

# Home Care at a Crossroads

*Minnesota's Impending Long-Term Care Gap*



**Gail MacInnes, MSW**  
**Dorie Seavey, Ph.D.**

**PHI**

Quality Care  
THROUGH  
Quality Jobs

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Finally, we want to thank the home care workers of Minnesota for the work they do every day to ensure quality care and services for tens of thousands of Minnesotans.



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## *Executive Summary*

**M**innesota is at a crossroads with respect to ensuring high-quality, accessible home care for older adults and people with disabilities. The actions taken now to address rapidly growing demand for home-based long-term services and supports and the lack of available home care workers will determine the quality, cost, and setting of care for Minnesotans for decades to come. Due to a combination of factors—specific to home care occupations, and more broadly demographic—Minnesota faces a care gap over the next decade of more than 53,000 workers needed to provide home care services. Minnesota has an opportunity to address this workforce challenge now by investing in quality jobs for all home care workers and building efficient infrastructure for home care delivery.

## I. Introduction

Over several decades, Minnesota has made significant investments aimed at deinstitutionalizing care for its citizens and “rebalancing” the state’s system of long-term services and supports (LTSS). As a result of these efforts, Minnesota is often cited as a leader among U.S. states in providing opportunities for individuals who need assistance with everyday living activities to receive services in their own homes. Of Minnesota’s Medicaid and state-funded LTSS spending, 60 percent goes to services provided in individuals’ homes and communities rather than in institutions. This compares to an average of 30 percent of LTSS funding spent on home and community-based services in states overall.<sup>1</sup>

Despite this strong history, challenges for ensuring access and quality in long-term services and supports remain. For example, the number of Minnesotans on waiting lists for home and community-based services rose steadily from 2006 to 2010.<sup>2</sup>

Like other states across the nation, Minnesota currently faces rapidly growing demand for home care services due to the aging of the population and the desire of older Minnesotans and younger people with disabilities to receive LTSS at home. The population of Minnesotans over 65 is projected to grow from 670,429 in 2010 to over 1,193,124 in 2030,<sup>3</sup> a nearly 80 percent increase.

Demand is increasing among the state’s younger individuals with disabilities as well. For example, the number of children identified as having an autism spectrum disorder increased at rates of 12 to 17 percent per year between 2003 and 2008. In 2008, 12,704 children in Minnesota were identified as having an autism spectrum disorder.<sup>4</sup>

These trends come as no surprise. Several reports over the last few years have highlighted the need for Minnesota to prepare for the growing “age wave.” However, these reports, with the exception of the July 2012 workforce work group recommendations to the Governor’s Taskforce on Health Reform, have not discussed the fundamental issue of building a home care workforce to meet increased demand for home-based LTSS.<sup>5</sup>

Reflecting patterns of growth in aging and disability, the demand for services provided by Minnesota’s home care workers has been growing dramatically. Within publicly financed home care programs alone, according to a report by the Minnesota Department of Human Services to the legislature, a total of 25,762 Minnesotans were receiving personal care assistance services in 2011.<sup>6</sup> This number is more than double the number of recipients (9,590) the program served in 2002.

Furthermore, over the current decade (2010–2020), the projected demand for home care workers exceeds that for any other occupation in Minnesota’s economy. In a time of stagnant job growth overall, job growth in this sector is good news for Minnesota’s economy. Unfortunately, home care worker jobs in Minnesota typically lack family-sustaining wages and benefits, resulting in difficulty attracting and retaining individuals to perform this important work.

The combination of insufficient supply of home care workers and concurrent burgeoning demand means that Minnesota faces a serious challenge

## Minnesota’s Direct-Care Workforce at a Glance\*

### Demographic Characteristics

#### Gender

- Female: 86%
- Male: 14%

#### Average Age

- All direct-care workers: 41
- In nursing care facilities: 39
- In home health care: 44

#### Race/Ethnicity

- White, non-Hispanic: 79%
- African American, non-Hispanic: 11%

#### Immigration Status

- Foreign born: 10%

#### Education

- High school diploma or less: 38%
- Some college or advanced degree: 62%

#### Head of Household

- Single parent: 22%

### Employment & Income Characteristics

#### Employment Status

- Employed full-time year-round: 38%
- Employed part-time or full-time part of the year: 62%

#### Median Annual Earnings

- All direct-care workers: \$15,500
- In home health care: \$12,000
- In nursing care facilities: \$21,574

#### Family Poverty Status

- In households under 100% of the federal poverty line: 16%
- In households under 200% of the federal poverty line: 44%

#### Reliance on Public Benefits

- In households receiving any public assistance: 43%

\*For “At A Glance” Data Sources, see page 13.

to continuing to offer access to quality care for older Minnesotans and individuals with disabilities in their homes and communities. Recent work to integrate care for individuals who are eligible for both Medicare and Medicaid could present additional workforce challenges if it weakens Minnesota's ability to implement statewide policies and standards to build the home care workforce. However, this effort to improve care for Medicare- and Medicaid-eligible individuals could also offer opportunities. For example, providers could be required to meet specific workforce standards or encouraged to incorporate the unique expertise and role of home care workers into the work of interdisciplinary care teams to improve care for individuals with functional limitations.

This paper explores the basic parameters of the Minnesota direct-care workforce overall, and the challenges Minnesota faces in ensuring an adequate home care workforce in particular. The data show that without strategic action, Minnesota's decades-long investment in rebalancing its system of LTSS is threatened. We offer recommendations for how this challenge can be addressed through workforce investments that promote quality of care and improve the efficiency of Minnesota's system of LTSS.

## II. Minnesota's Direct-Care Workforce

Minnesota's direct-care workers are the state's frontline paid caregivers who provide daily services and supports to persons with disabilities and chronic care needs, including elders and individuals with physical or intellectual and developmental disabilities. Some of these workers provide services in residential or community-based settings such as nursing homes, assisted living facilities, or group homes. However, the majority of Minnesota's direct-care workers provide services in the consumer's own home.

This largely female workforce is responsible for 70 to 80 percent of the paid hands-on care delivered to older Minnesotans and individuals with disabilities. These workers assist individuals with self-care and everyday living activities such as eating, bathing, and dressing and, sometimes, also with paramedical tasks.

In standardized government surveys of employment and compensation,<sup>7</sup> direct-care workers

are officially counted as Personal Care Aides;<sup>8</sup> Home Health Aides;<sup>9</sup> and Nursing Aides, Orderlies and Attendants.<sup>10</sup> Home care workers typically fall into the Personal Care Aide and Home Health Aide occupational categories. The Personal Care Aide occupational category also includes direct support professionals—workers who provide services and supports to individuals with intellectual and developmental disabilities.

### A Large and Growing Workforce

As policymakers consider the challenge of building the Minnesota home care workforce, an important aspect to keep in mind is the massive size and economic importance of this workforce.

#### Minnesota's Largest Occupational Groups

<b>Direct-Care Workers</b>	<b>112,200</b>
<b>Retail Salespersons</b>	<b>82,010</b>
<b>RNs and LPNs</b>	<b>74,740</b>
<b>Teachers from Preschool to 12th Grade plus Special Ed</b>	<b>74,010</b>
<b>Fast Food and Counter Workers</b>	<b>63,250</b>
<b>Law Enforcement/Public Safety Workers</b>	<b>43,370</b>

Like other historically important workforces—such as textile workers, miners, railroad laborers, and steel and automotive workers—the size of today's direct-care workforce is such that it will help shape the 21st century economy.<sup>11</sup>

In response to enormous demand created by our aging nation, the direct-care workforce has already surpassed the size of other large occupations and is projected to grow dramatically for decades to come. **Minnesota's direct-care workforce today totals over 112,000 workers and is larger than any other occupational grouping in the state.**

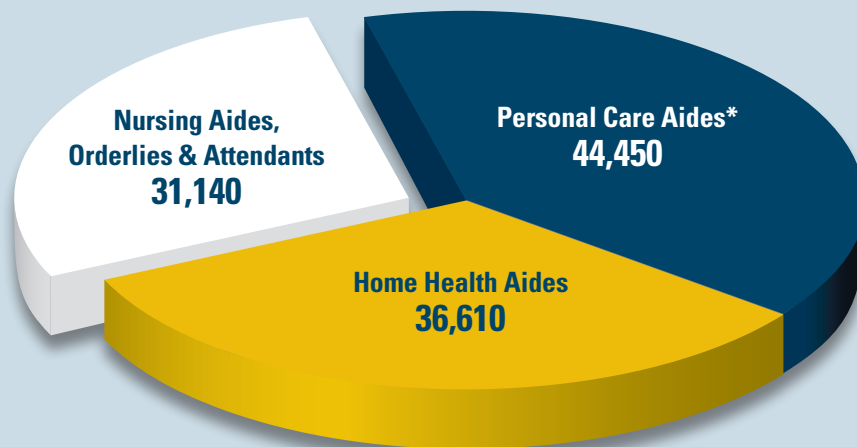
The vast majority of direct-care workers in Minnesota (72 percent) are employed as Home Health Aides and Personal Care Aides, working largely in home and community-based programs. Within the Personal Care Aide category, approximately 6,500 are paid family caregivers through the Medicaid state plan.<sup>12</sup>

### Minnesota's Home Care Occupations Are Creating the Most New Jobs

The enormity of this workforce, and its importance for Minnesota's economy, cannot be overstated. Two home care occupations top the list of occupations projected to create the most new jobs in Minnesota between 2010 and 2020. Together, demand for Personal Care Aides and Home Health Aides is expected to generate nearly 50,000 new positions over the decade, accounting for 13 percent of all job growth in Minnesota. **In other words, home care worker positions are expected to account for more than one in every ten new jobs expected in the state over the next 10 years.**

Personal Care Aides and Home

### Breakdown of Minnesota's Direct-Care Workforce, 2011



\* The Personal Care Aide estimate is from the U.S. Bureau of Labor Statistics and is based on employer surveys. According to the Minnesota Department of Human Services, claims data from 2011 suggests a much larger population of 75,258 individual "PCA providers" active on a monthly basis in MN Health Care Programs (MHCP). Totals and estimates in this paper conservatively rely on the lower BLS estimate. For more detail, see the Data Sources on pg. 13.

### Occupations Generating the Most New Jobs, 2010-2020

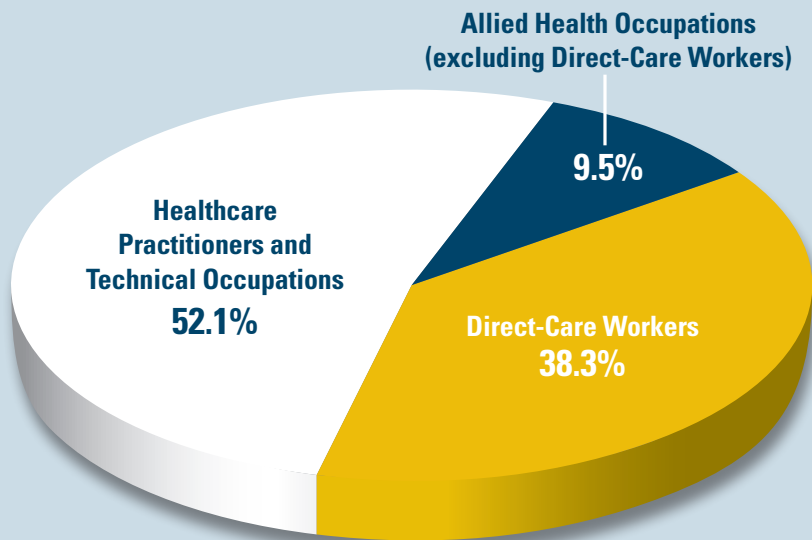
Occupation	Openings due to growth
1. Personal Care Aides	27,579
2. Home Health Aides	20,594
3. Registered Nurses	12,582
4. Retail Salespersons	12,228
5. Office Clerks, General	8,274
6. Heavy and Tractor-Trailer Truck Drivers	7,774

### Fastest-Growing Occupations, 2010-2020\*

Occupation	Growth rate
1. Personal Care Aides	62.2%
2. Home Health Aides	53.6%
3. Childcare Workers	24.6%
4. Heavy and Tractor-Trailer Truck Drivers	22.7%
5. Registered Nurses	22.0%
6. Sales Representatives, Services	15.6%
7. All Occupations in Minnesota	13.0%

\* Projected to produce at least 5,000 jobs due to growth alone over the decade.

### Minnesota's Health Care Workforce, 2011



Health Aides are also projected to be the first and second fastest-growing occupations in the state, increasing by 62 percent and 54 percent, respectively, over the period 2010 to 2020. In contrast, Minnesota jobs overall are expected to increase by 13 percent over the same period.

Considering that home care worker jobs will account for more than one in every ten new jobs in Minnesota over the next decade, the importance of making the wages for these jobs family-sustaining is critically important.

In addition to comprising a very significant portion of the Minnesota workforce overall, the direct-care workforce is a large and growing component of the state's health care

workforce. **Direct-care workers account for 38 percent of Minnesota's entire health care workforce,** outnumbering by four to one all allied health occupations (e.g., medical and dental assistants and therapy assistants and aides).<sup>13</sup> As the population of older Minnesotans increases along with the number of Minnesotans with multiple chronic conditions and LTSS needs, direct-care workers will play a central role in helping to deliver high-quality, efficient care that helps consumers avoid unnecessary hospital admissions and institutionalization.

## III. *Barriers to Establishing a Stable Home Care Workforce*

Minnesota's demand for home care cannot be met without making home care jobs competitive enough to attract and retain enough workers. Due to the generally problematic quality of these jobs, the home care workforce is characterized by high rates of turnover. A 2009 evaluation of the Minnesota Personal Care Assistance Program found turnover rates of more than 50 percent for many employers.<sup>14</sup>

**High rates of turnover negatively impact the quality of care and are costly for providers and, ultimately, taxpayers.**

Such high rates of turnover negatively impact the quality of care and are costly (at least \$2,500 per worker<sup>15</sup>) for providers and, ultimately, taxpayers, whose tax dollars fund a large portion of long-term services and supports. Minnesota home care jobs could be improved and turnover reduced by offering family-sustaining wages, full-time work, benefits, and improved training for workers, supervisors, and employers. Factors that contribute to high turnover for these jobs include:

### **Uncompetitive Wages**

Home and community-based direct-care occupations in Minnesota are among the state's lowest-paying jobs, with wages



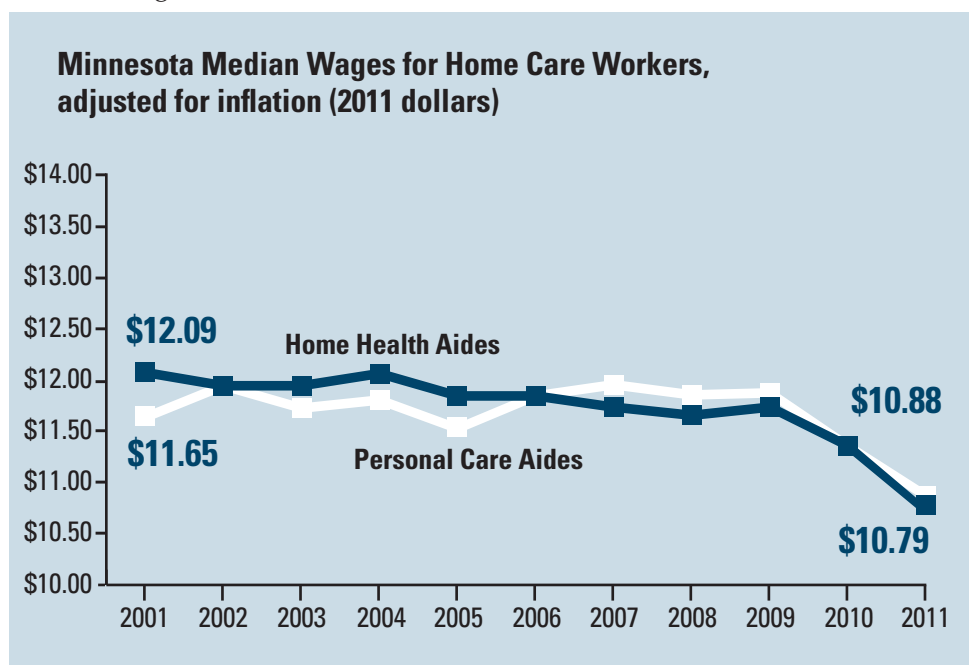
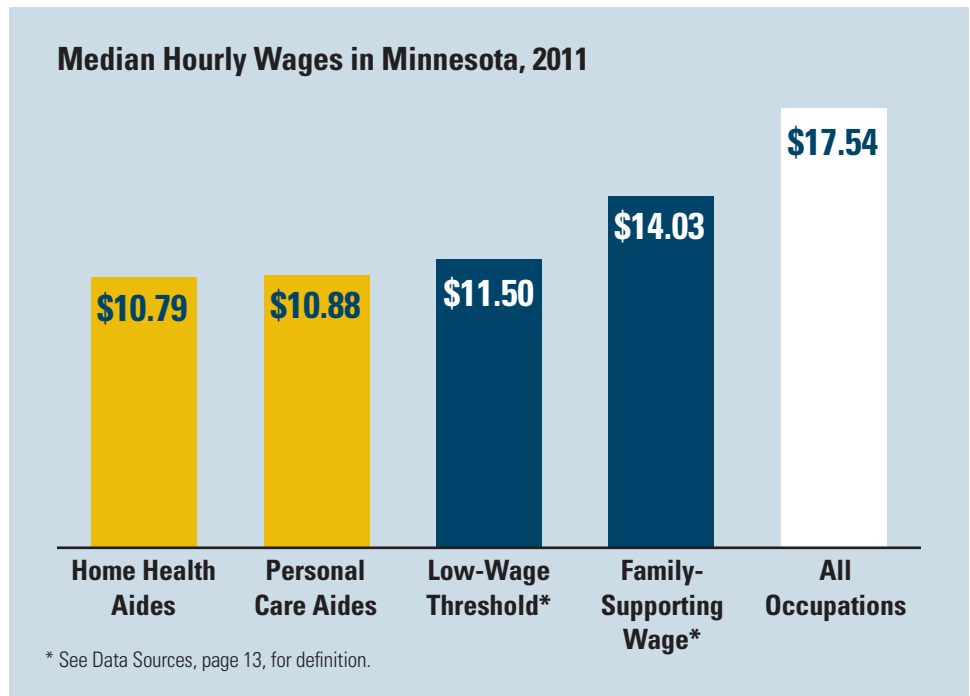
that fall below the state's "low-wage threshold" of \$11.50 per hour. The low-wage threshold refers to the 25th percentile wage for all occupations in Minnesota—a wage level that signals very low-wage earnings relative to the rest of wage earners.

The inadequacy of Minnesota's home care worker wages is further underscored by comparing them to the "family-supporting wage" standard defined by Minnesota's JOBS NOW Coalition.<sup>16</sup> JOBS NOW defines a family-supporting wage as one that covers the cost of basic needs such as food, housing, health care, clothing, transportation, and child care. This definition is based on a "no-frills" standard of living that excludes debt payments, skills training, entertainment, restaurant meals, and vacation. JOBS NOW estimates that to cover the average annual cost of meeting basic needs for a family of four with two workers in Minnesota, each worker must earn \$14.03 per hour. As the chart above illustrates, Minnesota's home care worker wages fall well below this basic standard.

Not only are Minnesota's home care worker wages inadequate, they are declining, even as demand for home care workers increases. Mirroring a trend of shrinking inflation-adjusted hourly wages (*i.e.*, "real wages") for direct-care workers and other low-wage occupations nationwide, real wages for all home care occupations in Minnesota have declined over the past decade. Real wages for Personal Care Aides have declined by 7 percent over the period, while those for Home Health Aides have fallen by 12 percent. As noted in the recommendations from the workforce work group to the Governor's Health Reform Taskforce, increased wages and benefits for home care workers would increase the supply and improve the stability of this essential workforce.<sup>17</sup>

### Part-Time Work— Impact on Annual Earnings

In addition to low wages, a high incidence of part-time work limits the annual earnings of Minnesota's direct-care workers. More than 60 percent of direct-care workers in the state report working less than full-time for the year. For home care workers in particular, staffing and scheduling practices make it difficult to accumulate the hours they would like to work on a regular basis.



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The structure of home care work, usually involving work with several different clients, hinders the ability of aides to obtain stable income and dependable work schedules and assignments. Frontline aides typically bear the entire risk of lost hours and income due to changes in client status resulting from events such as hospitalization, death, or a reduction in care hours.<sup>18</sup>

A high incidence of part-time work combined with low wages limits the annual earnings of Minnesota's direct-care workers. From 2008 to 2010, median annual earnings for direct-care workers in Minnesota averaged \$15,500. Earnings ranged from \$12,000 in home health care agencies to \$21,574 in nursing care facilities.

### **Lack of Health Insurance Coverage**

Another element of compensation that is lacking for many of Minnesota's direct-care workers is employer-sponsored health insurance coverage. A 2009 study conducted by The Lewin Group and PHI found that, due to low pay or part-time status or both, many direct-care workers in Minnesota lack private health insurance. More than a third of survey respondents had been uninsured in the last year.<sup>19</sup>

Such high rates of uninsurance have significant implications for the stability of Minnesota's direct-care workforce because, as research has indicated, the provision of health insurance coverage is an important factor in the recruitment and retention of direct-care workers. Of employers who responded to the survey, 81 percent rated lack of health insurance as an important driver of turnover among direct-care workers.<sup>20</sup>

The low rate of employer-sponsored health insurance coverage for direct-care workers creates another problem: cost-shifting to the public system. More than a quarter (26 percent) of Minnesota direct-care workers receive coverage through a public insurance program, such as Medical Assistance or MinnesotaCare.<sup>21</sup>

### **Reliance on Public Subsidies Required to Meet Basic Needs**

Low-wages, lack of benefits, and less than full-time work, as detailed above, all contribute to the poor quality of Minnesota's direct-care jobs. Not surprisingly, despite their essential and difficult work, over 40 percent of Minnesota's direct-care workers live in households that rely on some form of public assistance, such as food stamps or Medicaid, in order to provide for their families.<sup>22</sup> This is because nearly half (44.4 percent) of direct-care workers in Minnesota live in households with incomes at or below 200 percent of the federal poverty line, a near-poverty threshold that typically makes households eligible for public assistance programs. More than half (57 percent) of Minnesota's Personal Care Aides, the fastest-growing occupation in Minnesota, live in these very low-income households.

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## **Over 40 percent of Minnesota's direct-care workers live in households that rely on some form of public assistance.**

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### **Inadequate Training**

In 2009, the Minnesota legislature created a training requirement for Personal Care Aides that includes training on infection control and universal precautions, body mechanics, understanding behavior, boundaries and protection, and self-care. This required training is a valuable first step toward greater professionalization of the occupation. However, significant additional training and support for Minnesota's home care workers is needed.

Minnesota's home care workers need to be equipped for the challenges of providing services to a growing number of individuals who are living with multiple and complex chronic conditions and functional limitations. These workers should be provided training that enables them to understand common chronic disease conditions, recognize early warning signs of problems, and communicate with other health care professionals as part of interdisciplinary teams. Such training can enable home care workers to play an essential role in avoiding costly hospitalizations or nursing home placements.

**Minnesota's home care workers need to be equipped for the challenges of providing services to a growing number of individuals who are living with multiple and complex chronic conditions and functional limitations.**

## IV. Minnesota's Emerging "Care Gap"

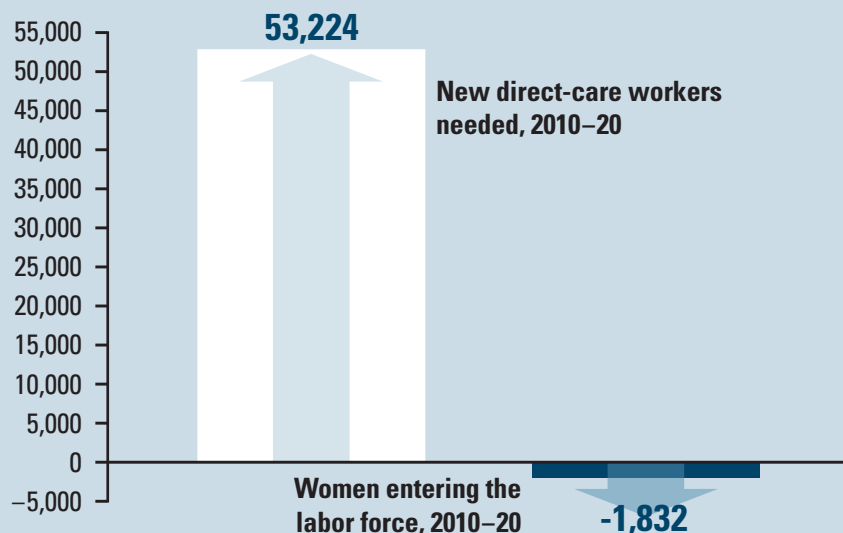
Minnesota's rapidly growing demand for direct-care workers amplifies the challenge of making direct-care jobs competitive so that enough workers will be attracted to this work to meet increased demand—especially at a time when the state's labor force growth is slowing due to the aging of the population.

Over the period 2010 to 2020, the Minnesota Department of Employment and Economic Development projects demand for 53,224 new direct-care worker positions. At the same time, the number of women entering the Minnesota labor force aged 25–54—the core labor pool from which the state's direct-care workers are traditionally drawn—is expected to decline by nearly 2,000 workers. **As the chart below illustrates, Minnesota faces a massive care gap over the next decade.**

Without significant policy action to attract and retain additional direct-care workers, this care gap could impede Minnesota's policy goal of providing older adults and people with disabilities with the opportunity to receive needed care and services in their homes and communities rather than in institutions.

A lack of available direct-care workers is already hindering the movement of consumers out of institutions in other states. A survey of states that have implemented the federal Money Follows the Person (MFP) demonstration program found that half of the states reported an inadequate supply of direct-care workers in the community as a barrier to helping consumers move out of institutions.<sup>23</sup>

**Demand for New Minnesota Direct-Care Workers Outstrips Number of Women Ages 25–54 Entering Labor Force**



## V. Summary and Recommendations

Minnesota's direct-care workers now constitute the largest occupational grouping in the state. Totalling over 112,000, the number of direct-care workers exceeds retail salespersons, registered nurses (RNs) and licensed practical nurses (LPNs), and all teachers from pre-school through high school. Home and community-based direct-care occupations are the fastest-growing jobs in the state.

Beyond sheer numbers and rate of growth, direct-care workers are important because they make up a large (38 percent) and growing percentage of Minnesota's health care workforce overall. As the population ages in the decades to come, the bulk of the care needed by individuals with chronic illnesses and functional limitations will be the assistance with everyday living activities provided

by home care workers. **Therefore, a focus on strengthening the direct-care workforce is as essential, if not more so, for preparing for future needs as attention to bolstering other health care occupations.**

At the same time, poor job quality—more than four in ten direct-care workers rely on public assistance as a result of low wages and part-time hours—hampers recruitment and retention for this workforce. In order to attract enough workers to meet the demand for high-quality, accessible LTSS, these jobs must be made more competitive, especially at a time when the state aims to offer more home- and community-based service options to elders, their families, and persons living with disabilities.

Careful injection of public and private investments can help re-shape the structure and quality of these vital occupations so that they reflect the importance of this work and these jobs to Minnesota families and communities. Recommendations for strategies to address Minnesota's direct-care workforce crisis are as follows:

### ► Invest in Quality Jobs

Minnesota should **increase wages and benefits** for home care workers in order to make these jobs more attractive to job seekers. The wage and benefit levels should reflect the important role these workers play in ensuring consistent, quality care for all Minnesotans who need it. In addition to improving wages and benefits, **increased training and creation of advancement opportunities** are also important strategies for stabilizing the workforce to meet current and future demand for services.

### ► Build Workforce Infrastructure

Minnesota should develop efficient mechanisms for deploying the home care workforce to consumer homes on a daily basis and for providing supportive resources for both consumers and workers. A key building block for the in-home services infrastructure of any state is a "**matching service registry**"—that is, a publicly funded service that offers a dynamic platform for matching supply and demand by allowing consumers to tap into an up-to-date bank of available workers, while also enabling workers to signal their availability for employment.<sup>24</sup> The most effective registries include additional services such as worker screening and orientation, access to consumer and worker training, and recruitment and outreach to potential workers.

**In order to attract enough workers to meet the demand for high-quality, accessible LTSS, these jobs must be made more competitive.**

► **Monitor the Workforce and Make Data Publicly Available**

Minnesota should **collect, analyze, and publicly report basic data** across long-term care settings and programs on workforce volume (the number of full- and part-time workers); workforce stability (turnover and vacancy rates); and worker compensation (average hourly wage and benefits, health insurance, paid time off).<sup>25</sup> Transparency in this regard will allow competition among providers to improve job quality and will assist state policymakers in identifying gaps and formulating policy strategies.

► **Continue and Increase Supports for Family Caregivers**

Equitable treatment of paid family caregivers is also an essential workforce strategy to address Minnesota's serious care gap. The 20 percent cut in wages for paid family caregivers enacted by Minnesota's legislature in 2011, and now delayed until July 2013, should be reconsidered in light of the critical projected need for direct-care workers across the state.

► **Promote Training and Credentialing**

Minnesota should promote **training and credentialing** for home care workers that prepares them for the unique and, oftentimes, complex needs of the individuals they serve. Training and credentialing standards that are accepted across settings and providers statewide will help workers to establish base competence, and to meet the varying needs of multiple clients.

Among the recommendations of the workforce work group to the Governor's Health Care Reform Task Force is additional funding for the Health Support Specialist (HSS) Registered Apprenticeship Program. As the work group noted, support for the apprenticeship program could help providers "meet the increasing demands for highly-skilled frontline caregivers in older adult services."<sup>26</sup>

## VI. Conclusion

Minnesota has been a leader in creating a vision for and investing state funds in the transformation of its LTSS system from institutional care to home and community-based services. This report calls for renewed state leadership to ensure that this transformation moves forward—strengthened by workforce development strategies to improve the quality of the jobs and, thus, the quality of care.

## Recommendations

- **Invest in Quality Jobs**
- **Build Workforce Infrastructure**
- **Monitor the Workforce and Make Data Publicly Available**
- **Continue and Increase Supports for Family Caregivers**
- **Promote Training and Credentialing**

### Endnotes

- 1 Data from "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers." <http://www.longtermscorecard.org/DataByState/State.aspx?state=MN>.
- 2 United Cerebral Palsy. "The Case for Inclusion, 2012." <http://www.ucp.org/the-case-for-inclusion/2011/>.
- 3 Projections of Future Growth of the Older Population, U.S. Administration on Aging website: [http://www.aoa.gov/AoARoot/Aging\\_Statistics/future\\_growth/future\\_growth.aspx#state](http://www.aoa.gov/AoARoot/Aging_Statistics/future_growth/future_growth.aspx#state). Downloaded June 8, 2012.
- 4 Report of the Minnesota Senate Autism Task Force, March 2009. <http://www.health.state.mn.us/ommh/projects/autism/reporttogov2009.pdf>.
- 5 Citizens League. December 2010. "Moving Beyond Medicaid: Long-Term Care for the Elderly and a Life Quality and Fiscal Imperative." <http://www.citizensleague.org/publications/reports/485.RPT.Moving%20Beyond%20Medicaid.pdf>. Minnesota State Demographic Center. "The Long Run Has Become the Short Run: Budget Implications of Demographic Change." <http://www.demography.state.mn.us/documents/LongRun.pdf>. Minnesota Department of Public Health. July 2012. Workforce Work Group Priority Recommendations to the Governor's Health Care Reform Taskforce" <http://mn.gov/health-reform/images/TaskForce-2012-07-12-WFWG-Priority-Recommendations.pdf>
- 6 Disability Services Division, Minnesota Department of Human Services. February 2011. "Personal Care Assistance Services—A Report to the 2011 Minnesota Legislature."
- 7 These surveys are conducted under the auspices of the Bureau of Labor Statistics, the Census Bureau, and state labor market information agencies.
- 8 **Personal Care Aides** may work in either private or group homes. They have many titles, including personal care attendant, personal assistant, and direct support professional (the latter work with people with intellectual and developmental disabilities). In addition to providing assistance with activities of daily living (ADLs)—such as eating, dressing, bathing, and toileting—these aides often help with housekeeping chores, meal preparation, and medication management. They also help individuals go to work and remain engaged in their communities. A growing number of personal assistance workers are independent providers employed and supervised directly by consumers.
- 9 **Home Health Aides** provide essentially the same care and services as nursing assistants, but they assist people in their own homes or in community settings under the supervision of a nurse or therapist. They may also perform light housekeeping tasks.
- 10 **Nursing Aides** generally work in nursing homes, although some work in assisted living facilities, other community-based settings, or hospitals. They assist residents with ADLs, and also perform clinical tasks such as range-of-motion exercises and blood pressure readings. In some states, they may also administer oral medications.
- 11 Dorie Seavey. "Caregivers on the Front Line: Building a Better Direct-Care Workforce." *Generations*, Winter 2010–11, Vol. 34 No. 4, page 27.
- 12 Minnesota Department of Human Services. May 2012. "Continuing Care Legislative Summary," page 1. Document #: DHS-6531A-ENG. <https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-6531A-ENG>.
- 13 **Allied Health Occupations** refer to Healthcare Support Occupations (SOC Code 31-0000).
- 14 The Lewin Group. July 2009. "Recommendations for Minnesota's Personal Care Assistance Program: Final Report," page 27. <http://rtc.umn.edu/docs/MNPCAFinalReport.pdf>.
- 15 Dorie Seavey. October 2004. *The Cost of Frontline Turnover in Long-Term Care*. Better Jobs Better Care. <http://www.directcareclearinghouse.org/download/TOCostReport.pdf>.
- 16 <http://www.jobsnowcoalition.org/econ-lit/cost-of-living/cost-of-living.html>
- 17 Minnesota Department of Public Health. July 2012. Workforce Work Group Priority Recommendations to the Governor's Health Care Reform Taskforce. <http://mn.gov/health-reform/images/TaskForce-2012-07-12-WFWG-Priority-Recommendations.pdf>
- 18 PHI. February 2012. "Value the Care, No. 6: Home Care Jobs: The Straight Facts on Hours Worked," page 3. <http://phinational.org/policy/wp-content/uploads/phi-value-the-care-06.pdf>.
- 19 The Lewin Group. October 2009. "Final Report - Costs and Options for Insuring Minnesota's Direct-Care Workforce," page 26. [http://www.dhs.state.mn.us/main/groups/aging/documents/defaultcolumns/dhs16\\_147636.pdf](http://www.dhs.state.mn.us/main/groups/aging/documents/defaultcolumns/dhs16_147636.pdf).
- 20 Ibid, page vi.
- 21 PHI analysis of U.S. Census Bureau, Current Population Survey, pooled state data for Minnesota from the 2009, 2010, and 2011 Annual Social & Economic (ASEC) Supplements.
- 22 Data on direct-care worker reliance on public benefits are from PHI's analysis of U.S. Census Bureau, Current Population Survey, pooled state data for Minnesota from the 2009, 2010, and 2011 Annual Social & Economic (ASEC) Supplements.
- 23 Kaiser Commission on Medicaid and the Uninsured. December 2011. "Money Follows the Person: A 2011 Survey of Transitions, Services and Costs." <http://www.kff.org/medicaid/upload/8142-02-2.pdf>.

- 24 D. Seavey and A. Marquand. Spring 2011. "Building Infrastructure to Support CLASS: The Potential of Matching Service Registries." The SCAN Foundation, CLASS Technical Assistance Brief Series No. 16.  
<http://www.directcareclearinghouse.org/download/scan-classact-20110415.pdf>.
- 25 Center for Medicare and Medicaid Services, National Direct Service Workforce Resource Center. February 2009. "The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection."  
[www.dswresourcecenter.org/tiki-download\\_file.php?fileId=13](http://www.dswresourcecenter.org/tiki-download_file.php?fileId=13).
- 26 Minnesota Department of Public Health. July 2012. Workforce Work Group Priority Recommendations to the Governor's Health Care Reform Taskforce. <http://mn.gov/health-reform/images/TaskForce-2012-07-12-WFWG-Priority-Recommendations.pdf>

### Data Sources

Occupational projections data are from Minnesota Department of Employment and Economic Development, available at:

<http://www.positivelyminnesota.com/apps/lmi/projections/> and wage estimates are from the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics (OES) Program, available at: <http://www.bls.gov/oes/tables.htm>.

The "low-wage threshold" refers to the 25th percentile wage for all occupations in Minnesota—a wage level that signals very low-wage earnings relative to the rest of wage earners. At the 25th percentile, 25% of the workforce earns less and 75% earns more. The "family sustaining wage" refers to a standard developed by the JOBS NOW Coalition, available at:

<http://www.jobsnowcoalition.org/econ-lit/cost-of-living/cost-of-living.html>.

The MHCP count of individual PCA providers enrolled and active on a monthly basis in 2011 was provided by MHCP Provider Relations Training and Communications.

Data on direct-care worker earnings, labor force participation, poverty status, and reliance on public benefits are from PHI's analysis of U.S. Census Bureau, Current Population Survey, pooled state data for Minnesota from the 2009, 2010, and 2011 Annual Social & Economic (ASEC) Supplements.

Care gap estimates are derived using: occupational projections data for direct-care workers (see first data source above), population estimates and projections from the MN Department of Administration, *Minnesota Population Projections by Age and Gender, 2010–2060* (available at: <http://www.demography.state.mn.us/resource.html?id=32539>); and labor force participation rates from the MN State Demographic Center (November 2007) Minnesota Labor Force Projections 2005-2035 (available at:

<http://www.demography.state.mn.us/documents/MinnesotaLaborForceProjections20052035.pdf>).



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**PHI** 400 East Fordham Road, 11th Floor • Bronx, NY 10458 • Tel: 718.402.7766  
Fax: 718.585.6852 • E-mail: [info@PHInational.org](mailto:info@PHInational.org) • [www.PHInational.org](http://www.PHInational.org)