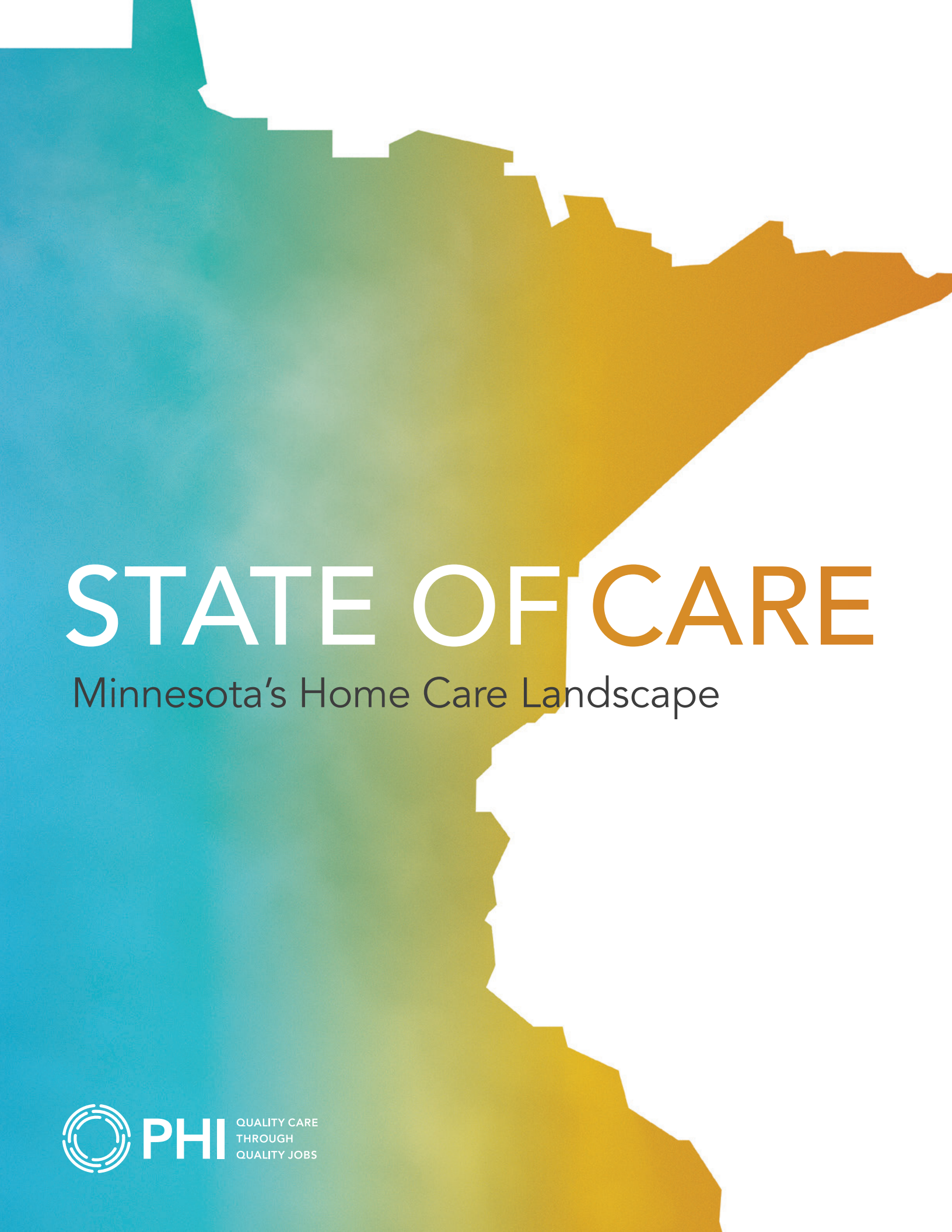


# STATE OF CARE

## Minnesota's Home Care Landscape

PHI
QUALITY CARE
THROUGH
QUALITY JOBS

PHI works to transform eldercare and disability services. We foster dignity, respect, and independence—for all who receive care, and all who provide it. The nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.



## CONTENTS

# EXECUTIVE SUMMARY

To ensure older adults in Minnesota can maintain independence, dignity, and a high standard of health, we must increase both the quality and the quantity of the healthcare workers who support them. This report takes a special look at the state's home care landscape. PHI conducted extensive research on the direct care workforce, training, and provider landscape in rural Minnesota to assess current its opportunities, challenges, and gaps in services—and propose potential solutions for consideration. The goal of this report is to inform and strengthen the ambitious work already being undertaken by local stakeholders to ensure older adults and the individuals who care for them can live with dignity, respect, and independence.

Home care workers help older adults negotiate the daily tasks essential to living independently, serving as a lifeline for individuals who wish to remain in their homes and communities. These workers help clients bathe, dress, eat, and perform routine activities, providing eight out of every ten hours of paid, hands-on caregiving. Yet despite surging demand for home care services, the poor quality of these jobs threatens the stability of the workforce, in turn undermining the availability of reliable, quality care for older adults.

Approximately 93,000 home care workers—including personal care aides and home health aides—provide caregiving services for older adults and people with disabilities in Minnesota each day.[1] Significant demand is driving job growth in this sector. Minnesota will see openings for home care workers increase by 27 percent between 2014 and 2024. In all, the state will need more than 25,000 additional home care workers to meet market needs.[2] Yet as the demand for long-term care intensifies, entrenched workforce and service gaps will leave many of the state's older adults without the support they need grow old with health and dignity, particularly in Greater Minnesota.

In Minnesota, the average hourly wage for home care workers is $11.48, while the average hourly wage in the state for all occupations is $18.88. Moreover, adjusted for inflation, hourly wages for home care workers have declined over the last decade.[3] The prevalence of part-time work further limits annual earnings. More than 75 percent of home care workers in Minnesota report working less than full-time, and nearly half live in households relying on some form of public assistance.[4]

Further, this workforce often experiences inadequate training, poor supervision, and a lack of professional advancement opportunities. Required training for home care workers is limited and often fails to include basic communication and problem-solving skills that are needed to build the critical relationships between caregivers and older adults that underlie quality care. Supervision in the field is minimal and often amounts to policy enforcement rather than supportive problem-solving. Undervalued and poorly integrated into care teams, home care workers rarely see opportunities for career growth.

All of these factors contribute to an unsustainably high rate of annual turnover within the home care workforce, ranging from 40 to 60 percent nationwide. The result is a profusion of inconsistent, poor-quality care at a time when older adults are increasingly choosing to remain in their homes and communities and would benefit most from experienced workers who can provide familiarity and safety.

The quality of home care jobs has significant influence on vacancies within the workforce. Further, minimal training and supervision limit the ability of home care workers

1. This total includes approximately 27,000 home health aides and 66,000 personal care aides.
2. U.S. Department of Labor, Bureau of Labor Statistics, Employment Projections Program (2015, December 8). National Employment Matrix, 2014-2024. Retrieved from: http://www.bls.gov/emp/.
3. U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics (2016, March 30). May National Employment and Wage Estimates United States, 2005 to 2015. Retrieved from http://www.bls.gov/oes/#data.
4. PHI analysis of the American Community Survey, U.S. Census Bureau (2015). 2010-2014 ACS 5-year PUMS. Retrieved from http://www.census.gov/programs-surveys/acs/data/pums.html.

to be effective in their roles. *The Star Tribune* recently highlighted the stark contrast between low training standards and the "life-and-death" tasks often required of home care workers.[5] Given the persistence of poor-quality jobs and the state's decreasing unemployment rates, today's vacancies are likely to grow dramatically.

These critical problems are heightened in Minnesota's vast rural communities, where demographic shifts and service gaps are felt more acutely. While, overall, the state ranks near the middle nationwide in the size of its elder population, its rural counties are aging more quickly. In some rural counties, more than a quarter of the population is aged 65 and older. Further, the movement of younger generations, who are leaving these counties to live in metropolitan areas, is compounding an already severe workforce shortage. Long-term care services are also scarcer in rural communities, and training for new workers is largely lacking.

**In Minnesota, the average hourly wage for home care workers is $11.48, while the average hourly wage in the state for all occupations is $18.88.**

Yet with concerted effort, Minnesota is well-positioned to address current workforce shortages. The state leads the nation in the effectiveness of its long-term services and supports, according to AARP's Long-Term Services and Supports Scorecard.[6] This ranking reflects a broad vision for home and community-based services (HCBS) in Minnesota and work throughout the state to realize that vision.

Today, many state leaders are looking to confront the workforce shortage and further Minnesota's goal of providing quality HCBS for its older adult population:

- The Department of Human Services (DHS) led the first ever Direct Care/ Support Workforce Summit in July 2016, yielding five key themes to inform future actions: increase worker compensation, expand the worker pool, enhance worker training, increase job satisfaction, elevate the profession, and raise public awareness.

- LeadingAge Minnesota, a large-scale provider association, has begun convening an annual Workforce Solutions Conference. The second annual conference in 2016 presented new strategies for aging services providers to recruit, retain, and develop caregiving staff, including how to cultivate a culture of hospitality, enhance job satisfaction, recruit a diversified workforce, and create career pathway programs.

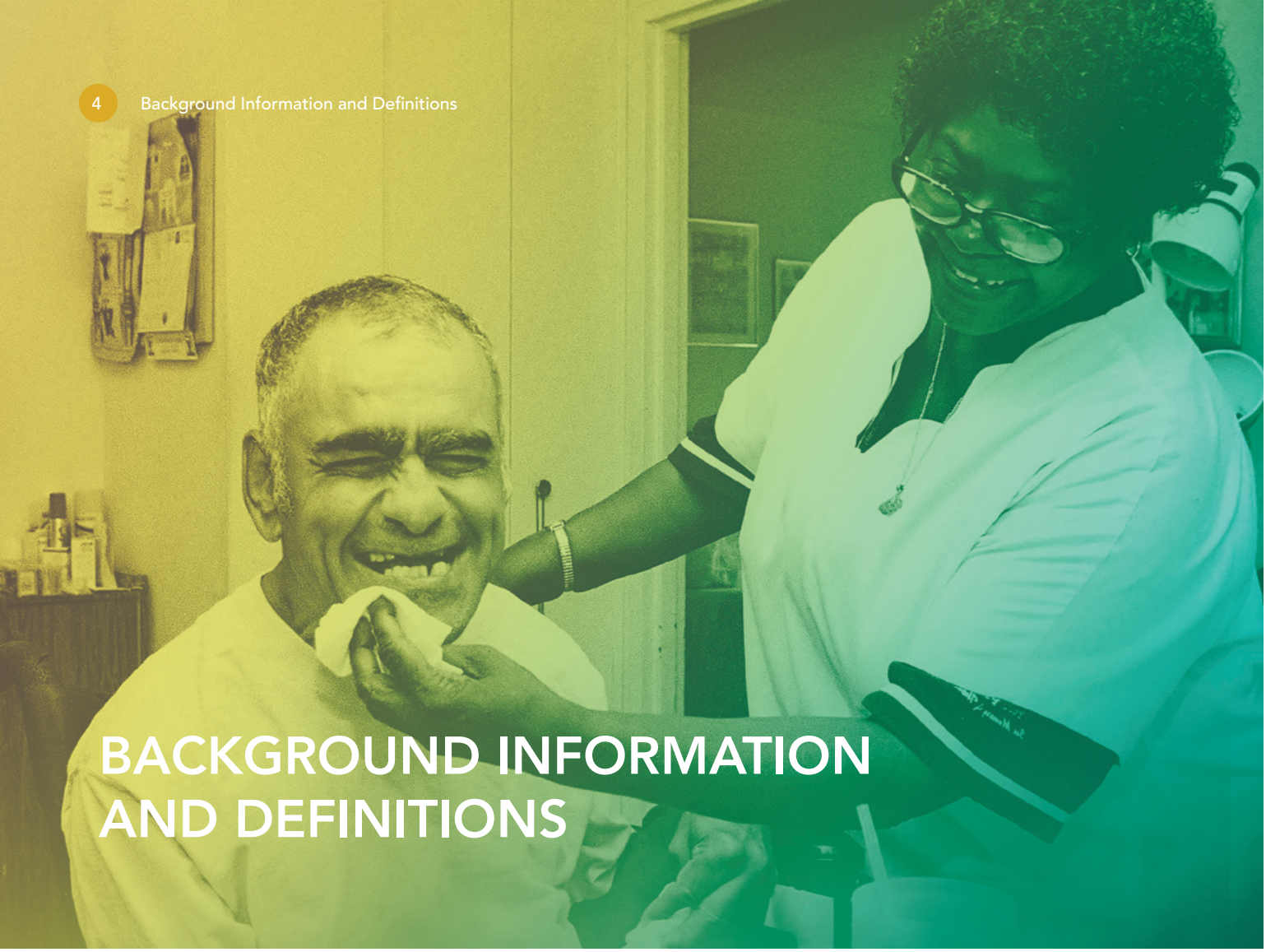
- Service Employees International Union (SEIU) Healthcare Minnesota is leading efforts to update and expand training requirements. Since 2014, SEIU has represented the approximately 20,000 personal care aides (PCAs) employed through the state's consumer-directed programs. To ensure workers were prepared to effectively support their clients, funding for training was included in the first contract negotiated between SEIU and the state of Minnesota, which took effect in 2015.

- The Office of the Legislative Auditor has been asked by legislators to conduct a far-reaching financial and performance review of HCBS providers. The evaluation, to be completed in early 2017, will provide a high-level assessment of the availability and type of HCBS for older adults and people with physical and developmental disabilities, and offer specific detail on financial oversight issues for a small number of HCBS providers.

The current juncture is one of both crisis and opportunity. The solutions necessary to improve quality of care for older adults in Minnesota will require improving the quality of jobs for a vast and growing low-wage workforce. PHI's analysis of Minnesota's home care landscape was made possible with support from and in collaboration with the Margaret A. Cargill Philanthropies.

5. Chris Serres, "Care aides get little to no training for life-and-death tasks," Star Tribune, September 2, 2014.

6. AARP, The Commonwealth Fund, and the SCAN Foundation, "Minnesota: 2014 State Long-Term Services and Supports Scorecard Results," 2014.



# BACKGROUND INFORMATION AND DEFINITIONS

Home care workers provide the majority of hands-on support for older adults who wish to remain in their homes and communities. Two official occupations comprise the home care workforce: personal care aides and home health aides. Each occupation requires different levels of certification and provides distinct levels of care and assistance.

In Minnesota, personal care aides (PCAs), called personal care assistants locally, help people maintain independence in their homes and communities by helping with: activities of daily living, such as eating, bathing, dressing, meals, and mobility; observation and redirection of behaviors; and some health-related tasks. These services are provided through personal care agencies, which are not required to have a state license but must be enrolled as Minnesota Health Care Programs providers.[7]

Individual PCAs must pass a criminal background check and complete and successfully pass an online training course.[8]

Home health aides (HHAs) provide medically-oriented tasks at a person's place of residence in order to maintain health or aid in the treatment of illness.[9] These tasks include: assisting in administration of certain medications; supporting ambulation and exercise; assisting with instrumental activities of daily living, such as managing medications, meals, transportation, and finances; and providing hands-on personal care. These services are provided through Medicare-certified home health agencies, while individual HHAs must be certified by the Minnesota Department of Health (MDH).

7. For a list of PCA employment and enrollment requirements, see Appendix A.
8. Some consumer-directed programs, discussed on the following page, allow consumers to conduct their own training, rather than use the online training.
9. Tasks are considered "medically oriented" if they are required to maintain the recipient's health or to facilitate treatment of an illness or injury and have been ordered by a physician.

Long-term services and supports (LTSS) provided by home care workers are financed through a combination of public and private funds. Medicaid is the primary payer of services for low-income individuals, through the state's Medical Assistance program, and through additional waiver programs, which allow the state to more flexibly use Medicaid dollars towards HCBS. An additional state program, MinnesotaCare, provides coverage for people who do not have access to affordable health insurance but whose income is above the threshold of eligibility for the state's Medicaid program.[10]

Medicare plays a much smaller role in funding long-term care. Medicare covers short stays (up to 100 days) in skilled nursing facilities after a hospital admission and will also cover home health services on a part-time, intermittent basis if they are deemed necessary as home-based support following discharge from a nursing facility. For older adults who are ineligible to receive Medicaid or Medicare coverage, they must use their own savings or private long-term care insurance, if applicable, to cover institutional care or HCBS.

Minnesota's LTSS for older adults are overseen by the Department of Human Services (DHS) and MDH. DHS is responsible for managing and developing Medicaid policies, as well as community services, resources, and options counseling for older adults. In addition, DHS approves and regulates PCA agencies. MDH licenses nursing homes, assisted living, and home care and home health agencies.[11]

The state also offers consumer-directed personal care options. The first is the state's PCA program, in which individuals needing assistance qualify for a certain number of hours of service through Medicaid. Consumers can choose between a traditional agency model of care and PCA Choice. Through PCA Choice, consumers assume responsibility for recruitment, scheduling, respite coordination, evaluation, and documentation of hired staff. Using this model, consumers must work with a PCA Choice agency, which handles billing and taxes and ensures the PCA has completed the necessary training and criminal background check.

The other consumer-directed options available to Minnesotans are budget model programs through the Consumer Support Grant Program (CSG) and the Consumer Directed Community Supports (CDCS) program. CSG allows consumers to convert Medicaid funding into a cash grant and manage and pay for a variety of home and community-based services themselves, while CDCS provides a similar option through several Medicaid Waiver programs.

## METHODOLOGY

PHI drew from a wide range of public data sources and stakeholder interviews to develop our analysis of Minnesota's home care landscape. Initial research, which helped to inform themes for the interviews, included a review of relevant articles, publications, and published research on the Minnesota long-term care system. Stakeholders were targeted and identified by referral, or "snowball sampling" where one interviewee leads to the identification of another interviewee or group of interviewees. More than 30 stakeholders representing 17 different groups were interviewed between the period of December 2015 through April 2016. Each was selected to represent one of three broad categories: provider organizations and associations (seven), city and state agencies (five), and advocacy groups/advocates (five).

Initial interviews with primary stakeholders were conducted in an unstructured format, with the goal of identifying new themes and testing out hypotheses about the provider landscape that surfaced during the background research. These themes informed a semi-structured interview protocol, customized by type of organization, which was utilized for later interviews. The benefit of the semi-structured method for this type of research is that it provides a list of topics to cover, while affording the researcher the opportunity to pursue threads outside of the scope of the interview guide, by including open-ended questions.

10. MinnesotaCare covers home care services but not PCA services.

11. Minnesota classifies Medicare certified agencies as home health agencies (HHAs). They must also carry a Minnesota comprehensive home care license. Agencies that are not federally certified by Medicare are classified as state licensed-only home care agencies. These agencies may hold a comprehensive or a basic home care license.

# GROWING OLDER ADULT POPULATION, INSUFFICIENT CARE

Minnesota's population is aging. According to the Minnesota State Demographic Center:

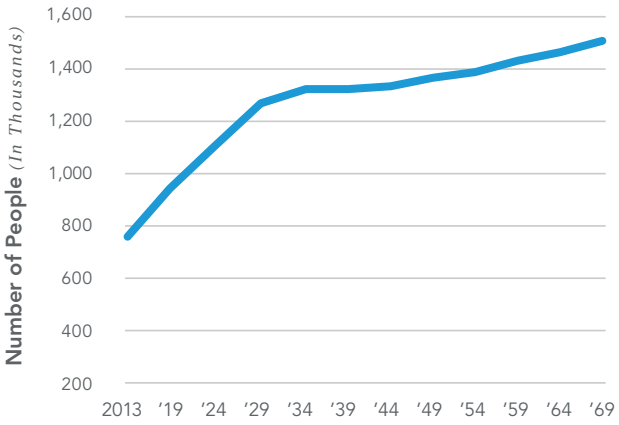
- The number of Minnesotans turning 65 in this decade (about 285,000) will be greater than in the past four decades combined.
- Around 2020, Minnesota's 65 and older population is expected to eclipse the K-12 population (aged 5 to 17) for the first time in history.
- The number of people age 65 and older in Minnesota will grow dramatically in the next 10 years—from approximately 870,000 in 2017 to 1.2 million in 2027. By 2030, more than 1 in 5 Minnesotans will be age 65 and older.[12]

Following national trends, the first cohort of the state's baby boomer population has begun to turn 65. This influx, along with an overall longer life expectancy for Minnesotans, has meant that the older adult population is growing at a much faster pace than other age groups. As the DHS Continuing Care Administration reports: "Between 2010 and 2020, the population 65+ will increase by 40 percent, while the under-65 population is forecasted to increase by about 4 percent. Between 2020 and 2030, the comparable figures are 36 percent in the older group and less than one percent for the younger group."[13]

However, while Minnesota ranks among the middle of U.S. states in its proportion of older adults (they represent 14 percent of the overall population as of 2014), the proportion of older adults in rural counties is much higher, near 20 percent. In some rural counties, such as Traverse and Aitkin, those numbers are considerably higher: 28 percent and 26 percent, respectively.[14]

## Minnesota Older Adult Population

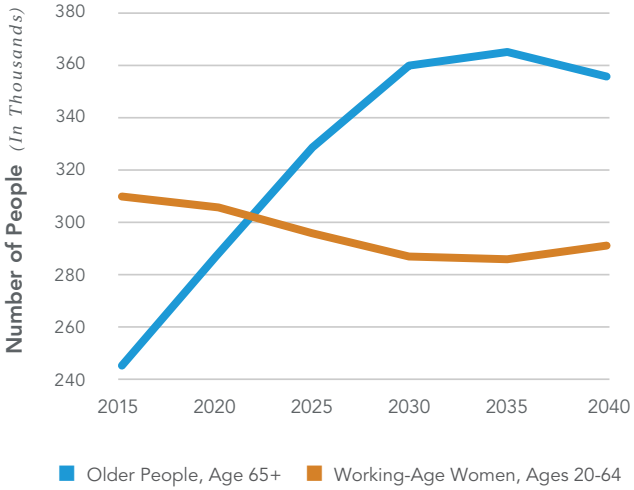
People Age 65+, 2015-2065




**Source:** Minnesota Population Projections by Age and Gender, 2015-2065. Minnesota State Demographic Center, August 2015.

## Rural Minnesota "Care Gap"

Older People, Age 65+ vs. Working Women, Ages 20-64




**Source:** Minnesota State Demographic Center. (2014, March). Minnesota County Population Projections by Age and Gender, 2015-2045.

12. Minnesota State Demographic Center, Data by Topic: Aging, Retrieved from https://mn.gov/admin/demography/data-by-topic/aging/.
13. Continuing Care Administration, "Status of Long-Term Care in Minnesota 2010: A Report to the Minnesota Legislature," pg. 2, 2010.

(A complete listing of rural counties and their older adult populations can be found in Appendix C.) The proportion of older adults in rural towns, in part, results from the flight of young adults to metropolitan areas. Many rural towns have found that when young people leave for college, they do not return. Instead, they look for better jobs with higher pay, as well as a different setting.

At the same time, health care—and particularly long-term care—services are scarcer in rural counties. Of active physicians, 85 percent worked in metropolitan counties as of 2005.[15] Professional home health agencies have been concentrated in cities as well, with 73 percent serving clients in the Twin Cities.[16] Long distances between sparsely located clients have complicated the delivery of home-based services outside of Minnesota's major cities.

Communities are also experiencing a decline in the number of informal and family caregivers available to provide support. One contributing factor is that the current generation of older adults had fewer children than did previous cohorts: 1.9 children per couple on average, compared to 3.2 in the 1950s. A greater number of older adults are also living alone, either because they never married or are now widowed or divorced. These demographic trends are exacerbated in rural counties as a result of urban flight among younger family members.

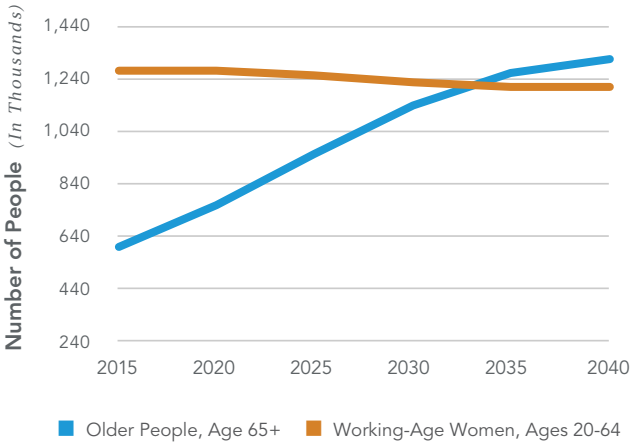
With fewer family members available to provide care there is an increased demand for paid assistance. In the last few years alone, that shift has become clear: In 2014, the most recent year for which this data is available, 30,740 individuals used personal care services in the state, a 29 percent increase from 2009.[17]

Yet this growing need has not been accompanied by an expanding workforce. Minnesota's labor force is facing considerable strain as the workforce ages. In particular,

14. U.S. Census Bureau. (2014, July 1). Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: 2014 Population Estimates. Retrieved from http://factfinder.census.gov.
15. Jay Fonkert, "Rural Minnesota's Health Care Workforce," Rural Minnesota Journal, p. 58, Spring 2007.
16. Fonkert.
17. Minnesota Department of Human Services, Minnesota Data by County, 2009 Q1 – 2014 Q4: http://acrs.truvenhealth.com/MNLTSS/content/CountiesDetail.html.

## Non-Rural Minnesota "Care Gap"

Older People, Age 65+ vs. Working Women, Ages 20-64




**Source:** Minnesota State Demographic Center. (2014, March). Minnesota County Population Projections by Age and Gender, 2015-2045.

the numbers of workers who have traditionally filled the role of caregiver—women aged 25 to 54—is declining. At the same time, a shrinking unemployment rate is creating greater competition for fewer younger employees. This situation is exacerbated by the industry's dependency on a low-wage/high-turnover employment model. "In a word," argues the Continuing Care Administration, "the projected labor force supply for long-term care is likely to be inadequate without significant changes in labor deployment, recruiting and maintenance."[18]

This is not only a matter of future, anticipated care gaps; rather, stakeholders interviewed for this report described the current situation as a crisis. Representatives from LeadingAge Minnesota—a provider association of independent senior housing, assisted living, in-home care, adult day services and skilled nursing facilities—explained that among their two thousand members, maintaining a quality workforce was the "number one issue." Providers interviewed for this report, representing personal care, home health, and assisted living services, used words such as "terrifying" and "untenable" to characterize the workforce shortages that they and their clients face.

Several providers explained that while they have historically received a steady stream of applications regardless of whether they were hiring, over the past three years, the number of applicants has dropped off and job openings remain vacant. This has been the case despite increasingly aggressive recruitment methods, including use of social media, signing bonuses, and additional incentivizing tactics.

An agency coordinating care for self-directed clients reported similar challenges. Though consumers are "using every means available," from personal networking to social media to websites such as care.com and craigslist.com, "everyone is having difficulty finding someone." One consumer, using the self-directed model of care, reported that he spent eight weeks aggressively seeking out applicants and interviewing 33 in order to find a qualified PCA to hire. Having such difficulties in hiring, he explained, causes consumers to internalize a message that there is something wrong with them—that they are helpless.

18. Continuing Care Administration, "Status of Long-Term Care in Minnesota 2010: A Report to the Minnesota Legislature," 2010.

# ADDRESSING MINNESOTA'S CARE GAP

## A WELL-ESTABLISHED SYSTEM OF HOME AND COMMUNITY-BASED SERVICES

With concerted effort, Minnesota is well positioned to make the necessary changes to address workforce shortages. The state's ranking as first in the nation in delivering services and supports to older adults on the 2014 AARP Long-Term Services and Supports Scorecard in large part reflects thorough and ongoing work to rebalance care delivery towards HCBS. In 2001, the Minnesota Legislature enacted comprehensive reform provisions to rebalance the state's long-term care system. It established benchmarks aimed at reducing nursing home utilization, expanded the availability of home and community-based options, and mandated biennial updates to the legislature.

As of 2014, older adults would need to pay 100 percent of their median incomes to afford 44 hours of weekly home health services.

As an AARP case study reports, "Minnesota has a mature, well-established LTSS system that provides alternatives to nursing homes for people seeking publicly supported service. The state funds both Medicaid and non-Medicaid HCBS programs, and is a national leader in operating integrated health and LTSS managed care programs." [19] The case study notes Minnesota's strong commitment to HCBS, long history of managed care in health and LTSS systems, and the development of housing alternatives for older adults as key reasons for the state's successes.

Minnesota also ranks first in the availability of assisted living and residential care alternatives.

Indeed, the majority of Medicaid and other state funds are allocated towards HCBS: 65 percent of Medicaid and state LTSS spending is allotted to home and community-based settings, the second highest proportion of state funds in the country. Of new Medicaid LTSS users, 80 percent first receive services in the community. Further, a well-established and statewide managed care program creates the potential for effective care coordination across the continuum of care and incentivizes use of home and community-based options. In AARP's scorecard, Minnesota secured the top ranking in access to Medicaid-funded LTSS. Generous financial eligibility rules and widely available information and options counseling through the state's Aging and Disability Resource Center have made this possible.

## QUALITY AND AFFORDABILITY GAPS

It is worth noting that the metrics for which Minnesota scored lowest on the AARP scorecard were clustered in home health services, particularly in the areas of affordability and effective transitions. Minnesota ranked 49th out of 50 states in median annual home care private pay cost as a percentage of household income. As of 2014, older adults would need to pay 100 percent of their median incomes to afford 44 hours of weekly home health services[20], as opposed to the 47 percent of median income paid by households in the top-ranked state. Home health quality measures and transition efficacy also lag, despite the state's high scores in other areas of LTSS performance. Minnesota ranks 39th in the percentage of home health recipients who require hospital admissions (28 percent), and 25th in the percentage of people with 90-or-more-day nursing home stays successfully transitioning back to the community (8 percent).[21]

19. Robert Mollica and Leslie Hendrickson, "State Long-Term Services and Supports Scorecard, What Distinguishes High- from Low-Ranking States? Case Study: Minnesota," AARP, May 2012, pg. 20.
20. The Genworth 2013 Cost of Care Survey uses 44 hours-worth of services to define the average cost of home health services.
21. AARP, The Commonwealth Fund, and the SCAN Foundation, "Minnesota: 2014 State Long-Term Services and Supports Scorecard Results," 2014.


## INSUFFICIENT CAPACITY

As noted earlier in this report, since the launch of the state's 2001 long-term care reform initiative, biennial reports to the Minnesota Legislature have gathered information about capacity issues and gaps in the delivery of LTSS to older adults. All counties in Minnesota have participated in producing this Gaps Analysis Study.[22]

The most recent analysis, published in 2015, identifies transportation, chore, personal care, and respite care as areas presenting the most significant service gaps for older adults. Approximately one in five lead agencies identified PCA services among their top three most significant gap areas. PCA and respite services were also reported to have the greatest reductions in availability over the prior two years. Perhaps most importantly, agencies reported that when needed services are not offered, those seeking them do not find alternatives. As a result, most older adults turn to support from family and friends if it is available or elect to receive care in more restrictive settings at hospitals or nursing homes.

In responding to questions about service availability, agencies cited the following factors as contributing to gaps: provider reimbursement rates, recruitment and retention challenges among service providers and frontline staff, a shortage of trained staff, and a lack of funding. These reactions were reinforced by interviews conducted for this report among stakeholders ranging from policymakers, consumer advocates, and home care providers. The scarcity of qualified workers was frequently referred to as a "crisis." Interviewees overwhelmingly cited demographic shifts, inadequate reimbursement rates, and lack of funding to explain the shortage.

Despite Minnesota's recent budget surpluses, stakeholders identified a "lack of political appetite" for increases in human services funding. Furthermore, a number of interviewees noted that while associations

22. Minnesota Department of Human Services, "Gaps Analysis Study," Prepared by Wilder Research for the Minnesota Department of Human Services, August 2015.

and organizations representing nursing homes are politically connected within the state and have successfully fought for higher reimbursement rates, those representing home care services do not have the same clout. Nursing homes, in turn, are able to provide higher wages and compete with home health agencies for the same pool of potential workers. While greater numbers of older people prefer to age in place, "policy and funding decisions are not caught up to what's happening on the ground," explained one stakeholder. Changes in LTSS, she noted, are instead progressing very slowly.

### UNIQUE CHALLENGES IN RURAL COUNTIES

As detailed in the following section, LTSS are less available in rural communities than in cities. Barriers such as distance, transportation, and resources are more likely to be prohibitive to care delivery in rural environments. Representatives from the Minnesota River American Automobile Association (AAA) noted, for instance, that the service area covered by their agency spans two-and-a-half hours by car, making vehicle ownership a necessity for providing care. Additionally, as many stakeholders noted, the cost of owning and maintaining a car in the state's colder regions is greater than in more temperate areas. Though even when significant travel is not required, home care assignments in rural areas can be inconsistent and work hours limited. The thin population density of these regions means that few people needing services are within easy reach of each other. At the same time, the small number of home care worker candidates is a disincentive to agencies considering developing recruitment and training programs.

Together, demographic shifts in population, changes in the economy, and a workforce plagued by subpar wages and conditions have created a climate in which traditional methods of recruitment and retention *no longer work*. County and tribal agencies and providers reported in the Gaps Analysis Study that "no strategies were currently underway to either increase the availability of services or reduce barriers to access." Most stakeholders contributing to the report felt that guidance and additional resources were needed in order for counties to implement change locally. Strategies such as increasing reimbursement rates, providing grant funds, developing training models, and enacting legislative reforms were suggested.

# CHANGING DEMOGRAPHICS OF RURAL MINNESOTA

### AGING POPULATION

As previously noted, while Minnesota's older adult population is set to double in the next two decades, rural Minnesota is aging even more rapidly. Already, some rural counties have more than twice the proportion of older adults as does the state overall. By 2030, reports the Rural Minnesota Journal, "about 22.6 percent of Greater Minnesota's population will be 65 and over, compared to 20.6 percent for the state as a whole, and 19 percent for the Twin Cities."[23] At that time, an estimated 115,212 older adults in rural counties will need some level of long-term care.

According to the Minnesota Department of Human Services' Baby Boomer Survey 2010, most of these older adults would like to live independently at home. Were they to require assistance with health or daily living, more than 40 percent said they would like to receive that help at home. Another 28 percent would want to move to an assisted living setting.[24] Over the last decade, the number of assisted living facilities in Minnesota has grown by 181 percent and in-home service providers by 115 percent to meet this need. But growth has been uneven throughout the state, and rural communities still suffer from major gaps in services, particularly within home care.

23. "Where Will Rural Baby Boomers Live in Their Later Years?" LaRhae Khantterud, Rural Minnesota Journal 2012, volume 7, p. 2.
24. Khantterud, p. 15.

## INCOME AND WORKFORCE GAPS

An added challenge for older adults in rural Minnesota is an overall average income level that is lower than their metropolitan counterparts', leaving a large proportion of this population unable to meet the cost of living. Of the rural population aged 65 to 74, 46 percent have incomes below 200 percent of the federal poverty line, compared to 33 percent of the Twin Cities metro population. In Traverse County, where the median income for those 65 and older is $26,000, the cost of living is estimated at about $35,000.[25] More than a third of older adults in rural counties said they do not know how they will pay for aging services, the highest rate reported among any of the state's geographic areas.[26]

Projections by the state demographer and others show the greatest number of rural job openings will be in health care.

As long-term care needs grow, insufficient income and service gaps will leave many of the state's older adults in rural communities without the means to age with health and dignity. A decades-long exodus of young workers has weakened the ability of small communities to meet residents' caregiving needs. Projections by the state demographer and others show the greatest number of rural job openings will be in health care. Demand for long-term care workers, in particular, is expected to grow 45 to 65 percent.[27] However, the severe labor shortage across rural Minnesota threatens the state's ability to meet these needs:

The Minnesota Department of Employment and Economic Development projects job growth of about 159,000 jobs in Greater Minnesota between 2010 and 2020. In that ten-year span, however, the workforce is expected to grow by only 98,500. That leaves more than 60,000 jobs potentially unfilled.[28]

This workforce squeeze, argues the Center for Rural Policy and Development, is the "single biggest problem" facing long-term care in rural Minnesota.

## RECRUITMENT AND TRAINING CHALLENGES

A thin labor market not only hurts recruitment efforts, but also impacts the ability of employers and educators to provide quality training to potential workers. Demand for workers with home care skills in a given geographic area might not be sufficient to warrant or maintain training programs. Of the state's 147 approved training sites for certified nursing assistants (CNAs) and HHAs, only 25 percent are located in rural counties. Cook and Lake counties in the northeast corner of the state together cover more than 6,000 square miles but include just one approved CNA/HHA training site. Approximately 37 percent of rural counties have no approved sites.

Several employers interviewed for this report have grappled with the lack of trained workers, as well as the need to devise innovative means of training when funds are scarce. Employers also pinpointed challenges to quality training, such as geographic isolation, prohibitive distances between clients, and inability to achieve economies of scale. One provider noted that it takes her more than two hours of travel to meet with the care providers association, limiting her ability to engage with a valuable resource to her agency.

25. Khantterud, p. 6.
26. Khantterud, p. 14.
27. Center for Rural Policy and Development, "Long-term care workforce challenges in rural Minnesota," April 2015. P. 19.
28. Kyle Uphoff, "Understanding Skills Shortages and Regional Economies," Rural Minnesota Journal, 2012, p. 2.

# QUALITY OF JOBS, QUALITY OF CARE

Though demographic and economic shifts provide important context for rural Minnesota's workforce crisis, the substandard quality of jobs available to home health aides and personal care assistants significantly impair the ability of long-term care organizations to cope with these challenges. As one rural-based provider explained, supermarkets in her county pay $3.00 an hour above what aides earn and usually provide greater security and an easier workday. Aides at her agency, she explained, have incredibly stressful jobs, requiring heavy lifting, managing behavior that is, at times, difficult, and being on their feet for hours at a time.

The complexity of home care jobs has intensified in recent years as client acuity levels have risen. Several stakeholders remarked that people who used to receive care in hospitals are now in nursing homes, residents once in nursing homes are now in assisted living facilities, and residents once in assisted living are now increasingly supported at home.

PHI's analysis of the U.S. Census Bureau's American Community Survey confirms these findings about job quality.[29] Home care workers experience low wages, part-time and inconsistent work, a lack of benefits, and insufficient education. Almost half of aides rely on public assistance. The median annual earnings for home care workers is about $12,500, reflecting the part-time and erratic hours that characterize the work.[30] Meanwhile, the Minnesota Department of Employment and Economic Development estimates that the cost of living for single, childless adults is upwards of $30,000, rising to more than $52,000 for households with at least one child.[31]

As the figure on the following page shows, hourly wages for home care workers (HHAs and PCAs combined) vary by more than a dollar across different regions. It is noteworthy that of the six regions with the highest average wage, four are comprised completely or primarily of metropolitan counties. The remaining two are mixed areas with both rural and metropolitan counties.

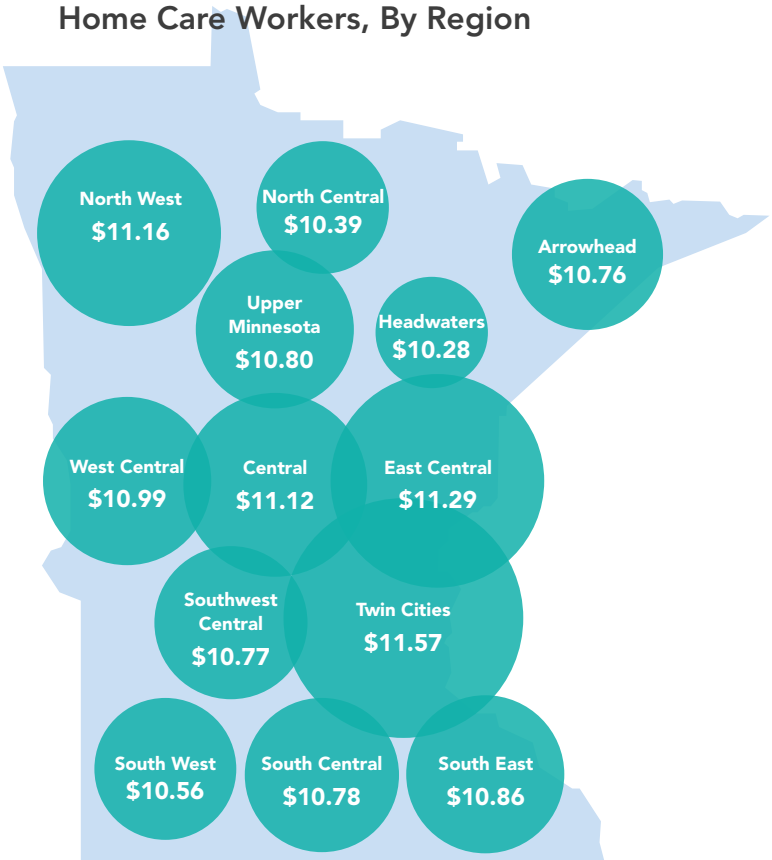
29. PHI analysis of the American Community Survey, U.S. Census Bureau (2015). 2010-2014 ACS 5-year PUMS. Retrieved from http://www.census.gov/programs-surveys/acs/data/pums.html.
30. For additional information, see the home care workforce demographics in Appendix B.
31. Minnesota Department of Employment and Economic Development, Cost of Living in Minnesota, Labor Market Information, 2016. Retrieved from http://mn.gov/deed/data/data-tools/col/.

The three regions with the lowest wages are comprised primarily of rural counties.

Unreliable, insufficient hours compound income insecurity for home care workers. Approximately 76 percent of home care workers nationwide work part-time, a greater proportion than the average among all occupations of 69 percent.[32]

Additional job quality issues impacting home care workers include inconsistent training (detailed in the following section), inadequate supervision, and scarce opportunities for professional growth and advancement. As a result, workers may not have the essential skills or support needed to carry out their duties in a positive and effective manner. In PHI's experience, workers who lack confidence and feel they are ineffective are more likely to leave their jobs.

## Average Hourly Wages for Minnesota Home Care Workers, By Region




Home care, long considered "domestic labor," has a history of being undervalued and underpaid. Instead, the industry is marked by jobs with limited opportunity and workers with limited power to change the circumstances of their profession. The demographic profile of Minnesota's home care workforce reflects the state's low-income workforce overall: 80 percent of home care workers are female, 37 percent are people of color, and 21 percent are immigrants. Though more than half have graduated high school, only 22 percent have completed an Associate's or Bachelor's degree. (A full breakdown of workforce demographics can be found in Appendix B.)

The quality of home care jobs has a significant impact on turnover rates and quality of care. Besides the financial cost of high turnover (at least $2,500 per worker), each termination—voluntary or otherwise—compromises a caregiving relationship and the quality of services a client receives. Turnover adversely affects continuity of care. According to the Better Jobs Better Care report, *The Cost of Frontline Turnover in Long-Term Care*, "frontline workers play an important role in monitoring the day-to-day physical and mental health of clients...high turnover causes the loss of this important source of information about patient well-being."[33] Further, turnover contributes to staffing shortages and promotes rushed and unsafe delivery of care.

Through decades of work with long-term care providers, PHI has identified the most effective factors to improving retention among direct care workers: higher wages; comprehensive benefits (most critically, health insurance); full time hours; adult learner-centered, competency-based training; and skilled, supportive supervision. Each requires investment to positively impact job quality and, in turn, improve care—investments that are particularly critical in Minnesota's rural counties.

**Source:** Minnesota Department of Employment and Economic Development. (2016, June 9). Occupation Employment Statistics. Retrieved from https://mn.gov/deed/data/data-tools/oes/.

32. PHI analysis of the American Community Survey, U.S. Census Bureau (2015). 2010-2014 ACS 5-year PUMS. Retrieved from http://www.census.gov/programs-surveys/acs/data/pums.html.
33. Dorie Seavey, "The Cost of Frontline Turnover in Long-Term Care," Better Jobs Better Care, October 2004, p. 15.

# TRAINING LANDSCAPE AND TESTED INNOVATIONS

## HOME HEALTH AIDE TRAINING

Minnesota uses the federal CNA requirements as the basis for training HHAs, which is a minimum of 75 hours of instruction and 16 hours of clinical experience. For every 12 months of employment, licensed HHAs must complete at least 8 hours of in-service training in relevant home health care topics. All HHAs must follow their client's plan of care, which is developed by a registered nurse who is also responsible for supervising the aide.

HHA training is provided at MDH-approved sites across the state. There are 147 sites approved for either CNA, or combined CNA and HHA training. The majority of sites are community and technical colleges, but some high schools, independent training centers, and provider agencies also provide training. However, to become an HHA, one must complete a training that specifically includes HHA material, rather than one that is exclusively for CNAs. MDH has approved three curricula for use at these training sites, only one of which currently includes training for HHAs (that of the Minnesota State Colleges and Universities system).[34] In theory, an HHA training program could design its own curriculum, based on required competencies, and have it approved for use by MDH; to date, none have pursued this route.

## PERSONAL CARE ASSISTANT TRAINING

Training requirements for PCA certification are minimal in comparison to HHA and CNA requirements. PCAs must complete a 24-hour orientation, along with a competency evaluation that captures knowledge of specific competencies outlined by the state. Minnesota is one of only 26 states that requires agencies to provide training to new PCAs and one of only eight states to designate the number of training hours PCAs must complete. There are no federal training standards for PCAs.

34. The Minnesota State Colleges and Universities system includes 24 technical and community colleges and seven state universities across the state.

## BEST PRACTICES: PHI's Homecare Aide Workforce Initiative (HAWI)

In 2013, PHI launched a collaborative effort to improve the quality of home care services for older New Yorkers, with lead funding from the Harry and Jeanette Weinberg Foundation. Three home care agencies were supported to implement several of PHI's best practices in recruitment, training, and retention. Nearly 600 individuals were trained to be hired as home health aides.

The HAWI training and employment demonstration reinforces the link between quality training, job satisfaction, and the workforce stability that underscores quality care. An independent third-party evaluation demonstrated that graduates of the HAWI training and employment program were more confident in their skills and more satisfied with their jobs than were peers who completed the employers' traditional training and hiring processes. The impact for workforce turnover and continuity of care is clear:

- On average, 88 percent of home care workers trained and hired through HAWI retained employment at three months, compared to 76 percent of other home care workers hired during the same period. At six months, retention was 76 percent on average for HAWI new hires, compared to 64 percent for peers.
- Home care agencies participating in HAWI sustained respectable levels of continuity of care (0.67 of 1.00) during a tumultuous period of state regulation changes, in which client advocates feared continuity of care would decline.

PCA orientation is usually provided through an online course and evaluation, which individuals must often complete from home, as few personal care agencies have computers available for new employees. An individual must complete the training and be enrolled as a provider through DHS in order to begin work as a PCA.[35]

DHS regulates training and provides online competency tests for PCAs. The training covers topics such as: Overview, Emergencies, Infection Control and Standard Precautions, Body Mechanics, Understanding Behaviors, Boundaries and Protection, Timesheet Documentation, Fraud, and Self-Care. Consumer-directed aides are often trained by their consumer-employers.[36]

### PCA TRAINING GAPS AND SOLUTIONS

Despite the existence of PCA training regulations in Minnesota, many stakeholders believe that the required training is insufficient to develop a quality workforce. Interviewees familiar with the online PCA training noted that questions on the final competency test are so easy to answer that many workers skip the orientation and immediately take the test. Stakeholders explained that this low bar "essentially provides no standards at all." Others identified an additional training need for older adults using the consumer-directed model to prepare them to hire, orient, and supervise.

Through decades of experience as a workforce and organizational development consultant for leading home care providers, PHI has frequently seen the impact of inadequate entry-level training on job satisfaction and turnover. Home care workers who lack access to quality training are more likely to feel insecure in their abilities to support clients' health and overwhelmed by the demands of their roles. For this reason, inadequate training poses a significant challenge to cultivating a skilled, reliable workforce. An independent evaluation of the Homecare Aide Workforce Initiative, a multiyear training and employment demonstration undertaken recently by PHI in partnership with three home care agencies (see table on the following page), offers concrete evidence in support of these conclusions.

Several organizations in Minnesota have begun to tackle this challenge by pushing for more comprehensive training standards and developing additional content beyond the minimal state requirements. In Fall 2015,

35. See Appendix A.

36. The online training may be waived by consumer-directed participants in the Consumer Support Grant Program (CSG) and the Consumer Directed Community Supports (CDCS) program, who can elect to train their own aides.

following contract negotiations with SEIU Healthcare Minnesota, the union that represents many of Minnesota's PCAs,[37] the state tasked a Training and Orientation Committee to address low training standards. Made up of representatives from DHS and SEIU, as well as workers and consumers, the Committee meets monthly to provide recommendations on training standards. Members are reviewing the content and implementation of the online PCA orientation, as well as broader tensions between maximizing consumers' choice in hiring and providing structure for worker training.

As a first step, the group identified core needs requested by home care workers. Surveys indicated that most were interested in CPR, first aid, and dementia support skills. In Summer 2016, the Committee produced four recommendations that have been approved by the commissioner for implementation:

1. Free CPR and first aid training will be made available on a first-come, first-serve basis to 2,200 PCAs, beginning at the end of July 2016.

2. All workers in the SEIU bargaining unit will have free access to the online resources of the College of Direct Support, which offers web-based training courses for direct support staff, people with disabilities, and their families, with content developed by the Research and Training Center on Community Living at the University of Minnesota.[38]

3. A voluntary training program will be piloted and evaluated at a handful of personal care agencies, which will cover topics of independent living, consumer-directed philosophy, respectful communication, and the medical versus social model of delivering care.

4. A separate pilot will provide tools to reduce burnout and stress.

The committee also resolved factual errors in the online PCA orientation and has initiated a broader review to improve the required online training.

Many high-road employers provide, in addition to the state's online program, their own robust training and orientation for new hires. One agency interviewed created a three-day, PowerPoint-based training covering skills from dressing and bathing to dementia care. They also require at least two days of job shadowing to ensure aides can demonstrate those skills. Though the state does not consider the three-day training a reimbursable expense, the agency pays new hires during the training period. Another employer uses a supplemental 16-hour online training created by Educare, alongside five hours of classroom instruction and a robust job shadowing program. Other agencies opt to hire CNAs or HHAs who have already been trained and licensed at an outside facility, typically a community college.

## BETTER PCA AND HHA TRAINING METHODS

While Minnesota's training requirements for HHAs are consistent with the federal minimum and its PCA standards exceed national requirements, the state has no guidelines for how to deliver training. Without standards for instructors, and with agencies facing constrained resources, much of Minnesota's home care training is conducted through purely didactic methods in the form of lectures and video tapes. The work of education researchers over several decades, as well as PHI's own experience, has shown that this is the least effective approach to training prospective home care workers, many of whom face language barriers and have had limited access to quality education.

Alternative teaching methods promote effective training outcomes. For example, it has been shown that adult learners integrate knowledge best through an engaging and participatory classroom that is centered on strong relationships between and among instructors and students. Both content and teaching methods need to be adapted to include problem-solving activities, role-plays, case studies, small-group discussions, and other interactive exchanges.

PHI has documented more than a dozen case studies demonstrating the impact of quality training and coaching supervision.[39] Innovations in training delivery, particularly when combined with on-the-job workplace supports and effective supervision, can contribute to prospective home care workers' success in a challenging workforce landscape.

37. Since 2014, SEIU represents those PCAs working through the state's consumer-directed programs (PCA Choice, CDCS, and CSG), currently numbering around 20,000 workers.

38. See: https://mn.gov/dhs/partners-and-providers/training-conferences/long-term-services-and-supports/college-of-direct-support/.

39. See: http://phinational.org/consulting/resources/case-studies-profiles. For more information, see: PHI, Adult learner-centered training: An introduction for educators in home and residential care, November 2008.educators in home and residential care, November 2008.

# RECOMMENDATIONS AND CONCLUSION

An increase in the number of older adults living in Minnesota—particularly in Greater Minnesota—is driving the need for a stable, well-trained, and respected caregiving workforce. Yet despite growing demand, significant challenges threaten the state's ability to deliver quality long-term care services: poverty-level wages and poor job quality for home care workers, rising costs for home health services, low provider reimbursement rates, and low rates of successful client transitions from nursing homes back into the community. Rural counties face additional hurdles due to sparse populations, acute transportation needs, and a significant lack of resources.

Home care workers are the frontline of long-term care and can play a productive role in improving the health of clients.

Of particular note are the challenges in finding and maintaining a well-trained workforce, as described consistently by providers interviewed for this report. Interviewees suggested that training standards are insufficient and the resources needed to improve training programs are scarce. In rural counties in particular, too few HHA training sites exist to prepare the workforce currently needed to care for older adults in these regions.

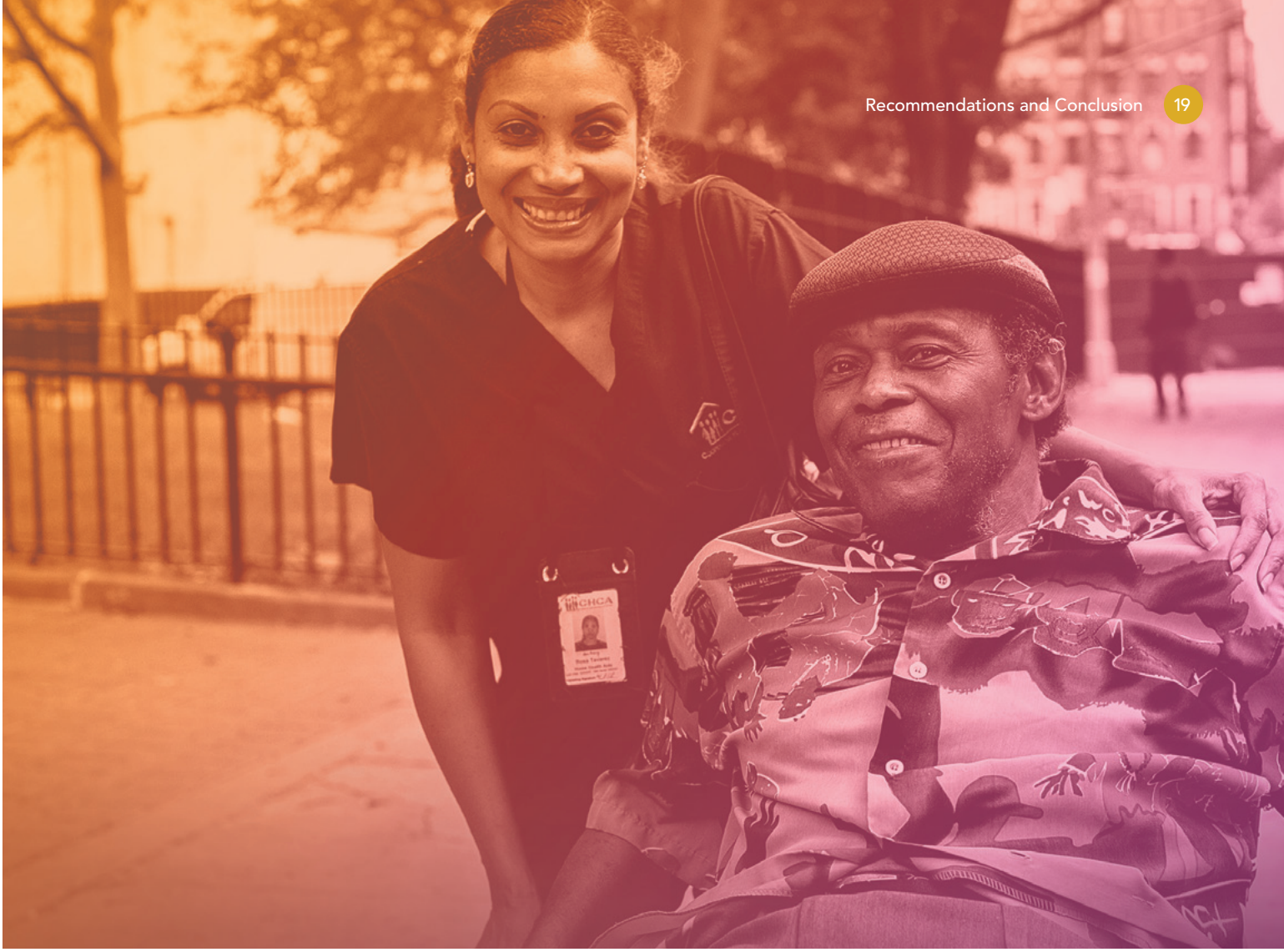
As the state continues to grapple with worker shortages, policy- and practice-based solutions will be necessary to bolster home care worker recruitment and retention. Public education initiatives can raise awareness and support from key stakeholders, while interventions at home care agencies and training sites can ensure that workers have the skills and support needed to provide reliable, quality care. In the absence of such measures, high turnover rates will continue to adversely impact the continuity and quality of care for older adults in Minnesota and impose high financial costs for home care employers—both organizations and individuals.

## ELEVATING THE ROLE OF THE AIDE

Informed by discussions with key stakeholders in Minnesota's long-term care sector, wide-ranging research, and evaluation results of PHI programs, PHI sees maximizing the role of home care workers as a crucial priority to improve the quality of care for older adults. Home care workers are the frontline of long-term care and can play a productive role in improving the health of clients. A multi-pronged approach to maximizing the role of the aide begins with the training, supervision, and workplace supports integral to a reliable, skilled direct care workforce.

**RECRUITMENT:** To expand recruitment, providers will need to reach new populations through persuasive recruitment materials that clearly convey the opportunities and challenges of employment in this sector. Home care can offer meaningful careers for individuals in low-income communities who face multiple barriers to employment, whether they are balancing work and family demands or have had limited access to formal work and educational opportunities. In PHI's experience, the most successful candidates are dedicated individuals with a caring disposition, interest in health care careers, and/or informal experience as caregivers for loved ones.

A recruitment approach that is tailored to the needs and circumstances of jobseekers in this sector will be critical to success for employers and candidates. A robust screening process should include multiple points of contact with an employer, as well as support and resources for candidates, such as connections with available community services. Agencies must



clearly define the characteristics of a successful home care worker and articulate job expectations during recruitment. It is crucial for employers to provide opportunities for candidates to demonstrate their ability to meet quality expectations before relying on them to deliver person-centered care.

PHI recognizes that successful home care agencies are committed not just to finding the right staff, but also to keeping the right staff. Our approach to maximizing long-term worker retention focuses on creating a workplace culture of retention, starting with an effective orientation program and employer commitment to a variety of initiatives that enhance relationships, skills, and voices for all staff.

**ENTRY-LEVEL TRAINING:** State training requirements often leave workers unprepared to provide supportive, compassionate care for older adults. The experiences of both PHI and the stakeholders in Minnesota interviewed for this report demonstrate that a lack of adequate preparation can cause home care workers to leave within their first few months of employment. Remedying this deficiency will require instructional methods that engage adults who may face multiple barriers to learning.

PHI's nationally recognized core curricula for entry-level PCA and HHA certification provides nearly double the required minimal 75 hours of training required by the state. The curriculum is built on a foundation of communication and problem-solving skills that are essential to strong caregiver-client relationships. PHI's materials embody an Adult Learner-Centered Training approach that places the learner's needs and experiential knowledge at the center of the instructional process—in contrast to the traditional teacher-centered approach that positions the educator as the expert to impart knowledge. Trainers function instead as learning facilitators with an array of interactive activities, such as call and response and role play, to build on what learners already know.

## LOCAL PROGRAM HIGHLIGHTS: LeadingAge Minnesota

The local branch of a national provider association for nonprofit long-term care service providers, LeadingAge Minnesota and its member organizations have led several initiatives to strengthen caregiving for older adults.

**RAISING AWARENESS**
Face Aging MN is a statewide campaign launched in 2015 by members of Care Providers of Minnesota and LeadingAge Minnesota to raise the visibility of key issues in aging services and to shift attitudes about older adults and caregivers.

**RURAL WORKFORCE DEVELOPMENT**
The Ecumen Scholars program led by Ecumen, a large-scale provider, and HealthForce Minnesota is cultivating the skills and leadership of nurses across senior care settings, with a particular emphasis on rural Minnesota, offering important lessons for rural workforce development in home care.

**CAREER PATHWAYS**
The Health Support Specialist (HSS) Registered Apprentice Program, adapted by LeadingAge Minnesota and HealthForce Minnesota, leverages on-the-job training and online courses to create flexible career pathways for Nursing Assistants and improve organizational culture, offering key program elements that can be applied in home care.

**SHARING BEST PRACTICES**
LeadingAge Minnesota fosters dialogue between member organizations through their annual Workforce Solutions Conference, which explores new interventions to strengthen caregiving, as well as through their Foundation's Workforce Solutions Grants, which assist providers with planning and initial implementation costs for new and proven best practices to address workforce challenges.

PHI assists long-term care organizations in developing entry-level and advanced training programs and curricula—offering curriculum development, training, and train-the-trainer seminars to introduce employers' instructional staff to adult learner-centered principles and teaching methodologies. These interventions can also be adapted to enhance and expand online training models. We are committed to building internal training capacity within employers and training partners, such as community colleges and vocational programs. For rural communities in particular, PHI sees high school facilities and adult education providers as existing infrastructures that can be leveraged to support quality home care training programs where none, or few, exist.

**ADVANCED ROLES:** Career advancement opportunities can maximize the roles of home care workers within the aging and health care systems. PHI has piloted several advanced roles that build on workers' experience in the field to improve care quality, including: **Peer Mentors** to support new workers in their transitions to the job; **Care Connections Senior Aides** to stabilize the home care environment and support effective care transitions by facilitating communication and problem-solving between a client's home and care coordination team; **Specialty Aides** to address specific health or chronic conditions such as diabetes, dementia, and asthma/COPD, as well as palliative care, cultural competence, and elder abuse prevention; and Assistant Trainers to strengthen hands-on learning and support in entry-level and in-service trainings.

Employers can leverage advanced roles to improve the quality of care for older adults. As discussed earlier in the report, the complexity of home care jobs has intensified in recent years as client acuity levels have risen. Condition-specific training curricula that bolster home care workers' clinical knowledge of common chronic conditions and familiarity with the care transitions space—when a client moves between an institution and HCBS setting—is in high demand. Further, as recent pilot demonstrations by PHI and additional organizations have shown, investments in advanced roles and specialty training for home care workers can have a significant impact on reducing re-hospitalizations. PHI's Care Connections Senior Aide pilot, mentioned in the prior paragraph

above, yielded notable improvements in re-hospitalization rates for members of the participating managed long-term care plan.

Demonstrating a viable career path beyond entry-level caregiving is also critical to improving recruitment and retention among Minnesota's home care workforce. Promoting experienced home care workers into advanced roles ensures that newly hired workers are supported by peers who intimately understand the demands of caregiving roles. For example, PHI's Peer Mentor role promotes retention by assisting new hires to successfully transition from pre-employment training to working in clients' homes. In communities where many new hires were previously unemployed or have never held a formal job, this intervention is critical to retention at the beginning of employment. Further, the existence of advancement opportunities for home care workers offers employers a competitive edge in the recruitment process, as accessible career ladders for home care workers are scarce.

**COMMUNICATION SKILLS AND SUPERVISION:** The critical skills of listening, feedback, self-management, and self-awareness in the home care environment can support productive relationships, empower staff, and create a respectful workplace. The PHI Coaching Approach® to Communication is a signature curriculum that builds essential communication and problem-solving skills through training and support PHI provides not only to entry-level aides, but also to all levels of an organization's staff. The goals of the training are to strengthen teams, enhance staff leadership and decision-making, and improve caregiving relationships to foster higher quality care. Similarly, PHI Coaching Supervision® training offers an alternative to traditional, punitive approaches to supervising home care workers. Coaching Supervision helps managers and supervisors to solve work-related problems, empower frontline staff, and balance that support with accountability for high-quality outcomes.

In PHI's experience, home care agencies that prioritize the sustainability of new organizational practices attain the greatest impact from these interventions. This includes maintaining sufficient staff capacity for implementation, developing mechanisms to ensure engagement from both executive leadership and frontline staff, and leveraging new practices to support the organization's business strategy, whether the provider is for-profit or nonprofit. The most successful interventions have active support from staff at all levels, which can be achieved through strategies like cross-department implementation and retaining a dedicated staff member to serve as the on-site champion and resource for the new interventions.

## SUPPORTING LOCAL PROGRAMS

A number of high-road employers in Minnesota are engaged in innovative recruitment, training, and workforce support strategies—particularly in rural areas, where providers have implemented practices as varied as providing employees cars for travel, using smart phone technology as employee portals, and creating new recruitment paradigms that look outside the traditional labor pools. These initiatives can be evaluated, strengthened, and potentially scaled up across the state. The best and most effective should be highlighted as models to build momentum for a stronger and more standardized approach to home care workforce development throughout Minnesota.

## PUBLIC POLICY INITIATIVES AND EDUCATION

Best-practice models established at the city and county levels can be coupled with public education initiatives to ensure the deepest possible long-term impact. The use of electronic and earned media outlets can build awareness of Minnesota's challenges to care for its most vulnerable citizens—and the critical role a skilled home care workforce can play in its successes.

A first step is to share existing research and calls to action to engage a wide group of stakeholders, including employers and other community providers, aging and workforce advocates, consumers, and policymakers at both the county and state level. These groups will contribute to a dialogue on what is needed to enhance the workforce infrastructure in Minnesota, promoting further collaboration. For example, TakeAction Minnesota is amplifying the voices of both older adults and home care workers to raise awareness of shared priorities and solutions. Their Care Worker Action program is cultivating leaders and advocates among non-unionized home care workers, while their partnership with Caring Across Generations is engaging teams of older adults in Greater Minnesota to develop and champion solutions that benefit the individuals who receive and provide long-term care.

Work to elevate the profile of existing collaborations that advance the stability and quality of home care jobs is key to promoting further adoption. As noted, DHS and SEIU are advancing PCA training methods and standards through a Training and Orientation Committee. Gathering information on cost efficiencies and improved care outcomes that have resulted from high-road training and employment interventions is critical to make the case to manage care companies and other payers that investment in the home care workforce has proven returns.

Some Minnesota home care agencies, associations, and coalitions, including the Best Life Alliance, already advocate for increased reimbursement rates for home and community-based services—a crucial first step toward improving wages and benefits for home care workers. PHI can assist these stakeholders to identify adequate reimbursement rate levels that incentivize job quality and serve as a partner in developing an advocacy campaign to target state policymakers. PHI has a strong track record with this type of collaboration. We have achieved strategic gains in reimbursement rate increases with partners in New York, and will apply a similar approach to our upcoming Taub Foundation-funded efforts in New Jersey.

## RURAL SOLUTIONS

The recommendations highlighted above stand to significantly advance home care workforce and care delivery across Minnesota; however, rural-specific adaptations must be put in place to address the significant service and employment gaps in those regions. Employer best practices that aim to overcome the geographic spread within rural counties, such as issuing company cars, developing phone-based technologies, and adapting elements of rural workforce programs like Ecumen Scholars (described in the table on the previous page), can be scaled across multiple agencies. Successful implementation of innovations in training and career advancement would require central locations in rural communities. Organizations rooted in these areas, such as LeadingAge, can play a critical role in creating workforce development hubs that leverages existing local infrastructure.

Minnesota's vast network of community colleges, already centrally involved in training HHAs, as well as some high schools, can provide valuable resources and partnership opportunities in rural areas. HealthForce Minnesota, Minnesota State Colleges and Universities' Center of Excellence in healthcare, promotes collaboration between educational institutions, community partners, and employers to connect jobseekers with relevant skills in a high-demand industry. Though focused primarily on training and career pathways in nursing, HealthForce Minnesota offers a prime example of how colleges in Greater Minnesota can be leveraged to address workforce challenges. Similarly, through our partnerships with Bronx Community College and Hostos Community College in New York, PHI is developing successful home care training programs that build on the existing framework of higher education.

## CONCLUSION

PHI's analysis of Minnesota's home care landscape and the unique experiences of older adults and caregivers in Greater Minnesota illustrates an immediate crisis that is becoming increasingly more entrenched. Current systems and practices could be better equipped to handle the surging demand for home care services and the persistently sub-par reality of home care employment. Home care workers enter the field understanding the demands inherent to providing in-home care, but with a strong desire to make a difference in the quality of life of their clients. But when dedicated, caring individuals are faced with insufficient training, inadequate supervision, and the knowledge that decades of experience are unlikely to yield increased wages or career advancement, they may increasingly turn to retail and other industries that present few barriers to employment. To improve the quality of care for older adults, we must begin, as many high-road employers and advocates in Minnesota have already done, by valuing the role of home care workers—both as it is currently conceived and, as it can potentially evolve: to contribute more integrally to improving healthcare for older adults in Minnesota.

# APPENDIX A

## PCA Enrollment, Employment, and Training Requirements, Minnesota

Personal Care Aide/Assistant (PCA): Individual employed by a personal care assistance provider agency who is certified by Department of Human Services (DHS) and provides personal care services.

### INITIAL ENROLLMENT SCREENING

1. Determine if the person meets the personal care assistant criteria.
2. Request and keep a copy of the person's certificate showing successful completion of the Individual PCA Training requirements
3. Verify to ensure the person is not on the Office of Inspector (OIG) Exclusion list.
4. Verify to ensure the person is not on the Minnesota Health Care Programs (MHCP) Enrolled Provider Excluded Provider Lists as an excluded individual provider
5. Submit a background study to DHS Licensing through NETStudy. Use the Agency ID assigned to the PCA Agency at the time of enrollment with MHCP
6. Wait to receive notice from DHS Licensing that the person is one of the following before you allow them to begin work as an individual PCA provider:
   - not disqualified or
   - has a set-aside to the disqualification

An individual who is employed as a personal care assistant must meet two sets of requirements.

### EMPLOYMENT REQUIREMENTS

1. Be 18 years of age or older.
2. Be employed by a PCA provider agency.
3. Initiate and clear a criminal background study.
4. Enroll with DHS as a PCA once all employment criteria are met.

### REQUIREMENTS SPECIFIC TO PROVIDING SERVICES

1. Effectively communicate with the person and the PCA provider agency.
2. Be able to provide covered PCA services according to the person's PCA care plan.
3. Respond appropriately to the person's needs.
4. Report changes in the person's condition to the qualified professional.
5. Maintain daily written records including, but not limited to, time sheets.
6. Complete training and orientation on the needs of the recipient.
7. Be supervised by the consumer or the qualified professional.

**A person age 16 or 17 may be a PCA with the following additional requirements:**

- Employed by only one PCA provider agency responsible for compliance with current labor laws
- Supervised by a qualified professional every 60 days

**A PCA may not be the:**

- Paid legal guardian of an adult
- Legal guardian of a minor
- Parent or stepparent of a minor child recipient
- Recipient of PCA services
- Responsible party of a recipient
- Spouse of a recipient

A PCA is limited to providing and being paid for up to 275 hours per month of PCA regardless of the number of recipients being served or the number of PCA provider agencies enrolled with.

### TRAINING REQUIREMENTS

The 2009 Minnesota Legislature required all PCAs to complete standardized training. DHS developed an online PCA worker training that meets this mandate. The online PCA worker training is available to anyone who wishes to provide PCA services. The training consists of nine modules and a certification test.

**PCAs are required to complete the DHS training:**

- Before completing the Minnesota Health Care Programs enrollment process as a PCA
- Within one year after the training is available in multiple languages, if currently enrolled and affiliated with a PCA agency

**PCAs must complete the competency test with a score of 80 percent or higher. The training is captioned and includes the following basic components:**

- Basic first aid
- Basic roles and responsibilities of an individual PCA
- Occupational Safety and Health Administration (OSHA) universal precautions
- Vulnerable adult and child maltreatment

**Training:**

- Is available online 24 hours a day
- Is free to the public
- Offers a separate test-out process

PCAs receive a certificate after successful completion of the test. The person may use the certificate as many times as needed for employment with one or more PCA agencies. The training and test are currently available in English. The training and test will be available in five additional languages: Hmong, Russian, Somali, Spanish, and Vietnamese.

**Provider agencies are responsible to:**

- Obtain a copy of the certificate of completion (this ensures PCAs have taken and passed the required training)
- Provide DHS with a copy of the certificate during the enrollment process

**DHS allows PCA agencies to make resources available for their employees to:**

- Review the online modules and
- Take the required test [40]

40. Source: Minnesota Department of Human Services. Retrieved from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_052161.

# APPENDIX B

## Home Care Workforce Demographics, Minnesota and U.S.[41]

| | Minnesota | U.S. |
|---|---|---|
| **Age** | | |
| 16-24 | 23% | 10% |
| 25-34 | 24% | 19% |
| 35-44 | 16% | 20% |
| 45-54 | 17% | 23% |
| 55-64 | 14% | 20% |
| 65+ | 6% | 8% |
| Mean | 39.19 | 44.31 |
| Median | 37.09 | 45.01 |
| **Gender** | | |
| Male | 20% | 11% |
| Female | 80% | 89% |
| **Race and Ethnicity** | | |
| White, Not Hispanic or Latino | 63% | 42% |
| Black or African American | 21% | 28% |
| Spanish, Hispanic, or Latino | 3% | 21% |
| Other and Two or More Races | 15% | 10% |
| **Citizenship** | | |
| U.S. Citizen | 79% | 72% |
| U.S. Citizen by Naturalization | 12% | 15% |
| Not a Citizen of the U.S. | 9% | 13% |
| **Marital Status** | | |
| Married | 39% | 38% |
| Widowed | 3% | 6% |
| Divorced | 15% | 18% |
| Separated | 4% | 6% |
| Never Married or Under 15 Years Old | 39% | 33% |
| **Education Level** | | |
| Less than High School | 15% | 19% |
| High School Diploma or Equivalent | 29% | 35% |
| Some College, No Degree | 35% | 28% |
| Associate's Degree | 10% | 8% |
| Bachelor's Degree or Higher | 12% | 10% |
| **Employment Status** | | |
| Full Time/Full Year | 25% | 32% |
| Full Time/Part Year | 6% | 7% |
| Part Time/Full Year | 44% | 36% |
| Part Time/Part Year | 27% | 24% |
| 1 thru 40 | 70% | 61% |
| More than 40 | 30% | 39% |
| **Health Insurance** | | |
| Any Health Insurance Coverage | 80% | 74% |
| Health Insurance Through Employer/Union | 39% | 34% |

41. Source: PHI analysis of the American Community Survey, U.S. Census Bureau (2015). 2010-2014 ACS 5-year PUMS. Retrieved from http://www.census.gov/programs-surveys/acs/data/pums.html.

## Home Care Workforce Demographics, Minnesota and U.S. continued

| | Minnesota | U.S. |
|---|---|---|
| Health Insurance Purchased Directly | 10% | 11% |
| Public Coverage | 39% | 36% |
| **Personal Earnings** | | |
| Mean | $16,791.86 | $16,347.46 |
| Median | $12,496.04 | $13,394.93 |
| **Family Income** | | |
| Mean | $55,887.21 | $56,195.38 |
| Median | $41,698.96 | $42,633.79 |
| **Federal Poverty Status** | | |
| <100% | 25% | 24% |
| <138% | 38% | 37% |
| <200% | 55% | 55% |
| <300% | 71% | 74% |
| <400% | 84% | 86% |
| 400% or more | 17% | 14% |
| **Public Assistance** | | |
| Any Public Assistance | 48% | 51% |
| Yearly Food Stamp Recipiency | 30% | 33% |
| Health Insurance through Medicaid/Means-Tested Public Coverage | 32% | 28% |
| Received any Cash Assistance Income Past 12 months | 6% | 4% |

# APPENDIX C

## Older Adult Population, Minnesota, By County, 2014[42]

(Rural counties highlighted in orange.[43])

| | Total Population | Age 65-69 | Age 70-74 | Age 75-79 | Age 80-84 | Age 85+ | **Total 65+** | **% of Population** |
|---|---|---|---|---|---|---|---|---|
| Aitkin | 15771 | 1491 | 1352 | 883 | 529 | 486 | **4741** | **30** |
| Anoka | 341864 | 15011 | 10344 | 6689 | 4479 | 4210 | **40733** | **12** |
| Becker | 33259 | 2121 | 1536 | 1145 | 848 | 776 | **6426** | **19** |
| Beltrami | 45664 | 2157 | 1495 | 1187 | 812 | 918 | **6569** | **14** |
| Benton | 39506 | 1600 | 1205 | 872 | 718 | 951 | **5346** | **14** |
| Big Stone | 5127 | 315 | 270 | 251 | 234 | 246 | **1316** | **26** |
| Blue Earth | 65385 | 2559 | 1844 | 1435 | 1188 | 1451 | **8477** | **13** |
| Brown | 25292 | 1347 | 1056 | 863 | 825 | 977 | **5068** | **20** |
| Carlton | 35571 | 1762 | 1372 | 1064 | 801 | 783 | **5782** | **17** |
| Carver | 97338 | 3328 | 2283 | 1536 | 1229 | 1314 | **9690** | **10** |
| Cass | 28559 | 2260 | 1902 | 1187 | 743 | 698 | **6790** | **24** |
| Chippewa | 12110 | 652 | 525 | 415 | 374 | 481 | **2447** | **20** |
| Chisago | 54025 | 2524 | 1897 | 1233 | 881 | 991 | **7526** | **14** |
| Clay | 61286 | 2254 | 1701 | 1409 | 1072 | 1317 | **7753** | **13** |
| Clearwater | 8791 | 510 | 423 | 340 | 204 | 237 | **1714** | **19** |
| Cook | 5233 | 469 | 332 | 193 | 138 | 140 | **1272** | **24** |
| Cottonwood | 11633 | 697 | 551 | 453 | 429 | 483 | **2613** | **22** |
| Crow Wing | 63265 | 4116 | 3405 | 2303 | 1626 | 1656 | **13106** | **21** |
| Dakota | 412529 | 17451 | 11940 | 8048 | 5960 | 6567 | **49966** | **12** |
| Dodge | 20353 | 784 | 646 | 476 | 367 | 409 | **2682** | **13** |
| Douglas | 36790 | 2352 | 1959 | 1404 | 1034 | 1214 | **7963** | **22** |
| Faribault | 14192 | 836 | 698 | 569 | 475 | 610 | **3188** | **22** |
| Fillmore | 20776 | 1186 | 936 | 727 | 599 | 780 | **4228** | **20** |
| Freeborn | 30840 | 1845 | 1488 | 1236 | 958 | 1097 | **6624** | **21** |
| Goodhue | 46423 | 2610 | 1928 | 1470 | 1148 | 1430 | **8586** | **18** |
| Grant | 5956 | 377 | 338 | 226 | 192 | 253 | **1386** | **23** |
| Hennepin | 1212064 | 50783 | 33717 | 24075 | 18915 | 23986 | **151476** | **12** |
| Houston | 18738 | 1080 | 795 | 595 | 535 | 625 | **3630** | **19** |
| Hubbard | 20573 | 1588 | 1276 | 926 | 591 | 483 | **4864** | **24** |
| Isanti | 38413 | 1787 | 1450 | 1021 | 609 | 726 | **5593** | **15** |
| Itasca | 45589 | 3050 | 2426 | 1618 | 1191 | 1291 | **9576** | **21** |
| Jackson | 10269 | 524 | 425 | 373 | 319 | 401 | **2042** | **20** |
| Kanabec | 15930 | 946 | 784 | 561 | 356 | 311 | **2958** | **19** |
| Kandiyohi | 42285 | 2114 | 1682 | 1270 | 975 | 1329 | **7370** | **17** |
| Kittson | 4435 | 277 | 206 | 185 | 137 | 195 | **1000** | **24** |
| Koochiching | 12856 | 881 | 640 | 534 | 370 | 374 | **2799** | **22** |
| Lac qui Parle | 6891 | 429 | 353 | 294 | 283 | 356 | **1715** | **25** |
| Lake | 10680 | 728 | 610 | 482 | 371 | 432 | **2623** | **25** |
| Lake of the Woods | 3918 | 282 | 209 | 162 | 101 | 108 | **862** | **22** |
| Le Sueur | 27770 | 1432 | 1085 | 787 | 571 | 570 | **4445** | **16** |
| Lincoln | 5788 | 316 | 307 | 288 | 223 | 308 | **1442** | **25** |

42. Source: U.S. Census Bureau. (2014, July 1). Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: 2014 Population Estimates. Retrieved from http://factfinder.census.gov.

43. As defined by Human Resources & Services Administration's "List of Rural Counties and Designated Eligible Census Tracts in Metropolitan Counties." Retrieved from ftp://ftp.hrsa.gov/ruralhealth/Eligibility2005.pdf.

## Older Adult Population, Minnesota, By County, 2014 continued

(Rural counties highlighted in orange.)

| | Total Population | Age 65-69 | Age 70-74 | Age 75-79 | Age 80-84 | Age 85+ | **Total 65+** | **% of Population** |
|---|---|---|---|---|---|---|---|---|
| Lyon | 25665 | 1042 | 790 | 610 | 541 | 718 | **3701** | **14** |
| McLeod | 35882 | 1830 | 1484 | 1093 | 787 | 1060 | **6254** | **17** |
| Mahnomen | 5505 | 301 | 214 | 175 | 118 | 117 | **925** | **17** |
| Marshall | 9417 | 516 | 429 | 365 | 250 | 322 | **1882** | **20** |
| Martin | 20220 | 1173 | 917 | 759 | 613 | 922 | **4384** | **22** |
| Meeker | 23107 | 1233 | 964 | 738 | 584 | 632 | **4151** | **18** |
| Mille Lacs | 25884 | 1318 | 1211 | 820 | 630 | 673 | **4652** | **18** |
| Morrison | 32810 | 1676 | 1383 | 1007 | 803 | 880 | **5749** | **18** |
| Mower | 39323 | 1885 | 1400 | 1146 | 1089 | 1408 | **6928** | **18** |
| Murray | 8470 | 557 | 466 | 358 | 301 | 339 | **2021** | **24** |
| Nicollet | 33093 | 1512 | 1007 | 789 | 572 | 716 | **4596** | **14** |
| Nobles | 21590 | 934 | 726 | 592 | 501 | 641 | **3394** | **16** |
| Norman | 6639 | 379 | 318 | 268 | 207 | 273 | **1445** | **22** |
| Olmsted | 150287 | 6301 | 4933 | 3752 | 2813 | 3221 | **21020** | **14** |
| Otter Tail | 57635 | 3814 | 3093 | 2342 | 1704 | 1991 | **12944** | **23** |
| Pennington | 14058 | 680 | 543 | 379 | 273 | 426 | **2301** | **16** |
| Pine | 29095 | 1621 | 1436 | 1016 | 693 | 595 | **5361** | **18** |
| Pipestone | 9281 | 481 | 339 | 353 | 287 | 428 | **1888** | **20** |
| Polk | 31704 | 1590 | 1183 | 958 | 734 | 944 | **5409** | **17** |
| Pope | 10984 | 736 | 560 | 454 | 315 | 429 | **2494** | **23** |
| Ramsey | 532655 | 22454 | 15226 | 11148 | 8993 | 11153 | **68974** | **13** |
| Red Lake | 4043 | 216 | 169 | 154 | 116 | 93 | **748** | **19** |
| Redwood | 15515 | 833 | 715 | 568 | 438 | 634 | **3188** | **21** |
| Renville | 15025 | 788 | 676 | 545 | 449 | 602 | **3060** | **20** |
| Rice | 65151 | 2883 | 2137 | 1647 | 1227 | 1297 | **9191** | **14** |
| Rock | 9553 | 523 | 418 | 347 | 281 | 387 | **1956** | **20** |
| Roseau | 15679 | 755 | 604 | 439 | 290 | 375 | **2463** | **16** |
| St. Louis | 200949 | 11001 | 7837 | 5906 | 4548 | 5284 | **34576** | **17** |
| Scott | 139672 | 4574 | 3256 | 2168 | 1428 | 1526 | **12952** | **9** |
| Sherburne | 91126 | 3340 | 2301 | 1504 | 996 | 1156 | **9297** | **10** |
| Sibley | 14918 | 710 | 600 | 484 | 402 | 414 | **2610** | **17** |
| Stearns | 152912 | 6402 | 4641 | 3787 | 2934 | 2869 | **20633** | **13** |
| Steele | 36573 | 1690 | 1293 | 1061 | 805 | 1014 | **5863** | **16** |
| Stevens | 9800 | 393 | 324 | 267 | 260 | 358 | **1602** | **16** |
| Swift | 9436 | 569 | 382 | 344 | 318 | 404 | **2017** | **21** |
| Todd | 24264 | 1420 | 1180 | 854 | 599 | 594 | **4647** | **19** |
| Traverse | 3387 | 182 | 178 | 157 | 165 | 188 | **870** | **26** |
| Wabasha | 21362 | 1289 | 930 | 670 | 480 | 624 | **3993** | **19** |
| Wadena | 13757 | 764 | 711 | 537 | 436 | 518 | **2966** | **22** |
| Waseca | 19025 | 953 | 652 | 503 | 409 | 565 | **3082** | **16** |
| Washington | 249283 | 11449 | 7652 | 5244 | 3645 | 3938 | **31928** | **13** |
| Watonwan | 11083 | 519 | 476 | 390 | 322 | 419 | **2126** | **19** |
| Wilkin | 6495 | 327 | 255 | 229 | 196 | 168 | **1175** | **18** |
| Winona | 51097 | 2445 | 1706 | 1391 | 980 | 1186 | **7708** | **15** |
| Wright | 129918 | 5048 | 3696 | 2488 | 1602 | 1769 | **14603** | **11** |
| Yellow Medicine | 10109 | 510 | 442 | 353 | 301 | 422 | **2028** | **20** |
| **STATE TOTAL** | **5457173** | **250447** | **181244** | **131944** | **99845** | **116662** | **780142** | **14** |

PHI QUALITY CARE THROUGH QUALITY JOBS

400 East Fordham Road, 11th Floor
Bronx, NY 10458
Phone: 718.402.7766
Fax: 718.585.6852
Email: info@PHInational.org
www.PHInational.org