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COMPARATIVE PERSPECTIVES OF DIRECT SUPPORT PROFESSIONALS
WORKING WITH ADULTS WITH INTELLECTUAL DISABILITIES REGARDING
STANDARD COMPETENCIES

By

Cynthia Anne Bayes
B.S., Eastern Kentucky University, 1977
M.P.A., University of Louisville, 1991

A Dissertation
Submitted to the Faculty of the
Graduate School of the University of Louisville
in Partial Fulfillment of the Requirements
for the Degree of

Doctor of Philosophy

Department of Leadership, Foundations
& Human Resource Education
University of Louisville
Louisville, Kentucky

December 2010

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A Dissertation Approved on

December 1, 2010

By the following Dissertation Committee:

Dr. Thomas Simmons, Dissertation Director

Dr. Monica Delano, Committee Member

Dr. Sandra Mlinarcik, Committee Member

Dr. Joseph Petrosko, Committee Member

DEDICATION

My mother, Nan, and my husband, Garry were my biggest fans and encouragers. Each had a loving and unique way of expressing their pride and support with all of my endeavors, and especially my educational accomplishments. Sadly, they both left this world as I was finishing my course work. Since their passing, I have continued to be encouraged to finish this educational pursuit by remembering their supportive and motivational words and ways.

My parents and grandparents instilled a strong value for education. I am grateful for the opportunity of a supportive family and for the many gifts that afforded me throughout my life, both as a student and as an individual contributing to the learning of others. To my mother, my husband, and my family I dedicate this dissertation, as I could not have done it without the support and contributions from them.

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Special appreciation goes to Dr. Thomas Simmons, who served as Dissertation Chair, as well as guide and encourager. I owe a debt of gratitude to the Committee members, Dr. Monica Delano, Dr. Sandra Mlinarcik, and Dr. Joseph Petrosko, for helping shape my vision into a proposal and bringing it to fruition, for challenging me when I was going off course, for patience and perseverance with me throughout the process. This completed research project came together as a result of the many suggestions from the entire Committee.

A very special appreciation to Sandy Mlinarcik for the many hours you invested talking about ideas, reading drafts and providing coaching and encouragement. I honestly do not think I would have finished without your support. Thank you for not letting me give up.

Thanks to my sister, Vicki Smith for reading, and rereading, and for never allowing me to let go of this dream. Also to my family who was always encouraging, patient and loving.

Finally, to my many friends who patiently waited and allowed me to prioritize working on the dissertation over spending time with them.

ABSTRACT
Comparative Perspectives on Standard Competencies

Cynthia A. Bayes

December 1, 2010

There is a growing shortage of Direct Support Professionals (DSPs) in the field of intellectual and developmental disabilities. This shortage is at a crisis now and will continue to become more of a crisis unless changes are made. This is a crisis for many community employers and even more of a crisis for the people with disabilities who are faced with constant turnover and the discontinuity created by the withdrawal, gaps in services, and introduction of new people who are likely to leave the position during the first year of employment (Larson & Hewitt, 2005).

High turnover, vacancy rates and inadequate staff development are extremely costly to agencies. More important and less easily measured are the hardships these factors create for people who are the intended service recipients.

The recruitment and retention of qualified DSPs is of critical concern due to the increasing demand. This staffing demand is partly fueled by aging caregivers and the increased lifespan of persons with disabilities. At the very time that demand for staffing is increasing, so is staff turnover.

This research was designed to assess and compare Direct Support Professionals' (DSPs) and DSP supervisors' perceptions of what DSPs know about and how they value a set of fifteen competencies. This set of competencies is called the Community Support Skill Standards (CSSS), developed for the DSPs (Taylor, Bradley & Warren 1996). The CSSS has become the accepted standards in the field, having gained adoption by the National Alliance for Direct Support Professionals (NADSP).

Further, this research was designed to determine if age, gender, ethnicity, training, and years of experience predict DSPs' knowledge or value of the competencies. One hundred nine DSPs and ninety supervisors completed a scalar survey instrument. The DSPs consistently rated their knowledge and value of the competencies higher than did supervisors. Both DSPs and supervisors rated value for the competencies higher than knowledge of the competencies. The largest differences between the knowledge perception between DSPs and supervisors were the competencies of (a) Vocational, Education, and Career Support, (b) Education, Training, and Self-development, and (c) Facilitation of Services. Regarding the value placed on the fifteen competencies, DSPs and supervisors reported the strongest differences of (a) Facilitation of Services, (b) Vocational, Education, and Career Support, and (c) Participant Empowerment. A linear relationship exists between total DSP knowledge and value scores and certain demographic data, most notably, education, which predicts less knowledge and less value the higher the education level.

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CHAPTER I

BACKGROUND, PROBLEM, AND RESEARCH DIRECTION

People with Intellectual and Developmental Disabilities (I/DD) are part of our society. The 2006 U.S. Census reported 4.7 million people with I/DD live in the United States. It is estimated that family caregivers are providing residential support for 2.8 million people with I/DD. Further it is estimated that the need for additional support from people in addition to the family caregiver will continue to increase because 717,000 of family caregivers are 60 years of age and older. In Kentucky, there were an estimated 10,769 individuals with I/DD living with aging caregivers in 2006 (Braddock, Hemp, & Rizzolo, 2008). As this group of caregivers' age it is imperative to provide additional community supports to keep their relatives at home as long as desired. It is equally critical to expand community residential supports to meet the needs when these aging caregivers can no longer provide for their relatives (Braddock, 1999). Community service providers must have a trained and qualified workforce to meet the current and future demand.

In the field of intellectual and developmental disabilities, there have been severe and persistent shortages of employees to provide supports and services. The lack of direct-support professionals (DSP) to carry out community services and supports has reached crisis proportions. In fact, this workforce shortage is the most critical barrier to fully implementing the 1999 Supreme Court's decision of *Olmstead v. L.C.*, as well as

expansion of community-based services in general (Larson & Hewitt, 2005). The phrase *direct support professional* is used to describe a person whose primary job function (at least 50% of their working hours) is devoted to providing support, training, supervision and personal assistance to people. DSPs work in a variety of settings such as nursing homes, home-health agencies, hospitals, and intermediate-care facilities. This research is focused on DSPs who work with people with intellectual and developmental disabilities (I/DD). It is important to explore the background of working with and caring for people with I/DD.

Background of the Problem

People have lived and communalized for over 4 million years (Lissner, 1957). It can be assumed that throughout time there have been some humans who were more capable and some less capable in any given people group. Hence, it is very likely that mental retardation or intellectual disability has always been part of the human condition. In the Middle Ages people with intellectual disabilities were received by religious sects and perceived as children of God (Scheerenberger, 1983), and many were cared for in churches or state-sponsored homes, orphanages, or hospitals. This attitude of care went through several changes and shifted from people perceived as of God, to persons who were evil and of the devil. During this time some people lived with their families rather than obtaining care from a church or other entity.

In the 1600's, protection and care for persons labeled with mental retardation shifted to various institutions, such as charitable facilities, monasteries, workhouses, and prisons. The people who provided the protection and care of the individuals were often undesirables themselves and were harsh and uncaring. The care of persons with an

intellectual disability increasingly became the responsibility of government. Larger facilities were built with major emphasis on providing care in the least expensive ways possible.

As the large facilities continued to grow in the late 1880's, even though some residents were ready for discharge, there were no other places for these individuals to receive care. Therefore, most of the residents remained in the facility, often working and caring for others in the facility (Scheerenberger, 1983, p. 124). Elaboration will be presented in Chapter 2. In subsequent years, institutions were the main resources for caring for people when the family was unable to do so.

One of the many problems institutions experienced was the recruitment and retention of staff. During the 1920s and 1930s it was common to have a 200% turnover rate per year, which significantly affected the quality of care of residents (McNairy, 1924). The same kinds of influences contributed to recruitment and retention that continue today. Because of staff shortages, people were required to work long hours and had few days off. Low pay and no fringe benefits further hindered recruitment and retention, much as it does today. As community services expanded, staffing continued to be a problem (McNairy, 1924, p. 273).

Legal Aspects

The disability field learned from the experience and success of the 1960s Civil Rights movement in the United States. Just as this movement advocated for the rights of African Americans, the disability movement began to use the court system to bring about changes, based on the constitutional rights of people with disabilities. During the 1970s and 1980s, there were state and federal class-action suits to improve institutional

conditions (Scheerenberger, 1983). More recently, class-action suits have focused on access to services.

Since the late 1990's there have been at least thirteen class action lawsuits related to people with I/DD waiting for services and the lack of access to services. Kentucky benefited from one such lawsuit settlement, which advocated on behalf of 1800 people on a waiting list. As a result Kentucky was mandated to increase funding for community services from 2006-2010. Another benefit of this settlement was the creation of a new Medicaid waiver, entitled the Michelle P. Waiver, for persons with intellectual and developmental disabilities that were waiting for services (Braddock, 2008).

In addition to state legislation, Congress enacted a number of important laws that mandated community supports. The Vocational Rehabilitation Act, passed by Congress in 1973, provided employment protection for people with disabilities. Supports and services for people with disabilities were further expanded by the 1975 passage and subsequent amendments of the Developmental Disabilities Assistance and Bill of Rights Act. The next major piece of legislation was the 1990 passage of the Americans with Disabilities Act, which further extended the civil rights of people with disabilities. Additionally the 1999 Supreme Court decision in *Olmstead v. L.C.* and the 2001 New Freedom Initiative continued to solidify the basic human right of citizens with intellectual disabilities to live in the community.

The Present Crisis

The lack of Direct Support Professionals (DSPs) to carry out community services and supports has reached crisis proportions. This is a crisis for many community employers and even more of a crisis for the people with disabilities who are faced with

constant turnover and the discontinuity created by the withdrawal, gaps in services, and introduction of new people who are likely to leave the position during the first year of employment (Larson & Hewitt, 2005).

This workforce shortage has been nationally acknowledged (ANCOR, 2001a), as the benefits of community-based services and supports are better understood. High turnover, vacancy rates and inadequate staff development are extremely costly to agencies. One study in Kentucky estimates training and recruitment costs at \$3,200.00 for every new DSP who leaves the position within the first three months of hire, (Mlinarcik, 2008). More important and less easily measured are the hardships these factors create for people who are the intended recipients of these much-needed services.

The recruitment and retention of qualified DSPs is of critical concern due to the increasing demand. This demand is being fueled by aging caregivers, the increased lifespan of persons with disabilities, and class-action lawsuits. At the very time that demand for staffing is increasing, so is staff turnover.

Over the last two decades, there has been progress with preparing DSPs for work in the field of disabilities. Through the efforts of the College for Direct Support Professionals, a standardized skill set called the Community Support Skill Standards (CSSS) was developed for these employees. These skills, knowledge, and attitudes are the expectations of an experienced DSP, not the minimum criteria for a new employee (Taylor, Bradley & Warren 1996). The CSSS has become the accepted standards in the field, having gained adoption by the National Alliance for Direct Support Professionals (NADSP). The NADSP is a non-profit, membership organization comprised of agencies, organizations, and individuals who are committed to advocating for and assisting people

to live self-determined lives through community support services. This organization partners with several key national organizations, such as American Network of Community Options and Resources, or ANCOR that increases NADSP's advocacy and ability to reach more DSPs and families receiving services. NADSP is the professional organization recognized for offering the standard of performance for Direct Support Professionals. With this agreed upon standard competencies for DSPs current agency providers who employ and supervise DSPs know the basic skills to plan and implement the best training to prepare DSPs for the workforce. These standard competencies allow current providers not only to plan training, they also provide benchmarks for DSP performance evaluations and ongoing staff development. These DSP competencies set the standard for agencies and supervisors to establish clear training initiatives, clear expectations, and accountability of DSPs

Many organizations have implemented the CSSS with and without additional competencies with good results. However, these efforts continue to fall short of preparing sufficient staff to meet the demands of this current employment crisis.

Statement of the Problem

There is good evidence that employees do not remain with a job when they do not feel adequately trained and lack the confidence to perform (Braddock & Mitchell, 1992; Department of Employee Relations, 1989; Larson & Lakin, 1992, 1999; Larson, Lakin, & Bruininks, 1998). It has been assumed that DSPs generally agree and accept the CSSS competencies because these are the standards endorsed by the NADSP. However without sufficient knowledge of the value and acceptance DSPs place on each of the competencies, employers may not be providing the most effective staff development.

Likewise, what remains unknown is the employers' value and acceptance of the CSSS competencies and the employers' intent of training DSPs on these competencies. Without appropriate information, employers may make faulty assumptions about the training needs of DSPs, which may contribute to higher DSP turnover. Even if trained, if DSPs do not value the competencies, then training may be less effective, contributing to high turnover.

Purpose of the Study

The purpose of this quantitative research study was to ascertain the level of knowledge of, and value placed on, the 15 competencies recognized by the NADSP, by the DSPs, and whether this correlates with the perception of DSP Supervisors regarding the knowledge and value placed on the competencies by DSPs in the state of Kentucky.

Hypotheses and Research Questions

The research breaks down into two main hypotheses and the research questions that lead to an analysis of these hypotheses:

1. H_0 : There are no significant differences in the perceptions of DSPs and DSP Supervisors regarding the knowledge of the standard competencies for a successful DSP;

H_A : Significant differences exist between perceptions of DSPs and DSP Supervisors regarding the knowledge of the standard competencies for a successful DSP.

Two research questions relate to these hypotheses:

- a. What do DSPs self-report as their level of knowledge of each of the 15 standard competencies? and

- b. What do DSP Supervisors report is their perceptions of DSPs' level of knowledge of each of the 15 standard competencies?
- 2. H_0 : There are no significant differences in the perceptions of DSPs and DSP Supervisors regarding the value placed on the standard competencies of a successful DSP.
 H_A : Alternative Hypothesis 2: Significant differences exist between perceptions of DSPs and DSP Supervisors regarding the value of the standard competencies for a successful DSP.

Related research questions:

- a. What do DSPs self-report as the value they place on each of the 15 standard competencies?
 - b. What do DSP Supervisors report as their perceptions of the value DSPs place on each of the 15 standard competencies?
- 3. H_0 : No linear relationship exists between knowledge and value of the fifteen competencies and age, gender, ethnicity, education, work experience, and amount of training.

These questions were explored by examining the data considered the independent variables. The data sheet explored the demographic factors of age, gender, ethnicity, educational history of level attained and college major, and employment history, including previous DSP experience and years of related employment. These independent variables provided the data to learn the factors contributing to the development of competencies. The interventions explored were the formal and informal training DSPs receive. The mediating factors are life experiences that may have contributed to the

perceptions of the stakeholders. The dependent variables were the perceptions of the importance of the DSP competencies and the perceptions of the training and preparation of DSPs (see Table 1).

Research Rationale

These questions were approached with comprehensive research methodologies.

Quantitative research methods were employed. Quantitative research is defined as:

inquiry that is grounded in the assumption that features of the social environment constitute an objective reality that is relatively constant across time and settings. The dominant methodology is to describe and explain features of this reality by collecting numerical data on observable behaviors of samples and by subjecting these data to statistical analysis. (Gall, Borg, & Gall, 1996, p. 767)

This research used an electronic survey to collect data about the perceptions of DSP training from two stakeholder groups: DSPs and DSP Supervisors.

The data was analyzed through a multivariate analysis of variance (MANOVA), using the two stakeholder groups, the mean scores obtained on knowledge, and value placed on each of the 15 standard competencies. A series of *t*-tests was completed for all knowledge and value items found to be significant through the MANOVA. Each of the 15 DSP competencies was analyzed once on the responses to knowledge of the competencies and through a separate set of *t*-tests on the value of each of the competencies. This analysis identified any significant differences between the DSP survey responses and the responses of supervisors.

A series of correlations were completed to identify possible contributing factors to the DSP's responses to knowledge and value of the competencies. An analysis using multiple-regression was completed separately for knowledge and value to identify

predictors. The following demographic factors were explored: age, gender, ethnicity, education, amount of training, and work experience.

Table 1

Theoretical relationships of Independent Variable and Perceptions

Independent variables		Dependent variables	
Demographic factors	Interventions	Mediating factors	Outcomes
Personal identity	Orientation to DSP position	Personal life experiences	DSP Knowledge of and value for DSP competencies
Age			
Gender			
Ethnicity			
Educational history	Formal training		Supervisor perception of DSP knowledge of and value for the DSP competencies
High school	Classroom		
GED	On the job		
Amount of college	Computer		
College major	Mentoring		
Employment history	Informal training		
Previous DSP experience	Observation		
Number of years in previous DSP	Trail & error		
Similar positions to a DSP	Experience		
Various types of employment	Peer consults		
Number of years of employment			

Note. GED = General Education Development; DSP = direct-support professional.

Definitions of Terms

Ability. A person's current capacity to engage in behavior (Rothwell & Sredl, 1992).

Attitude. "A feeling, perhaps best assessed as expressed by individuals to other people" (Rothwell & Sredl, 1992, p. 510).

Behavior. "Action taken by human beings" (Rothwell & Sredl, 1992, p. 510).

Competency. A set of knowledge, skills, and abilities obtained through formal or informal education, work experience, or other means required to perform a job (Craig, 1996).

Direct-support professional (DSP). A person whose primary job function (at least 50% of working hours) are devoted to providing support, training, supervision, and personal assistance to people with disabilities.

Home and community-based services waiver (1981 Pub. L 97-35). Provides Medicaid funding to states for services such as case management, homemaker assistance, home-health aides, personal care, residential and day habilitation, transportation, supported employment, home modification, occupational speech, physical therapy, behavioral therapy, and respite care (Braddock, 1999, p. 48).

In-home services. Support services provided in an individual's own home or the family's home. Services might include homemaker, home-health aides, personal care, respite, and therapy.

Intellectual disability. A disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in fewer conceptual, social, and practical adaptive skills. This disability originates before the age of 18 (Schalock et al., 2007).

Knowledge. Facts and information necessary for performing a job or task (Rothwell & Sredl, 1992).

Mental retardation. A disability that occurs before age 18, characterized by significant limitations in intellectual functioning and adaptive behavior as expressed in fewer conceptual, social, and practical adaptive skills. It is diagnosed through the use of

standardized tests of intelligence and adaptive behavior (Luckasson, R., Borthwick-Duffy, S., Buntinx, W., Coulter, D., Craig, E., Reeve, A, et al. (2002).

Skill. “Ability associated with successful performance”Rothwell & Sredl, 1992, p. 530).

Stakeholders. Individuals or a group with a direct or indirect stake in the work of DSPs because they are affected by the actions and behavior of the DSP.

Supervisor of direct support professionals. A person whose primary job involves supervising DSPs. The supervisor may provide direct support and other functions; however, 50% or more of the supervisor’s working hours are involved in direct supervision of DSPs.

Summary

Chapter 1 introduced the various issues related to the crisis of insufficient and inadequately trained DSPs to work in the community with people who are labeled with intellectual and other developmental disabilities. Special attention was given to the contributing factors that brought about this employment crisis and the role of staff training in maintaining employees. Research questions centered on the industry-accepted 15 competency areas and asked both DSPs and DSP Supervisors about these competencies in terms of knowledge base and value of each competency, and the demographics that may influence knowledge and value of these competencies.

Overview of Subsequent Chapters

Chapter 2 provides a comprehensive review of the related literature. Chapter 3 presents an overview of the methods used in this study. Chapter 4 will reveal the results and statistical treatment of the data. Chapter 5 will summarize the conclusions emerging

from this study's research questions, as well as similarities with and differences from other research on this topic.

CHAPTER II

REVIEW OF THE LITERATURE

The following review of literature provides a context for the original research described in subsequent chapters, a context that includes a conceptual framework, a brief history of how care for people with disabilities has evolved over time, how the role of Direct Support Professional (DSP) has evolved, the expanding need for such care providers, a description of the current crisis, and a discussion of the fifteen competencies DSPs are expected to master.

The Conceptual Framework

The DSPs and DSP supervisors in this study are adults. Some of them have developed their skills with this set of competencies through training, some from job experience and coaching. However, it is not clear exactly how the DSPs learned about the competencies. Andragogy is the study of adult learning. Better understanding andragogy may contribute to furthering DSPs learning of the competencies. As such, it deserves some attention before moving on to the more concrete aspects of this study.

History of the theory

In the late 1960's Malcom Knowles put forth the concept of andragogy, as "the art and science of helping adults learn" (Knowles, 1980). Later others suggested Knowles set forth some guidelines for adult learning, rather than an actual theory. Most agree that

adult learning theory has been influenced through the behaviorist, cognitivist, humanist, and social learning research (Merriam & Caffarella, 1999). For the most part the concept of andragogy is grounded in the humanistic literature and social learning, which takes into account the learners' immediate environment. Hence, adult learning is the interaction of the person, the environment, and the behavior (Merriam & Caffarella, 1999, p. 139).

Components and Assumptions of Andragogy

Typically, andragogy has the following traits (Knowles, 1980):

- Self-Concept: As a person matures, he or she moves from dependency to self-directness.
- Experience: Adults draw upon their experiences to aid their learning.
- Readiness: The learning readiness of adults is closely related to the assumption of new social roles.
- Orientation: As a person learns new knowledge, he or she wants to apply it immediately in problem solving.
- Motivation (Later added): As a person matures, he or she receives their motivation to learn from internal factors.

Where used

“Within companies, instructional methods are designed for improving adult learners’ knowledge and skills. It is important to distinguish the unique attributes of adult learners so as to be better able to incorporate the principles of adult learning in the design of instruction” (Yi, 2005).

Application to this research

The principles of adult learning theory are the foundation of this research on the competencies of Direct Support Professionals. These principles are particularly meaningful to the development of the competencies and skills of Direct Support Professionals employed with people with intellectual and developmental disabilities. Understanding and applying these principles in the work place hold promise for increasing the competency level of DSPs. Next the various work environments and care of people with I/DD will be explored.

The History of Care for People with Disabilities

It is likely that mental retardation or intellectual disability has always been a part of the human condition (Lissner, 1957). What was it like for the earliest ancestors with intellectual disabilities? As early as 7,000 B.C. the care and treatment of persons with physical and mental disorders was provided by the shaman or medicine man, or a caring member of the tribe. Infants with severe impairments probably did not survive birth. Individuals who were not capable of hunting and keeping pace with the nomadic lifestyle were likely destroyed. As well as speculation, there are some examples that demonstrate that prehistoric ancestors provided care and compassion for individuals who needed assistance (Scheerenberger, 1983).

In the Middle Ages, women who could not care for their infants were encouraged to take them to a church for their care. At this time, people with intellectual disabilities were perceived as innocents and children of God (Scheerenberger, 1983, p. 31). Because of this welcoming spirit, many individuals with an intellectual disability were cared for in churches or state-sponsored homes, orphanages, or hospitals. The churches' attitude of

care transitioned over time from perceiving these children of God, to persons who were considered evil and of the devil. The Inquisition and the Reformation provided little hope of mitigating this negativity for people with an intellectual disability. During this time, not all people with disabilities were cared for by the church; some people lived with their families and received care from family members.

In the 1600's, another shift took place and care of people with intellectual disabilities was done in various institutions, such as charitable facilities, workhouses, and other buildings that were no longer used for their original purposes. These residential facilities of the Middle Ages often housed people together who were considered to be "undesirable" (e.g., mentally retarded, mentally ill, and criminals). The people who provided care of the individuals were often "undesirable" people themselves. The care in these facilities continued to worsen and the lack of good care resulted in a high death rate (Gay, 1966).

The harshness of life for persons with intellectual disabilities continued through the 19th century. Most continued to live in facilities; some were cared for in their family home; some were allowed to roam on their own. Regardless of one's disability, whether it was an intellectual disability, mental illness, or physical disability, people with all types of disabilities were congregated in institutions. The care of persons with an intellectual disability increasingly became the responsibility of government. These facilities were often reported to provide extremely poor care of residents. For example in 1670, 75% of the infants admitted to the Foundling's Hospital of Paris did not survive past 3 months (Abt, 1965). Even the most basic care, clothing, fresh air and water, bathing, and medical treatment were not available.

Known for his leadership of service to the poor in the 1600's, Vincent de Paul, made some strides in improving the treatment and conditions for persons who were considered to be mentally ill or intellectually disabled. de Paul and followers maintained that "mental disease is no different from bodily disease. Christianity demands the humane and the powerful to protect and of the skillful to relieve the one as well as the other" (Hamilton, 1978, p. 10). Through the efforts of Pinel, reform of the facilities for the mentally ill and intellectually disabled began. One of the most revolutionary reforms came in 1793 at a residential treatment center, Bicetre, when Pinel removed the chains of some residents (Haggard, 1934).

Conditions began to improve in the late 19th century when several small private residential schools were opened. Seguin, known as the father of special education, started such a school with only one student (Sheerenberger, 1983, p. 68). Guggenbuhl brought additional reforms, purporting that health and training were the potential cure for the persons cared for in the school (Kanner, 1964). Along with the introduction of educating individuals with intellectual disabilities came more humane care and treatment. This trend was soon replaced with larger facilities where more people could be cared for, with major emphasis on doing so in the least expensive ways possible.

Even as the United States was moving into a progressive period of reform and more involvement by the federal government during 1900–1919, the care of persons with intellectual disabilities did not change significantly until there were reputable opportunities to expose the deplorable care and conditions in facilities for individuals with intellectual disabilities (May, 1964). While this exposure did increase the sensitivity

of some, the negative attitudes toward people with an intellectual disability were such that it would take a longer period to change this general perception.

In the early 1900s, with the establishment of special education, more opportunities became available for individuals with an intellectual disability. At the same time, there was more support for community programming, which resulted in less dependency on institutions for care. As early as 1919, Fernald and many practitioners in the field of intellectual disabilities such as psychologists, teachers, school administrators, and social workers were expressing concern for the care and training of people with intellectual disabilities and wanted a full array of comprehensive services (Fernald, 1919). When families were unable to care for a family member with a disability, institutions remained the primary resource. Due to long waiting lists and overcrowding, more and more institutions were built.

Staff recruitment and retention was a major problem in the institutions. Many factors such as low wages, long hours, and lack of fringe benefits contributed to this problem (Scheerenberger, 1983, p. 197). The same influences contributed to recruitment and retention that continue today. As community services expanded, staffing continued to be a problem, both at the institutions and in community services.

Development of the Role of Direct Support Professionals

Even in facilities, people were expected to work the farmlands to produce food, and care for others in the facility (Gay, 1966, p. 118). As the large facilities continued to grow it soon became apparent that even though some residents had reached the upper age limits or were considered ready to be discharged, there were no other options for these individuals to receive care. Many had been abandoned by family and the negative

attitudes of the public did not welcome people back into society. Because of having nowhere else to go for their care, most of the residents remained and cared for others in the facility (Scheerenberger, 1983, p. 124).

During the last 30 years, there has been a major shift in DSPs working in smaller settings, rather than the larger institutions. The average number of people with disabilities per residential setting shifted from 22.5 in 1977 to 2.8 in 2003 (Prouty, Smith, & Lakin, 2004). Similar shifts also took place in vocational and day programs during the same period (Wehman, Revell, & Kregel, 1998). These modifications have caused the roles and responsibilities of the DSP to change from that of a primary caregiver to a more active, community-based role. The role is more complex, having less direct supervision, fewer coworkers, and more decision making as DSPs function independently in the community.

In 1981, Public Law 97-35, entitled the Medicaid Home and Community Based Services Wavier, provided a stimulus for community services and family supports, and a reduction of dependence on institutional care. It is now the principle source of funding for in-home services, comprising 70% of the funding in the United States (Rizzolo, Hemp, & Braddock, 2006). In 2006, 45% of the Home and Community Based Services recipients lived with their family (Lakin, Prouty, & Coucouvanis, 2007).

There has been a trend in our nation of providing less service in institutions, as evidenced by facility census and closures. The United States' institutional care census peaked in 1964 at 194,650 individuals. The downward trend in reliance on institutions has declined over the last 39 years, by an average of 4% each year. There were no institutional closures between 1960 and 1969; however, there has been a large and steady

increase in closures since 1990. The number of people residing in institutions has decreased by 41% since 1990 (Braddock, 1999).

The Expanding Need for Direct Support Professionals

At a time when a larger pool of potential workers is required to meet expanding needs, there is a smaller pool from which to recruit. There are several additional workforce influences to be considered. The baby-boom generation, persons born between 1946 and 1964, created a supply pool for DSPs between 1976 and 1986. During this time the number of people in the U.S. aged 20–44 years old, the age group for most DSPs was at its highest (Fullerton, 1997). As the need for DSPs was rapidly increasing, during the next decade, 1986–1999, there was a much smaller percentage of 20–44 year olds in the workforce (Larson & Hewitt, 2005; U.S. Census Bureau, 2001). The U.S. Census Bureau projects the workforce for this age group to further decline by 2010.

In addition to the changing role of the DSP, the demographics have changed. A 1977 national study found 78% of DSPs were women, 40% had been educated beyond high school and 56% were under the age of 30 years when they started. Those demographics changed, evidenced in studies conducted in the 1990s when women made up 66%–96% of the DSP workforce; 50% had some college, and 35% had college degrees; their average age was 35 years (Scheerenberger, 1983, p. 5)

The increasing lifespan of people with I/DD is another influence in the demand for expanding community services. The mean average age at death has increased from 19 years in 1930, to 59 years in 1970 and 66 years in 1993. In 1993, the mean age for the general population was 70 years. This increase in lifespan requires the provision of

supports for longer durations of time (Braddock, 1999, p. 61). Aging of persons with I/DD parallels that of the general population, including caregivers of people with I/DD.

As a result of aging caregivers, increased lifespan of persons with disabilities, and class-action law suits, the demand for community services is increasing, which drives the demand for more qualified DSPs. The recruitment and retention of qualified DSPs is a critical concern. In 2001 the Bureau of Labor Statistics projected a 63% increase in the need for DSPs through 2010 (Bureau of Labor Statistics, 2001). This projection was twice that of competing industries such as fast-food staff and nursing aides.

There is another impact created by the baby-boom generation. Not only is this group aging beyond the average age of DSPs, it is projected this group will cause a huge expansion in the need for community social services. As a result of the aging population in the U.S., the Bureau of Labor Statistics projects a 62% increase in the number of home-care aides by 2010 (Bureau of Labor Statistics, 2001). The outcome of these changes is a smaller recruitment pool of DSPs and a larger demand for DSPs.

There are a number of factors affecting the demand for continued expansion of community services. In addition to the downward trend in institutional care, another influence of the increased demand for community services comes from the international community. The United Nations Convention on the Rights of Persons with Disabilities projects rapid growth in the number of citizens with disabilities, as well as their caregivers, to ratios never before seen. This creates challenges for healthcare programs and consequences for financial support of persons with disabilities.

High Turnover of DSPs

As the demand for staffing is increasing, so is staff turnover (Braddock, 1999, p. 69). There are widely recognized causes of turnover such as low wages, isolation of the position, lack of training, and not feeling valued (Mlinarcik, 2008).

DSP turnover rates have been averaging between 40% and 70%, reported in many studies of community residential settings over the past 30 years (e.g., American Network of Community Options and Resources [ANCOR], 2001a; Braddock & Mitchell, 1992; George & Baumeister, 1981; Lakin, Bruininks, Hill, & Hauber, 1982; Larson & Lakin, 1992; Larson, Lakin, & Bruininks, 1998). Additional and more recent studies of community residential supports report an average turnover rate of 49% (Division of Developmental Disabilities, 2001; Effective Compensation, 2001; Heneman & Schutt, 2001; Hewitt, Larson, & Lakin, 2000). In 2001, the Bureau of Labor Statistics projected a 63% increase in the need for DSPs through 2010.

A major impact on the DSP workforce is low wages and inadequate benefits, which are directly associated with high turnover rates (Braddock & Mitchell, 1992; Hewitt et al., 2000; Lakin & Bruininks, 1981; Larson, Lakin, & Bruininks, 1998). While provider agencies are struggling with a smaller recruitment pool, they also face the challenges associated with high DSP turnover. These problems are costly from an agency perspective but also from a recipient perspective, as it causes discontinuity of care, as well as disruptions in relationships with DSPs (Braddock & Mitchell, 1992 p. 12).

Studies show a high correlation between low wages and turnover. The 2007 Bureau of Labor Statistics reported that the wages for DSPs working in private community settings is far below the wage for all workers covered by unemployment

insurance (\$18.84), as well as DSPs in state operations (\$12.22) and nursing homes (\$11.27). During this same time, the national average DSP salary was \$10.66, just above the poverty level at \$9.62 (Bureau of Labor Statistics, 2007).

Turnover and vacancies of DSPs can be a barrier to receiving quality support. One study revealed that 28% of the DSP supervisors identified training DSPs as a challenge and a distraction from other responsibilities. Further, these supervisors viewed the efforts required to recruit and train DSPs because of high turnover as preventing them from making other program improvements. Some supervisors also reported increases in the number of incident reports and maltreatment reports they attributed to quality of the DSPs and the supervision they received. Families are the first to experience the direct impact of staff turnover and poorly trained employees. Some families reported staff training and follow up was weak (Larson, Hewitt, & Lakin, 2004).

These changing workforce influences are causing DSP recruitment to be the biggest challenge for community agencies, as this potential workforce pool shrinks. (Barry Associates, 1999; Cohen, 2000; Hewitt et al., 2000; Irwin Siegel Agency, 2001; Developmental Disabilities Service Division, 2000; Test, Solow, & Flowers, 1999). Not only is this shortage a challenge for provider agencies, it results in high vacancy rates—11% in the United States (ANCOR, 2001a)—which mean DSPs are not available to provide in-home services to families. One study reported 56% of the families did without services because there were no DSPs to provide the services (Hewitt et al., 2000).

Competencies

This research has adopted the definition of a competency as a set of knowledge, skills, and abilities obtained through formal or informal education, work experience, or

other means required to perform a job (Craig, 1996). Initial research of competencies yielded general competency clusters, rather than job specific competencies, such as that of Henschke in examining the competencies of managers in training and development (Henschke, 1991). Knowles (1962) developed a theory on competency-based training, which assisted many fields and professions in developing standard competencies and ways to best train adults on the identified competencies. Knowles taxonomy started with the roles of a position, then defined the functions of that position and from there could identify the competencies and the skills. This theory assumes that the learner has certain competencies and needs to develop certain specific competencies related to a specific job or profession (Craig, 1996, pp. 16).

Competencies Specific to DSPs

A survey of DSPs indicated they were aware that additional training on the Community Support Skill Standards (CSSS) was a need. The literature focuses on entry-level training of staff working in the field and says little about the ongoing staff training required to become proficient (Taylor, 1998). Hewitt and O'Neill (1998) found that the training of DSPs did not develop the knowledge, skills, and attitudes necessary to keep pace with the growing expectations of the role. Training is generally focused at the beginning of employment, commensurate with regulatory requirements, and is rarely competency based (Hewitt & Larson, 1994). Competency-based training addresses the learning of knowledge, skills, and attitudes of employees with the goal of changing the outcome, that is, how the employee performs.

Through 1993 funding by the U.S. Department of Education, 23 industries were identified for a national voluntary skill-standards assessment. One of the 23 industries

was that of community human services. This opportunity led to the most comprehensive job analysis of the DSP. It was completed by Taylor, Bradley, and Warren in 1996, through the use of the “Developing a Curriculum” process. This process uses structured activities to determine essential skills, knowledge, and attributes. A set of 12 standard DSP competencies came out of this process. These outcomes were validated through a national survey and resulted in the CSSS. The CSSS were piloted by the Human Services Research Institute (HSRI), an entity known for many years of devotion to promoting quality in the service system for people with mental retardation/developmental disabilities, as well as other service systems (Taylor, 1996). The following year, the President’s Committee on Mental Retardation (PCMR) recognized and highlighted the National Community Support Skill Standards, with the publication, “Opportunities for Excellence: Supporting the Frontline Workforce” (U.S. Department of Health and Human Services, 1997). Upgrading the quality of the direct support workforce was a primary focus of The President’s Committee on Mental Retardation, during the 1990’s. The PCMR’s recommendations to President Clinton in 1995 focused on the need for more education to this work force as the primary method of improving quality in the field of mental retardation.

In 1998, Hewitt conducted a job analysis to further validate the 12 standard competencies outlined in the CSSS (Hewitt, 1998). Hewitt found that DSPs acknowledged the need for training and wanted more training. Further, administrators recognized the complete CSSS, but only focused training in two specific competency areas: Documentation and Communication. Administrators identified many barriers to staff training such as the expense involved and the challenges of covering for staff while

they participated in training. Until these training barriers are addressed, it is unlikely that DSP training will receive the priority and implementation it needs.

Since the development and implementation of the CSSS, it is now seen as a national effort endorsed and supported by the following leaders in the disability field: Council for Standards in Human Services Education, Child Welfare League of America, Coalition of Citizens with Disabilities (CCD), American Network of Community Options and Resources (ANCOR), National Association of State Directors of Vocational Technical Education Consortium, National ARC, American Association of Community Colleges, The National Assembly of National Voluntary Health and Social Welfare Organizations, Inc., National Association of State Directors of Developmental Disabilities Services, Inc., National Association of Alcohol and Drug Addiction Counselors Certification Commission, and the International Association of Psychosocial Rehabilitation Services (National Organization for Human Services, 2006).

The literature on DSP training, recruitment, and retention has had three comprehensive reviews. The first was completed by Lakin in 1981 and covered the period of 1900 through 1978. The second literature review was completed in 1998 and covered literature from 1975 through 1995 (Larson, Lakin, & Bruininks, 1998). Later a review was completed by Hewitt, focused on state, regional, and national studies from 1990 to 2001.

There is much literature that provides information regarding the expenses and costs involved in replacing a DSP (Employment Management Association, 2001; George & Baumeister, 1981; U.S. Department of Labor, as cited in Mercer, 1999; Zaharia

&Baumeister, 1978). Less literature focuses on the costs to recipients, their quality of life, broken relationships, and trust.

The definition of a DSP has evolved from a basic caregiver to the one produced by the CSSS completed by Taylor et al. in 1996: “The Community Based Human Service Practitioner assists the participant to lead a self-directed life and contribute to his or her community, and encourages attitudes and behaviors that enhance inclusion in his or her community.” These shifts have also increased the complexity of decisions affecting recruitment, retention, and training. Recent exposés on television and in newspapers highlighting poor decisions and failures of DSPs have increased the scrutiny of this position (Boo, 1999; Cororan & Fahy, 2000). Thus, there has been increased attention to training and support for DSPs.

The CSSS identified the essential benchmarks, or knowledge, skills, and attitudes for experienced, master’s level DSPs. These benchmarks were described by DSP peers and supervisors and are evidence of the increasing complexity of the role. The literature does not support the development or implementation of specific training and education toward these recognized competencies.

Community Support Skill Standards

Following is a detailed description of each competency.

Competency Area 1: Participant Empowerment. The competent community support human service practitioner enhances the ability of the participant to lead a self-determining life by providing the support and information necessary to build self-esteem and assertiveness, and to make decisions.

Competency Area 2: Communication. The community-support human-service practitioner should be knowledgeable about the range of effective communication strategies and skills necessary to establish a collaborative relationship with the participant.

Competency Area 3: Assessment. The community-support human-service practitioner should be knowledgeable about formal and informal assessment practices in order to respond to the needs, desires, and interests of the participants.

Competency Area 4: Community and Service Networking. The community-support human-service practitioner should be knowledgeable about the formal and informal supports available in the community and should be skilled in assisting the participant to identify and gain access to such supports.

Competency Area 5: Facilitation of Services. The community-support human-service practitioner is knowledgeable about a range of participatory planning techniques and is skilled in implementing plans in a collaborative and expeditious manner.

Competency Area 6: Community Living Skills and Supports. The community-support human-service practitioner has the ability to match specific supports and interventions to the unique needs of individual participants and recognizes the importance of friends, family, and community relationships.

Competency Area 7: Education, Training and Self-Development. The community-support human-service practitioner should be able to identify areas for self-improvement, pursue necessary educational/training resources, and share knowledge with others.

Competency Area 8: Advocacy. The community-support human-service practitioner should be knowledgeable about the diverse challenges facing participants (e.g., human rights, legal, administrative, and financial) and should be able to identify and use effective advocacy strategies to overcome such challenges.

Competency Area 9: Vocational, Educational and Career Support. The community-based support worker should be knowledgeable about the career and educational concerns of the participant and should be able to mobilize the resources and support necessary to assist participants to reach their goals.

Competency Area 10: Crisis Intervention. The community-support human-service practitioner should be knowledgeable about crisis prevention, intervention, and resolution techniques and should match such techniques to particular circumstances and individuals.

Competency Area 11: Organization Participation. The community-based support worker is familiar with the mission and practices of the support organization and participates in the life of the organization.

Competency Area 12: Documentation. Community-based support workers are aware of the requirements for documentation in their organization and are able to manage these requirements efficiently (Taylor et al., 1996).

The Executive Committee of the NADSP approved the addition of the following competencies:

Competency Area 13: Building and Maintaining Friendships and Relationships. Supports the individual in the development of friendships and other relationships.

Competency Area 14: Provide Person Centered Supports. Provides support using a person-centered approach, assists in developing and implementing person-centered plans.

Competency Area 15: Supporting Health and Wellness. Promotes the health and wellness of all individuals (NADSP, 2007).

Competencies Specific to DSPs in Kentucky

In the Commonwealth of Kentucky, DSPs employed in the Supports for Community Living Waiver (SCL) are required to participate in the following training (see Appendix A): Ensure that each employee prior to independent functioning completes training which shall include:

Orientation to the agency

First aid

Cardiopulmonary resuscitation

Crisis prevention and management

1. Values base
2. Goals of Crisis Intervention – Calm not Control
3. Six Action Phases of a crisis:
 - Phase I – Prevention/maintaining calm
 - Phase II – Early intervention and identification of triggers and agitation
 - Phase III – Intervention during acceleration to full crisis
 - Phase IV – De-escalation/stabilization
 - Phase V – Restoration and re-integration
 - Phase VI – Debriefing/developing collaborations

Identification and prevention of abuse, neglect, and exploitation;

Part I: Understanding the culture of abuse

1. Disability and Abuse/Neglect/Exploitation
2. Abuse/Neglect indicators
3. Personal and organizational factors leading to abuse
4. KRS209 Reporting Requirements

Part II: Developing emotional responsibility

1. Support relationship/responsible role
2. Command vs. Control
3. Emotionally responsible approach

Abuse Prevention strategies

Rights of individuals with disabilities; and

1. Historical perspectives
2. Federal/legislative mandates
3. Values base
4. Ensuring human rights for all
5. Self-advocacy

Preventative strategies

Individualized instruction on the needs of the SCL recipient to whom the trainee provides supports

Medication administration training per cabinet-approved curriculum;

1. Legal issues involved in medication administration
2. Drug classes
3. Recording and using agency medication forms

4. Procedures for the destruction of medication
5. Side effects of medication
6. Storing medication appropriately
7. Self-administration

Medications and seizures;

1. Observe and report symptoms
2. Recognize seizures
3. Provide ordered treatments

Individualized instruction on the needs of the SCL recipient to whom the trainee provides supports;

Core training, consistent with a Division of Mental Health/Mental Retardation approved curriculum

Values

1. Definition
2. Role of perceptions and attitudes
3. Labels and Stereotypes

Community Inclusion

1. Definitions and perspectives
2. Roles of natural supports and how to build them
3. Learn how to be a good social guide

Person Centered Planning

1. Five Accomplishments
2. System centered vs. Person centered
3. Planning process

4. Teams and communication

Positive Behavior Support

1. Role of choice
2. Common areas of frustration
3. Proactive strategies
4. Behavioral issues associated with brain injury

Sexuality issues

1. Perceptions of sexuality
2. Understanding brain function in relation to sexuality
3. Education
4. Ensuring safety and preventing abuse

Self-Determination

1. Define the five principles of self-determination
2. Discuss tools of implementation
3. Explore self-advocacy

Strategies for successful teaching

1. Define the goal of teaching
2. Outline the steps in the teaching process
3. Evaluation of outcomes and implementing strategies for success

(907 KAR 1:145. Supports for community living services for an individual with mental retardation or a developmental disability, 2007).

A comparison was made to identify how the competencies are addressed through the required training for the Supports for Community Living waiver. This analysis is captured in Appendix B.

Kentucky has not formally adopted the competencies supported by the NADSP. The Supports for Community Living training requirements do not highlight the NADSP competencies in the required training.

Training: One Method of Addressing Turnover

Because of the shortage of DSPs and the lack of capacity to deliver all of the services recipients need, there is not enough time for training. Frequently training is limited to that required through regulations and is often limited to the initial time shortly after hiring. This minimal approach to training prohibits DSPs from acquiring the knowledge, skills, and attitudes necessary to be competent.

In addition to the limits caused from the time and expense involved, there are other barriers to acquiring training for DSPs. For the most part training is not competency based but rather is documented by the time one sits in a training session. Another barrier to DSPs training has to do with much of the training not being “transportable” from agency to agency. Because most agencies do not document the demonstrated competency in the actual work setting or provide any kind of credential, DSPs often must repeat the initial training with each new job. A national study in 1990 determined that the average classroom training time was just over 36 hours with another 36 hours of on-the-job training (Braddock & Mitchell, 1992).

How do DSPs feel about the training they receive? There is not a lot of data on training or the challenges it presents. In 2000, one study looked at DSPs’ opinions of

their proficiency. In general, 92% felt their training had prepared them to complete most of the duties. They felt more capable in some skill areas than others (Hewitt et al., 2000). Another study documented the administrators' thoughts about DSPs that they would benefit from training in documentation, communication, and crisis intervention. The DSPs thought they would benefit from additional training in crisis intervention, education, self-development, and advocacy (Test et al., 2004, p. 13). Many agencies report problems in getting DSPs to attend training (Larson, Lakin, & Bruininks, 1998; Larson Lakin, & Hewitt, 2002). There is a growing concern, reported by agencies, that expectations are being reduced in an effort to maintain employees (ANCOR, 2001b). This approach may have helped retain new employees; however it has reduced job satisfaction with longer-term employees and people receiving supports, as they share concerns about basic health and safety (Anderson & Hewitt, 2002; Larson, Lakin, & Bruininks, 1998).

While the negative impact of poorly trained DSPs on support recipients cannot be underestimated, there are numerous influences of poor performance on an agency as a whole. Some of the most prevalent indicators are recipients becoming dissatisfied and leaving; increased costs of operations (related to overtime, higher workers compensation, and insurance premiums as a result of accidents and increased supervision); and higher turnover as a result of dissatisfaction, increased recruitment, hiring, and training costs. (Bowsher, 1998; Carr, 1992). At the same time DSPs are receiving low wages, which is contributing to high turnover, agency providers are spending more money to increase retention, which precludes paying DSPs higher wages (ANCOR, 2001b; Braddock & Mitchell, 1992; Hewitt & Lakin, 2001).

Summary of Chapter 2

This review of the literature documents the longstanding problems related to recruiting, training, and retaining Direct Support Professionals to work with people with I/DD. While the literature identifies a set of competencies for DSPs, the review did not identify a survey for assessing the DSP's knowledge or value regarding the competencies. This research focused on the competency training of DSPs as one potential method of addressing these staffing problems.

CHAPTER III

METHODOLOGY

This descriptive study applied quantitative research methods to explore perceptions of training and job competencies of DSPs. These perceptions were explored by surveying both DSPs and DSP Supervisors, and involved a set of standardized competencies.

This chapter contains an overview of the study design and includes the population and sampling procedure, the survey tool and methods of collecting data, applicable hypotheses, and the processes of analyzing the data. The results of this research hold potential to revise the training of DSPs who work with individuals with intellectual or developmental disabilities.

Participants and Sampling Procedure

The sample for this study included two participant groups comprised of staffs that provide direct support and DSP Supervisors. These two groups were comprised of adults without disabilities. All participants were adults over the age of 18.

Participants did not receive any payment and were not charged to participate in this research. The University of Louisville Institutional Review Board requires a data and safety-monitoring plan for all studies posing greater than minimum risk. This research did not involve risk to the participants and therefore a data and safety-monitoring plan

was not required. No identifying data of the subjects was collected or made available to anyone other than the principal investigator.

The sample was derived through electronic and written communications with agencies listed on the current Supports for Community Living Waiver (SCL) Provider Directory (see Appendix C). There are 169 Supports for Community Living provider agencies located throughout the Commonwealth of Kentucky. This directory was screened and providers who were not likely to have Direct Support Professionals in their employment were excluded for the invitation letters. For example, agencies that only provide SCL Case Management or Physical Therapy would not employ Direct Support Professionals. All participants were volunteers. A letter of invitation to participate in this study included the purpose of the study (see Appendices D and E) and an electronic link to SurveyMonkey, an online survey service. The SurveyMonkey link contained the informed consent form, the survey (see Appendices F and G), and the instructions for completion. Printed copies of the survey were also available upon request to anyone who did not have access to the online survey. In an effort to meet the needs of all volunteers, the invitation offered to assist with potential accommodation should any be required. However, none was requested.

Participants were allowed as long as necessary to review the informed consent and the survey, until such time that the individual was comfortable in making a personal decision about whether to participate in this study. Potential participants were provided the contact information to ask the researcher questions related to the study and to ask the Human Studies Committee questions about rights. Additionally, the survey also included one more attempt to assist the participants by asking, “Before you proceed, would you

feel more comfortable talking with the researcher about the informed consent or any other aspects of this research? If yes, please call the researcher at 502-802-2564.” A close date was eventually established for the survey and only participants who completed the survey prior to the close date were included in this study.

Hypotheses and Research Questions

The research breaks down into two main hypotheses and the research questions that lead to an analysis of these hypotheses:

1. H_0 : There are no significant differences in the perceptions of DSPs and DSP Supervisors regarding the knowledge of the standard competencies for a successful DSP;

H_A : Significant differences exist between perceptions of DSPs and DSP Supervisors regarding the knowledge of the standard competencies for a successful DSP.

Two research questions relate to these hypotheses:

- a. What do DSPs self-report as their level of knowledge of each of the 15 standard competencies? and
 - b. What do DSP Supervisors report as their perceptions of DSPs' level of knowledge of each of the 15 standard competencies?
2. H_0 : There are no significant differences in the perceptions of DSPs and DSP Supervisors regarding the value placed on the standard competencies of a successful DSP.

H_A: Alternative Hypothesis 2: Significant differences exist between perceptions of DSPs and DSP Supervisors regarding the value of the standard competencies for a successful DSP.

Related research questions:

- a. What do DSPs self-report as the value they place on each of the 15 standard competencies?
 - b. What do DSP Supervisors report as their perceptions of the value DSPs place on each of the 15 standard competencies?
3. H₀: No linear relationship exists between knowledge and value of the 15 competencies and age, gender, ethnicity, education, work experience, and amount of training.

The Source of the Data: Survey Instruments and Data Sheet

A comprehensive review of the literature was completed to locate any applicable surveys or other assessment tools to measure perceptions regarding the 15 competencies. The most relevant, existing tools were employee performance surveys. No appropriate assessments were found and therefore the researcher developed the surveys for this research.

In order to measure participant perceptions, a survey in the form of a Likert scale was used to rate the level of agreement with the statements regarding the importance and value of the 15 competencies. A Likert scale often measures along a five-point scale from “strongly disagree” to “strongly agree” with a neutral point in the middle (Instructional Assessment Resources, 2009). I used a 10-point rating scale and did not include a “neutral” point. It was assumed that all participants were familiar with the content, and

without a neutral point were forced to choose along the continuum from low to high. This approach allowed the survey to measure both the direction of the participant's perception (disagree or agree) and the intensity (e.g., strongly agree or agree).

Each of the potential responses was assigned a weight. The choices ranked from low to high and included "Extremely Low," 1 point, markers for points 2–9, and "Extremely High" at 10 points. These scores or ratings were used to describe and analyze the respondents' perceptions.

The validity and reliability of the survey was checked by conducting a pilot study. The pretest included a small sample of each of the groups involved in the study. This group was chosen for two reasons, all had worked in the field of ID/DD for many years and worked either both as a DSP or as a DSP and in a supervisory role with DSPs and were interested in this research. For the aforementioned reasons the participants in the pilot study were considered experts in the field of DSPs. Initially the email with the invitation letters was sent to the group. Some of the participants were unable to open the invitation letters and were also unable to open the survey link contained in the letter. As a result of this problem it was determined that an older version of the software was needed to increase the likelihood that participants could open the invitation letters. This information was considered to be invaluable and was corrected to prevent others from experiencing the same problem. A second email with the invitation letters was sent to the same group. Feedback indicated that the invitation letters were considered appropriate to the audience and the content was well presented and easily understood. The group determined the survey links were operational. There was general agreement that the directions for completing the survey were appropriate and helpful, however the language

within the survey raised questions. This group of experts was familiar with these standard competencies. The DSPs understood and implemented these competencies within their work. Likewise, the supervisors understood, taught, and coached DSPs regarding these competencies on a continuous basis. This researcher and the pilot study experts concluded the definitions of these competencies should not change, as this standard language was accepted and sanctioned on a national basis. It was determined that the survey could be enhanced by adding an example to each competency. The examples were developed by using the Skill Statements from the National Alliance of Direct Support Professionals Competency Areas (National Alliance for Direct Support Professionals, 2007). The invitation letters were emailed to the expert group a third time. Feedback from this group indicated satisfaction with the revisions. This concluded the pilot study.

Throughout the pilot study, it should be noted that none of the experts who participated actually completed the survey and no data was collected.

A separate survey was created for each of the two stakeholder groups. The surveys consist of three parts (see Appendix D and E). The first section of each survey provided basic information about the purpose of the study, then asked participants to self-evaluate their level on two ratings for each of the 15 competencies:

1. Knowledge of the competency/skill for DSPs
2. Value placed on this competency/skill for DSPs

DSPs responded for themselves. Supervisors responded on behalf of the DSPs they supervise. For each of the competencies, DSPs and DSP Supervisors were asked for a rating ranging from Extremely Low (1) to Extremely High (10).

The second part of the survey provided the opportunity for participants to share additional information in the form of open-ended questions.

1. Are there other competencies not listed above that you think should be added to the list?
2. Is there anything you would like to share? Please make any additional comments.

The last section of the survey was the data sheet, which asked basic demographic information such as age, gender, ethnicity, education, amount of training, and employment history. In this survey section, data was gathered that may identify contributing factors toward DSPs' and DSP Supervisors' perspectives about the knowledge and value of the 15 competencies. In addition to the basic demographic information, each participant group was asked at least one question specific to the group.

1. DSPs were asked about the length of time employed as a DSP, the amount of training received, and the total time working with people with disabilities, as well as other work experience.
2. DSP Supervisors were asked whether they were a DSP prior to becoming a supervisor, length of time as a supervisor, and total time working with people with disabilities, as well as other work experience.

While there is no published validity or reliability for this survey instrument, a Cronbach's alpha coefficient was completed to determine internal consistency (Gall, Borg, & Gall, 1996). The Cronbach's alpha was completed on the two sample groups and the 15 competencies (see Table 2). A factor analysis was completed for each of the 15 competencies, for each of the sample groups, to further ensure the survey measured the

intended content. The factor analysis was conducted to produce two factors: one for knowledge of the competency and a separate one for value placed on the competency.

Data Collection

Once the dissertation committee approved the research proposal, the online application for the University of Louisville Institutional Review Board (IRB) was completed. After IRB approval was obtained, then contact began with the people discussed in the “Participants and Sample” section of this chapter to solicit volunteers.

The first contact was to a group of DSPs and DSP Supervisors to create the volunteer sample for the pilot study. This was accomplished through a face-to-face request with a large group. Through this request, several DSPs and DSP Supervisors volunteered to participate as a sample group. A similar approach was completed with a large group of local agency providers to begin the dialogue about the upcoming research. Gall, Borg and Gall (1996) suggest pre-contacting the potential participants to persuade them to participate.

In order to reach the stakeholder groups, electronic or paper versions of letters were forwarded to provider agencies listed on the Division of Developmental and Intellectual Disabilities, Supports for Community Living Waiver Branch website (Appendix B). These letters were sent to the agency contact person and requested assistance in distributing the letters of invitation to the specific subject groups. This strategy did not involve any sharing of client names or other information and afforded the strictest of confidence and anonymity. Agency directors were asked to forward the e-mail message to DSPs and DSP Supervisors. Each stakeholder group received an invitation letter and survey instructions specific to that group.

A reminder e-mail was sent to the original agency contact people approximately 5 days prior to the close of the survey. An offer was made to cover any agency expense incurred, such as mailing hard copies.

Each participant who completed a survey did so by logging onto SurveyMonkey to access the informed consent before beginning the survey. When SurveyMonkey is not accessible, a paper version of the informed consent and the survey was provided.

Data Analysis

Quantitative analysis of the survey results included calculating descriptive statistics, multivariate analysis of variance (MANOVA), *t*-tests, and multiple regression analyses. (Refer to Appendix H for the Competency and Abbreviation Charting Scale.)

Descriptive statistics. To understand each variable in detail, measures of central tendency (mean, median, and mode) and measures of dispersion (variance, skewness, and kurtosis) were obtained. Frequency tables provided points of reference, and correlations screen out any interactions or confounding variables, and reveal potential areas for further study.

MANOVA The data was analyzed through a MANOVA using the two stakeholder groups as the independent variable and the mean scores obtained on knowledge and value placed on each of the 15 standard competencies as dependent variables. All survey participants were anonymous. Thus, it was not possible to link the data from a supervisor with the data from supervisees of that supervisor. Multilevel analysis methods, such as hierarchical linear modeling (HLM), were not used, as it requires that data at one level of analysis (e.g., supervisees) be linked with specific data at

a different level of analysis (e.g., a particular supervisor). Such a grouping was not possible with this study. Each person responding to the survey did so independently.

Two MANOVA analyses were performed. In each, the independent variable was group (two levels, DSP and supervisor of the DSPs). For the first MANOVA, the dependent variables were ratings for *knowledge* of the 15 competencies. For the second MANOVA, the dependent variables were ratings for *value* placed on the 15 competencies.

The overall MANOVA tests were statistically significant, and a series of *t*-tests were completed for each of the dependent variables. For example, when the MANOVA for the knowledge items was significant, *t*-tests were performed for each competency comparing the mean rating of the DSP knowledge rating with the knowledge rating of DSP supervisors. Following the advice of Stevens (2009) for situations in two-group MANOVA where the number of dependent variables is greater than 7, the level of significance for each of the univariate *t*-tests will be .05.

Multiple-regression. Correlation coefficients and multiple regression analyses were performed on DSP's selected knowledge ratings and selected value ratings. This part of the statistical analysis included only the DSP subject group, not the supervisor group. The demographic variables age, gender, ethnicity, education, amount of training and work experience served as predictors in these analyses.

For knowledge ratings, three multiple regression analyses were performed. In preparation for these analyses, three competencies were selected as follows: First, the mean knowledge rating for each competency was recorded for the DSP group. Second, the mean knowledge rating for each competency was recorded for the DSP supervisor

group. Third, the difference between each set of means was calculated (DSP mean - DSP supervisor mean). The difference scores were rank ordered, and the three competencies with the largest discrepancies between the DSP and the DSP supervisor were used in regression analyses. Thus, regression analyses focused on those ratings that might be most interesting, in terms of contrast between DSP and DSP supervisors.

Each multiple regression analysis followed the same format. The dependent variable was the DSP knowledge mean rating for that competency. The predictor variables were: (a) age, (b) gender, (c) ethnicity, (d) education level, (e) amount of work experience, (f) amount of training received, and (g) value rating for the competency. Simultaneous entry of predictor variables was used. The squared multiple regression correlation (R squared) was calculated as well as the partial regression coefficient for each predictor variable.

For value ratings, the same format as that followed by knowledge ratings was used. Three multiple regression analyses were performed. In preparation for these analyses, three competencies were selected as follows: first, the mean value rating for each competency was recorded for the DSP group. Second, the mean value rating for each competency was recorded for the DSP supervisor group. Third, the difference between each mean was calculated (DSP mean minus DSP supervisor mean). The difference scores were rank ordered, and the three competencies with the largest positive discrepancies between the DSP and the DSP supervisor were used in regression analyses. Again, these analyses provided a focus on potentially problematic value ratings.

Each multiple regression analysis followed the same format. The dependent variable was the DSP value rating. The predictor variables will be these: (a) age, (b)

gender, (c) ethnicity, (d) education level, (e) amount of work experience, (f) amount of training received, and (g) value rating for the competency. Simultaneous entry of predictor variables was used. The squared multiple regression correlation (R squared) was calculated as well as the partial regression coefficient for each predictor variable.

In total, six multiple regression analyses were performed and are reported in the dissertation text: three on knowledge ratings of DSPs and three on value ratings of DSPs.

MANOVA power analysis. For two-group MANOVA, a power analysis table in Stevens (2009) was used. Using the closest possible approximation in the table, to detect a medium effect size, with Type I error = .05, a sample size of 100 subjects per group would achieve a power of .86.

Regression power analysis. For multiple regressions, a power analysis procedure described by Cohen and Cohen (1983) was used. To detect an R squared value of .15 (medium effect size), with Type I error = .05, and power of .85, a sample size of 97 subjects is required. Since a minimum *n* of 100 for the DSP group was obtained for the MANOVA, there was sufficient power for the regression analyses.

Multiple regression analysis was completed for each of the competencies. The first series was completed for the knowledge of each competency and included the demographic data referenced above:

$$\begin{aligned} \text{Knowledge} = & \text{age} + \text{gender} + \text{ethnicity}^1 + \text{education} + \text{work experience} \\ & + \text{training received} + \text{value}. \end{aligned}$$

¹ Ethnicity proved too homogeneous to use in the regression analysis.

$$\begin{aligned}\text{Knowledge} = & \beta_0 + \beta_1(\text{age}) + \beta_2(\text{gender}) + \beta_3(\text{ethnicity}) + \beta_4(\text{education}) \\ & + \beta_5(\text{work experience}) + \beta_6(\text{training}) + \beta_7(\text{value}) + \varepsilon.\end{aligned}$$

This series of multiple regression equations, examining knowledge, totaled 15, one for each competency.

Likewise, a separate series of multiple regression analysis was completed for value placed on each competency, using the same set of demographic data:

$$\text{Value} = \text{age} + \text{gender} + \text{ethnicity} + \text{education} + \text{work experience} + \text{knowledge}$$

$$\begin{aligned}\text{Value} = & \beta_0 + \beta_1(\text{age}) + \beta_2(\text{gender}) + \beta_3(\text{ethnicity}) + \beta_4(\text{education}) \\ & + \beta_5(\text{work experience}) + \beta_6(\text{training}) + \beta_7(\text{knowledge}) + \varepsilon.\end{aligned}$$

This series of multiple regression equations, examining value, totaled 15, one for each competency.

Summary of Chapter 3

This research explored the similarities and differences in perceptions among staff providing direct support and the supervisors of staff providing support on the 15 standard competencies for DSPs. Efforts were made to examine the knowledge base and value placed on the competencies and what implications could be drawn as a result. These comparisons were obtained through a survey. Limitations of this research include constraints of the survey and a possible pattern to respondents who self-selected to participate.

CHAPTER IV

RESULTS

This chapter provides the results of the research and statistical analysis of the data. Direct Support Professionals do not remain with a job when they do not feel adequately trained and lack the confidence to perform (Braddock & Mitchell, 1992; Department of Employee Relations, 1989; Larson & Lakin, 1992, 1999; Larson, Lakin, & Bruininks, 1998). Without sufficient knowledge regarding the level of knowledge and value DSPs place on each of the competencies, employers may not provide the most effective staff development. Without appropriate information, employers may make faulty assumptions about the training needs of DSPs, or even worse, underestimate or undervalue their employees, both of which may contribute to higher DSP turnover.

The purpose of this preliminary quantitative research study was to ascertain the level of knowledge of, and value placed on, the fifteen competencies recognized by the National Alliance of Direct Support Professionals, by the DSPs, and whether this correlates with the perception of DSP Supervisors regarding Kentucky DSPs' knowledge of and value for the competencies.

Hypotheses and Research Questions

The research breaks down into two main hypotheses and the research questions that lead to analysis of these hypotheses:

1. H_0 : There are no significant differences in the perceptions of DSPs and DSP Supervisors regarding the knowledge of the standard competencies for a successful DSP;

H_A : Significant differences exist between perceptions of DSPs and DSP Supervisors regarding the knowledge of the standard competencies for a successful DSP.

Two research questions relate to these hypotheses:

- a. What do DSPs self-report as their level of knowledge of each of the 15 standard competencies? and
 - b. What do DSP Supervisors report as their perceptions of DSPs' level of knowledge of each of the 15 standard competencies?
2. H_0 : There are no significant differences in the perceptions of DSPs and DSP Supervisors regarding the value placed on the standard competencies of a successful DSP.

H_A : Alternative Hypothesis 2: Significant differences exist between perceptions of DSPs and DSP Supervisors regarding the value of the standard competencies for a successful DSP.

Related research questions:

- a. What do DSPs self-report as the value they place on each of the 15 standard competencies?
- b. What do DSP Supervisors report as their perceptions of the value DSPs place on each of the 15 standard competencies?

3. H_0 : No linear relationship exists between knowledge and value of the fifteen competencies and age, gender, ethnicity, education, work experience, and amount of training.

These hypotheses and questions were examined through a survey of the agencies approved for the Supports for Community Living Waiver throughout the state of Kentucky. Demographic information such as age, gender, ethnicity, educational history, and employment history, was collected and analyzed. Particular attention was given to the amount of training DSPs received. The dependent variables were the perceptions of the importance of the DSP competencies and the perceptions of the training and preparation of DSPs.

Sample

The sample was composed of volunteer participants who were willing to complete a survey regarding the standard fifteen competencies for DSPs. Recruitment of participants included a series of email invitations and various invitations at gatherings of providers of the Supports for Community Living Waiver. The email invitation included a link to the survey, through Survey Monkey, a web-based program. Hard copies of the survey were made available upon request. The sample consisted of individuals currently employed as a Direct Support Professional or a Supervisor of DSPs.

The survey was open to participants for one month. During that time, 118 DSPs responded to the survey. Of these, 109 completed all of the knowledge and value ratings on the survey and those data were used in the analysis. One hundred six DSP Supervisors responded to the survey, of which 90 answered every question and can be included in this study.

Validity and Reliability

A thorough review of the literature failed to identify a survey tool to measure the perspectives of DSPs and DSP Supervisors regarding the fifteen national competencies. In the absence of such a tool, a survey was developed specifically to ascertain the level of knowledge of and value placed upon the competencies. One survey was developed specifically for DSP participants and another separate survey was developed specific to DSP Supervisors. These two surveys were drafted in Survey Monkey and reviewed by a sampling of DSPs and DSP Supervisors. Once this group determined the survey to be readable and understandable, Dr. Thomas Simmons reviewed and approved it.

While there is no published validity or reliability for the survey instruments, a Cronbach's coefficient alpha was completed to determine internal consistency (Gall, Borg, & Gall, 1996). Cronbach's alpha indicates the degree to which a set of items are related to one another.. Cronbach's alpha coefficients were calculated for knowledge items and value items. Cronbach's alpha is sensitive to skew. It can be viewed as a measure of how well the sum score on the selected items capture the expected score in the entire domain, even if that domain is heterogeneous.

The Cronbach's alpha was completed on the two sample groups and the fifteen competencies (see Table 2). To further ensure the survey measured the intended content, a factor analysis was completed for each of the fifteen competencies, for each of the sample groups. The factor analysis was conducted to determine whether there were two factors: one for knowledge of the competency and a separate one for value placed on the competency.

Table 2

Reliability Statistics: Cronbach's coefficient alpha.

Competencies	Overall	DSPs	DSP Supervisors
Knowledge	0.96	0.95	0.95
Value	0.97	0.96	0.96
N	199	109	90

Findings: Descriptive Statistics

Interval Variables

Table 3 shows descriptive statistics for demographic and training interval variables. The DSPs ranged in age from 20 to 66 years with an average of 39 years, 9 months. Mean and median ages are close together at around 40. The maximum number of years as a DSP is 27, but the mode is 0 years, a symptom of high turnover. Supervisors average more years as supervisors than DSPs do as DSPs, another symptom of high turnover for DSPs. The average total time working with people with disabilities is about 12.5 years, the same as the average amount of time that supervisors have been at their jobs. Yearly training is perceived to average around 36 hours.

Table 3

Descriptive statistics, interval variables.

	N	Min	Max	Mean	Std. Deviation
Age	189	20	66	40.72	11.342
Years of Experience as a DSP Supervisor	183	0	36	12.30	9.911
Years of Experience as a DSP	146	0	27	5.38	5.587
Years at this Job	159	0	30	6.18	6.440
Previous Years as a Supervisor	46	1	27	7.70	6.044
Years Working with Disabled	177	0	35	12.58	9.845
Years in Other Work	87	0	30	10.55	9.550
Total Hours of Training	165	0	1500	231.32	293.109
DSP Training - First 3 Months	87	1	50	33.61	17.672
DSP Training - First Year	137	6	50	34.92	15.374
Average Yearly DSP Training	131	3	50	36.59	15.229
Total Value for Competencies	199	44	150	129.07	20.558
Total Knowledge of Competencies	199	50	150	118.77	21.148

Note: $p < .05$ for both Kolmogorov-Smirnov and Shapiro-Wilk tests for normality. None of these continuous variables is in a normal distribution.

Knowledge and Competencies. Table 3 contains descriptive statistics for total knowledge of and total value for the competencies. People who chose the very highest value for each question achieved a score of 150. The lowest scores were 50 for knowledge and 44 for value. A regression analysis using standardized data revealed that knowledge and value were significantly correlated: that for every unit increase in total knowledge (the independent variable), value (the dependent variable) for that competency went up by about two-thirds of a unit ($R^2 = .409$, $F = 71.026$, $p < 0.001$).

Figure 1 shows that the standardized version of value was appropriate to use for a regression analysis. The histogram has a normal shape and the plot of residuals passes a visual examination to ascertain that the points fall in a straight-enough line. The model is not perfect, however. It accounts for just 41% of the variance in total value for competencies. More will be added to it later in this analysis.

Figure 1. Histogram and normal plot of regression standardized residual, total value.

Figure 2 is a boxplot of total DSP knowledge across all competencies as self-reported vs. how supervisors perceive it. Figure 3 shows the same comparison for values for competencies. (These are the two main variables that can be used as interval variables for analysis. The individual competency variables are treated as categorical.) In both knowledge and value, DSPs perceive themselves as higher on the scale than the supervisors perceive them to be. One possible issue in turnover might be a discrepancy between how DSPs perceive their knowledge and value for competencies and how their supervisors think they know and value them. Supervisors perceive DSP knowledge to be lower than DSPs do. This could result in a lack of respect that DSPs might consider as unfair.

Figure 2. Total DSP knowledge as self-reported compared with how it is perceived by supervisors.

Figure 3. Total DSP value as self-reported compared with how it is perceived by supervisors. Here again, Supervisors perceive DSP value for competencies as lower than the DSPs report it for themselves. DSPs as a group value competencies very much.

Figure 4 shows one interpretation of how much the DSPs know: that acquired by adding their self-reported knowledge and values and their supervisors' assessment of their knowledge and values across all competencies. The data require standardization for regression analysis (as in Figure 1).

Figure 4. Histogram of both groups' knowledge and value totaled. The data are heavily skewed to the left, as is typical with Likert-scale data such as this.

Figure 5 consists of four separate histograms that make several aspects of the data clearer. Although total supervisors' perceptions of knowledge scores are approximately normally distributed, total self-reported knowledge scores are not: they are heavily skewed to the left. Regarding value, both groups are skewed to the left. DSPs report that they value competencies very highly, with what could be a few outliers at the bottom of the scale. This particular subset of the data raises the question of acquiescence or social desirability bias on the part of the DSP group, although perhaps they simply value the competencies as highly as this instrument reports.

Figure 5. Histograms of knowledge and value by group.

One supervisor in particular seemed to feel very negatively about how DSPs value the competencies; indeed, two DSPs reported low values for the competencies. Supervisors in general were mixed in their perceptions of DSPs' values for the competencies. The distribution of DSP value for competencies pairs interestingly with their knowledge: their value for knowledge outstrips their perception of having knowledge. This might indicate that DSPs would embrace more training. Supervisor data reflects that they do not understand how DSPs feel, and this could deter them from offering more training (assuming, of course, that training is the solution that DSPs seek and that it accomplishes the goal of increasing knowledge. This analysis calls the second of these two assumptions into question).

Categorical and Recoded Continuous Variables

Some data was collected as categorical information. In addition, in the case of interval variables with influential outliers, I used the SPSS software to calculate categories based on the actual spread of the data. The new variables were available for a different set of tests, tests that are robust to outliers. Tests of differences in means based

on variables with outliers can be problematic; this approach solved that problem.

Categorizing interval variables also solved another problem: not one of the variables in Table 3 is normally distributed. Tests that rely on normality (such as t-tests) are therefore suspect.

One hundred eighteen DSPs volunteered to complete the survey, of which 109 survey results were included. There were 97 female and 12 male participants, a proportion similar to that of the DSP population at large. The survey tool requested respondents to indicate one of four responses for ethnicity: African American, Hispanic, Caucasian, or Other. As a result of the low diversity these responses were put into dichotomous groups of either Caucasian or “Other.” Of the respondents, 98 were Caucasian and ten indicated one of the other ethnicities. Seven DSPs did not respond to the questions related to education.

Gender and ethnicity. Figure 6 shows categorical demographic information related to gender and ethnicity. One hundred six supervisors responded of which 90 results are included. Sixteen contained missing data. The supervisors ranged in age from 20 to 64 years, with an average age of 40 years. There were 78 female and 17 male supervisor participants. The majority, 94%, was Caucasian and five indicated “other” for ethnicity. Figure 1 depicts the gender and ethnicity of the research participants. So few people are in the “other” ethnicity category that it was dropped from further analysis.

Figure 6. Bar chart of gender and ethnicity of DSPs and supervisors.

Level of education. The education of the DSP group ranged from 48 (43%) with GEDs and high school graduates, 64 (57%) with some college education or a college degree (see Figure 7). The question regarding degree major was completed by 30 DSPs. More than half of the degrees were in the human services field, five were in an unrelated field, and six were in education or special education.

Figure 7. Bar chart of DSP and supervisor level of education.

The education of the supervisor group ranged from nine with GEDs or high school diplomas, 24 (7%) with some college and 59 (66%) were college graduates. Only

43 college graduate supervisors indicated the degree major completed. Human service degrees comprised 60%, while 21% were unrelated to human services. The supervisor group contained four registered nurses.

Work experience. The next figures contain visual interpretations of the data in Table 4, which follows the figures. Figure 8 contains bar charts both stacked and side-by-side, for the purpose of comparing DSPs' and supervisors' prior years of experience as DSPs. Roughly one quarter of the respondents in both categories gave no answer to this question. New DSPs tend to be relatively inexperienced. Of current DSPs, about 35% had one year or less of experience before beginning their current job. Among supervisors, this number is much smaller, just under 10%. A majority of the DSP supervisors reported having worked as DSPs before becoming supervisors of DSPs. Almost 43% of them worked as DSPs for two to six years before becoming supervisors. Their work experience as DSPs ranged from three months to twenty-five years; however, a large number of supervisors worked for one to three years. Among current DSPs, approximately 21% reported two to six years of prior experience. It is interesting that more than half of the DSPs who responded to the question reported less than seven years of experience. Only 14% reported twelve or more years of experience.

Figure 8. Bar charts of previous years as DSPs for DSPs and supervisors. This chart includes only years before coming to this job.

Experience at their current jobs is shown for both DSPs and supervisors in Figure 9. The vast majority of DSPs (44%) have two years or less experience at their current jobs, another indicator of high turnover. Just under 19% have lasted for three years. Only 37%, or a little over a third, have been at their current jobs for four years or less. By contrast, supervisors are spread more evenly. The distribution of their years suggests that those who make it past the five-year milestone tend to stay on.

Figure 9. Bar charts of years at their current jobs for both DSPs and supervisors.

Figure 10 provides information on how long DSPs have been working in the field of ID/DD. This is a relatively normal distribution. Only 10% have been in the field for less than one year. Fifteen percent have been in the field for 20 or more years (three people for close to 40 years). Despite the high turnover rate, DSPs stay in the field, perhaps because they like the work itself but not the work environment. The turnover might indicate large numbers of DSPs seeking a good working environment to do work they enjoy given the right circumstances.

Figure 10. Bar chart of total DSP experience, DSP estimates only, previous and current jobs added together.

Table 4

DSP years of experience

Years	Current Position		Previous Position		Total	
	N	%	N	%	N	%
< 1	7	7	26	31	9	9
1	15	17	3	4	5	5
2	17	19	8	10	11	11
3	16	18	5	6	9	9
4	5	6	5	6	7	7
5	5	6	6	7	7	7
Total, 5 or less	65	73	53	63	48	48
0 – 5	65	73	53	63	48	48
6 – 10	12	14	15	18	17	17
11 – 20	9	10	14	17	21	21
21-30	3	3	2	2	14	14
Total	89		84		100	

Figure 11 is a detailed breakdown of those from both groups with less than five years of DSP experience. Almost one-fourth of them have a year or less of experience and almost half have two years or less. Most of them have had three years of experience as DSPs. From this figure, it appears that three years could be a burnout point for DSPs—or it could be the point at which many move on to supervisory roles.

Figure 11. Breakdown of DSPs with five or fewer years of total DSP experience.

The DSP supervisors surveyed reported a total of 619 years of work experience with individuals with disabilities (Figure 12). This sum equates to an average of just less than 8 years of work experience each. Thirty-six supervisors, more than 20%, had work experience in the disability field of seventeen years or more, but they are, on the whole, more evenly spread out across experience levels than are DSPs, who are heavily weighted at the lower end of the scale.

Figure 12. Bar chart of years spent working with people with disabilities.

Training. A large number of DSPs and supervisors did not respond with the requested information regarding hours of training received during the first three months. Many respondents made comments about not remembering or said they were not sure of their answers. Figure 13 is a bar chart of their estimates. Most estimated that DSPs received more than 40 hours of training during their first three months. Figure 14 shows their estimates for the first year of training hours and Figure 15 shows their estimates for average yearly training.

Figure 13. Bar chart of DSPs' and supervisors' estimates of training during the first three months.

Figure 14. Bar chart of DSP and Supervisor estimates of training during the first year.

Figure 15. Bar chart of DSPs' and supervisors' estimates of average hours of training per year.

As can be seen in Table 5, there were no significant differences in the mean estimates of number of hours training for any of the three categories (a) training during the first three months, (b) training during the first year, and (c) average yearly training.

Table 5

Three t-tests of differences between DSP and supervisor estimates of training, equal variances not assumed

	<i>t</i>	<i>df</i>	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					<i>Lower</i>	<i>Upper</i>
First 3 Months	-.647	136.608	.519	-1.669	-6.770	3.431
First Year	.627	134.252	.532	1.644	-3.543	6.831
Average Yearly	-.792	126.389	.430	-2.096	-7.333	3.141

Individual competencies. Appendix I contains frequencies and histograms, one for each competency, first by knowledge and then by value. Supervisors consistently rated both knowledge and value lower than DSPs did.

Analysis of Data

Quantitative analysis of the survey results included calculating multivariate analysis of variance (MANOVA), t-tests, correlations, and multiple regression analyses.

Analysis of Variance

The data from the survey results were analyzed through a series of MANOVA using the two stakeholder groups and the mean scores for knowledge and value placed on each of the fifteen standard competencies, treating the individual competencies as interval rather than as categorical variables. The first MANOVA used the dependent variable “knowledge” and the independent variables “group,” “DSP,” and “DSP supervisors.” These results are outlined in Table 7. A second MANOVA was completed

with the dependent variables using the ratings for value placed on the fifteen competencies. These data are reported in Table 8.

In an effort to correct the multiple comparisons of the fifteen competencies, a Bonferroni correction was calculated ($.05/15$), and yielded a $p < .0033$, rather than the typical significance alpha level of $p < .01$ or $p < .05$ (Weisstein, 2010). Because of reducing the threshold for significance to .0033, the probability of a Type 1 error for the set of 15 competencies was less than .05.

Table 6

MANOVA: Comparison of Fifteen Knowledge Ratings, DSPs vs. Supervisors

Competency	Mean Ratings		F ^{ab}
	<i>DSPs</i>	<i>Supervisors</i>	
Participant Empowerment	8.29	7.31	20.12*
Communication	8.71	7.46	34.94*
Assessment	8.13	6.82	24.53*
Community/Service Networking	7.61	6.81	9.74*
Facilitation of Services	8.25	6.41	55.32*
Community Living Skills/Supports	8.73	7.50	30.07*
Education, Training, Self-Development	8.59	6.48	73.88*
Advocacy	7.82	6.74	15.91*
Vocational, Educational, Career Support	8.73	6.40	109.55*
Crisis Prevention/Intervention	8.32	7.33	13.46*
Organizational Participation	8.75	7.84	15.27*
Documentation	8.65	9.37	9.37*
Building and Maintaining Friendships and Relationships	8.84	7.86	23.64*
Provide Person Centered Supports	8.72	7.77	21.86*
Supporting Health/Wellness	8.72	5.33	5.33*

Notes: Hotelling-Lawley Trace = 1.06, F (16, 182) = 12.04; ^a df for each F ratio was 1, 197;

^bBonferroni – corrected alpha was .0033.

*p < .0033

Table 7

MANOVA: Comparison of Fifteen Value Ratings, DSPs vs. Supervisors

Competency	Mean Ratings		F ^{ab}
	DSPs	Supervisors	
Participant Empowerment	9.04	7.73	36.22*
Communication	9.39	8.11	46.64*
Assessment	8.89	7.57	31.23*
Community/Service Networking	8.91	7.46	41.46*
Facilitation of Services	9.08	7.02	76.31*
Community Living Skills/Supports	9.37	8.12	39.23*
Education, Training, Self-Development	9.10	7.41	50.63*
Advocacy	9.10	7.70	40.83*
Vocational, Educational, Career Support	9.37	7.43	84.14*
Crisis Prevention/Intervention	9.28	8.33	19.26*
Organizational Participation	9.22	8.03	31.28*
Documentation	9.17	7.89	26.72*
Building/Maintaining Friendships/Relationships	9.33	8.47	21.52*
Provide Person Centered Supports	9.28	8.38	21.97*
Supporting Health/Wellness	9.21	8.84	3.67

Notes: Hotelling-Lawley Trace = 0.80, $F(16, 182) = 9.20$; ^adf for each F ratio was 1, 197;

^bBonferroni – corrected alpha was .0033.

* $p < .0033$

The MANOVA results indicate that each of the fifteen competencies are significant for both the level of knowledge and the value placed on the competency, with the exception of value of Supporting Health and Wellness. All of the knowledge ratings of the

competencies were significant and the value placed on the Supporting Health and Wellness competency was not significant. DSPs and supervisors perceive the same about the value placed by DSPs on Supporting Health and Wellness. In all other areas, perceptions are different between the two groups.

Comparison of Discrepancies between DSPs and DSP Supervisors

Knowledge. Table 8 contains the mean scores as well as the differences between the two groups for all pairings concerning knowledge. The competencies are depicted from the highest difference of the means to the lowest.

Table 8

DSP and Supervisor Mean Differences on Competency Knowledge with Descending Mean Differences

Competency	DSP		Supervisor		Mean Difference
	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>	
Vocational, Education, Career Support	8.73	1.23	6.40	1.89	2.33
Education, Training, Self-development	8.59	1.53	6.48	1.93	2.11
Facilitation of Services	8.25	1.61	6.41	1.88	1.84
Assessment	8.13	1.76	6.82	1.95	1.31
Communication	8.71	1.40	7.46	1.58	1.25
Community Living Skills/Supports	8.73	1.30	7.50	1.86	1.23
Advocacy	7.82	1.89	6.74	1.89	1.08
Crisis Prevention / Intervention	8.32	1.72	7.33	2.08	0.99
Participant Empowerment	8.29	1.50	7.31	1.58	0.98
Friendships / Relationships	8.84	1.30	7.86	1.57	0.98
Provide Person Centered Supports	8.72	1.40	7.77	1.48	0.95
Organizational Participation	8.75	1.50	7.84	1.78	0.91
Community / Service Networking	7.61	1.85	6.81	1.75	0.80
Documentation	8.65	1.69	7.97	1.41	0.68
Supporting Health / Wellness	8.72	1.32	8.24	1.62	0.48

Notes: SD = Standard Deviation

DSPs rated the three highest knowledge categories as (a) Building and Maintaining Friendships and Relationships, (b) Organizational Participation, and (c) Community Living Skills and Supports. DSPs rated knowledge of Community and Service Networking as the lowest competency. DSP supervisors rated DSPs highest in knowledge for the competencies of (a) Supporting Health and Wellness, (b) Documentation, and (c) Building and Maintaining Friendships and Relationships. Supervisors rated DSPs lowest on knowledge of Vocational, Educational, and Career Support. The three largest disparities between the DSP and supervisor ratings of knowledge were (a) Vocational, Education, and Career Support; (b) Education, Training, and Self-development; and (c) Facilitation of Services.

Once the three largest disparities between knowledge ratings were identified, multiple regression analyses were completed for these competencies. As these data do not address the research questions specific to this research, results are reported in Appendix J.

Value. Table 9 outlines the value mean scores, as well as the differences between the two groups. The competencies are depicted from the highest difference of the value means to the lowest.

Table 9

DSP and Supervisor Means Differences on Competency Value with Descending Mean Differences

Competency	DSP		Supervisor		Mean Difference
	Mean	SD	Mean	SD	
Facilitation of Services	9.08	1.2	7.02	2.07	2.06
Vocational, Education, Career Support	9.37	0.94	7.43	1.95	1.94
Participant Empowerment	9.04	1.21	7.33	1.82	1.71
Education, Training, Self-development	9.10	1.36	7.41	1.97	1.69
Community / Service Networking	8.91	1.25	7.45	1.92	1.46
Advocacy	9.10	1.16	7.70	1.89	1.40
Assessment	8.89	1.17	7.56	2.12	1.33
Documentation	9.17	1.33	7.88	2.14	1.29
Communication	9.39	0.97	8.11	1.64	1.28
Community Living Skills / Supports	9.37	0.99	8.12	1.77	1.25
Organizational Participation	9.22	1.19	8.03	1.80	1.19
Intervention	9.28	1.13	8.33	1.88	0.95
Provide Person Centered Supports	9.28	1.13	8.37	1.59	0.91
Friendships / Relationships	9.33	0.97	8.46	1.62	0.87
Supporting Health / Wellness	9.21	1.04	8.84	1.63	0.37
DSP Competency Value (n=109)		Supervisor: Competency Value (n=90)			
SD = Standard Deviation					

DSPs consistently rated themselves higher than supervisors did in both knowledge of and value placed on the competencies. The mean scores from DSPs indicate the competency of Communication as the highest valued of the fifteen competencies. The next most highly valued competencies were Community Living Skills and Supports, and Vocational, Education and Career Supports. The competency the DSPs valued least was Participant Empowerment. Supervisors perceived DSPs to value the competency of Supporting Health and Wellness as highest, followed by Building and Maintaining Friendship and Relationships and Providing Person Centered Supports. The supervisor group rated Facilitation of Services as the lowest perceived competency of DSP supervisees.

A comparison of the mean differences placed on the value of the fifteen competencies shows the largest mean differences between DSPs and DSP Supervisors are (a) Facilitation of Services, (b) Vocational, Education, and (c) Career Support and thirdly, Participant Empowerment. Refer to Table 9.

Knowledge vs. value. In addition, DSPs and supervisors consistently scored value higher than knowledge as shown in Table 10. The exact meaning of these differences is uncertain and may vary from person to person. The paired-samples t-tests of each knowledge score vs. its accompanying value score have confidence intervals below zero in every instance, meaning that the differences are negative: that values are higher than knowledge in every paired instance. All results in the table are statistically significant at $p < .05$, and most are significant at $p < .001$. If the more stringent alpha of .0033 is used for a Bonferroni Correction, all differences are significant with the exception of Pair 12, Documentation.

Table 10

Paired Samples Test of Each Knowledge Score vs. Each Value Score

		Paired Differences		95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Lower	Upper			
Pair 1	K1 - V1	-.598	1.337	-.785	-.411	-6.310	198	.000
Pair 2	K2 - V2	-.673	1.381	-.866	-.480	-6.877	198	.000
Pair 3	K3 - V3	-.759	1.382	-.952	-.566	-7.743	198	.000
Pair 4	K4 - V4	-1.005	1.680	-1.240	-.770	-8.438	198	.000
Pair 5	K5 - V5	-.734	1.472	-.939	-.528	-7.032	198	.000
Pair 6	K6 - V6	-.633	1.211	-.802	-.464	-7.378	198	.000
Pair 7	K7 - V7	-.704	1.388	-.898	-.509	-7.150	198	.000
Pair 8	K8 - V8	-1.136	1.696	-1.373	-.899	-9.448	198	.000
Pair 9	K9 - V9	-.819	1.355	-1.009	-.630	-8.528	198	.000
Pair 10	K10 - V10	-.980	1.521	-1.192	-.767	-9.090	198	.000
Pair 11	K11 - V11	-.347	1.297	-.528	-.165	-3.771	198	.000
Pair 12	K12 - V12	-.251	1.657	-.483	-.020	-2.139	198	.034
Pair 13	K13 - V13	-.543	1.145	-.703	-.383	-6.689	198	.000
Pair 14	K14 - V14	-.583	1.264	-.760	-.406	-6.505	198	.000
Pair 15	K15 - V15	-.538	1.113	-.693	-.382	-6.812	198	.000

Regressions

Once the three highest differences of value ratings were identified, a multiple regression analysis was completed for these competencies. The results are displayed in Appendix J and Appendix K.

Table 11 contains details of regression analysis that describes the linear relationship between the dependent variable (total knowledge) and the predictors. Ethnicity was too homogeneous to use in the regression. Age was not a significant predictor. Gender, education, hours of training, and total experience as a DSP all predicted total knowledge, in the following ways:

- Being female predicts slightly more than 8 points *more* total knowledge.
- Each level of education predicts slightly more than 5 points *less* total knowledge.
- Each hour of training predicts a very slight *decrease* in total knowledge.
- Each additional year of experience predicts just under a point *more* total knowledge.

A linear relationship exists between total knowledge of the fifteen competencies and most of the measured demographics. However, this accounts for only 23.4% of the variance in total knowledge score. Hence, these variables alone do not account for the majority of the variance in total knowledge.

Table 11

Unstandardized Coefficients^a for Regression of Knowledge Score on Five Predictor Variables

Variable	Unstandardized Coefficients		t	Sig.
	<i>B</i>	<i>Std. Error</i>		
(Constant)	135.242	10.756	12.573	.000*
Age	-.186	.155	-1.194	.235
Gender	8.008	4.469	1.792	.076
Education	-5.040	1.827	-2.758	.007*
Total Hours of Training	-.012	.005	-2.379	.019*
Total DSP Experience	.714	.218	3.278	.001*

Notes: ^aDependent Variable: Total Knowledge of Competencies.

*p < .05

Table 12 shows the results of a similar regression analysis, this time of total value. Again, ethnicity was not used. Neither age, gender, nor hours of training were significant

predictors of total value. However, education and DSP experience did predict total value. Every step of increase in level of education predicts 6.5 points *less* of total value score. Experience predicts just under a tenth of a point *more* in total value. The demographic variables together predict 18.5% of the variance in total value. Hence, these variables do not account for a majority of the variance.

Table 12

Unstandardized Coefficients^a for Regression of Value Score on Five Predictor Variables

Variable	Unstandardized Coefficients		t	Sig.
	<i>B</i>	<i>Std. Error</i>		
(Constant)	145.841	11.487	12.696	.000*
Age	-.129	.166	-.777	.439
Gender	6.577	4.772	1.378	.171
Education	-6.508	1.951	-3.335	.001*
Total Hours of Training	-.002	.006	-.422	.674
Total DSP Experience	.09	.233	2.619	.010*

Notes: ^a Dependent Variable: Total Value of Competencies

* $p < .05$

It is likely that knowledge and value of the competencies go hand in hand: that if one has knowledge, one also has value for that knowledge, or that if one values a competency, one also acquires knowledge for it. Adding total value to the model for predicting total knowledge results in a much better model. R^2 in that equation is .57 (57% of the variance is accounted for). Value predicts a small *increase* in knowledge (.62, $p = .000$), education no longer has a significant effect, hours of training again predict a slight

decrease in knowledge (-.011, $p = .006$), and experience as a DSP predicts an *increase* (.337, $p = .049$). Adding total knowledge to the list of predictors for total value also improves that model ($R^2 = .542$). Knowledge predicts a very slight *increase* in value (less than a point, $p = .000$) and age and gender have no effect, but education is notable, if not significant ($p = .055$), in that it predicts a 3-point *decrease* in total value. Neither training nor experience predict value if knowledge is part of the equation.

Correlations

Correlations provided information regarding how the individual competencies relate to demographics. Correlations can be reliable because they are robust to non-normal data. By using partial correlations, it was possible to use both DSP and supervisor reports of competencies. According to this analysis (Table 13), age correlates negatively with knowledge of Community Living Skills and Supports, Advocacy, and Documentation. The competencies reported in Table 13 were selected based on the results of the regression analysis. It must be noted that these results are exploratory only because of Type 1 error inflation.

Table 13

Correlations between Competencies and Demographics.

		Age	Gender	Education	Years Working with Disabled
Value: Participant Empowerment	Corr.	-.065	.092	.012	.154
	Sig.	.403	.232	.876	.044*
Value: Communication	Corr.	-.018	.030	.042	.150
	Sig.	.820	.696	.587	.051†
Knowledge: Community and Service Networking	Corr.	-.143	-.102	.056	-.107
	Sig.	.062†	.187	.466	.164
Knowledge: Community and Living Skills	Corr.	-.179	-.045	-.018	-.049
	Sig.	.019*	.557	.815	.523
Knowledge: Education, Training, and Self-development	Corr.	-.031	.085	-.176	.012
	Sig.	.689	.272	.022*	.873
Value: Education, Training, and Self-development	Corr.	.001	.025	-.145	.081
	Sig.	.987	.742	.059†	.293
Knowledge: Advocacy	Corr.	-.163	.003	.039	-.075
	Sig.	.034*	.965	.609	.333
Value: Advocacy	Corr.	-.146	.028	.019	.069
	Sig.	.057†	.715	.808	.368
Value: Vocational, Educational, and Career Support	Corr.	.004	.009	-.027	.151
	Sig.	.962	.910	.728	.049*
Value: Organizational Participation	Corr.	.015	.097	-.153	.060
	Sig.	.842	.209	.047*	.434
Knowledge: Documentation	Corr.	-.191	-.060	.089	-.023
	Sig.	.013*	.437	.248	.762
Knowledge: Building and Maintaining Friendships and Relationships	Corr.	-.146	.062	-.158	-.101
	Sig.	.057†	.419	.039*	.191
Value: Provide Person-centered Support	Corr.	-.014	.122	-.081	.156
	Sig.	.853	.113	.292	.042*
Knowledge: Supporting Health and Wellness	Corr.	-.076	.140	-.157	-.015
	Sig.	.325	.069†	.041*	.844
Value: Supporting Health and Wellness	Corr.	-.056	.167	-.111	.068
	Sig.	.468	.029*	.151	.379

*p < .05; †p < .10.

Other correlations of interest that do not rise to the level of statistical significance (meaning that they are meaningful only for this particular population) are that age correlates negatively with knowledge of Community and Service Networking, negatively with a value for Advocacy, and negatively with knowledge of Building and Maintaining Friendships and Relationships. Women have a higher value for supporting health and wellness than males do and their knowledge may be slightly higher than males. Education correlates negatively with knowledge of Education, Training, and Self-development, negatively with a value for Organizational Participation, negatively with knowledge of Building and Maintaining Friendships and Relationships, and negatively with a knowledge of Supporting Health and Wellness. In this population, education correlated negatively with a value for Education, Training, and Self-development. Years working with individuals with disabilities correlates positively with values for Participant Empowerment, for Vocational, Educational, and Career Support, and for Providing Person-centered Support. In this particular population it correlates positively with a value for Communication.

Table 14 contains only the significant findings, in a slightly different format for the sake of clarity. From Table 14 it is clear that age and education work against certain knowledge and values. Experience, on the other hand, has no detrimental effects, but it does have a positive relationship with certain values. No other demographics predict competencies positively except for being a female predicting a value for Supporting Health and Wellness.

The correlations were tested for statistical significance using the .05 level of significance for each test. Since there was no correction for inflation of Type 1 error,

some of the significant tests may not be replicable. These correlations should be viewed as exploratory analysis.

Table 14

Summary of Correlations between Knowledge and Value for Competencies and Demographics.

Demographic	Direction	Knowledge or Value?	Competency
Age	-	Knowledge	Community and Service Networking
	-	Knowledge	Community and Living Skills
	-	Knowledge and Value	Advocacy
	-	Knowledge	Documentation
	-	Knowledge	Building and Maintaining Friendships and Relationships
Gender	+,F	Knowledge and Value	Supporting Health and Wellness
Education	-	Knowledge and Value	Education, Training, and Self-development
	-	Value	Organizational Participation
	-	Knowledge	Building and Maintaining Friendships and Relationships
	-	Knowledge	Supporting Health and Wellness
Experience	+	Value	Participant Empowerment
	+	Value	Communication
	+	Value	Vocational, Educational, and Career Support
	+	Value	Provide Person-centered Support

Additional Competencies

The survey for DSPs and DSP supervisors included the question, “Are there additional competencies not listed above you think should be added? If so, please write them below.” Only a few DSPs and supervisors replied to this question. The results were categorized into actual suggestions for additional competencies, dilemmas expressed, and opinions or comments regarding training.

Behavior supports, nutritional value, computer training, autonomy and independence, and family dynamics were suggestions for additional competencies of benefit for DSPs. One supervisor suggested, “Understanding how to empower those we support,” which is already a current competency entitled Participant Empowerment. Another DSP suggested autonomy and independence, which is the basis of the Participant Empowerment competency. Both DSPs and supervisors mentioned family dynamics as an additional competency needed. The topic of family dynamics is addressed in two current competencies, Building and Maintaining Friendships and Relationships and Community Living Skills and Supports. Both of these competencies recognize the importance of family and family relationships. The suggestion of nutritional value is covered in the competency of Supporting Health and Wellness. Nevertheless, it is interesting that DSPs and supervisors did not perceive these competencies as being on the list. A number of DSPs and supervisors mentioned additional competencies that were categorized as dilemmas. These responses included such things as differences of opinions with guardians, dealing with power struggles, and how to safeguard the individual’s privacy. Several DSPs and supervisors made comments about methods of training rather than suggesting additional competencies. One trend had to do with the benefits of face-to-

face training and training completed in natural environments as opposed to online training. This is perhaps an area for further study, and might shed some light on why training has a negative effect, if any, on knowledge of and value for competencies.

The second open-ended question on the survey was, “Is there anything you would like to add?” The participant responses covered a variety of topics; however, the comments were categorized into personal information and training comments. Several DSPs and supervisors mentioned family members with disabilities. Others mentioned formal education accomplishments. DSPs and supervisors made numerous comments and remarked upon their inability to remember how much training they received. Many contributions were positive about the topics covered and the amount of training they received. Several people mentioned that they have daily training opportunities, but these comments cannot be taken as representative of the entire group.

Summary of Chapter 4

This chapter reported the research data and findings. The research findings dictated the rejection of the two proposed null hypotheses and answered all of the research questions. A significant difference was identified between the DSP group and the supervisor group with regard to the perception of knowledge and the value placed on the fifteen competencies. In addition, certain demographics predicted both knowledge and value—in the case of education, negatively. Demographics also predicted knowledge and value for some specific competencies.

The next chapter will discuss the research findings as related to the research questions, the literature review, and the theoretic framework.

CHAPTER V

SUMMARY AND CONCLUSIONS

This final chapter contains discussion of the results, conclusions about this current research, identification of research limitations, and recommendations for future research. Chapter V interprets the survey results presented in Chapter IV.

Overview

A shortage of trained staff available to provide direct, hands-on supports to people with intellectual and developmental disabilities (DSPs) has had a severe impact on the quality of life for this vulnerable population. This national workforce crisis is occurring concurrently with increased understanding of the benefits of community-based supports and an expansion of these services for this population. Staff shortages are costly and inefficient for provider agencies. More important and less easily measured are the hardships these factors create for people who are the intended recipients of these much needed services. Two of the contributing causal factors are high turnover and vacancy rates and inadequate staff training.

Recruiting and retaining qualified DSPs is of critical concern, especially during this time of increasing demand. Staff demands are increasing concurrently with an increase in staff turnover rates. Aging caregivers are fueling these staff demands, the increased lifespan of persons with disabilities, and class-action lawsuits.

Statement of the Problem

Employees do not remain with a job when they do not feel adequately trained and lack the confidence to perform (Braddock & Mitchell, 1992; Department of Employee Relations, 1989; Larson & Lakin, 1992, 1999; Larson, Lakin, & Bruininks, 1998). Organizations in this field assume that DSPs generally agree and accept the CSSS competencies because these are the standards endorsed by the NADSP. However, without sufficient knowledge of the value and acceptance DSPs place on each of the competencies, employers may not be providing the most effective staff development. Likewise, what remains unknown is the employers' value and acceptance of the CSSS competencies and the employers' intent of training DSPs on these competencies. Without appropriate information, employers may make faulty assumptions about the training needs of DSPs, and this may contribute to higher DSP turnover. Even if trained, if DSPs do not value the competencies, then training may be less effective, contributing to high turnover.

The purpose of this current research study was to identify DSPs' level of knowledge of, and value placed on, a validated set of 15 competencies recognized by the National Alliance of Direct Support Professionals (DSPs). Further, this research identified how this DSP data correlates with the perception of supervisors of DSPs regarding the knowledge and value placed on the competencies by DSPs.

Hypotheses and Research Questions

The research breaks down into two main hypotheses and the research questions that lead to analysis of these hypotheses:

H₀: There are no significant differences in the perceptions of DSPs and DSP Supervisors regarding the knowledge of the standard competencies for a successful DSP;

H_A: Significant differences exist between perceptions of DSPs and DSP Supervisors regarding the knowledge of the standard competencies for a successful DSP.

Two research questions relate to these hypotheses:

- a. What do DSPs self-report as their level of knowledge of each of the fifteen standard competencies? and
- b. What do DSP Supervisors report as their perceptions of DSPs' level of knowledge of each of the fifteen standard competencies?

H₀: There are no significant differences in the perceptions of DSPs and DSP Supervisors regarding the value placed on the standard competencies of a successful DSP.

H_A: Alternative Hypothesis 2: Significant differences exist between perceptions of DSPs and DSP Supervisors regarding the value of the standard competencies for a successful DSP.

Related research questions:

- c. What do DSPs self-report as the value they place on each of the fifteen standard competencies?
- d. What do DSP Supervisors report as their perceptions of the value DSPs place on each of the fifteen standard competencies?

H₀: No linear relationship exists between knowledge and value of the fifteen competencies and age, gender, ethnicity, education, work experience, and amount of training.

DSPs were to self-report and supervisors were to report their perceptions of the DSPs they supervise.

Discussion of Findings

The five research questions guided this study towards an analysis of the two main hypotheses. Hence the following discussion addresses each of these research questions one by one.

What do DSPs self-report as their level of knowledge of each of the fifteen standard competencies?

Consistently, DSPs' ratings were higher than supervisors' ratings on the level of knowledge of the competencies. This research does not provide a foundation for finding potential reasons for this disparity; however, personal experience in the field suggests the following possibilities:

- It is likely that the DSPs understand their roles better than the supervisors do.
- It is possible that some DSPs have not come to realize what they do not know yet, and thus are likely to self report a higher level of knowledge than they really know.
- Perhaps the DSPs are more committed to the position and to becoming competent.
- Many of these DSPs work in the community, away from direct supervision, so perhaps the supervisors lack the data necessary to grasp fully DSPs' competence.

As reported in Table 8, DSPs rated themselves highest on the competencies of Building and Maintaining Friendships and Relationships and on Organizational Participation. The DSPs rated Community and Service Networking, and Advocacy as the lowest two competencies in terms of knowledge.

The evolving shift in the field of ID/DD from larger to smaller groupings is requiring changes in the role of a DSP. This trend is visible in smaller residential settings as well as in vocational and day programs (Wehman, Revell, & Kregel, 1998). These changes have caused the roles and responsibilities of a typical DSP to change from that of a primary caregiver to a more active, community-based provider. The role is more complex, having less direct supervision, with fewer coworkers for input and companionship and more decision-making power as DSPs function independently in the community.

What do DSP Supervisors report is their perceptions of DSPs' level of knowledge of each of the fifteen standard competencies?

This research revealed some important information about the perspective of supervisors. Supervisors rated every competency lower than did the DSPs (Table 9). Supervisors rated as highest DSPs' level of knowledge of Supporting Health and Wellness, followed by Documentation. Supervisors rated Vocational, Educational and Career Support and Facilitation of Services as the lowest competencies. The mean differences in these ratings from largest to smallest identify gaps in knowledge and may provide insight into DSP training needs. For example, one focus of training may be the topic Supported Employment: it is the largest difference in perceived knowledge. It falls under the competency of Vocational, Education and Career Support. Low competency

related to Vocational, Education may be one of the causal factors for Kentucky ranking low for individuals accessing Supported Employment, at 21%, (Braddock, D., Hemp, R., & Rizzolo, M. (2008).

One might assume that supervisors of DSPs would tend to go to the middle of the rating when evaluating the group of DSPs supervised. A supervisor might determine that supervisees fall in a typical bell shaped curve and hence gravitate to the middle ratings. Other supervisors might believe their supervisees are extremely well-trained and therefore gravitate to the higher ratings, while others may evaluate in the direct opposite. It is likely that there is some error of central tendency wherein the supervisors rated their DSP supervisees toward the midpoint, to avoid making hard judgments (Gall, 1996). There is research to support supervisors tend to be more critical and report lower ratings than self-reports. One such study by Harris and Schaubroeck (1988), indicated the self-ratings demonstrated significantly higher levels of favorability than supervisory assessments (Harris and Schaubroeck, 1988). Balancing the central tendency, however, are biases inherent in scalar questionnaires: social desirability bias and agreeableness.

A comparison of the average scores for the DSP group and the supervisor group indicates the second largest differences between their perceptions lies in the level of knowledge for Education, Training and Self-development. It is important to note the competency related to Education, Training and Self-development is the sole competency focused on the DSP and efforts toward developing skill level.

This discrepancy between DSPs' and supervisors' perceptions of the knowledge level of the competencies could create problems with training. These differences in perception suggest some further questions for supervisors and DSPs to consider while

planning DSP training. Are the most experienced DSPs and supervisors less willing to integrate new training into their work and knowledge? Are there some more experienced supervisors who do not value newer methods of approaching support in this field? The results of the correlations reported in Table 13 indicate that they may be wise to rely on their own experience rather than on training. On the other hand, perhaps those who rely on training rather than experience might have difficulty communicating with a supervisor who has many years of experience in the field but who has not kept up with or does not value the current training. This might suggest the need for additional training or re-training of supervisors—or indeed, the results of this study indicate that training would benefit from being more in line with experience than with higher education programs.

One consideration for the future is the strategy of involving parents and natural support providers in the training process. Increased knowledge and understanding of the fifteen competencies for all team members may provide a better support system for all involved.

What do DSPs self-report as the value they place on each of the fifteen standard competencies?

DSPs consistently scored the value of the fifteen competencies higher than the level of knowledge (Table 10). The most highly valued competency was Building and Maintaining Friendships and Relationships. DSPs rated Assessment as the least valued competency, followed by Advocacy.

The competency with the closest alignment between value and knowledge was Organizational Participation, with a mean difference of .47. DSPs rated this competency among the higher grouping on both value and knowledge. This close alignment was

particularly interesting as the role of the DSP is often seen as working in isolation and away from the rest of the organization. Today's DSP has an active, community-based role, with less direct supervision and fewer coworkers, who functions more independently in the community (Prouty, Smith, & Lakin, 2004, Wehman, Revell, & Kregel, 1998). It is interesting to note the supervisors' perception was very closely aligned between the value and knowledge on Organizational Participation.

The DSP mean difference between value and knowledge on Organization Participation was closely followed by (a) Building and Maintaining Friendship and Relationships and Supporting Health and Wellness at .49, (b) Education, Training, and Self-development, and Advocacy at .51, and (c) Documentation at .52.

The competency rated by DSPs with the largest difference between value and knowledge was Community Service and Networking. This competency was rated the second from the bottom of the value rating, with a mean of 8.91 and the lowest knowledge rating, with a mean of 7.61, yet the largest mean difference of 1.30. What are the implications of this DSP gap between mean knowledge & value scores? Given the average years of service for the DSP participant group was nine years, six months, which appears to indicate that even with this large amount of experience, DSPs continue to perceive their level of knowledge regarding community services as insufficient. This begs the question as to whether this low perception of knowledge of Community Service and Networking is actually a lack of knowledge or a lack of confidence in knowledge. Additional questions and discussions with DSPs would be necessary to answer this question.

What do supervisors of DSPs report as their perceptions of the value DSPs place on each of the fifteen standard competencies?

As reported in Table 10, supervisors rated their perception of the DSPs' value ratings to be lower than the value the DSPs placed on each of the fifteen competencies. Supervisors perceived DSPs to rate Supporting Health and Wellness as the highest valued competency. While this competency was not one of the most highly valued by the DSPs, Supporting Health and Wellness had the least mean difference between the value ratings by supervisors and DSPs.

Supervisors perceived the DSP supervisees to have the least value for the competency of Facilitation of Services. The DSPs actually rated the value of Facilitation of Services fourth from the bottom; however, this competency was the largest mean difference between the value ratings of DSPs and supervisors. The competency DSPs rated as the least valued was Assessment. The DSPs rated Communication as the most highly valued competency.

The level of knowledge of, and value placed on the fifteen competencies were significantly related between both participant groups. The one competency in which the supervisors perceived the knowledge to exceed the value rating was Documentation. The largest difference between supervisors and DSPs was Supporting Health & Wellness, which yielded a gap of 3.51. Next largest difference was Vocational, Educational & Career Support, at 1.02. The closest alignment of value and knowledge was Organizational Participation. This was also the same with the DSP responses.

Is there a relationship between the value and knowledge of the fifteen standard competencies and age, gender, ethnicity, education, work experience, and amount of training?

Each of these factors is addressed individually, then as a group of predictors. The age of the DSP and supervisor groups was very similar. The DSPs ranged in age from 20-66, with an average of 39 years, six months. The supervisors' age range was 20-64 with an average age of 41 years. Of the two participant groups, 29 did not respond to the question regarding age.

Both the DSP and supervisor groups were disproportionally comprised of females. Of those who replied to the gender question, 97 DSPs and 78 supervisors were female. Only 12 DSPs were male and 17 supervisors were male.

Eight DSPs and 21 supervisors did not complete the question regarding ethnicity. There was little diversity between both groups and ethnicity was disproportionately Caucasian. This research included 98 Caucasian DSPs and 78 Caucasian supervisors. These groups of participants were so homogeneous that ethnicity was omitted from the regression analysis.

With regard the education, the DSPs reported 48 had a GED or a high school diploma. It should be noted the minimum education for the Supports for Community Living Waiver is a GED or high school diploma. The DSPs reported 64, or more than half had some college or were a college graduate. Many DSPs did not report the major focus of degree. However, for the ones who responded, only five were in an unrelated field, and therefore the majority were either degreed in human services or education/special education.

The demographics of this group indicated supervisors of DSPs have more education than DSPs. All except nine supervisors reported some college or college graduate status. This research indicated an inverse relationship between the respondents' education and the level of knowledge reported on the competencies. This was a surprising research result. Without further research, the causal factors cannot be known. However, there are several perspectives to be considered. Perhaps the more education, the more one might over-analyze before responding. DSPs and Supervisors with college education may be looking at the competencies from a different perspective that of school and educational factors, more so than strictly experience. People with higher education may have felt more confident & motivated to respond. Educational programs might lag behind DSP practice. Experience seems to have a more positive effect than education does, which is all the more reason to keep DSPs with experience in the field.

Perhaps the economic trends with unemployment in Kentucky at 10% may contribute to the high prevalence of college graduates working as DSPs and supervisors of DSPs. (U.S. Department of Labor, Bureau of Labor Statistics, 2010). However, it is also possible that as the DSP recognition and role has developed, it is a more highly valued profession, for college graduates.

DSP participants were largely new in the position. It is most revealing to see the total number of years of work experience as a DSP. When combining the experience in the current DSP position with the experience in previous DSP positions, 59% of this group worked one year or less. This research supported the findings that Direct Support Professionals do not remain with a job when they do not feel adequately trained and lack

the confidence to perform (Braddock & Mitchell, 1992; Department of Employee Relations, 1989; Larson & Lakin, 1992, 1999; Larson, Lakin, & Bruininks, 1998).

However this DSP group was unique in that some of the participants had many years of service, which increased the overall average length of service. This group was comprised of 65% who had worked up to five years as a DSP. Fewer than 17% of this group worked between 6 and 20 years, and 14% worked as a DSP for more than 20 years. For this reason, this group may not be considered a true representative sample of DSPs. Some of the DSPs and supervisors who volunteered to participate in this survey are not representative because it is partially comprised of veterans, with longer work experience than typical. For the most part, DSPs are either relatively new to the position, or they have been employed as a DSP for a long time. However this group continues to rate the skill level less than the value they place on the competencies.

According to Hewitt & Larson (2008), the average age of DSPs working in Personal and Home Care was 44 years and 35 years for those working in Community Vocational settings. This group of DSPs was 39 years. The gender of these groups was predominately female, 90% and 81% respectively. This group of DSPs was 89% female. Likewise, in the Hewitt data, the DSPs were mostly Caucasian, 45% and 59%, while this research group was 91% Caucasian and 9% other. Other ethnicity was 23% African American and 17% other, Hispanic, Spanish, and Latino for the Personal and Home Care group and the Community Vocational settings was 59%, 22%, and 8%. There was no educational data for the group of DSPs working in Personal and Home Care; however, the DSPs in Community Vocational settings was 50% with some college and 35% were college graduates. This research group's education level was 43% were high school

graduates or recipients of a GED, 27% had some college, and 30% were college graduate. The DSP research group's work experience ranged from, three months to 30 years, 11 months, with an average of 9 years, 6 months.

Regarding the amount of training the DSPs received, questions were asked about training during the first year as a DSP and then the average number of hours of training you receive annually. More than half of the DSPs reported receiving less than 50 hours of training in first year and supervisor responses supported this response. Only 17% of the DSPs reported 50 hours of training during the first year of employment. It must be noted that the maximum response to the training related questions was 50 hours and this could be a limitation of this study. There was a discrepancy in the DSP and supervisor responses to the average annual training received. Only 4% of DSPs reported receiving an average of 50 hours of training on an annual basis, while 17% of supervisors of DSPs reported 50 hours of training provided.

In general, this group of participants may not represent a typical group of DSPs. It is interesting to consider the concept of self-selection to participate in this research. Did DSPs respond because of their high level of commitment to the position? This research group did not involve enough male participants, and thus there was only minimal gender distribution. However, in previous research that was highly controlled for such factors as education level, online access, geographic location, occupation and income, found significant evidence that females disproportionately respond more frequently (Smith, 2008). This was little ethnic diversity among this group of DSPs. Also some of this group appears to have more DSP experience and more education than the typical DSP.

This research supported an acceptance of both alternative hypotheses: that DSPs and supervisors perceive DSPs knowledge of and value for the fifteen competencies differently. In fact DSPs perceive themselves to have higher knowledge and value than supervisors do. The research also revealed other interesting findings, such as which specific knowledge and values were rated highest by DSPs and supervisors, that DSPs and supervisors rated value higher than knowledge for every pairing, that education level negatively predicts knowledge and value for several competencies, that experiences does no harm and provides a benefit in terms of value. The data set is extremely rich and many more conclusions might be drawn from it—but that is outside the scope of this dissertation.

Limitations of the Research

A limitation of this research could be the self-selection of the respondents. The participants were volunteers who decided to participate in the survey, either online or with a paper survey. This researcher could not control the selection process (Bethlehem, 2010).

Because of the anonymous responses in this research, it is not possible to pair DSP responses with the DSP's direct supervisor, and this created a major limitations. This inability to pair DSPs with their supervisors weakens the generalizations that may be made. It is not possible to know if the DSP supervisors were rating specific DSPs they directly supervise, or whether the supervisors are rating the generic DSP. Future research should aim for a sampling in which there is a direct pairings of DSPs with their direct supervisors.

Another limitation of this study may be the composition of the participants. The respondent groups, both DSPs and supervisors, are too homogeneous. While there was diversity with age and years of DSP experience, the low gender and ethnic diversity make it difficult to generalize and draw good conclusions. The homogeneity of the groups may not reveal important differences in the perspectives of the level of knowledge of and the value placed on the fifteen competencies.

A limitation of this study was the number of hours of training on the survey. The drop down menu had a maximum of 50 hours for each of the three questions related to the amount of training. In order to accommodate this limitation, any response larger than 50 hours was recorded as the maximum of 50 hours.

Recommendations for Future Research

Plans are in place to transition the required training for the *Supports for Community Living Waiver* to an online training curriculum, entitled *The College for Direct Support*. This training is a national curriculum, based on the validated competencies involved in this research and considered necessary for DSPs in the field of Intellectual and Developmental Disabilities. Even though it is a national curriculum, it can be modified and include additional training specific to Kentucky. There is good evidence that staff development is especially effective when the learner can control the pace of the learning, as well as, when and where the learner chooses. (Hewitt, p.167). It would be interesting to see the same population surveyed after the implementation of the online training. This recommended research could measure the efficacy of online training, as well as the knowledge and value placed on the fifteen competencies. The current study could be viewed as a baseline or before the intervention of College for

Direct Supports, followed by a replication of this study for comparison. A before and after comparison may impact improvement and the extent of the improvement.

This research focused only on DSPs and supervisors working in the field of intellectual disability and developmental disabilities, in community settings. Additional research may involve DSPs working with the elderly, children in special and regular education classrooms, or persons with physical disabilities and no intellectual disabilities. Further research may include replicating this study with DSPs & supervisors in facilities, and with other population groups. Additional research could explore how supervisors of DSPs rate themselves on the knowledge and value of the competencies. Also, additional attention could focus on supervisors who were first DSPs before becoming a supervisor.

Analysis of responses to the open-ended question regarding suggestions for additional competencies was disappointing. Technology was the one suggestion made by one individual response. However, the limited number of DSPs who responded electronically, may be evidence of the need for additional knowledge with computers

The survey for DSPs and supervisors of DSPs included the following question, “Are there additional competencies not listed above you think should be added? If so, please write them below.” Responses to this question provided several recommendations, however some of those recommendations were already included in the existing 15 competencies. Several of the participant suggested competencies, such as behavior supports, nutritional value, computer training, and family dynamics, should be further studies. Are these suggested competencies already embedded in the existing competencies? At a minimum these suggestions are worthy of consideration for future effective training for DSPs.

It may be beneficial if future research focused on the personal background of the DSPs and Supervisors, rather than limiting to education and work experience. This suggested research could include such questions, “Are you a parent? Are you a parent of a child with disabilities? Do you have a family member or close personal relationship with someone who has disabilities?”

Now that we know the level of knowledge and value the DSPs and supervisors place on these standard competencies, further research could examine the gaps between the value and knowledge of the competencies. This research could reveal the best focus for future training initiatives.

Further research should include a more thorough examination of how DSPs & supervisors of DSPs actually learn and transform their perceptions of their work and the people with whom they work. For example, what are the contributing factors that facilitate a DSP or supervisor to move from thinking in a deficit model, in which the focus is on the things the person cannot do, to a capacity model in which the DSP focuses on the things the person can do or has the potential to learn. When some of these facets of adult learning can be better understood, then appropriate revisions can be made to the training requirements for DSPs and supervisors of DSPs. These revisions will need to be made to the general content of the curricula and perhaps more importantly to the methods in which is the training is presented to facilitate more of a transformation in the adult learners.

There is much promise in a more comprehensive understanding and subsequent implementation of transformative learning theory for the improvement of the training and

learning experiences of DSPs and supervisors. The research and writing of Jack Mezirow and Patricia Cranton could facilitate this process, (Mezirow, J. 1991, Cranton, P. 1994). In addition to the potential benefits of revision to the content and methods of presenting the required training for DSPs and supervisors, it may also be beneficial to examine the methods of evaluating the training. Do we know if DSPs and supervisors are learning and implementing learning after completing the training? Does anything change in the work place as a result of the DSP going through completing the required training? Additional research and exploration on the evaluation of required training could be enlightening and present additional ideas for modifying the required training content and methods of training. The writings of Donald Kirkpatrick on the Four Levels of Training Evaluation should be further explored to determine potential training modifications for DSPs. Kirkpatrick's four levels of evaluation are the standard accepted in the training field.

Kirkpatrick in *Level 1 Reaction* explores the learners' reaction to the training and would explore how the learner liked or thought about the learning experience. The current evaluation practice uses this level. *Level 2 Learning* evaluates what improvement the learners made in terms of their skills, knowledge, or attitude, as a result of the training. This level could be determined by asking DSPs and supervisors to take a pre-test and a post-test. While this still falls short, it would be an improvement. Kirkpatrick's *Level 3* is the evaluation where it appears the most could be learned through further research on the DSP competencies. Kirkpatrick's *Level 3 Transfer* evaluates if the learner will change his/her behavior as a result of the training. Will the newly learned skills, knowledge, or attitudes transfer into the work place and day-to-day operations? This level truly assesses the training's effectiveness. It is more difficult to evaluate, however it

could be incorporated into ongoing DSP evaluations, including observing the DSPs and DSP supervisors during engagement in typical work. Kirkpatrick's *Level 4 Results* evaluates the success of the training in terms of the bottom line, taking into account such things as increased productivity, increased quality, decreased costs, reduced accidents or incident reports, things that would contribute to improved financial outcomes. This Level is the most challenging to assess and is not addressed in these recommendations, other than to mention the indications that improved learning and skill development leads to lower turnover and lower vacancy rates.

This research and findings serve to capture the complexities of the Direct Support Professional workforce and their training needs. In light of the current crisis of recruitment and retention in the DSP workforce, it is imperative to aggressively implement options to correct the training needs or this crisis will only continue and worsen.

This research and findings serve to capture the complexities of the Direct Support Professional workforce and their training needs. In light of the expanding crisis of DSP recruitment and retention, fueled by aging caregivers, the increased lifespan of persons with disabilities, and state and national litigation, such as the 1999 Supreme Court decision in *Olmstead v. L.C.* and the 2001 New Freedom Initiative, it is imperative to aggressively implement immediate corrective action. While the full impact of the 2010 Affordable Care Act is unknown at this time, it will likely have far-reaching implications regarding the need for DSPs and worsen this crisis.

In 2001, the Bureau of Labor Statistics projected a 63% increase in the need for DSPs through 2010 (Bureau of Labor Statistics, 2001). In Kentucky, there were an

estimated 10,769 individuals with I/DD living with aging caregivers in 2006 (Braddock, Hemp, & Rizzolo, 2008). As this group of caregivers' ages, it is imperative to provide additional community supports to keep their relatives at home as long as desired. It is equally critical to expand community residential supports to meet the needs when these aging caregivers can no longer provide for their relatives (Braddock, 1999). Community service providers must have a trained and qualified workforce to meet this current and future demand.

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APPENDICES

Appendix A

Waiver Training Requirements

Department for Behavioral Health, Developmental and Intellectual Disabilities, Supports for Community Living Waiver Training Requirements

Division of Developmental and Intellectual Disabilities (DDID) SCL Screening and Training Requirements

Requirements for all newly hired staff and volunteers:

- Negative TB risk assessment (or test if applicable) completed in the past 12 months and received within 7 days of the date of hire or date of volunteer services;
- A criminal records check from the Kentucky Administrative Office of the Courts (AOC) completed prior to employment;
- A central registry check completed within 30 days of the date of hire; and
- A nurse aide abuse registry check completed prior to employment.

Training requirements for all staff:

Level I: Shadow another staff or family member/guardian/caregiver (at least 18 years old)

Level II: Independent functioning without ability to administer medications.

Must have following training prior to working alone:

- First Aid (excluding licensed or registered nurses)
- CPR
- Crisis Prevention and Management
- Identification and prevention of abuse, neglect, and exploitation
- Rights of persons with disabilities
- Individualized instruction of the needs of the SCL recipient to whom the staff provides support

Level III: Independent functioning with ability to administer medication.

Must have the following training prior to working alone:

- Medication administration training per cabinet-approved curriculum

- Medications and seizures
- First Aid (excluding licensed or registered nurses)
- CPR
- Crisis Prevention and Management
- Identification and prevention of abuse, neglect, and exploitation
- Rights of persons with disabilities
- Individualized instruction of the needs of the SCL recipient to whom the staff provides support

Core training:

All employees must complete core training, consistent with a DDID-approved curriculum, no later than 6 months from the date of employment.

Training requirements for volunteers:

- Orientation to the agency
- First Aid (excluding licensed or registered nurses)
- CPR
- Individualized instruction of the needs of the SCL recipient to whom the staff provides support

8/3/2009 DEPARTMENT FOR BEHAVIORAL HEALTH, DEVELOPMENTAL AND INTELLECTUAL DISABILITIES Division of Developmental and Intellectual Disabilities (DDID) 8/3/2009

Case Management Training:

All newly hired case managers must complete the DDID-approved Case Management training within the first 6 months of the date of hire or as soon as possible following the sixth month of hire if the case manager is unable to complete training within the first 6 months due to the unavailability of the training.

Agency trainer qualifications: training	Trainer qualification	Recommended training length
CPR/First Aid	As per current SCL Waiver regulation	Per instructor certification
Medication administration	As per current SCL Waiver regulation	6–8 hours
Medication and SEIZURES	As per current SCL Waiver regulation	3 hours
DMR crisis prevention and intervention AND/OR Crisis management	<p><u>DDID Crisis Prevention and Intervention</u></p> <p>Attend DDID Crisis Prevention and Intervention Training of Trainers AND have a H.S. Diploma with 2 years ID/DD experience or be qualified as a SCL IDP.</p> <p><i>Crisis Management</i></p> <p>Per qualifications of system utilized (MANDT, CPI, SCIP, NVCR, etc.)</p> <p><i>Note: Crisis Management systems (not Crisis Prevention/De-escalation) to be determined by the agency. Any system teaching restraint should be utilized on an individualized basis, and should be taught as emergency safety procedure and only utilized as a last resort in the event of harm to self or harm to others.</i></p> <p><i>*If problems with crisis prevention/management are noted on certification review, completion of DDID Crisis Prevention and Intervention Curriculum may be required.</i></p>	<p>12 hours (2 days)</p> <p>Per instructor certification</p>
Identification and reporting of abuse, neglect, and exploitation/abuse prevention	H.S. Diploma with 2 years ID/DD experience or be qualified as a SCL IDP AND completion of KRS 209 Training. Trainers to complete KRS 209 training every 2 years or if new information becomes available.	2–3 hours
Rights of persons with disabilities	H.S. Diploma with 2 years ID/DD experience or be qualified as a SCL IDP.	3 hours
DDID core training	Attend DDID Core Training TOT AND have H.S. Diploma with 2 years ID/DD experience or be qualified as a SCL IDP.	8–12 hours

<http://www.mhmr.ky.gov/mr/files/SCLTrainingLevels.pdf>

Appendix B

Comparison of Training Requirements for the Supports for Community Living

Waiver and the Fifteen Competencies

Competency	SCL Required Training	Training Objectives	Recommended Training Length
Supporting Health and Wellness	CPR/First Aid	Per American Red Cross or other nationally accredited entity	Per instructor certification
Supporting Health and Wellness	Medication Administration	8. Legal issues involved in medication administration 9. Drug classes 10. Recording and using agency medication forms 11. Procedures for the destruction of medication 12. Side effects of medication 13. Storing medication appropriately 14. Self-administration	6 – 8 hours
Supporting Health and Wellness	Medication and Seizures	4. Observe and report symptoms 5. Recognize seizures 6. Provide ordered treatments	3 hours
	DDID Crisis Prevention and Intervention	4. Values base 5. Goals of Crisis Intervention – Calm not Control 6. Six Action Phases of a crisis:	12 hours (2 days)

Competency	SCL Required Training	Training Objectives	Recommended Training Length
		<ul style="list-style-type: none"> Phase I – Prevention/maintaining calm Phase II – Early intervention and identification of triggers and agitation Phase III – Intervention during acceleration to full crisis Phase IV – De-escalation/stabilization Phase V – Restoration and re-integration Phase VI – Debriefing/developing collaborations 	
	Identification and reporting of abuse, neglect, and exploitation/Abuse Prevention	Part I: Understanding the culture of abuse 5. Disability and Abuse/Neglect/Exploitation 6. Abuse/Neglect indicators	2 – 3 hours

Competency	SCL Required Training	Training Objectives	Recommended Training Length
		7. Personal and organizational factors leading to abuse	
		8. KRS209 Reporting Requirements	
		Part II: Developing emotional responsibility	
		4. Support relationship/responsible role	
		5. Command vs. Control	
		6. Emotionally responsible approach	
		7. Abuse Prevention strategies	
Participant Empowerment	Rights of Persons with Disabilities	6. Historical perspectives	3 hours
		7. Federal/legislative mandates	
		8. Values base	
		9. Ensuring human rights for all	
		10. Self-advocacy	
		11. Preventative strategies	
Participant Empowerment	DDID Core Training	Values	8 – 12 hours
		4. Definition	
		5. Role of perceptions and attitudes	
Community and Service Networking		6. Labels and Stereotypes	
		Community Inclusion	

Competency	SCL Required Training	Training Objectives	Recommended Training Length
Assessment		4. Definitions and perspectives	
		5. Roles of natural supports and how to build them	
		6. Learn how to be a good social guide	
		Person Centered Planning	
		5. Five Accomplishments	
		6. System centered vs. Person centered	
		7. Planning process	
		8. Teams and communication	
Participant Empowerment		Positive Behavior Support	
		5. Role of choice	
		6. Common areas of frustration	
		7. Proactive strategies	
		8. Behavioral issues associated with brain injury	
		Sexuality issues	
		5. Perceptions of sexuality	
		6. Understanding brain function in relation to sexuality	
		7. Education	
		8. Ensuring safety and	

Competency	SCL Required Training	Training Objectives	Recommended Training Length
		preventing abuse	
		Self-Determination	
		4. Define the five principles of self-determination	
		5. Discuss tools of implementation	
		6. Explore self-advocacy	
		Strategies for successful teaching	
		4. Define the goal of teaching	
		5. Outline the steps in the teaching process	
		6. Evaluation of outcomes and implementing strategies for success	
	DDID Case Management Training	1. Become familiar with the guiding principles of person-centeredness that direct case management	8 hours – Live Training and 4 – 8 hours – online modules
		2. Become familiar with the multiple roles and responsibilities of the case manager including assessing,	

Competency	SCL Required Training	Training Objectives	Recommended Training Length
		planning, coordinating, monitoring, evaluating, and advocating	
		3. Learn about SCL processes and procedures, including risk management and documentation	
		4. Demonstrate how a person centered approach is the cornerstone of services	
		5. Understand ethical considerations including confidentiality, informed consent, and choice	
		6. Understand guardianship and conservatorship	
		7. Learn how to access and utilize multiple resources that may enhance the lives of individuals	
		8. Learn about self-care	

Appendix C

Waiver Provider Directory

Department for Behavioral Health, Developmental and Intellectual Disabilities,

Supports for Community Living Waiver Provider Directory

Program: Supports for Community Living	
A Brighter Choice, LLC 215 S 4th St Danville, KY 40422 www.abrighterchoice.net	Contact Person: Linda Dye Email: carebylinda@bellsouth.net Contact Number: 859-583-4331
A Step in Time, LLC 135 Fallow Circle Georgetown, KY 40324-	Contact Person: Kimberlin Alsop Email: kmwilson1nurse@aol.com Contact Number: (502) 867-8137 Fax: 502 867-8137
Abilities Unlimited 309 West Main Street Frankfort, KY 40601 http://abilitiesunlimitedonline.com/Provi	Contact Person: Gayle Carter Email: mzgaylebch@aol.com Contact Number: 502-226-2334 Fax: (502) 226-3112
Abundant Solutions, LLC 2212 Outer Circle Drive Crestwood, KY 40014-	Contact Person: Tina Baldwin Email: AbundantSolution@aol.com Contact Number: (502) 836-0701 Fax: (502) 243-9848
Access Community Assistance, Inc 159 St. Matthews Avenue #10 Louisville, KY 40207- Provider Profile	Contact Person: Susan Stokes Email: susanstokes@hmr-aca.com Contact Number: 502-899-3205 Last Edit Date : 11/24/2009
Active Day of Elizabethtown-Bardstown 1238 Woodland Drive Elizabethtown, KY 42701 www.activeday.com/KY/Elizabethtown	Contact Person: Barbara Murphy Email: bmurphy@activeday.com Contact Number: (270) 763-9192 Fax: (270) 763-9279
Active Day of Louisville 4028 South Third Street Louisville, KY 40214	Contact Person: Cathryn Bucher Email: cbucher@activeday.com Contact Number: (502) 366-5777 Fax: (502) 366-4599
Active Day of Owensboro 1035 Frederica Street, Suite 170 Owensboro, KY 42302	Contact Person: Denise Townsend Email: dtownsend@activeday.com Contact Number: (270) 683-6127 Fax: (270) 683-3072
Active Day of Somerset 20 Oakhill Road Oakhill Center Somerset, KY 42503	Contact Person: Jeannice Ledford Email: jledford@activeday.com Contact Number: (606) 678-8566 Fax: (606) 677-9863
Adanta Group, The 259 Parkers Mill Road	Contact Person: Jamie Burton Email: jsburton@adanta.org

Somerset, KY 42501	Contact Number: (606) 679-4782 Fax: 606-677-1746
Adult Day Care Center of Lexington, Inc 2526 Regency Road, Suite 140 Lexington, KY 40503- www.adclexington.org	Contact Person: Kate McAllister Email: katemcallister@adclexington.org Contact Number: (859) 381-9888 Fax: (859) 381-0888 Last Edit Date : 11/13/2009
Advocate Homes 117 Letton Drive Danville, KY 40422 www.advocatehomes.net	Contact Person: Renee Staed Email: rstaedadvhomes@bellsouth.net Contact Number: (859) 236-5400 Fax: (859) 236-5024
Agape Community Living 4300 Outer Loop, Ste 7 Louisville, KY 40219	Contact Person: Carol Vibbert Email: carol@agapecl.com Contact Number: 502-235-2023 Fax: 502-742-3141
Alternative Outlook, LLC 6905 Hwy 550 East Hindman, KY 41822 Mailing Address: P O Box 1251 Hindman, KY 41882	Contact Person: Robert Jackson Email: alternativeoutlook@yahoo.com Contact Number: 606-946-2977 Fax: 606-946-2925
Alternative Services for Individuals 3921 Bardstown Road Louisville, KY 40218 Mailing Address: PO Box 991234 Louisville, KY 40269	Contact Person: Frederick Davis Email: fld567@aol.com Contact Number: 502-493-2512 Fax: 502-493-2513
Apple Patch Community 7408-A Highway 329 Crestwood, KY 40014- www.applepatch.org	Contact Person: Chris Stevenson Email: cstevenson@applepatch.org Contact Number: (502) 657-0103 Fax: (502) 657-0107
Applied Behavioral Advancements, LLC PO Box 1659 Somerset, KY 42502	Contact Person: Christopher George Email: chrisgeorge_bcba@mac.com Contact Number: 606-677-2636 Fax: 606-677-0412
Arc of Owensboro, Inc 731 Jackson Street Owensboro, KY 42302 Mailing Address: PO Box 1833 Owensboro, KY 42303-1833	Contact Person: Stephanie Hobbs Email: shobbs@bellsouth.net Contact Number: (270) 685-2976 Fax: (270) 685-2036
Area Life Center 257 Combs Road Suite 2 Hazard, KY 41701-	Contact Person: James Buddy Turner Email: buddyturneredarealifecenter@yahoo.com Contact Number: (606) 436-2308 Fax: (606) 436-0069
Aspen Community Living 7111 Dixie Highway Florence, KY 41042- www.aspencommunityliving.com	Contact Person: Jeni Rolfes Email: jeni@aspenccl.com Contact Number: (859) 525-4920 Fax: (859) 525-4920
Aspen Community Living 8920 Stone Green Way Suite # 100 Louisville, KY 40220	Contact Person: Jeni Rolfes Email: louisvilleinfo@aspenccl.com Contact Number: 502/491-3930
Aspen Community Living 1795 Alysheba Way Suite # 3206	Contact Person: Katy Poole Email: lexingtoninfo@aspenccl.com Contact Number: 859/263-2600

Lexington, KY 40509	Fax: 859/263-2655
Aspen Community Living 2225 Old Lawrenceburg Rd, Ste 1 Frankfort, KY 40601	Contact Person: Jeni Rolfes Email: frankfortinfo@aspencol.com Contact Number: 502-226-3552 Fax: 502-226-4354
Barren River Adult Day Care Center 800 Park Street Bowling Green, KY 42102 Mailing Address: PO Box 1867 Bowling Green, KY 42101	Contact Person: Gerri Glenn Email: ggcglenn@chc.net Contact Number: (270) 796-5555 Fax: (270) 796-5550
Barrowman Case Management, Inc 4750 Hartland Pkwy Suite 200 Lexington, KY 40515 Contact Person: Carla Barrowman Email: carlabarrowman@insightbb.com Contact Number: (859) 271-4246 Fax: (859) 271-0433	Services Available: SCL – Case Management
BAWAC, Inc 7970 Kentucky Drive Florence, KY 41042P	Contact Person: Ken Schmidt Email: kschmidt@bawac.org Contact Number: (859) 371-4410 Fax: (859) 371-1726
Behavior Support Services, LLC PO Box 680 1407 B Hillwood Drive Murray, KY 42071	Contact Person: Thomas McElrath Email: behaviorservices@yahoo.com Contact Number: (270) 759-9977 Fax: (270) 759-9972
Blessed Assurance Community Services 10233 Boston Road Boston, KY 40107	Contact Person: Debbie Strobel Email: blessednboston@gmail.com Contact Number: (502) 833-0210 Fax: (502) 833-0510
Bluegrass Community Care, Inc 217 Augusta Drive Georgetown, KY 40324	Contact Person: Jennifer Graham Email: bluegrasscare@roadrunner.com Contact Number: (502) 867-7177 Fax: (502) 867-7177
Bluegrass Community Living, Inc 107 Broadbill Court Georgetown, KY 40324-	Contact Person: Stephanie Baker Email: bakermarvin@bellsouth.net Contact Number: (502) 570-9269
Bluegrass Regional MH/MR Board 3479 Buckhorn Drive Lexington, KY 40515	Contact Person: Jerry Kersey Email: jwkersey@bluegrass.org Contact Number: (859) 271-3812 Fax: (859) 245-2981
Broadening Horizons, Inc 176 Enterprise Dr Suite 4 P. O Box. 1618 Somerset, KY 42501	Contact Person: Karen Whitaker Email: broadeningh@yahoo.com Contact Number: (606) 679-1173 Fax: (606) 679-1110
Buckhorn Lake area Support Team, Inc 2555 1/2 North Main St Hazard, KY 41701	Contact Person: Regina Hamilton Email: reginamhamilton@yahoo.com Contact Number: 606-487-1050 Fax: 606-487-1051
C.A.N Help, Inc 2003 Merlin Avenue Somerset, KY 42503	Contact Person: Karen Wilson Email: kwilson@canhelpinc.com Contact Number: 606-676-0545 Fax: 606-676-0123
CAKY Bowling Green	Contact Person: William Buck

980 Morgantown Rd Bowling Green, KY 42101 Mailing Address: PO Box 1113 980 Morgantown Road Bowling Green, KY 42102-1113	Email: wbuck@rescare.com Contact Number: (270) 746-0830 Fax: (270) 793-9767
CAKY Elizabethtown 107 Financial Place Elizabethtown, KY 42701	Contact Person: Jeff Rubin Email: jrubin@rescare.com Contact Number: (270) 769-6410 Fax: (270) 769-6520 Last Edit Date : 9/10/2009
CAKY Frankfort 555 Duncan Road Frankfort, KY 40601	Contact Person: Jeff Justice Email: jjustice@rescare.com Contact Number: (502) 695-3575 Fax: (502) 695-3846
CAKY Hazard 264 Broadway Hazard, KY 41701 Mailing Address: PO Box 2142 Hazard, KY 41702	Contact Person: Lynn Whitaker Email: Lwhitaker@rescare.com Contact Number: (606) 487-0744 Fax: (606) 487-9553
CAKY Henderson 600 US Highway 41 A Henderson, KY 42420-	Contact Person: Sally Phillips Email: sphillips@rescare.com Contact Number: (270) 826-0667 Fax: (270) 826-2392
CAKY Lexington 500 Bellerive Blvd. Nicholasville, KY 40356-	Contact Person: Brandon Griffith Email: bgriffith@rescare.com Contact Number: (859) 313-5042 Fax: (859) 313-5224
CAKY Louisville 175 Market Place Dr Louisville, KY 40229	Contact Person: Alex Scholtz Email: alexscholtz@rescare.com Contact Number: (502) 955-8166 Fax: 502-955-8195
CAKY Madisonville 170 Bean Cemetery Road Madisonville, KY 42431	Contact Person: Kellie Root Email: karoot@rescare.com Contact Number: (270) 825-2557 Fax: (270) 825-2458
CAKY Morehead 1034 East Main Street Morehead, KY 40351	Contact Person: Solmon Parker Email: sparker@rescare.com Contact Number: (606) 783-1518 Fax: (606) 783-9903
CAKY Owensboro 3120 Warehouse Road Owensboro, KY 42301-	Contact Person: Amy Rowan Email: arowan@rescare.com Contact Number: (270) 688-9168 Fax: (270) 688-9079
CAKY Pikeville HC 63, Box 800 Inez, KY 41224	Contact Person: Janine Raines Email: jraines@rescare.com Contact Number: (606) 298-0865 Fax: (606) 298-0643
CAKY Somerset PO Box 717 180 Mercury Blvd Somerset, KY 42501P	Contact Person: Matt Williams Email: mwilliams@rescare.com Contact Number: (606) 678-5186 Fax: (606) 679-8930
CAKY Symsonia 102 CAKY Dr Benton, KY 42025	Contact Person: Greg Widmer Email: gwidmer@rescare.com Contact Number: (270) 527-2255

Mailing Address: PO Box 628 102 CAKY Drive Symsonia, KY 42025-	Fax: (270) 527-0817
CAKY Winchester 625 Tech Drive Winchester, KY 40391	Contact Person: Matt Williams Email: mwilliams@rescare.com Contact Number: (859) 737-5220 Fax: (859) 737-5221
Campbellsville Active Day Center 1860 Old Lebanon Road Campbellsville, KY 42718	Contact Person: Amy Wright Email: awright@activeday.com Contact Number: (270) 465-9279 Fax: (270) 677-9863
Cardinal Hill Adult Day Health 2050 Versailles Road Lexington, KY 40504	Contact Person: Beth Monarch Email: bam@cardinalhill.org Contact Number: (859) 254-5701 Fax: (859) 367-7126
Cardinal Hill of Northern Kentucky 31 Spiral Drive Florence, KY 41042 www.cardinhill.org	Contact Person: Lisa West Email: lmw@chhs-nky.org Contact Number: (859) 525-1128 Fax: 859-371-0899
Cascades of the Bluegrass, LLC 470 Conway Court, Ste B-6 Lexington, KY 40511 www.CASCADESBLUEGRASS.COM	Contact Person: Lee Ann Honaker Email: leeann@cascadesbluegrass.com Contact Number: 859 277-3558 Fax: 859 225-2394
Cedar Lake Lodge 3301 Jericho Road LaGrange, KY 40031 Provider Profile	Contact Person: Jason Squires Email: jsquires@cedarlake.org Contact Number: (502) 222-7157 Fax: (502) 222-7150
Cedar Lake Residences, Inc 7984 New LaGrange Road Louisville, KY 40222 www.cedarlake.org	Contact Person: Martina Netherton Email: mnetherton@cedarlake.org Contact Number: 502-327-7706 Fax: (502) 327-7417
Champion Supports & Services 3409 North Mayo Trail Pikeville, KY 41501- www.championsupportsandservices.com	Contact Person: Tonya Newsome-Sanders Email: tnews@hotmai.com Contact Number: (606) 432-8666 Fax: (606) 432-8159
Choices Unlimited 5530 Reidland Rd Paducah, KY 42003 Mailing Address: PO Box 3531 Paducah, KY 42002	Contact Person: Larry Morgan Email: larrymorgan@mail.com Contact Number: 270-793-9117 Fax: 270-582-1192
Chransye, Inc 1043 Center Drive Richmond, KY 40475	Contact Person: Britta Woods Email: chransye1@qx.net Contact Number: (859) 626-1042 Fax: (859) 626-1146
Close To Home, LLC 600 Perimeter Dr Lexington, KY 40517	Contact Person: Carol Filson Email: closetohome01@aol.com Contact Number: (859) 259-2011

www.closetohome01@aol.com	Fax: (859) 259-2012
Comfort Hills LLC 5401 Highway 7 N Whitesburg, KY 41858 Provider Profile	Contact Person: Glenda Banks Email: glendaibanks@yahoo.com Contact Number: 606-633-0562 Fax: 606-633-0562
Communicare, Inc 320 Ring Road Elizabethtown, KY 42701 Mailing Address: 107 Cranes Roost Elizabethtown, KY 42701	Contact Person: Robin Flowers Email: rflowers@communicare.org Contact Number: (270) 769-3377 Fax: (270) 769-6974
Community Choices Unlimited, Inc 739 East Main Street Frankfort, KY 40601	Contact Person: Stacy Milligan Email: comchoices@aol.com Contact Number: (502) 223-2488 Fax: (502) 223-2458
Community Connections, Inc PO Box 468 Allen, KY 41601	Contact Person: Linda Gearhart Email: edcommunityconnections@gmail.com Contact Number: (606) 874-1900 Fax: (606) 874-1902
Community Family Living 610 Valley College Drive Louisville, KY 40272	Contact Person: Jonah Rawal Email: cflcd@hotmail.com Contact Number: (502) 777-5210 Fax: (502) 935-1899
Community Living Services 1904 Embassy Square Boulevard Louisville, KY 40299-	Contact Person: Jill Halevan Email: jhalevan@comlivserv.com Contact Number: (502) 491-1119 Fax: (502) 491-1032
Community Living, Inc 333 Guthrie, Suite 308 Louisville, KY 40202	Contact Person: Stephen Zaricki Email: szaricki@communitylivinginc.com Contact Number: (502) 585-5272 Fax: (502) 585-5277
Community Opportunities, Inc 325 Clifty Street Somerset, KY 42501	Contact Person: Justin Smith Email: justin.smith@communityopportunities.net Contact Number: 606 679-9009 Fax: 606-679-1110
Community Options (Paducah) 1721 McIntosh Way Bowling Green, KY 42104	Contact Person: Jonathan Howard Email: jonathan.howard@comop.org Contact Number: 615-885-1099
Community Options, Inc 1721 McIntosh Street Bowling Green, KY 42104-	Contact Person: Jonathan Howard Email: Jonathan.Howard@comop.org Contact Number: (270) 780-9330 Fax: (270) 780-9332
Community Ties of America, Inc 2333 Alexandria Dr, Ste 216 Lexington, KY 40504 Provider Profile Contact Person: Tim Lloyd Email: t.lloyd@comties.com Contact Number: 859-221-8277 Fax: 888-661-4505	

Last Edit Date : 11/25/2009	
Community Transitions, Inc 606 West Lexington Ave. Winchester, KY 40391 Mailing Address: P.O. Box 4360 Winchester, KY 40392	Contact Person: Ramona Bowling Email: ctiedrb@insightbb.com Contact Number: (859) 744-7051 Fax: 859-744-7052
Comprehend, Inc 741 Kenton Station Road Maysville, KY 41056	Contact Person: Kelly Miller Email: kmiller@comprehendinc.com Contact Number: (606) 759-7161 Fax: (606) 759-4895
Coons Care, LLC 760 Stone Lane Sadieville, KY 40370	Contact Person: David Coons Email: davidtinacoons@yahoo.com Contact Number: 502-857-9814
Courage To Change P O Box 2678 London, KY 40743	Contact Person: David Tipton Email: david_tipton1@netzero.com Contact Number: (606) 877-9008 Fax: (606) 877-1785
Crossroads of Hope, Inc 3004 Shute St Ashland, KY 41105 Mailing Address: PO Box 1729 Ashland, KY 41105-1729	Contact Person: Valerie Frasure Email: FrasureV@aol.com Contact Number: (606) 326-9921 Fax: 606-326-0492
Cumberland River Homes 108 Farris Street Salem, KY 42078-9385	Contact Person: Marie Burkhardt Email: mariebrh@aol.com Contact Number: (270) 988-4913 Fax: (270) 988-3128
Cumberland River MH/MR Board 1203 American Greetings Road Corbin, KY 40701 Mailing Address: PO Box 568 Corbin, KY 40702	Contact Person: Danny Jones Email: djones@crccc.net Contact Number: (606) 528-7010 Fax: (606) 528-5489
Cypress Community Services, LLC 517 Southland Dr, Ste B Lexington, KY 40503	Contact Person: Kim Gibson Email: Kimddg@aol.com Contact Number: 859 351-7075 Fax: 859 368-8188
Day Spring 3430 Day Spring Court Louisville, KY 40213	Contact Person: Deborah Kern, RSM, MSSW Email: Deborah.Kern@DaySpringKY.org Contact Number: (502) 636-5990 Fax: (502) 636-5980
Dreams With Wings, Inc 1579 Bardstown Rd Louisville, KY 40205	Contact Person: Jenifer Frommeyer Email: j.frommeyer@dreamswithwings.org Contact Number: (502) 459-4647 Fax: (502) 456-5705
East Kentucky Support Services 35 Reel View Dr Jeremiah, KY 41826 Mailing Address: PO Box 133 35 Reel View Drive Jeremiah, KY 41826	Contact Person: Daren Compton Email: daren.compton@eastkentuckysupportservices.com Contact Number: 606-633-7272 Fax: (606) 633-2793
Easter Seals West Kentucky	Contact Person: Ken Lucas

2229 Mildred St Paducah, KY 42001 Mailing Address: 801 North 29th Street Paducah, KY 42001	Email: gkennedy@eswky.com Contact Number: (270) 443-1200 Fax: (270) 444-0655
Eckman Freemand & Associates, Inc 3660 Walden Dr, Ste A Lexington, KY 40517	Contact Person: Cindy Whitehouse Email: cwhitehouse@eckmanfreeman.com Contact Number: 859-273-8107 Fax: 859-273-8412
Employment Solutions 1084 Whipple Court Lexington, KY 40511	Contact Person: Rick Christman Email: rchristman@mail.employmentsolutionsinc.org Contact Number: (859) 253-2658 Fax: (859) 254-2171
ETA Day Care Center, LLC 724 West Breckinridge St Louisville, KY 40203 Mailing Address: PO Box 1051 Louisville, KY 40203	Contact Person: Angelique Walton Email: mail.exceptionalteens@insightbb.com Contact Number: 502-290-1585 Fax: 502-290-4286
EverCare, LLC PO Box 1251 Hindman, KY 41822	Contact Person: Angela Estes Email: evercare2003@yahoo.com Contact Number: (606) 946-2078 Fax: (606) 946-2925
Evergreen Presbyterian Ministries, Inc 1830 Destiny Place, Ste 106 Bowling Green, KY 42104	Contact Person: LaJohnda Sparkman Email: lsarkman@epmi.org Contact Number: 270-846-0565 Fax: 270-846-0551
Everyday Matters, LLC 628 Tenton Tail Frankfort, KY 40601 Mailing Address: PO Box 523 628 Teton Trail Frankfort, KY 40601	Contact Person: Kelley Hawkins Email: kverydaymatters@aol.com Contact Number: (502) 875-5173 Fax: (502) 875-5174
Family Ties, LLC 1488 McKinley Avenue Danville, KY 40422-	Contact Person: Robin Mohler Email: robinfoxm@yahoo.com Contact Number: (859) 326-0689 Fax: (859) 236-7987
Four Rivers Behavioral Health 425 Broadway, Suite 201 Paducah, KY 42001	Contact Person: Terry Hudspeth Email: CEO@4rbh.org Contact Number: 270-442-5088 Fax: 270-442-3268
Frankfort Active Day Center 99 C. Michael Davenport Blvd. Frankfort, KY 40601	Contact Person: Melissa Barnett Email: mbarnett@activeday.com Contact Number: (502) 875-7555 Fax: (502) 875-7588
Full Circle Supports, LLC 480 Lexington Rd Suite G Versailles, KY 40383-	Contact Person: Diana LeMay Email: dlemay@fullcirclesupports.com Contact Number: (859) 879-1880 Fax: (859) 879-0702
Hands of Hope, LLC 8313 Madisonville Road Hopkinsville, KY 42240 Mailing Address: 3555 Quisenberry Ln Hopkinsville, KY 42240	Contact Person: Nina Shearon Email: nshandsofhope@yahoo.com Contact Number: 270-889-0340 Fax: 270-889-0340
Harbor House of Louisville, Inc	Contact Person: Maria Smith

2231 Lower Hunters Trace Louisville, KY 40216	Email: msmith@hhlou.org Contact Number: (502) 719-0072 Fax: (502) 719-0078
Harmony Care 92 C. Michael Davenport Blvd Frankfort, KY 40601 Mailing Address: Po Box 4042 Frankfort, KY 40601	Contact Person: Carla Andrade Email: harmonycarecarla@fewpb.net Contact Number: (502) 330-2596
Healing Hands Physical Therapy, LLC 11901 Shelbyville Road Suite 125 Louisville, KY 40243	Contact Person: Ronald Cole Email: physicaltherapy@lycos.com Contact Number: (502) 499-5559 Fax: (502) 499-5399
Homeplace Support Services, LLC 725 South 2nd St Danville, KY 40422-	Contact Person: Carlos Serna Email: guanacatog@aol.com Contact Number: (859) 936-2010 Fax: 859-936-2099
Hometown Connections, Inc PO Box 1976 401 South Dixie Street London, KY 40743-	Contact Person: Cami Watkins Email: camiwatkins@hotmail.com Contact Number: (606) 862-8855 Fax: (606) 862-8128
Hopkinsville Active Day Center 921 North Main Street Hopkinsville, KY 42240	Contact Person: Jodie Oliver Email: joliver@activeday.com Contact Number: (270) 886-3656 Fax: (270) 886-5211
Hugh Edward Sandefur Training Center 1449 Corporate Court Henderson, KY 42420	Contact Person: Patrick Reed Email: Patrick@hesandefur.com Contact Number: (270) 827-2401 Fax: (270) 827-9575
Independent Industries, Inc 4000 McCollum Court Louisville, KY 40218	Contact Person: Shelly Buntain Email: shellyb@iinc.org Contact Number: (502) 451-4631 Fax: (502) 451-4833
Independent Opportunities - Lake Cumberland PO Box 3126 128 Brian's Way West Somerset, KY 42564-3126	Contact Person: Shannon McCracken Email: smccracken@independentopportunities.com Contact Number: (606) 678-4840 Fax: (606) 678-4855
Independent Opportunities- Richmond PO Box 1328 918 Red House Road Richmond, KY 40475	Contact Person: Johnny Callebs Email: jcallebs@independentopportunities.com Contact Number: (859) 626-9206 Fax: (859) 626-8880
Independent Opportunities, Inc PO Box 5067 1501 South Main Street London, KY 40741	Contact Person: Gary Bultema Email: gbultema@independentopportunities.com Contact Number: (606) 877-9209 Fax: (606) 877-1770
Inspired Living, LLC 4011 West Laurel Rd London, KY 40743 Mailing Address: PO Box 2454 201 South Main Street London, KY 40743-	Contact Person: Duane Ramer Email: dlramer@live.com Contact Number: (606) 877-1552 Fax: (606) 877-1594
Irvco, LLC 263 Boiling Springs Drive	Services Available: SCL – Behavior Support Contact Person: Irvin Smith

Lexington, KY 40511-	Email: IRVCO@windstream.net Contact Number: (859) 252-3679 Fax: (859) 252-3679 Last Edit Date : 9/30/2009
Jessamine County Association 109 South Main St Nicholasville, KY 40356	Contact Person: Teri Dietrick Email: jcaec@windstream.net Contact Number: 859-885-9383
JU Kevil Memorial Foundation 1900 South Tenth Street Mayfield, KY 42066 Mailing Address: PO Box 345 Mayfield, KY 42066	Contact Person: Leigh Ann Jarvis Email: mail@jukevil.com Contact Number: (270) 247-5396 Fax: (270) 247-1233
Kaleidoscope, Inc 10330 Bunsen Way Louisville, KY 40299-	Contact Person: Darla Bailey Email: darla@kaleidoscopeservices.org Contact Number: (502) 495-1662 Fax: (502) 495-1665
Kentuckiana Nursing Services 2210 Meadow Dr., Suite 4 Louisville, KY 40218-	Contact Person: Kimberly Arington Email: aringtonkns@yahoo.com Contact Number: (502) 540-1482 Fax: (502) 540-5626
Kentucky Independent Choices, LLC 227A West Main Street Frankfort, KY 40601	Contact Person: Fedelis Mbuagbaw Email: bavenyuo73@hotmail.com Contact Number: (502) 223-2026 Fax: (502) 875-3060
Kentucky River Community Care, Inc 115 Rockwood Lane Hazard, KY 41701	Contact Person: Carolyn Scott Email: carolyn.scott@krccnet.com Contact Number: (606) 436-5761 Fax: (606) 436-5761
Latitude Artist Community 167 Saunier Ave. Lexington, KY 40507	Contact Person: Crystal Bader/Bruce Burris Email: latitudearts@yahoo.com Contact Number: (859) 806-0195 Fax: (859) 233-7927
Laurel Springs, Inc 51 Twin Ponds Lane London, KY 40743 Mailing Address: PO Box 226 London, KY 40743-0226	Contact Person: Janice Taylor Email: lspringsed@windstream.net Contact Number: (606) 877-6445 Fax: (606) 877-6574
LifeSkills, Inc 380 Suwannee Trail Bowling Green, KY 42103 Mailing Address: P O Box 6499 Bowling Green, KY 42102	Contact Person: Alice Simpson Email: asimpson@lifeskills.com Contact Number: (270) 901-5000 Fax: (270) 842-0054
Lifetime Potentials, Inc 153 Blake Dr Jackson, KY 41339 Mailing Address: PO Box 798 Jackson, KY 41339-	Contact Person: Ryan Murphy Email: lifetimepotentials@hotmail.com Contact Number: (606) 693-0994 Fax: (606) 693-0959
Lincoln Way 245 West Dixie Ave # 3 Elizabethtown, KY 42701	Contact Person: Amanda McGrew Email: amandamcgreww@lincolnwayfhp.com Contact Number: (270) 765-1877 Fax: (270) 765-1871

LINKS of Kentucky 310 West Columbia Street Somerset, KY 42501	Contact Person: Jerry McDonald Email: linksofky@windstream.net Contact Number: (606) 451-0541 Fax: (606) 451-0543
Lords Legacy Life Ministries, Inc 4750 Hartland Pkwy Suite 232 Lexington, KY 40515-	Contact Person: Lauran Norwood Email: Lnorwood@lordslegacyministries.org Contact Number: (859) 245-2233
Louisville Independent Case Management, LLC 2210 Goldsmith Lane, Suite 106 Louisville, KY 40218	Contact Person: Amy Newkirk Email: awnnewkirk@gmail.com Contact Number: (502) 452-9089 Fa Contact Person: Isaiah Hoagland
Loving Care, Inc 9508 Fairmount Road Louisville, KY 40291-	Email: isaiahhoagland@yahoo.com Contact Number: (502) 387-9164 Fax: 502-290-5481x: (502) 479-5855
Marshall County Assoc for Exceptional Child-Adult PO Box 423 198 Old Symsonia Road Benton, KY 42025	Contact Person: Diana Wall Email: dianaw@m-c-e-c.org Contact Number: (270) 527-1327 Fax: (270) 527-2299
Mattingly Center, Inc 1520 Baxter Avenue Louisville, KY 40205	Contact Person: Barbara Henchey Email: Barbara@mattinglycenter.org Contact Number: (502) 451-6200 Fax: (502) 451-6861
Meeting Challenges, LLC 3834 Taylorsville Rd, Ste 4 Louisville, KY 40220	Contact Person: Darlene Mayer Email: meetingchallenge@bellsouth.net Contact Number: (502) 457-3930 Fax: (502) 968-0330
Mending Hearts 16 Kenmont Rd Jeff, KY 41751 Mailing Address: P O Box 157 16 Kenmont Road Jeff, KY 41751	Contact Person: Shirlyn Perkins, RN Email: sperkins@mendingheartsvinc.com Contact Number: 606-439-3130 Fax: 606-439-3132
Mountain Comprehensive Care Center 104 South Front Avenue Prestonsburg, KY 41653-1646	Contact Person: Rebecca Williamson Email: rwilliamson@mtcomp.org Contact Number: (606) 886-8572 Fax: (606) 886-4434
Mountain Serenity 490 Williams Branch Road Hazard, KY 41701	Contact Person: Penny Caudill Email: pcmtserenity@aol.com Contact Number: (606) 378-2215 Fax: (606) 378-2223
My Home Place 710 Mount Eden Rd Shelbyville, KY 40066 Mailing Address: PO Box 1294 Shelbyville, KY 40066	Contact Person: Ronnie Myatt Email: myhomeplaceky@aol.com Contact Number: (502) 647-3474 Fax: (502) 647-9572
Nathaniel House, Inc 2399 Irvine Rd Richmond, KY 40475 Mailing Address:	Contact Person: Dawn DeBoard Email: nhinc@roadrunner.com Contact Number: (859) 626-3502

PO Box 2078 2399 Irvine Road Richmond, KY 40476-	Fax: 859-626-1620
New Perceptions, Inc 1 Sperti Drive Edgewood, KY 41017	Contact Person: Bob Ryan Email: bryan@newperceptions.org Contact Number: (859) 344-9322 Fax: (859) 344-9332
NorthKey Community Care 7075 Industrial Road Florence, KY 41042	Contact Person: Owen Nichols, Psy.D., MBA Email: onichols@northkey.org Contact Number: 859-578-3252 Fax: (859) 342-4059
Omni Visions, Inc 231 East Arch Street Madisonville, KY 42431	Contact Person: Bill Heaton Email: bheaton@omnivisions.com Contact Number: (270) 825-1698 Fax: (270)825-8050
Options for Individuals, Inc 1204 South Third Street Louisville, KY 40203	Contact Person: Michelle Linville Email: mlinville@opts4ind.org Contact Number: (502) 636-9198 Fax: 502-636-9190
Options Unlimited, Inc 205 Castle Rock Drive Shepherdsville, KY 40165	Contact Person: Willie Byrd Email: williebyrd@juno.com Contact Number: (502) 955-7271 Fax: (502) 955-7221
Pathways Comprehensive Care Center PO Box 790 1212 Bath Avenue – 8th floor Ashland, KY 41105-0790	Contact Person: Kim McClanahan, Ph.D. Email: kim.mccclanahan@pathways-ky.org Contact Number: (606) 329-8588 Fax: (606) 329-8195
Peak Community Supports, LLC 1517 Gagel Ave Louisville, KY 40216	Contact Person: Alex Gibbons Email: agibbons@peaksupports.org Contact Number: 502-363-1700 Fax: 502-363-1705
Pennyroyal Center 609 Hammond Plaza Hopkinsville, KY 42241 Mailing Address: PO Box 614 1507 South Main Hopkinsville, KY 42241	Contact Person: David Ptaszek Email: dptaszek@pennyroyalcenter.org Contact Number: 270-886-7171 Fax: 270-885-5871
Pioneer Vocational/Industrial Service, Inc PO Box 1396 150 Corporate Dr. Danville, KY 40423-1396	Contact Person: Ron Zimmerman Email: ron@pioneerservices.org Contact Number: (859) 236-8413 Fax: (859) 238-7115
Planning for Life, Inc 7806 Stonydale Lane Louisville, KY 40220-	Contact Person: Joan Bishop Email: planningforlife@insightbb.com Contact Number: (502) 475-6255 Fax: (502) 614-6085
PrinceCare Group/Mariposa Place 2007 Frankfort Ave Louisville, KY 40206	Contact Person: Erin Davis Email: princecaregroup@yahoo.com Contact Number: (502) 896-8147 Fax: 502-896-8149
Quest Community Services, Inc 2901 Hwy 1651 Whitley City, K 42653 Mailing Address:	Contact Person: Larry Holden Email: larryquest@highland.net Contact Number: (606) 376-7117

PO Box 1571 Whitley City, KY 42653	Fax: (606) 376-7118
Quest Farms, Inc 627 Glass Pike Georgetown, KY 40324	Contact Person: Joe Richey Email: joerichey@questfarm.org Contact Number: (502) 535-6064 Fax: (502) 535-5295
Random House Community Living 5505 Random Way Louisville, KY 40291	Contact Person: Tim Bomar Email: timbomar@bellsouth.net Contact Number: 502-239-7799 Fax: 502-239-2809
REACH of Louisville 501 Park Avenue Louisville, KY 40208	Contact Person: Marsha Illback Email: illbackm@reachoflouisville.com Contact Number: (502) 585-1911 Fax: 502-589-1582
Redwood School & Rehab Ctr, Inc 71 Orphanage Road Ft. Mitchell, KY 41017	Contact Person: Pam Millay Email: pmillay@redwoodnky.org Contact Number: (859) 331-0880 Fax: (859) 331-6177
Rellim, Inc 341-8 East Irvine Street Richmond, KY 40475	Contact Person: Howard Miller Email: reliminc@live.com Contact Number: (859) 623-9090 Fax: (859) 623-9933
Richmond Active Day Center 928 Commercial Drive, Suite 2 Richmond, KY 40475	Contact Person: Jeannice Ledford Email: jledford@activeday.com Contact Number: (859) 625-9977 Fax: (859) 626-0256
River Valley Behavioral Health PO Box 1637 1100 Walnut Street Owensboro, KY 42302-1637	Contact Person: Michele Rhodes Email: Rhodes-Michele@rvbh.com Contact Number: (270) 689-6500 Fax: (270) 689-6664
Russell Springs Active Day Center 1165 Lakeway Drive Russell Springs, KY 42642	Contact Person: Linda Arnold Email: lamold@activeday.com Contact Number: (270) 866-4877 Fax: 270-866-4978
Seven Counties Services, Inc 3717 Taylorsville Road Louisville, KY 40220	Contact Person: Robyn Thomas Email: rthomas@sevencounties.org Contact Number: (502) 459-5292 Fax: (502) 452-9079
Southwest Center 8007 Terry Road Louisville, KY 40258-	Contact Person: Dana Slucher Email: dana_slucher@bellsouth.net Contact Number: 502-935-1848 Fax: 502-933-7833
St Mary's Center 11700 Main St Louisville, KY 40253 Mailing Address: PO Box 43443 Louisville, KY 40253-0443	Contact Person: Sr. Regina Bevelacqua Email: regina@saintmaryscenter.org Contact Number: 502-244-0082
Steps Ahead Inc 414 Quail Run Rd. Versailles, KY 40383 Mailing Address: PO Box 302 Versailles, KY 40383	Services Available: Contact Person: Jill Brown Email: jillbrown.stepsahead@gmail.com Contact Number: 859-509-1618 Fax: 859-873-0037

	Case Management
Strategic Partnerships 1100 Walnut St Owensboro, KY 42301 Mailing Address: PO Box 1637 1100 Walnut Street Owensboro, KY 42302-1637	Contact Person: Gayle DiCesare Email: Hullinger-Scott@rvbh.com Contact Number: (270) 689-6500 Fax: (270) 689-6724
Support Source, LLC 233 Stable Way Nicholasville, KY 40356-	Contact Person: Dr. Sheryl Bruner Email: sheryl.bruner@insightbb.com Contact Number: 859-948-9404 Fax: 859-278-8500
T. J. Samson Adult Health Care 922 Happy Valley Road Glasgow, KY 42141	Contact Person: Therese Klein Email: tklein@tjsamson.org Contact Number: (270) 651-4743 Fax: (270) 651-4740
Tom Jones and Associates, LLC 615 Jones Lane Versailles, KY 40383- Contact Person: Tom Jones Email: TomJonesandAssoc@aol.com Contact Number: (859) 873-4263 Fax: (859) 873-4263 Last Edit Date : 11/11/2009	Services Available: SCL – Case Management
Treasured Friends, LLC 64 Roger Combs Blvd. Hindman, KY 41822 Mailing Address: PO Box 1130 Hindman, KY 41822-1130	Contact Person: Shane Stanley Email: Treasuredfriends@gmail.com Contact Number: 606-785-0440 Fax: 606-785-0423
Tri-Generations LLC 436 Hotchkiss St. Campbellsville, KY 42718-	Contact Person: Karen Gardner Email: kgardner@tri-generations.org Contact Number: (270) 469-1236 Fax: (270) 469-0914
Tri-Generations LLC 90 Venture Way Somerset, KY 42501-	Contact Person: Karen Gardner Email: kgardner@tri-generations.org Contact Number: (606) 416-5870 Fax: (606) 416-5871
Tri-Generations LLC 6900 Huston Road, Ste 25 Florence, KY 41042- www.tri-generations.org	Contact Person: Donna Turner Email: dturner@tri-generations.org Contact Number: (859) 525-4192 Fax: (859) 525-0164
Tri-Generations, LLC 11800 Brinley Avenue, Suite 101 Louisville, KY 40243-	Contact Person: Kitty Davidson Email: kdavidson@tri-generations.org Contact Number: (502) 253-6825 Fax: (502) 253-6828
Vicare Medical Staffing, LLC 4119 Browns Lane, Building 3 Hikes Point Office Park Louisville, KY 40220	Contact Person: Amy E. Robertson Email: amy@vicare1.com Contact Number: (502) 384-1840 Fax: (502) 384-1850
Volunteers of America 8172 Mall Road Suite 231 Florence, KY 41042	Contact Person: Anabelle Matusoff Email: amatusoff@voaorv.org Contact Number: 859-372-5600 Fax: 859-372-5606
WATCH, Inc 702 Main Street	Contact Person: Peggy Williams Email: watch@murray-ky.net

Murray, KY 42071	Contact Number: (270) 759-1842 Fax: (270) 761-1453
Welcoming Changes, LLC 625 Leawood Dr, Ste C Frankfort, KY 40601 Mailing Address: 312 Hermitage Dr Frankfort, KY 40601	Contact Person: Tim Childers Email: atp40802@yahoo.com Contact Number: 502-229-0468
Wendell Foster Center, Inc 815 Triplett St Owensboro, KY 42301 Mailing Address: PO Box 1668 815 Triplett Owensboro, KY 42302-1688	Contact Person: Cindy Parish Email: Cparish@wfcampus.org Contact Number: (270) 683-4517 Fax: (270) 683-0079
Westport Medical 8700 Westport Road Suite 112 Louisville, KY 40242P	Contact Person: Brenda Wiggins Email: thewiggins4@yahoo.com Contact Number: (502) 425-4726 Fax: (502) 425-7560
Womack Carter Options 411 N 4th St Murray, KY 42071 Mailing Address: PO Box 687 Benton, KY 42025	Contact Person: Bonnie Womack-Carter Email: bonniecarter@mchsi.com Contact Number: (270) 767-1543 Fax: (270) 767-1545
Zoom Group 410 West Chestnut Street, Suite 900 Louisville, KY 40202	Contact Person: Annie Rosenberg Email: arosenberg-sattich@zoomgroup.org Contact Number: (502) 581-0658 Fax: (502) 581-9520

Appendix D

Invitation Letter to Direct Support Professionals

Date

Dear Direct Support Professional:

In your valued role as a Direct Support Professional, you have a unique perspective and for this reason your input is extremely important. I am inviting you to complete a survey to share your perspective. This survey is part of a research study exploring the perceptions among recipients of direct supports, Direct Support Professional and Direct Support Professional supervisors with regard to the importance and preparation of a standard skill set or competencies. Please note your participation in this survey has no foreseeable risks or penalties. However I anticipate substantial potential in the training and preparation of Direct Support Professionals as a result of this research.

Please note the data collected in your survey will be held in confidence to the extent of the law. Representatives of the University of Louisville (Department of Leadership, Foundations, and Human Resources Education and the Human Studies Committee) may inspect these surveys. Absolute confidentiality cannot be guaranteed.

Your completed survey will be maintained in a locked file cabinet at my home. In the event that the research results are published, your identity will not be disclosed. Your participation in this survey is strictly voluntary. You voluntarily agree to participate by completing and submitting the survey. You may elect to not participate without being subject to any penalty or lose of any benefits you would have otherwise been entitled.

You may decline to answer any survey question that makes you feel uncomfortable for any reason.

Please feel free to call me, Cindy Bayes at 502-802-2564 or email at cindyb115@gmail.com if you have any questions about this research survey. If you have questions about your rights as a participant, please call the University of Louisville Human Studies Committee office at 502-852-5188. Any questions discussed with a member of the Human Studies Committee will be confidential. This Committee is composed of faculty and staff at the University of Louisville. This Committee has reviewed and approved this research.

To complete the survey, please click on the website:
http://www.surveymonkey.com/s.aspx?sm=EY1UIAP7pCVIII2OcSu22w_3d_3d. After completing the survey click on the “submit button and the survey will be sent to me. This completes your participation.

I look forward to receiving your completed survey with two weeks of this letter. Thanks so much for your participation. Your feedback is very important to me and essential to this research.

Sincerely,

Cindy Bayes
3538 Hurstbourne Ridge Blvd.
Louisville, KY 40299
502-802-2564
Cindyb115@gmail.com

Appendix E

Invitation Letter to Supervisors of Direct Support Professionals

Date

Dear Direct Support Professional Supervisor:

In your valued role as a Direct Support Professional Supervisor, you have a unique perspective and for this reason yours input is extremely important. I am inviting you to complete a survey to share your perspective. This survey is part of a research study exploring the perceptions among recipients of direct supports, Direct Support Professionals and Direct Support Professional Supervisors with regard to the importance and preparation of a standard skill set or competencies. Please note your participation in this survey has no foreseeable risks or penalties. However I anticipate substantial potential in the training and preparation of Direct Support Professionals as a result of this research.

Please note the data collected in your survey will be held in confidence to the extent of the law. Representatives of the University of Louisville (Department of Leadership, Foundations, and Human Resources Education and the Human Studies Committee) may inspect these surveys. Absolute confidentiality cannot be guaranteed. Your completed survey will be maintained in a locked file cabinet at my home. In the event that the research results are published, your identity will not be disclosed.

Your participation in this survey is strictly voluntary. You voluntarily agree to participate by completing and submitting the survey. You may elect to not participate without being subject to any penalty or lose of any benefits you would have otherwise been entitled. You may decline to answer any survey question that makes you feel uncomfortable for any reason.

Please feel free to call me, Cindy Bayes at 502-802-2564 or email at cindyb115@gmail.com if you have any questions about this research survey. If you have questions about your rights as a participant, please call the University of Louisville Human Studies Committee office at 502-852-5188. Any questions discussed with a member of the Human Studies Committee will be confidential. This Committee is composed of faculty and staff at the University of Louisville. This Committee has reviewed and approved this research.

To complete the survey, please click on the website:
http://www.surveymonkey.com/s.aspx?sm=EY1UIAP7pCVIII2OcSu22w_3d_3d . After completing the survey click on the “submit button and the survey will be sent to me. This completes your participation.

I look forward to receiving your completed survey with two weeks of this letter. Thanks so much for your participation. Your feedback is very important to me and essential to this research.

Sincerely,

Cindy Bayes
3538 Hurstbourne Ridge Blvd.
Louisville, KY 40299
502-802-2564
Email: cindyb115@gmail.com

Appendix F

Survey for Direct Support Professionals

Thank you for participating

Thank you for taking the time to complete this survey about Direct Support Professionals (DSP's). Your input is very important in helping me learn how to improve training and preparation for Direct Support Professionals. This survey is also part of an educational requirement.

This survey should only take about 15 minutes to complete. Your answers will be completely anonymous. In fact you will notice that no identifying information is required. In order to obtain the most accurate information please respond truthfully and completely.

If you have any questions, please contact me at cindyb115@gmail.com

Now, let's get started

In order to progress through this survey, please use the following navigation links:

- Click the Next >> button to continue to the next page.
- Click the Previous >> button to return to the previous page.
- Click the Exit the Survey Early >> button if you need to exit the survey.
- Click the Submit >> button to submit your completed survey.

Direct Support Professional

You will be asked two ratings about each of the fifteen (15) standardized competencies/skills for Direct Support Professionals (DSP's). First you will see the definition of the competency, then you will be asked to rate yourself. The first rating asks for your current level of KNOWLEDGE of the competency or skill. The second asks about the VALUE you place on the competency or skill. Please rate each competency on a scale from 1 to 10. One for extremely low knowledge or value of the competency. Ten means extremely high knowledge or value of the competency.

1. PARTICIPANT EMPOWERMENT: enhances the ability of the participant to lead a self-determining life by providing the support and information necessary to build self-esteem, and assertiveness; and to make decisions.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. COMMUNICATION: is knowledgeable about the range of effective communication strategies and skills necessary to establish a collaborative relationship with the participant.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Copy of page:

3. ASSESSMENT: is knowledgeable about formal and informal assessment practices in order to respond to the needs, desires and interests of the participants.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
Knowledge	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Value	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. COMMUNITY and SERVICE NETWORKING: is knowledgeable about the formal and informal supports available in his or her community and skilled in assisting the participant to identify and gain access to such supports.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. FACILITATION of SERVICES: is knowledgeable about a range of participatory planning techniques and is skilled in implementing plans in a collaborative and expeditious manner.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6. COMMUNITY LIVING SKILLS and SUPPORTS: has the ability to match specific supports and interventions to the unique needs of individual participants and recognizes the importance of friends, family and community relationships.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7. EDUCATION, TRAINING and SELF-DEVELOPMENT: is able to identify areas for self improvement, pursue necessary educational/training resources, and share knowledge with others.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. ADVOCACY: is knowledgeable about the diverse challenges facing participants (e.g. human rights, legal, administrative and financial) and should be able to identify and use effective advocacy strategies to overcome such challenges.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

9. VOCATIONAL, EDUCATIONAL and CAREER SUPPORT: is knowledgeable about the career and education related concerns of the participant and should be able to mobilize the resources and support necessary to assist the participant to reach his or her goals.

	Extremely Low									Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

10. CRISIS PREVENTION and INTERVENTION: is knowledgeable about crisis prevention, intervention and resolution techniques and should match such techniques to particular circumstances and individuals.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

11. ORGANIZATION PARTICIPATION: is familiar with the mission and practices of the support organization and participates in the life of the organization.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

12. DOCUMENTATION: is aware of the requirements for documentation in his or her organization and is able to manage these requirements efficiently.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

13. BUILDING and MAINTAINING FRIENDSHIPS and RELATIONSHIPS: supports the individual in the development of friendships and other relationships

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

14. PROVIDE PERSON CENTERED SUPPORTS: provides support using a person centered approach, assists in developing and implementing person centered plans.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

15. SUPPORTING HEALTH and WELLNESS: promotes the health and wellness of all individuals.

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

16. Are there additional competencies not listed above you think should be added? If so, please write them below:

17. Is there anything you would like to add? (Your input is very important, please share.)

Getting to know you

Please share some basic demographic information about yourself. This will help the researcher.

18. My current Age is:

19. My Gender is:

☐ Male

☐ Female

20. My predominant ethnicity is:

☐ African American

☐ Hispanic

☐ Caucasian

☐ Other

Other (please specify)

21. My Education completed is:

☐ High School

☐ GED

☐ Some College

☐ College graduate

College graduates: List your Major below

22. My employment history includes:

	Years	Month
Length of Time in Previous DSP positions	<input type="text"/>	<input type="text"/>
Length of Time in CURRENT DSP position	<input type="text"/>	<input type="text"/>
Total amount of time working with people with disabilities	<input type="text"/>	<input type="text"/>

23. My training history includes:

	Hours of Training
Amount of Training when I first started as a DSP (during the first 3 months)	<input type="text"/>
Amount of Training during my first year as a DSP	<input type="text"/>
Average amount of Training I receive each year	<input type="text"/>

Comment:

Thanks for completing this survey

Thank you for your time & valuable input. As soon as you clicked the "Submit" button, survey response was submitted. The SurveyMonkey program is collecting your information and adding it to others who have completed the survey.

Thanks again for contributing to this research.

Appendix G

Survey for Supervisors of Direct Support Professionals

Supervisor Perspective: DSP Competency Research

3. ASSESSMENT: is knowledgeable about formal and informal assessment practices in order to respond to the needs, desires and interests of the participants.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. COMMUNITY and SERVICE NETWORKING: is knowledgeable about the formal and informal supports available in his or her community and skilled in assisting the participant to identify and gain access to such supports.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. FACILITATION of SERVICES: is knowledgeable about a range of participatory planning techniques and is skilled in implementing plans in a collaborative and expeditious manner.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6. COMMUNITY LIVING SKILLS and SUPPORTS: has the ability to match specific supports and interventions to the unique needs of individual participants and recognizes the importance of friends, family and community relationships.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Supervisor Perspective: DSP Competency Research

7. EDUCATION, TRAINING and SELF-DEVELOPMENT: is able to identify areas for self improvement, pursue necessary educational/training resources, and share knowledge with others.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. ADVOCACY: is knowledgeable about the diverse challenges facing participants (e.g. human rights, legal, administrative and financial) and should be able to identify and use effective advocacy strategies to overcome such challenges.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

9. VOCATIONAL, EDUCATIONAL and CAREER SUPPORT: is knowledgeable about the career and education related concerns of the participant and should be able to mobilize the resources and support necessary to assist the participant to reach his or her goals.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

10. CRISIS PREVENTION and INTERVENTION: is knowledgeable about crisis prevention, intervention and resolution techniques and should match such techniques to particular circumstances and individuals.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Supervisor Perspective: DSP Competency Research

11. ORGANIZATION PARTICIPATION: is familiar with the mission and practices of the support organization and participates in the life of the organization.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

12. DOCUMENTATION: is aware of the requirements for documentation in his or her organization and is able to manage these requirements efficiently.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

13. BUILDING and MAINTAINING FRIENDSHIPS and RELATIONSHIPS: supports the individual in the development of friendships and oother relationships

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

14. PROVIDE PERSON CENTERED SUPPORTS: provides support using a person centered approach, assists in developing and implementing person centered plans.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Supervisor Perspective: DSP Competency Research

15. SUPPORTING HEALTH and WELLNESS: promotes the health and wellness of all individuals.

Rate the Direct Support Professionals you supervise for this competency in terms of:

	Extremely Low	2	3	4	5	6	7	8	9	Extremely High
KNOWLEDGE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VALUE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

16. Are there additional competencies not listed above you think should be added? If so, please write them below:

17. Is there anything you would like to add? (Your input is very important, please share.)

Getting to know you

Please share some basic demographic information about yourself. This will help the researcher.

*** 1. My current Age is:**

*** 2. My Gender is:**

☐ Male

☐ Female

3. My predominant ethnicity is:

☐ African American

☐ Hispanic

☐ Caucasian

☐ Other

Other (please specify)

Supervisor Perspective: DSP Competency Research

4. My Education completed is:

- ☐ High School
☐ GED
☐ Some College
☐ College graduate

College graduates: List your Major below

5. My employment history includes:

	Years	Months
Amount of time as a DSP before becoming a Supervisor	<input type="text"/>	<input type="text"/>
Amount of time as a Supervisor of DSP's	<input type="text"/>	<input type="text"/>
Amount of time as a Supervisor before this current position	<input type="text"/>	<input type="text"/>
Total amount of time working with people with disabilities	<input type="text"/>	<input type="text"/>

6. Training provided to the DSP's under My Supervision:

	Hours of Training
Amount of Training provided to a new DSP during first 3 months	<input type="text"/>
Amount of Training provided to a new DSP during the first year	<input type="text"/>
Average amount of Training provided to DSP's each year	<input type="text"/>

Comment:

Thanks for completing this survey

Thank you for your time & valuable input. As soon as you clicked the "Submit" button, survey response was submitted. The SurveyMonkey program is collecting your information and adding it to others who have completed the survey.

Thanks again for contributing to this research.

Appendix H

Competency and Abbreviation Charting Scale

Competency and Abbreviation	Knowledge	Value
PARTICIPANT EMPOWERMENT: (EMPR) enhances the ability of the participant to lead a self-determining life by providing the support and information necessary to build self-esteem, and assertiveness; and to make decisions.	K1	V1
COMMUNICATION: (COMM) is knowledgeable about the range of effective communication strategies and skills necessary to establish a collaborative relationship with the participant.	K2	V2
ASSESSMENT: (ASSES) is knowledgeable about formal and informal assessment practices in order to respond to the needs, desires and interests of the participants.	K3	V3
COMMUNITY and SERVICE NETWORKING: (NWK) is knowledgeable about the formal and informal supports available in his or her community and skilled in assisting the participant to identify and gain access to such supports.	K4	V4
FACILITATION of SERVICES: (FACL) is knowledgeable about a range of participatory planning techniques and is skilled in implementing plans in a collaborative and expeditious manner.	K5	V5
COMMUNITY LIVING SKILLS and SUPPORTS: (CLSS) has the ability to match specific supports and interventions to the unique needs of individual participants and recognizes the importance of friends, family and community relationships.	K6	V6
EDUCATION, TRAINING and SELF-DEVELOPMENT: (ETSD) is able to identify areas for self improvement, pursue necessary educational/training resources, and share knowledge with others.	K7	V7

Competency and Abbreviation	Knowledge	Value
ADVOCACY: (ADV) is knowledgeable about the diverse challenges facing participants (e.g. human rights, legal, administrative and financial) and should be able to identify and use effective advocacy strategies to overcome such challenges.	K8	V8
VOCATIONAL, EDUCATIONAL and CAREER SUPPORT: (VECS) is knowledgeable about the career and education related concerns of the participant and should be able to mobilize the resources and support necessary to assist the participant to reach his or her goals.	K9	V9
CRISIS PREVENTION and INTERVENTION: (CPI) is knowledgeable about crisis prevention, intervention and resolution techniques and should match such techniques to particular circumstances and individuals.	K10	V10
ORGANIZATION PARTICIPATION: (OP) is familiar with the mission and practices of the support organization and participates in the life of the organization.	K11	V11
DOCUMENTATION: (DOC) is aware of the requirements for documentation in his or her organization and is able to manage these requirements efficiently.	K12	V12
BUILDING and MAINTAINING FRIENDSHIPS and RELATIONSHIPS: (BMFR) supports the individual in the development of friendships and other relationships	K13	V13
PROVIDE PERSON CENTERED SUPPORTS: (PCS) provides support using a person centered approach, assists in developing and implementing person centered plans.	K14	V14
SUPPORTING HEALTH and WELLNESS: (HLTH) promotes the health and wellness of all individuals.	K15	V15

Appendix I

Boxplots for all Competency Scores

Perceptions

Competency

Knowledge

Value

4 Community and Service Networking

5 Facilitation of Services

6 Community Living Skills and Supports

Perceptions

Competency

Knowledge

Value

7 Education, Training, and
Self-Development

8 Advocacy

9 Vocational, Educational,
and Career Support

Perceptions

Competency

Knowledge

Value

10 Crisis Prevention and Intervention

11 Organization Participation

12 Documentation

Perceptions

Competency

Knowledge

Value

13 Building and Maintaining
Friendships and
Relationships

14 Provide Person Centered
Sports

15 Supporting Health and
Wellness

Appendix J

Multiple Regression Results—Knowledge

Regression Results for three largest Knowledge mean difference DSPs vs. Supervisors

Vocational, Education and Career Support (Knowledge)

Independent Variable	Regression Coefficient	Standard Error	t-Value
Intercept	2.52	1.22	2.05*
Age	-0.01	0.01	-1.20
Education	-0.10	0.09	-1.03
Ethnicity	0.30	0.35	1.14
Gender	-0.04	0.32	-0.14
Training	0.00	0.00	0.31
Value: Voc. Edu.	0.73	0.11	6.77**
YearsExp	0.00	0.02	0.18
R ² = 0.39			
Value			

*p< .05 **p< .01

The multiple regression analysis for the level of knowledge of the competency entitled Vocational, Education and Career Support reports for every one unit of value increase, knowledge increases by .73.

Education, Training, and Self-Development (Knowledge)

Independent Variable	Regression Coefficient	Standard Error	t-Value
Intercept	1.62	1.10	1.47
Age	0.00	0.01	0.15
Education	-0.11	0.11	-1.01
Ethnicity	-0.01	0.39	-0.03
Gender	0.10	0.35	0.29
Training	-0.00	0.00	-1.19
Value: Education, Training And Self-development	0.77	0.09	8.94 **
Years Exp	0.03	0.02	1.61
R ² = 0.52			

**p< .01

The multiple regression analysis for the level of knowledge of the competency entitled Education, Training and Self-development reports for every one unit of value increase, knowledge increases by .77.

Facilitation of Services (Knowledge)

Independent Variable	Regression Coefficient	Standard Error	T-Value to test
Intercept	2.30	1.51	1.53
Age	-0.01	0.01	-0.55
Education	0.08	0.14	0.53
Ethnicity	-0.20	0.50	-0.39
Gender	-0.53	0.46	-1.16
Training	0.00	0.00	0.29
Value: Facilitation Of Services	0.71	0.13	5.56**
YearsExp	0.01	0.02	0.29
R2 = 0.27			

**p< .01

Appendix K

Multiple Regression Results—Value

The largest mean differences between DSP and supervisors were the competencies of Facilitation of Services, Vocational, Education, and Career Support, and Participation Empowerment.

Multiple Regression: Facilitation of Services (Value)

Independent Variable	Regression Coefficient	Standard Error	T-Value
Intercept	6.14	0.88	6.99
Age	0.00	0.01	0.19
Education	-0.08	0.10	-0.82
Ethnicity	0.34	0.36	0.95
Gender	0.36	0.33	1.09
Knowledge: Facilitation	0.37	0.07	5.56**
Training	-0.00	0.00	-1.02
Years of Experience	-0.01	0.02	-0.89
R ² = 0.32			

**p< .01

Multiple Regression: Vocational, Education and Career Support (Value)

Independent Variable	Regression Coefficient	Standard Error	T-Value
Intercept	5.20	0.83	6.23
Age	0.00	0.01	0.48
Education	0.01	0.08	0.19
Ethnicity	0.07	0.28	0.28
Gender	0.05	0.25	0.20
Knowledge: Vocational, Education and Career Support	0.47	0.07	6.77**
Training	-0.00	0.00	-1.53
Years of Experience	0.00	0.01	0.07
R ² = 0.39			

**p< .01

Multiple Regression: Participant Empowerment (Value)

Independent Variable	Regression Coefficient	Standard Error	T-Value
Intercept	4.52	0.89	5.06
Age	-0.00	0.01	-0.16
Education	0.06	0.10	0.58
Ethnicity	-0.46	0.36	-1.27
Gender	0.27	0.33	0.81
Knowledge: Participant Empowerment	0.53	0.07	7.73**
Training	-0.00	0.00	-0.79
YearsExp	-0.01	0.02	-0.40
R2 = 0.45			

**p< .01

Appendix L

DSP Comments Regarding Training

- Always training to learn more of how to care for our clients
- Don't know just started
- Have son with disability
- Don't remember how much training, but it seemed like a lot.
- Lots and lots of training hours, including CPR, Medication training, First Aid & a variety of classes.
- Whatever requirements are, I'm up to date.
- Not for sure about training
- not sure
- I'm not positive about the training hours answers
- Everything going well.
- I feel I get great training to do my job correctly.
- I am still in training because there is always more to learn each day, forever changing.
- I receive daily training as needed.
- Receive daily training as needed
- Daily training as needed
- It is really hard to calculate the amount of hours in first 3 months, first year and each year... We are receiving training daily almost.. There is always something to improve within our program to make the individuals lives better!!!

- It's hard to recall exact amounts of training, so the amounts listed are my best guess. When I first started as a DSP, there was initial training and orientation which probably was more extensive. After that there have been quarterly trainings.
- Started with a college degree. Entered a Master's Degree program in my first year of teaching.

Appendix M

Competency Frequencies (Grouped)

	Median	Mode	Range	Minimum	Maximum	Sum
K1	8.00	8	8	2	10	1562
V1	9.00	10	7	3	10	1681
K2	8.00	9	7	3	10	1620
V2	9.00	10	6	4	10	1754
K3	8.00	8	8	2	10	1500
V3	9.00	10	9	1	10	1651
K4	7.00	8	9	1	10	1443
V4	9.00	10	9	1	10	1643
K5	8.00	8	9	1	10	1476
V5	9.00	10	9	1	10	1622
K6	9.00	9	8	2	10	1627
V6	9.00	10	7	3	10	1753
K7	8.00	8 ^a	9	1	10	1519
V7	9.00	10	9	1	10	1659
K8	8.00	8	8	2	10	1459
V8	9.00	10	7	3	10	1685
K9	8.00	8	8	2	10	1528
V9	9.00	10	9	1	10	1691
K10	8.00	9	9	1	10	1567
V10	9.00	10	9	1	10	1762
K11	9.00	9	8	2	10	1660
V11	9.00	10	7	3	10	1729
K12	9.00	9	7	3	10	1660
V12	9.00	10	8	2	10	1710
K13	9.00	9	6	4	10	1671
V13	9.00	10	6	4	10	1779
K14	8.00	8	8	2	10	1650
V14	9.00	10	8	2	10	1766
K15	9.00	9	8	2	10	1693
V15	9.00	10	8	2	10	1800

Appendix N: Individual Competency

Frequency Tables

Table K-1

Participant Empowerment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1	.5	.5	.5
	3	1	.5	.5	1.0
	4	2	1.0	1.0	2.0
	5	17	8.5	8.5	10.6
	6	15	7.5	7.5	18.1
	7	35	17.6	17.6	35.7
	8	59	29.6	29.6	65.3
	9	33	16.6	16.6	81.9
	10	36	18.1	18.1	100.0
	Total	199	100.0	100.0	

Table V-1

Participant Empowerment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	1.0	1.0	1.0
	4	3	1.5	1.5	2.5
	5	10	5.0	5.0	7.5
	6	11	5.5	5.5	13.1
	7	22	11.1	11.1	24.1
	8	36	18.1	18.1	42.2
	9	45	22.6	22.6	64.8
	10	70	35.2	35.2	100.0
	Total	199	100.0	100.0	

Table K-2

<i>Communication</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	3	1.5	1.5	1.5
	4	1	.5	.5	2.0
	5	11	5.5	5.5	7.5
	6	16	8.0	8.0	15.6
	7	29	14.6	14.6	30.2
	8	44	22.1	22.1	52.3
	9	49	24.6	24.6	76.9
	10	46	23.1	23.1	100.0
	Total	199	100.0	100.0	

Table V-2

<i>Communication</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	3	1.5	1.5	1.5
	5	6	3.0	3.0	4.5
	6	7	3.5	3.5	8.0
	7	22	11.1	11.1	19.1
	8	21	10.6	10.6	29.6
	9	52	26.1	26.1	55.8
	10	88	44.2	44.2	100.0
	Total	199	100.0	100.0	

Table K-3

<i>Assessment</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1	.5	.5	.5
	3	4	2.0	2.0	2.5
	4	14	7.0	7.0	9.5
	5	19	9.5	9.5	19.1
	6	13	6.5	6.5	25.6
	7	36	18.1	18.1	43.7
	8	40	20.1	20.1	63.8
	9	35	17.6	17.6	81.4
	10	37	18.6	18.6	100.0
	Total	199	100.0	100.0	

Table V-3

<i>Assessment</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	.5	.5	.5
	2	1	.5	.5	1.0
	3	2	1.0	1.0	2.0
	4	4	2.0	2.0	4.0
	5	13	6.5	6.5	10.6
	6	8	4.0	4.0	14.6
	7	17	8.5	8.5	23.1
	8	44	22.1	22.1	45.2
	9	48	24.1	24.1	69.3
	10	61	30.7	30.7	100.0
	Total	199	100.0	100.0	

Table K-4

<i>Community and Service Networking</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	.5	.5	.5
	3	7	3.5	3.5	4.0
	4	7	3.5	3.5	7.5
	5	20	10.1	10.1	17.6
	6	29	14.6	14.6	32.2
	7	36	18.1	18.1	50.3
	8	46	23.1	23.1	73.4
	9	31	15.6	15.6	88.9
	10	22	11.1	11.1	100.0
	Total	199	100.0	100.0	

Table V-4

<i>Community and Service Networking</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	.5	.5	.5
	3	2	1.0	1.0	1.5
	4	5	2.5	2.5	4.0
	5	7	3.5	3.5	7.5
	6	15	7.5	7.5	15.1
	7	26	13.1	13.1	28.1
	8	41	20.6	20.6	48.7
	9	39	19.6	19.6	68.3
	10	63	31.7	31.7	100.0
	Total	199	100.0	100.0	

Table K-5

Facilitation of Services

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1	1	.5	.5	.5
2	1	.5	.5	1.0
3	5	2.5	2.5	3.5
4	6	3.0	3.0	6.5
5	25	12.6	12.6	19.1
6	24	12.1	12.1	31.2
7	31	15.6	15.6	46.7
8	40	20.1	20.1	66.8
9	32	16.1	16.1	82.9
10	34	17.1	17.1	100.0
Total	199	100.0	100.0	

Table V-5

Facilitation of Services

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1	1	.5	.5	.5
2	1	.5	.5	1.0
3	5	2.5	2.5	3.5
4	3	1.5	1.5	5.0
5	12	6.0	6.0	11.1
6	14	7.0	7.0	18.1
7	28	14.1	14.1	32.2
8	29	14.6	14.6	46.7
9	40	20.1	20.1	66.8
10	66	33.2	33.2	100.0
Total	199	100.0	100.0	

Table K-6

<i>Community Living Skills and Supports</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	2	1.0	1.0	1.0
	3	2	1.0	1.0	2.0
	4	3	1.5	1.5	3.5
	5	10	5.0	5.0	8.5
	6	9	4.5	4.5	13.1
	7	32	16.1	16.1	29.1
	8	40	20.1	20.1	49.2
	9	53	26.6	26.6	75.9
	10	48	24.1	24.1	100.0
	Total	199	100.0	100.0	

Table V-6

<i>Community Living Skills and Supports</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	.5	.5	.5
	4	2	1.0	1.0	1.5
	5	11	5.5	5.5	7.0
	6	3	1.5	1.5	8.5
	7	18	9.0	9.0	17.6
	8	23	11.6	11.6	29.1
	9	51	25.6	25.6	54.8
	10	90	45.2	45.2	100.0
	Total	199	100.0	100.0	

Table K-7

Education, Training and Self-development

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1	1	.5	.5	.5
3	10	5.0	5.0	5.5
4	7	3.5	3.5	9.0
5	13	6.5	6.5	15.6
6	17	8.5	8.5	24.1
7	33	16.6	16.6	40.7
8	42	21.1	21.1	61.8
9	34	17.1	17.1	78.9
10	42	21.1	21.1	100.0
Total	199	100.0	100.0	

Table V-7

Education, Training and Self-development

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1	1	.5	.5	.5
3	5	2.5	2.5	3.0
4	3	1.5	1.5	4.5
5	9	4.5	4.5	9.0
6	15	7.5	7.5	16.6
7	17	8.5	8.5	25.1
8	37	18.6	18.6	43.7
9	39	19.6	19.6	63.3
10	73	36.7	36.7	100.0
Total	199	100.0	100.0	

Table K-8

<i>Advocacy</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	2	1.0	1.0	1.0
	3	5	2.5	2.5	3.5
	4	8	4.0	4.0	7.5
	5	24	12.1	12.1	19.6
	6	31	15.6	15.6	35.2
	7	25	12.6	12.6	47.7
	8	40	20.1	20.1	67.8
	9	33	16.6	16.6	84.4
	10	31	15.6	15.6	100.0
	Total	199	100.0	100.0	

Table V-8

<i>Advocacy</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	.5	.5	.5
	4	4	2.0	2.0	2.5
	5	9	4.5	4.5	7.0
	6	15	7.5	7.5	14.6
	7	28	14.1	14.1	28.6
	8	18	9.0	9.0	37.7
	9	49	24.6	24.6	62.3
	10	75	37.7	37.7	100.0
	Total	199	100.0	100.0	

Table K-9

Vocational, Educational, and Career Support

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	2	1.0	1.0	1.0
	3	3	1.5	1.5	2.5
	4	14	7.0	7.0	9.5
	5	12	6.0	6.0	15.6
	6	17	8.5	8.5	24.1
	7	29	14.6	14.6	38.7
	8	43	21.6	21.6	60.3
	9	40	20.1	20.1	80.4
	10	39	19.6	19.6	100.0
	Total	199	100.0	100.0	

Table V-9

Vocational, Educational, and Career Support

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	.5	.5	.5
	2	1	.5	.5	1.0
	4	3	1.5	1.5	2.5
	5	12	6.0	6.0	8.5
	6	13	6.5	6.5	15.1
	7	18	9.0	9.0	24.1
	8	25	12.6	12.6	36.7
	9	48	24.1	24.1	60.8
	10	78	39.2	39.2	100.0
	Total	199	100.0	100.0	

Table K-10

Crisis Prevention

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	.5	.5	.5
	2	3	1.5	1.5	2.0
	3	1	.5	.5	2.5
	4	11	5.5	5.5	8.0
	5	9	4.5	4.5	12.6
	6	15	7.5	7.5	20.1
	7	32	16.1	16.1	36.2
	8	32	16.1	16.1	52.3
	9	52	26.1	26.1	78.4
	10	43	21.6	21.6	100.0
	Total	199	100.0	100.0	

Table V-10

Crisis Prevention

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	.5	.5	.5
	2	1	.5	.5	1.0
	3	1	.5	.5	1.5
	4	1	.5	.5	2.0
	5	5	2.5	2.5	4.5
	6	7	3.5	3.5	8.0
	7	15	7.5	7.5	15.6
	8	30	15.1	15.1	30.7
	9	40	20.1	20.1	50.8
	10	98	49.2	49.2	100.0
	Total	199	100.0	100.0	

Table K-11

<i>Organization Participation</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1	.5	.5	.5
	3	3	1.5	1.5	2.0
	4	3	1.5	1.5	3.5
	5	11	5.5	5.5	9.0
	6	10	5.0	5.0	14.1
	7	17	8.5	8.5	22.6
	8	34	17.1	17.1	39.7
	9	69	34.7	34.7	74.4
	10	51	25.6	25.6	100.0
	Total	199	100.0	100.0	

Table V-11

<i>Organization Participation</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	1.0	1.0	1.0
	4	5	2.5	2.5	3.5
	5	6	3.0	3.0	6.5
	6	7	3.5	3.5	10.1
	7	16	8.0	8.0	18.1
	8	31	15.6	15.6	33.7
	9	49	24.6	24.6	58.3
	10	83	41.7	41.7	100.0
	Total	199	100.0	100.0	

Table K-12

<i>Documentation</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	.5	.5	.5
	4	9	4.5	4.5	5.0
	5	4	2.0	2.0	7.0
	6	10	5.0	5.0	12.1
	7	22	11.1	11.1	23.1
	8	41	20.6	20.6	43.7
	9	61	30.7	30.7	74.4
	10	51	25.6	25.6	100.0
	Total	199	100.0	100.0	

Table V-12

<i>Documentation</i>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1	.5	.5	.5
	3	5	2.5	2.5	3.0
	4	4	2.0	2.0	5.0
	5	9	4.5	4.5	9.5
	6	9	4.5	4.5	14.1
	7	12	6.0	6.0	20.1
	8	25	12.6	12.6	32.7
	9	46	23.1	23.1	55.8
	10	88	44.2	44.2	100.0
	Total	199	100.0	100.0	

Table K-13

Building and Maintaining Friendships and Relationships

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	5	2.5	2.5	2.5
	5	7	3.5	3.5	6.0
	6	14	7.0	7.0	13.1
	7	17	8.5	8.5	21.6
	8	41	20.6	20.6	42.2
	9	65	32.7	32.7	74.9
	10	50	25.1	25.1	100.0
	Total	199	100.0	100.0	

Table V-13

Building and Maintaining Friendships and Relationships

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	3	1.5	1.5	1.5
	5	6	3.0	3.0	4.5
	6	8	4.0	4.0	8.5
	7	4	2.0	2.0	10.6
	8	28	14.1	14.1	24.6
	9	63	31.7	31.7	56.3
	10	87	43.7	43.7	100.0
	Total	199	100.0	100.0	

Table K-14

Provide Person Centered Supports

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1	.5	.5	.5
	3	1	.5	.5	1.0
	4	3	1.5	1.5	2.5
	5	4	2.0	2.0	4.5
	6	15	7.5	7.5	12.1
	7	23	11.6	11.6	23.6
	8	54	27.1	27.1	50.8
	9	50	25.1	25.1	75.9
	10	48	24.1	24.1	100.0
	Total	199	100.0	100.0	

Table V-14

Provide Person Centered Supports

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1	.5	.5	.5
	4	1	.5	.5	1.0
	5	6	3.0	3.0	4.0
	6	5	2.5	2.5	6.5
	7	19	9.5	9.5	16.1
	8	26	13.1	13.1	29.1
	9	51	25.6	25.6	54.8
	10	90	45.2	45.2	100.0
	Total	199	100.0	100.0	

Table K-15

Supporting Health and Wellness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1	.5	.5	.5
	3	1	.5	.5	1.0
	4	1	.5	.5	1.5
	5	8	4.0	4.0	5.5
	6	8	4.0	4.0	9.5
	7	20	10.1	10.1	19.6
	8	37	18.6	18.6	38.2
	9	70	35.2	35.2	73.4
	10	53	26.6	26.6	100.0
	Total	199	100.0	100.0	

Table V-15

Supporting Health and Wellness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1	.5	.5	.5
	4	2	1.0	1.0	1.5
	5	5	2.5	2.5	4.0
	6	4	2.0	2.0	6.0
	7	8	4.0	4.0	10.1
	8	21	10.6	10.6	20.6
	9	63	31.7	31.7	52.3
	10	95	47.7	47.7	100.0
	Total	199	100.0	100.0	

Histograms

Figure K-1 Participant empowerment: Knowledge

Figure V 1 Participant empowerment: Value

Figure K-2 Communication: Knowledge

Figure V 2 Communication: Value

Figure K-3 Assessment: Knowledge

Figure V 3 Assessment: Value

Figure K-4 Community and service networking: Knowledge

Figure V 4 Community and service networking: Value

Figure K-5 Facilitation of services: Knowledge

Figure V 5Facilitation of services: Value

Figure K-6 Community living skills and supports: Knowledge

Figure V 6 Community living skills and supports: Value

Figure K-7 Education, training and self-development: Knowledge

Figure V 7 Education, training and self-development: Value

Figure K-8 Advocacy: Knowledge

Figure V 8 Advocacy: Value

Figure K-9 Vocational, educational and career support: Knowledge

Figure V 9 Vocational, educational and career support: Value

Figure K-10 Crisis prevention and intervention: Knowledge

Figure V 10 Crisis prevention and intervention: Value

Figure K-11 Organizational participation: Knowledge

Figure V 11 Organizational participation: Value

Figure K-12 Documentation: Knowledge

Figure V 12 Documentation: Value

Figure K-13 Building and maintaining friendships and relationships: Knowledge

Figure V 13 Building and maintaining friendships and relationships: Value

Figure K-14 Provide person centered supports: Knowledge

Figure V 14 Provide person centered supports: Value

Figure K-15 Supporting health and wellness: Knowledge

Figure V 15 Supporting health and wellness: Value

Appendix O

Correlations between Competencies and Selected Demographics

Statistically significant correlations are flagged with yellow highlighting.

Correlations that are nearly statistically significant are flagged with grey highlighting. All significance is 2-tailed. Type I error is inflated, so this is exploratory only.

		Age	Gender	Education	Years working with disabled
K1	Corr.	-.114	.068	-.033	-.044
	Sig.	.140	.376	.670	.568
	df	168	168	168	168
Value: Participant Empowerment	Corr.	-.065	.092	.012	.154
	Sig.	.403	.232	.876	.044
	df	168	168	168	168
K2	Corr.	-.122	.047	-.035	-.029
	Sig.	.114	.546	.648	.707
	df	168	168	168	168
Value: Communication	Corr.	-.018	.030	.042	.150
	Sig.	.820	.696	.587	.051
	df	168	168	168	168
K3	Corr.	-.081	.007	-.053	-.003
	Sig.	.291	.925	.490	.972
	df	168	168	168	168
V3	Corr.	.004	.062	-.125	.108
	Sig.	.959	.423	.106	.160
	df	168	168	168	168
Knowledge: Community and Service Networking	Corr.	-.143	-.102	.056	-.107
	Sig.	.062	.187	.466	.164
	df	168	168	168	168
V4	Corr.	-.054	.031	-.035	.075
	Sig.	.484	.684	.652	.334
	df	168	168	168	168
K5	Corr.	-.093	.017	-.009	-.020
	Sig.	.225	.824	.905	.796
	df	168	168	168	168
V5	Corr.	-.072	.097	-.076	.038
	Sig.	.350	.209	.323	.622
	df	168	168	168	168

		Age	Gender	Education	Years working with disabled
Knowledge:	Corr.	-.179	-.045	-.018	-.049
Community and	Sig.	.019	.557	.815	.523
Living Skills	df	168	168	168	168
V6	Corr.	-.123	.055	-.081	.008
	Sig.	.110	.479	.296	.913
	df	168	168	168	168
Knowledge: Education, Training, and Self-development	Corr.	-.031	.085	-.176	.012
	Sig.	.689	.272	.022	.873
	df	168	168	168	168
Value: Education, Training, and Self-development	Corr.	.001	.025	-.145	.081
	Sig.	.987	.742	.059	.293
	df	168	168	168	168
Knowledge: Advocacy	Corr.	-.163	.003	.039	-.075
	Sig.	.034	.965	.609	.333
	df	168	168	168	168
Value: Advocacy	Corr.	-.146	.028	.019	.069
	Sig.	.057	.715	.808	.368
	df	168	168	168	168
K9	Corr.	-.136	.047	-.079	-.009
	Sig.	.077	.544	.305	.909
	df	168	168	168	168
Value: Vocational, Educational, and Career Support	Corr.	.004	.009	-.027	.151
	Sig.	.962	.910	.728	.049
	df	168	168	168	168
K10	Corr.	-.100	.022	-.022	.016
	Sig.	.194	.779	.777	.840
	df	168	168	168	168
V10	Corr.	-.014	.008	-.003	.117
	Sig.	.852	.919	.968	.127
	df	168	168	168	168
K11	Corr.	-.076	.087	-.121	-.043
	Sig.	.323	.261	.116	.579
	df	168	168	168	168
Value: Organizational Participation	Corr.	.015	.097	-.153	.060
	Sig.	.842	.209	.047	.434
	df	168	168	168	168
Knowledge: Documentation	Corr.	-.191	-.060	.089	-.023
	Sig.	.013	.437	.248	.762
	df	168	168	168	168
V12	Corr.	-.098	.084	-.085	.057
	Sig.	.205	.276	.270	.463
	df	168	168	168	168
Knowledge: Building and Maintaining Friendships and Relationships	Corr.	-.146	.062	-.158	-.101
	Sig.	.057	.419	.039	.191
	df	168	168	168	168
V13	Corr.	-.059	.141	-.100	.047
	Sig.	.445	.067	.196	.545
	df	168	168	168	168

		Age	Gender	Education	Years working with disabled
K14	Corr.	-.080	.021	-.111	-.064
	Sig.	.302	.785	.151	.408
	df	168	168	168	168
Value: Provide Person- centered Support	Corr.	-.014	.122	-.081	.156
	Sig.	.853	.113	.292	.042
	df	168	168	168	168
Knowledge: Supporting Health and Wellness	Corr.	-.076	.140	-.157	-.015
	Sig.	.325	.069	.041	.844
	df	168	168	168	168
Value: Supporting Health and Wellness	Corr.	-.056	.167	-.111	.068
	Sig.	.468	.029	.151	.379
	df	168	168	168	168

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DOB: January 15, 1955

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University of Louisville

Graduation: December 2010

Primary Focus: Occupational Training and Development

M. Public Administration

University of Louisville, 1991

Louisville, KY

Primary Focus: Program Planning and Development

B.S., Psychology

Eastern Kentucky University, 1977

Richmond, KY

PROFESSIONAL
EXPERIENCE:

July 1987 to Present. Seven Counties Services, Inc.

Division Director: Specialized Community Services

Adhere to state and federal budget guidelines. Track and monitor revenues and expenditures from five funding sources, with an annual budget over \$4.5 million. Provide financial narratives and progress reports. Member of the management team that plans and develops new programs and services.

March 1986 to July 1987. Commonwealth of Kentucky, DCBS **Family Service Worker, Principal**

Secured residential placements for dependent children with special needs. Monitored foster homes per federal and state guidelines. Provided family and group counseling as required.

AWARDS:

ARC of Kentucky: President's Award 1996

President's Committee on Mental Retardation,
appointed to the Kentucky Delegation

Seven Counties Services:

110% Award in Recognition of Extra Effort 1989

Best of the Best Award 1995

CEO Outstanding Effort Award 1995

Quality Award for Leadership 1996 and 1997

PROFESSIONAL SOCIETIES:

ARC of Kentucky

The Association for Persons with Severe handicaps (TASH),
International and Chapter