Recommendations to Expand, Diversify, and Improve Minnesota's Direct Care and Support Workforce

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Work Plan

Olmstead Subcabinet
Cross-Agency Direct Care and Support Workforce Shortage Working Group
July 16, 2018

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Introduction

In March 2018, the Cross-Agency Direct Care and Support Workforce Shortage Working Group submitted a recommendations report to the Olmstead Subcabinet.[1] This report laid out a strategic vision for tackling the crisis in the direct care and support workforce. The cross-agency working group identified seven prioritized recommendations, and each recommendation contained subordinate strategies. The Subcabinet then requested the following actions:

- Add Activity Person-Centered Planning 4B.1a
    - The working group will further review and edit the recommendations included in the report to:
        - Prioritize the direct care report recommendations for implementation; and
        - Review and update the direct care report recommendations to identify:
            - which recommendations would need legislative action,
            - which would require state agency action, and
            - which ones require collaborative community efforts.
- Report back to the Subcabinet at the July 23, 2018 meeting.
- Adjust Activity Person-Centered Planning 4B.2
    - Develop implementation plan and work plan based upon recommendations *[for strategies and activities to recruit, train and retain workers to better meet Minnesota's Direct Care/Support Workforce needs.]*
    - Submit implementation plan and work plan to Subcabinet for review by September 30, 2018.

In April 2018, members of the working group divided into sub-teams to develop the work plans for each recommendation. The sub-team members are listed in Appendix A. Going forward, members of the cross-agency working group, including members of the disability community, family members, advocates, and others have expressed interest in continuing this work.

The working group prepared this report in response to the first part of the Subcabinet's direction. This report uses the following definitions as to what is required to implement these activities. Pending Subcabinet review and approval, the assessment by the affected state agencies as to what additional resources and policies would be needed to implement these activities will be included in the next report due in September 2018. The definitions used to answer the question in the columns that appear in the report are below:

Would need legislative action: This is answered "Yes" if the activity would require a change in statute, authority or appropriations.

Would require state agency action: This is answered "Yes" if any state agency action is necessary for the activity to occur. It does not presume that funding, staffing and other resources are currently available to implement the activity, only that one or more state agencies would need to take action for this activity to occur.

[1] See page 133 of Olmstead Subcabinet Meeting Agenda, March 26, 2018: http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs-299179.pdf. Accessed May 21, 2018.

Would require collaborative community efforts: This is answered "Yes" if voluntary efforts by community stakeholders would be needed for this activity to occur. If the activity only requires that some stakeholders comply with new or changing policies and procedures (such as a mandatory wage report) that is not considered collaborative community efforts.

As stated in the March 2018 report:

> ***The widespread inability to find direct care and support workers jeopardizes the health and well-being of Minnesotans with disabilities and older adults who depend on those services to remain in the most integrated settings possible. Even when caregivers can be hired, many people with disabilities describe a pattern of compromising their own needs to accommodate caregivers. In other cases, family members are forced to walk away from their own careers to care for loved ones themselves.***
>
> ***Despite the depth of need and a passion for the work, direct care and support professionals often report poor job satisfaction due to low wages and a lack of benefits, such as paid time off and health coverage. The need to earn a livable wage drives a striking percentage of direct care and support professionals out of the industry. This leave agencies and other providers struggling – or unable – to provide the requested services to people in need.***

The seven prioritized recommendations from the March 2018 report with subordinate strategies are listed below:

1. **Increase worker wages and/or benefits**
   Strategies:
   A. Provide a livable wage to enhance job satisfaction and retention, and address statutory limits on reimbursement rates that make it difficult for providers to pay direct care workers a livable wage.
   B. Require provider reporting of wages paid to track progress toward a livable wage.
   C. Offer or improve benefits provided to direct care workers, including health coverage, paid time off, and holiday pay.
   D. Assess the potential of creating an employee pool group consisting of direct care workers throughout the state to achieve the best possible health coverage at the most affordable price.

2. **Expand the worker pool**
   Strategies:
   A. Create incentives for high school and college students choosing direct care and support career paths.
   B. Expand the worker pool to non-traditional candidates.
   C. Explore options to address transportation barriers for direct care workers and the people who depend on their services.
   D. Provide resources to help organizations utilize recruitment and retention strategies known to increase the quality of candidates hired.
   E. Develop a service corps through partnerships with colleges, universities, and/or private partners.
   F. Develop apprenticeship opportunities.

3. **Improve the workforce by enhancing training for direct care workers**
   Strategies:

A. Assess the value of developing a training and scholarship program consistent with the Minnesota Department of Employment and Economic Development's career pathway model.
B. Promote use of existing training and development options.
C. Provide tiered credential options and career ladders for direct care workers.

4. Increase job satisfaction (including quality of the job)

Strategies:

A. Ensure access to effective supervision.
B. Recognize exceptional direct care and support work.

5. Raise public awareness by promoting direct care and support careers

Strategies:

A. Leverage Minnesota's career, training, and business services to develop a statewide recruitment and promotional plan to attract jobseekers to direct care worker careers.
B. Create a recruitment and retention guide, promotional materials, and public service announcements on direct care and support careers targeted to potential workers.
C. Develop an educational awareness plan on direct care and support careers targeted to high school students.

6. Promote service innovation

Strategies:

A. Identify and promote the use of technology solutions.
B. Support the development of service options for shared services and shared living in the most integrated setting.
C. Examine possible policy or regulatory barriers to the employment of potential direct care workers or the accessibility of services by the people who need them.

7. Enhance data collection

Strategies:

A. Gather and report longitudinal direct care worker workforce data across long-term services and supports in Minnesota.
B. Identify ongoing data needs for monitoring workforce issues.
C. Gather and report annual direct care worker workforce data across service types and populations receiving long-term services and supports.
D. Monitor improvements or worsening of the workforce issues based on baseline data.
E. Provide funding to allow monitoring of the relationship between critical incidents, recidivism of institutionalization, and emergency room visits based on reductions or increases in vacancy and turnover rates.
F. Provide funding to conduct a statewide study of emergency rescue personnel who respond to people who fall in their homes or need assistance with toileting or other activities of daily living due to lack of direct care workers.

All of the recommendations include, in addition to the activities listed in the work plan below, these additional overarching activities for the cross-agency working group:

- Consulting with DHS and DEED government relations directors on any Olmstead directives that may come to the 2019 session.
- Documenting progress going forward at regular intervals.

Workplan

Recommendation 1: Increase worker wages and/or benefits

Strategy 1.A: Provide a livable wage to enhance job satisfaction and retention, and address statutory limits on reimbursement rates that make it difficult for providers to pay direct care staff a livable wage.

Strategy 1.B: Require provider reporting of wages paid to track progress toward a livable wage.

Strategy 1.C: Offer or improve benefits provided to direct care workers, including health coverage, paid time off, and holiday pay.

Strategy 1.D: Assess the potential of creating an employee pool group consisting of direct care workers health coverage at the most affordable price.

1	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
1.A.1	• Work for a competitive workforce wage adjustment, both in a one-time increase in compensation and indexed adjustments every two years. This should be based on the average of the Bureau of Labor Statistics Occupational Classifications (SOC codes) for similarly skilled/educated occupations and include total compensation. In addition, bring all Direct Care Workers (DCW) wages up to the level of the highest paid DCW, as the highest priority for wage increases. • Explore Personal Care Assistant (PCA) reimbursement rates to allow for differentiating rates based on level of training and care required. The PCA reimbursement rate is the same for all recipients except during this past legislative session when an enhanced rate of 5% will be allocated for consumers who receive more than 12 hours per day of PCA services. This activity will help address the urgent staffing crisis consumers requiring extensive assistance with Activities of Daily Living (ADL) who may have the greatest degree of difficulty in obtaining direct care staff.	High	Yes	Yes	Yes

1	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
	• Both reimbursement rates and compensation rates are regulated in Minnesota through statute, and therefore it is a necessity to build support for needed legislation by activating provider and worker organizations in a public education campaign that incorporates the impacts of the worker shortage on people in the local community. • See Appendix B: Direct Care Staff Wage Analysis for supporting data.				
1.A.2	• Assess the state of financial sustainability of PCA providers given the increases in expenses against a reimbursement rate that has not had the degree of adjustments with increased regulated expenditures. • Identify PCA providers which are non-profit. Pull data on financial status from most recently available Federal 990s. Prepare report. • This requires determining a working definition of financial sustainability and identifying financial metrics to utilize for report analysis. • Develop a financial stability survey. Do a random sample of PCA providers that are for profit, and conduct the survey. Prepare report. Note: Many providers have multiple lines of business and it may not be practical to separate PCA or to determine the financial impact of PCA on the overall organization. • Work with Propel Non-profits (formerly Non-Profits Assistance Fund and MAP for Non-profits) to identify the criteria they use to determine whether an organization is credit worthy. Use that or similar criteria to assess financial strength.	Medium	No	Yes	Yes
1.A.3	• Develop a report on a comprehensive overview on all reimbursement rates for all programs in Long Term Services and Supports (LTSS), the people served, services covered, average wage by Direct Care Workers (DCWs) in each LTSS area and total number of people served.	High	No	Yes	No
1.A.4	• Engage all stakeholders in a public education campaign about the direct worker care crisis, an overview of Long Term Services and Supports, and why implementing the action items as solutions to this crisis is in the best interest of all Minnesotans. • Related to Strategies 2.4 and 2.5.	Medium	No	No	Yes

1	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
	• See Appendix C for supporting data from a survey of the Minnesota First Provider Alliance members.				
1.B.1	• Make reporting of workforce data mandatory for all providers across all LTSS programs. • Policy analysis would need to look at legislative language in order to provide basis for action and also for analysis on results of such mandated reporting. Could build upon HF2373 and SEIU contract.	High	Yes	Yes	No
1.C.1	• Make it possible for Direct Care Workers and employers to be flexible in the use of compensation funds, so that a range of benefits or wages could be selected by the worker. • Policy analysis would be considerable to assess what it would take to make it possible with regard to the legal issues that are central to this item.	Low	Possibly	Yes	Yes
1.D.1	• Pursue ways of maximizing the purchasing power of Direct Care Workers (DCWs) for benefits. This includes coordination with public health care program eligibility standards and buying into state programs such as MinnesotaCare. This would require legislative action. • A team of experts would be needed throughout the duration of the work. Initial conversation has taken place with some individuals about such an effort. • Any proposal will require policy analysis and would need to look at compensation. • Statewide health care coverage survey to be conducted by Minnesota Department of Health for Long Term Services and Supports direct care workforce, and providers.	Medium	Yes	Yes	Yes

Recommendation 2: Expand the worker pool

Strategy 2.A: Create incentives for high school and college students choosing career direct care and support career paths

Strategy 2.B: Expand the worker pool to non-traditional candidates

Strategy 2.C: Explore options to address transportation barriers for direct care workers and the people who depend on their services

Strategy 2.D: Provide resources to help organizations use recruitment and retention strategies known to increase the quality of candidates hired

Strategy 2.E: Develop a service corps through partnerships with colleges, universities, and/or private partners

Strategy 2.F: Develop apprenticeship opportunities

2	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
2.A.1	• Identify current employee/loan forgiveness programs which offer recruitment benefits of scholarships, tuition reimbursement, child care, transportation and other resources for the purpose of identifying "gaps" in availability to home care agencies. • Develop similar employee programs (e.g., Minnesota Department of Human Services Nursing Facility Employee Scholarship Program, Leading Age Minnesota Foundation Scholarships, Minnesota Department of HCBS Employee Scholarship Grant Program) or expand programs to include home care workers who are caring for people with disabilities under the age of 65. • Look at replicating or expanding federal/ state programs whereby college loans are forgiven for individuals who enter certain occupational fields (in this case direct care). • Identify existing programs for apprenticeship programs to provide a career pathway from direct care worker to LPN/RN and develop communication/marketing plan to reach home care agencies and other provider agencies across the state. Coordinate with state home care/PCA organizations. • Related to Strategy 3.A	Medium	Yes	Yes	Yes

2	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
2.B.1 and 2.D.1	• Review legislative/congressional directives for mandatory work assignments for individuals receiving public assistance • Work with the Minnesota Department of Human Services (DHS) to review possibilities of recruiting newly arrived immigrant populations to be direct care workers • Work with the Minnesota Department of Employment and Economic Development (DEED) to advertise openings in Workforce Centers, with youth service agencies, with adult serving agencies, etc., through the use of Direct Support Connect – an online job board matching workers looking for work and users of service looking for workers. • Work with the Minnesota Department of Education and other secondary educational organizations to build awareness of Direct Support Connect, to build awareness of the direct care workforce shortage and to encourage volunteer or part time work. • Work with Minnesota State Colleges and Universities, the University of Minnesota, and private college consortiums to also marker Direct Support Connect to student populations. • Work with advocacy groups to recruit non-traditional candidates. • Work to increase salaries/reimbursements. • Related to Strategy 1.A	High	No	Yes	Yes
2.C.1	• Examine conclusions reached by MnCOTA (Minnesota Council on Transportation Access) concerning employment related transportation barriers faced by youth and low-income adults. • Survey present and potential direct care workers concerning transportation barriers to employment. • Working with the Minnesota Department of Transportation (MnDOT) and the Metropolitan Council propose strategies to overcome barriers including such ideas as van pools, car sharing, and greater access to public transportation. • Look at expansion of transportation programs in DEED such as “Getting to Work.”	High	Possibly	Yes	Yes

2	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
2.E.1 and 2.F.1	• Develop Service Corps project design. • Identify potential members of service corps: o High school juniors/seniors interested in health careers (high school credit). o Post-secondary students interested in health careers (credits/credentials) and in other academic areas e.g., this group would be provided with the potential of tuition forgiveness or scholarships for part time direct care work commitment. • Work with accrediting agencies and Minnesota Department of Labor and Industry (DLI) to secure portable credentials leading to higher levels in health care. • Design marketing campaign to recruit corps/apprenticeship members. • Identify service corps funding sources (state/federal agencies/new legislation.) • Identify existing state/federal volunteer organizations for potential affiliation. • Related to Strategy 1.A and 3.A	High	Yes	Yes	Yes

Recommendation 3: Improve the workforce by enhancing training for direct care and support professionals

Strategy 3.A: Assess the value of developing a training and scholarship program consistent with the Minnesota Department of Employment and Economic Development's career pathway model.

Strategy 3.B: Promote use of existing training and development options.

Strategy 3.C: Provide tiered credential options and career ladders for direct care and support professionals.

3	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
3.A.1	• Create a direct care worker career pathway development team with representatives from state agencies, labor, advocacy, education, and service provider organizations. • Pathway Development Team will identify competencies required, available training, gaps in training, barriers/challenges to expanding training, and plan to develop an identified pathway. • Pathway Development Team will work with other professional organizations such as the Board of Nursing to work through scope of practice issues which might arise. • Work with Board of Nursing to explore admission criteria for LPN programs so direct care experience will be a factor consider in admissions decisions. • Related to Strategy 1.A	High	No	Yes	Yes
3.A.2	• Continue funding SEIU training. Identify a robust set of courses/offerings which are eligible for training funds. • Work with Minnesota State to offer courses/trainings throughout Minnesota. • Related to Strategy 2.B	High	Yes	Yes	No
3.A.3	• Publicize (through workforce centers, schools, employers, etc.) the direct care worker connection to existing career ladders—i.e., being a direct care worker is a great starting point for other health and human service careers.	High	No	Yes	No

3	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
	• Create collateral and online materials to be used by workforce centers, career counselors, employers, etc. to visually depict the opportunities to advance to other health and human service occupations from a direct care worker starting point. Identify training requirements and costs along with salaries associated with advancement on a career ladder.				
3.A.4	• All state-funded health and human service-related scholarship programs (e.g., MDH Home and Community-Based Services Scholarship Grant Program) should be expanded and amended to include direct care worker eligibility. • An inventory of these programs and any factors that limit inclusion of these workers will be created. • Legislation will be advanced to expand funding and increase access. • Related to Strategy 2.A	High	Yes	Yes	Yes
3.A.5	• Develop a Direct Care Service Corps program that will provide financial support to post-secondary students who choose to work as a direct care worker while enrolled in college. • Related to Strategy 2.E and 2.F	High	Yes	Yes	Yes
3.B.1	• Compile list of existing training and development options such as: PCA Choice, SEIU, DHS Individual PCA training, other provider training, etc. and publicize to employers (agencies and individuals) and direct care workers.	High	No	Yes	Yes
3.C.1	• Related to Activity 3.A.1. • Develop direct care staff (“Level 2” or “Lead”, for example) that can assist with training of new worker. Create a reimbursement code and fund this type of service. • Peer training, allow senior direct care workers to train new staff. A policy barrier may exist if training is taking place and one of the two people (trainer or trainee) is not getting paid – most likely the trainee. DHS does not permit billing for two people at the same time in the PCA program for training.	Medium	Yes	Yes	No

Recommendation 4: Increase job satisfaction (including quality of the job)

Strategy 4.A: Ensure access to effective supervision.

Strategy 4.B: Recognize exceptional direct care and support work.

4	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
4.A.1	• Implement for all Long Term Services and Support (LTSS) consumers, surveys of consumers with mandated reporting on their satisfaction with supervision, direct care workers, and their providers. • Policy analysis would need to look at legislative language in order to provide basis for action and also for analysis on results of such mandated reporting.	High	No	Yes	Yes
4.A.2	• The Minnesota Department of Human Services (DHS) implements an overall job satisfaction rating for all supervisors and direct care workers in aggregate. All Long Term Services and Support (LTSS) providers are mandated to conduct job satisfaction surveys by direct care workers and on supervision. • Priority within this implementation item is to address the unlicensed area first on provider metrics, job satisfaction metrics, and participant/consumer satisfaction surveys. In context of Long Term Services and Supports, unlicensed services are to have measures on quality indicators, job satisfaction metrics, and as importantly, participant/consumer satisfaction surveys. • Policy analysis would need to look at legislative language in order to provide basis for action and also for analysis on results of such mandated reporting.	High	No	Yes	Yes
4.A.3	• Re-engineer and expedite the Personal Care Assistant onboard process to reduce time lag, from initial recruitment of first time workers to deployment. Conduct provider education so that agencies are also working to reduce time lag from recruitment to deployment of direct care workers. • Also increase awareness of the PCA 10 lessons to increase success of the PCA testing by direct care workers through the following e-link: http://registrations.dhs.state.mn.us/videoConf/Default.aspx?BusinessUnitID=16. • Related to strategies for Recommendation 3.	Medium	No	Yes	Yes

4	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
4.B.1	• Assess what currently exists for awards and recognition. Home Health Aides, PCA,s CNA's, Health Service Assistants, Social Service Assistants, are some but not all who comprise Long Term Services and Supports direct care workers. We will work with an organization that could be part of a recognition program—such as Odyssey by DHS, or multiple entities that would support this effort on raising visibility, public awareness about Long Term Services and Supports professionals.	Low	No	Yes	Yes

Recommendation 5: Raise public awareness by promoting direct care and support careers

Strategy 5.A: Leverage Minnesota's career, training, and business services to develop a statewide recruitment and promotional plan to attract jobseekers to direct care worker careers.

Strategy 5.B: Create a recruitment and retention guide, promotional materials, and public service announcements on direct care worker careers targeted to potential workers.

Strategy 5.C: Develop an educational awareness plan on direct care worker careers targeted to high school students.

The activities to implement Recommendation 5 each target all three strategies.

5	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
5.A.1 and 5.B.1 and 5.C.1	• Create a recruitment and retention guide, marketing materials and PSAs promoting direct care worker careers. o Research if existing guides, marketing materials and PSAs can be used rather than creating original materials. o Analyze existing materials to assess if they are adequate for our purposes. o Choose the guide, marketing, and PSA (if they exist) that best fit our purpose, edit/tweak it if necessary. o If existing materials are not adequate, create a new recruitment and retention guide, marketing materials, and/or PSAs. • Related to Recommendation 2 and Strategy 1.A	High	No	Yes	Yes
5.A.2 and 5.B.2 and 5.C.2	• Utilize social media to promote direct care worker careers. o Compile list of social media sites that are already promoting direct care worker careers. o Identify additional social media avenues such as state agency sites. o Work with state agency and other organization's communications staff to provide information and materials for social media sites.	High	No	Yes	Yes

5	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
5.A.3 and 5.B.3 and 5.C.3	• Develop a seminar on direct care worker careers that can be replicated and offered in WorkForce Centers and other organizations involved in workforce development. o Examine existing classroom-style and virtual seminars to assess if existing materials can be used. o If existing seminar is not viable, create a seminar including a PowerPoint and associated materials for classroom settings, and an online version that can be posted on state agency webs or other channels.	High	No	Yes	No
5.A.4 and 5.B.4 and 5.C.4	• Use GovDelivery to promote job vacancies directly to job seekers. o Prepare materials and list of events, etc., that can be promoted through GovDelivery. o Work with state agency personnel to plan a GovDelivery email campaign. o Implement the plan, start promoting direct care worker careers with GovDelivery.	High	No	Yes	No
5.A.5 and 5.B.5 and 5.C.5	• Do statewide direct care worker education and hiring events in WorkForce Centers. o Create a plan in coordination with DEED, DHS, local Workforce Development Boards, Minnesota State colleges, and other partners in the workforce development system. o Implement the plan and hold a statewide event that can be replicated for future events. • Related to Strategy 2.B	Low	No	Yes	No
5.A.6 and 5.B.6 and 5.C.6	• Develop a plan to promote Direct Support Connect (directsupportconnect.com). o Gather existing promotional materials for Direct Support Connect. o Provide materials to state agencies and other organizations for use with Strategies 1-5 above.	High	No	Yes	Yes

5	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
	○ Print and distribute promotional materials to WorkForce Center personnel and DHS grant recipients statewide. • Related to several strategies that also reference Direct Support Connect.				
5.A.7 and 5.B.7 and 5.C.7	• Develop and educational awareness plan targeted to Minnesota Family Investment Plan (MFIP) recipients, high school students, and other audiences. ○ Identify a lead staff person or contractor who would be dedicated to this project full time for approximately 6 months. ○ Staff person or contractor develops the plan. ○ Plan is implemented in coordination with DHS, DEED, MDE and OHE. • Related to Recommendation 2.	Low	No	Yes	Yes
5.A.8 and 5.B.8 and 5.C.8	• Promote and distribute direct care worker videos on YouTube, state websites, social media, etc. ○ Research and gather existing direct care worker career videos from online and other sources ○ Share videos as appropriate on existing websites, social media sites, etc.	Medium	No	Yes	Yes

Recommendation 6: Promote service innovation

Strategy 6.A: Identify and promote the use of technology solutions.

Strategy 6.B: Support the development of service options for shared services and shared living in the most integrated setting.

Strategy 6.C: Examine possible policy or regulatory barriers to the employment of potential workers or the accessibility of services by the people who need them.

6	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
6.A.1	• Develop a computer program that enables coordination among agencies to meet service user and agency needs with regions of the state. • May need policy changes for working with multiple providers and development/spread of available technology.	High	No	Yes	No
6.A.2	• Develop system for PCA Choice and Consumer Directed Community Supports (CDCS) consumers to network in order to identify backup or emergency on-call staff. • Utilize Direct Support Connect to identify backup staff. Currently developed but marketing needs to be done to register more direct care workers and service users. This would not require additional funding except for staff time in marketing. • Explore other mechanisms to create emergency on-call systems amongst consumers. This would require use of technology and policy changes/fiscal notes to create a mechanism to pay on-call staff.	High	No	Yes	Yes
6.A.3	• Promote the use of assistive technology (AT), including communications technology, to support Olmstead goals while reducing staff time. State departments, local agencies and providers all need to encourage the use of AT through the planning and service delivery processes and work to educate and train consumers on applications of AT which can supplement or replace human assistance to reduce staff needed.	High	No	Yes	Yes

6	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
	• State agencies have collaborated to create the "Minnesota Guide to Assistive Technology" which supports people through the process of identifying how AT can help meet their support needs. The Guide is found at https://mn.gov/admin/at/				
6.A.4	• Expand the use of monitoring technology to support Olmstead goals while reducing staff time. Properly deployed monitoring technology can support people to live more independently and to reduce the need for people in situations such as overnight asleep staffing in group residential settings.	High	No	Yes	Yes
6.A.5	• Explore how assistive technology could be used more frequently to replace staff time for things like automatic catheter drains. This is currently available to people in HCBS waivers but could look at expanding to be available for people in state plan services.	High	No	Yes	Yes
6.B.1	• Service dogs/animals could be explored as a way to replace one-on-one people assistance. Policy issue as some consumers may need assistance to pay for basic food, veterinary care, and other costs associated with these animals.	Medium	Possibly	Yes	Yes
6.B.2	• Establish program to hire more people with disabilities who could provide assistance to other people with disabilities. For example, people with physical disabilities could redirect behaviors or monitor people with different types of disabilities. Requires policy changes to allow recipients to provide services.	Medium	No	Yes	Yes
6.B.3	• Examine ways that current Day Training and Habilitation (DTH) or other transportation vehicles could be used to shuttle direct care workers back and forth to consumers' homes when not being used.	Medium	No	Yes	Yes
6.B.4	• Creating incentives for direct care workers to recruit other direct care workers. This could be monetary or in the form of gift cards.	Medium	No	Yes	Yes
6.B.5	• Examine current policies around MFIP recipients to develop policies to prevent losing benefits by going to work as direct care workers. • Related to 5.A.7	Medium	Possibly	Yes	No

6	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
6.B.6	• Publicize Direct Support Connect, DHS' online job matching system designed to match workers looking for direct support jobs with consumer seeking direct support workers. Have publicity materials available at workforce centers and other prominent places/job boards. This website currently exists but additional marketing needs to be done.	Medium	No	Yes	Yes
6.C.1	• The Minnesota Department of Human Services (DHS) is designing Life Sharing supports for interested people with disabilities and non-related families in Minnesota. Life Sharing will use existing service structures to make it possible for a person with a disability to live with a non-related family member and share experiences. It communicates mutuality: a real community life, not a service life, is the expectation. If policy changes are needed, DHS will work to propose needed legislation and CMS approval as necessary.	Low	No	Yes	Yes

Recommendation 7: Enhance data collection

Strategies 7.A, 7.B, 7.C, and 7.D are combined into 7.G: Articulate an ideal monitoring system and data needs, determine existing data sources, determine gaps.

Strategy 7.A: Gather and report longitudinal direct care and support workforce data across long-term services and supports in Minnesota.

Strategy 7.B: Identify ongoing data needs for monitoring workforce issues.

Strategy 7.C: Gather and report annual direct care and support workforce data across service types and populations receiving long-term services and supports.

Strategy 7.D: Monitor improvements or worsening of the workforce issues based on baseline data.

Strategy 7.E: Provide funding to allow monitoring of the relationship between critical incidents, recidivism of institutionalization, and emergency room visits based on reductions or increases in vacancy and turnover rates.

Strategy 7.F: Provide funding to conduct a statewide study of emergency rescue personnel who respond to people who fall in their homes or need assistance with toileting or other activities of daily living due to lack of direct care and support staff.

7	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
7.G.1	• In order to determine existing data sources and determine gaps at the *population level*: compile all available population level data, survey data, and program data for Minnesota into a report or tool.	High	No	Yes	No
7.G.2	• In order to gather data on sustainability at the *employer level*: refer to Recommendation 1, Activity 1.A.2**.** Assess the state of financial sustainability of Personal Care Assistants (PCA) providers given the increases in expenses against a reimbursement rate that has not had the degree of adjustments with increased regulated expenditures.	Medium	No	Yes	Yes
7.G.3	• In order to gather data at the *program level:* See Recommendation 1, Activity 1.A.3. Develop a report on a comprehensive overview on all reimbursement	High	No	Yes	No

7	Activities	Priority	Legislative Action?	State Agency Action?	Collaborative Community Effort?
	rates for all programs in Long Term Services and Supports (LTSS), the people served, services covered, average wage by Direct Care Workers (DCWs) in each LTSS area, and total number of people served.				
7.G.4	• In order to gather data at the *program level,* ensure that future direct care worker legislation provides for data collection results/monitoring. See Recommendation 1, Activity 1.B.1. Make reporting of workforce data mandatory for all providers across all LTSS programs.	High	Yes	Yes	No
7.G.5	• In order to compile *population* wide and *program* level data: Modify current Information Technology (IT) systems as needed to report/capture data.	High	No	Yes	No
7.E.1	• Create hospital and nursing home admission and discharge code/codes to allow monitoring of critical incidents, recidivism of institutionalization, and emergency room visits due to lack of home care.	High	No	Yes	Yes
7.F.1	• Explore incident report data submitted to DHS for MA population. Note if data exists for reason/cause of incident indicating lack of direct care workers. If so, compile and track number and type of incidents, associated costs if incident resulted in visit to provider/specialty/hospital.	Medium	No	Yes	Yes

Strategy and Recommendation Relationships

Some strategies in the work plan target similar tools and activities. There may be synergies and efficiencies if sub-teams targeting similar tools and activities work together. For example, Direct Support Connect is a job board for direct support workers, home care workers, and PCAs. Strategies 2.B, 2.D, 5.A, 5.B, 5.C, 6.A and 6.B include activities that touch Direct Support Connect. Another example is surveys. Strategies 1.A, 1.D, 2.C, 4.A, and 7.G include activities that require surveys. Continued sub-team communication and collaboration is essential for maximizing these efficiencies.

Work on some strategies will result in progress on multiple recommendations. These relationships were identified by the working group and are shown in the table below. An 'x' indicates a relationship between work on a strategy and progress on a recommendation.

	R1	R2	R3	R4	R5	R6	R7
1.A	x	x					x
1.B	x						x
1.C	x						
1.D	x						
2.A		x	x				
2.B	x	x					
2.C		x					
2.D	x	x					
2.E	x	x	x				
2.F	x	x	x				
3.A	x	x	x				

	R1	R2	R3	R4	R5	R6	R7
3.B			x				
3.C			x				
4.A			x	x			
4.B				x			
5.A	x	x			x		
5.B	x	x			x		
5.C	x	x			x		
6.A						x	
6.B		x			x	x	
6.C						x	
7.G	x						x
7.E							x
7.F							x

Acknowledgements

DHS and DEED staff would like to acknowledge individuals who work in creating this report. The majority of the work was done by working group members and their voluntary group leaders. The following individuals served as “Team Leaders”: David Niermann (DEED), Robin Pikala (Direct Care worker), Valerie DeFor (Minnesota State – Health Force One), Steve Kuntz (DEED(, Larry Eisenstadt (DEED), Oriane Casale (DEED), and Jesse Bethke Gomez (Metropolitan Center for Independent Living), who actually took on leading two of the groups.

Appendix A has a list of the workgroup members who served on these seven different work teams. You will note that many of these individuals served on more than one workgroup and as many as three. We really want to acknowledge their commitment to this work to recruit, retain and improve the direct care staff/workforce shortage.

We would especially like to recognize Oriane Casale (DEED), Nitika Moibi (Minnesota Department of Health), Diane Drost (parent and disability advocate) and Valerie DeFor (Minnesota State – Health Force One) for the extra time they spent researching and gathering information on various issues and from different sources. Also, to Dan Newman for providing management leadership from DHS and gathering information about the provider reimbursement rates. Also, thanks to Dena DeLisle (Adena LLC) who joined this group quite recently and put together the provider survey that appears in Appendix C.

These groups took on much work as is evident in this report on a very short timeline. This involved sometimes having to fit in a lot of extra time and effort to complete these work plans under strict deadlines which all managed to do. Finally, we would like to acknowledge Erica Klein, senior management consultant from Management Analysis and Development (MAD) who kept the groups on track, provided resources to them, and compiled the work of the teams to put together this report.

The full roster of the cross-agency working group appears in Appendix D.

Appendix A: Sub-team membership

Recommendation 1: Increase worker wages and/or benefits

Group members: Jeff Bangsberg (disability advocate), Oriane Casale (DEED), Jesse Bethke Gomez (Metropolitan Center for Independent Living)*, Tyler Frank (SEIU Healthcare MN), Lori Dusan (family member and advocate), Curtis Buhmann (DHS), Dan Newman (DHS), Andre Best (PCA agency and First Provider Alliance representative)

Recommendation 2: Expand the worker pool

Group members: Larry Eisenstadt (DEED)*, David Niermann (DEED), Adesewa Adesiji (DEED), Steve Kuntz (DEED), Mohamed Mourssi-Alfash (disability advocate), Diane Drost (parent and disability advocate), Nitika Moibi (MDH), Valerie DeFor (HealthForce Minnesota – Minnesota State), Dena Belisle (PCA agency and First Provider Alliance representative), Linda Wolford (DHS)

Recommendation 3: Enhance training for direct care and support professionals

Group members: Robin Pikala (State Provider Cooperation Committee)*, Jeff Bangsberg (disability advocate), Tyler Frank (SEIU Healthcare MN), Lori Dusan (family member and advocate), David Niermann (DEED), Adesewa Adesiji (DEED), Valerie DeFor (HealthForce Minnesota – Minnesota State)*, Shelly Elkington (Avenues for Care, Inc. provider agency), Dena Belisle (PCA agency and First Provider Alliance representative)

Recommendation 4: Increase job satisfaction (including quality of the job)

Group members: Jesse Bethke Gomez (Metropolitan Center for Independent Living)*, Mohamed Mourssi-Alfash (disability advocate), Lisa Flynn (Hiawatha Homes/Home Care Association representative), Linda Wolford (DHS)

Recommendation 5: Raise public awareness by supporting direct care and support careers

Group members: David Niermann (DEED)*, Robin Pikala (State Provider Cooperation Committee), Adesewa Adesiji (DEED), Steve Kuntz (DEED), Larry Eisenstadt (DEED)

Recommendation 6: Promote service innovation

Group Members: Steve Kuntz (DEED)*, Jesse Bethke Gomez (Metropolitan Center for Independent Living), Lori Dusan (family member and advocate), Dena Belisle (PCA agency and First Provider Alliance representative), Linda Wolford (DHS)

Recommendation 7: Enhance data collection

Group members: Oriane Casale (DEED)*, Mohamed Mourssi-Alfash (disability advocate), Jim Liebert (DHS), Dan Newman (DHS), Nitika Moibi (MDH), Lisa Flynn (Hiawatha Homes/Home Care Association representative), Kay Kammen (DEED), Linda Wolford (DHS)

*Indicates group leader

Appendix B: Direct Care Staff Wage Analysis

DEPARTMENT OF HUMAN SERVICES

Comparative wage analysis of home and community based services direct care staff

June 2018

Department of Human Services
Disability Services Division
540 Cedar Street
St. Paul, MN 55155

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.is, call 651-431-4300, 867-267-2655, or use your preferred relay service. ADA1 (2-18)

As requested by Minnesota Statute 3.197: This report cost approximately $5,000 to prepare, including staff time, printing and mailing expenses.

Printed on recycled paper.

Introduction

This analysis examines wages for direct care staff in the home and community-based service (HCBS) fields compared with other occupations with similar education, experience and training requirements.

Summary of findings

Compared to all Bureau of Labor Statistics (BLS) occupations with the same education, experience and training requirements, direct care staff in home and community based services have significantly lower wages than the average worker with the same requirements. The average wage is 11 percent higher for all occupations with the same classifications than the average wage is for direct care workers.

This analysis highlights that direct care occupations are paid significantly less than other occupations with the same education and training requirements.

Defining direct care-staff occupations in the HCBS field

This analysis defines the average wage paid to HCBS direct care workers by utilizing the wage codes used in the Disability Waiver Rate System (DWRS). DWRS sets rates for most home and community-based services provided under the disability waivers, including residential services such as foster care, day services and unit-based services that help people live and work in the community.

The system sets rates based on data of average provider costs across the state. The formula starts with Bureau of Labor statistics (BLS) direct care-wage codes and then applies other costs to the wage value such as PTO, training costs, employee benefits, employer taxes, transportation, administrative and program costs, absence costs and indirect-time costs. The value of cost components are based on intensive research DHS and independent research firms conducted in 2010 and 2016. Predominant wage codes used in the formula are shown in Table 1:

Table 1: Predominant wage codes used in rate setting formula

BLS Code	Occupation	Median Wage in Minnesota (as of 12/31/16)
21-1093	Social and human service assistants	$15.57
31-1011	Home health aides	$11.87
31-1014	Nursing assistants	$13.39
39-9021	Personal care aides	$11.15

Other wage codes are used in specialized services, for example employment supports, behavioral support or services incorporating nursing. However, in most rate frameworks, the wage used is a combination of the codes listed In Table 1 (e.g., x percent of one code and y percent of another). This is because there is no wage code

that isolates workers in the home and community-based service fields separate from workers in other settings, i.e., nursing homes and hospitals.

The most recent analysis on direct care staff wages conducted by the National Core Indicators in 2015 found that the average wage paid to direct care staff in Minnesota was $12.66. In DWRS, the composite wage used for residential services is $13.53 and $15.33 in day services. This analysis uses the weighted average wage in the DWRS frameworks of $14.03 as a proxy for HCBS direct care staff wages to consider how these wages compare with the wages paid in other competing industries.

Occupations with similar entry requirements

In 2016, BLS published job characteristics and educational data for each BLS wage code (Employment Projections: Measures of Education and Training, Bureau of Labor Statistics, 2016). It categorized each wage code by:

- Typical education needed for entry (eight options ranging from Doctoral/professional degree to no formal educational credential)
- Work experience in a related occupation (three options ranging from "5 years or more" to none)
- Typical on-the-job training for competency (six options ranging from internship/residency to none).

For our analysis, we defined the classifications for direct care staff in HCBS by identifying how BLS categorized the specific codes used in DWRS. The most predominant classifications for direct care occupations used in DWRS are shown in Table 2.

Table 2: Most predominant classifications for direct care occupations

BLS Code	Occupation	Education	Work experience	Training
21-1093	Social and human service assistants	High school	None	Short-term on the job
31-1011	Home health aides	High school	None	Short-term on the job
31-1014	Nursing assistants	High school	None	Short-term on the job
39-9021	Personal care aides	High school	None	Short-term on the job

To isolate other occupations that are comparable to direct care-staff jobs, we identified all occupations that had the same classifications for all three measures. There were a total of 76 occupations. They included:

- Customer service representatives
- Office clerks
- Receptionists
- Bus drivers
- Delivery truck drivers
- Production workers
- Childcare workers
- Sales workers
- Security guards
- Shipping workers
- Hotel clerks
- Data entry workers
- Tire repairers
- Tellers
- Maintenance assistants

For a full list of these occupations, see Appendix A.

Wage comparison

This analysis compared the average direct care-staff wage of $14.03 to the weighted average wage of all occupations defined in appendix A with the same classifications. The range in wages across these occupations was $10.05 for gaming dealers and $28.25 for media communication workers. The most populated occupations are shown in Table 3.

Table 3: Wage comparison of most populated occupations

Occupation	Total number of workers in MN	Average wage in MN
Personal care aides	67,420	$ 11.83
Customer service representatives	56,610	$ 18.51
Office clerks, general	53,070	$ 17.00
Stock clerks and order fillers	33,440	$ 13.43
Secretaries and administrative assistants, except legal, medical, and executive	29,860	$ 18.81
Home health aides	25,200	$ 12.69
Receptionists and information clerks	17,880	$ 14.34
Bus drivers, school or special client	15,720	$ 15.97
Light truck or delivery services drivers	14,750	$ 17.96
Shipping, receiving, and traffic clerks	13,950	$16.98

Conclusions

Of all the 76 occupations meeting the same education, training and experience classifications, the weighted average wage was $15.62. This is 11.35 percent higher than the weighted average direct care staff wage of $14.03.

If the HCBS direct care staff wage codes were excluded from the calculation, the weighted average wage of the occupations on this list would be $16.46, a value that is 17.31 percent higher than the weighted average direct care-staff wage.

Table 4

Table 4: BLS occupations with the identified education, experience, and training classifications

BLS occupational title	Total number of Minnesota workers	Minnesota hourly mean wage
Personal care aides	67,420	$11.83
Customer service representatives	56,610	$18.51
Office clerks, general	53,070	$17.00
Stock clerks and order fillers	33,440	$13.43
Secretaries and administrative assistants, except legal, medical, and executive	29,860	$18.81
Home health aides	25,200	$12.69
Receptionists and information clerks	17,880	$14.34
Bus drivers, school or special client	15,720	$15.97
Light truck or delivery services drivers	14,750	$17.96
Shipping, receiving, and traffic clerks	13,950	$16.98
Social and human service assistants	13,820	$16.53
Helpers: Production workers	11,000	$13.01
Security guards	10,950	$15.53
Childcare workers	10,140	$11.76
Driver/sales workers	8,770	$12.70
Recreation workers	8,010	$13.65
Tellers	7,890	$13.22
Postal service mail carriers	6,420	$23.86
Reservation and transportation ticket agents and travel clerks	5,530	$21.66
Office and administrative support workers, all other	5,500	$16.11
Fitness trainers and aerobics instructors	5,140	$19.12
Hotel, motel, and resort desk clerks	4,730	$10.94
Loan interviewers and clerks	4,530	$20.52
Nonfarm animal caretakers	3,220	$12.16
Data entry keyers	3,110	$15.97
Mail clerks and mail machine operators (except postal service)	2,950	$15.21
Interviewers (except eligibility and loan)	2,800	$16.94

BLS occupational title	Total number of Minnesota workers	Minnesota hourly mean wage
Merchandise displayers and window trimmers	2,480	$14.79
Information and record clerks, all other	2,460	$19.97
Postal service mail sorters, processors and processing-machine operators	2,300	$23.61
Order clerks	2,170	$17.02
Gaming dealers	2,150	$10.05
File clerks	1,920	$15.69
Helpers: Installation, maintenance and repair workers	1,890	$14.24
Personal care and service workers, all other	1,710	$12.00
Residential advisors	1,680	$16.66
Protective service workers, all other	1,600	$18.02
Postal service clerks	1,530	$21.99
Tire repairers and changers	1,530	$13.47
Cargo and freight agents	1,360	$23.34
Community health workers	1,360	$18.29
Library assistants, clerical	1,150	$14.82
Office machine operators (except computer)	1,140	$15.83
Veterinary assistants and laboratory animal caretakers	1,040	$14.44
Financial clerks, all other	960	$18.15
Couriers and messengers	950	$15.17
Switchboard operators (including answering service)	910	$15.78
Media and communication workers, all other	860	$28.25
Gaming and sports book writers and runners	840	$10.40
Weighers, measurers, checkers and samplers, recordkeeping	800	$17.09
Word processors and typists	700	$18.88
Transportation security screeners	670	$19.71
Coin, vending, and amusement machine servicers and repairers	620	$18.78
Funeral attendants	610	$14.10

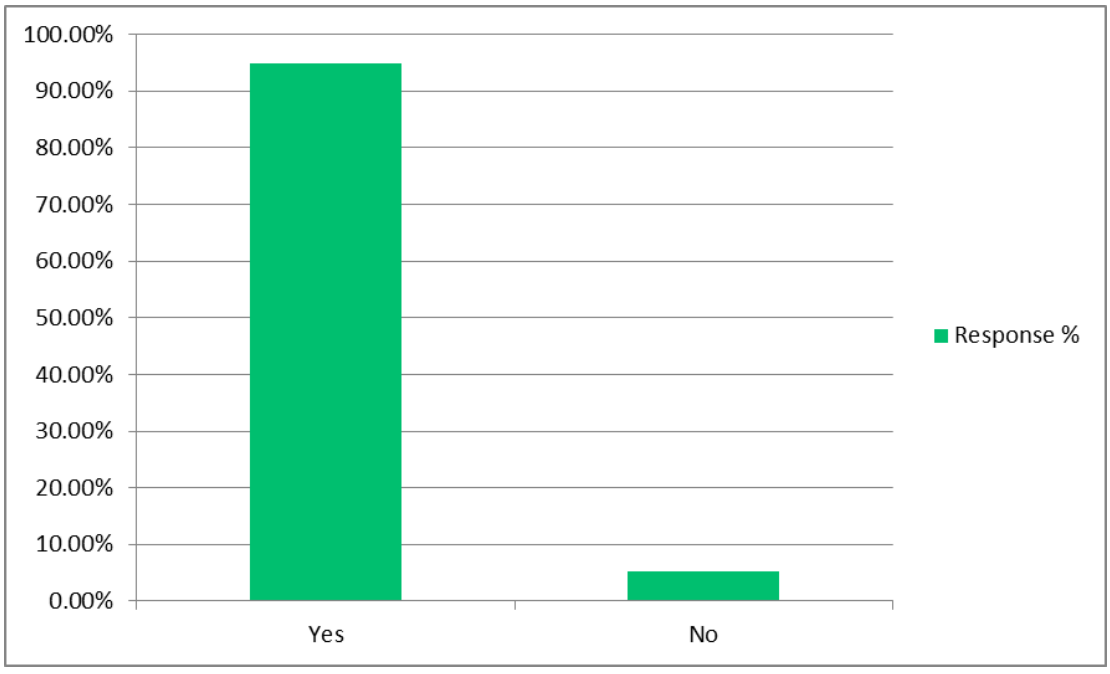
BLS occupational title	Total number of Minnesota workers	Minnesota hourly mean wage
Transportation workers, all other	480	$15.04
Photographic process workers and processing machine operators	450	$14.17
Pharmacy aides	450	$12.76
Furniture finishers	440	$17.20
Gaming cage workers	420	$13.27
Meter readers, utilities	340	$23.84
Baggage porters and bellhops	330	$10.73
Physical therapist aides	320	$17.87
Orderlies	320	$17.45
Helpers: Pipelayers, plumbers, pipefitters, and steamfitters	290	$16.97
Entertainment attendants and related workers, all other	290	$12.01
Media and communication equipment workers, all other	250	$24.93
Helpers: Electricians	240	$14.24
Locker room, coatroom and dressing room attendants	150	$11.35
Parking enforcement workers	140	$16.64
Radio operators	120	$25.03
Costume attendants	120	$18.29
Bridge and lock tenders	70	$28.24
Textile knitting and weaving machine setters, operators and tenders	50	$13.63
Gaming service workers, all other	40	$10.21
Correspondence clerks	30	$21.26
Manufactured building and mobile home installers	30	$15.53

Appendix C: PCA Provider Survey

Minnesota First Provider Alliance conducted a survey of their members on PCA vacancies, benefits offered, training and client feedback, all issues of interest to the Working Group. A total of 77 provider agencies have responded to date (June 7, 2018). Results in full are provided below. The following bullets provide a summary of the results:

- On average each respondent currently has approximately 14 PCA vacancies in their agency.
- 9.2 percent of the PCA jobs in responding agencies are currently unfilled.
- In answer to the question on what impacts these vacancies will have on clients, 22 of 59 respondents, or 37 percent, mentioned institutionalization (hospitals, nursing homes, assisted living, inability to continue to live in their own homes) in an open-ended question.
- Close to 40 percent of PCAs who work for the responding agencies are family members of the clients.
- About 50 percent of the responding agencies offer PTO and holiday pay and about 44 percent offer health benefits. About 85 percent provide staff training.
- Most responding agencies receive client feedback and try to use this to improve their services.

Are you having difficulty filling PCA vacancies?



Answer Choices	Response %	Response Count
Yes	94.81%	73
No	5.19%	4

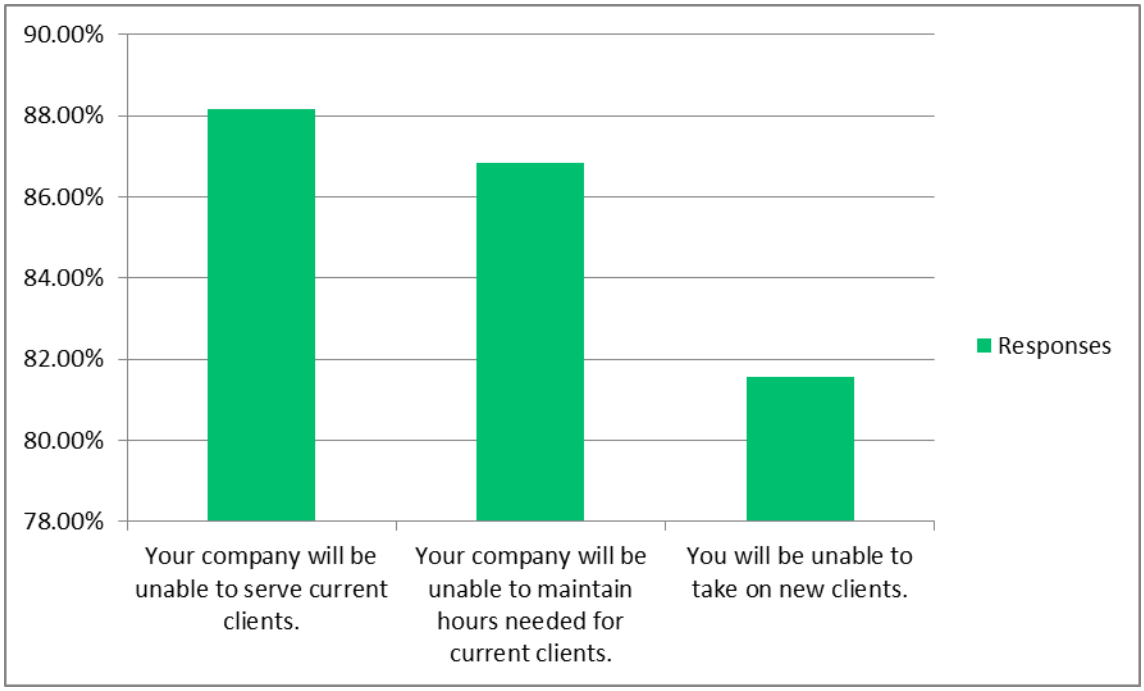
How many open PCA positions do you have open today?

Summary: On average each respondent currently has approximately 14 PCA vacancies in their agency.

How many PCAs are currently employed at your company?

Summary: 9.2 percent of the PCA jobs in responding agencies are currently unfilled.

What could be the impact of not filling vacancies? Check all that apply.



Answer Choices	Response %	Response Count
Your company will be unable to serve current clients.	88.16%	67
Your company will be unable to maintain hours needed for current clients.	86.84%	66
You will be unable to take on new clients.	81.58%	62

Would there be any other impacts on the client community?

Responses

- Clients may not be serviced if we can’t fill vacancies
- Yes
- Huge. Clients WILL be institutionalized like years ago.
- With 40 hours/week very hard to find PCA for existing services.
- No
- "1. Some patients will be left without care
- 2. Long delay in replacing PCAs who terminate"
- Clients either have to go without or go into a facility; negatively impacts client's ability to work and be productive members of the community
- No
- People without proper care may end up going into institutions thus costing our programs more and moving independent living efforts backwards.
- Even difficult to have back up
- There have been clients who have had to move to assisted living or nursing homes, taking them out of their homes and out of the communities where they have been productive contributors to the economy.
- Yes, they will not receive care for the number of hours they require. Quality of care will also be impacted negatively
- Clients would be unable to participate in outside activities, family, friends. Clients would have little say as to hours/times of work by PCA.
- Clients with complex medical needs will have to move to nursing homes.
- Question number 4 above doesn't apply to us currently
- Client will have to look from another community.
- Not able to produce quality services in a timely fashion
- Client will look for other companies that might have enough employees.
- Cover current employee's time off, cover emergencies for clients (hospitalizations, etc.)
- Clients may not be able to stay in their homes, be forced into nursing homes.
- People cannot receive the service or the quantity of service they need
- Our client's lives are negatively affected when they do not have staff because their basic needs cannot be met. If a person's basic needs cannot be met, they cannot flourish and enjoy life as they would like. Their health, both, physical and mental, is also at risk when they do not have a staff person to assist them in completing their ADLs.
- Yes. Many clients are potentially becoming vulnerable adults due to the PCA/Caregiver shortage. Clients are falling and being admitted to Hospitals more often due to lack of PCA/Caregiver coverage. We have also seen more clients who prefer to live at home have to go into a facility due to lack of PCA's/Caregivers.
- If you can’t provide the service they will need to go somewhere else
- They might have to go into Nursing Homes or Assisted Living homes to get the cares they need instead of being in their home with families and getting the same cares
- Clients are frustrated that we have trouble finding quality help with experience and maturity. They can become disenfranchised to accepting help even if they really need it due to many bad experiences in keeping help.
- WE turn away clients probably since Jan. 1st 2018 at minimum 15 new clients.

- 6
- Clients will be at risk of not being able to live independently in the community and may be forced to live in institutions to receive the care needed.
- We had had to turn away new referrals because we cannot guarantee that we will have applicants. It is senseless to do an intake for someone you may not be to offer any services to.
- Clients going without care for long periods of time.
- Responsible parties become exhausted
- There will be no continuity of care
- No
- The client may have to be put in an institution due to the shortage of workers. The staff aren't always willing to drive a distance to work with clients out of town because of the rates us agencies receive and can't offer higher compensation to staff.
- Yes, it would impact with their social and well as their physical needs
- People will be unable to leave the hospital or TCU or be forced to move into nursing homes or long term care facilities
- They wouldn't get the help they need to continue living in their homes
- Clients go into the hospital because of a lack of staff. Clients die because there is no one in the home. Clients are unable to pursue their goals and live their lives in meaningful ways.
- We are a PCA Choice company. Sometimes clients leave our program because they are struggling to find staff, and then they go to Traditional PCA companies and are told there are no staff available there either. Our workforce is in a crisis, especially so for clients who use wheelchairs and need higher levels of care.
- Yes people that are perfectly able to stay in the home will have to move to nursing facilitys. This would be a huge cost to tax payers
- Yes. Increased hospital visit due to skin breakdown. I have also had 2 clients leave my agency due to unfilled shifts and move to tiny rural towns where their family is one hour away from them. They did NOT want to move and leave their home of many years, but they have been forced to make these decisions due to staffing.
- Not having staff to meet the client’s needs...gives us a bad reputation to not find adequate staff due to low wages.
- Yes not having enough staff to meet their needs
- Clients have few options for PCA's. Often the PCA's we have take a lot of coaching, are late for work, pure work ethics, but Clients regard a bad PCA is better than no PCA.
- Clients who can't get their shifts filled will probably just have to let go of their services and go to a facility, or settle for a less committed PCA.
- Huge impact – client’s needs are not being met.
- Yes, not able to even try and staff brand new clients who have no one to help them causing some to be forced into some kind of facility. Going against the very nature of PCA services which is keeping clients independent in the community out of facilities.
- Yes may not be able in their homes
- Our PCA Choice clients are struggling to fill necessary shifts. Most of our clients are 12-24 hour per day services so this means they need 5-10 PCAs. Many are barely getting by with 2-3 PCAs. This means we often have to allow OT that we cannot bill for. We have a few clients who may have no choice other than a nursing home or group home. Fact is very few nursing homes or group homes will accept clients with this level of cares. We MUST see rate/wage increases or the PCA program will fail and cost the state more with costly facilities.
- Loss of revenue

- When clients go underserved, there is a direct correlation to their physical and mental health as observed by increased hospital and emergency room visits and the increase in drugs used to treat depression, anxiety, and mental illness.
- Yes, EMS would receive the calls
- Clients will move into assisted living and other facilities
- Clients cannot actively have interaction in their community. When a client has an active staff, their life is greatly enhanced.
- PCAs are demanding more than $13 per hour
- Yes, Caregivers turnover is most impacting the care of our clients.
- NA
- Not able to do all that they want to be doing

How many of your PCA are family members taking care of a family member?

Summary: Close to 40 percent of PCAs who work for the responding agencies are family members of the clients.

Do you offer benefits? Check all that apply.

Answer Choices	Response %	Response Count
Health Benefits	43.66%	31
PTO	50.70%	36
Holiday Pay	50.70%	36
Staff Training	84.51%	60

Do you receive feedback on quality of care from clients? And what do you do with that feedback?

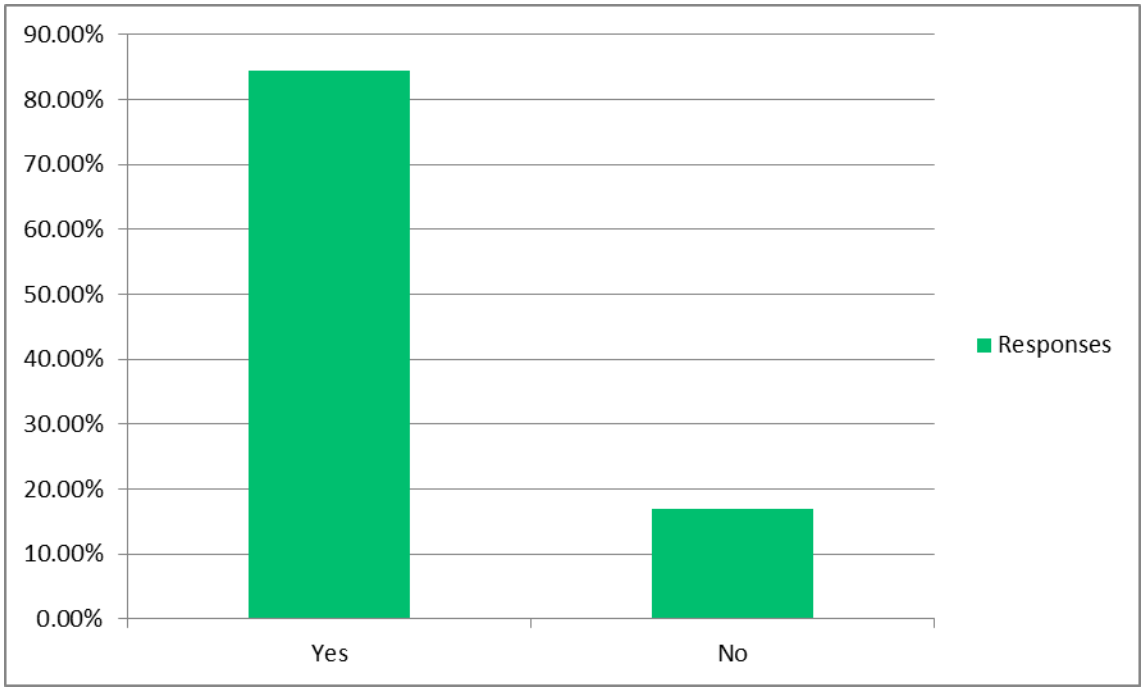
Responses

- Yes. We keep them.
- Yes, through client surveys, sup visits, or conversations. Address any issues that require follow up with caregivers: training, instructions, etc.
- Yes
- Yes. Discuss it.
- Working with PCA and client's to improve the services.
- Sometimes, we take it into consideration of how to give PCA raises.
- Yes. We share with the staff and use for training
- Yes. We address concerns.
- We use feedback to keep doing what is right and eliminate problems before they arise
- This information is scanned into the client file
- Follow up
- yes, we give the feedback back to the PCA
- I try to reorient my workers to do better
- Periodic surveys, feedback during QP/Supervisory nurse home visits. Follow up with person involved to make improvements.
- Yes. Change care plans. Retrain pcas.
- Yes
- "Yes, we get feedback from clients.
- We plan to buy gift cards for a ""thank you"" for doing a good job. "
- "Yes, feedback is not enough staffing coverage and not enough pay to keep staff.
- Quality of care feedback is good.
- We pay for an ongoing posting of Indeed. We are constantly recruiting for PCA positions. We have increased our wages. A huge issues is especially when we are going to have to 15 per hour with the new Mpls/St. Paul wages. Will the state reimburse agencies to help with the increase wages are mandated to pay.
- Overtime, is an issues for a number of families. They used to pay able to work up to 48 hours and it was straight time. We have cut overtime due to the fact we now to pay 1.5 for over 40 and some clients can't handle another caregiver to come in for those extra hours.
- Yes, we consider and make changes as needed.
- Yes, PCA evaluations and satisfaction surveys
- We hear feedback that we care and when we have staff available they are well trained. We also receive feedback that the lack of staff creates challenges for these clients as well as make them not feel cared for. We often times can only offer verbal reassurance that we are trying to find staff. Many times we send a supervisor to cover if there is no staff.
- Yes we do. Our LSW's or RN's also follow up with our clients regularly to ensure their safety and that all of their cares are being met in the home and that the PCA/Caregiver is prompt with their schedule and follows the Care Plan. We document our follow ups. We forward any changes in condition to the recipients Responsible Party and to their Case Manager, if they have one. We also have the Client/Responsible Party complete an Agency Survey for further feedback.

- Yes, we try to make the best of it by adjustments to the service if needed
- Yes we do, we have nurses and HR checks in with our clients to make sure cares are being met and they are satisfied. If not we train, write up, look for another PCA to fit their needs and maybe that PCA will work for another client or not at all
- Yes, we work together with our QP to help train the PCA if necessary, however, most of the issues are due to the PCA's poor work ethics.
- Yes we do an in depth evaluation after 6 weeks on company and care providers. We review the information and respond and make training or policy changes as we go.
- Nothing
- Utilize the feedback to implement training for the PCA's or provide positive feedback to the PCA's as encouragement to continue doing a great job...
- Yes, we utilize feedback to develop a plan with recipients to improve their individual quality of care so that it meets their expectations.
- Yes, we use the feedback to improve operations.
- PCA Choice families fall under union so they get PTO and Holiday pay. tradition families do not as they typically do not have enough hours to meet the criteria for our agency.
- Supervisory visits documented satisfaction with care and many times, clients compliment their PCAs greatly.
- yes we receive them and we pass to the Pca's in order to improve their work and understanding with the clients
- "Yes through visit and survey.
- We use the feedback to enhance patient care"
- sometimes, most them are verbal
- yearly report
- Yes
- Yes, they always ask that the PCA receive higher rate of pay because they enjoy their staff and their quality of care the staff provide that allows them to continue to stay home.
- Yes, we compile them in a report
- yes, we do quality assurance surveys
- Yes. Improve practices and/or maintain promote the goods ones.
- Yes, review and that gives us areas of weakness and additional trainings needed
- We relay it to the DSP.
- Yes and we address it if it is negative feedback.
- Positive feedback most of the time.
- Yes. After an internal staff discussion, we will address with the client, staff, training program, do what it takes to make the client feel confident of their care. However, the candidates who work for $11/hr are many times very inexperienced, and lack professionalism. Increased training costs money so that is not an unlimited budget.
- We do our best to hire qualifies staff...but doesn't always work like that...with higher wages...more qualified staff...
- They are upset that we don't have staff to send to their home to help with their needs. Clients then go with help or services
- QP's keep in constant contact with clients. PCA's have evaluations that are based on client feedback. Training for PCA's
- Yes. Use it to shape the company/industry - training, going to DHS for changes, etc.
- Yes
- Yes, we address problematic issues immediately and praise/reward the PCA's who are doing a great job!
- yes, corrective actions or celebrations depending on

- Yes we go over it with PCAs to improve care
- Many PCA Choice clients are not having all of their needs met due to lack of staff and costly expenses to advertise (out of pocket). One client has lost weight due to not having enough help to eat regularly. We are now helping by paying to run job ads, building a web site job board, offering hiring bonuses with little to no increase in applicants.
- Yes. Used it as a training tools, and ways to improved services delivery
- We have conducted customer satisfaction surveys in the past and have found that, indeed, clients are highly appreciative of having caregivers. However, clients are truly concerned about the shortage of pca staff these days.
- Raise for their workers
- work on the feedback and see if we can get better service everyday
- Clients are asking More money for their PCAs
- Yes try to make the service better
- Yes we put in it in employee files and follow up on anything that needs attention or improvements

As an employer, have you offered any opportunities to improve the skills of your PCAs?



Answer Choices	Response %	Response Count
Yes	84.42%	65
No	16.88%	13

If yes, please explain.

Responses

- Annual training
- Support through supervisors, nurses. Job Shadowing, Competitive Edge Program, and opportunities to work with multiple clients with diverse care needs.
- In-house training, mentoring.
- RN doing training for PCA in the client place.
- "1. Regular meetings and training
- 2. Supervision by a Registered Nurse
- 3. Sharing compliance information"
- Complex cares training specific to our client needs
- We offer yearly training on safety and emergencies
- Training giving Bonuses
- We provide annual training for all staff who provide personal care to clients to maintain an 8 hour per year education program, because many of our PCA's in the PCPO program also care for our comprehensive licensed clients too and require 8 hours of education per year. We also provide hands on training through our RN's for any on site education needed to care for that particular client. I want to also add a comment for question #7 that PTO is only offered to PCA Choice as required with the union. We cannot afford to offer PTO all of our staff!
- Training, albeit inadequate
- additional training
- Periodic mailings to all PCA's (approx. 6/yr) on topics that affect care.
- PCAs are trained to meet every need of their clients that are identified on the care plan.
- PCA staff are trained and constantly update their knowledge and keep up with changes in industry.
- Training and promotion
- Annual training
- Training opportunities from what is offered online
- "We offer additional training at any time they request on any IADL's and health related tasks.
- 24 phones available to employees/clients or questions/concerns"
- Further training by our QPs, online training modules, annual training, etc.
- Nurse, QPs provide training
- We offer ongoing training.
- We have our PCA's/Caregivers log in to a training portal online and go through extra training regarding Person Centered cares, Bloodborne Pathogens, Fraud Prevention, Safety, Mandated Reporting and First Aid.
- More training
- We have quarterly, and annual visits from Qualified Professionals and they go over all the cares and offer all the training they need and ask if there is training they would like. There is a test sent out annually to PCAs about Vulnerable Adults and we get those back and address them depending on their % correct as needed
- We have added training on "What is a PCA's role", Falls Prevention, Hygiene, Positive Supports, HIV and Hepatitis C information.
- We currently is College of direct support for annual and specific client training. Plus we do on the site training. We also do training that is needed on site during RN supervision visits.

- PCA Training
- We offer quarterly continuing education with one-on-one training and instruction.
- RN training, training materials, performance reviews, etc.
- We offer paid training for CPR/first Aid, periodic trainings on mental health issues, Nurse delegated trainings.
- Aromatherapy training
- Yes, we offer training to help PCA's better serve their clients. we also offer one on one help in case the PCA has questions
- In house training/ certifications
- CEU's and yearly training
- We provide training to all staff once hired and as needed throughout their employment.
- In-service, training and supervision
- We offer continuing education units
- In office training, training with QP
- We are not the employer - we are choice. But we do offer training and have a scholarship for those pursuing higher education
- We offer as mush training as they need to make sure they a qualified to complete the task
- Ongoing training with qualified professional.
- We offered a free CPR class to all of our PCA's, additional training from our QP, shadow training with other more experienced PCA's, however all of that costs money.. Again, very tight budgets.
- "Offer free CPR/First Aid class
- Education thru College of Direct Support at least every other month"
- Semi-monthly education
- Every PCA has an opportunity to receive 12 hours of paid training a year. PCA's maintain a higher pay if they do complete annual training. Training includes Red Cross First Aid/CPR and Person Centered class room subjects based on requests by PCA for health needs of clients. Cofe' meetings throughout our region are shorter 3 hr sessions that include PCA round-table discussions, Home-study workbooks and College of Direct Support options for those who can't come to class. Training Details at: http://www.homeatheartcare.com/employee-training.html
- Annual trainings
- Training with multiple clients dealing with a variety of disabilities causing the PCA to be ready to work with almost any client in MN.
- We provide additional training.
- We provide in the know training which is continuing education for CNAs and tuition reimbursement for CNA education
- Web based video resources online
- We do semi-yearly in services training
- Move into to higher paid positions within the programs
- trainings
- Continues training and higher wage
- Training
- Annual training
- Annual in-service training for every employee
- More training and we also have tuition reimbursement for CNA programs if the pca continues to work for us for 1 year

Appendix D: Roster

CROSS-AGENCY WORKING GROUP MEMBERSHIP ROSTER
Expand, Diversify and Improve Minnesota's Direct Care/Support Workforce
Update: June 2018

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