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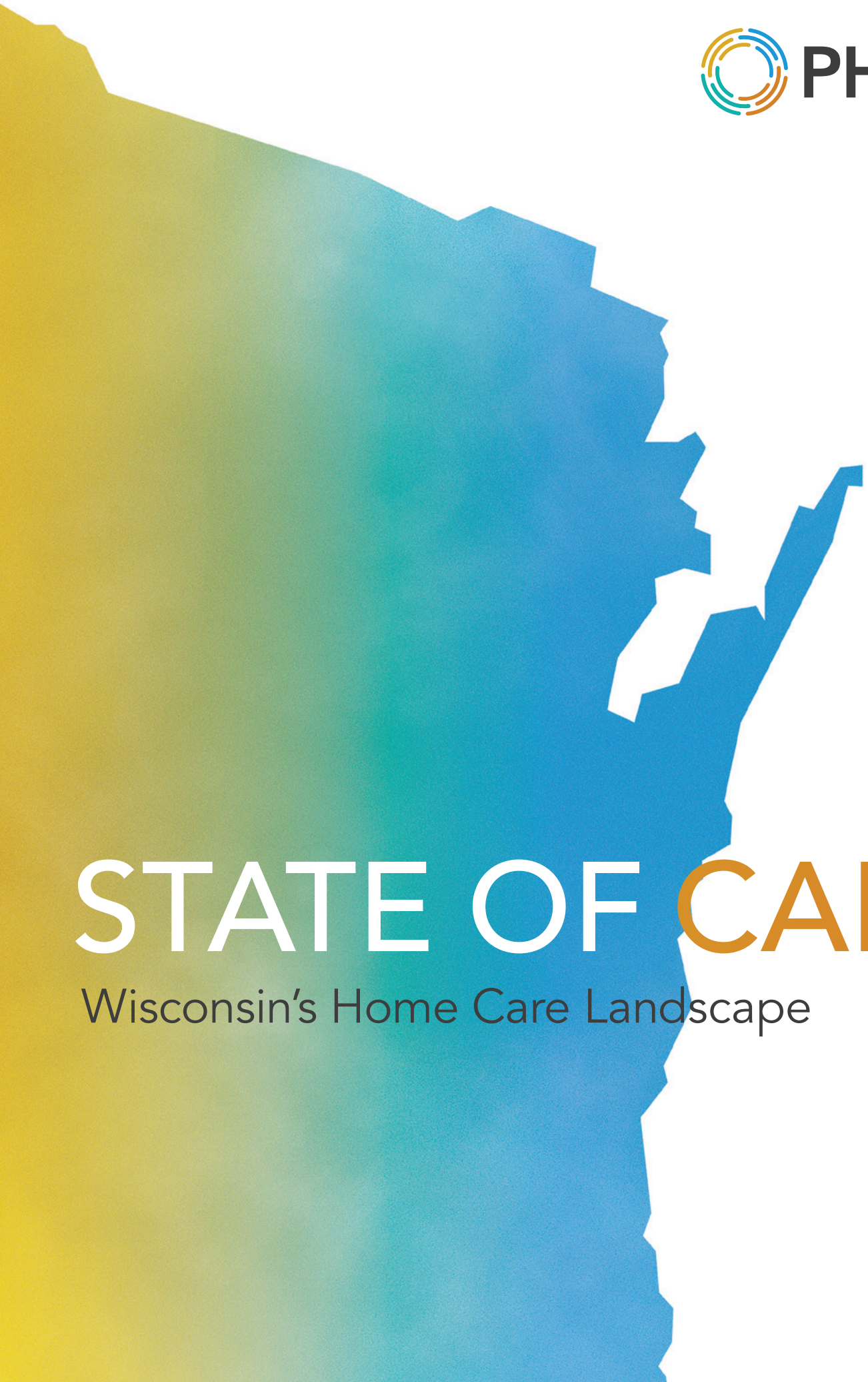


STATE OF CARE

Wisconsin's Home Care Landscape

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

CONTENTS

2 Executive Summary

4 Background Information and Definitions

7 Older Adult Population, Insufficient Care

11 Addressing Wisconsin's Care Gap

16 Quality of Jobs, Quality of Care

18 Training Landscape and Tested Innovations

20 Conclusion and Recommendations

27 Appendix A: Home Care Worker Training Requirements in Wisconsin

28 Appendix B: Home Care Workforce Demographics, Wisconsin and Nationally, 2015

30 Appendix C: Older Adult Population by County in Wisconsin, 2015

32 Appendix D: Labor Force Participation and Unemployment Rates in Wisconsin, by Selected Characteristics, 2015

33 Notes

EXECUTIVE SUMMARY

Across the country, home care workers assist older adults and people with disabilities with daily tasks such as bathing, dressing, eating, and mobility. These services help people who wish to remain in their homes and communities to live independently. Home care workers provide more hands-on care than any other health care occupational group, and demand for their services is growing rapidly as Americans age. Yet despite the importance of this work to the safety and wellbeing of clients and their families, home care continues to offer poor quality jobs that lead to high turnover and widespread vacancies. These trends in turn undermine the quality of care available to those who need it most.

More than 39,000 home care workers—including personal care aides and home health aides—provide caregiving services to older adults and people with disabilities in Wisconsin each day.[1] The population of adults over the age of 65 in the state will grow 72 percent from 2015 to 2040, driving demand for these services: Wisconsin will need nearly 20,000 additional home care workers by 2024.[2] However, without improvements to the quality of home care jobs, the state faces serious gaps in the workforce and risks leaving older adults without the supports they need.

The median hourly wage for home care workers in Wisconsin is $10.47, while starting wages are even lower. Adjusted for inflation, hourly pay for home care workers has declined 7 percent over the last decade.[3] Due to limited compensation and hours—nearly three-fourths of home care workers in the state work part-time—home care workers earn a median annual income of approximately $12,600. Nearly one-quarter of these workers live below the federal poverty line, and more than half rely on some form of public assistance.[4]

In addition to low pay, home care workers generally receive inadequate training, poor supervision, and few advancement opportunities. The result is a workforce unprepared to effectively communicate and problem-solve with their clients and lacking the knowledge to serve people with complex needs. Home care work can also be isolating without the employment supports and camaraderie inherent to a centralized workplace.

Over time, these factors contribute to burnout and high rates of turnover among home care workers. Annual turnover for this workforce in Wisconsin typically surpasses 50 percent.[5] This phenomenon negatively affects continuity of care, reducing stability for clients and preventing the development of caregiving relationships to support effective home and community-based services.

The effects of high turnover worsen when employers are unable to attract new workers to fill open home care positions. Recent surveys from long-term care advocacy groups in Wisconsin have revealed widespread turnover and vacancies in this sector, which have created alarming gaps in service delivery.[6] Further, the demand for home care is increasing at a time of decreasing unemployment, meaning that jobseekers have more occupational options that may offer better conditions or compensation than direct care.

These challenges are heightened in Wisconsin's rural communities. By 2040, the population of adults over the age of 65 will grow by 64 percent in rural areas. This population is also expected to need higher levels of care than its non-rural counterpart. Mortality rates from heart disease, stroke, cancer, and chronic respiratory

disease are elevated in rural settings across the Great Lakes region—Michigan, Minnesota, Ohio, and Wisconsin—relative to non-rural areas.[7] These diseases predict activity limitations and the likelihood of needing caregiving later in life.[8]

Yet Wisconsinites needing home care in rural communities will be met with a smaller pool of caregivers. By 2040, the population of women between the ages of 20 and 64—who overwhelmingly comprise the home care workforce—will stagnate statewide and decrease by 9 percent in rural areas. Additionally, the starting home care wage in rural towns is $8.60, compared to $9.61 in urban centers, and the time required for workers to reach clients in rural communities is considerably longer than in more densely populated regions in the state. These factors further impede job quality among home care workers and compound the barriers to their recruitment and retention.

More than 39,000 home care workers—including personal care aides and home health aides—provide caregiving services to older adults and people with disabilities in Wisconsin each day.

Despite the magnitude of these challenges, Wisconsin is well-positioned to address its current workforce shortage. The state ranks eighth in the nation in the effectiveness of its long-term services and supports.[9] This ranking reflects work that the state and actors throughout the industry have undertaken to develop a strong system of home and community-based services.

A growing number of state leaders are confronting Wisconsin's workforce shortage and working to improve access to home and community-based services for older adults and people with disabilities. Recent developments include:

- The Long-Term Care Advisory Council was established in 2008 to advise the Wisconsin Department of Health Services on successfully implementing a new managed long-term care waiver. Beginning in 2016, the Council's charge included workforce issues, and they recently issued recommendations to strengthen the state's long-term care workforce.

- The Long-Term Care Workforce Alliance is a coalition of public and private organizations that works to improve the recognition, retention, recruitment, and economic status of the long-term care workforce. The Alliance convenes frequent meetings that allow provider and consumer groups to share best practices, as well as to coordinate advocacy efforts.

- An assortment of providers and consumer groups have named the workforce shortage a top legislative priority. Organizations including the Wisconsin Health Care Association, LeadingAge Wisconsin, Wisconsin Assisted Living Association, Wisconsin Personal Services Association (WPSA), and Survival Coalition have issued reports that quantify gaps in the direct care workforce and describe the resultant impact on home care clients throughout the state. These reports indicate that, in 2016, 93 percent of personal care providers found it difficult to fill openings and 95 percent of people with physical disabilities said it was hard to find workers. Home health aide certifications and renewals were also found to have declined by 24 percent between 2012 and 2015.[10]

To understand the home care delivery system throughout Wisconsin, PHI analyzed the state's challenges, opportunities, and best practices in this sector. This landscape study pays special attention to Wisconsin's rural communities, where service delivery challenges and workforce needs are greater. PHI's analysis was made possible by Margaret A. Cargill Philanthropies, to inform efforts to improve the quality of home care jobs and the delivery of care statewide.

BACKGROUND INFORMATION AND DEFINITIONS

Home care workers provide 8 out of every 10 hours of paid long-term services and supports. Two occupations make up the home care workforce in Wisconsin: personal care aides (further categorized as household/chore services, personal assistance, or personal care services) and home health aides. While both occupations provide services in home and community-based settings, their training, skills, and responsibilities differ. The figure below shows the range of Medicaid-funded responsibilities across home care worker titles.

PERSONAL CARE AIDES

The state's 31,900 personal care aides provide home care clients with non-medical social supports, as well as a few medical tasks that can be delegated by a nurse.[11] These services are classified in Wisconsin as either "supportive home care" or "personal care." All personal care aides must pass a criminal background check before providing services, and training requirements vary across service areas.

SUPPORTIVE HOME CARE WORKERS include two tiers of services: household and chore services and personal assistance.[12] Household and chore services include routine housework along with seasonal tasks like snow shoveling. Personal assistance entails hands-on support with activities such as dressing, bathing, and grooming. Supportive home care workers must be trained in state-specified topics, including basic home care and policies and procedures.

PERSONAL CARE PROVIDERS also deliver hands-on assistance with activities of daily living, but unlike supportive home care workers, they might perform clinical tasks under the supervision of a nurse, such as checking clients' vital signs, providing catheter care, and simple wound care.[13] Personal care providers can perform light housekeeping but only in areas of the home where they provide other services. Before they begin work, these workers must be trained by their supervising nurses on the tasks required for each client.

HOME HEALTH AIDES

Wisconsin's 7,200 home health aides primarily focus on medical and clinical tasks.[14] State regulations require that home health aides be certified as nursing assistants, which means their formal skills and training are more advanced than those of personal care workers.[15] This additional training ensures that home health aides can safely provide services to people with various complex medical conditions. (Eleven other states also require home health aides to be certified as nursing assistants.) Home health aides can provide personal care, but only if their supervising nurses determine these tasks cannot be effectively delegated to personal care aides.

Wisconsin Medicaid Home Care Services, by Responsibility and Occupational Group

	Personal Care Aides			Home Health Aides
Responsibilities	Household / Chore Services	Personal Assistance	Personal Care Services	Home Health Services
Major seasonal housework (e.g. snow shoveling, refrigerator cleaning, and car washing)	●			
Cleaning (all areas of the home)	●			
Meal preparation	●	●	●	●
Cleaning (areas used during service delivery)		●	●	●
Assistance with bathing, grooming, dressing, eating, and ambulation		●	●	●
Assistance with therapeutic exercises		●	●	●
Assistance with bill-paying, transportation, and employment support		●		
Observing and reporting changes in condition			●	●
Nurse-delegated tasks			●	●
Tasks that cannot be safely delegated to personal care aides				●

Figure Source: Wisconsin Department of Health Services (DHS), Division of Long Term Care. 2016. *Managed Care Organization Training and Documentation Standards for Supportive Home Care, P-01602*. Madison, WI: DHS; Wisconsin Department of Health Services (DHS). 2015. *Wisconsin Administrative Code, Personal Care Services.* DHS 107.112 and *Home Health Aide Services.* DHS 133.17.

PAYING FOR LONG-TERM SERVICES AND SUPPORTS

Public programs account for most of the home care spending in Wisconsin. Statewide, 230,000 older adults and people with disabilities rely on Medicaid to cover these services.[16] Annual Medicaid spending on these client populations totaled $5 billion during the 2015 state fiscal year, equivalent to nearly two-thirds of total Medicaid spending.[17] Among older adults living in Wisconsin, 104,000 needed help attending medical appointments or with other activities outside the home, and 57,000 required assistance with dressing, bathing, and eating in 2015.[18] Approximately 62,000 adults over the age of 65 were enrolled in Medicaid during the same time period.[19]

Many people rely on Medicaid to pay for long-term care because private financing options are too expensive. According to 2013 estimates, the typical adult over the age of 65 in Wisconsin would need to spend nearly every dollar they earn to afford the average cost of private-pay home care; only seven states rank worse in this regard.[20] Private long-term care insurance is costly as well, and such plans typically offer limited benefits.[21]

People are eligible for Medicaid programs if they meet income requirements. Personal care and home health services are covered by every program in Medicaid, but supportive home care is only available through state waiver programs, which offer robust long-term care services through innovative payment models. Individuals are only eligible for waiver programs if they are over the age of 65 or have a disability.

Wisconsin contracts with 44 Aging and Disability Resource Centers (ADRCs) to help older adults and people with disabilities access the Medicaid program best suited to their needs, strengths, goals, and preferences. In addition to long-term care benefits counseling, ADRCs connect clients with other health and wellness programs. They provide information and resources on a variety of topics, including transportation, financial assistance, respite care, and home modifications. The services provided by ADRCs in Wisconsin are the fourth most comprehensive in the country.[22]

The Wisconsin Department of Health Services (DHS) oversees the Medicaid home care system by issuing and enforcing regulations. While some people receive personal care and home health services under the state health plan, DHS is largely uninvolved in delivering home care services; the state delegates these responsibilities to private, intermediary organizations known as managed care organizations (MCOs). Under managed care programs, MCOs assemble an interdisciplinary team that works with clients, known as "members" or "consumers," to identify their care needs and use state funding to assemble a network of providers to deliver services to meet those needs.[23] Additionally, under the Include, Respect, I Self-Direct (IRIS) program, consumers manage their own services with assistance from IRIS consultant and fiscal employment agencies. While IRIS is exclusively a self-directed program, each managed care program also offers a self-directed option, and one in five managed care enrollees exercises this option.[24]

Medicare, in turn, plays a smaller role in home care delivery. Medicare covers short stays of up to 100 days in skilled nursing facilities after a hospital admission, as well as home health services on a part-time, intermittent basis, provided these services are deemed necessary following discharge from the nursing facility.

METHODOLOGY

PHI based this home care landscape analysis on public data, available research, and interviews with long-term care leaders throughout Wisconsin. Interviewees were selected using a "snowball sampling" method, in which interview subjects were identified by other interviewees. We interviewed people representing both urban and rural areas. In total, we interviewed 33 stakeholders representing 20 organizations, including 9 provider organizations, 5 consumer groups or consumers, 3 state agencies, and 3 MCOs. Interviews were conducted using standardized questions about the home care landscape, with an emphasis on the workforce, together with follow-up questions about other issues that surfaced.

Our definition of "rural areas" is based on the federal Health Resources and Services Administration's definition of "rural counties."[25] Counties are considered rural if they are not included in metropolitan statistical areas. (See Appendix C for a list of rural counties in Wisconsin.)

OLDER ADULT POPULATION, INSUFFICIENT CARE

WISCONSIN POPULATION PROJECTIONS

Wisconsin's older adult population is growing rapidly. However, the primary labor pool from which the direct care workers and family caregivers who care for these residents have traditionally been drawn—working-age women—is dwindling. These trends raise a troubling question: will there be enough people to care for Wisconsin's older adults?

In 2015, 902,000 people over the age of 65 resided in Wisconsin.[26] This group comprised 16 percent of the total population. Among this older adult cohort, 32 percent had a disability, 13 percent needed help attending medical appointments or with other activities outside the home, and 7 percent required assistance with activities inside the home, such as dressing, bathing, and eating.[27] Moreover, 31 percent of older Wisconsin residents lived alone in 2015, which means they might not have immediate access to informal caregivers.[28]

Projected Population in Wisconsin by Age and Gender, 2015 to 2040

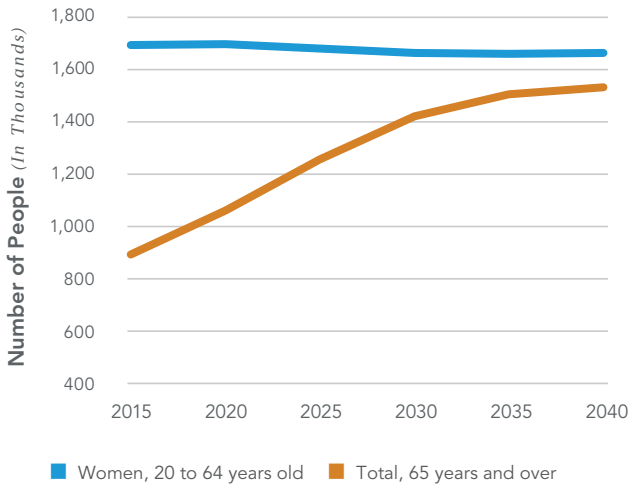
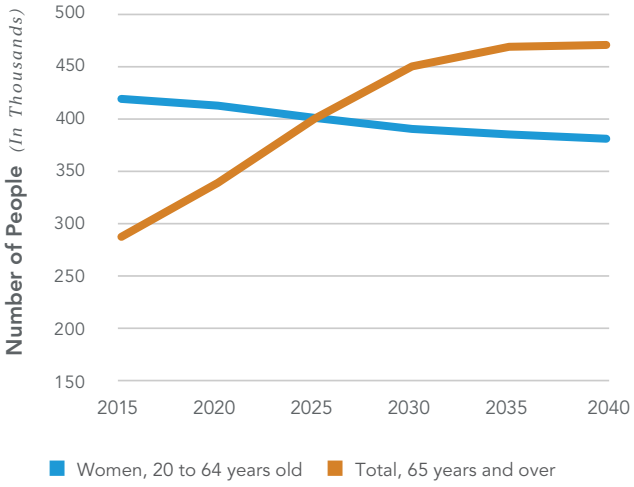


Figure Source: Wisconsin Department of Administration. 2013. *County Age-Sex Population Projections, 2010-2040.* http://www.doa.state.wi.us/Divisions/Intergovernmental-Relations/Demographic-Services-Center/Wisconsin-Population-Projections/ and U.S. Census Bureau. 2014. *American Community Survey (ACS), 2010-2014, 5-Year Public Use Microdata Sample.* https://www.census.gov/programs-surveys/acs/data/pums.html; statistical programming and data analysis by Carlos Figueiredo.

Projected Population in Rural Wisconsin by Age and Gender, 2015 to 2040



From 2015 to 2040, the state's population of older adults will grow by more than 640,000 people, while the population that makes up nearly 90 percent of the home care workforce in Wisconsin, women between ages 20 and 64, will decline by 32,000 (see figure above).[29] Additionally, while there are currently two working-age women for every older Wisconsinite, these two populations will be nearly equal in size by 2040.

Population trends for older people and working-age women are especially concerning in rural areas. The statewide population decline among working-age women is largely attributable to demographic shifts in these areas. By 2040, rural areas in Wisconsin are projected to lose nearly 38,000 women between the ages of 20 and 64, while this cohort will grow by nearly 6,000 in non-rural areas. This trend can be explained by two factors: younger baby boomers are aging out of this cohort, and younger women are leaving rural areas in search of opportunities elsewhere, including out of state.[30]

In 2015, 288,000 adults over the age of 65 lived in rural counties in Wisconsin—or 19 percent of the total rural population.[31] However, unlike younger populations, older adults are likely to remain in these counties. From 2015 to 2040, the population of older adults in rural areas will grow by 185,000 people, or 64 percent.[32]

Taken together, these projections indicate older adults will outnumber working-age women in all but eight rural areas in Wisconsin after 2025. In some counties, this "care gap" will be more extreme. For example, in Bayfield and Adams counties, by 2040 the population of adults ages 65 and older will be more than twice as large as the population of women between the ages of 20 and 64.

Rural counties are more sparsely populated than urban counties. On average, there are approximately 8 adults over the age of 65 and 12 women between ages 20 and 64 per square mile in rural areas, compared to approximately 37 older adults and 79 working-age women per square mile in urban areas.[33] Similarly, health care providers serve much larger geographic areas in rural counties. Among all types of health care providers, home care providers are the most disproportionately scarce in rural counties relative to non-rural counties. Thus, home care workers in rural counties must travel longer distances to serve their clients, as well as to visit their employers' offices.

GROWING CARE NEEDS AMONG OLDER ADULTS

Compared to previous generations, middle-aged adults in the U.S. are expected to live longer and experience higher rates of chronic and complex illnesses for which they will require more care. People aged 45 to 64 were more likely to have hypertension, diabetes, and poor self-reported health status in 2010 relative to the same age cohort in 1994.[34] They were also more obese, less physically active, and experienced higher rates of disability.

Health acuity and care needs overall are likely to be higher in rural areas. Among all age groups in the Great Lakes region—Michigan, Minnesota, Ohio, and Wisconsin—mortality rates from heart disease, cancer, respiratory disease, and stroke are higher in rural areas than in urban areas. Nationally, these mortality disparities have widened over the past 15 years.[35] Rates of health conditions that often predict complications and mortality, including obesity, physical inactivity, and diabetes, are also higher in rural areas of the Midwest.[36]

Wisconsin has additionally seen increasing prevalence of Alzheimer's disease and related dementias. The state estimates that 115,000 of its residents lived with these

Figure Source: Wisconsin Department of Administration. 2013. *County Age-Sex Population Projections, 2010-2040.* http://www.doa.state.wi.us/Divisions/Intergovernmental-Relations/Demographic-Services-Center/Wisconsin-Population-Projections/.

conditions in 2015.[37] By 2040, that population will more than double, with dementia projected to affect 242,000 people. Within this population, the state estimates that approximately one in four people will rely on Medicaid for health and long-term care services.

The rates of chronic conditions and lifestyle factors discussed above all suggest that Wisconsin's older adults will increasingly face limitations in performing activities of daily living in the coming decades.[38] With this growing need for assistance will come increased reliance on paid caregivers. Among community-dwelling U.S. adults over the age of 65 in 2011, those who required assistance with one or two daily activities received 13.7 hours of paid caregiving each month on average, while those who required assistance with three or more received 69.9 hours.[39] Further, baby boomers (born between 1946 and 1964) are significantly less likely to have access to family caregivers—including spouses and proximal adult children—compared to previous generations.[40] As such, demand for paid caregiving will exceed the growth rate of the older adult population. In Wisconsin, the demand for home care workers will increase by 29 percent from 2014 to 2024, while the older adult population will only grow by 19 percent by 2025.[41]

THE HOME CARE WORKFORCE SHORTAGE

Reports from across the country have noted a rising shortage of direct care workers, leaving home care providers and families without the supports they need to fill cases and care for their loved ones. The surging demand for direct care workers, paired with a rapidly aging U.S. population, suggests this shortage will intensify in the coming years.[42]

Many long-term care leaders and workforce advocates confirm that the caregiver workforce shortage is already affecting Wisconsin. The Wisconsin Personal Services Association (WPSA), an organization representing 73 personal care providers, surveyed its members in 2015 and 2016 and found that 93 percent of personal care providers reported difficulties in filling job openings, and 70 percent were unable to staff all authorized hours.[43]

In the absence of paid caregivers, people needing in-home support typically rely on families and friends for assistance. However, family caregiving can be arduous and costly, forcing relatives to limit their work hours and pay for health care costs out-of-pocket. Nationwide, family caregivers provided 37 billion hours of unpaid caregiving in 2013, worth an estimated $470 billion in

Health Care Establishments per 1,000 Square Miles in Rural and Non-Rural Counties in Wisconsin, by Industry, 2015

Facility type	Rural Counties	Non-Rural Counties	Statewide
Home Care Providers	32.41	441.82	159.57
Offices of Physicians	10.18	99.16	37.82
Assisted Living Facilities	7.79	39.59	17.67
Facilities for People with Intellectual and Developmental Disabilities	4.31	20.27	9.27
Nursing Care Facilities	3.75	13.32	6.72
Hospitals	1.90	6.18	3.23
Continuing Care Retirement Communities	0.91	5.65	2.38

Figure Source: PHI analysis of: U.S. Bureau of Labor Statistics. 2017. *Quarterly Census of Employment and Wages (QCEW), State and County Wages.* https://www.bls.gov/cew/

services.[44] In Wisconsin, MCOs and Include, Respect, I Self-Direct (IRIS) consultants help consumers draw on their informal caregiving networks, so when consumers seek paid caregivers, it is often because they require skilled care and have exhausted other alternatives.

Gaps in home care services are often the result of short staffing, as many leaders in Wisconsin report. The Survival Coalition, representing people with disabilities throughout the state, found that among their constituents surveyed in 2016, 95 percent reported difficulties in finding home care workers.[45] Moreover, 85 percent of the respondents reported not having enough workers to fully cover open shifts. The Survival Coalition also gathered personal stories to humanize these trends. In one, a short-staffed Florence county resident attempted to transfer into bed without assistance and fell. The resident stayed on the floor for nine hours until a worker began her shift the next morning. Another story involved a Winnebago county resident who could not find a replacement for a sick home care worker and was forced to stay in bed for 15 hours without access to the restroom.

In 2015, labor force participation in the state fell below 80 percent among people between the ages of 55 and 59.

LABOR MARKET FACTORS

As the economy has improved in recent years, the pool of jobseekers in Wisconsin has contracted. Unemployment peaked in 2010 at 8.7 percent, but is now just 4.1 percent.[46] Working-age adults have seen a growing number of employment options, and businesses across industries are raising wages to fill open positions, among other recruitment strategies.

In contrast, home care providers in Wisconsin have struggled to raise wages due to chronically low reimbursement rates from the state, which pay for home care services for Medicaid beneficiaries. Providers across the country report similar challenges, and some states have addressed low reimbursement through policy reforms and adjustments. Maine, New York, and Washington have increased reimbursement for the specific purpose of improving job quality.[47]

To ensure a sufficient supply of home care workers in an increasingly competitive market, it is also important to understand labor trends among different groups. Participation in the labor force and unemployment rates in Wisconsin vary across demographic cohorts. Younger people between the ages of 20 and 24 tend to experience higher rates of unemployment (7 percent) due to limited experience in the workforce, among other factors. Older adults participate less in the labor force as they reach retirement age. In 2015, labor force participation in the state fell below 80 percent among people between the ages of 55 and 59 and below 60 percent among those between the ages of 60 and 64. Women with children ages 18 and under also participate in the labor force at lower rates than men, possibly attributable to familial responsibilities and lack of accessible child care, among other factors.[48] (See Appendix D for labor force participation and unemployment data.)

Expanding the home care workforce to address the growing shortage of workers requires investment in three primary areas—partnerships with community organizations, customized training, and on-the-job supports—to identify and recruit non-traditional candidates, reduce their barriers to employment, and ensure their retention on the job. Some organizations have already explored such strategies. For example, one Wisconsin provider partnered with local child care providers to link its workforce with childcare services. Another home care employer provides extensive job shadowing to new hires in an effort that leverages experienced workers to help younger workers and their clients feel more comfortable with a new caregiving dynamic. Recruiting from outside the traditional labor pools for home care workers will require support at the state level for investments in job quality, in addition to buy-in from provider organizations. Key to gaining this support will be effective demonstration of the connections between strengthening home care jobs and advancing economic opportunities in underserved communities across the state.

ADDRESSING WISCONSIN'S CARE GAP

IMPROVING ACCESS TO HOME AND COMMUNITY-BASED SERVICES IN WISCONSIN

As the older adult population in Wisconsin grows, policymakers are striving to increase the availability of home care through Medicaid programs. State spending on home and community-based services totaled $966 million in 2015, accounting for 52 percent of total long-term care spending.[49] Wisconsin ranks 18th among states in its percentage of long-term services and supports funding directed at home and community-based services. While the proportion of state spending on home care might seem high, home and community-based services are significantly less costly than institutional care. According to Genworth's *2015 Cost of Care Survey*, the average cost of home care for a Wisconsin resident is approximately $50,000 a year, compared to roughly $90,000 for nursing home care.[50] Further, individuals often prefer to age with independence in their homes and communities: 9 in 10 older adults nationwide say they would like to remain in their homes as long as possible.[51]

Medicaid programs available to Wisconsinites differ in structure, eligibility guidelines, and covered services. Enrollees in the state's fee-for-service plan might receive personal care, but Medicaid waivers offer more robust services (including supportive home care) through innovative payment models. Family Care, a managed long-term care waiver created in 1999, and IRIS, a self-directed program created in 2008, both offer comprehensive long-term care coverage without waiting lists. These waivers are currently offered in tandem in 65 counties, and they will cover the entire state by early 2018.[52] Notably, Family Care and IRIS only cover long-term care services: members use the state Medicaid plan to pay for other health care services, such as acute and preventative care. People in 13 Wisconsin counties can enroll in the Family Care Partnership Program, which was created in 1996, and people over the age of 55 in Milwaukee and Waukesha county can enroll in the state's Program of All-Inclusive Care for the Elderly (PACE), which has been in operation for over 25 years. The Partnership and PACE both offer a full range of benefits, including long-term care, doctor's visits, hospital care, and other health services.[53] Nearly two-thirds of enrollees in Wisconsin's newer waiver programs receive services in their homes, and only 5 percent live in institutional settings.[54]

In the six counties where managed long-term care and IRIS are not available, residents can enroll in two fee-for-service waivers: the Community Options Program (COP) and the Community Integration Program (CIP).[55] COP serves older adults and people with disabilities, while CIP serves people with intellectual and developmental disabilities. County agencies operate these waivers, and there are waiting lists to enroll.

The expansion of programs available for long-term care recipients and the growing population of older adults have fueled demand for home care services. Home care worker employment in Wisconsin grew from 32,450 in 2005 to 39,130 in 2015—a 21 percent increase.[56] Additionally, the number of home care providers grew by more than 1,500 between 2014 and 2015.[57] Because home care services are largely publicly funded, the increase in demand applies pressure to the state budget, and service efficiency becomes increasingly important.

Once Family Care and IRIS are available statewide, many clients will no longer need to wait to enroll in long-term care programs. However, this does not mean people can access services once they enroll in public programs.

The challenges that providers have seen in successfully recruiting and retaining home care workers likely mean that clients must wait until workers are available before receiving essential home care services.

GROWING DEMAND, FEWER AUTHORIZED HOURS

Home care providers in Wisconsin have reported a new challenge to maintaining adequate staffing levels: a higher volume of low-hour cases. Though the growing demand for services has increased providers' caseloads, each new case has fewer hours of care authorized by its care plan. To illustrate this point, the overall number of Family Care member service hours increased by 10 percent on average each year from 2009 to 2016, but over the same period, annual service costs for each member increased by just 1 percent on average each year.[58] Low-hour cases pose a challenge to effectively scheduling home care workers across multiple clients and makes it harder for workers to achieve full-time hours.

The move to managed care in Wisconsin may have contributed in part to the decrease in hours authorized for long-term care. MCOs determine the number of service hours for each member in their plan.[59] The tools they use to assess member needs are developed in-house and approved by the state. Conversely, for services provided through fee-for-service programs such as IRIS, CIP, COP, and the state's Medicaid plan, registered nurses employed at home care agencies assess the number of hours of care for each client using the state-mandated Personal Care Screening Tool (PCST).[60] Providers and MCOs are required to substantiate authorized hours with documentation such as medical records, physicians' orders, and assessments of environmental factors in the home. Despite regulatory standards that govern these different assessment processes, the gap between hours authorized by personal care providers and MCOs suggests that other factors may be influencing their decisions. MCOs are reimbursed for the average cost of each member's services, and there may be financial incentives to their careful management of service hours. Because personal care providers are paid a fixed rate by the hour, they have less incentive to limit service hours.

57 percent of personal care providers in Wisconsin have set a minimum number of authorized hours for cases they will accept.

There were concerns at the state level that allowing personal care providers to conduct needs assessments might encourage fraud,[61] although federal investigations into three personal care providers in Wisconsin had not shown any indication of fraud.[62] In July 2016, the health department awarded a three-year, $16 million contract to Liberty Healthcare Corp. to independently conduct needs assessments. However, the contract was cancelled in July 2017, after it was determined that other state-level changes would reduce fraud—including the growing role of managed care and new federal regulations that require stricter timekeeping among personal care aides.[63]

The trends that drive fewer authorized hours per client also yield shorter work shifts, in some cases as brief as 15 minutes, which are difficult given the time and travel costs between visits. In response, 57 percent of personal care providers in Wisconsin have set a minimum number of authorized hours for cases they will accept.[64] Minimum hour requirements are typically one or two hours.

INADEQUATE REIMBURSEMENT RATES

In addition to restricting authorized hours, the state has also managed long-term care costs by freezing reimbursement rates, which providers believe are already too low to effectively deliver services. Fee-for-service personal care rates have not increased in nearly 10 years; the hourly rate has remained stagnant at $16.08 since 2008.[65] In 2012, WPSA surveyed its members and found fee-for-service personal care costs were 15 to 20 percent higher than reimbursement rates.[66]

Home care providers report that reimbursement for managed care services is also inadequate to cover the costs of providing services. In Wisconsin, MCOs can only offer providers reimbursement rates within the parameters of per-member, per-month payments from the state. While many managed care plans work closely with providers to adjust their rates and account for the needs of their members, the plans are nevertheless financially constrained.

The effects of low reimbursements vary across the state. Some providers subsidize home care services through revenue generated from other product lines. Others have been forced to cut administrative costs. In a recent survey administered from 2015 to 2016, WPSA found that half of their members had laid off staff or reduced staff hours within the last 12 months.[67] One rural provider eliminated the executive director position and distributed high-level management responsibilities among other staff. In addition to personnel cuts, some providers were forced to shorten their training programs or eliminate them altogether. And in extreme cases, low reimbursement rates have proven untenable for home care providers, and the agencies have either stopped offering Medicaid-funded personal care services or gone out of business. If these trends continue, access to care will be further undermined for Wisconsin home care clients.

UNIQUE CHALLENGES IN RURAL AREAS

Meeting the needs of older residents in Wisconsin's rural areas is especially challenging. Because public transportation options are lacking, fewer than 1 percent of all workers in rural areas use this method of transportation to get to work.[68] As such, home care workers who serve remote areas must rely on a functioning vehicle. Driving long distances imparts wear on their vehicles, and vehicle maintenance can add financial stress to low-income workers. Home care workers might not be able to afford timely car repairs, which means that when a worker's vehicle breaks down, their clients will likely experience gaps in service.

For workers who do travel, the salted, icy road conditions during Wisconsin's winter season can be both damaging to vehicles and dangerous for drivers.

Traveling to clients in the outer reaches of rural Wisconsin can be logistically onerous for home care workers for other reasons. While providers are required to pay workers for travel time between cases, they are not reimbursed by managed care plans for these costs, unless the plans deem travel reimbursement as essential. For example, one MCO increases reimbursements to cover travel time when workers are required to drive more than 50 miles to serve their clients. Yet reimbursement policies vary among plans, and long travel times may not meet such high thresholds. This can pose burdens on providers to either cover the costs for their workers or limit long-distance travel. For workers who do travel, the salted, icy road conditions during Wisconsin's winter season can be both damaging to vehicles and dangerous for drivers. Providers and consumers struggle to find workers willing to make these tough commutes, especially when clients only need one or two hours of care.

To mitigate these concerns, consumers, providers, and MCOs have begun coordinating their efforts. Providers might ask their clients in one area to modify their schedules to make it possible for one worker to serve them consecutively. When a provider is unable to staff a shift, they might ask another provider if they have workers available. If an area lacks sufficient workers, an MCO might fill the unmet need by encouraging providers in other counties to expand their service areas.

When consumers cannot find workers through agencies, or when they prefer to hire workers directly, they might turn to self-directed options. Through self-direction, consumers are responsible for attracting workers from their communities. In such cases, consumers take on additional employer-related responsibilities, such as hiring, training, and determining compensation for workers. They must offer wages within a range that is determined by local labor market data, but they may be able to pay more than agencies in their area. Consumers receive support with managing these responsibilities from consultants and fiscal employment agencies under IRIS and from MCOs under self-directed managed care programs.

STAKEHOLDER COLLABORATION AND INGENUITY

Wisconsin has a vibrant, well-organized ecosystem of providers and organizations invested in long-term care and its workforce. Personal care providers are members of WPSA and the Wisconsin Independent Living Network. LeadingAge Wisconsin members include both nursing homes and home health providers. Nursing homes are also represented within the Wisconsin Health Care Association. Assisted living providers are members of both the Wisconsin Center for Assisted Living and the Wisconsin Assisted Living Association.

Consumers have also formed alliances and associations to improve long-term care; more than 40 of these groups are members of the Survival Coalition. Together, they work to improve policies and practices that affect people with disabilities. The Coalition's research has effectively described the workforce shortage and its detrimental effects on clients with disabilities.[69] In addition to

workforce issues, the Coalition also works to improve transportation, employment supports, educational opportunities, and long-term care financing for people with disabilities.

As well, the state government has brought together stakeholders to inform policymaking on these issues. For example, the Long-Term Care Advisory Committee, established in 2008 and comprised of 23 members, represents diverse interests in long-term care. In 2016, the Wisconsin DHS Secretary Linda Seemeyer asked this group for guidance on quantifying and alleviating the shortage of long-term care workers with special attention to differences among types of providers.

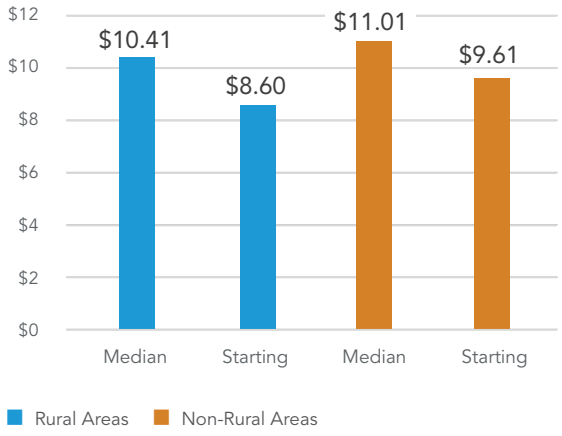
The abovementioned groups are all members of the Wisconsin Long-Term Care Workforce Alliance, which conducts regular meetings to gather insights, coordinate strategy, and develop innovative workforce solutions. Members of the Alliance also developed a new standardized training module on Alzheimer's disease and related dementias for personal care aides.

These stakeholders have held events to discuss legislative priorities, to advocate at the state capitol, and to share industry best practices. They have also released studies on the effects of the workforce shortage, including workforce turnover and vacancies for personal care aides, training enrollment and certification renewals for home health aides, and gaps in services for people with disabilities. Their combined efforts have garnered impressive results: in February 2017, Wisconsin Governor Scott Walker asked for a 4 percent reimbursement increase to personal care providers and nursing homes in his 2017-19 budget proposal—a direct result of advocacy from leaders in the long-term care community.[70] Leaders in the long-term care community agree the reimbursement increase is promising but remain concerned that the change is too marginal to fully address the workforce shortage statewide.[71]

QUALITY OF JOBS, QUALITY OF CARE

The poor quality of home care jobs underpins the most pressing challenges facing Wisconsin's home care sector, including the state's alarming workforce shortages and its gaps in service delivery for clients. Providers cannot attract workers who are willing to perform complex and demanding, yet poorly compensated, work. Moreover, because rural areas are spread out and sparsely populated, providers there struggle to find workers who can drive long distances to serve clients for low pay, especially when clients need just one or two hours of service. Attracting new home care workers to the field to meet rising demand is also a challenge given the diminishing labor pool and increased competition, which is becoming more acute as home care wages become less competitive with wages in other sectors.

Home Care Worker Wages in Wisconsin, 2015



The demanding nature of home care work is not reflected in the low level of compensation historically afforded to this workforce. Home care workers provide services in strangers' homes, with little to no support or supervision. Their services regularly require physical and emotional strength, clinical knowledge, and adept communication and problem-solving skills. When emergencies arise, workers must exercise quick, sound judgement. They must have the emotional maturity and resilience to develop trusting relationships, which can be especially crucial when clients have behavioral health issues or diseases like Alzheimer's and other forms of dementia. It is psychologically taxing work that often requires managing—both first- and second-hand—a range of emotions associated with chronic conditions, disease, discomfort, immobility, isolation, and death.

Further, home care can be dangerous work. Home care workers are at elevated risk for contracting infectious diseases, and on-the-job injuries are common.[72] Workers are on their feet for hours at a time, and lifting and repositioning clients is strenuous. Relative to the average U.S. worker, home health aides and personal care aides are 15 percent and 44 percent more likely to be injured on the job, respectively.[73] Finally, aides are often expected to perform this difficult work in perpetuity without opportunities for advancement.

Compounding the challenges involved in the work itself is the fact that home care worker wages in Wisconsin have not kept up with the rising cost of living over the past 10 years: the 2015 median hourly wage of $10.47 represented a 7 percent decrease from the 2005 inflation-adjusted median hourly wage ($11.26). Additionally, home health aides typically earn only $0.79 more than personal care aides statewide and just $0.44 more than personal care aides in rural areas,[74] which means that wages are not competitive enough to make the additional training required of home health aides worthwhile. (While home health aides must hold certified nursing assistant credentials, training is minimal for personal care aides; for example, personal care aides who provide chore services are not trained in interpersonal skills, such as conflict management.) From 2012 to 2015, 24 percent fewer people applied for the certification required to perform home health work, and certification renewals fell by 24 percent.[75] Further, people who complete the training can earn higher wages working in nursing homes, where nursing assistants typically earn $12.95 statewide and $12.90 in rural areas.

Figure Source: PHI analysis of: Wisconsin's WORKnet. 2015. *Occupational Employment Statistics, May 2015*. http://worknet.wisconsin.gov/worknet/worknetinfo.aspx?htm=progdesc_long&menuselection=#OES.

While home care workers in rural areas earn a median hourly wage of $10.41—a figure skewed by older, more experienced workers who generally earn more—the mean entry level wage is $8.60.

Moreover, entry-level wages for home care workers in rural areas are not sufficiently competitive with fast food jobs, which offer a $8.17 starting wage, or retail jobs, which offer $8.21.[76] Like these entry-level positions, home care jobs have low barriers to entry, which means that employers from each sector recruit from the same pool of workers. Home care jobs do not require prior experience, and nearly half of the home care workforce in Wisconsin has a high school education or less.

Poor job quality makes it difficult not only to attract new workers but also to retain the existing workforce.

However, as unemployment falls and competition for new workers escalates, jobs with low barriers to entry in other sectors are increasingly offering higher wages. Providers report that job applicants can often earn higher wages working at Kwik Trip, a convenience store chain that originated in Wisconsin. In Kenosha county, a new Amazon.com distribution center offers a starting hourly wage of $15 with benefits. The distribution center created 2,000 new jobs in 2015,[77] which likely made a significant impact on the pool of jobseekers in the surrounding area: when it opened, approximately 6,100 unemployed people in the county were looking for work.[78] And in recent years, Culver's, a fast food chain with 136 locations throughout Wisconsin, raised its hourly wage to $10.10 for people over the age of 18.[79] Even people participating in the state's self-directed care programs, which allow consumers to recruit their own workers and to determine workers' wages, must offer rates within the typical range of home care wages in their counties. These consumers are therefore also limited in offering compensation that can effectively compete with those of other industries.

Compounding recruitment challenges is the fact that home care work is typically part-time: only 29 percent of home care workers in Wisconsin have full-time hours throughout the year. Because authorized hours continue to decrease, it has become increasingly difficult for providers and workers to patch together enough service hours to create full-time work. When accounting for unpaid travel time to and from the first and last cases of the work day, eight hours of wages often takes nine hours to earn. Additionally, when a client enters the hospital for a long-term stay, their assigned worker can lose hours or even weeks of work.

The combination of low wages and part-time hours limits annual earnings for home care workers. The median annual income for home care workers in Wisconsin is $12,600, and 22 percent of the workforce lives below the federal poverty line. Over half of home care workers rely on public benefits to support themselves and their families, including 35 percent relying on food stamps and 29 percent relying on Medicaid for health care.[80] Public benefit eligibility can also disincentivize home care workers from taking on more hours of work. According to a survey of WPSA members from 2015 to 2016, 72 percent reported they are aware of staff who have declined additional hours or a raise due to the possibility of losing their public benefits.[81]

Poor job quality makes it difficult not only to attract new workers but also to retain the existing workforce. As reported by Wisconsin home care providers, annual turnover can be as high as 67 percent and typically exceeds 50 percent.[82] High turnover has a steep financial cost for providers, estimated nationally at $2,500 per worker.[83] Additionally, when a home care worker leaves her job, information on her client's physical and mental health that comes from day-to-day caregiving is also lost. The revolving door of home care workers is especially problematic for people with Alzheimer's and related dementias, for whom consistency and routine can be critical for their wellbeing and condition management. According to the Wisconsin Alzheimer's Association, family caregivers report that regular replacement of caregiving staff can be acutely distressing for their family members with Alzheimer's and related dementias.

TRAINING LANDSCAPE AND TESTED INNOVATIONS

HOME HEALTH AIDE TRAINING

In Wisconsin, training requirements for home health aides exceed the 75-hour federal standard. The state's home health aides must complete 120 hours of training, including 32 hours of experiential training in a clinical setting. Following training, these aides must demonstrate their skills through a competency exam. The required content of Wisconsin's home health aide training also goes beyond federal requirements. For example, training on Alzheimer's disease and related dementias in Wisconsin is more expansive than the federal standard. However, the experiential portion of home health aide training is not required to take place in home and community-based settings; rather, it is held in a skilled long-term care facility or a hospital. In addition to the 120-hour core requirements, once home health aides are hired by a home care agency, they must complete a brief supplemental training provided by their employers; the state mandates that this orientation include training on basic home care tasks and employer policies.

PERSONAL CARE AIDE TRAINING

Personal care aide training requirements differ among chore services, personal assistance, and personal care service areas (see figure on page 5). The state requires that supportive home care workers receive training on policies and procedures, billing and payment processes, responding to an emergency, and homemaking skills. Aides who provide personal assistance must also be trained on serving different populations, depending on the populations served by their employers; these populations may include older adults, people with physical disabilities, and people with intellectual and developmental disabilities. Personal care aides must also be trained in how to work effectively with clients, including interpersonal skills, cultural competency, and conflict resolution. (Chore service providers are not required to receive training on interactions with clients.) Aides who provide personal care under all waivers and the state Medicaid plan must be trained by a registered nurse on the specific needs and preferences of each

client. While valuable for client care, this approach can be burdensome for providers, especially when workers cannot attend their shifts and providers must quickly find a replacement (and orient the new worker to the client's needs and preferences).

Providers and consumer advocates recognize some shortcomings in personal care aide training. A few groups have developed their own training regimens, with financial assistance from the state Department of Workforce Development and other sources. For example, WPSA developed three train-the-trainer modules:

- "Direct Care Competencies I" was developed in 2004 and prepares instructors to train workers on how to aid with activities of daily living. WPSA staff estimate that between 1,000 and 3,000 personal care workers have been trained statewide on this curriculum. Trainers report 96 percent satisfaction with the training.[84]

- "Direct Care Competencies II" prepares nurses to provide advanced clinical training for personal care aides on medical and clinical tasks. The program has been offered four times since it was created in 2015, and nearly 100 nurses have completed the training. According to WPSA, 90 percent of nurse instructors, workers, and clients report satisfaction with the module.[85]

- Finally, WPSA worked with the Wisconsin Alzheimer's Association in 2014 to develop a specialized training on caring for people with Alzheimer's disease and related dementias. Approximately 100 home care workers and trainers had completed the training as of March 2017.[86]

In addition to WPSA's efforts, the state's ombudsman program wants to improve training to prevent older adult abuse and neglect. Ombudsman staff have trained MCO employees in recognizing and reporting signs of these conditions and hope to expand the reach of their training to others in long-term care. Abuse and neglect prevention training for home care workers could also help address these issues proactively. PHI's Training to Prevent Adult Abuse and Neglect (TPAAN) curriculum, for example, helps aides understand the conditions that precipitate abusive behavior, acquire skills to create an abuse-free environment, and learn applicable laws and reporting requirements for when abuse or neglect occurs.

State lawmakers have also recognized that current training requirements for personal care providers are inadequate. The Wisconsin DHS announced it might soon change training requirements for personal care aides through new regulations. The new requirements will aim to "strengthen orientation and ongoing training standards in order to improve the quality of services provided by personal care workers and staff."[87] The group that will deliberate over new requirements includes WPSA members, facilitating the use of existing training programs to inform the rulemaking process. Notably, supportive home care worker training requirements will not be affected by these new regulations, which may widen the training gap between personal care and supportive home care providers.

TRAINING METHODS

Because Medicaid reimbursement rates for providers are insufficient to cover even the core costs of home care provision, most providers are unable to invest in the additional costs of developing and sustaining a high-quality training program. Training costs are not built into provider reimbursement rates. In response, providers must implement innovative strategies in order to promote high-quality training while managing costs. Some Wisconsin providers offer job shadowing to new workers as a method of helping them learn from the daily practices of experienced aides. Others have designed training programs that promote interaction between trainees and instructors.

According to home care providers, the training programs available to prospective home care workers in Wisconsin often lack skills demonstrations and dynamic activities such as role playing and group problem-solving. Trainers tend to rely on didactic teaching methods and videos, which can be less compelling and effective for jobseekers in home care, particularly those with little formal education experience. These observations are common to direct care training offerings across the country, and alternative teaching methods have been identified to ensure better learning outcomes among nontraditional learners—those who are less receptive to traditional methods like lectures and reading assignments. For example, adult learner-centered training methodology recognizes a range of cognitive strengths, with some adults learning best by seeing, hearing, or performing training material. Adult learner-centered training emphasizes engagement and participation among students and between students and their instructors. Wisconsin training providers would benefit from adaptations to home care curricula that include problem-solving activities, role plays, case studies, small-group discussions, and other interactive exchanges.

CONCLUSIONS AND RECOMMENDATIONS

Demographic changes across Wisconsin, coupled with the expansion of home and community-based services statewide, have made it imperative that the state prioritize the development of a stable, well-trained, and supported home care workforce. Despite the growing demand for home care services, the shortage of available workers in this field continues to worsen, negatively affecting older adults and people with disabilities. With stagnant reimbursement rates, home care struggles to compete with the wages offered by fast food and retail companies in most Wisconsin communities. Moreover, the number of authorized hours per case has fallen in recent years, making it increasingly complex for providers and workers to create schedules that lead to full-time work. These low wages and part-time hours make home care a poverty-level job for many. As the workforce crisis intensifies, it is clear that the current conditions of home care work are unsustainable.

Rural areas of Wisconsin are particularly challenged in recruiting and retaining home care workers to provide quality home care services to their residents.

Rural areas of Wisconsin are particularly challenged in recruiting and retaining home care workers to provide quality home care services to their residents. These sparsely populated regions require workers to drive long distances to provide services, often with significant costs to employers and workers. Fewer people are available to enter the home care sector in rural communities. As young adults and family members leave for urban areas, the pool of potential workers grows smaller, driving even greater competition for home care workers in rural markets.

Wisconsin cannot afford to forgo investments in job quality for its home care workforce. A combination of policy- and practice-based interventions are recommended to increase wages, guarantee full-time work, and ensure adequate reimbursement rates so that employers can provide fair and competitive compensation for home care workers. Policymakers should consider working with stakeholder groups—including MCOs, providers, and clients—to provide a rate sufficient to support recruitment and retention for home care workers. Better compensation alone will not solve Wisconsin's workforce crisis; employers will also need to adopt practices that add value to home care jobs and help reduce feelings of isolation in the field. Workforce support begins with high-quality pre-employment training, but it also includes ongoing, effective management practices.

Through decades of work with long-term care providers, PHI has identified the most valuable factors to improving retention among direct care workers: higher wages; comprehensive benefits (most critically, health insurance); full-time hours; adult learner-centered, competency-based training; and skilled, supportive supervision. Each requires investment to positively impact job quality and, in turn, ensure older adults and people living with disabilities can reliably access home care services from dedicated, skilled home care workers.

These conclusions are supported by prevalent research in the field. A 2015 analysis of the National Home Health Aide Survey revealed strong correlation between job satisfaction and intent to leave: home care workers who were satisfied in their jobs were more likely to stay. Controlling for job satisfaction, the study demonstrated positive correlations between low intent to leave and the following job quality measures: accessing health insurance, feeling valued by one's organization, feeling respected by one's supervisor, working full-time, and having a consistent client assignment. Factors negatively correlated with low intent to leave included having an injury within the past six months and working part-time but wanting more hours.[88]

RECRUITMENT STRATEGIES THAT WORK

As noted throughout this report, the labor pool for home care workers in Wisconsin is shrinking due to demographic shifts and falling unemployment across the state, and this trend is particularly acute in rural areas. It can be challenging to reach potential workers through traditional methods, such as online job postings and newspaper ads. Additionally, some employers fear that frequently posting home care job vacancies indicates poor job quality.

Bringing new workers into the home care field will require rigorous and inventive recruitment practices. The recruitment process for providers in Wisconsin often includes a job posting, an interview, a state-required background check, and pre-employment training. PHI's experience shows that recruitment should also include an assessment of a potential worker's values and experiences related to caregiving. Gaining familiarity with the field is also important: before workers apply for home care jobs, they should have the opportunity to learn about home care through educational presentations, materials, or demonstrations. Once a worker applies for a position, employers should ask interview questions that extend beyond logistical topics such as availability and transportation. Interviews should also assess an applicant's commitment to home care work, as well as an applicant's skills in conflict resolution and communication. An applicant's responses to these questions could help employers develop targeted training programs to build up specific competencies.

To improve recruitment in areas where job candidates are scarce, it may be possible to recruit from populations that experience high unemployment or participate in the labor force at lower rates than the broader working-age population. Some of these untapped labor pools include: younger workers between the ages of 20 and 24; working-age parents with children under 18; retirement-age adults over 55; and informal caregivers, including family members.

YOUNGER WORKERS. Recruitment efforts targeting young people through informational sessions at high schools and college campuses can introduce potential jobseekers to the field of paid caregiving as a first step in employment in the health care field. As the population of older adults grows, it is increasingly likely that younger people will have experience with informal caregiving, which provides an important foundation for moving into a professional role as a home care worker.

PHI's experience has shown that younger workers often need specialized, ongoing support to navigate the challenges of home care work. To improve retention among younger workers at an employer agency in New York, PHI helped develop a case management position specific to supporting job candidates and incumbent workers between the ages of 18 and 24. Through the program, younger workers were also offered group and one-on-one coaching sessions to discuss their jobs, troubleshoot workplace issues, and review strategies for success. In 2016, retention among younger workers was 85 percent after three months on the job and 52 percent after one year.

WORKING-AGE PARENTS. Providers could recruit people who are out of the workforce and providing informal caregiving for dependent family members, who may be interested in obtaining full- or part-time employment in home care jobs. Access to this recruitment pool can be facilitated through partnerships with local organizations including childcare providers, parent teacher associations, and informal caregiving networks (see below).

RETIRED ADULTS. By age 60, more than 40 percent of people in Wisconsin no longer participate in the labor force.[89] However, research shows that people over the age of 50 value flexible work hours, and a large proportion retire to spend more time with their families.[90] Their desire for fewer work hours might make this population well-suited for home care work, especially when clients require limited hours of service. Recruitment strategies for this populations could target civic, service, and faith-based organizations.

INFORMAL CAREGIVING NETWORKS. To meet the growing demand for home care, communities will need to maximize the caregiving capacity of both paid and unpaid caregivers. Already, MCOs and IRIS consultant agencies help their clients identify methods for strengthening informal caregiving, including connecting neighbors and sharing resources—such as lawn maintenance or house-cleaning services—collectively, reducing clients' reliance on paid caregiving.

People enrolled in long-term care programs can also offer their families, friends, and neighbors compensation in exchange for services. Among family caregivers nationally, 61 percent adjust their work hours or leave the labor force to attend to caregiving responsibilities.[91] Paying family members to take on caregiving responsibilities could mitigate the lost income when a family member reduces work hours. Some providers already specialize in hiring family and friends, and this approach of hiring from a person's social network is foundational to self-direction. Additionally, home care providers report that a paid caregiver who knows a client personally is less likely to turnover in the role. Also, these paid caregivers are more likely to live near their clients, which addresses the challenges in Wisconsin associated with long travel times in rural areas and few authorized hours overall.

These strategies could inform an approach that helps home care providers build a new pipeline of workers by tapping clients' social networks. Once employed by an agency, these workers may be willing to serve new cases as well.

ENTRY-LEVEL TRAINING

As noted above, many of Wisconsin's long-term care leaders recognize that state requirements for personal care workers are inadequate and that training for home health aides does not always equip workers with the necessary skills to perform home care. In response, some groups have developed innovative training programs, such as the modules offered by WPSA. Providers also commonly use online training programs, especially in rural areas where administrative staff might not be able to provide extensive pre-employment training to individuals or small groups in-person given large travel distances. PHI's experience suggests that a blended approach—combining interactive, in-person training with eLearning content—is most effective when using online curricula. Training providers in Wisconsin could leverage online eLearning training models to supplement or enhance engagement with classroom content.

Training could also be improved through the adoption of adult learner-centered training models. In contrast to traditional instruction that positions the educator as an "expert" to impart knowledge to the learner, PHI's adult learner-centered training approach places the needs of learners at the forefront. As described earlier in this report, in this model trainers serve as learning facilitators who use an array of interactive activities, such as call-

and-response and role playing, among others, to build on trainees' existing knowledge and to guide learning.

PHI's training approach also emphasizes the importance of communication and conflict resolution between workers and their clients through the PHI Coaching Approach®. This method emphasizes active listening;

When workers are well-trained in communication, they provide more attentive care and form more trusting relationships with their clients.

self-management and reflection; clear, non-judgmental communication; and collaborative problem-solving. When workers are well-trained in communication, they provide more attentive care and form more trusting relationships with their clients, thus are better-positioned to discover and report changes in their clients' health, which can prevent or mitigate costly health issues over the long term. Further, in cases where consumers recruit friends and family members to provide paid care, there is a risk that these relationships could sour due to work-related conflicts. However, high-quality communication and conflict resolution training could equip consumer-directed workers with the skills to navigate these challenges.

Through 25 years of experience working with direct care workers, trainers, and employers, PHI has shown that high-quality training improves recruitment and retention. In 2014, we completed the Homecare Aide Workforce Initiative (HAWI), a 27-month demonstration in which PHI helped several major UJA-Federation home care agencies implement high-quality entry-level training and employment practices for 600 home care workers and ensure specialized training in areas such as dementia care for 400 more.

The HAWI training provided 120 hours of instruction in core clinical and relational competencies required for success in home care, including the PHI Coaching Approach to Communication, which builds communication and problem-solving skills specific to direct care. The training was designed around adult learner-centered principles, building on trainees' existing knowledge about home care and delivered through interactive methods including role playing, call-and-response, and hands-on demonstration.

Findings from HAWI offer a model to strengthen workforce training, employment, and quality of care: HAWI new hires were more than twice as likely to be retained at three months and 64 percent more likely to be retained at six months compared to home care workers hired before the program.[92]

SPECIALTY TRAINING

As Wisconsin offers new options for home and community-based care, home care workers must acquire the necessary skills to serve older adults and people with disabilities with more complex needs. In this context, better understanding of chronic conditions could help workers provide high-quality care. These skills are especially critical when clients transition into the community from a hospital or institutional setting. PHI's specialty training interventions impart specialized knowledge about health conditions, including those that are often associated with avoidable hospital or emergency department admissions; the training topics include diabetes, Alzheimer's disease and related dementias, palliative care, hypertension and heart disease, asthma and chronic obstructive pulmonary disease (COPD), behavioral health, cultural competency, and falls prevention. PHI's specialty training modules are delivered in a blended eLearning format that incorporates photos, video, animation, and audio instruction to engage learners and augment learners' interaction with trainers.

Wisconsin home care workers would also benefit from improved training on abuse and neglect—a concern widely recognized by state leaders, including the state's ombudsman. In 2015, PHI piloted a training program in Michigan aimed at preventing abuse and neglect among home care workers and their clients. An independent evaluation found that:

- 92 percent of trainees indicated the training improved their ability to recognize abuse;
- 91 percent reported the training improved their ability to prevent abusive situations; and
- 60 percent used prevention techniques learned in the training, among whom 96 percent indicated that this training helped prevent an abusive situation.[93]

Online training can also facilitate ongoing skill development. This approach might be especially useful in rural areas, where home care workers often live far from their employers, requiring long-distance travel to participate in professional development trainings. Additionally, training supported by mobile devices could help refresh a home care worker's skills when in the field.

RETENTION SUPPORTS

While better training and compensation can improve both recruitment and retention among home care workers, a stable workforce also depends on ongoing support. New workers can learn from more experienced home care workers through peer mentorship programs. Effective management practices can also help workers feel supported in the field, even without direct supervision. And employers can minimize barriers that impede retention among their workforce through an array of workplace supports.

PEER MENTORSHIP. Peer mentors help new employees navigate both personal and professional challenges in home care work, building on mentors' own experiences as direct care workers. Mentorship provides new workers with ongoing support after they have undergone pre-employment training and offers seasoned workers a meaningful opportunity for advancement. PHI has delivered peer mentor training and program design to home care agencies using a model in which mentors contact new workers twice a week during their first 12 weeks of employment to discuss their experiences on the job, provide guidance with specific challenges, and even visit the worker in the field to resolve conflicts or demonstrate appropriate caregiving techniques. This approach could benefit younger workers in particular, as they may have limited experience working without in-person support.

SUPPORTIVE WORKPLACE CULTURE. Management practices can help support home care workers in the field, ameliorating feelings of isolation and strengthening workers' connections to their employer agency. Key to improving relationships in home care is the development of communications, problem-solving, and team-building skills across an organization. Professional development training and leadership summits can equip managers with the tools to resolve conflicts with staff and empower their workers to make sound decisions in the home. One approach is PHI Coaching Supervision®, a proven curriculum developed specifically for direct care that helps supervisors solve work-related problems, empower frontline staff, and balance support with accountability for high-quality outcomes.

A supportive workplace culture should address the range of barriers that prospective and incumbent workers face in achieving and maintaining home care employment.

Home care providers in Wisconsin have used a variety of methods to create supportive workplace cultures. Many providers impart to new workers the importance of their mission through pre-employment orientation sessions. Some providers hold annual celebrations, where workers receive awards and gifts for their work throughout the year. One provider ensures that workers can contact management leaders throughout the day to discuss issues on the job. Another advises administrative staff to verbally express gratitude and appreciation when workers visit the central office. These strategies help workers feel connected with their employers and feel confident and supported in the field.

ACCESS TO BENEFITS. A supportive workplace culture should address the range of barriers that prospective and incumbent workers face in achieving and maintaining home care employment. Employers and training programs can partner with community organizations and develop referral relationships to help workers access supportive services like child care, housing, transportation, and health care. Investments in case management capacity within a training program or employer agency can meaningfully impact trainee success, helping keep workers on the job and allowing them higher levels of engagement with their work.

PHI successfully implemented a program in New York that created a partnership between a community-based financial services provider and a home care agency. Through the program, new workers received financial consulting during pre-employment training. The financial institution collaborated with the provider agency to develop operational practices that encourage workers to engage in positive financial behaviors such as opening checking and savings accounts, debt consolidation, direct deposit, and split direct deposit to develop savings. Though few workers had bank accounts prior to employment, 90 percent of the agency's home care workers now use direct deposit, which is a more efficient, secure, and predictable method for receiving paychecks and thereby controlling finances. Financial support programs can also support aides in accessing the Earned Income Tax Credit (EITC), which can significantly increase their annual incomes—up to $6,000 a year for some workers. These strategies can reduce financial stress and uncertainty among home care workers, improving their ability to stay focused on the job.

One Wisconsin provider promotes financial well-being through an employee assistance fund that workers can access to pay for pressing concerns, such as rent and car repairs, without having to pay back the money. The fund is supported through annual fundraising efforts. According to this provider, the fund minimizes stress among workers, reduces missed shifts, lowers turnover, improves retention, and limits gaps in service for clients.

OPPORTUNITIES FOR ADVANCEMENT

Improving the quality of home care jobs also requires creating opportunities for advancement, as jobseekers may be deterred by the perception that career growth is not possible in this field. While the majority of jobseekers in direct care roles do not have the time or resources to pursue advanced degrees in nursing, which can require multiple years of college-level education, providers and care plans can create rungs in the career ladder that leverage home care workers' experience to improve service delivery. Opportunities for advancement should recognize and capitalize on the existing skills of frontline workers to support other workers, facilitate care coordination, and/or provide specialized care for clients with complex health conditions.

While advancement models for home care workers are rare in Wisconsin, one provider developed a new position that offers a higher wage with benefits. Workers promoted to this role are required to remain on-call for a regularly scheduled 30 hours per week. The provider can deploy them when other home care workers are not available for shifts, or when home care workers are not available to see new clients. This approach is designed to reduce gaps in service and preserve quality of care. However, the provider struggles to fill these advanced roles because clients in need of on-call aides often have wide-ranging care requirements, which on-call aides are not always prepared with the knowledge and skills to meet. Workers in this advanced role would benefit from additional training in condition-specific topics as well as problem-solving skills.

Peer mentorship opportunities, described above, can benefit new workers while also providing an opportunity for advancement for incumbent workers. Experienced workers can also help lead orientations and trainings as Assistant Trainers; PHI's experience has shown that experiential input from those who have worked at the direct care level improves the effectiveness of training.

Technology can also play a role in supporting advanced roles for home care workers. For example, some families hire home monitoring companies that install sensors and pressure pads to ensure client safety when caregivers are not present. The client and the informal caregiver receive a phone call from the company if the sensors indicate the client has fallen or left the home unaccompanied. An advanced aide added to this workflow could provide support in responding to these alerts when clients and their informal caregivers are unavailable or unresponsive. Advanced aides could leverage their experience in home care to problem-solve with the client using technology or through in-person visits.

Advanced aides can also improve communication among home care clients, workers, and care teams using coaching and technology solutions. PHI's Care Connections Project developed an advanced aide role to coach home care workers in problem-solving, including using technology to communicate with MCO staff and report changes in client conditions. Through tablet-based reporting software, home care workers were prompted, once each shift, to answer a series of yes/no questions pertaining to the client's condition. The software generated alerts based on the answers, coded to the severity of the change, which were transmitted to a registered nurse at the home care agency who could respond by text or phone. Together, the home care worker, advanced aide (known as a Care Connections Senior Aide, or CCSA), and nurse could then problem-solve to resolve the issue in the home and determine the next steps required in the client's care.

Improvements in job quality for home care workers will be essential to addressing gaps in service delivery and preventing them from worsening as care demand rises in the coming decades.

The CCSAs also visited entry-level workers to coach them in enhanced observation, recording, and reporting skills to prevent health complications when clients returned home from institutional care settings. CCSAs were also deployed to mediate conflicts between workers and their clients, strengthening these relationships and allowing workers to stay on assigned cases—a particularly useful benefit for clients who experience high worker turnover.

Over an 18-month period, 8 CCSAs helped improve care for more than 1,200 clients. Preliminary data from this demonstration indicate that clients who received the advanced aide/technology intervention experienced an 8 percent reduction in emergency room visits compared to clients served before the Care Connections Project began. This type of approach could help improve care for clients throughout Wisconsin, especially those in remote, rural areas where technology-based care coordination tools could minimize the effects of the long distances that separate MCOs, providers, and workers.

CONCLUSION

Wisconsin's long-term care sector faces key challenges in ensuring that home care is available to its residents at levels adequate to support health, safety, and independence. Improvements in job quality for the workers who provide that care will be essential to addressing existing gaps in service delivery and preventing them from worsening as care demand rises in the coming decades.

Older adults and people with disabilities in Wisconsin can currently enroll in new Medicaid long-term care programs without delay. However, once they enroll, many cannot access the services they need due to a statewide shortage of home care workers. With low wages, insufficient hours, inadequate training, and few opportunities for advancement, the current state of home care employment does not support the needs of jobseekers, incumbent workers, or clients. Turnover among home care workers is high, and many employers struggle to fill vacancies. It is especially difficult to recruit new workers in rural areas, where wages are lower, travel times to clients are longer, and the labor pool is smaller than in other regions of the state.

In response to these issues, some long-term care leaders have adopted methods to improve recruitment and retention. Even under immense financial pressure, providers have found ways to fund better wages, workforce supports, and opportunities for advancement. But additional investment and coordination is necessary—at the state level, from providers, and among advocates and workforce development organizations—to meaningfully advance the quality of home care jobs and the sustainability of long-term care in Wisconsin.

APPENDIX A

Home Care Worker Training Requirements in Wisconsin

TRAINING REQUIREMENTS FOR PERSONAL CARE PROVIDERS[94]

The personal care worker shall be assigned by the supervising registered nurse to specific recipients to do specific tasks for those recipients for which the personal care worker has been trained. The personal care worker's training for these specific tasks shall be assured by the supervising registered nurse. Additionally, personal care workers must receive an orientation before providing services to a client. Orientation includes training on the following topics:

- Policies and objectives of the provider.
- Information concerning specific job duties. Training shall be provided for each skill the personal care worker is assigned and shall include a successful demonstration of each skill by the personal care worker to the qualified trainer, under the supervision of the RN supervisor, prior to providing the service to a client independently.
- The functions of personnel employed by the provider and how they interrelate and communicate with each other in providing services.
- Health and safety procedures for working in a home environment.
- Epidemiology, modes of transmission and prevention of infections and the need for routine use of current infection control measures as recommended by the U.S. Centers for Disease Control and Prevention.
- Responding to medical and non-medical emergencies.
- Ethics, confidentiality of client information, and client rights.

TRAINING REQUIREMENTS FOR SUPPORTIVE HOME CARE WORKERS[95]

Personal care aides who provide personal assistance must complete training before providing services, while aides who provide household or chore services can complete training within two months of starting work. Training must include:

- Policies, procedures, and expectations for workers;
- Billing and payment processes and relevant contact information;
- Recognition of and response to an emergency;
- Member-specific information;
- The general target population;
- Providing quality homemaking and household services; and
- Working effectively with members.

Aides who only provide household or chore services are exempt from training on the general target population, and working effectively with members.

TRAINING AND CERTIFICATION REQUIREMENTS FOR HOME HEALTH AIDES[96]

Home health aides must be certified and listed on the Nurse Aide Registry. The training program is 120 hours in length, and it must include 32 hours of clinical experience. Once trainees complete the training, they must pass a competency exam. The topics covered by CNA training include:

- Interpersonal communication and social interaction;
- Basic nursing skills;
- Personal care skills;
- Basic restorative services;
- Rights of clients; and
- Alzheimer's and other dementias.

Once home health aides are hired, their employers must provide a brief orientation that covers the following topics:

- Policies and objectives of the agency;
- Information concerning specific job duties;
- The functions of health personnel employed by the home health agency and how they relate to each other in providing services;
- Information about other community agencies, including emergency medical services; and
- Ethics, confidentiality of patient information, and patients' rights.

APPENDIX B

Home Care Workforce Demographics in Wisconsin and Nationally, 2015

	Wisconsin	National
Age		
16-24	18%	10%
25-34	21%	19%
35-44	17%	20%
45-54	19%	23%
55-64	18%	20%
65+	8%	8%
Median	41	45
Sex		
Male	13%	11%
Female	87%	89%
Race and Ethnicity		
White Only, Not Hispanic or Latino	71%	42%
Black or African American	18%	28%
Hispanic or Latino	5%	21%
Other	6%	10%
Citizenship		
U.S. Citizen by Birth	94%	72%
U.S. Citizen by Naturalization	3%	15%
Not a Citizen of the U.S.	3%	13%
Marital Status		
Married	41%	38%
Widowed	4%	6%
Divorced	13%	18%
Separated	3%	6%
Never Married	39%	33%
Educational Attainment		
Less than High School (HS)	10%	19%
HS or GED	36%	35%
Some College, No Degree	38%	28%
Associate's Degree	7%	8%
Bachelor's Degree or Higher	9%	10%
Employment Status		
Full Time/Full Year	29%	32%
Full Time/Part Year	6%	7%
Part Time/Full Year	39%	36%
Part Time/Part Year	26%	24%
Under 40 Hours per Week	65%	61%
40 or More Hours per Week	35%	39%

Home Care Workforce Demographics in Wisconsin and Nationally, 2015 continued

	Wisconsin	National
Health Insurance		
Any Health Insurance Coverage	78%	74%
Health Insurance Through Employer/Union	38%	34%
Health Insurance Purchased Directly	12%	11%
Medicaid, Medicare, or Other Public Coverage	37%	36%
Personal Earnings		
Mean	$14,700	$16,357
Median	$12,600	$13,287
Family Income		
Mean	$53,000	$54,480
Median	$42,500	$41,750
Federal Poverty Status		
<100%	22%	24%
<138%	33%	37%
<200%	54%	55%
<300%	72%	74%
<400%	86%	86%
400% or more	14%	14%
Public Assistance		
Any Public Assistance	51%	51%
Nutrition Assistance	35%	34%
Medicaid	29%	28%
Cash Assistance	3%	4%

Table Source: U.S. Census Bureau. 2014. *American Community Survey (ACS), 2010-2014, 5-Year Public Use Microdata Sample.* https://www.census.gov/programs-surveys/acs/data/pums.html; analysis by PHI and Carlos Figueiredo.

APPENDIX C

Older Adult Population by County in Wisconsin, 2015

Rural counties highlighted in orange.

	Total Population	Age 65-69	Age 70-74	Age 75-79	Age 80-84	Age 85+	Total 65+	% of Total
Adams	20,148	1,878	1,575	1,066	617	509	5,645	28
Ashland	15,843	927	710	472	333	391	2,833	18
Barron	45,563	2,960	2,350	1,568	1,209	1,256	9,343	21
Bayfield	14,977	1,341	980	636	418	354	3,729	25
Brown	258,718	11,849	7,986	6,031	4,325	4,739	34,930	14
Buffalo	13,192	868	618	520	349	347	2,702	20
Burnett	15,159	1,343	1,061	763	481	435	4,083	27
Calumet	49,762	2,258	1,643	1,153	840	864	6,758	14
Chippewa	63,531	3,535	2,532	1,765	1,307	1,498	10,637	17
Clark	34,445	1,617	1,257	958	781	939	5,552	16
Columbia	56,743	3,236	2,257	1,610	1,199	1,222	9,524	17
Crawford	16,391	1,113	898	646	374	465	3,496	21
Dane	523,643	23,592	14,905	9,702	7,306	9,075	64,580	12
Dodge	88,502	4,493	3,306	2,636	2,050	2,276	14,761	17
Door	27,554	2,550	1,908	1,313	860	970	7,601	28
Douglas	43,601	2,623	1,740	1,216	872	936	7,387	17
Dunn	44,497	2,304	1,571	1,053	821	1,009	6,758	15
Eau Claire	102,105	5,026	3,367	2,316	1,812	2,200	14,721	14
Florence	4,464	364	304	237	140	123	1,168	26
Fond du Lac	101,973	5,539	4,022	2,783	2,297	2,677	17,318	17
Forest	9,057	631	497	358	292	238	2,016	22
Grant	52,250	2,521	1,908	1,603	1,245	1,349	8,626	17
Green	37,186	2,109	1,489	1,085	833	950	6,466	17
Green Lake	18,856	1,263	971	712	517	549	4,012	21
Iowa	23,813	1,446	967	658	534	544	4,149	17
Iron	5,794	510	400	277	238	259	1,684	29
Jackson	20,554	1,212	946	650	450	442	3,700	18
Jefferson	84,559	4,470	3,156	2,324	1,471	1,629	13,050	15
Juneau	26,224	1,657	1,262	892	611	612	5,034	19
Kenosha	168,437	7,237	5,010	3,656	2,618	2,991	21,512	13
Kewaunee	20,366	1,216	912	681	498	615	3,922	19
La Crosse	118,212	5,879	3,968	3,021	2,358	2,760	17,986	15
Lafayette	16,829	868	625	550	438	390	2,871	17
Langlade	19,223	1,361	1,016	874	534	628	4,413	23
Lincoln	27,980	1,745	1,352	1,067	719	811	5,694	20
Manitowoc	79,806	4,689	3,562	2,658	1,980	2,308	15,197	19
Marathon	135,868	7,040	5,258	3,890	2,913	3,236	22,337	16
Marinette	40,884	2,818	2,310	1,616	1,132	1,263	9,139	22
Marquette	15,075	1,131	859	686	378	401	3,455	23
Menominee	4,573	222	162	110	66	29	589	13
Milwaukee	957,735	39,763	25,329	18,872	15,392	19,355	118,711	12

Older Adult Population by County in Wisconsin, 2015 continued

	Total Population	Age 65-69	Age 70-74	Age 75-79	Age 80-84	Age 85+	Total 65+	% of Total
Monroe	45,549	2,469	1,800	1,203	916	928	7,316	16
Oconto	37,435	2,441	1,739	1,301	844	762	7,087	19
Oneida	35,567	2,751	2,162	1,633	1,095	1,089	8,730	25
Outagamie	183,245	8,294	5,912	4,212	3,040	3,385	24,843	14
Ozaukee	87,850	5,125	3,734	2,589	2,005	2,380	15,833	18
Pepin	7,290	478	351	288	200	225	1,542	21
Pierce	40,889	1,965	1,202	922	621	655	5,365	13
Polk	43,441	2,751	2,005	1,511	976	1,014	8,257	19
Portage	70,408	3,508	2,487	1,891	1,243	1,475	10,604	15
Price	13,645	1,060	783	620	433	456	3,352	25
Racine	195,080	9,925	6,943	5,073	3,552	4,080	29,573	15
Richland	17,495	1,068	785	667	426	610	3,556	20
Rock	161,448	8,088	5,872	4,462	3,192	3,355	24,969	15
Rusk	14,124	994	737	573	425	439	3,168	22
St. Croix	87,513	4,056	2,719	1,799	1,243	1,328	11,145	13
Sauk	63,642	3,591	2,612	1,857	1,355	1,679	11,094	17
Sawyer	16,376	1,322	1,067	740	414	400	3,943	24
Shawano	41,304	2,449	2,182	1,532	1,083	1,136	8,382	20
Sheboygan	115,569	6,205	4,417	3,260	2,458	2,914	19,254	17
Taylor	20,455	1,102	841	745	531	602	3,821	19
Trempealeau	29,550	1,554	1,203	912	635	729	5,033	17
Vernon	30,506	1,782	1,342	1,009	754	862	5,749	19
Vilas	21,387	2,001	1,646	1,178	755	703	6,283	29
Walworth	102,804	5,598	3,962	2,708	1,839	2,197	16,304	16
Washburn	15,552	1,282	991	643	468	444	3,828	25
Washington	133,674	7,206	5,130	3,644	2,665	3,125	21,770	16
Waukesha	396,488	22,349	15,365	11,042	8,826	10,016	67,598	17
Waupaca	51,945	3,133	2,373	1,721	1,401	1,708	10,336	20
Waushara	24,033	1,838	1,386	1,015	668	656	5,563	23
Winnebago	169,546	8,145	5,763	4,332	3,400	4,050	25,690	15
Wood	73,435	4,289	3,183	2,493	1,881	2,211	14,057	19
STATE TOTAL	**5,771,337**	**298,023**	**209,643**	**152,259**	**112,952**	**129,257**	**902,134**	**16**
RURAL TOTAL	**1,500,907**	**91,876**	**69,462**	**51,184**	**36,002**	**39,545**	**288,069**	**19**

Table Source: U.S. Census Bureau. 2015. *Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios, 2015 Population Estimates.* https://factfinder.census.gov/bkmk/table/1.0/en/PEP/2015/PEPAGESEX/0400000US55|0400000US55.05000?slice=GEO~0400000US55; analysis by PHI.

APPENDIX D

Labor Force Participation and Unemployment Rates in Wisconsin by Selected Characteristics, 2015

	In the Labor Force	Unemployed
Age		
Population 16 Years and Over	67%	4%
20 to 24 Years	83%	7%
25 to 29 Years	87%	5%
30 to 34 Years	87%	4%
35 to 44 Years	86%	4%
45 to 54 Years	85%	3%
55 to 59 Years	78%	3%
60 to 64 Years	59%	3%
65 to 74 Years	24%	2%
75 Years and over	6%	3%
Educational Attainment, Population Ages 25 to 64		
Less than High School Graduate	61%	9%
High School Graduate	78%	5%
Some College or Associate's Degree	83%	4%
Bachelor's Degree or Higher	88%	2%
Gender and Family Composition, Ages 25 to 64		
Male	84%	4%
Female	79%	4%
Without Children	78%	4%
With Own Children Under 18 Years	81%	4%
With Own Children Under 6 Years Only	81%	5%
With Own Children Under 6 to 17 Years Only	83%	3%
With Own Children Under 6 Years and 6 to 17 Years	74%	4%
Poverty Level		
At or Above the Poverty Level	86%	3%
Below Poverty Level	56%	19%

Table Source: U.S. Census Bureau. 2015. *American Community Survey (ACS), Table S2301: Employment Status.* https://factfinder.census.gov/bkmk/table/1.0/en/ACS/15_1YR/S2301/0400000US55/0500000US55059; analysis by PHI.

NOTES

1. This total includes 32,000 personal care aides and over 7,000 home health aides. PHI analysis of: U.S. Bureau of Labor Statistics. 2016. *Occupational Employment Statistics, May 2015 State Occupational Employment and Wage Estimates.* https://www.bls.gov/oes/current/oessrcst.htm.

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