

Personal Care Assistants: Recommendations for Provider Standards

Report to the Minnesota Legislature 2009

Minnesota Department of Health

February 2009



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Personal Care Assistants: Recommendations for Provider Standards

February 2009

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As requested by Minnesota Statute 3.197: This report cost approximately \$11,500 to prepare, including staff time, printing and mailing expenses.

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Summary: Personal Care Assistants: Recommendations for Provider Standards

Personal Care Assistant (PCA) services are available to many low-income and disabled individuals in Minnesota under the Medical Assistance (MA) State program. These services provide recipients assistance with daily care needs allowing them to remain in their home rather than being in an institution-like setting.

The 2008 Legislature directed the Minnesota Department of Health to provide recommendations to the legislature for provider standards for personal care assistant services as described in Minn. Stat. §256B.0655.

The recommendations contained in this report include:

- The Minnesota Dept of Human Services (DHS) shall retain the authority to regulate and oversee all PCA services that exclusively use MA dollars.
- Enrollment standards for individual PCAs should require that a PCA must complete, and provide evidence of having completed, a basic core set of training prior to enrollment with DHS. Included in the recommendations are the minimum training requirements and core curriculum that should be a part of this training. PCAs providing services to any recipient qualified as having complex medical or unique needs must have additional training. Prior to enrollment with DHS, a PCA must pass a criminal background check.
- Enrollment standards for PCA agencies should require that all PCA agency managers, qualified professionals, financial, and other key staff of the agency complete the DHS “Steps for Success” training program prior to enrollment with DHS. All agency owners, managers and qualified professionals must pass a background check prior to enrollment. Agencies must have written grievance policy and compliance procedures for both staff and recipients. Agencies must pay a fee to enroll with DHS as a provider.
- Standards for individual PCA accountability should require that individual PCAs shall be removed from the PCA registry if disqualified for a violation of the Minnesota Vulnerable Adults Act (VAA), or fraudulent or abusive activities.
- Standards for accountability of PCA agencies should require that agencies that have been disenrolled due to fraud, abuse or substantiated complaints about quality of care and any individuals with ownership, administrative or managerial ties to the disenrolled entity, shall be barred from establishing a new agency for 5 years.

- Standards for assessors should require training for the individuals who are responsible for conducting the assessment of recipients.
- Standards for supervision of PCAs should require a qualified professional (QP) be involved in the supervision of PCA services and that QP supervision standards should be developed.
- Quality Assurance and ensuring stakeholder connectivity should be part of DHS program assurance; DHS should establish an Advisory Council to work with DHS program integrity, quality assurance, training development and other oversight concerns. DHS should utilize mechanisms to obtain regular feedback from each PCA recipient about their experience with PCA services and programs.

Background and Process

Personal Care Assistant (PCA) services are available to many low-income and disabled individuals in Minnesota under the Medical Assistance (MA) State program. These services provide recipients assistance with daily care needs such as eating, bathing and dressing as well as more specialized tasks including health care or redirection/intervention for behaviors. PCA services allow the recipient to remain in their home rather than being in an institution-like setting.

The 2008 Legislature directed that “the commissioner of health, in consultation with the commissioner of human services, shall provide recommendations to the legislature by February 15, 2009, for provider standards for personal care assistant services as described in section 256B.0655” (Laws of MN 2008, chapter 230,secs. 6 and 7). The Minnesota Department of Health (MDH) is responsible for licensing and regulation of home health care providers pursuant to Minn. Stat. §144A.43 –144A.47. The Minnesota Department of Human Services (DHS) administers the state’s MA home care program which includes services provided by PCAs.

MDH licensed home care services and the MA home care services have many similarities. The two types of services differ, however, in how they are regulated. The Minnesota Department of Health licenses home care providers. Persons or entities providing home care services for a fee as defined in Minn. Stat. §144A.43, subd. 4, are required to be licensed under the Minn.Stat. §144A.46.

PCA services are a Medical Assistance (MA) benefit. Agencies providing PCA services are funded for these services with monies derived 100% from public (government) funds. States that provide personal care services through a MA State plan program must conform to the general Medicaid program requirements outlined in section 1902 of the Social Security Act. Those regulations require that the state Medicaid agency develop personal care assistant requirements and standards. In addition, the State Medicaid agency must provide for quality assurance of the program including oversight and enforcement of these providers.

At the beginning of the process to evaluate standards for PCA services for this report, MDH was aware that DHS had been working on an in-depth review of the DHS administered MA Home Care Program, which includes personal care assistant services as defined in Minn.Stat. §256B.0655. Their review included gathering input from stakeholders. MDH had conducted a similar evaluation in 1998 utilizing input from a large group of stakeholders. This was in response to a Legislative directive in Laws of Minnesota 1997, chapter 195, section 5, authorizing the MDH to create a licensure category for personal care assistant providers. MDH completed its report, “A Draft of Proposed Rules for a Unique Licensure Category for Providers of Personal Care Assistant Services”, (1999 MDH Report) and draft rules in January of 1999. Due to the projected costs of implementing the licensure of PCAs at that time, and budget

constraints, the recommendations from the report were not acted on and the rule was never promulgated.

Because of both the comprehensive undertaking of the 1999 MDH Report and DHS's recent comprehensive review of PCA services, MDH decided it would be duplicative to create another group specifically to formulate recommendations for this report. Additionally, MDH was aware that the Office of the Legislative Auditor (OLA) was conducting a review of PCA services. The OLA report was released on January 23, 2009. Therefore, with all the past and current review of PCA services it seemed prudent to use the information garnered through these various efforts to inform recommendations in this report.

Staff from MDH's Compliance Monitoring Division widely circulated the 1999 MDH Report, and over the fall and early winter of 2008 attended and participated in the various DHS committees that were looking at PCA issues. In addition staff met individually with a number of interested groups to hear their concerns and thoughts on this issue. Those groups included:

- Local Public Health Association;
- Public Health Nurses with Douglas and Renville County Public Health,
- PCA work group of the MN Consortium for Citizens with Disabilities,
- Staff from MN Disability Law Center,
- Staff from DHS Disability Services Division,
- DHS Managed Care PCA Program Integrity Work Group,
- DHS Medicaid Home Care Advisory Work Group,
- Staff from Office of Legislative Auditor,
- Staff from the Office of Ombudsman for Long-term Care,
- MDH staff from Licensing and Certification, Community and Family Health (PHN program), MN Children with Special Health Needs, Home Health Care (state licensing only), and Office of Health Facilities Complaints.

Many of the issues identified in the 1999 MDH Report were similar to thoughts and concerns that were heard when staff met with the above groups. What has changed is the exponential growth in the numbers of PCA providers and recipients. Staff also heard that the kinds of PCA services provided had expanded beyond physical needs, particularly to services related to behaviors. The primary concern that we heard in 1999 and continues to be a concern is ensuring that there are adequate safeguards to protect the recipients of PCA services, balanced with the recipients' desire to remain as independent as possible. The recommendations we heard included:

- require training for PCAs and agencies that provide PCA services;
- ensure that providers of PCA services are held accountable for their actions including being prohibited from providing services;

- ensure that assessors have guidance on assessment for PCA services and that the state works collaboratively with local public health/counties on assessment processes;
- provide clearer and more information to recipients on the roles/responsibilities of the PCA; and
- ensure that recipients are fully informed of their rights and grievance options.

It should be noted that DHS has been working to incorporate into the PCA Program many of the recommendations that came from the various workgroups and from the 1999 MDH Report. This report will continue to build upon those efforts.

Introduction

The purpose of this report is to recommend standards to improve oversight by DHS of the personal care assistant providers and services as described in Minn. Stat. §256B.0655. The recommendations are not exhaustive; they address key concerns identified by numerous stakeholders and previous reports on PCA services, and serve as a basis for DHS to consider as it moves forward in improving the state's PCA program. Based on MDH's experiences in regulation of health care providers and services, the report also includes some recommendations for implementation as well as areas that merit additional study.

Form of Regulation

Before discussing our recommendations for standards, we must first address the issue as to what type of regulation is needed.

Recommendation: The Minnesota Dept of Human Services shall retain the authority to regulate and oversee all PCA services that exclusively use MA dollars. References to PCA in licensure statutes (Minn. Stat. § 144A.43-144A.47) shall clearly state exemption from licensure for MA PCA services.

One of the first items to address is whether licensure is the appropriate form of regulation. Licensure is a very restrictive form of state regulation for agencies or professions.

Minnesota Statutes, Chapter 214, lists the following criteria for regulation: The legislature declares that no regulation shall be imposed upon any occupation unless required for the safety and well-being of the citizens of the state. In evaluating whether an occupation shall be regulated, the following factors shall be considered:

- 1) whether the unregulated practice of an occupation may harm or endanger the health, safety and welfare of citizens of the state and whether the potential for harm is recognizable and not remote;
- 2) whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability;
- 3) whether the citizens of this state are or may be effectively protected by other means; and
- 4) whether the overall cost effectiveness and economic impact would be positive for citizens of the state. (Minn.Stat. §214.001, subd. 2)

Finally, Chapter 214 states that "if the legislature finds after evaluation of the factors identified in subdivision 2 that it is necessary to regulate an occupation not heretofore

credentialed or regulated, then regulation should be implemented consistent with the policy of this section, in modes in the following order:

- 1) creation or extension of common law or statutory causes of civil action, and the creation or extension of criminal prohibitions;
- 2) imposition of inspection requirements and the ability to enforce violations by injunctive relief in the courts;
- 3) implementation of a system of registration whereby practitioners who will be the only persons permitted to use a designated title are listed on an official roster after having met predetermined qualifications; or
- 4) implementation of a system of licensing whereby a practitioner must receive recognition by the state of having met predetermined qualifications, and persons not so licensed are prohibited from practicing.”

The provisions in Chapter 214 about occupational regulation show the state’s policy that the least restrictive form of regulation be imposed. MDH concludes that the best form for PCA and PCA services regulation remains the enrollment or registry that currently exists through DHS, not to separately license all individual PCAs and PCA agencies. DHS should strengthen its oversight as will be addressed in this report’s recommendations for standards. PCA services are a MA benefit best regulated by DHS in its administration of the state’s MA program.

Regarding the times when licensure is appropriate, there must not only be significant harm warranting such protection, but the profession must have a distinct scope of practice and entry qualifications. Finally, the license requirement must be cost effective. In Minnesota, the costs of licensing activities administered by the state are paid for by the licensees through fees. Minn Stat. §16A.1285, subd. 2 further states that regulatory or licensure costs must be recouped so that funds are not under-recovered or over-recovered and are assessed every two years. MDH concludes that it is not economically prudent to license PCAs or PCA agencies. DHS has reported that there are over 35,000 individuals providing PCA services and over 600 PCA agencies currently enrolled as MA providers. Implementing licensure for this large of a number would be very costly. In the 1999 MDH Report, the cost estimates to implement were over \$1 million and at that time, the number of providers was estimated to be 150. Since DHS has an existing registry of PCAs and enrollment processes for PCA agencies, building on those requirements would provide additional assurances that basic health and safety standards have been met.

Office of the Legislative Auditor (OLA) commented on this in their recent “Evaluation Report – Personal Care Assistance January 2009.” OLA stated that DHS has responsibility for the overall administration of the state’s publicly funded health care programs and that state law assigns DHS some duties specific to PCA services, and that DHS has authorized agencies to play a major role in the day-to-day administration of PCA services. OLA also stated that although the Legislature could require licensure, other approaches might be less expensive and equally effective in ensuring oversight of these services.

Recommendations for PCA Provider Standards

MDH recommends that the following standards should be in place for the PCA program:

- I. Enrollment Standards for Individual PCA
- II. Enrollment Standards for PCA Agencies
- III. Standards for Accountability of Individual PCA
- IV. Standards for Accountability of PCA Agencies
- V. Standards for Assessments of Recipients
- VI. Standards for Supervision of PCAs
- VII. Quality Assurance and Ensuring Stakeholder Connectivity

I. Enrollment Standards for Individual PCA

Recommendation: Prior to enrollment with DHS, a PCA must complete, and provide evidence of having completed, a basic core set of training.

Public dollars are spent on PCA services and there must be state accountability for assuring that the individuals providing the PCA services have a minimum level of training in order to protect and maintain the health and safety of recipients. Minn. Stat. § 256B.0655 requires that a PCA must complete at least one of 5 training requirements. Those 5 training requirements vary widely in scope and breadth of training, from an accredited educational program for registered or licensed practical nurses to a determination by the PCA agency that the PCA has the skills required through training OR experience to perform PCA services. Determining sufficient experience can be quite subjective, and even more so when personal care providers vary in their scope and breadth of backgrounds and educational training. While some agencies have developed good policies and practices in this area this is not consistent across all agencies. Therefore, requiring a base set of training for any PCA is important.

Recommendation: The minimum training requirements and core curriculum should include but not be limited to:

- ***an overview of Minnesota Statutes relating to PCA and home care services including what a PCA does, what's required and allowed as a PCA***
- ***HIPAA and data privacy***
- ***First Aid and CPR***
- ***handling of emergencies and use of emergency services***
- ***reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557***
- ***home care bill of rights***
- ***handling of clients' complaints and reporting of complaints***
- ***services of Ombudsmen for Long Term Care, Mental Health and Developmental Disabilities, Managed Care and others as appropriate***

- ***observation, reporting, and documentation of client status and of the care or services provided***
- ***basic infection control***
- ***maintenance of a clean, safe, and healthy environment***
- ***medication reminders***
- ***appropriate and safe techniques in personal hygiene and grooming, including bathing and skin care, the care of teeth, gums, and oral prosthetic devices, and assisting with toileting***
- ***adequate nutrition and fluid intake including basic meal preparation and special diets***
- ***communication skills***
- ***reading and recording temperature, pulse, and respiration***
- ***basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional***
- ***physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family***
- ***safe transfer techniques and ambulation***
- ***range of motion and positioning.***

This set of training requirements is similar to those required for individuals who provide services as a home health aide or home care aide in a MDH licensed home care agency. PCAs perform many of the same functions and it makes sense to standardize training across service providers regardless of the funding sources. A basic level of knowledge is needed to provide services safely. The delivery of the service should always be oriented to the individual receiving the service per the care plan and the recipient's needs. It is at that point that the recipient, responsible party or a qualified professional can provide additional training to the PCA.

This training can be provided through a variety of methods using state approved curriculum (in a classroom such as community or technical colleges, via computer modules using the College of Direct Support materials at job centers or in some supervised setting). There are already MDH approved training courses for nursing assistants and home health aides, and a variety of online courses developed by academics (such as the U of M, Institute on Community Integration) that can be evaluated and endorsed as state approved.

Standardized and state approved curricula will assure a base level of content and allow for the core training to be recognized across agencies and employers. It also builds on an existing curriculum, limiting need for additional investing to develop training.

OLA also recommended that DHS should define a set of topics on which PCAs should receive training. The OLA report also commented that staff with limited amounts of training provided most PCA services, and PCA agencies varied significantly in the way they trained their employees.

OLA also stated that DHS should consider ways to help recipients and PCA agencies in training PCAs such as directing them to training resources, develop materials or videos that recipients or agencies could use, or contracting with vendors that offer meaningful and appropriate training on-line.

Implementation Considerations:

Making Training Transferrable. We suggest that this core training be completed once and be transferrable between employers. Additional in-services and updates could be developed to ensure PCAs remain current in these areas. Also, given that we have shortages of health care professions, requiring this level of training and competency could be an opportunity for individuals interested in direct care to further pursue education and training to move into a health care profession.

Paying for training. How required training is paid for has been an ongoing issue for the PCA program. Some concerns we heard are that persons who might become PCAs are unable to afford the training and thus creates a barrier to entry to an employment field where there is a shortage of workers. Some expressed concern that there are insufficient public funds to pay upfront for the training and if it were required would result in less money available to pay the PCAs. Others indicated that it is common business practice that people hired for positions have acquired the base level of training when hired for the position and that additional training is provided on the job and paid for by the employer and that this should be the same for PCAs.

One approach to this may be to require that the training be paid for initially by the person taking the training (PCA) and then reimbursed by the employer (PCA agency or recipient) after 90 days on the job, over an agreed amount of time, not to exceed 30 days. Providing reimbursement to the individual for training would become an investment to assist in spurring more interest in pursuing health careers, in a time when there is a high demand for qualified health care providers.

Recommendation: PCAs providing services to any recipient qualified as having complex medical or unique needs must have additional training, and that training will utilize a state approved curriculum.

Standardized and state approved curricula will assure a consistent level of content in the training and result in the hiring agency or PCA recipient having some degree of confidence that necessary skills have been taught to the PCA. In fact, in order to qualify for more PCA time, current law states at Minn. Stat. § 256B.0655, subd. 4 (4) “a recipient shall qualify as having complex medical needs if the care required is difficult to perform and because of recipient ‘s medical condition requires more time than community-based standards allow or requires more skill than would ordinarily be required and the recipient needs or has one or more of the following:

- daily tube feedings;
- daily parenteral therapy;

- wound or decubiti care;
- postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, mechanical ventilation;
- catheterization;
- ostomy care;
- quadriplegia; or
- other comparable medical conditions or treatments the commissioner determines would otherwise require institutional care.

The previous list clearly establishes a need for more than the base or community-standards level of training.

Recommendation: Prior to enrollment with DHS, a PCA must pass a criminal background check.

Since PCAs provide direct care services to vulnerable populations, often independently without direct supervision, it is important that they be screened for criminal and maltreatment history via a background check. State law currently requires PCAs to apply for a criminal background study when they first enroll as a PCA but does not require that the background study be completed before the individual can begin to provide services. This current background check does not examine individual criminal history in other states outside of Minnesota and further review should be done to determine the appropriate scope of the background check needed.

OLA also commented that despite some limitations, background checks are an important method of screening out individuals who pose a risk to vulnerable individuals.

II. Enrollment Standards for PCA Agencies

Recommendation: Prior to enrollment with DHS, all PCA Agency managers, financial and other key staff of the agency as determined by DHS must complete the DHS “Steps for Success” training program.

Part of the cost of doing business is compliance with applicable governmental regulations and adherence to sound business practices. We have heard in our meetings with various stakeholders that providers support the efficacy of the DHS’s “Steps for Success” training program. This optional training covers administrative and program requirements and responsibilities. Administrative and program requirements for PCA services can be complex and confusing. Requiring that all providers have this basic training will assist in ensuring that providers have a better understanding of their responsibilities. In addition, DHS may also want to consider requiring completion of training on financial areas such as training on the MN-ITS, DHS on-line billing system.

OLA recommended that the legislature should require representatives of new and existing agencies to periodically complete comprehensive state training on PCA standards and practices. In addition, OLA stated the training should be mandatory rather than optional for all providers.

Recommendation: All agency owners, managers and qualified professionals (QP) must pass a background check prior to enrollment with DHS.

Individuals who own and administer agencies utilize public dollars and oversee services provided to vulnerable adults; therefore it is important that persons in those positions be screened for criminal and maltreatment history via a background check. Currently not all managing individuals in an agency are required to have a background check. Background checks are required on PCAs and for some, but not all, qualified professionals (QP) who have supervisory oversight of PCAs. Conducting the background check on these additional staff adds that additional level of protection.

Recommendation: Agencies should be required to have written grievance policy and complaint procedures for both staff and recipients. This information must be made available to staff and recipients along with the Home Care Bill of Rights.

Providing methods for both recipients and PCAs to address concerns about care is critical in ensuring the health and safety of these individuals. Recipients or their family need to know where to express concerns about staff, about the quality of services, concerns about privacy and respect. PCAs also need a mechanism in place to address concerns they may have about a recipient, other staff or the agency for which they work.

Recommendation: Agencies must pay a fee to enroll with DHS as a provider.

Currently there is no fee charged to prospective agencies who wish to enroll with DHS as a provider. DHS does charge a fee for its optional "Steps for Success" training and fees for background checks. Fees generated from regulated individuals and businesses would defray the cost to the state of administering oversight of the practitioners and businesses. A fee will support the costs to the state in effectively administering the PCA program and Minn. Stat. §16A.285 references the collection of a fee by the state to cover *regulatory* costs.

III. Standards for Accountability of Individual PCAs

Recommendation: Individual PCAs shall be removed from the PCA registry if disqualified for a violation of the Minnesota Vulnerable Adults Act (VAA), violations covered under MN 245C.14 relating to individuals providing direct services, or was disenrolled by any state MA program.

This is consistent with disqualification of health care providers in licensed settings. While background checks are already required for PCAs, additional action to protect recipients of these services is needed. While DHS has denied a number of individuals enrollment as a PCA for failing to meet the existing criminal background check, and has removed individuals names from the registry for inappropriate action, ensuring that DHS has explicit statutory authority to remove individuals is critical to protecting these vulnerable populations.

IV. Standards for Accountability of PCA Agencies

Recommendation: Agencies that have been disenrolled as a MA provider and any individuals with ownership, administrative or managerial ties to the disenrolled entity, shall be barred from establishing a new agency for 5 years. Language authorizing this should be added to Minn. Stat. §256B.0655, and language in Minn. Stat. § 144A.46, subd 3. can be used as model language.

DHS has disenrolled service providers only to discover that the individuals involved in the disenrolled agency have established a new agency under a different business name. MDH has successfully used the “owners and managerial official” authority to keep de-licensed home care providers from establishing new home care agencies and perpetuating harmful service delivery and/or business practices. (See: Minn. Stat. §144A.43, et seq. and Minn. Rules, Parts 4668.0003 and 4668.0012) DHS should also review other criteria that might be considered such as substantiated abusive or illegal billing practices, substantiated complaints about quality of care and other violations of federal or state regulations.

OLA also recommended that the Legislature should amend state law to explicitly authorize DHS to reject agency applications for PCA enrollment in cases where the agency’s owners or administrators have previously documented violation of federal or state regulations.

V. Standards for Assessments of Recipients

Recommendation: Training should be required for the individuals who are responsible for conducting the assessment of recipients. This training should be developed in collaboration with individuals who are responsible for conducting assessments and should be of a quality and caliber to assure inter-rater reliability.

The local public health staffs’ role in the assessments is vital to how the PCA program functions. Representatives of local public health agencies have identified that assessors need clearer direction and guidelines from DHS in interpreting existing laws or

guidelines related to assessments. This is particularly true in the assessment of individuals with behavioral and mental health issues.

There appears to be inconsistency throughout the state in how assessments are done and types of services authorized as a result. Guidelines from DHS can help ensure that assessments are fair and reasonably consistent across the state.

The OLA report recommended that Minnesota has not established sufficient guidance and controls to ensure reasonably consistent, sound assessments of individuals' need for PCA services. There has been insufficient training of PCA assessors, reflecting uneven availability of state training courses over time and the absence of state requirements for minimum training levels.

VI. Standards for Supervision of PCAs

Recommendation: A qualified professional (QP) must be involved in the supervision of PCA services.

Currently a PCA recipient may waive the involvement of a QP in the supervision of PCA services. Waiving involvement of the QP has resulted in lack of accountability for and financial abuse of public funds and PCA services not being provided appropriately or safely. There are no effective methods of remedy in dealing with the PCA recipient for failure to fulfill the role of supervision properly. Supervision, onsite or otherwise, by a QP is needed to ensure that the PCA provides services that meet the needs of the recipient appropriately and safely.

Recommendation: Supervision standards should be developed for QPs and should include orientation of the PCA to the individual needs of the recipient; and supervising and evaluation of the PCA through observation of the PCA's work.

Supervision standards need to be developed and followed to ensure not only quality care provided by the PCA but also to ensure that recipient's health needs are being addressed. Because of the uniqueness of the individuals receiving these services, one set timeline for supervisory visits is not always appropriate. In addition, the state must be mindful of the potential use of technology to assist in supervision; it might reduce the need for the more traditional face-to-face process. Supervision requirements must remain flexible enough to factor in the PCA's skills and the recipient's ability to direct their own care.

OLA report provided recommendation that the Legislature should clarify state statutes to ensure that all PCA recipients have their services periodically supervised by a QP. It stated Minnesota laws have contradictory requirements for supervision of PCA services. DHS currently allows recipients to forgo supervision by a QP. The OLA also commented on the importance of supervision in ensuring service quality.

VII. Quality Assurance and Ensuring Stakeholder Connectivity

Recommendation: Establish, legislatively, an Advisory Council to work with DHS on PCA program integrity, quality assurance, training development and other oversight concerns. This Council should include at least two recipients of PCA services.

Due to the complexity of PCA services and the individuality of the recipients of those services, it is important to ensure that stakeholders be included in the work of creating a more effective PCA program within Minnesota. While it is challenging to meet all the needs of those providing or receiving PCA services it is a value for the State to work collaboratively and openly in developing the components of the PCA program.

Recommendation: Utilize various methods of gathering ongoing feedback from each PCA recipient such as completion of annual surveys about their experience with PCA services and programs. This information would be an integral part of DHS's quality assurance review of PCA services.

A quality assurance plan is required by Minn. Stat. § 256B.0655, subd. 9 (2) and allows for recipient surveys. Recipient surveys and other feedback mechanisms should be utilized so that feedback is obtained and can be utilized to make improvements to the services as well as measuring outcomes. PCA services are 100% publicly funded. It is important to solicit feedback on how the services are delivered and operating. Recipients, as participants in a publicly funded program, should be providing feedback to the state on a regular basis. In addition, this could provide an opportunity for the recipient to raise issues/concerns that they may be afraid to raise with family, their PCA or others.

Other Considerations

Behavioral/Mental Illness and role of PCAs

Continuing review needs to be done for standards relating to providing PCA services for individuals with behavioral/cognitive disorders or mental illness. The OLA report indicated that increases in costs and numbers of individuals served by PCA program can be tied to changes in MA level of services and the deinstitutionalization of many MA recipients.

We heard concerns about the increased use of PCA services for individuals with behavioral/mental health needs. We also heard that there was a lack of training/resources available to PCAs as to how to work with individuals with these types

of needs and a lack of resources/training available to local public health on how to assess needs in this area. There were questions raised as to whether PCA is the right source of care for this population. However, it seemed that it is the only service that may be available in some areas of the state.

Discussions on this issue have been going on among DHS program areas and additional discussion and analysis is needed. Developing a service type that can more suitably meet behavior needs could improve the effectiveness of service delivery to recipients and oversight and accountability of the PCA program. It is also consistent with DHS's over all equity goal to "provide the right service at the right time through comprehensive assessment and service planning."

Recipient Education

There needs to be more training/education available for the recipient or responsible party as to what PCA services they may be eligible for, what has been authorized and how those services are provided. Recipients also need clear information as to their roles/responsibilities if they choose these services, and resources that are available to assist them in working with PCA. Recipients must also have clear information on their rights and what to do if they have questions, concerns or complaints. In addition, if a recipient is unable to direct their own care and a responsible party is appointed, the responsible party must have clear information as to their role and responsibilities.

Health Care Home/Coordination of Care

PCA services and recipients of those services need to be tied to the "health care home". A health care home is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities. Minnesota is currently working to develop a plan in response to legislation in 2008, which makes it a requirement for Medicaid populations.

It will be important for MA recipients, PCAs and PCA agencies to understand their roles and responsibilities relating to the health care home, and to utilize this to ensure coordination of the care, which results in the desired outcomes and quality of life. It is important to ensure that health care home concepts are incorporated into the PCA program.

Administrative Simplification

One of the repeated comments/concerns that arose was that of the confusing and extensive administrative requirements for PCA agencies, PCAs, assessors and recipients. Knowing what forms needed to be completed was problematic. When both Medicare and Medicaid are payers, duplication of forms to be completed is required. When the Medicaid services are provided by a Managed Care Organization (MCO) there may be requirements of MCO that are duplicative to the MA required forms.

Finding ways to reduce the paperwork and eliminate duplication would help reduce administrative costs and help recipients have a clearer understanding of why various forms/information is needed.

Statutes and rules often refer to documentation requirements and yet are not clear as to what specifically is needed for each document. For example, there are requirements in the “service plan” that are duplicative of what is required in the “care plan” or in some instances better fit in the “care plan”.

PCA assessments are another area that causes some confusion for both providers and recipients. Assessments are completed to identify the client’s needs and determine services to be provided. The assessment currently seems to be used to address a number of needs and the frequency of assessments/re-assessment can be confusing. This also seems to be complicated by whether the services are provided by a MCO or are fee-for-service.

Working in collaboration with a group of stakeholders, DHS should pursue and clarify requirements, forms, and processes as well as look to ensure they are consistent and not duplicative when possible.

Workforce Shortages

Minnesota like many other parts of the United States is facing shortages in health care fields. As our population ages and with advances in medical technology we envision that the need for skilled providers will continue to be a huge demand. In exploring training needs we became aware that the majority of individuals who chose to become PCAs remain in the field either as a PCA or advance to other health care occupations. It may be advantageous to review how to tap this resource, and create opportunities for individuals who are interested in advancing their career. A collaboration among Higher Education, Department of Employment and Economic Development, MDH, DHS should further look at this potential opportunity.

Conclusion

PCA services are critical for some of Minnesota's most vulnerable citizens. Taking steps to ensure that standards and oversight of the people who provide those services is important to promote, protect and maintain the health and safety of the recipients. Moreover, standards for organizations that employ the PCAs are needed because they must be good stewards of public funds. The state must be accountable for appropriate expenditures of those public dollars.

These baseline standards and recommendations are intended to provide some initial direction and guidance on provider standards. It is, however, only a part, and continued collaborative work needs to continue to further develop and solidify the requirements for this vital service.