

Training New York City Home Care Aides: A Landscape Survey

By Carol A. Rodat



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PHI (www.PHInational.org) 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.

Our work is anchored in New York City, where PHI sponsors a service network that provides high-quality home care for thousands of elders and people with disabilities, including:

Cooperative Home Care Associates (CHCA), a South Bronx home care agency owned by its 2,000 employees, which provides employer-based training to hundreds of inner-city women each year; and

Independence Care System (ICS), a nonprofit managed-care program that serves more than 5,000 New Yorkers with functional limitations resulting from age or disability.

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I. Introduction

Home care aides comprise one of the largest occupations in New York City, numbering nearly 158,000 workers serving more than 300,000 clients annually. In recognition of the importance of the home care aide workforce and the need for good training and employment opportunities, the New York City Council made a grant to PHI to study the landscape of home care aide training in New York City.

Overview

This report is the third in a series of studies of New York’s home care aide training “system,” which also includes “Preparing New York’s Home Care Aides for the 21st Century”¹ (October 2010) and “Improving New York’s Home Care Aide Training System”² (September 2013). We recommend the earlier papers to readers who want a more detailed look at the City’s training system.

This study is different from the earlier reports in that it includes the training programs licensed by the New York State Education Department (SED). As such it is the most complete picture to date of New York City’s home care training programs. Designed to map the terrain over which an individual must travel in order to be trained as a home care aide, this third report will provide the City Council and other policymakers with a map to guide future decisions related to the training of this important workforce.

This report details both the strengths and challenges of the training system, but it is important to recognize that the landscape that it depicts continues to shift. We speak to some of these ongoing changes, including current demonstration programs designed to improve the training process.

A section on New York’s Medicaid Redesign—the changes in policy, delivery, and payment practices that impact home care services—underscores the need for the New York City Council and other policymakers to support this workforce in order to improve the care for the City’s

elderly and disabled residents who depend on home care aides. Moreover, as this report makes clear, a well-trained home care workforce is vital to the economy and well-being of all New Yorkers.

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For readers who are interested in the primary findings of this study, we have included a “Key Findings” section at the beginning of this paper. In addition, the final section of the paper makes recommendations for strengthening New York City’s home care training system.

This study is the most complete picture to date of New York City’s home care training programs.

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Though this study is intended for policymakers and regulators, as we filled in the spaces on the map, we realized that the individual who is interested in becoming a home care aide has little guidance regarding how to access affordable, quality training. Consequently, we make several recommendations to address that issue as well.

Methodology

This study assesses the current status of New York’s three separate training alternatives for home care aides: training by an employer who is also a provider of home care services, training in a community college or publicly supported school, and training in a for-profit training program.

Two agencies oversee these three training options. The NYS Department of Health (DOH) is responsible for the employer-based home health aide training programs. Its staff have the dual tasks of setting the guidelines for all training—including developing the curriculum outline for classroom training and the health-related tasks for which aides must show competency—as well as establishing the requirements for program approval and licensing. The regional DOH offices handle the ongoing monitoring and review of changes to the individual training programs. In New York City, this is the Metropolitan Area Regional Office.

The NY State Education Department (SED) uses the DOH guidelines but approves those programs that fall within its purview: the proprietary training schools and post-secondary schools (e.g., community colleges and employment centers).

We examined DOH and SED training programs using a data set for 2013 that was jointly reviewed and approved by the two agencies. This data set shows the number of certificates by occupation, by method of training and certification, and by licensing entity. We chose to omit the numbers from the Emergency Medical Services for Children as these numbers are small and focused on serving a different population. To look at trends, we also analyzed data from 2012. However, the 2012 data sets were inconsistent or, in some cases, unavailable. Unfortunately, while the demographic data exists, the ability to present New York City data separate from that of New York State was limited by the availability of staff resources at the state level to filter the data for our needs.

In addition to the data analysis, key informant interviews formed an important part of the study. We interviewed the lead individuals in the licensing agencies, gathering their methods for licensing and re-approving training programs and their recommendations for improving the system. These individuals were not only generous with their time, but proved to be eager to improve home care aide training as is exhibited by their recommendations.

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We also interviewed personnel in the Workforce1 Centers, which helped us understand the process and “pathway” that individuals traverse to access training and employment. In addition, we interviewed staff at eight of the largest proprietary schools in metropolitan New York City, and staff at 1199SEIU who have partnered with both CUNY and the for-profit training schools to assist personal care aides in upgrading to home health aide certification. Finally, we met regularly with numerous employers and trainers over the period of the study.

Our understanding of the industry was also enhanced over the last two years through the Homecare Aide Workforce Initiative.

The presentation of the employer-based training programs is based in part on PHI's engagement in the DOH-sponsored workgroups organized to consider improvements to the home health aide training programs. PHI is also affiliated with Cooperative Home Care Associates, a Licensed Home Care Services Agency (LHCSA) in the Bronx that annually trains 600 home health aides. Our understanding of the industry was also enhanced over the last two years through the Homecare Aide Workforce Initiative, a home care aide training and

employment project funded by the Weinberg Foundation and the Caring Commission of the UJA-Federation of New York, which is described in a later section of this report.

Key Findings

- 1. The Home Health Aide (HHA) occupation is becoming the dominant aide occupation in New York City**, with more HHA certificates being awarded through entry-level training as well as through upgrading and competency evaluation. The aide population used to be evenly split between personal care aides (PCAs, also known as home attendants) and home health aides. Medicaid Redesign, however, legislated parity in the wages and benefits between the two occupations, increasing the attractiveness of the HHA job. More importantly, Medicaid Redesign transitioned the population receiving Medicaid-funded personal care services to comprehensive long-term care management programs, and this change, which will be followed by other care models that incorporate the Medicare home care benefit, has led to a preference among providers for home health aides who can perform health-related tasks for their clients.
- 2. More aides are receiving HHA certification from proprietary training programs.** Historically, the employer-based training programs certified the most home care aides. Current data suggests that this has changed. In 2013, 64 percent of the certificates from all methods of certification (e.g., upgrading, entry-level training) came from proprietary training schools. In part the increase in these numbers is due to the use of a select group of proprietary programs by 1199SEIU for their upgrading program. However, it may also be due to the ability of individuals to quickly enroll and complete the proprietary programs, as well as a lack of information concerning the full range of options, including employer-based training.
- 3. There is variation in cost and employment outcomes in the training programs across the New York City training landscape.** Despite the alignment between DOH and SED requirements, there remain differences in the costs of the training programs, with the SED programs charging fees and tuition and DOH programs being limited to charging \$100 for incidentals. DOH-licensed training programs exist in order for employers to have a steady supply of workers. Therefore, employment is almost assured for those aides who achieve certification through an employer-based training program. It is not clear that employment is either assured or quick for those aides who achieve certification through entry-level training courses operated by SED-licensed programs.

Despite the alignment between DOH and SED requirements, there remain differences in the costs of the training programs.

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- 4. Training in foreign languages is necessary and deserving of further attention.** Data from SED and DOH indicate that a number of training programs are training in Spanish, Russian, and Chinese. However, many other languages are spoken in New York City in the home care client population. In fact, PHI translated the required test questions into Korean, Italian, and Haitian-Creole as well as Chinese and Russian. However, the database provides no indication of training programs in these additional languages, most likely because regulatory changes caused disruption in foreign-language training during the reporting period.³

More importantly, PHI's analysis of the textbook publishing field indicates that additional translations beyond that which exists in Spanish from Hartman Publishing are unlikely. Therefore, the field would benefit from the development of agreed-upon translated materials that follow the required New York State Home Care Curriculum.

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- 5. There is alignment between DOH and SED.** When PHI studied the home care aide training programs in 2010, there was little alignment and consistency between the training programs. Since then, the home health aide training program guidelines have been revised and both agencies are using these requirements to frame the approval process for training programs. This consistency minimizes some of the confusion that previously existed.
- 6. Training requirements need to be examined in light of Medicaid Redesign.** The minimum number of hours of training required for HHA certification (75) is deemed to be insufficient by regulators as well as some employers in light of the complex population being served in home care today. The required in-service hours, twelve for HHAs and six for PCAs, are largely dedicated to topics that are mandatory (e.g., infection control, HIPAA), which means that the annual in-service is used primarily to meet regulatory requirements with little time left to expand knowledge.

At a minimum aides need increased training on the signs and symptoms of specific diseases and conditions.

At a minimum, with increasing emphasis on care coordination and management, aides need increased training on the signs and symptoms of specific diseases and conditions that need to be observed and communicated in order to reduce unnecessary ER or hospitalization use. A small

number of employer-based training programs already provide additional hours in chronic diseases, Alzheimer's and dementia, and palliative and end-of-life care. The question remains as to whether the core curriculum, which sets the floor, should be expanded or employers should be left to tailor additional training to their client populations and their workers. Either approach would require the "buy-in" of managed-care plans, which are now the primary payers.

- 7. The New York State Home Care Registry (HCR) is underutilized and could provide valuable information on the workforce if properly staffed and resourced.** This study included a review of the required use of the registry by the state licensing agencies. Both SED and DOH enter trainees into the registry at the beginning of a class, and employers

must check the registry to confirm certification and approval for employment (an acceptable criminal history record check). Both DOH and SED indicated that the HCR has untapped capacity to guide policymaking. From the beginning, however, the HCR has been understaffed. To quote one official, “There’s been more turnover in the HCR staffing than there is in the home care workforce.”

The state could make better use of the registry data by reporting total number of aides employed with percentages working for more than one employer. The HCR could also match training classes to employment, thereby giving SED the needed data to evaluate outcomes. There are many more ways in which the data could be structured for better functionality and mined in order to identify the training programs with the best outcomes and proficiency.

There are many ways in which the data could be structured in order to identify the training programs with the best outcomes and proficiency.

- 8. Potential trainees deserve better information before entering a training program.** Interviews with training programs, employers, and Workforce1 Centers indicate that potential trainees often have an inadequate understanding of their options before selecting a training program. More importantly, potential students have no means of comparing one program to another in order to determine which provides the best training and connection to employment. Interviews with community-based organizations and Workforce1 Centers indicate a desire on their part to know which employers operate with good training and employment practices. Tighter integration between the workforce development system and training and employment programs would benefit the health and economic policy goals of the New York City and the state.

II. The Home Care Aide Workforce

Occupational Titles

New York City’s home care aides are divided among two occupations: personal care aides (PCAs), known as home attendants in New York City, and home health aide (HHAs). PCAs provide assistance with Activities of Daily Living (ADLs), such as bathing and dressing, as well as Instrumental Activities of Daily Living (IADLs), such as laundry, shopping, and meal preparation. HHAs provide the same assistance with ADLs and IADLs⁴ as well as some health-related tasks (e.g., taking vital signs, changing dry dressings). A third category of home care aides, personal assistants (PAs), are hired directly by the consumers for whom they work. PAs, estimated at about 25,000,⁵ are not required to have any formal training, although the consumer trains the assistant in specific tasks. Personal assistants are not the subject of this study as they need neither training nor certification.

Size and Projected Growth of the Aide Workforce

New York State’s nearly 265,000 home care aides are highly concentrated in New York City as can be seen in Table 1.

Table 1: Number of Personal Care Aides and Home Health Aides in New York City and New York State, and Projected Growth, 2012-2022

| Occupational Title | NYC | Rest of State | NYS Total | Projected Growth, 2012–2022 |
|---------------------------------------|--------|---------------|-----------|-----------------------------|
| Personal Care Aide (“Home Attendant”) | 71,380 | 64,760 | 136,140 | +36.9% |
| Home Health Aide | 86,680 | 41,800 | 128,480 | +44.3% |

Source: NYS Department of Labor, Occupational Wages (including employment) by region, updated 2014, 1st quarter.⁶

The concentration of the workforce in New York City results from the high concentration of Medicaid beneficiaries who use home and community-based services (HCBS). Data from October 2013 shows more than eight out of ten Medicaid HCBS dollars (\$490 million of \$578 million) were spent on services delivered in New York City.⁷

The home health aide occupation is growing more quickly than that of home attendant.

Medicaid Redesign is already impacting the growth of these occupations. Historically the workforce has been relatively evenly split between these two occupations, but now the home health aide occupation is growing more quickly than the home attendant occupation, a trend that will continue. Though the proportions are shifting, together these occupations remain among the City’s fastest growing.

Demographic Characteristics of the Aide Workforce

In order to create a demographic picture of the home care aides—sometimes referred to as “direct-care workers”—we must use data that is available only on a statewide basis and includes personal care aides as well as nursing, psychiatric and home health aides. The nursing aides, known as certified nursing assistants (CNAs), and psychiatric aides work primarily in facilities. Their numbers are smaller than home care aides and, as we report later in this study, some CNAs have begun to seek home health aide certification as nursing facilities downsize and more clients are moved to home and community-based settings.

Not surprisingly, the direct-care workforce is predominately a female occupation, with women comprising close to 86 percent of the workforce in New York State. Not only is the workforce overwhelmingly female, it is also over 74 percent minority (see Table 2). Black, non-Hispanic workers make up the largest racial/ethnic group (42 percent), and workers who identify as Spanish, Hispanic, or Latino comprise another 23 percent of the labor force. More than half the workforce—57 percent—are foreign born.

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Table 2: Race and Ethnicity of New York State Direct-Care Workers

| Race and Ethnicity | Percent |
|------------------------------|---------|
| Black, Non-Hispanic | 41.9% |
| White, Non-Hispanic | 25.8% |
| Spanish, Hispanic, or Latino | 22.7% |
| Other, Non-Hispanic | 9.6% |
| Foreign born | 57% |

Source: PHI analysis of U.S. Census Bureau, Current Population Survey, pooled data from the 2010, 2011, and 2012 Annual Social & Economic (ASEC) Supplements.

Table 3: Marital Status of New York State Direct-Care Workers

| Marital Status | Percent |
|--------------------|---------|
| Never Married | 38.2% |
| Married | 37.1% |
| Previously Married | 24.7% |
| Single Parent | 18.4% |

Source: PHI analysis of U.S. Census Bureau, Current Population Survey, pooled data from the 2010, 2011, and 2012 Annual Social & Economic (ASEC) Supplements.

Table 4: Educational Level of New York State Direct-Care Workers

| Educational Level | Percent |
|---------------------------|---------|
| High School or less | 59.3% |
| Some College, no degree | 18.3% |
| Associate Degree | 10.6% |
| Bachelor's Degree or more | 11.8% |

Source: PHI analysis of U.S. Census Bureau, Current Population Survey, pooled data from the 2010, 2011, and 2012 Annual Social & Economic (ASEC) Supplements.

months. Experienced aides have also seen hours decrease as managed-care plans substitute day care for home care or assign more aides to a case in order to avoid overtime costs.

Approximately 37 percent of direct-care workers are married, while 38 percent have never been married, and nearly 25 percent were previously married (see Table 3). Further, just over 18 percent of the state's direct-care workers are single parents.

As shown in Table 4, New York State direct-care workers typically have no more than a high school education: 59 percent have a high school degree or less. However, 18 percent have some college, more than 10 percent have completed associate degrees, and nearly 12 percent hold bachelor's degrees or more.

Data on labor force participation levels indicates that among personal care aides, close to 56 percent work year round/full time, while 20 percent work year round/part time. One in four (24 percent) personal care workers work part year—with slightly more than half of those working full time during that period.⁸

Though parallel data are not available, the degree of full-time work for home health aides is likely lower compared to the figures for personal care aides, since home health aides may be assigned shorter-hour cases under the Medicare home health benefit. Traditionally, this has made it more difficult for home health aides to patch together full-time work.

In addition, New York's transition to managed care appears to be affecting the ability of aides to get full-time hours. Notably, split shift cases have shifted to "live-in" or 24-hour shifts in which aides are not paid for sleep hours. In addition, we are finding that new aides are given part-time work that may last for

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III. The Growing Value of the Home Care Aide Occupation

Growing Demand for Home-Based Care

Home care aides are vital to New York’s health and aging systems and the local economy. Already employing one in seven low-wage workers in New York City, the two home care occupations are expected to grow by about 40.5 percent between 2012 and 2022, with continued high growth for several decades. This is due to the growing number of individuals who need long-term care, the desire of individuals to receive care at home, and state and federal policies that encourage home and community-based care.

Medicaid Redesign is driving much of the growth of home care services and the associated jobs. These initiatives promote the use of home and community-based services along with care management and coordination in order to achieve better health for New Yorkers. To meet its goal of “Care Management for All” and associated Medicaid savings, New York is increasingly investing its Medicaid dollars in home care and ambulatory services.

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Recent reform initiatives such as the Delivery System Reform Incentive Payment (DSRIP) plan and the Balancing Incentive Program (BIP) also encourage community-based care and coordination of services, particularly services delivered outside of institutional settings.⁹ All of these policy initiatives underscore the importance of the home care aide who is often said to be the “eyes and ears” in the home, helping care coordinators to learn and respond to changes in condition that often lead to hospitalization.

Improving Employment Opportunities

Not only is home care preferable to consumers and policymakers looking to control costs, but also it offers employment opportunities to a growing number of New Yorkers, particularly those without either a high school diploma or GED. Training is needed, but certification can be gained in a short period of time and at minimal cost (depending upon the site of the training).

While the NYC Labor Market Information Service does not classify the home health aide occupation as “promising,”¹⁰ it notes that there are opportunities for aides to advance their careers. PHI is working with the NYC Labor Market Information Service to map career pathways, including the training required and the cost, from home care aide to many of the new health care jobs resulting from Medicaid Redesign. Historically, it was assumed that the home care aide became a certified nursing assistant (CNA) and then a licensed practical nurse (LPN). Today, however, there are new opportunities within home care. New York is considering the creation of an Advanced Aide occupation and is already deploying workers in the field of ambulatory care, using people with experience for health coaching, navigation, and specialty care.

Landmark state legislation in 2010 created wage parity in New York City.

Though home care remains a relatively low-wage occupation, as a result of Medicaid Redesign, home health aides, who long earned \$2 per hour less than home attendants, have received a significant pay increase—a recognition of the value these workers bring to health reform. Landmark state legislation in 2010 created wage parity in New York City, with all aides who work on a case that is paid for by Medicaid¹¹ receiving \$10 per hour in wages, and another \$4.09 in supplemental income and/or benefits. If an aide is a member of a labor union, she may have hourly differentials that provide more income as well as continuous health insurance coverage even when she splits her time between two union employers.¹²

There have been recent changes in federal health care policy that also seek to better reward the value of home care work. The U.S. Department of Labor has promulgated a regulatory change that extends the protections of the Fair Labor Standards Act (FLSA) to the home care aide workforce. Implementation is scheduled to go into effect on January 1, 2015, and if there are no further delays, aides will receive overtime compensation at time and a half of their base wage, or \$15 an hour. FLSA coverage will also require employers to provide for pay for the time spent traveling between cases when done for the same employer.

Opportunities for Advancement

Better wages will help to increase workforce capacity, but these changes are not sufficient to stabilize the workforce. Professional growth is also important. In 2010, Governor Andrew M. Cuomo introduced the concept of an Advanced Aide, an opportunity for advancement within the occupation. While that legislation has yet to pass, it has prompted the industry to begin to design, test, and deploy home care aides in ways that bring greater benefit to the aide as well as the delivery system.

Better wages will help to increase workforce capacity, but these changes are not sufficient to stabilize the workforce.

There are several large home care providers in New York City that are piloting an advanced role, including a Rehab Aide at the Visiting Nurse Service of New York and a Senior Aide at Independence Care System, a managed long-term care plan that has integrated home health aides from Cooperative Home Care Associates into their interdisciplinary care teams. Others, such as the Jewish Home Lifecare system, are having the aide enter patient information through mobile devices in order to update care coordinators.

The Advanced Aide legislation would expand the aide's scope of practice under certain prescribed conditions; however, the experimentation is already underway, and it is expected that when there is agreement on legislation, the development of a pathway to a new title and increased wages will have moved along significantly.

IV. Home Care Aide Training Requirements

Minimum Training Requirements

The New York Department of Health (DOH) sets the minimum hourly requirements for training to become a personal care aide or home health aide (see Table 5).

Table 5: Minimum Training Requirements for Home Care Occupations

| Occupation | Minimum Training Hours | Supervised Practical Training Requirements | Annual Minimum In-Service Requirements |
|--------------------|--|---|--|
| Personal Care Aide | 40 hours | Not broken out by hours but competency must be demonstrated in personal care skills (e.g., bathing, oral hygiene, transferring) | 6 hours |
| Home Health Aide | 75 hour minimum: 40 for personal care and 35 for health-related tasks, including 16 hours of Supervised Practical Training | 16 hours: 8 in a lab and 8 in a home-like setting | 12 hours |

As is noted in the chart, the training is composed of a minimum number of hours of classroom training and, for home health aides, Supervised Practical Training (SPT), which is the demonstration and performance of specific skills, eight hours of which occur in the lab setting and eight hours of which must be done in a patient-care setting outside of the training program classroom. DOH-licensed training programs do their SPT at adult day health programs. Training programs licensed by the New York State Education Department (SED) mostly use assisted living facilities for their clinical skills training and assessment, which they refer to as Supervised Clinical Experience (SCE).

In addition to the minimum number of training hours for entry-level certification, there are also required annual in-service hours, a substantial amount of which are dedicated to what are referred to as “mandatories” (e.g., infection control, HIPAA compliance, emergency preparedness). These in-services are intended to refresh and add to an aide’s knowledge and are provided by the employer. Since the in-service training is required in order for an aide to maintain her certification, the aide’s time is not compensable.

In addition to the minimum number of training hours for entry-level certification, there are also annual in-service requirements.

Requirements for Entering a Training Program

There are only minimal requirements for entering a home care training program. Both DOH and SED make recommendations regarding the candidates' qualifications; however, screening is left up to the training programs. The DOH *recommends* that a trainee:

- Have a “sympathetic attitude toward the sick,”
- Show emotional maturity and an ability to deal with the demands of the job,
- Be at least 18 years of age or older, and
- Be able to read, write, and carry out directions.

Additionally, the SED recommends that trainees have an eighth-grade reading level, but like the other recommendations, this is not a hard and fast rule.

Since candidates must be in good physical health, a physical exam is required. The exam must include the following: check of vital signs and immunizations, which must be updated as necessary; a TB test; and a toxicology screen.

A trainee cannot be hired by a licensed home care provider if he or she has been convicted of certain criminal offenses. For this reason, most employer-based training programs pay for and complete a criminal history record check in advance of enrolling the aide in a training program. A potential trainee must produce personal identification that verifies that the trainee is a legal resident of the United States.

Training Curriculum and Course Materials

To ensure comparable content and performance measures, home health aide training programs (HHATPs) operated under SED and DOH are required to base their training, including all lesson plans and training materials, on the Home Care Curriculum and the Health-Related Tasks Curriculum¹³ developed by DOH.

All home health aide training programs are required to use a published text that fully represents the DOH Home Care and Health-Related Tasks curricula. The DOH also requires that a training program use a text that has a written “bank” of test questions. These questions must

comprehensively test the student in the areas taught and the questions must be rotated from class to class. Furthermore, if a student is retaking a test in order to pass, the program must use a different version of the test. DOH requires a minimum passing score of 80 percent.

As of 2014, only two companies—Hartman Publishing and Select Publishing—have developed textbooks that meet the curriculum and testing requirements.

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Training Methods

Many of the training programs use a didactic method of training, involving primarily lecture and textbook learning. However, educational research suggests that for adult learners, particularly those with limited educational experience or learning barriers, such as those who may not be proficient in English, an adult learner-centered approach is more successful than traditional didactic methods. Some programs use these learner-centered approaches, relying on multiple activities to engage learners and build on what they already know or have experienced in order to build confidence in their abilities. Training programs that have adopted an adult learner-centered approach develop their own “learning materials” for use in the classroom.

Testing and Performance Standards

The home care aide training program is required to test the students using written and/or oral tests and observing the trainee performing the required skills in a laboratory or patient care setting to assure the trainee’s competence. The DOH requires the programs they license to have policies and procedures that describe their quality management program and include an annual evaluation of the training program. One of the important components of the evaluation is the requirement that it include a student evaluation of the program, including the effectiveness of communication between the instructor and the students.

Foreign Language Training

In order to train home health aides in a foreign language, an RN instructor must be bilingual—i.e., fluent in both English and the language in which the training program is going to be taught. In addition, she must document fluency with two written references (e.g., proof of graduation from a school, employer, or other organization in which the targeted language is spoken), one of which can be from the sponsoring organization. Classes can only be taught in one language at a time and not through an interpreter.

Where Entry-Level Training Occurs

An individual can receive training to become a home care aide from the following training entities:

- Licensed Home Care Services Agencies (LHCSAs), home care providers licensed by DOH to operate an approved home care aide training program;
- Proprietary schools approved by SED, Bureau of Proprietary School Supervision (BPSS); and,
- Colleges, post-secondary schools, and Educational Opportunity Centers (EOCs) whose training courses are approved by SED, Office of the Professions (OP).

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Table 6 provides the number of programs and in some instances, the number of sites operated by a single company, according to the licensing agency.

Table 6: Home Care Aide Training Programs (PCA and HHA) in NYC (2013)

| Licensing Agency & Department | Number of Training Programs and Sites |
|---|---------------------------------------|
| NYS DOH, Bureau of Home Care and Hospice Surveillance | 141 in 173 sites ¹⁴ |
| NY SED, Bureau of Proprietary School Supervision (BPSS) | 43 in 59 sites |
| NY SED, Office of the Professions (OP) | 7 sites |

Source: NYS DOH response to Freedom of Information Law request (FOIL #14-04-428), NY State Education Department, Bureau of Proprietary School Supervision and the Office of the Professions.

Table 7: Comparison of Number of DOH and SED Certifications in 2013

| | PCA | HHA | Totals |
|-----------|-------|--------|--------|
| DOH | 8,491 | 14,721 | 23,212 |
| SED, BPSS | 7,169 | 25,281 | 32,450 |
| SED, OP | 377 | 1,881 | 2,258 |

Note: These numbers exclude the certifications for Emergency Medical Services for Children, training for which only occurs through SED-licensed training programs.

In upstate New York, high schools at times have provided home health aide training, and these programs are also licensed by SED. No high schools in New York City offer home health aide training at this time.

While the DOH-licensed employer-based training programs have historically dominated the landscape, the proprietary programs are now training more home health aides than DOH-licensed programs, as shown in Table 7.

Upgrading Aide Certification

When New York embarked upon Medicaid Redesign, individuals receiving Medicaid-funded personal care services were the first to transition to managed long-term care. In order to preserve the continuity of care, the managed-care plans were required to contract with the existing employer and continue to use the same home attendant, provided the client wished to retain the same aide. This policy, known as “continuity of care,” created a large degree of stability for the workers as well as the clients. However, as Medicaid Redesign continues to integrate additional populations into managed care, including those with Medicare coverage, providers prefer to assign home health aides to their clients. Home health aides have more training and can support clients by providing some health-related tasks.

Aides can upgrade their certification from personal care aide (PCA) to home health aide (HHA) through either a DOH-licensed provider or an SED-licensed program. To “upgrade,” a PCA must take an additional 35 hours of training, which consists of the health-related tasks and new content areas required for HHA certification (e.g., complex modified diets, assisting with a dressing change), and demonstrate competency in both knowledge and skills. Table 8 provides the number of certificates that were issued in 2013 through the “upgrading” process.

Table 8: Number of PCAs Upgraded to HHA by Licensing Agency (2013)

| Licensing Agency | PCA Upgrades to HHA |
|------------------|---------------------|
| DOH | 2,412 |
| SED, BPSS | 6,277 |

Table 8 provides the number of certificates that were issued in 2013 through the “upgrading” process.

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Upgrading allows the aide to add on to her existing course work rather than repeating the hours of training already taken. PCAs who cannot demonstrate competency in the personal care tasks may be required to take the full 75-hour entry-level HHA course. In interviews, employer-based training programs reported that anywhere between 10 and 12 percent of PCAs who seek to upgrade cannot pass the course work and competency evaluation required to be certified as a home health aide.

To “upgrade,” a PCA must take an additional 35 hours of training and demonstrate competency in both knowledge and skills.

Training programs that are organized so that the personal care training is taught first, with the health-related tasks last, can accommodate PCAs who may wish to upgrade by allowing them to enter the class for the last portion of the training—provided the program does not exceed the required 20:1 ratio of students to instructor. Other training programs, licensed by both DOH and SED, offer the 35 hours of instruction needed to upgrade as a “stand-alone”

program for aides who have demonstrated adequate knowledge and competency in the personal care skills prior to entering the class.

To date, a total of 8,500 aides and other home care workers have completed the courses through the 1199SEIU upgrading initiative.

Because the demand for PCAs to upgrade to home health aide certification exceeded the number who could be accommodated at existing Supervised Practical Training (SPT) sites, in 2013 the DOH issued changes to their SPT requirements. When PCAs

upgrade to HHA through an employer-based program, the entire 16 hours of SPT may take place in the training program’s skills laboratory, as long as the trainees have been employed as certified PCAs and have experience providing personal care services in a patient’s home.¹⁵ The changes also require that the skills must be demonstrated on a volunteer or “pseudo-patient,” as opposed to a mannequin.¹⁶

In response to New York’s Medicaid Redesign, 1199SEIU, the labor union representing the majority of the PCAs, funded their upgrading as well as that of other home care workers (e.g., housekeepers working in the Expanded In-Home Services for the Elderly Program). Through a voucher program, unionized aides were able to attend courses at either Lehman College (part of the CUNY system) or one of the proprietary training programs selected by the union.

Workers paid a \$25 registration fee and could attend upgrading classes, for which the union paid \$225, or the union paid \$350 for their members to take the full home health aide training course. The union contracted with proprietary schools in the Bronx, Brooklyn, Queens (including Far Rockaway), and Manhattan. The union upgrading program is still in existence and has issued over 10,000 vouchers, 15 percent of which were for the full home health aide training. To date, a total of 8,500 aides and other home care workers have completed the courses through the 1199SEIU upgrading initiative.

Competency Testing in Lieu of Training

Certain types of experienced health care workers may pass a comprehensive written test and demonstrate competency in the necessary skills to work as a home health aide rather than complete an entire training course. This route to certification, however, is limited to:

- Nursing assistants with one year of full-time experience in a general hospital within the past five years;
- An individual with documented home health aide or nurse aide training and competency evaluation from an out-of-state program;
- A home health aide with documented home health aide training and a successful competency evaluation who has not been employed as a home health aide for the past 24 consecutive months;
- A nursing student who has completed the fundamentals of nursing coursework in an approved school of nursing; and,
- Veterans who were trained in the United States Military as medical technicians or medics.

In addition to these groups, which must pass a competency evaluation to receive certification, RNs and LPNs who are currently licensed and registered in New York State may be employed as home health aides without taking the HHA training course or the competency evaluation.

Table 9 provides the number of home health aide certificates issued through upgrade trainings, competency evaluations, and nurse aide transitions in 2013. The category listed as “Competency Evaluation” is primarily aides who, having not worked as a home health aide over the last 24 months, were required to demonstrate competency for the purposes of reactivating their home health aide certification. The category listed as “Nurse Aide Transition” represents individuals who have completed the CNA training and need to add the home care tasks to their knowledge in order to receive HHA certification and be able to work in home care. This category

Table 9: Number of HHA Certificates by Method and Agency (2013)

| Licensing Agency | Method | Number of Certificates |
|------------------|----------------------------|------------------------|
| NYS DOH | Competency Evaluation | 1,444 |
| | Nurse Aide Transition | 1,026 |
| | Personal Care Aide Upgrade | 2,412 |
| SED, BPSS | Nurse Aide Transition | 6 |
| | Personal Care Aide Upgrade | 6,277 |
| SED, OP | Nurse Aide Transition | 83 |
| | Personal Care Aide Upgrade | 1,498 |

Source: NYS DOH and SED data run for PHI.

is representative of workers who are moving out of the nursing home setting or wish to add hours of work outside of a facility.

The number of home health aide certificates obtained through the proprietary programs (6,277) and CUNY (1,498) are likely reflective of the large effort undertaken by 1199SEIU to upgrade their personal care aide members.

V. DOH-Licensed Employer-Based Training Programs

Home care aides are primarily employed by Licensed Home Care Services Agencies (LHCSAs), DOH-licensed providers of home care services. Because the primary business of a LHCSA is to provide aide services, many prefer to operate their own home care aide training programs. The LHCSA that has a training program stands a better chance of ensuring sufficient capacity to meet service demands and, more importantly, has an opportunity to imbue potential hires with the skills and knowledge that are important to that company. A training program also provides employers the opportunity to observe the student over the course of the training to determine whether or not he or she is likely to make a good employee. For these reasons, the LHCSA community remains very committed to employer-based training.

Some LHCSAs serve populations that speak foreign languages, and their ability to service these populations depends on having aides who speak the appropriate language. As a result, these LHCSAs sponsor training programs that offer training in the languages spoken by their clients.

A training program provides employers the opportunity to observe the student over the course of the training to determine whether or not he or she is likely to make a good employee.

Employer-Based Program Fundamentals

Number of Programs. In 2013, 141 DOH-approved home health aide training programs (HHATPs) and 97 personal care aide training programs operated in New York City.¹⁷ Of the 141 HHATPs, data shows 12 train in either Spanish or Chinese¹⁸ but it is likely that more programs are training in a variety of languages.¹⁹ All of the LHCSAs with HHATPs operate under the DOH requirements described in the previous section of this report.

The larger LHCSAs run training programs every month, sometimes training multiple classes at the same time.

Just as there are LHCSAs that operate in all five boroughs, there are LHCSAs that operate training programs in multiple sites and some that choose to train out of a single site. Some of the training programs employ full-time trainers while others recruit RNs who work on a per diem basis. The larger LHCSAs run training programs every month, sometimes training multiple classes at the

same time. A DOH-licensed HHATP must run one full training program every three years in order to maintain approval for training.

Recruitment of Trainees. The key to filling a training class is recruitment of potential trainees. Training programs use a variety of methods, including advertising in “penny savers,” paying their employees a bonus for each trainee referred, and even out-sourcing the recruitment to firms whose business is to supply workers to large industries. “Word of mouth” remains the strongest means of recruitment, particularly if the recommendation comes from an aide who is happy with

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her employment situation. LHCSAs will often register their need for trainees with the Workforce1 Centers or with community-based organizations that assist low-income and homeless residents to find employment.

Interviews with staff at Workforce1 Centers revealed that they receive requests from LHCSAs to identify either unemployed individuals interested in becoming aides or already-certified aides. Since the goal of the centers is to help businesses operate and expand by offering cost-saving recruitment services, the counselors are eager to fulfill these requests and refer clients to LHCSA training and employment programs. However, Workforce1 Center staff report that they receive requests from many LHCSAs but have no means of distinguishing one employer from another. They would like to be able to assess employment outcomes, so they could be assured of referring their clients to good employers, particularly now that the wages have improved and demand remains high.

When a potential employee approaches a LHCSA for training, she is usually asked to attend an orientation session. At orientation, recruits learn about the nature of the job, the compensation, and the pre-enrollment requirements to enter a training class. In some cases, the potential trainee will take a literacy test, and some LHCSAs will evaluate candidates for their need for assistance in overcoming barriers to employment. Those who need such assistance (e.g., child day care, medical care) will either be given case management services or referred out to an organization such as a **Single Stop Center** that specializes in accessing these supports.

Addressing barriers to employment is an important part of helping many trainees enter and complete a training class.

Addressing barriers to employment is an important part of helping many trainees enter and complete a training class. In addition, aides who have been unemployed or underemployed need to

be aware of how employment may affect their access to public benefits. PHI's recently completed **study** of the impact of increased wages (resulting from the Wage Parity Law) on tax credits and other public benefits²⁰ recommends confidential counseling to ensure aides understand the supports available to them and how to use these supports to maximize their economic stability.

Providers want to be sure that the candidates they train will be eligible for employment at the end of the course, so two additional steps are often required before being admitted to training: a physical exam and criminal history record check. In some cases, the cost of the medical exam, around \$125, is passed on to the trainee, causing another potential barrier to enrollment. In addition, if the aide is asked to use her own physician, it can take some time to complete the exam. Aides referred to Mobile Health are able to complete the process more quickly.

Training Costs. DOH-licensed programs are prohibited from charging fees for training, with the exception of \$100 for "incidentals" such as training materials, all of which must become the property of the aide upon completion of the course. Additional costs for the aide may include purchase of a uniform and shoes as well as transportation. However, free tuition makes the LHCSA training programs considerably less expensive than those that are licensed by SED, which charge fees or tuition.

"Word of mouth" remains the strongest means of recruitment, particularly if the recommendation comes from an aide who is happy with her employment situation.

Free tuition makes the LHCSA training programs considerably less expensive than those that are licensed by SED, which charge fees or tuition.

LHCSAs incur costs for operating HHATPs. These costs vary depending upon the length of the training and the services and supports they provide. Estimates range from \$1,200 per student to \$2,800 when a program provides case management services as well as transportation. For LHCSAs, the key issue is how to recover these costs through reimbursement since the programs are not allowed to charge tuition, and there is no other consistent funding mechanism.

Training Materials. As has been previously discussed, HHATPs may use any learning materials that follow the DOH Home Care Curriculum and Health-Related Tasks Curriculum. In addition, DOH requires use of a text book that includes the required content as well as a “bank” of test questions. Most HHATPs use *Providing Home Care: A Textbook for Home Health Aides*, 4th Edition (Hartman Publishing, Inc.). However, the training programs are required only to make the text available in the classroom. Aides often do not own the textbook, but instead use training materials to study between training sessions.

Training in a Foreign Language. HHATPs currently train in a number of foreign languages (Spanish, Russian, and Chinese). In 2013, foreign language training programs awarded 4,091 personal care aide certificates. Foreign language trainings for home health aides awarded 5,673 certificates.

Interviews with DOH

PHI interviewed DOH staff regarding their satisfaction with the HHATPs and their recommendations for improvement. Notably, staff provided a picture of ongoing cooperation and engagement with their colleagues in SED. In fact, the data that was made available for this report was reviewed at a joint meeting of DOH and SED.

The top recommendation from DOH staff was to centralize HHA testing as is done for CNAs rather than to continue the current method that has each HHATP test their trainees. DOH believes this would provide an additional measure of protection for the public since insufficient personnel resources are available to review the training programs to the degree that may be desired or warranted.

The top recommendation that DOH made was to have centralized testing.

DOH also has concerns that the consumers found in the adult day health programs or other settings allowed for the Supervised Practical Training (SPT) may not be representative of the clients found in most home care settings in which the aides ultimately work. In particular, they observed that the clients of the adult day programs may not have the same prevalence of dementia found among home care clients.

The length of training continues to be the greatest concern for the quality of the home health aide training. DOH staff do not consider the minimum required training of 75 hours sufficient to prepare aides for the types of clients and circumstances they will encounter. They identify specific areas deserving of increased attention: wound care (e.g., signs of infection, circulation changes) and recognizing symptoms of drug interactions.

VI. SED-Licensed Training Programs

In addition to the home health aide (HHA) and personal care aide (PCA) training offered through providers of home care services, training in New York City is also offered through two types of programs licensed by the New York State Education Department (SED). Different departments and staff within SED have responsibility for licensing each of these programs.

The Bureau of Proprietary School Supervision (BPSS) licenses the training programs operated by for-profit schools. The Office of the Professions (OP) licenses the programs that are operated out of colleges, universities, and Educational Opportunity Centers. The Office of Career and Technical Education (CTE) licenses programs in school districts, which are operated by the Boards of Cooperative Educational Services (BOCES)²¹ and postsecondary training institutions. Although New York City has developed various programs within its Career and Technical Education division, including those designed for careers in health care, none include home health aide training at this time.

Proprietary Training Schools

Number of Training Programs and Certificates. In New York City, the proprietary training schools account for the greatest number of home care aide certificates issued. The BPSS licenses about 90 programs, 43 of which are in New York City, operating from 59 sites. Table 10 shows the number of personal care aide and home health aide certificates issued in 2012 and 2013 from proprietary training programs.

Table 10: Number of SED Proprietary Training Schools and Certificates Issued in 2012 and 2013

| Year | Training Programs and Sites | PCA and HHA Certificates Issued in NYS |
|------|-----------------------------|--|
| 2012 | NYC: 46, in 79 sites | PCA: 6,961 HHA: 23,786 |
| 2013 | NYC: 43 in 59 sites | PCA: 7,169 HHA: 25,281 |

Source: SED Bureau of Proprietary School Supervision

While several proprietary schools offer training to upgrade personal care aides, a few schools also offer training for certified nursing assistants to become home health aides,

which involves adding skills and tasks that are required to provide care in a home rather than an institution (e.g., meal preparation). However, because a CNA with two years of work experience can take a competency test in order to obtain a home health aide certificate, very few CNAs complete the training through a proprietary school. In 2013, six CNAs completed the Nurse Aide Transition course in one of the BPSS-licensed programs.

BPSS Oversight. The BPSS provides oversight by reviewing the licensing agreements with the schools and, on occasion, visiting the schools. BPSS also reviews the enrollment agreements between the schools and the students. Surveys of the proprietary schools occur every four years

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under the auspices of the BPSS. Additionally, BPSS verifies that RN instructors are licensed and able to communicate in the language of instruction when the program is teaching in a foreign language.

A proprietary school's application for licensure renewal is approved unless there is a change in the program, in which case the renewal application is reviewed. New schools or schools with identified problems are granted a two-year license rather than the standard four years.

Proprietary training programs must submit data annually through the Occupational Education Data Survey (OEDS) system. In addition, the proprietary schools enter their enrollees and graduates in the Home Care Registry (discussed in more detail in Section IX below).

The New York State Education law specifies that enrollment must be done by a salaried employee of the school who has a private school agent's certificate from the Department of Education.²² The "certified enrollment agent" is responsible for reviewing the enrollment agreement with the student and discussing the student's plan for paying the required tuition. The agent may approve a payment plan, including a moderate fee for the administrative costs that accrue to the school. BPSS is not involved when a school advises a student with respect to the loan; however, BPSS reports that if the school makes such a loan, the field associate would review it in order to prevent any abuse to the student.

Training Program Requirements. In recent years, the proprietary training programs aligned their program requirements with those of DOH. The maximum student to teacher ratio is 20:1 for skills demonstration and 30:1 for theory instruction. The minimum requirement for training hours for home health aide certification is 83, which includes time for testing not included in DOH minimum hours. The SED reports that the proprietary school training breaks into 20 hours of theory and 20 hours of skill training to complete personal care aide training, followed by 35 hours for the health-related tasks curriculum and 8 hours for hands-on practical training. The practical training of 8 hours in a home-like setting, called Supervised Clinical Experience (SCE), is equivalent to DOH's Supervised Practical Training.

In recent years, the proprietary training programs aligned their program requirements with those of DOH.

In order to be admitted to a proprietary training program, students must be at least 18 years of age and have either a high school diploma, a GED, or a passing grade on the Wonderlic Basic Skills Test. Students also must complete the physical exam described previously.

Certification Requirements. To pass the skills and knowledge classroom training, a trainee must answer 70 percent of the test questions correctly. In addition, the student must demonstrate competency in all the skills enumerated in the DOH Skills Checklist. Attendance is also considered: personal care aide students must have an 85 percent attendance record, while home health aide students must attend every class (100 percent).

In New York City, 32 percent of the proprietary home health aide training programs are offered in a foreign language.

Foreign Language Programs. In New York City, 32 percent of the proprietary home health aide training programs are offered in a foreign language. According to proprietary school staff, training is available in Spanish, Chinese,

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Russian, Polish, and American Sign Language. However, in 2013, the data shows that proprietary schools awarded certificates in only Spanish (6,287), Chinese (2,683), and Russian (739).

Interviews with Proprietary Schools. PHI interviewed staff members from eight of the largest proprietary training programs in the metropolitan area to develop a better understanding of the cost of the programs and how these programs provide practical skills training.

Staff report significant variation in the sites used for the Supervised Clinical Experience. One program used client homes and the remainder conducted the training and competency testing at assisted living facilities or adult day health programs. The use of congregate sites is less time intensive and allows for the testing of more students. The RN educator from the training program accompanies the students to the SCE setting and reportedly supervises no more than three students during testing.

Unlike DOH provider training programs, proprietary schools charge fees for their training programs. The limited data we were able to gather through our interviews indicated a range of fees, from a low of \$325 to a high of \$699. No guidelines identify appropriate fees for these programs.

Unlike DOH provider training programs, proprietary schools charge fees for their training programs.

At one time, proprietary training schools were paid through Individual Training Grants (ITGs) that prospective students received from the Workforce1 Career Centers. However, this practice ended in 2010 as the NYC Department of Small Business Services found oversight was inadequate.

SED does not collect data on the fees charged by the proprietary programs, and it is not clear if the fees are affordable for the students. For example, one community-based organization reports that several of their clients defaulted on loans taken to attend home health aide training programs. The women were told that the program provided “financial aid,” but then were referred for loans. In addition, they were promised employment upon graduation, but were given very little assistance in actually finding jobs.

NYC Public College Programs

Number of Training Programs and Certificates. Another resource for home health aide training is the City University of New York (CUNY) system, which offers home care aide training at several of its senior and community college campuses.²³ In addition, training is offered by the Manhattan Educational Opportunity Center (EOC)²⁴ operated and funded through the State University of New York (SUNY). These programs (listed in Table 11) are reviewed and licensed by SED’s Office of the Professions (OP). None of these programs are currently training in a foreign language, although Lehman College has applied to SED to train in Spanish.

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Table 11: Community Colleges and Schools Offering Home Care Aide Training and Upgrading

| School | Sponsor/System | Borough(s) | Approved Programs |
|--|----------------|--------------------|---|
| Hostos Community College | CUNY | Bronx | 1 HHA |
| LaGuardia Community College | CUNY | Queens | 1 HHA 1 PCA to HHA (Long Island City) |
| Lehman College | CUNY | Bronx and Brooklyn | 1 HHA – Bronx 1 PCA – Bronx 1 PCA to HHA – Bronx 1 PCA to HHA – Brooklyn |
| Manhattan Educational Opportunity Center | SUNY | Manhattan | 1 HHA |
| City College of New York | CUNY | Manhattan | 1 HHA 1 PCA |
| Queensborough Community College | CUNY | Queens | 1 HHA |

Despite the number of approved programs in the public college systems, few aides are trained through these programs. Only 179 students were trained in 2012; in 2013, 1,497 were trained. The increase is largely attributable to the 1199SEIU upgrading program, which used Lehman College in addition to the proprietary schools.²⁵

Educational Opportunity Centers (EOCs). In the case of an EOC, the student must be low-income; a U.S. citizen, permanent resident, or refugee; a resident of New York for at least one year; and a non-college graduate. If an applicant meets the low-income guidelines, the training is free of charge.

Office of the Professions Oversight. If a college or EOC wishes to offer a new program, they apply to SED’s Office of the Professions and initially receive a one-year approval; thereafter, the approval is for two years. However, if they don’t train within the year, they must reapply. Applications for new programs and renewals must specify:

- Class size,
- Ratio of students to instructor (20:1),
- Number of classes,
- Instructor credentials,
- Contracts with sites for supervised clinical training, and
- Curriculum content outline.

Despite the number of approved programs in the public college systems, few aides are trained through these programs.

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Requirements for instructor to student ratios and instructor credentials are the same as for DOH programs. The minimum number of instructional hours required is 83. There are currently three programs approved to provide upgrade training, and one application pending to provide the upgrade training in Spanish.

The SED Office of the Professions is developing materials to improve the efficiency of the process for submitting and approving an application so that approval and review will be much faster. The department formally reviews the data submitted for the renewals every two years.

Unlike other licensing departments, the Office of the Professions does not allow the programs it licenses to use adult day health programs for the supervised clinical training. Their programs use adult homes, assisted living facilities, or client homes for that portion of the program.

BOCES and Career and Technical Education. Across New York State, 37 Boards of Cooperative Educational Services (BOCES) provide shared educational programs and services to school districts. BOCES is not available to the NYC school system which instead has Career and Technical Education (CTE) programs operated within the City's Department of Education (DOE). CTE programs are designed to provide vocational and technical training that is linked to stable or growing sectors of the labor market and economy.

The BOCES system of training is in many ways more suited to the counties outside of New York City.

The BOCES system of training is in many ways more suited to the counties outside of New York City, particularly those that are rural. New York City has a far more concentrated home care delivery system with many training programs, and can attract sufficient numbers of students to fill the classes. In upstate New

York, provider presence is sparse, particularly providers approved to operate training programs. The BOCES system draws its students from multiple counties, and thereby fills its classes.

Interviews with SED Personnel. Interviews with SED personnel overseeing home care training programs revealed similar concerns to those expressed by DOH staff. Staff expressed an ardent desire to have metrics that would allow them to compare the programs they license as well as to track outcomes (e.g., employment and retention). They expressed concern about how trainees find jobs, and also concern that trainees can complete training before a criminal history record check, which may eliminate the possibility of home care employment.

SED staff made additional recommendations regarding programs that train in foreign languages. They believe the texts used in the courses should be translated into the language of the students. Also they strongly recommend the use of contextualized training for trainees for whom English is their second language and referral to ESL classes before entering training, particularly if the candidate cannot understand or speak any English.

Like their counterparts at DOH, SED staff strongly recommend that the state move to centralized testing for the Home Health Aide certification.

SED staff strongly recommend that the state move to centralized testing for the Home Health Aide certification.

VII. Comparing DOH-Licensed and SED-Licensed Training Programs

We found the following differences between programs licensed by DOH and SED:

Cost: SED-licensed programs charge either tuition (in the case of public colleges) or fees (in the case of proprietary programs), which range from \$250 to more than \$650. DOH-licensed programs limit fees to no more than \$100 for “incidentals,” which may include training materials. DOH-licensed programs must also be able to verify any associated costs for which trainees are charged.

Hours of Training: Minimum hours of training are similar across both DOH-licensed and SED-licensed training programs. DOH requires a minimum of 75 hours of training, while SED programs require 83 hours. The SED-licensed program hours differ from DOH as they often include time needed for testing, while the DOH minimum does not. (See Table 12 on next page for a comparison of program requirements.)

Supervised Practical Training (SPT) Settings and Ratios: DOH-licensed programs begin practical training in the classroom lab, where students watch demonstrations and then are observed doing “return demonstrations.” For SPTs, DOH allows the use of any patient care setting other than a nursing home, which is not permitted under federal regulations. However, most DOH-licensed programs contract with adult day health programs for this segment of the training.

SED-licensed programs also have students learn, practice, and demonstrate skills in the lab prior to going into the patient-care setting. SED-licensed proprietary programs may use adult day health programs or assisted living facilities for their clinical experience. The SED-licensed programs that are approved by the Office of the Professions reportedly never use adult day programs but rather prefer adult homes or assisted living facilities. The DOH ratio of students to RN for SPTs in the clinical setting is no more than 10:1 and the SED ratio is reported to be 3:1.

Passing Scores and Attendance: The DOH requires a score of 80 percent for passing a written test, while the SED programs report a passing score is 70 percent. SED BPSS requires 85 percent attendance for personal care training, and 100 percent attendance for home health aide training. Both programs use a skills checklist to ensure competency in required skills.

Connection to Employment: Because DOH-licensed training programs are operated by employers, trainees who complete the programs have a direct connection to employment. SED programs often leave trainees to search for jobs on their own. In some cases, trainees complete training but then are barred from employment due to their criminal history background check.

Personal care aides are using the SED-licensed programs for upgrading because they work for agencies that don’t offer training or they are members of 1199SEIU and are taking advantage of the union’s upgrading program.

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Table 12: Comparison of DOH and SED Training Program Requirements

| Training Program | Agency, Department | Minimum Hours | Tuition or Fees | Time Required for Completion | Certificate Validity |
|--------------------|--------------------|--|---|------------------------------|--|
| Personal Care Aide | DOH | 40 | Limited to \$100 for supplies and materials | Within 60 days | Indefinite |
| | SED, BPSS | 40 | May charge fees | No specific limit | Indefinite |
| | SED, OP | 40 | May charge tuition and fees; some students may have grants or vouchers | No specific limit | Indefinite |
| Home Health Aide | DOH | Total hours: 75 (without including time for testing). Includes 16 hours of SPT, 8 hours in lab and 8 hours in home-like setting. | Fees limited to \$100 for supplies and materials that belong to the student | Within 60 days | Aide must work as an HHA in the last 24 months to retain certification |
| | SED, BPSS | Total hours: 83 (includes time for testing). Includes 8 hours of SCE in a home-like setting. | Tuition and fees may be charged. | No specific limit | Aide must work as an HHA in the last 24 months to retain certification |
| | SED, OP | Total hours: 83 (includes time for testing). Includes 8 hours of SCE in a home-like setting. | Tuition and fees may be charged and individual grants or vouchers or other form of tuition assistance may be used | No specific limit | Aide must work as an HHA in the last 24 months to retain certification |

Literacy Testing: SED programs use the Wonderlic Basic Skills test for literacy testing of those candidates who have neither a high school diploma nor GED. The Test of Adult Basic Education (TABE) is reportedly not popular with SED-licensed programs. DOH does not have the same requirement although their guidelines say that candidates should be able to “read, write and carry out directions.” Staff from SED and DOH have concerns that the English language skills of the aides may be insufficient to ensure communication with RNs throughout the course of their work.

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Certified Admissions Agent: SED-licensed programs require that a certified admissions agent be responsible for enrollment, which includes assessing the candidate for the training program; ensuring that the potential trainee has the physical exam; is at least 18 years of age; and has a high school diploma, GED, or passing grade on the Wonderlic Basic Skills Test. The agent also completes a general interview with the potential student, and reviews the student's payment plan. Anecdotes, however, suggest that students may not be getting the advice they need regarding the costs of borrowing money to pay the program fees.

Trainee Bill of Rights and Responsibilities: DOH-licensed home health aide training programs must provide all trainees with a Trainee Bill of Rights and Responsibilities, which DOH makes available to the HHATPs. The Trainee Bill of Rights requires that each program provide every trainee with the course description, entrance requirements, schedule and location of all training, dress code, textbooks and materials and their costs, evaluation criteria, attendance requirements, and completion requirements, including the requirement that the successful graduate receive the NYS Certificate within ten business days of successful course completion.

Length for Approval to Operate: The DOH issues a license to operate an HHATP for up to three years, and the sponsoring organization must have been in operation for at least one year prior to the application. The DOH also requires an HHATP to conduct one full 75-hour training within a three-year period in order to maintain approval. Programs that fail to do so must reapply for approval.

The SED issues a two-year license to new schools or schools with identified problems; otherwise, the school is granted a four-year license. An SED-licensed school's application for licensure renewal is approved automatically unless BPSS is notified that the program has been modified, in which case the license is reviewed.

Programmatic Emphasis: The SED licensing staff emphasize that they are schools rather than employers and therefore aren't designed with hiring in mind. Several SED staff emphasized the importance of the ability of the Nurse Educator to be competent as an educator first and foremost. SED staff also describe a dual role in protecting the student and the public. They feel a duty to the student since tuition is paid for the training programs.

DOH staff emphasize the importance that the aide be competent in skills and knowledge in order to take care of sick and vulnerable clients. The DOH *Guide to Operation of a Home Health Training Program* emphasizes home care experience for the Nurse Educator rather than an educational background.

VIII. Promising Demonstrations and Models

In an effort to adapt to changes in New York’s delivery of long-term services and supports and to increase the value of aide services, many New York providers and partners are experimenting with training recruitment, content, and delivery. We discuss a few of these programs below.

Entry-Level and Specialty Training Demonstrations

HHA Train-the-Trainer Program: The New York City Department of Small Business Services (SBS) and the New York Alliance for Careers in Healthcare (NYACH) joined with PHI and two CUNY schools (Lehman College and Queensborough Community College) in a demonstration designed to improve the recruitment, training, and employment of low-income women in New York City. The schools agreed to use PHI’s entry-level curriculum and the trainers received training in adult-learner methods of instruction as well as coaching to improve their skills. Workforce1 Centers close to the schools were trained in specific screening methods and criteria for recruitment. And finally, unionized employers were selected to participate in the hiring of the aides upon completion of the program and certification. This program is currently being evaluated and refined.

Many New York providers and partners are experimenting with training recruitment, content, and delivery.

Homecare Aide Workforce Initiative: PHI will soon complete this 27-month demonstration, funded by the Weinberg Foundation and the Caring Commission of the UJA-Federation of New York. This initiative engaged three LHCSAs in a demonstration of specific recruitment, training, and employment strategies designed to improve the retention and satisfaction of the aides. The three sites used PHI’s recruitment and screening approach as well as its entry-level adult learner-centered curriculum, and employed experienced home health aides as assistant trainers in the classroom. The sites also trained peer mentors to support the trainees who were hired following the training, and provided “specialty” training for incumbent aides in areas such as dementia and end-of-life care. A third-party evaluation of the approach, which ultimately trained over 700 entry-level home health aides and 400 incumbent aides, will be available in late 2014.

Mobile technology demonstration: The United Hospital Fund (UHF) has funded an evaluation of two demonstrations that are using hand-held mobile technology for home health aides to enter patient data on a regular basis and transmit the data to RNs to review for the purpose of improving care. Jewish Home Lifecare System (JHL) with Home Assistance Personnel, Inc. (HAPI), its affiliated LHCSA, is using tablets and the e-Caring software program for patients who are enrolled in Senior Health Partners, a managed long-term care program (MLTCP). Independence Care System (ICS), also an MLTCP, with Cooperative Home Care Associates, its affiliated LHCSA, is using a Samsung tablet and the Care at Hand software. These two programs include training for the aides in the use of the specific technological devices. In the ICS-based

program, the aides go into the field to train other aides on the use of the tablet. The evaluation will study the efficacy of the training, the satisfaction of the aide with the technology and their new reporting role, patient satisfaction, and outcomes for a control and intervention group.

Advanced Roles Demonstrations

Despite the delay in legislating an Advanced Aide occupational title in New York, several home care programs have already developed new models that include advanced training and redesigned job responsibilities that better respond to the care management and coordination needs of their client populations:

Advanced training and redesigned job responsibilities better respond to the care management and coordination needs of their client populations.

Visiting Nurse Service of New York (VNSNY) Health Coach Model: The Health Coach role is intended to reduce the potential for recurrent stroke through maintenance of blood pressure. Aides are taught motivational interviewing techniques as well as specific content related to diet, exercise, medications, and how blood pressure is related to stroke. The aide interviews the patient every two weeks, alternating between phone and in-person. Each aide has four “at-risk” patients as well as other home health aide work with clients without vascular conditions. Sessions between the aide and patient are recorded in order to give the aide feedback.

VNSNY Rehab Aide: This model funds specialized home-based orthopedic care as an alternative to rehab in a hospital or nursing home, and creates a career ladder for home health aides. For the pilot, 14 home health aides were selected, all of whom were guaranteed 40 hours of work a week and received a four-day training. The training consisted of: Day 1—Background on Orthopedic Procedures and Care; Day 2—Support for the Physical Therapy Plan of Care; Day 3—Support for the Occupational Therapy Plan of Care; Day 4—Falls Prevention and Customer Service. VNSNY has since decided to add cardiac care, speech therapy, and neurological conditions to the training.

Independence Care System (ICS) and Cooperative Home Care Associates Senior Aide: The Senior Aide role at ICS had a successful year-long pilot and has since been expanded to include six aides. Each Senior Aide is assigned to two Interdisciplinary Care Teams (ICTs) for which they provide a more direct connection to the aides providing daily assistance to ICS members. The Senior Aides receive training in peer coaching, communications, and problem solving. Responsibilities include monthly calls to check in with ICS members served by the ICTs and field visits to provide additional support to aides directly serving the ICS members.

PROMISE, or Preventing Re-hospitalizations through Oversight, Mentoring, Instruction and Self-Empowerment: Currently being designed by Health and Hospitals Home Care and the LHCSA People Care, this program includes additional aide training on the top five diagnoses in home care with the highest rates of re-hospitalization and emergency visits: congestive heart failure, diabetes, hypertension, asthma/COPD, and behavioral health (dementia and Alzheimer’s disease). The developers plan on adding training on substance abuse and mood disorders for the next cohort.

Aides are hand-selected and receive 32 hours of additional training on disease management, signs and symptoms of decompensation, communication, and standards of care for each of the five conditions. The aides also receive training on specific intervention tools, their new role, and the need to have ongoing communication with the care managers.

Additional Initiatives

Core Competencies Analysis: New York is one of four states volunteering to validate the Core Competencies for the Direct Service Workforce developed by the CMS National Direct Service Workforce Resource Center. This initiative involves a review of the training requirements and competencies for direct-care workers, including home care aides, who work with older adults, people with physical disabilities, people with developmental and intellectual disabilities, and those with substance abuse and mental health conditions. Each of these populations will eventually be served through a care coordination model, and this initiative may serve to illuminate the training direct-care workers need to either serve a population with broader needs or to move among populations.

Advanced Aide Occupational Title: To create a portable Advanced Aide occupational title, New York will need to make changes in requirements to either expand or add specificity to what home health aides are allowed to do in the home. This will require additional curricula, competencies, and testing.

In July 2014, the DOH announced the creation of a workgroup that will provide guidance to the department on advanced tasks that could be performed by properly trained and supervised home health aides in home care and hospice settings, if authorized as an exemption to the Nurse Practice Act in the New York State Education Law. Governor Cuomo proposed such an exemption in his Executive Budget and later in a program bill. The workgroup will meet throughout the remainder of 2014 for the purposes of developing recommendations for a future legislative proposal. The workgroup includes representatives from academic institutions, home care providers, nurses, nurse educators, home health aides, pharmacists, and individuals who may receive services performed by Advanced Home Health Aides.

IX. The New York Home Care Registry: Tool for Assessing Quality and Capacity

New York State authorized the creation of a Home Care Registry (HCR) in 2008 in response to the fraud and abuse found in several home care aide training programs. For each training program, the HCR includes:

- Name of the nurse instructor,
- Names of the trainees enrolled, and
- Date that each trainee completes or drops out of the program.

For those aides who successfully complete their programs, the HCR prints out certificates. Both DOH- and SED-licensed training programs follow this process.

Licensed home care providers are required to check the HCR to ensure that all of their hires have completed an approved training program. The HCR indicates whether an employee is “approved” or “disapproved” for employment based on: a) the criminal history record check and any disqualifying crime subsequent to the check; b) whether the aide has been reported by an employer for having mistreated or neglected a client or misappropriated funds; and c) whether the aide has worked within the last 24 months and therefore has a valid certificate. Employers must enter the aide’s date of hire, update the aide’s personal information (e.g., name change) if needed, and record the end of employment.

Licensed home care providers are required to check the HCR to ensure that all of their hires have completed an approved training program.

The HCR could play a broader role in helping policymakers to strengthen the home care workforce.

The HCR is a useful tool for ensuring that aides who are sent into private homes have the requisite training and have not been convicted of certain crimes. But the HCR could play a broader role in helping policymakers to strengthen the home care workforce. For example, the registry is the most current and accurate source of data with respect to workforce capacity. Today, the registry reports that over 300,000 home care aides are working in New York State. The NYS Department of Labor data shows a total of 264,620 as its data lags behind actual experience. The registry can quantify the number of aides working for more than one employer, and it contains information that would allow reporting of the time span between training and employment.

The HCR has some limitations. For example, it does not collect information on how many cases or the number of hours per case that an aide is working; however, by analyzing the number of aides working for more than one agency, we can use the registry to assess trends in part-time employment (which appears to be increasing). Another limitation is that the registry does not include the personal assistants who work in the Medicaid consumer-directed program. Therefore, the registry would not show if a certified home health aide were employed by a client in the consumer-directed program.

Despite its limitations DOH officials report that they review the registry contents to assess changes in workforce and training capacity. SED officials expressed the desire to receive reports from the HCR that would enable them to assess their licensee's training program outcomes, for example, with respect to length of time between training and employment. Both departments agree that the HCR is an underutilized tool that could provide the data necessary to compare training programs and outcomes and to strengthen the training system overall.

Both departments agree that the HCR is an underutilized tool.

X. The Future of Home Care Aide Training

New York State is dramatically restructuring its long-term care delivery system. Medicaid Redesign is enrolling into managed-care insurance plans nearly all elders and people with disabilities needing long-term Medicaid-funded personal care services. The intent of these reforms is to generate significant savings for New York State, and through care coordination, better outcomes for low-income Medicaid recipients. The result will be to shift long-term care away from a fee-for-service payment system, which tends to encourage overutilization of services, toward a "capitated" payment formula, which provides to the insurance plan a set

The transition to managed care has disrupted the way in which the long-term care system supports the training of the home care workforce.

number of dollars, per individual per month, for a broad spectrum of services, adjusted for acuity. Managed-care plans receive Medicaid payments from New York State and, in turn, coordinate and pay a broad range of provider agencies for the long-term care services needed by consumers.

This transition has disrupted the way in which the long-term care system supports the training of the home care workforce. Those programs that were historically paid on a fee-for-service basis, such as the Personal Care Services

Program, the Long Term Home Health Care Program and the Certified Home Health Agency long-stay cases,²⁶ had reimbursement rates that included an add-on for Home Care Workforce Recruitment, Training and Retention. That money helped employers pay for their training programs, since DOH-licensed programs are barred from charging fees for training. As the

patient population has moved into managed care, those dollars have moved into the capitation rates but they are not specifically quantified or set aside for training. In fact, the LHCSAs are having to use more of the payments they receive to cover the increase in wages associated with the Wage Parity Law, increasing the pressure on them to reduce the cost of training.

While New York State policymakers paid attention to the need for wage parity for the home health aides and continuity of care through the transition to managed care, initially, little attention was paid to the policy goal of having a well-trained home care aide workforce. Recently, however, the state has acknowledged that Medicaid Redesign and its progeny, Health Homes and the Delivery System Reform Incentive Payment (DSRIP) program, cannot succeed without attention to the health care workforce. Each of these programmatic models, as well as the Managed Long Term Care Plans, is now being asked to provide plans for their health workforce needs, including training and retraining. Ensuring adequate funds to maintain the employer-based training programs is essential to meeting the City's future workforce needs.

Policymakers paid little attention to the policy goal of having a well-trained home care aide workforce.

XI. Recommendations

While this study was intended to primarily reflect the training landscape for one of New York City's most important occupations, the findings also highlight that, for a potential trainee, the system is difficult to navigate. In fact, a low-income woman looking for a training program has little to guide her decision making, and virtually no way to compare programs to one another.

For a potential trainee, the system is difficult to navigate.

Cost is also an issue. Proprietary training schools require either fees or a voucher from 1199SEIU in order to enroll in the program. Low-income women do not have the resources to cover the costs and may be forced to take out loans that they can't afford.

Not only is it difficult for trainees to compare the quality of training programs, state officials also lack data to make these assessments.

Policymakers should seek to address this issue, and several of the recommendations below are directed toward this goal.

The New York City Council, Mayor's office, and government agencies can play a key role in supporting quality home care training. The City already has agencies, structures, and services that demonstrate a deep commitment to the economic well-being of its residents—and as shown above, home care can provide an excellent employment opportunity for hundreds of thousands of New Yorkers.

The City can easily address the recommendations below for potential trainees. In addition, we recommend that the City Council, in concert with the Mayor's office, convene a group

Home care can provide an excellent employment opportunity for hundreds of thousands of New Yorkers.

that would prioritize these recommendations, identify funding needed, and attach a time frame for moving forward.

For Potential Trainees

1. Develop a visual “Training Map” of the training opportunities and how to access each. Include the costs of the training, estimated time to completion, and starting wages. Indicate locations and phone numbers and the information a person needs to bring in order to apply for training.
2. Mount consumer protection efforts to determine whether or not predatory lending is occurring in the for-profit schools. The New York Office of Workforce Development could play an important role as they have in the “Know Before You Enroll” campaign. Where necessary, the City could engage state officials and the stakeholders (e.g., managed care plans, labor) to design the regulatory and legislative agenda needed to secure improvement.
3. Develop information in several languages that describes the job, the training requirements, the costs associated with training, and the sites for training in a specific language. This information should be accessible to those with low literacy skills and should include individual profiles of trainees who achieved certification and found employment.
4. Develop a set of questions potential trainees can use when evaluating a training program.
5. Include the “Training Map” and other materials prominently on websites that people are likely to use such as the New York City website. Make the materials available to every Workforce1 Center and distribute widely to community-based organizations with employment programs.

System Improvements

1. Fund and staff the Home Care Registry in order to supply the information needed to evaluate training programs and determine capacity needs.
2. Educate staff in the Workforce1 Centers as to how to advise potential trainees. Special attention should be paid to explaining the options for training, potential career paths, and the nature of the job.
3. Develop a method for rating the training programs using rates of completion, employment, and retention over time.
4. Develop a plan for improving the training in foreign languages. At a minimum, the plan would include an assessment of the languages in which training is being taught, identification of the best learning materials, and translation of the learning materials as needed. Assessment should include the availability of ESL courses throughout the City.
5. Make referral to ESL training a requirement for potential trainees who cannot understand enough English to follow instructions and communicate with the care team. Also ensure the availability of contextualized training materials for ESL learners.

6. Develop a course to be offered through CUNY that will prepare nurse instructors to teach the aide training in an adult learner-centered manner.

State Policy

1. Assess the amount of funding in the capitation rates that is dedicated to home care aide training and match it to previous Workforce Recruitment and Retention funding to ensure that adequate reimbursement is provided to employer-based training programs. This financial analysis should be used to determine where training should occur and how it will be funded in the future.
2. Develop a mechanism for rating the quality of the Home Health Aide Training Programs, and making this information available to potential trainees, Workforce1 Centers, and community-based organizations that assist unemployed and low-income individuals in entering the job market.
3. Require managed-care plans with at least 40 percent of their service utilization dedicated to home care aide services to develop workforce development plans that focus on the recruitment, training, and employment policies of their subcontractors.
4. Require DSRIP projects that involve home care aides to specifically address that workforce in their workforce development plans.

Appendix A: A Home Care Aide Training Timeline

- 1986** Home Care Core Curriculum addresses personal care and home health aide training requirements.
- 1989** Home Care Core Curriculum updated.
- 1992** Home Care Core Curriculum mandated for use for entry-level training.
Department of Social Services clarifies “permissible” and “non-permissible” tasks for personal care aides.
- 2003** PHI publishes “Training Quality Home Care Workers” (http://www.directcareclearinghouse.org/download/PHI_Training_Overview.pdf.)
- 2006** Home Care Core Curriculum updated.
- 2007** Investigation by NYS Attorney General of Home Care Aide Training Programs.
- 2008** Home Care Registry authorized.
- 2009** Home Care Registry implemented.
- 2010** Providers must enter all employed aides into Home Care Registry by September 25, 2010.
DOH convenes Home Health Aide Training Program workgroup to update and improve HHA training program requirements.
PHI publishes “Preparing New York’s Home Care Aides for the 21st Century,” an overview of New York’s home care aide training system (<http://phinational.org/research-reports/preparing-new-yorks-home-care-aides-21st-century-overcoming-fragmentation>).
- 2011** DOH reaches consensus on changes to HHATP Guidelines.
- 2012** DOH issues *Guide to Operation of a Home Health Aide Training Program* on February 1 and notifies providers of HHATP changes effective July 1, 2012. FAQs developed and published (https://www.health.ny.gov/professionals/home_care/hhtap_training_program_faq.htm)
SED BPSS aligns policy with NYS DOH ([http://acces32.nysed.gov/bpss/documents/RevisedHomeHealthAideEquipmentListToBeUsedByBPSSchools.pdf](http://acces32.nysed.gov/bpss/documents/RevisedHomeHealthAideEquipmentListToBeUsedByBPSSSchools.pdf))
- 2013** Revised HHATP Guidelines issued, dated July 1. Replaces the February 1, 2012 version and includes the changes through “Dear Administrator Letters” (DALs) issued on February 19, 2013 (DAL HCBS 13-03) and June 24, 2013 (DAL HCBS 13-10 and 13-12). Revised FAQs issued regarding SPTs for PCAs, program requirements for PCA upgrading, and amendments to foreign language training requirements.
PHI completes translation of test bank of questions in Russian, Chinese (simplified), Korean, Haitian-Korean, and Italian.
PHI publishes *Medicaid Redesign Watch #3, Improving New York’s Home Care Aide Training System* (<http://phinational.org/research-reports/medicaid-redesign-watch-3-improving-new-yorks-home-care-aide-training-system>).
- 2014** *Training New York City Home Care Aides: A Landscape Survey* published.

Endnotes

- 1 PHI, "Preparing New York's Home Care Aides for the 21st Century," October 2010 at: <http://phinational.org/research-reports/preparing-new-yorks-home-care-aides-21st-century-overcoming-fragmentation>.
- 2 PHI, "Medicaid Redesign Watch #3: Improving New York's Home Care Aide Training System," September 2013 at: <http://phinational.org/research-reports/medicaid-redesign-watch-3-improving-new-yorks-home-care-aide-training-system>.
- 3 For further information on foreign language programs, see PHI, "Medicaid Redesign Watch #3: Improving New York's Home Care Aide Training System" (September 2013) at: <http://phinational.org/research-reports/medicaid-redesign-watch-3-improving-new-yorks-home-care-aide-training-system>.
- 4 Activities of Daily Living include self-care activities: bathing, dressing, eating, ambulation, toileting, and grooming. Instrumental Activities of Daily Living include shopping, housekeeping, food preparation, taking medications, phoning, transportation, and managing finances.
- 5 Communication with Bryan O'Malley, Executive Director, Consumer Directed Personal Assistance Association of New York State, July 2014.
- 6 Employment and wage data by region found at: www.labor.state.ny.us/stats/lswage2.asp. Employment projections 2012–2022 found at <http://www.labor.state.ny.us/stats/lproj.shtm>.
- 7 Samis, Sarah, "Home and Community-Based Care in New York's Medicaid Program: New Data on Service Use and Spending," Medicaid Institute at United Hospital Fund, March 2014, at: <https://www.uhfnyc.org/publications/880971>.
- 8 PHI analysis of U.S. Census Bureau, Current Population Survey, pooled data from the 2010, 2011, and 2012 Annual Social & Economic (ASEC) Supplements.
- 9 The Delivery System Reform Incentive Payment (DSRIP) program includes projects such as hospital-home care collaboration solutions and care transitions intervention models to reduce 30-day readmissions for chronic health conditions.
- 10 NYC Labor Market Information Service, "Employment in New York City Home Health Care Services," May 2009 at: http://www.nyc.gov/html/sbs/wib/downloads/pdf/home_health.pdf.
- 11 The payment by Medicaid may be in part or in full. Aides who work on a Medicare-only case are not required to receive the same wage and benefits; however, as a matter of practice, most employers do not discriminate against their workforce and simply pay the same wage.
- 12 The 1199SEIU Collective Bargaining Agreement allows the hours worked for two unionized employers to collectively count towards the 100 hours needed to be eligible for the union's health plan. A worker must work the 100 hours for two consecutive months. Therefore, aides whose hours are only part-time for one employer can supplement those hours at another unionized employer and maintain health coverage.
- 13 New York State Department of Health, "Home Care Curriculum," January 2007 at: https://www.health.ny.gov/professionals/home_care/curriculum/docs/home_care_curriculum.pdf
- 14 The number of DOH-approved Home Health Aide Training Programs in New York City in 2013 was reported in a response to PHI's Freedom of Information request. However, when PHI reviewed the listing of HHATPs from the Home Care Registry, we count 62 companies that offer training in the five boroughs of NYC. There are 69 PCA listings and 104 HHA listings. However, even these numbers cannot be validated as PHI notes that some companies have multiple listings despite the fact that we know some of the programs have closed. In other instances, a single corporation may be operating several programs under different names through purchase.
- 15 DAL at: <http://www.nyscal.org/files/2013/07/071713-DHCB-13-14-Guide-to-Operation-of-a-HHA-Training-Program-Revision-date-070113.pdf>.
- 16 Any training program electing to use their laboratory setting for the demonstration of skills by a PCA for the purpose of upgrading must have a record that distinguishes between those skills taught at a patient's bedside with supervision and those taught in the laboratory setting with a volunteer.

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- 17 Data from NYS Department of Health response to PHI's Freedom of Information request.
- 18 Data from DOH and SED consensus document with details of 2013 certifications by licensing agency.
- 19 Regulatory changes regarding foreign-language programs resulted in a gap in foreign-language trainings in 2013; see PHI, "Medicaid Redesign Watch #3: Improving New York's Home Care Aide Training System" at: <http://phinational.org/research-reports/medicaid-redesign-watch-3-improving-new-yorks-home-care-aide-training-system>.
- 20 Steven L. Dawson and Carol A. Rodat, "The Impact of Wage Parity on Home Care Aides: How Better Wages Affect Public Benefits, Tax Credits and Family Income," PHI, June 2014 at: <http://phinational.org/research-reports/impact-wage-parity-home-care-aides-how-better-wages-affect-public-benefits-tax>.
- 21 BOCES membership is not currently available to the state's five largest school districts: New York City, Buffalo, Rochester, Yonkers, and Syracuse.
- 22 New York State Education Law § 5004.
- 23 The City University of New York's seven community colleges include the Borough of Manhattan Community College, Bronx Community College, Hostos Community College, Kingsborough Community College, LaGuardia Community College, Stella and Charles Guttman Community College, and Queensborough Community College.
- 24 The State University of New York (SUNY) has 10 Educational Opportunity Centers, several Educational Opportunity Programs and Counseling and Outreach Centers. In NYC, Educational Opportunity Centers are in Manhattan, Brooklyn, Queens, and the Bronx, and there is a Counseling and Outreach center in the Bronx.
- 25 1199SEIU will also use Lehman College to upgrade personal care aides who speak Spanish once approval of Lehman's application is received.
- 26 CHHAs are now paid an episodic payment by Medicaid and Medicare.