provides trainings through the Competency-Based IDD/MI Dual Diagnosis DSP Certification Program, designed by the National Association for the Dually Diagnosed. PA currently does not offer any apprenticeship programs.	PA does not currently have wage incentives based on role, training, or credentials.	PA utilizes provider associations to collect data around wage ranges, salaries, and executive salaries. PA mainly refers to the NCI State of the Workforce Survey and encourages, but does not require, DSPs to complete the survey each year.

Exhibit 4 (*continued*)					
State	**Differences Between DSPs from HHAs and PCAs**	**Qualifications and Requirements**	**Credentialing and DOL Apprenticeship**	**Payment Policies**	**Data Collection**
Rhode Island (RI)	DSPs are able to support individuals throughout the lifespan, requiring unique skills that adapt to evolving needs of clients.	Aged 18+; High school diploma or equivalent; Passing of state background check; Some programs require DSPs to own their own vehicle.	No credentialing or apprenticeship programs are currently in place.	RI does not offer pay differentiation based on training, credentials, or experience. DSP wage policies in RI are governed by a court-ordered consent decree, which resulted in average hourly pay wages of $20/hr.	RI collaborates with the Institute on Community Integration (ICI) at the University of Minnesota to administer a modified version of the NCI survey tailored to the state. DSPs can use SupportWise, an online data collection system that provides longitudinal and comparison data that updates in real time.
Tennessee (TN)	DSPs provide additional support in promoting independence, ensuring safety, and enhancing quality of life, which HHAs and PCAs typically do not provide as part of their services.	High school diploma or equivalent; Passing of state background check; Valid driver's license; Completion of initial trainings; No minimum age requirement.	Currently has one registered apprenticeship through the QuILTSS Institute, the TN DOL, and UnitedHealthcare Community Plan of TN.	Starting wage for DSPs is $15.37/hr, with incentives for DSPs who complete national certification and training programs.	TN is currently in year 6 of data collection via the TN LTSS Workforce Quality Improvement Survey, developed in collaboration with the ICI.

DISCUSSION

We reviewed existing definitions of DSPs, explored the literature and state workforce policies related to DSP roles and responsibilities, and gathered information from state developmental disability officials in five states to clarify the specific and unique duties that DSPs perform. Overall, we found the definition of DSPs has evolved over time with DSPs today assuming more responsibilities and a broader set of competencies to effectively serve several populations, including persons with disabilities and the elderly, in a variety of settings. Specifically, the role of DSPs has expanded beyond basic support, to include fostering community engagement supporting social inclusion, and advocating for the independence of individuals with disabilities. Recently, Congress has made several attempts to formally define the role of DSPs, recognizing their growing importance in supporting individuals with disabilities. State officials interviewed for this study highlighted the unique scope of DSP duties to include social integration, skill development, and fostering independence--distinguishing their duties from HHAs and PCAs.

According to the literature review and state interviews, the NADSP framework has emerged as a foundational guide for establishing DSP competencies, adapting to the increasing demands of habilitation services and emphasizing person-centered principles. However, adoption of this framework varies, with some states opting to develop their own competency standards in this field.

Direct Support Professionals Perform Different Tasks than Personal Care Aides, Home Health Aides, and Nursing Assistants

Across the five state interviews, a common theme emerged: DSPs perform tasks that are different than PCAs, HHAs, and Nursing Assistants (NAs) depending on the service provided. For instance, some DSP focus on community integration, while others provide employment support or behavioral assistance. Unlike HHAs, PCAs, and NAs who primarily offer personal care, DSPs promote socialization, training in independent living skills, and ensuring long-term retention of these abilities.

In contrast, the responsibilities of HHAs, PCAs, and NAs ensure the comfort and safety of those they support. Their primary responsibility is often short-term care or maintenance of physical health rather than fostering personal growth, community integration, or skill development. DSPs are required to understand each client's specific communication needs and take a person-centered approach to care, as outlined in state policy documents and Medicaid manuals. States emphasize that DSP roles vary based on the needs of individuals but consistently involve extensive responsibilities, such as promoting social interactions, fostering personal relationships, and supporting goal achievement. DSPs work in a variety of settings, including group homes, community programs, and assisted living facilities, often with diverse populations ranging from children to adults with disabilities. This diversity in roles and settings sets DSPs apart from HHAs and PCAs in particular, who primarily operate in private residences.

A critical distinction between DSPs and other direct care occupations like PCAs, HHAs and NAs is their involvement in setting and achieving goals for their clients, helping individuals exercise their rights, and promoting informed decision-making. States like Pennsylvania, Rhode Island, and New York underscore that DSPs are essential in maintaining personal relationships and improving quality of life, going beyond the task-oriented functions of HHAs, PCAs, and NAs. This multifaceted, person-centered care makes DSPs a crucial part of the support system for individuals with IDD.

Person-Centered Care

Several interviewees emphasized that DSPs are distinct from other human service professionals because of the highly individualized nature of the services they provide. The core of DSP work is person-centered care, which involves tailoring support to each individual's unique needs, preferences, and goals. This approach goes

beyond basic care by focusing on empowering individuals to make informed decisions, understanding and managing risks, and fostering independence. Interviewees pointed out that DSPs are not just caregivers but facilitators of autonomy and personal growth, playing a pivotal role in helping individuals lead more fulfilling and self-directed lives. Additionally, many state interviewees stressed that the work of DSPs is critical in enhancing the overall quality of life for the people they support. By promoting independence and balancing it with safety and well-being, DSPs ensure that individuals engage meaningfully in their communities and make decisions that shape their own lives.

This dual focus on independence and safety makes the role of DSPs unique and underscores their vital contribution to human services. DSPs are often required to exercise their own judgment in various situations, as they frequently work without direct supervision. This includes accompanying individuals to medical appointments and communicating with health care professionals on the person's behalf. In these instances, DSPs must advocate for the individual, relay important information, and ensure medical instructions are understood and followed appropriately. They must assess and respond to the unique needs of their clients in real-time, making decisions that balance safety, independence, and individual preferences. Whether it is handling unexpected challenges, adjusting care strategies, or managing complex behavioral issues, DSPs must rely on their experience, training, and understanding of the client to make informed decisions. This autonomy in decision-making is a critical aspect of the DSP role, as it allows them to provide tailored, person-centered support that adapts to the dynamic and evolving needs of the individuals they serve.

Community-Based Focus

DSPs operate in diverse settings, including community-based environments such as a person's own home or family home, or environments like group homes, day programs, or employment settings, where they support individuals in achieving personal goals. This focus on integration and goal-oriented support, sets DSPs apart from HHAs and PCAs in particular, who usually work in private residences, focusing primarily on providing personal care.

Promoting Relationships and Social Integration

Several states mentioned that DSPs support individuals in social interactions, skill-building, and independence--functions that transcend the care roles typically assigned to HHAs and PCAs. Interviewees also stressed the importance of DSPs in fostering meaningful personal relationships for their clients. DSPs help individuals build and maintain social connections, enhancing their overall well-being and quality of life. This relational aspect of DSP work is a key responsibility that extends beyond the primarily task-oriented functions typically associated with HHAs and PCAs.

Data Collections and Workforce Considerations

States are employing a variety of methods to gather data on the DSP workforce, with many relying heavily on the National Core Indicators (NCI) Survey. This tool serves as a valuable resource for understanding workforce trends, but it comes with limitations. These limitations were reported by some of the interviewees during the study, reflecting the experiences and perspectives of those who have engaged with the survey. One of the primary challenges is incomplete participation, as not all states or regions contribute fully to the survey, leading to gaps in the data. Furthermore, the survey often struggles to capture the nuanced regional differences within states, which can be significant given the varied needs and demographics of DSPs and the populations they serve.

For example, some states have only recently begun participating in the NCI survey and have encountered difficulties differentiating between DSPs who work with different age groups, such as those supporting children versus adults. This lack of distinction makes it harder to assess the specific challenges and demands facing DSPs across diverse service settings. Additionally, capturing geographic and demographic differences

within states remains a challenge, as workforce needs and conditions can vary widely between urban, suburban, and rural areas, as well as across different socioeconomic and cultural communities. Because of these limitations, some states supplement the NCI survey with additional data collection efforts by engaging a provider association or leveraging internal data systems. National data collection on the DSP workforce is incomplete.

Limitations

Some factors limited the scope of this review. We did not conduct a review of each state's definition of DSPs; only five states were selected for review. While many states utilize the NADSP framework, others develop individual frameworks to classify the DSP workforce.[24] Therefore, it is possible that some states may include additional or omit responsibilities as outlined by NADSP. Regardless, it is evident that all DSPs have a crucial responsibility: to foster self-determination, relationships, and independence among individuals with IDD. These limitations underscore the need for more comprehensive and nuanced data collection methods that can provide a clearer picture of the DSP workforce at both the state and local levels. Enhanced national data collection could help policymakers and administrators better understand workforce shortages and training needs. Ultimately, more accurate and detailed national data will be critical for shaping effective policy decisions, workforce development strategies, and targeted interventions to improve recruitment, retention, and overall job satisfaction of DSPs.

Conclusion

This study provides essential insights into the distinct duties and activities that distinguish DSPs from other direct care workforce occupations. Efforts to highlight the challenges faced by the DSP workforce continue to be hampered by a lack of comprehensive data collection on these workers. Strengthening data infrastructure for DSPs is critically important to allow for better tracking and workforce planning efforts and to inform policies to support DSP workers, including the calculation of Medicaid payment rates. As the demand for community-based services continues to grow, addressing these challenges will be essential to developing a skilled, stable DSP workforce capable of delivering high-quality care and support. The importance of DSP workers to the United States economy combined with increasing demand for services and persistent job quality, recruitment, and retention challenges in the sector make additional national data collection crucial.

APPENDIX A: STANDARD OCCUPATIONAL CLASSIFICATION STRUCTURE

Exhibit A-1. Standard Occupational Classification Structure				
Major Group	**Minor Group**	**Broad Group**	**Detailed Occupation**	
31-0000				Healthcare Support Occupations
	31-1100			Home Health and Personal Care Aides; and Nursing Assistants, Orderlies, and Psychiatric Aides
		31-1120		Home Health and Personal Care Aides
			31-1121	Home Health Aides
			31-1122	Personal Care Aides
		31-1130		Nursing Assistants, Orderlies, and Psychiatric Aides
			31-1131	Nursing Assistants
			31-1132	Orderlies
			31-1133	Psychiatric Aides
	31-2000			Occupational Therapy and Physical Therapist Assistants and Aides
		31-2010		Occupational Therapy Assistants and Aides
			31-2011	Occupational Therapy Assistants
			31-2012	Occupational Therapy Aides
		31-2020		Physical Therapist Assistants and Aides
			31-2021	Physical Therapist Assistants
			31-2022	Physical Therapist Aides

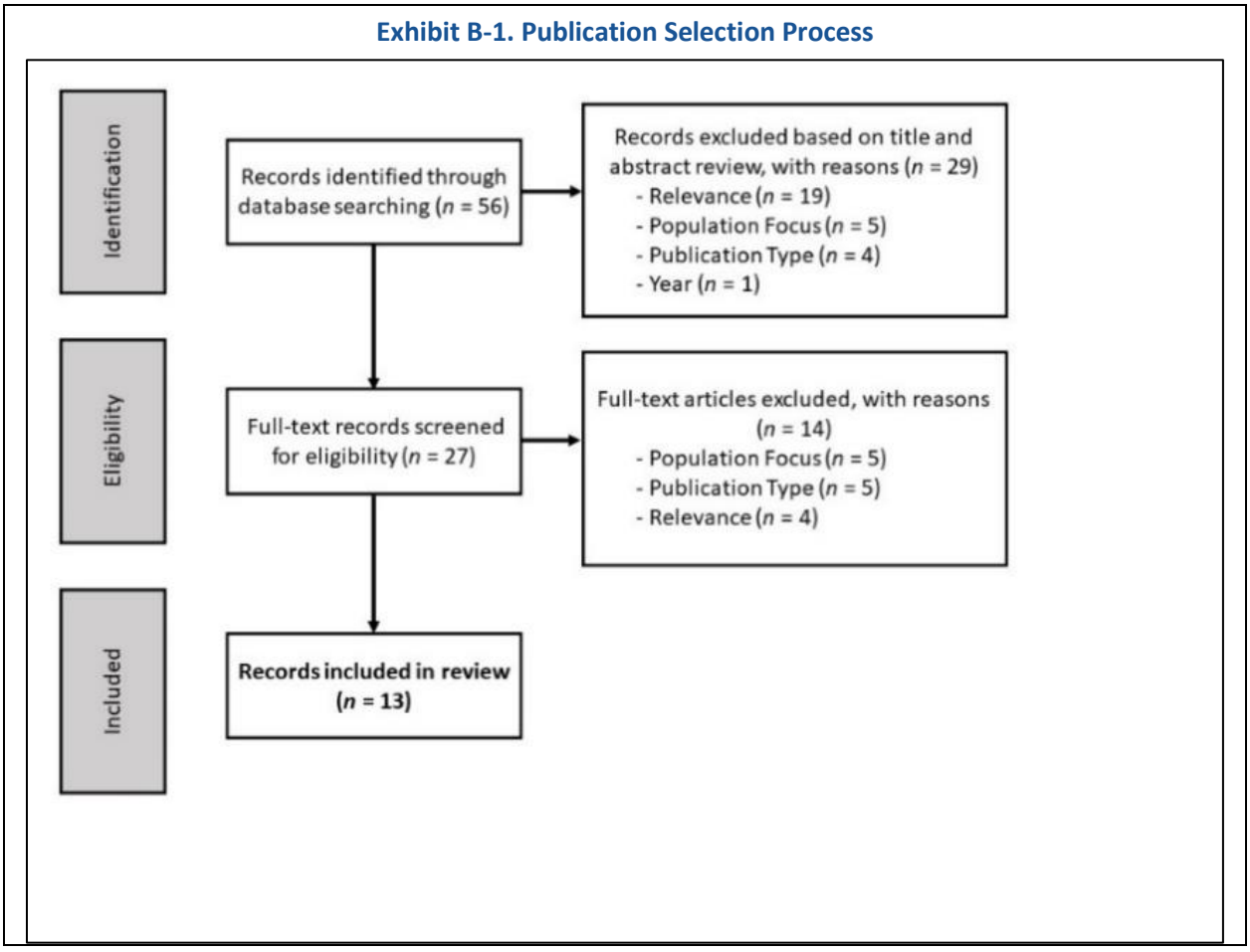
APPENDIX B: METHODS

To answer the first RQ, RTI conducted an environmental scan of the peer-reviewed literature using a rapid review approach, which involved the research team considering studies based off specific criteria. Researchers recommend rapid reviews for analyzing literature on federal and state-level policies, specifically when addressing urgent and timely RQs.[36]

Peer Reviewed Literature

RTI began the peer-reviewed literature review by working with a professional librarian to refine the approach to identifying relevant studies. ***Exhibit B-2*** details the databases and search terms used for this review. A total of 56 publications were identified from the initial search and subsequently screened for inclusion. Upon review of the titles and abstracts, 29 publications were excluded based on relevance (19), population focus (5), publication type (i.e., magazine articles, doctoral dissertations) (4), and year of publication (1). The remaining 27 publications then underwent a full-text review by two RTI analysts. Fourteen publications were excluded based on population focus (5), publication type (5), and relevance (4). The exclusions were reviewed by two RTI analysts to confirm their removal. A qualitative thematic analysis was conducted on the final 13 publications selected for inclusion. The publication selection process is summarized in ***Exhibit B-1***.

Exhibit B-1. Publication Selection Process



A team member imported the publications into a data charting tool, created to capture and organize information collected from the literature review. The tool allows information from the publications to be extracted and categorized based on applicability to the RQ(s) and themes within each question. For example, information from a publication can be categorized to support our first RQ, occupational characteristics of DSPs

that differ from other long-term services and supports (LTSS) providers, and then further sorted to address specifics such as qualifications, training, and responsibilities.

Grey Literature

RTI also conducted a review of the grey literature to identify additional resources detailing DSP duties, skills, roles, and functions. In addition to conducting a Google search, we also specifically searched the sites listed below:

- Americans with Disabilities Act (Home | ADA)
- Administration for Community Living, Direct Care Workforce Strategies Center (Building Workforce Data Infrastructure | ACL)
- Kaiser Family Foundation (KFF | Independent source for health policy research, polling, and news)
- National Alliance for Direct Support Professionals (Home | NADSP)
- National Council on Aging (Home | NCOA)
- U.S. Department of Labor, Office of Disability Employment Policy (Direct Support Professionals | DOL)[c]
- National Council on Disability (NCD | Home)
- ADvancing States (Welcome | ADvancingStates)
- College of Direct Support (CDS | Training | DirectCourse)[d]

Exhibit B-2. Publication Selection Guidelines

Database	Search Terms	Parameters
PubMed	("direct support professional*"[tiab] OR "direct support provider*"[tiab] OR "direct support workforce"[tiab] OR "direct support worker*"[tiab] OR "direct support staff*"[tiab] OR "direct service worker*"[tiab]) AND ("long-term support service*"[tiab] OR "LTSS"[tiab] OR "long term services and support*"[tiab] OR "long term service and support*"[tiab] OR "home and community based service*"[tiab] OR "HCBS"[tiab] OR "Medicaid"[tiab] OR "Long-Term Care"[Mesh] OR "Home Care Services"[Mesh] OR "Community Health Services"[Mesh:NoExp] OR "Medicaid"[Mesh] OR "competencies"[tiab] OR "competency"[tiab] OR "competence"[tiab] OR qualification*[tiab] OR education*[tiab] OR "skill"[tiab] OR "skills"[tiab] OR requirement*[tiab] OR "Clinical Competence"[Mesh] OR "Professional Competence"[Mesh] OR "Job Description"[Mesh] OR "Education, Professional"[Mesh:NoExp] OR "Education, Nonprofessional"[Mesh:NoExp] OR "turnover"[tiab] OR " turn over"[tiab] OR "crisis"[tiab] OR "staffing"[tiab] OR "workforce"[tiab] OR "Personnel Turnover"[Mesh] OR "Personnel Staffing and Scheduling"[Mesh:NoExp] OR "Workload"[Mesh] OR "Work Schedule Tolerance"[Mesh] OR "Workforce"[Mesh] OR "Work-Life Balance"[Mesh]) AND ("2014/01/01"[Date - Publication] : "3000"[Date - Publication]) Filters: English	• Focus on DSP occupational characteristics • Based in the United States • Published or references studies published during 2014-2024 • Written in English

[c] RTI has reviewed the roles and skills listed on the site but has chosen not to include them here, as they represent only a partial list.

[d] According to their website, the Core Competency program aligns with the Centers for Medicaid & Medicare Services (CMS) Core Competencies for the Direct Service Workforce. Additionally, their courses are based on 15 core competencies approved by the National Alliance of Direct Support Professionals.

Exhibit B-2 (*continued*)		
Database	**Search Terms**	**Parameters**
Web of Science	TS=("direct support professional*" OR "direct support provider*" OR "direct support workforce" OR "direct support worker*" OR "direct support staff*" OR "direct service worker*") AND TS=("long-term support service*" OR "LTSS" OR "long term services and support*" OR "long term service and support*" OR "home and community based service*" OR "HCBS" OR "Medicaid" OR "long term care" OR "home care" OR "community services" OR "competencies" OR "competency" OR "competence" OR qualification* OR education* OR "skill" OR "skills" OR requirement* OR "turnover" OR " turn over" OR "crisis" OR "staffing" OR "workforce" OR "personnel" OR "workload" OR "work schedule*" OR "workforce" OR "work life") and English (Languages) Timespan: 2014-01-01 to 2024-12-31 (Publication Date)	
CINAHL	("direct support professional*" OR "direct support provider*" OR "direct support workforce" OR "direct support worker*" OR "direct support staff*" OR "direct service worker*") AND ("long-term support service*" OR "LTSS" OR "long term services and support*" OR "long term service and support*" OR "home and community based service*" OR "HCBS" OR "Medicaid" OR "long term care" OR "home care" OR "community services" OR MH "Long Term Care" OR MH "Home Health Care" OR MH "Community Service" OR "competencies" OR "competency" OR "competence" OR qualification* OR education* OR "skill" OR "skills" OR requirement* OR MH "Clinical Competence" OR MH "Professional Competence" OR MH "National Vocational Qualifications" OR MH "Job Description" OR MH "Education, Allied Health" OR "turnover" OR " turn over" OR "crisis" OR "staffing" OR "workforce" OR "personnel" OR "workload" OR "work schedule*" OR "workforce" OR "work life" OR MH "Personnel Shortage" OR MH "Personnel Staffing and Scheduling" OR MH "Understaffing" OR MH "Personnel Turnover") Limiters - Publication Date: 20140101-20241231; English Language; Exclude MEDLINE records	
EBSCO Discovery Service	("direct support professional*" OR "direct support provider*" OR "direct support workforce" OR "direct support worker*" OR "direct support staff*" OR "direct service worker*") AND ("long-term support service*" OR "LTSS" OR "long term services and support*" OR "long term service and support*" OR "home and community based service*" OR "HCBS" OR "Medicaid" OR "long term care" OR "home care" OR "community services") AND ("competencies" OR "competency" OR "competence" OR qualification* OR education* OR "skill" OR "skills" OR requirement*) AND ("turnover" OR " turn over" OR "crisis" OR "staffing" OR "workforce" OR "personnel" OR "workload" OR "work schedule*" OR "workforce" OR "work life") Limiters - Published Date: 20140101-20241231; Language: English	

APPENDIX C: EXPANDED STATE INTERVIEW FINDINGS

How DSPs Differ from HHAs and PCAs

States define DSP roles in various policy documents that emphasize the person-centered and dynamic nature of DSP work across different settings and populations.

All interviewees emphasized that the range of roles and functions performed by DSPs is extensive. While the specific roles and functions may vary depending on the age, conditions, preferences, and needs of individuals as well as the type and location of the type of service provided by DSPs (e.g., community access and integration services, supported employment services), all interviewees concur that they are broad and significantly exceed the responsibilities typically assigned to PCAs and HHAs.

These expectations of the are often defined in official policy documents, such as Medicaid manuals. For example, the state of Georgia outlines these job functions in its policies and procedures for the Comprehensive Supports Waiver Program and New Options Waiver Program manuals.[37,38] Rhode Island provides role descriptions in the Rhode Island DSP Competencies Workgroup: Core Competencies guide, directly available on the state's website for the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals.[39] Similarly, New York provides role guidelines for DSPs publicly on their website for the Office for People with Developmental Disabilities.[40]

Representatives from Pennsylvania mentioned that a key role of a DSP is to assist individuals in every aspect of their lives--every activity, every relationship, and every decision by helping them understand and exercise their rights. New York noted that what differentiates DSPs from other human services professions is the "dynamic nature of the services that they provide," along with an emphasis on person-centered care and a commitment to upholding the dignity of risk.[e] Tennessee explained that, beyond providing essential assistance, support, and care, DSPs play a crucial role in promoting independence, ensuring safety, and enhancing the overall quality of life for individuals.

Georgia outlined the roles and responsibilities as defined in its Medicaid manual, stating that DSPs are tasked with a variety of duties. These include providing direct assistance in self-help, socialization, and adaptive skills training, as well as ensuring retention and improvement in these areas. They also deliver personal care, protective oversight, and supervision, implement behavioral support plans to mitigate maladaptive behaviors, and help individuals develop alternative adaptive skills. Furthermore, DSPs assist with training in independent community living skills and support individuals in achieving their goals as outlined in their current support plans. The interviewee from this state highlighted that DSPs adopt a more person-centered approach to support, in contrast to the more task-oriented focus typically associated with the work performed by similar professions, such as HHAs and PCAs.

Rhode Island noted that it adopted the definition of DSP developed by the University of Minnesota: "DSPs are the paid staff who support individuals with IDD to live their lives and enjoy the same opportunities and experiences as people without disabilities. DSPs support people in whatever ways they need to enhance inclusion and independence. Their work promotes informed decision-making, understanding risk, and exercising rights and choices."[41] This state also noted that a unique aspect of DSPs is their ability to support individuals throughout their entire life journey, from childhood to adulthood, necessitating a skill set that adapts to the evolving needs of their clients at different life stages.

[e] "Dignity of risk" refers to the concept that individuals, particularly those with disabilities or in vulnerable situations, have the right to take risks and make decisions that involve potential harm or failure as part of living a full and autonomous life.

Several states also highlighted that DSPs fulfill their roles in a wide range of settings and with diverse populations. For instance, DSPs work in community environments, group homes, assisted living facilities, and day programs. They serve individuals with a variety of needs, from physical disabilities to IDD, and their clients can range from children to adults. This diversity in work settings sets DSPs apart from PCAs and HHAs, who primarily operate within individual private residences.

Interviewees from all states agreed that DSPs are dedicated to providing person-centered care, tailoring their support to the unique needs and preferences of each individual. However, one interviewee contended that the health care sector, including HHAs and PCAs, is increasingly moving towards a more person-centered approach. Instead, they highlighted a key distinction between DSPs and HHAs or PCAs: DSPs have the ability to independently and without supervision administer medications and regularly perform health care interventions, such as managing feeding tubes, providing diabetes care, and even handling colostomy--tasks that HHAs and PCAs are not authorized to do. As a result, person-centeredness alone cannot be considered the most defining difference between these roles.

Beyond their foundational role, two states (Pennsylvania and Rhode Island) specifically highlighted that DSPs also play a crucial part in fostering and maintaining personal relationships for their clients. This involves not only supporting social interactions and connections but also helping clients build meaningful relationships that enhance their quality of life. On the other hand, New York noted a distinction between DSPs and other professions, such as HHAs and PCAs, by stating, "[these other professions] are not involved in setting goals or participating in goal achievement, which is a key responsibility of DSPs." This distinction underscores the unique and multifaceted role of DSPs, which encompasses both nurturing personal relationships and facilitating goal achievement to improve clients' overall well-being.

Qualifications and Requirements for DSPs

Within each state, DSPs must meet specific educational, training, and certification standards. These requirements, intended to assure that DSPs are adequately prepared to support individuals with disabilities, vary across states. This section describes each state requirement of the five states interviewed.

Exhibit C-1 summarizes the qualifications and requirements for the states interviewed.

Exhibit C-1. DSP Qualifications and Requirements in GA, NY, PA, RI and TN

State	Aged 18+	High school diploma or equivalent	Bachelor's (4-year) degree	Valid U.S. driver's license	Pass a state/ criminal background check	Pass the Test of Functional Health Literacy in Adults	Complete state-specific trainings	CPR and basic first aid certified
GA	X	X		X		X	X	X
NY		X		X	X		X	
PA	X		X				X	
RI	X	X		X	X			
TN		X		X	X		X	

In **Georgia**, the current requirements for DSPs include holding a high school diploma or General Educational Development (GED) equivalent, achieving a passing score on the Test of Functional Health Literacy in Adults, and being at least 18 years old. Additionally, DSPs must complete initial and annual training, maintain current CPR and basic first aid certifications, possess a valid Class C driver's license, and meet the state's training criteria. These requirements were updated approximately 2-3 years ago, during the pandemic, to enhance the qualifications needed for DSPs in the state.

In **Pennsylvania**, the requirements for becoming a DSP are established through state agreements with the Federal Government, provider qualifications, and state regulations,[42,43] be at least 18 years of age, complete all necessary pre-service and in-service training, and hold at least a four-year degree.[f] Before working independently with individuals, and within 30 days of being hired or beginning service, DSPs are required to complete basic training, followed by annual training.

Tennessee's requirements for DSPs are a high school diploma or GED equivalent, passing the state background check, and possessing a valid driver's license. Since Tennessee operates as a fully managed care state, providers that contract with managed care organizations have the discretion to impose additional requirements.[44] The state recently eliminated the minimum age requirement of 18 to support the expansion of the 1915(c) workforce, aligning with the 1115 waivers, which already had no minimum age requirement.

A state interviewee noted "We've heard clearly from our provider network that increasing hiring requirements for DSPs may not provide a strong return on investment. I interpreted the question as referring to the qualifications needed to become a DSP. However, once someone is hired, we do have a baseline training that all new hires must complete before they can begin serving a member. This training typically occurs within 30-60 days, and you may hear it referred to as 'pre and early training'."

In **New York**, the basic qualifications for DSPs include a high school diploma or GED, or alternatively, NADSP certification. All DSPs, whether employed by the state or voluntary non-profit providers, must pass clearance through various state protective and oversight databases. Additionally, a valid driver's license is a requirement for state-employed Direct Support Assistants (DSAs), a criterion that is not universally mandated for DSPs in the voluntary sector. Beyond these basic qualifications, there are notable differences in the standards and training provided. New York's state-managed service organization, which employs over 10,000 DSAs and accounts for about 20 percent of the direct care workforce, maintains higher standards due to its unionized environment and state employment status. DSAs must complete a comprehensive new employee orientation and training program before starting their roles. In contrast, the remaining 80 percent of the workforce, comprised of approximately 100,000 DSPs employed by voluntary non-profit providers, receives training that tends to be less uniform and less rigorous than the state-run program. These differences highlight the varying levels of training and qualification standards across the state-managed and voluntary sectors in New York.

Rhode Island's staff qualification requirements[45] are similar to those of the other four states interviewed: DSPs must be at least 18 years of age, have a high school diploma or a GED, and pass a criminal background check. In certain programs, DSPs are required to own a vehicle if their job responsibilities include transportation. The interviewee mentioned that the state is exploring the possibility of allowing 16-year-olds who are still in high school to participate in internships, providing them with a potential pathway to gain early experience in the field.

Credentialing and DOL Apprenticeship

In all of the states, the specific training requirements vary based on the services provided by the DSP, and some of these training requirements go beyond what is expected of CNAs, health aides, or PCAs.[16]

Georgia is currently evaluating three pilot programs that provide pathways for DSPs to earn a competency-based certification. These pilots are carried out through a collaboration with the DOL, the Institute on Human Development and Disability at the University of Georgia, and NADSP.

[f] When providing enhanced levels of Community Participation Support and the participant's assessed needs require the degree.

The Georgia DOL's Certified DSP apprenticeship program is one of the three pathways for DSPs to earn a competency-based certification.[21,46] Each apprentice completes 159 hours of virtual training and is paired with assigned mentors at their respective provider agencies. Both new hires and current DSPs must register as apprentices and complete a minimum of 2,000 hours of work to qualify for certification. The pilot program began in February 2024 and is scheduled to end in January 2025. These Registered Apprenticeships are industry-vetted, approved, and validated by the DOL, ensuring that they meet national standards for quality and effectiveness. The state is also piloting the Direct Support Professional Training and Assessment Program, led by the University of Georgia. This online credentialing option is designed for individuals already employed by support providers and includes approximately 50 hours of self-paced, competency-based training, followed by a remotely proctored exam. The state is hopeful that as more DSPs complete the program, it can be accredited by the National Commission on Certifying Agencies. The third pilot program is based on the NADSP E-Badge Academy. Participants complete 50 hours of online learning, with the completion of 15 e-badges required to earn the DSP I certification. A key incentive for earning the certification is that each DSP who earns a DSP certification, regardless of the pathway, will receive a one-time bonus or stipend, with DSP I certification earning a $5,000 bonus, DSP II Certification an additional $1,000 bonus, and DSP III Certification an additional $1,000 bonus. The pilots aim to support 200 DSPs to earn DSP I certification by January 31, 2025. The state intends to incorporate some of these programs into the home and community-based services (HCBS) IDD waiver.

To train its DSP workforce, Pennsylvania supplements the NADSP requirements with the Competency-Based IDD/MI Dual Diagnosis Direct Support Professional Certification Program developed by the National Association for the Dually Diagnosed. This program is specifically designed to certify the competencies of DSPs who support individuals with both developmental disabilities and serious mental illness. Furthermore, Pennsylvania has a longstanding tradition of developing its own training modules for DSPs, which are integrated into its learning management system. Pennsylvania currently does not have apprenticeship programs registered with the DOL.

A **Tennessee** representative shared that the state has a registered apprenticeship in partnership with Tennessee Board of Regents, which oversees Tennessee's community and technical colleges. The program is a public-private partnership involving the QuILTSS Institute; the Tennessee Department of Labor and Workforce Development; and UnitedHealthcare Community Plan of Tennessee, which serves the state's Medicaid population. The Bureau of TennCare and the Tennessee Department of Intellectual and Developmental Disabilities support the partnership. The DSP apprenticeship program is available to new hires and those already working with a participating employer partner and is designed as a work-based learning model where, apprentices receive both supervised on-the-job training and job-related online training. As they complete their training and reach specific work hour milestones, they earn a wage increase totaling $3.50 or more per hour by the end of the one-year program. Upon successful completion, participants earn a nationally recognized credential as a QuILTSS-certified DSP.[33]

Interviewees from **New York** indicated that they maintain a close working relationship with the local workforce agency, which recently reached out due to a noted decline in participation in the DSP apprenticeship program. In response, the state has organized a series of upcoming meetings to gain insights into the program and explore strategies for increasing staff engagement.[47] The DOL DSP apprenticeship program is implemented through a collaboration with the State University of New York.

A **Rhode Island** interviewee noted that the state has adopted the NADSP core competencies[39] with only minor modifications, though they are not mandatory. State efforts are underway to explore various training options for DSPs. In recent years, the state has allocated funds to allow providers to submit proposals and receive financial support for different types of DSP training programs. However, as of now, there are no mandated training requirements in place.

State DSP Payment Policies

DSP payments can affect recruitment, retention, and overall workforce stability. There are a variety of factors that affect wage structures, including state funding policies and Medicaid reimbursement rates. States vary in their approaches to DSP wage policies. Representatives of each state described approaches to supporting DSP wages.

Georgia reported that in order to secure a partnership with the DOL for the DSP apprenticeship program, certain wage-related expectations had to be met. The DOL required that DSPs be paid a minimum salary before the partnership could proceed. Furthermore, upon completion of the apprenticeship, DSPs are expected to receive a salary increase. These conditions were built into the apprenticeship program as a way to ensure that DSPs not only receive training but also see improvements in their compensation. The state is planning to embed wage increases into its Medicaid waiver program, where DSPs receive higher wages as they achieve higher levels of certification (DSP I, DSP II, DSP III). The current plan sets a base wage of $14 per hour, with wage differentials offered as qualification levels increase (up to $17.50 per hour for DSP III). Georgia has introduced several retention efforts, leveraging funds from the American Rescue Plan Act of 2021 to support training programs and offer bonuses.

Interviewees from the state of **Pennsylvania** said that the state does not currently have wage incentives based on role/function, training, or credentials, but the state is working towards creating a funding mechanism that allows for differentiated pay for credentialed staff.

The Pennsylvania Office of Developmental Programs (ODP) has also submitted to CMS a Performance-Based Contracting waiver request which includes reimbursing providers at higher rates for “Select” and “Clinically Enhanced” tiers. ODP has plans to use Pay for Performance to incentivize providers to develop and implement DSP and frontline supervisor credentialing programs.

Starting wages for DSPs in **Tennessee** have increased to $15.37 per hour, following approval by the legislature for the fourth consecutive time. The state ties wage increases to training and certification, offering progressive bonuses through programs such as the NADSP E-Badge Academy. The state also provides financial incentives to both DSPs and frontline supervisors for achieving national certifications, as well as to providers for supporting or facilitating the necessary training, with the aim of improving retention. Early results show strong participation, and an evaluation is underway to assess its effectiveness. Lastly, the state’s apprenticeship program follows the DOL's rules and regulations, offering progressive wage increases based on agreements between the provider and the apprentice. The structure of these wage increases is tailored to each provider's specific arrangement with the apprentice.

In **New York**, in recent years, the minimum wage has increased significantly from $7.50 to $15 per hour. It is challenging to attract and retain DSPs because they can find similarly paid jobs in other sectors, such as fast food, retail, and companies like Amazon, that may be less demanding. The state has been able to provide bonuses and stipends to DSPs through workforce initiatives funded by the American Rescue Plan Act to its state-managed service organizations. However, on the voluntary provider side (organizations not directly run by the state), they have independently recognized the value of credentialing DSPs. As a result, many of these organizations have started offering hourly pay increases, typically around $1, for DSPs who achieve higher certification levels, such as DSP III. This increase in pay is voluntary and not mandated by the state, but providers are choosing to do it because they see the benefits of having more qualified and efficient employees.

The interviewees further noted that the state has provided cost of living increases to organizations within the voluntary provider community, however there is inconsistency in how those funds are applied. The hope is

that the money will be used to support the workforce, but each organization has discretion over how they allocate the funds. Some organizations may choose to increase salaries, but the rate of increase can vary between them. There is statutory language that restricts how cost of living increases can be spent, ensuring that the money must first be directed to certain classifications of employees before it can be used for executive compensation. However, beyond these general restrictions, there is no strict formula or standardized approach to how the funds must be distributed, leading to variability across different organizations.

The **Rhode Island** wage structure for DSPs does not currently include any differentiation based on training or licensing. This is different from CNAs, who can earn varying wages depending on their qualifications. This difference highlights a notable gap in how these two roles are compensated. DSP wage policies in Rhode Island currently are governed by a court-ordered consent decree that requires the state to tackle issues like vacancy turnover rates and wage levels. Thanks to these regulations, DSP wages have become quite competitive, averaging around $20 per hour. This is a significant increase from the $14 to $15 per hour range that was common just a few years ago.

Data Collection

All state representatives interviewed were asked about the data that states use to track the DSP workforce. All of the states interviewed except Rhode Island noted they rely or partly rely on the NCI Survey to assess the state of the DSP workforce. Relevant data collection efforts also may take place at the federal level by agencies including the BLS and the U.S. Census Bureau.[7] The BLS and U.S. Census Bureau collect information pertaining to HCBS occupational characteristics and utilize the results to estimate employment rates, wages, demographics, and expected job growth.[7] However, these data collected at a national scale may omit key factors that may influence results in some states compared to others. These factors can include, sample sizes, state-level differences in DSP definitions, and provider low survey response rate. This section summarizes data collection efforts undertaken by each state interviewed for the current study.

New York has recently commenced state operations to report to the NCI survey by requesting providers to complete the NCI. This is a voluntary request, and the representatives noted that they do not receive 100 percent participation; however, "many of [the providers] have been doing [the survey]." The representatives noted potential areas where the NCI falls short of capturing the state of the DSP workforce in New York. For example, differentiating between ages of DSP care recipients is difficult in the state system (i.e., DSPs who only work with children vs. DSPs who only work with adults). The NCI asks respondents to differentiate DSPs that exclusively work with age-restricted populations; therefore, New York "always stipulates" that they are not able to provide that specific information. Additionally, New York reported that the NCI does not differentiate across within-state geographic and demographic differences. While the representatives appreciated the wider approach the NCI takes to maintain confidentiality, this generalization of New York State as a whole reduces the ability to distinguish significant challenges that affect different regions (e.g., New York City vs. upstate New York). Furthermore, the representatives shared their concerns for how the NCI compares results across different states, as not every state has the same care delivery system. The NCI data alone is not enough to capture the DSP workforce in New York; however, the representatives have received pushback from providers who state they are oversaturated with survey requests.

Similar to **Tennessee** representatives noted that creating a "one size fits all survey" to assess the national DSP workforce is difficult due to differences between states and within state-level regions. Currently, Tennessee is in year 6 of data collection via the Tennessee LTSS Workforce Quality Improvement Survey, developed in collaboration with the Institute on Community Integration (ICI) at the University of Minnesota. These surveys ask providers questions regarding average wage percentages, turnover percentages, and staff vacancy. Results from this annual survey provides avenues for improvement to the TennCare's QuILTSS Initiative.[4] The

representatives shared that they are currently developing additional survey methods to capture reasons for staff turnover, akin to an exit interview. The respondent also emphasized the importance of timely data, noting that it is particularly useful for evaluating whether an initiative is delivering short-term benefits, such as retaining the current workforce, and for identifying whether adjustments are necessary to enhance the effectiveness of newly implemented programs.

The **Rhode Island** representatives noted that, until recently, the state did not have sufficient data collection methods in place. Currently, Rhode Island collaborates with the ICI at the University of Minnesota to administer a modified version of the NCI SoTW survey that addresses the DSP workforce specifically in Rhode Island.[48] Providers utilize SupportWise, a data collection system developed by the ICI, when completing the survey. The representatives shared the benefits to utilizing SupportWise, one of which is a data dashboard that provides real-time staff turnover and retention updates. This dashboard also provides longitudinal data and comparisons to national benchmarks (pulled from other states' NCI surveys). The dashboard allows users to review data for specific groups (e.g., part-time and full-time DSPs). The representatives shared that Rhode Island now has a "100 percent participation rate from traditional providers" in completing the survey. This data is collected every six months as mandated in a consent decree by the Department of Justice in 2014. One interviewee noted that the current Rhode Island DSP survey does not include children who receive DSP services. As of the time of the interview, Rhode Island was the only state to be using SupportWise, as the ICI is still in the piloting phase of this system.

Pennsylvania representatives shared that they use provider associations at times to collect data around DSP wage ranges, salaries, and executive salaries. Pennsylvania also utilizes the NCI SoTW survey and shared that they "strongly encourage providers to participate" and complete the survey. The representatives found the NCI SoTW survey sufficient in capturing the data relevant to Pennsylvania's needs; therefore, the state prioritizes the NCI SoTW as their primary mode of data collection.

Similar to Pennsylvania, **Georgia** noted that they primarily utilize the NCI SoTW survey. The state was unable to provide exact annual counts of providers that participate in the survey but noted that they "get enough providers to participate that the data is accurate and… a good representation of the state." Georgia also contracts with an external entity that conducts annual quality reviews. The quality reviews consist of reviewing individuals who receive DSP services and reviewing the current service delivery system. Findings from the quality review and feedback are provided to the state. Additionally, Georgia distributes quarterly surveys to DSP service coordinators. The coordinators conduct in-person interviews with DSP care recipients to evaluate the quality-of-care delivery.

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ADL	Activity of Daily Living
BLS	DOL Bureau of Labor Statistics
CDSP	Certified Direct Support Professional
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nursing Assistant
CPR	Cardiopulmonary Resuscitation
DOL	Department of Labor (both U.S. and state)
DSA	Direct Support Assistant
DSP	Direct Support Professional
GED	General Educational Development
HCBS	Home and Community-Based Services
HHA	Home Health Aide
ICI	Institute on Community Integration
IDD	Intellectual/Developmental Disabilities
LTSS	Long-Term Services and Supports
NA	Nursing Assistant
NADSP	National Alliance for Direct Support Professionals
NCI	National Core Indicators
ODP	Office of Developmental Programs
OEWS	Occupational Employment and Wage Statistics
PCA	Personal Care Aide
QuILTSS	Quality Improvement in Long Term Services and Supports
RQ	Research Question
SOC	Standard Occupational Classification
SoTW	State of the Workforce survey

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