

**Testimony of Carol A. Rodat, NY Policy Director for PHI**  
**Legislative Proposals to Increase Work and Health Opportunities for Public and**  
**Affordable Housing Residents**  
**House Financial Services Housing Subcommittee**  
**Congressional Field Hearing**  
**Monday, July 20, 2009**  
**New York City, New York**

My name is Carol Rodat, and I am the New York Policy Director for PHI, formerly known as the Paraprofessional Healthcare Institute, ([www.PHInational.org](http://www.PHInational.org)). PHI is a national organization, located in the South Bronx, that works to improve the lives of people who need home and residential care—and the lives of the workers who provide that care. Using our workplace and policy expertise, we help consumers, workers, employers and policy-makers improve long-term care by creating quality direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers so that both may live with dignity, respect, and independence.

PHI endorses the “Together We Care Act of 2009” and improvements to Section 3 of the Housing and Urban Development Act of 1968 in the “Earnings and Living Opportunities Act” (ELOA) that are the subject of this hearing and which are designed to increase job opportunities and improve health care access for residents of public and subsidized housing. We appreciate the invitation to testify at this first field hearing, particularly since the intent is to create jobs in home and community-based care. We have considerable expertise in employment strategies and practices that are necessary to ensure the creation of quality jobs and better care and are pleased to be able to share our perspective with the Committee. In addition, this hearing also provides an opportunity to highlight the importance of the direct care workforce not only for our health care system, but also for our economy as a whole.

PHI has had significant experience in workforce development and the practice and policies that create a strong direct care workforce. PHI is one of three national advisers to the Centers for Medicare and Medicaid Services (CMS) Direct Service Worker Resource Center. In that role, we provide technical assistance to states that wish to stabilize and improve their home and community-based services workforce. PHI helped to craft a *Quality Care through Quality Jobs* school of thought, advocating and demonstrating at the national and state level that a “high investment, low turnover, high return” business model meets the goals of the health care and the workforce development systems. Most recently, our president, Steven Dawson, advised the

Institute of Medicine's (IOM) Committee on the Future Health Care Workforce for Older Americans, which published findings and recommendations in April 2008 in the landmark study, "Retooling for an Aging America: Building the Health Care Force." Mr. Dawson now serves as the co-convener of the Elder Workforce Alliance, a national coalition of organizations dedicated to promoting the recommendations of the IOM study.

Recognizing the future needs of this state and city, PHI staff authored "Addressing New York City's Care Gap," a study for the New York City Workforce Investment Board on the demographic trends shaping the home care workforce. That study, and our subsequent Labor Market report which is attached to this testimony, project a need for an additional 65,000 new home care jobs in New York City, and another 18,950 home health aides and 9,870 personal care aides for the rest of the state. Recognizing the importance of health insurance to this workforce, we recently finished two reports on the health insurance coverage of the home care aide workforce in New York – "Is New York Prepared to Care?" and "Health Insurance Coverage of New York's Home Care Aides," which provide a comprehensive analysis of the coverage rates, access to coverage, state programs designed to improve coverage, and the ways in which coverage can be expanded and enhanced. All are available on the New York page of PHI's PolicyWorks at: [www.PHInational.org/policy](http://www.PHInational.org/policy).

PHI is also affiliated with Cooperative Home Care Associates (CHCA), a twenty-five year old worker-owned licensed home care services agency, also located in the South Bronx. CHCA trains and employs home health aides and home attendants and currently employs over 1,500 aides. Our other affiliate is Independence Care System, a Medicaid Managed Long Term Care Program that serves over 1,300 individuals living with physical disabilities in the metropolitan area. We are also consultants to several nursing homes and long-term care systems. These direct experiences provide us with a perspective that is unique and attuned to the challenges and rewards that are part of both an employment and service model.

Between 1995 and 1997, CHCA secured funding from the New York City Housing Authority's (NYCHA) Allied Health Careers Training Services program to enroll approximately 10 participants in each of our four-week training cycles from among NYCHA residents. As of 2008, 6 percent of the aides in CHCA's training program were residents of NYCHA buildings, and 75 percent were hired into full-time positions as home health aides; of these, 81 percent retained employment for at least three months after graduating from our training program. Our experience with this approach has been extremely positive and we would welcome a renewal of this approach to recruiting, training and serving within public housing.

### **Home and Community-Based Care – a Labor Market Force**

Home and community-based care, a component of eldercare/disability services, will provide tremendous job growth in the years to come. Within home care, it is the home

care aides – personal care aides, home attendants (the term of choice for personal care aides in New York City), home health aides and consumer-directed personal assistants - who provide 70 to 80 percent of the paid hands on care for older persons, people living with disabilities and chronic care needs, and those with intellectual and developmental disabilities.

The latest employment estimates, from 2006, show that nationally the direct-care workforce at the national level surpasses the 3 million workers and projected demand calls for an *additional 1 million new positions* by 2016. Once it achieves a size of 4 million workers, this workforce will exceed RNs (3.1 million), teachers from kindergarten through high school (3.8 million), cooks and food prep workers (3.3 million), waiters and waitresses (2.6 million) and cashiers (3.4 million). Over the next decade, personal care and home health aides will be the second and third fastest-growing occupations in the country, outpacing all but network systems and data communications analysts and well ahead of nursing aides and orderlies who work in nursing facilities and hospitals. While 54 percent of the direct care workforce worked in home and community-based settings in 2002, by 2016, it is estimated that 64 percent will work in home and community-based settings. The growth in consumer-directed care amplifies these trends.

In New York, these projections hold true. Today, New York City's direct care workforce constitutes probably the largest occupational group in the economy, and these jobs in the City are projected to increase by 42 percent over the decade beginning in 2006. Home attendants and home health aides are among the small handful of jobs in New York City that meet the criteria of being both the fastest growing and generating the most job openings. Together, these two occupations will add about 65,000 jobs to the New York City economy between 2006 and 2016. Attached to this testimony, you will find a copy of our national occupational data as well as our New York City Labor Market Projections.

### **Differences in the Nursing Home and Home Care Workforce**

There are several differences between the home care and nursing home care workforce, beginning with the training requirements. The federal government sets the minimum requirements for training of certified nursing assistants (CNAs) and home health aides, but states are free to exceed the minimum. The federal minimums for each are:

*Certified Nursing Assistant (CNA)* – 75 hours, CNAs must pass a competency exam for certification. CNAs are listed on a state registry.

*Home Health Aide (HHA)* – 75 hours, Aides must pass a competency evaluation for certification that involves a written or oral exam and observation of demonstrated tasks. Not all states have a home health aide registry; New York is in the process of implementing a registry.

There is one additional difference between the training for CNAs and home health aides in that the training costs for CNAs is included on the cost reports and is reimbursable. Home health aide training is not included on the cost reports, although some states make additional monies available, as in the case of New York which has workforce recruitment and retention add-ons to the Medicaid rates.

There are no federal minimum requirements for personal care aides, and in fact, some states have no minimum requirements for the training of personal care aides, leaving it up to the provider or employer. There are also no minimum requirements for home care workers who serve people with intellectual and developmental disabilities, although they do receive training over the course of their employment and several states are using the online College of Direct Support Professionals to train this workforce.

New York State, however, not only has a minimum requirement of 40 hours for personal care aides, but recently extended the hourly minimums to assisted living facilities as well. The following chart provides some of the key differences in the occupations, although there are many similarities in the training, skills and duties of direct care workers in any of these occupations and settings.

<b>Nursing Home and Home Care Occupations</b>	<b>NYS Basic Training Requirements</b>	<b>Number of Direct Care Workers in NYS (2006)</b>	<b>Projected Increase by 2016</b>
Nursing Aides, Orderlies <sup>1</sup>	100 hours minimum, comprised of at least 70 hours of actual classroom and lab training plus 30 hours of supervised clinical training time with residents in a nursing home	104,210	11%
Home Health Aides	75 hours minimum, including 16 hours of supervised practical training	138,290	37.8%
Personal Care Aides/Home Attendants	40 hour minimum	74,680	35%

Employment estimates for aides are for 2006. These data and occupational projections are taken from the NYS Department of Labor (NYS DOL) Occupational Employment Statistics (OES) Program, available at: <http://www.labor.state.ny.us/workforceindustrydata/demand.asp>.

In addition to the differences in hours of training, there are specific areas of the training that the direct care worker in a facility would need to learn that home care workers

---

<sup>1</sup> Labor force statistics aggregate these two titles, thereby mixing nursing home and hospital workers. PHI has recommended that data related to these occupational titles be collected separately.

would not. For example, a CNA receives training in resident rights, facility safety and emergency procedures (e.g., evacuation of resident), isolation precautions, avoiding the use of restraints, incident reporting, the use of certain facility equipment that would not be found in most homes (e.g., whirlpool bath), fluid intake and output recording, and post-mortem care.

The difference between a home health aide and a personal care aide resides in the health-related tasks that a home health aide is allowed to perform: preparation of meals in accordance with modified diets or complex modified diets; administration of medications; provision of special skin care; use of medical equipment, supplies and devices; change of dressing to stable surface wounds; performance of simple measurements and tests to routinely monitor the patient's medical condition; performance of a maintenance exercise program; and, care of an ostomy after the ostomy has achieved its normal function.

A state's Nurse Practice Act identifies those tasks and duties which can be delegated by a nurse to a home health aide. These vary from state to state. For example, in New York, a home health aide may not change dressings or apply prescription or non-prescription medications to a patient with an unstable wound; give injections except for pre-filled insulin; fit, adjust or repair equipment; provide nasogastric or mix, hook up or infuse solutions used in total parenteral nutrition (TPN). There are, however, special circumstances in which a home health aide may undertake certain tasks or functions and these are only when the aide is working with a self-directing patient who has need for the task for routine maintenance of health, cannot perform the task themselves due to a disability, and has no informal caregiver.

### **Population and Need for Home Care Aides**

Recent changes in state health policy in New York as well as initiatives at the federal level to "re-balance" the long-term care system towards home and community-based care have served to downsize the institutional sector, lowering the future projections for certified nursing assistants, the direct care worker in nursing facilities.

The proposed legislation targets not only public housing residents who would be trained and employed as home care aides, but the elderly and people living with disabilities who have need of care at home. New York is home to 3.4 million individuals aged 60 or older, ranking New York third in the nation in the number of older adults. By 2015, older people will constitute 20-24 percent of the county population in 35 NY counties and 25-29 percent of the county population in 17 other NY counties. About a third of older New Yorkers live alone and more than a third also suffer from at least one disability. More than three-quarters of adults over 65 years suffer from at least one chronic medical condition, while an average 75 year old has 3 chronic conditions and takes 4 medications. These trends support the fact that two-thirds of older adults will need some form of long-term care at some point, while 11 percent will require care for more than 2 years. Twenty-five percent will rely on family

for at least 2 years, 35 percent will need residential care and 5 percent will spend more than 5 years in a nursing home.

As the population grows, individuals with impairments will also increase, requiring a comprehensive array of services and supports. A trained and ready workforce will be needed to serve not only those who wish to age in place, but also those with disabilities, chronic disease and functional limitations. Throughout the state, 11 percent of the population aged 21 to 64 years is living with a disability; however, this rate is much higher in New York City. In addition, 12 percent of the City's non-institutionalized civilian population has two or more disabilities compared to 7 to 9 percent in the rest of the state.

On an annual basis there are approximately 300,000 individuals receiving home and community-based care in New York through a variety of home care programs: the Medicaid-funded personal care services program, consumer-directed personal assistance, the various Medicaid home and community-based waiver programs (e.g., the Long Term Home Health Care Program, the Traumatic Brain Injury Program, the Nursing Home Transition and Diversion Program), the Expanded In Home Services for the Elderly (EISEP), the Medicaid Managed Long Term Care Program, the Program of All-Inclusive Care for the Elderly (PACE) and of course, the Medicare home health benefit. There are ample opportunities for home care aides to find work in a widely diverse field of programs serving a variety of individuals throughout the City and state.

### **Family Challenges**

Family caregivers make up the largest contingent of home care workers. In New York, it is estimated that there are 2.2 million family caregivers providing over \$24 billion economic value of unpaid labor. Families today face numerous challenges and obstacles in accessing adequate home care – even in a state like New York that leads the nation in home care programs and related expenditures:

- Access to services is predicated upon adequate personnel: RNs, therapists, and home care aides. Outside of the metropolitan New York City area, there are parts of this state with limited access to home care due to the inadequacy of the workforce.
- There is a growing and unfilled need for home care workers who speak Spanish, Russian, and various Chinese dialects as well as workers who can demonstrate cultural competency and sensitivity.
- There is a shortage of aides who can work nights and week-ends or who are willing to “live-in.”
- Outside of the NYC area, transportation to and from a client's home is a severe challenge.

There are several ways in which these challenges can be addressed:

1. Strengthen the home and community-based workforce by improving the wages and benefits of the home care aides. Home health aides in New York City lack parity with personal care aides who fall under the “Living Wage” and a minimum living wage standard for home care aides would benefit those in need as well as their families and the workers.
2. Establish a fair and transparent rate-setting process between home care contractors and providers that limits overhead and maximizes the percentage of the rate that goes to compensation (i.e., wages and benefits).
3. Ensure access to stable, affordable health insurance coverage for home care aides.
4. Improve the entry-level training for home care aides, using an adult learner centered approach to education which draws on the life experiences of the adult trainee and incorporates the skills needed to deliver person-centered care.
5. Provide supports for the newly trained and hired as transition into this workforce can be difficult. Ongoing access to public benefits and other services such as child care are important to the new aide. Establishing a Peer Mentor program can also provide the kind of counseling and support that improves the work experience.
6. Provide opportunities for advancement through either a management track or through increased training in specific diseases and conditions, thereby creating a “Senior Aide,” occupational title.
7. Improve state collection and reporting of core direct-care workforce data and calculate key indicators of workforce stability (e.g., turnover rates, compensation) in order to gauge progress in building and stabilizing the home and community-based workforce and identifying shortage areas.
8. Invest in programs that support family caregivers, including those which focus on service providers, enabling them to assist families, such as the United Hospital Fund’s *Next Step in Care* ([www.nextstepincare.org](http://www.nextstepincare.org)) that developed tools for both providers and family caregivers.

### **Together We Care Act of 2009**

These data make a strong case for this proposal which is a timely and efficacious response to today’s labor market and demographic needs. Rep. Velazquez’s bill will actively address the needs of HUD and its grantees to meet the legal obligations of Section 3 of the Housing and Urban Development Act of 1968.

However, I would be remiss if I did not emphasize several of the elements critical to success, some of which are addressed in the draft bill, and others that fall within the purview of the Secretary:

- **The Role of HUD in Relation to Other Agencies.** The states vary widely in their home care programs and the regulatory framework for those programs and their workers. Moreover, the health, aging, disability and mental health systems all have some role to play in home and community-based care. Add to this

complexity the workforce development component that recruitment and hiring brings to the situation and you have various systems which more often than not lack any means of adequately communicating or coordinating their goals and objectives. The goals and policies of state and local Workforce Investment Boards (WIBs) also need to be considered. Home care providers are often quite removed from the workforce development system, a system that nursing homes have made greater efforts to engage. Moreover, it has been our experience that the WIBs are often reluctant to use their funding for home care jobs because the pay is low and there are few opportunities for advancement – two criteria that often drive decisions around training funds and other grants.

- **Retention of Public Benefits and Continuity of Care.** The legislation includes a graduated treatment of income earned by home care aides for purposes of eligibility for benefits. This is an important feature as aides are acutely aware of the tension that exists between wages and public benefits. Any improvements in wages or additional hours can increase their rents, leading them to refuse additional hours which can work against the needs of their clients.
- **Recruitment/Outreach.** Outreach is critical to a strong recruitment effort for the pilot to work. Such outreach should include information that lets the potential trainee know that their benefits will not be jeopardized as well as an appraisal of their desire to care for others and a realistic preview of the job and its duties. While we applaud this pilot, we think it would be a mistake to hire people who are not inclined towards this kind of work simply to meet numerical targets.
- **Entry-Level Training and Support.** The draft bill states that there is a shortage of training programs in health care and long-term services that focus on home care. While this is certainly true in rural areas of the country, for Indian reservations and in the territories, there are ample training programs in most urban areas. The problem in areas with ample numbers of training programs, such as New York which has 160 companies operating home care training programs in New York City alone, is not access to training, but adequacy. PHI has documented the case and evidence for quality training as a key to preparing the worker to do the job correctly and safely and to obtain the confidence needed to work in a largely unsupervised setting. Many workers leave the field within days of starting because they don't feel prepared for the reality of the work. Programs such as a Peer Mentoring Program, booster sessions, and meetings of the graduating class of aides help build confidence, smooth the transition, and assist in problem solving which is so critical to job stability.
- **In-Service and Advanced Training.** The population needing home care is marked by a variety of diseases, conditions and disabilities – often in multiples for the same individual. Those who reach 80 years of age stand a 50 percent chance of having some form of cognitive impairment. There are curricula, skills

training and new techniques that can be used to better prepare the aide to be an active partner in the care team. Aides need more than the entry-level training; however, advanced skills and competency should be accompanied by a different occupational title and increased pay. Because the rates for home care aide services are often curtailed by state and federal budgets, employers often take the easiest path for meeting annual in-service training requirements – using videos or readings to further the training. Sound training is experiential and makes use of the learning from the time on the job while also preparing the aide in communication, active listening, problem-solving, and self-management. Task-based training is necessary, but it is not sufficient for the challenge of high quality home care services.

- **Asset Building.** One of the stated goals of this pilot and Section 3 of the Housing and Urban Development Act of 1968 is the training and hiring of low-income individuals for economic security. Few home care employers focus on the specific needs of their aides with respect to financial literacy, savings, pension and equity. There are a variety of practices that can assist aides, including allowing them to cash their check without paying fees to check-cashing vendors.
- **Grantees.** The legislation would provide grants for a geographic mix of sites and would consider the ability of an eligible entity to provide training that leads to high quality care. The workforce practices of the eligible entities such as wages and benefits, rates of turnover, hours of training, full-time work and retention efforts should be taken into consideration. Otherwise, the pilot program might train people who would still lack a quality job.
- **Evaluation.** The metrics that provide a picture of the quality of the job should also be collected in addition to numbers of public housing residents trained and residents served. Satisfaction with the job and the service are important measurements. HUD is also advised to carefully monitor the rates of payment for aide services and other state policies that can either restrict or enhance the wages and benefits of these new aides. A copy of PHI's recommended workforce measures can be found appended to this testimony.

### **Recommendations within the Larger Policy Context**

We would urge passage of the "Together We Care Act of 2009," but ask recognition of the fact that initiatives of this kind fit within the larger national context of health reform. The growing need for a well-trained stable workforce can be achieved through improved wages and benefits, better training and support, and opportunities for advancement. Proposals for national health insurance need to target the direct care workforce, including them in the grant programs to states and allowing the use of these funds for:

- Development of state workforce development plans

- Expansion and upgrading of training programs and development of an infrastructure for direct-care workers across long-term settings and programs
- Implementation of direct-care worker data collection and workforce monitoring systems (see appendix A, attached to this testimony)
- Establishment of recruitment and retention programs, including initiatives to enhance direct-care worker wages and benefits
- Creation of structures and coordinating resources to support workers and consumers in consumer-directed programs
- Development of programs that promote the role of direct-care workers in new cost-effective models of chronic care that include approaches such as remote monitoring, integrated continuing care across settings, and wellness and prevention.

PHI thanks the subcommittee and especially Congresswoman Velazquez and her staff for this opportunity to testify on this valuable proposal that is designed to meet the needs of public housing residents – those needing care at home, and those interested in home care employment. This legislation seeks to design an intervention that will make better use of our HUD’s financing and authority. We urge you, however, to use this opportunity not only to create a new program, but to create a program that improves the quality of these jobs. On behalf of the staff at PHI, I look forward to working with the subcommittee, Congresswoman Velazquez and the staff at HUD to make this initiative a success.

Φ Φ Φ