
New York's Home Care Aide Workforce

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A Framing Paper

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About this Report

This report is one of three papers that provide an in-depth study of the home care workforce in New York State. The initiative is supported by a grant from the United Hospital Fund, a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. The United Hospital Fund has a long history of support for analysis in the field of long-term care, with several studies of home care in New York City.

This paper, the first in this series, provides a context for understanding the major issues that shape these jobs: wages, benefits, training, and opportunities for advancement. The second paper, *Preparing New York's Home Care Aides for the 21st Century*, examines the current system of training home care aides, and makes recommendations for building a workforce development system that can meet the needs of the 21st century. The final paper, *Improving Wages for New York's Home Care Aides*, outlines factors that have suppressed wages for home health aides and a series of actions designed to improve both wages and the quality of the care by changing employer and payer practices. All three papers are available at: www.PHInational.org/policy.

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About PHI

PHI (www.PHInational.org) 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 policymakers 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. Visit PHI PolicyWorks (www.PHInational.org/policy) for a comprehensive look at the nation's direct-care workforce.

About the Author

Carol Rodat, PHI director of New York policy, has over 20 years of policy experience, having worked first in the field of child welfare policy for the Child Welfare League of America in Washington, D. C., and then as executive director of Hospital Trustees of New York State, where she initiated one of the first quality improvement projects in the state's hospitals. From 1993 to 2004, she served as president of the Home Care Association of New York State, a statewide not-for-profit organization active in state and federal home care policy.

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Introduction

Each day, across the state of New York, over 200,000 home care aides* provide essential daily services and supports to older persons, people living with physical disabilities and chronic care needs, and those with intellectual and developmental disabilities. For these consumers who are cared for in their own homes and communities, home care aides provide more than 70 percent of the hands-on services and support. These workers, thus, are a “life line” for hundreds of thousands of New York State’s elders and people with disabilities.

From an employment perspective, home care aides—officially two occupations, *personal care aides* and *home health aides*—constitute one of the state’s largest occupational groupings. Moreover, they comprise the single largest occupational grouping in New York City. Home care is one of the few jobs characterized by both rapid growth and large numbers of openings, with a projected need for another 100,000 workers over the next six years.¹ The scale of this workforce makes New York home to the second largest home care workforce in the country, behind only California.

Yet despite its size and importance, this workforce is largely invisible to the public and to policymakers. Because these are low-wage jobs that require minimal training, it is assumed that the work being done is of little value—and that the workers themselves are easily replaced.

Those who need home care services, however, have a different attitude: the assistance provided by their home care worker is essential to living independently and with dignity. In addition, these workers provide significant relief to families struggling with eldercare, childcare, and/or work responsibilities. Unfortunately, high turnover among aides—and a lack of attention to training and workforce development—undermines quality of care and quality of life for families across our state.

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Numerous factors play a role in the way New York has come to train, employ, and compensate its home care workforce. Most importantly, because public funds—i.e., Medicaid and

Medicare—pay for the vast majority of services, this is a highly regulated industry. Federal and state regulations, combined with funding and other policy decisions, have created, over time, a remarkably complex system of financing, regulation, and delivery for the state of New York.

This paper examines some of the historical and demographic forces, along with the regulatory decisions, that have come to shape New York’s home care workforce. It focuses exclusively on workers who care for elders and people with disabilities through programs overseen by the New York State Department of Health and the Office of Aging. These workers—referred to by many titles, including home health aide, personal care aide, personal assistant, home attendant and homemaker—compose the majority of New York’s home and community-based direct-care workforce. However, another group of workers—often called direct-care staff or direct support

* Throughout this paper, “home care aide” refers collectively to both *home health aides* and *personal care aides*, the two home care aide occupations defined by the US Department of Labor. *Personal Care Aides* were formerly referred to as *personal and home care aides* in the federal occupational titles and codes.

professionals—provide support to people with intellectual or developmental disabilities; these workers are subject to separate regulations under the state Office of Persons with Developmental Disabilities.

Our analysis of the direct-care workforce, as presented in this paper, is divided into five parts:

- Part I, **Labor Market Dynamics**, addresses the crucial role that home care aides play in providing services and supports to hundreds of thousands of New Yorkers who could otherwise not live in the community and, then, examines the size and projected growth of the home care workforce;
- Part II, **Understanding the Industry**, details the multiple occupational titles and associated gradations in responsibilities among home care aides as well as the various home care service providers and their complex subcontracting relationships;
- Part III, **Job Quality**, examines key job characteristics: compensation, training, and advancement opportunities;
- Part IV, **Workforce Development Policy**, looks at the barriers that have impeded efforts to invest in workforce recruitment and training and create a coherent statewide workforce policy; and
- Part V, **System Challenges and Policy Options**, summarizes the findings of this paper and proposes solutions.

This paper serves as the framing document for two additional reports that amplify the core job quality issues of compensation, training, and advancement. These reports have been informed by leaders in long-term care service delivery and financing who participated in focus group discussions conducted by PHI (and hosted by the United Hospital Fund) in spring 2010. These three papers, along with the results of the focus groups that are found in Appendix A, inform the policy recommendations for stabilizing and strengthening the home care workforce that are found at the end of this paper. (For copies of all three reports, go to: www.PHInational.org/policy).

Part I: Labor Market Dynamics

Rising Demand Resulting from Changing Demographics

Home care aides make it possible for people to return home from the hospital, continue to heal after rehabilitation, and remain in their communities despite the limitations of age, disability,

Home care aides provide 70 to 80 percent of the paid hands-on care in the home care setting.

or disease. They serve those needing short-term services as well as those whose needs are long-term. It is estimated that home care aides provide 70 to 80 percent of the *paid hands-on care in the home care setting*, with the remaining amount provided by licensed professionals—registered nurses, therapists, and social workers.²

New York's home care workforce provides ongoing support services on an annual basis to at least 275,000 residents³ with age-related, as well as other disabilities, chronic diseases, and functional limitations. Those who need services are a

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subset of the more than 1 million adults between the ages of 21 and 64 living with a disability and the rapidly growing senior population (over the age of 65).⁴

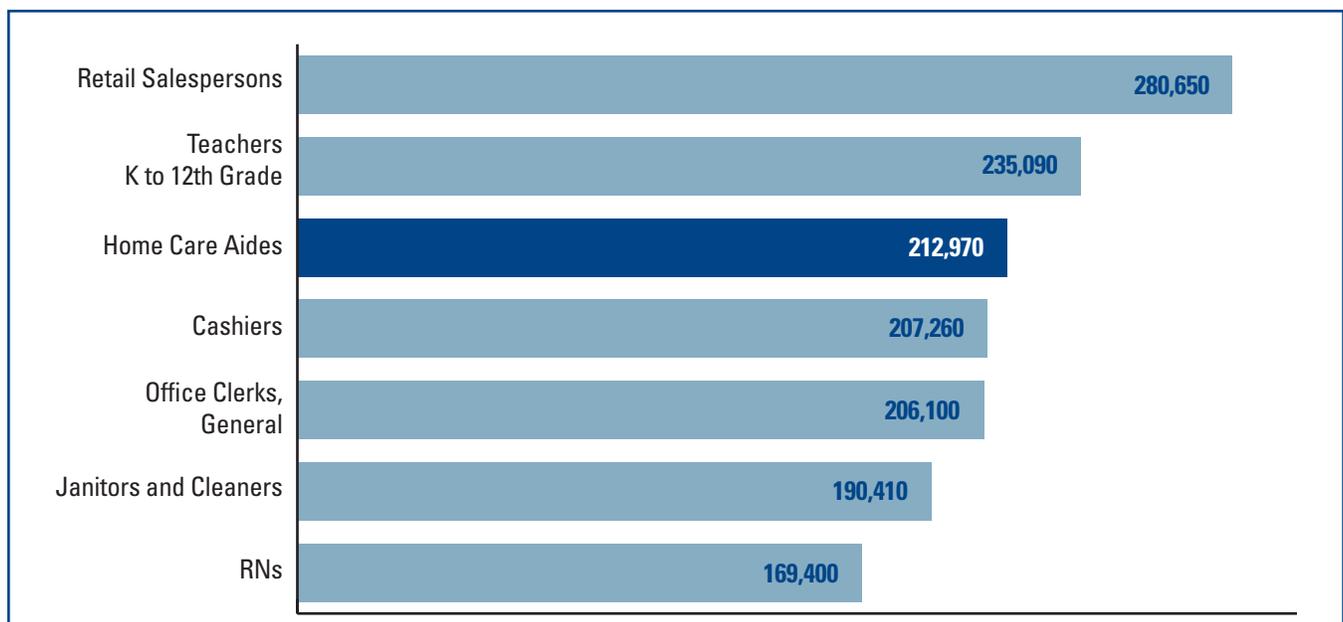
New York began 2010 with a population of 2.65 million individuals aged 65 or older—i.e., older adults made up more than 13 percent of the state's population. By 2030, the population over 65 is expected to increase by 54 percent, putting one in five New Yorkers over the age of 65.⁵

As the population shifts toward seniors, individuals with impairments will also increase, requiring a comprehensive array of services and supports. More than three-quarters of adults over 65 years suffer from at least one chronic medical condition, while an average 75 year old has three chronic conditions and takes five medications.⁶ These trends support estimates that two-thirds of older adults will need some form of long-term care at some point. Average length of care is estimated at three years.⁷

A Substantial and Growing Labor Market Force

The home care workforce not only constitutes the employment core of the eldercare/disability services sector, but the two job titles together—home health aide and personal care aide—make up one of New York's largest occupational groupings.

Figure 1: New York State's Largest Occupational Groupings, 2006



Source: NYS Department of Labor, Long-Term Occupational Projections, 2006–2016 New York State. Accessed on August 18, 2010, at: <http://www.labor.ny.gov/stats/demand.asp>.

The New York State Department of Labor states that “among the major occupational groups, the largest employment growth [over the decade 2006-2016] is projected to occur in healthcare support,” with home health aides driving much of this growth.⁸ *Home health aide* is the third fastest-growing occupation in the state and ranks fourth in number of projected job openings between 2006 and 2016.

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Demand for personal care aides is also contributing to job growth in home care services.⁹ *Personal care aide* ranks fourth among the fastest-growing occupations and eleventh in the projected number of openings. In every region of the state, the rate of increase in home health aide and personal care aide positions over this period is expected to be in the double digits. In hard numbers, this means that between 2006 and 2016, the demand for home care aides is expected to increase by over 100,000, as can be seen below.

Table 1: New York State Home Care Workforce, Percent Change Employment 2006–2016

Occupation	2006 Estimated Employment	2016 Projected Employment	Percent Change	Total Openings Expected
Personal Care Aides	74,680	100,790	35%	38,800
Home Health Aides	138,290	190,610	38%	64,700
All home care workers	212,970	291,400	37%	103,500

Source: NYS Department of Labor, Long-Term Occupational Projections, 2006-2016 New York State. Accessed on August 18, 2010, at: <http://www.labor.ny.gov/stats/demand.asp>.

Significantly, the increase in demand for home care aides—as well as the supply of potential workers—is not evenly distributed across the state. This means that it is important to look

More than half of the state's estimated home care workforce is employed in New York City.

separately at consumer needs and labor market trends in the upstate and metropolitan New York City areas.¹⁰

New York City

More than half of the state's estimated home care workforce¹¹—129,000 of 213,000 workers (or 61 percent)—is employed in New York City.¹² Home

care workers comprise three-quarters of the City's direct-care workforce, as compared to only 58 percent of the upstate direct-care workforce.

Table 2: New York State Direct-Care Workforce, By Region, 2006

Occupational Title	NYC	Rest of State
Home health aides	81,830 (47.3%)	56,460 (39.2%)
Personal care aides	47,160 (27.2%)	27,520 (19.1%)
All Home Care Workers	128,990 (74.5%)	83,980 (58.3%)
Nursing aides, orderlies and attendants	44,090 (25.5%)	60,120 (41.7%)
Total	173,080 (100%)	144,100 (100%)

Source: New York State Department of Labor, Long-Term Occupational Projections, 2006–2016, available at: <http://www.labor.state.ny.us/stats/lproj.shtm>

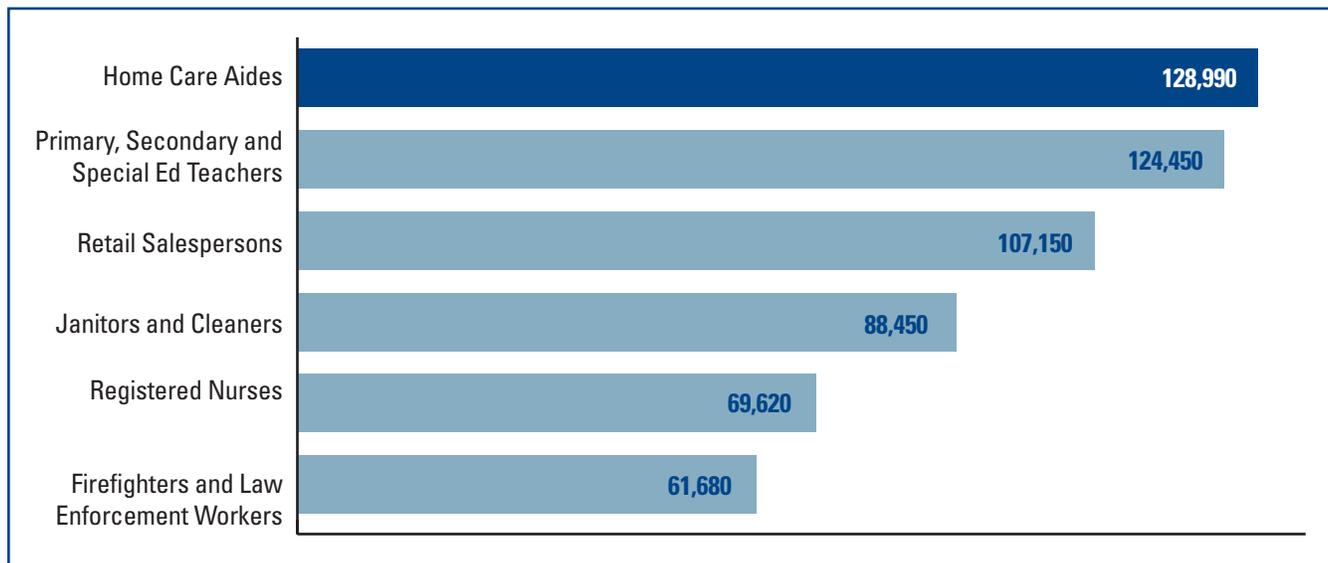
Note: Nursing aides, orderlies and attendants numbers may include staff in hospitals and other non-long-term care settings as well.

These differences in the distribution of home-based vs facility-based direct-care occupations reflect the City's robust home and community-based services. The City's population and housing density and the widespread availability of public transportation make delivery of home care services in the City more efficient than in other parts of the state.

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Notably, the 128,000 plus home care workers in New York City constitute *the largest occupational grouping in the City's economy*, outnumbering other groupings of workers such as teachers (124,450), registered nurses (69,620), and all firefighters and law enforcement workers (61,680).¹³

Figure 2: New York City's Largest Occupational Groupings, 2006



Source: NYS Department of Labor, Long-Term Occupational Projections, 2006–2016 New York State. Accessed on August 18, 2010, at: <http://www.labor.ny.gov/stats/demand.asp>.

In terms of occupational growth, in New York City, home health aide positions are growing at a rate of 41 percent and personal care aides at 34 percent. This means that over the decade 2006 to 2016, the City will need to fill 65,000 new home care positions. These jobs will likely be filled by a ready supply of immigrant women in need of entry-level employment.

Upstate New York

Upstate New York—i.e., areas outside of the metropolitan New York City area—relies much more heavily on nursing homes to provide services and supports to elders and people with disabilities. This is in part because providing home care services in low-density upstate rural and suburban communities is less cost-effective than in New York City. Aides must drive long distances between clients, making it difficult for agencies to arrange cases efficiently and harder for the workers themselves to earn a reasonable wage. As a result, direct-care workers in these areas generally prefer working in nursing facilities where wages are higher and hours more consistent.

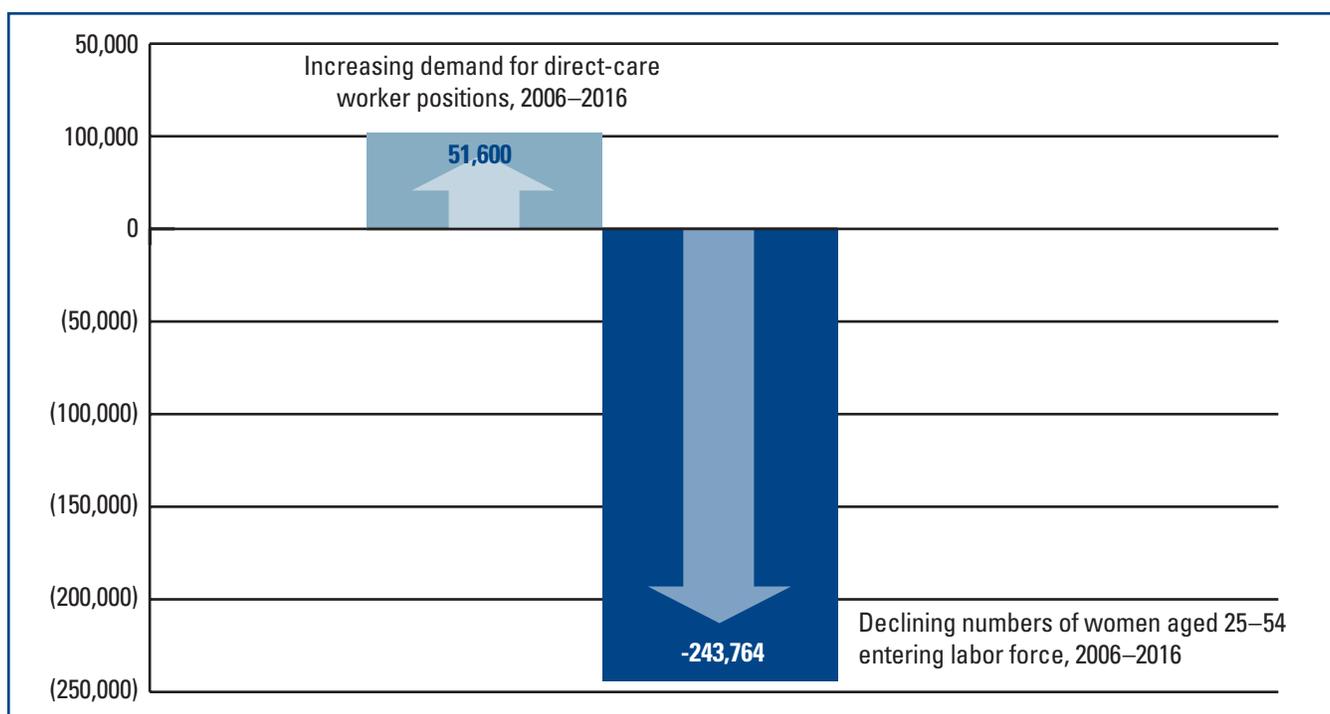
Providing home care services in low-density upstate rural and suburban communities is less cost-effective than in New York City.

Increasing consumer demand for home-based services upstate, thus, will be difficult to fulfill because home-based services don't offer very good jobs to home care aides. Moreover, there is an additional structural problem: the supply of labor to fill new direct-care positions—in home care and facility-based settings—is decreasing.

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Declining Labor Supply. Unlike New York City where there is a steady supply of new immigrant labor, in the rest of the state, the number of working-age women is declining. This is because of two factors: the aging of the population and net outmigration. As Figure 3 indicates, over the period 2006 to 2016, demand for new direct-care positions (home care workers plus nurse aides) outside of New York City is expected to reach 51,600. But at the same time, the number of women aged 25–54 projected to enter the labor force is expected to decline by over 240,000. These workers constitute the core labor pool from which direct-care workers traditionally are drawn. Consequently, upstate New York will face serious challenges in finding and keeping the number of home care workers it is projected to need.

Figure 3: Rest of State—Growing Demand for New Direct-Care Workers, but Number of Females Aged 25–54 Entering Labor Force is Contracting



Source: PHI analysis of 2000 US Census Interim State Projections of Population for 5-year age groups and selected age groups by sex (available at: <http://www.census.gov/population/www/projections/projectionsagesex.html>); NYC Population Projections by Age/Sex & Borough 2000–2030 Briefing Booklet, December 2006 (available at: http://www.nyc.gov/html/dcp/pdf/census/projections_briefing_booklet.pdf); and New York State Department of Labor, Long-Term Occupational Projections, 2006–2016 (available at: <http://www.labor.state.ny.us/stats/lproj.shtm>).

Increased Demand. Evidence of increasing demand for home care aides upstate can be seen in the growth of consumer-directed programs in which consumers have the option of recruiting, employing and training their own aides. Consumers may hire aides through a home care agency—the “agency with choice” model—or hire neighbors, friends or certain relatives to assist them. The increasing popularity of consumer direction outside of New York City may be attributable to the ability of consumers to hire friends and family members in areas where home care aides have been hard to find.¹⁵

From 2003–2008, recipients enrolled in the Consumer Directed Personal Assistance Program statewide increased by 60 percent with most of that growth outside of New York City.

The Consumer Directed Personal Assistance Program (CDPAP), which is funded by Medicaid, is the second fastest-growing home care program in the state after Medicaid Managed Long-Term Care. From 2003–2008, recipients enrolled in the program statewide increased by 60 percent. During that same timeframe, total CDPAP expenditures grew by 99.4 percent, with most of that growth occurring largely outside of New York City.

Table 3: CDPAP Regional Spending Growth and Recipient Counts, 2003-2008

Region of the State	Recipients (CY 2008)	Recipient Growth 2003–08	Expenditures (CY 2008)	Expenditure Growth 2003–08
New York City	2,310	40.4%	\$112 million	68.9%
Downstate—Nassau, Suffolk, Westchester, Putnam, Rockland Counties	2,047	70.4%	\$ 76 million	134.4%
Remaining Upstate Counties	4,748	68.0%	\$106 million	117.6%
Statewide	9,105	60.5%	\$294 million	99.4%

Source: NYSDOH Interim Report Home Health Reimbursement Workgroup, December 2009, Tables 1, 1A, 1B, 1C, 2, 2A, 2B, 2C

Part II: Understanding the Industry

Home Care Aide Occupations and Responsibilities

Occupational Titles

The US Department of Labor differentiates two home care occupations, tracking the number of positions and future demand for each. As noted above, these two occupations are officially titled *personal care aide* and *home health aide*.

The occupation of “personal care aide” encompasses aides with many different titles.

The occupation of “personal care aide,” in New York, encompasses aides with many different titles: homemakers, home attendants (used in New York City only), personal assistants, personal care staff, resident care aide, and direct support professionals (DSPs, who serve people with intellectual or developmental disabilities, form a separately regulated workforce, and, as noted above, are not discussed in this paper).

Table 4 shows the work sites, clients, employers and primary areas of assistance associated with the various home care aide occupational titles used in New York.

Table 4: Home Care Aide Occupational Titles, Work Sites, Employers and Duties

Occupational Title	Clients	Worksites	Employers	Duties
Personal Care Aide Level I (PCA I is primarily used in NYC; also called homemaker or housekeeper)	Elders, people with physical disabilities ¹⁶	Private homes	Licensed Home Care Services Agencies (LHCSAs) contracted with local Department of Social Services, Department of Aging, or Child/ Adult Protective Services	Instrumental Activities of Daily Living (IADLs)—housekeeping, shopping, cleaning, laundry, paying bills—but not tasks that require personal contact
Personal Care Aide Level II (Note: In NYC, a Personal Care Aide II is called a Home Attendant)	Elders, adults or children with physical disabilities	Private homes, adult homes, assisted living residences, adult day health programs, congregate care residences, Assisted Living Program (ALP)	LHCSAs	Activities of Daily Living (ADLs)—bathing, toileting, dressing, grooming, feeding, transferring, walking—and IADLs
Personal Assistant	Elders and people with physical disabilities who direct their own care	Private homes, consumer’s workplace	Consumer (in a consumer-directed program)	ADLs and IADLs, as well as clinical tasks (e.g., suctioning, changing a catheter)
Personal Care Staff (also known as Resident Care Aides)	Elders	Assisted living residences, adult homes, ALPs	LHCSAs, assisted living residence, adult home	ADLs
Home Health Aide	Elders, adults or children with physical disabilities	Private homes, adult homes, assisted living residences	LHCSAs, Certified Home Health Agencies (CHHAs), hospices	ADLs, IADLs, and health-related tasks (e.g., taking vital signs, dry dressing changes, range of motion exercises)

Responsibilities

Despite the differences in titles, the core services provided by all home care aides are typically very similar: assisting consumers with the Activities of Daily Living (ADLs: bathing, toileting, dressing, transferring, walking, eating) and Instrumental Activities of Daily Living (IADLs: shopping, preparing meals, light housework, managing money, laundry). The fundamental difference between the two occupations recognized

by the US Department of Labor—personal care aide and home health aide—relates to training requirements and regulations that concern designated “health-related” tasks, which, outside of consumer-directed programs, can be performed only by home health aides (see sidebar, p. 12).

Despite the differences in titles, the core services provided by all home care aides are typically very similar.

The federal government requires home health aides to receive 75 hours of training (see “Entry-Level Training,” p. 19) and to work under the supervision of a registered professional nurse (RN), who must provide supervision every 14 days. In most states, these aides provide short-term, post-acute support to Medicare beneficiaries. In New York, home health aides also provide services to Medicaid clients in need of skilled care on a long-term basis.

There are no federal training standards or supervision requirements for personal care aides.

By contrast, there are no federal training standards or supervision requirements for personal care aides who provide personal care and other support services to elders and people with disabilities who need ongoing assistance. These services are most often paid for by Medicaid.

Home Health Aides. Home health aides come under the regulatory authority of the New York State Department of Health (DOH). DOH publishes a “Home Health Aide Scope of Tasks,” which is the regulatory guidance for which tasks may be performed and under what circumstances. The DOH guidance takes into account federal regulations, its own rules and the state’s Nurse Practice Act, which is overseen by the New York State Department of Education.

The Nurse Practice Act governs the delegation of health-related duties and tasks to unlicensed personnel. Tasks are divided into three categories: permissible, permissible under special circumstances, and non-permissible. “Permissible tasks” are standard health-related duties of the home health aide (see sidebar, below). “Permissible under special circumstances” identifies tasks that the home health aide may provide to consumers under the following conditions:

- The consumer is self-directing;
- The consumer has need for assistance with the task or activity for routine maintenance of his or her health;

Health-Related Tasks Conducted by Home Health Aides

- Preparation of meals in accordance with modified diets or complex modified diets
- Administration of medications
- Provision of special skin care
- Use of medical equipments, 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
- Care of an ostomy site after the bowel has achieved its normal function

All of these tasks are “permissible” because they build upon a knowledge base of personal hygiene and household tasks that home health aides are routinely allowed to perform.

- The consumer cannot physically perform the task or activity because of his or her disability; and
- The consumer has no informal caregiver available at the time the task or activity must be performed.

Examples of tasks that fall under the category of “permissible under special circumstances” are the giving of pre-filled insulin injections, the setting or regulating of the oxygen flow rate, and assembling ventilator supplies and equipment. Non-permissible tasks include tube feeding, injection of any medication other than insulin, or insertion of a naso-gastric tube.

For a home health aide to perform any health-related task, the patient’s medical status must be reflected in a physician’s order and an RN must assess the functions, tasks, activities and degree of assistance needed by the patient. Permissible activi-

ties, including those under special circumstances, must be identified in the patient's plan of care and the home health aide must be supervised by an RN or therapist and, where indicated, receive on-the-job training in the patient's home in the performance of an activity.

Personal Care Aide. Personal care aides have traditionally provided the same support services as home health aides, with the exception of the health-related tasks discussed above. Though there is no federal training requirement for these aides, the state of New York requires personal care aides, who are regulated by the Department of Health (as opposed to Office of Mental Health or the Office of Persons with Development Disabilities), to receive 40 hours of training (see "Entry-Level Training," p. 19). In addition, there are very specific state regulations with respect to supervision of the personal care aide. At a minimum, every 90 days, a personal care aide must receive supervision from an RN who has experience in home health care.¹⁷

Challenges

New York has longed maintained a distinction between home health aides and personal care aides, assigning home health aides to home care clients with skilled care needs. However, the distinction between home health aides and personal care aides is increasingly becoming blurred by the proliferation of consumer-directed programs in which personal care aides perform the same health-related tasks as home health aides.

The distinction between home health aides and personal care aides is increasingly becoming blurred.

From a policy perspective, this bifurcation of the workforce creates a silo effect that makes the system of home and community-based care less efficient. Workers cannot move easily between different types of cases, and in some cases, become confused concerning what they can and cannot do with specific clients. For those entering the field, the decision as to what type of training and certification to pursue can be challenging. For consumers, the system is needlessly complex, making it difficult to sort out what their aides can or cannot do.

Employers and Subcontracting

Multiple Programs Providing Home Care Services

To better understand New York's home care workforce, some knowledge of the employers and how they derive their revenue is essential. New York is home to one of the most robust and diverse home and community-based systems of long-term care services in the nation. Yet the diversity of programs can be both daunting and confusing. In New York State, multiple public long-term care programs use the services of home care aides. These include: Personal Care Program; Medicaid Home Health Services; Long Term Home Health Care Program (LTHHCP); Hospice; Medicaid Managed Long Term Care Program; Expanded In-Home Services for the Elderly (EISEP); Homemaker Services; Consumer Directed Personal Assistance Program; Nursing Home Transition and Diversion Waiver; and Traumatic Brain Injury Waiver.

New York is home to one of the most robust and diverse home and community-based systems of long-term care services in the nation.

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Each of these programs and the provider organizations that are responsible for delivering services have their own regulatory requirements, including whether or not a personal care aide or a home health aide should be assigned to the client case (see Table 5). Sometimes the requirements regarding the type of aide assigned flow from the payer—Medicare or Medicaid—and other times they relate to the program or service the consumer is eligible for or the care plan developed for that individual.

Table 5: Type of Direct-Care Worker in NY's Home & Community-Based Programs

Home Care Programs & Services	Statewide Recipients (CY 2008)	Home Health Aide	Personal Care Aide/ Homemaker/ Personal Assistant
Personal Care Program	69,491		X
Home Health Services	81,423	X	
Hospice^a	1,913	X	X
Long Term Home Health Care Program^b	26,560	X	X
Managed Long-Term Care Plans	26,080	X	X
Program of All-Inclusive Care for the Elderly (PACE)	3,665	X	X
Consumer Directed Personal Assistance Program^c	9,105	X	X
Expanded In-Home Services for the Elderly (EISEP)^d	13,540		X
Traumatic Brain Injury Program^e	2,809		X
Nursing Home Transition and Diversion (NHTD) Waiver^f	30		X
Adult Day (Social and Medical)	17,626	X	X
Assisted Living Program^g	3,777	X	X

Source: NYSDOH Interim Report Home Health Reimbursement Workgroup, December 2009, Tables 2

a- Hospice providers report admissions for which Medicaid was the primary payer.

b- LTHHCP can use personal care aides for those cases that do not need the health-related tasks.

c- Currently there are no regulations within CDPAP mandating type of aide required. Consumers that are self-directing can hire any person they want, trained or not, and that person can perform any task requested. (New York prohibits payment to a spouse, parent, child, son-in-law or daughter-in-law.)

d- EISEP Recipients are for FY 2009 and refer to in-home services customers only, according to NYSOFA.

e- TBI Recipients are for July 2009, according to NYSDOH (July 29, 2009 RFA Questions and Answers document, accessed at: http://www.nyhealth.gov/funding/rfa/0905010831/questions_and_answers.pdf)

f- NHTD Recipients according to FOIL request from NYSDOH.

g- ALP Recipients based on December 31, 2008 DOH census.

The home care programs each have varying payment rates for service as well. In many instances, the program or agency that manages the client's overall care "outsources" the aide services by contracting with a Licensed Home Care Services Agency (LHCSA) that directly employs the aides.

History of Subcontracting Relationships

The subcontracting feature of the state's delivery system for home and community-based services—wherein a home care program contracts with a LHCSA that employs the aides to provide the services—is the result of several factors.

First, the personal care program in New York began as a public assistance program that in 1972 was converted to a Medicaid-funded personal care program in response to the federal government capping the federal program that funded social services. The original program was administered by the New York State Department of Social Services,¹⁸ which insisted that clients hire their own aides and that local social services departments retain day-to-day administration. Recognizing that payment to the aides was often tardy and there was little consistency in training and supervision, New York City began in 1980 to hire non-profit agencies to administer and supervise the personal care program.

At the same time, the Medicare home health program provided home health aide services to clients with short-term post-acute care needs. Certified Home Health Agencies (CHHAs) managed these cases, providing clients with visiting nurse services, physical and/or occupational therapy, and home health aide services as required. CHHAs were happy to contract with LHCSAs to provide the home health aide service for a negotiated price, because the CHHAs could then avoid employing the home health aides directly. Wary of dealing with a unionized workforce, the CHHAs, particularly those that were hospital-based, preferred to keep a workforce that might be targeted for unionization at bay.¹⁹

New York historically had two types of home care programs and aides.

Thus, New York historically had two types of home care programs and aides: home health aides caring for short-term post-acute clients needing skilled care, and home attendants (i.e., personal care aides) providing supportive care to clients

with long-term needs.²⁰ As explained above, federal and state regulations supported this bifurcation, calling for home health aides to be used in cases in which skilled care and health-related tasks were required. In recognition of these differences, the employers of home attendants in New York City were exempt from licensure until the early 1990s, long after other upstate agencies that provided home health and personal care aides had been licensed under New York State law.²¹

Structure of LHCSAs

The organizations that supply aides can be described as “staffing” agencies. Their primary business is to recruit, train²² and supervise, schedule, track and pay home care aides. This bundle of services has always been perceived as quite different from the nursing tasks that are the primary responsibility of clinically focused home health care programs.

While they all face the same licensure requirements, New York's 742 LHCSAs²³ vary considerably depending upon the types of contracts they have, the types of aides they employ, and their business model. Some LHCSAs provide only personal care aides, subcontracting with a city or county to provide services for the Medicaid personal care program. Other LHCSAs have contracts for home health and personal care aides, creating a more diverse business with a variety of contractual rates for an hour of service. They vary in size, with some employing several thousand workers, and others having 20 aides or fewer. They may have a single office, or have regional offices located over wide geographic areas. Some LHCSAs operate in the surrounding states as well.

Impact of Subcontracting on Wages for Aides

When negotiating contracts with agencies for personal care services, counties and cities originally set rates according to the historical costs, accounting for all past costs deemed to be “reasonable.”²⁴

Beginning in 1995, the state allowed counties to begin negotiating rates. By forcing LHCSAs to compete for contracts, this change pushed wages down for personal care aides. Subsequently, several cities and counties passed Living Wage ordinances, which established a wage and benefit floor for employees providing services under public contracts. The wage floor mitigated the ill effects of competing for contracts.²⁵

Home health aides' wages are not affected by living wage ordinances because the cities and counties do not directly contract for their services.

Home health aides' wages are not affected by living wage ordinances because the cities and counties do not directly contract for their services. Instead, a CHHA or another home care program (e.g., LTHHCP), which is managing the home care case, offers the LHCSA a "price" for an hour of aide service. The agency either accepts that price or loses the work.

Table 6 provides a comparison of the Medicaid rates that are paid for a specific service and the wages for aides that provide that service, using New York City as the example. The wage is determined by the LHCSA after it receives its service price from the home care program buying the service (e.g., CHHA or LTHHCP). The table shows that there are vast differences between the Medicaid rates paid to the subcontracting agencies and the actual wages paid to the aides.

Table 6: Examples of Home Care Service Medicaid Rates vs. Hourly Wages for Home Care Workers, NYC

Service	NYC Average Hourly Medicaid Rates	Payment to LHCSA for Hour of Service	NYC Hourly Wage	Occupation
Home Health Aide Service	\$20.19	\$12.50	\$8.00 (entry level)	Home Health Aide
Personal Care Service	\$17.48	\$17.48	\$9.96	Home Attendants

Sources: Home Health Aide Service payments from December 2009 DOH Home Health Care Reimbursement Workgroup Interim Report, Appendix D, reflect 2007 payments for CHHA "D" and Subcontractor "3." Personal Care Service payments from FY2009 Cooperative Home Care Associates HA/HSK rate setting sheet. The home attendant wage increased to \$10.00 per hour (NYC living wage) beginning in July of 2009.

Ultimately, having a large home care industry with hundreds of separate entities providing aide services has not been positive for the state's home care aides or their employers. With the industry structured this way, contractors (i.e., CHHAs and other clinical home care programs) are able to use competitive bidding to suppress prices, obtain discounts for volume, and arrange the terms of payment. This in turn compresses wages for home care aides, keeping tens of thousands of New York families in poverty or near-poverty. In most other states, the aide is employed directly by the agency or organization delivering clinical services.

Ultimately, having a large home care industry has not been positive for the state's home care aides or their employers.

State Examination of Subcontracting

In the 2009–2010 New York State Executive Budget, the governor proposed the elimination of subcontracting between CHHAs and LHCSAs

on the grounds that the change would not only save Medicaid expenditures, but allow the Department of Health to ensure that more of the Medicaid rate for an hour of home health aide service would be paid to the aide in compensation (i.e., wages and benefits). The New York State Legislature passed the budget without this provision, but directed the Commissioner of Health to establish a Home Health Care Reimbursement Workgroup to evaluate the practice of subcontracting along with a new payment methodology for CHHA Medicaid services. The workgroup delivered an interim report to the New York State Legislature in December 2009 that is silent on the practice of subcontracting, but recommends improving transparency by modifying cost and statistical reports that are submitted by providers. The report also calls for increased penalties for organizations that fail to submit their data in a timely manner.

Part III: Job Quality

Compensation

Wages

Across New York State, in 2009, the median hourly wage for all occupations was \$18.49. This compares to a median hourly wage of \$10.58 for personal care aides and \$10.53 for home health aides.²⁶

In New York City, more highly trained home health aides earn less than personal care aides.

These average hourly wages for home care aides, however, vary among employers, often as a result of a negotiated contract rate for services. Moreover, statewide average wages are skewed by the idiosyncrasies of the New York City labor market where more highly trained home health

aides earn less than personal care aides (see below). As noted above, more than half of the state's home care workforce is employed in the City.

Importantly, hourly wages do not provide an accurate picture of home care aides' median annual wages. Part-time hours reduce yearly earnings significantly. Median annual income for workers in New York's home health care services industry is \$16,000. Median annual income for PCAs is even lower, at \$14,400.²⁷

The low wages for home care aides reflect the industry's reliance on public funding. Medicaid reimbursements, along with subcontracting arrangements, compress wages that might otherwise rise as a result of increasing demand for services. Part-time hours impoverish workers even further.

The laws of supply and demand do affect wages marginally. Home health aides upstate earn slightly higher wages than those in New York City. This results from the limited supply of labor upstate versus the ready supply of underemployed and unemployed immigrant women in need of jobs in New York City.

New York City Wage Inversion. In New York City, unlike the rest of the state, home health aides are paid a starting wage of \$8.00 to \$8.50 per hour,²⁸ \$1.50 to \$2.00 less per hour than home attendants (i.e., personal care aides). This lower wage does not reflect the fact that home health

aides actually receive more training than home attendants and are allowed to perform more health-related tasks. This “wage inversion” is a consequence of the early unionization of home attendants and the City’s contract with the agencies that provide personal care services. Because the City provides personal care services through a public contract, home attendant wages are tied to the City’s living wage (\$10 per hour). The Home Attendant program also “builds” the rate for service reimbursement by starting with the wage to be paid and the cost of health insurance.

By contrast, home health aides have only recently unionized and have not yet seen the same benefits from collective bargaining. In addition, the City does not contract directly for home health aide services and thus the living wage ordinance does not apply to these workers. As a result

there is no “wage floor” other than the state’s minimum wage of \$7.25/hour.

Compensation disparities among the City’s home care workers are a problem because they lead to recruitment difficulties and elevated turnover for home health aides.

Compensation disparities among the City’s home care workers are a problem because they lead to recruitment difficulties and elevated turnover for home health aides. Home attendants as a group are significantly more stable than home health aides, with a turnover rate estimated at only 12 percent. This compares to a turnover rate of 25 percent or more for home health aides.²⁹

Health Benefits

Although there are a variety of benefits that can accrue to a worker (e.g., vacation, sick time, pension, insurance), health insurance is typically considered the most important, and due to its ever-increasing costs, has the greatest impact on wages. Indeed, benefits compete directly with wages in the home care industry, since both must be paid out of a single reimbursement stream. Health coverage is particularly important for home care workers as they tend to have both high rates of injury and chronic illness (e.g., diabetes, hypertension, asthma).³⁰ Moreover, studies show that health coverage for home care workers is strongly associated with improved retention.³¹

In 2008, PHI undertook the first comprehensive study of the health insurance status of home

Home care aides are twice as likely to be uninsured as the average New Yorker.

care aides in New York State. From that study, we learned that home care aides are twice as likely to be uninsured as the average New Yorker. Outside of New York City, only 25 percent of the aides are actually enrolled in employer-sponsored insurance. Furthermore, even if every home care agency in the upstate area offered a health insurance plan,

at current rates of eligibility and enrollment, only about 33 percent of the home care aides would be enrolled in employer-sponsored plans.³²

In New York City, unionization of these workers has enabled more home health aides and home attendants to secure health coverage. However, while home attendants have access to comprehensive coverage with no premium sharing, many home health aides have been limited to individual coverage capped at \$6,500 in annual medical expenses.³³ The home health aide plan requires aides to pay a share of the premium, which most cannot afford. Those home health aides

who do not work for a unionized employer may have no access to health insurance through their employer.

Eligibility requirements often prevent workers from enrolling in plans during their first three to six months of employment. In addition, they lose eligibility for coverage when they do not

Since home care hours tend to fluctuate as clients' care needs change, many workers are forced to move on and off their employer-based coverage from month to month.

work sufficient hours—usually between 80 and 120 for two consecutive months. Since home care hours tend to fluctuate as clients' care needs change, many workers are forced to move on and off their employer-based coverage from month to month.

Workers who can't afford or are ineligible for employer-based coverage may be able to enroll in public coverage. However, in order to meet the eligibility requirements which are income based,

they must cut back their work hours—an employment disincentive, which forces workers to live on less income and ultimately reduces the supply of experienced labor.³⁴

Thus, despite New York's progressive state policies, high levels of unionization and access to both employer-sponsored and public insurance, coverage remains unavailable, unaffordable or inadequate for many home care aides. Moreover, the current policies result in high levels of churning of workers on and off employer-based coverage, creating instability for workers and an enrollment nightmare for plan administrators.

Entry-Level Training

Home care aides, as compared to facility-based aides, work in relative isolation, providing care and support without much direct supervision or access to onsite consultation from professionals;

The quality of the services home care aides provide depends greatly on the quality of training they receive.

therefore, the quality of the services they provide depends greatly on the quality of training home care aides receive.

Home care clients often have complex physical and mental limitations caused by disease or disability. To provide quality support services, home care aides need to achieve competency

in three areas: personal care, health-related knowledge, and communication and interpersonal problem-solving.

Required Training Hours

Though all direct-care workers, regardless of their occupational title or the setting in which they provide services, essentially need similar skills, the different occupations have quite varied pre-employment training requirements.

New York requires home health aides to have 75 hours of pre-employment training, the minimum required under federal law. Though there is no similar federal training requirement for personal care aides, New York has set a minimum of 40 hours of training for personal care aides. In addition, home health aides must receive twelve hours of in-service training yearly, while personal care aides are only required to receive six hours.

Table 7 compares training requirements for personal care aides, home health aides, and—as a point of comparison—certified nursing assistants (CNAs). CNAs perform similar tasks to home health aides—and are subject to the same 75 hour federal training requirement—yet New York requires these workers to undergo 100 hours of training.

Table 7: Training Requirements for Direct-Care Workers

Occupational Titles	NYS Minimum Pre-employment Training Requirements	In-Service Training Requirements
Personal Care Aides (Home Attendants)	40 hour (NYS standard; there are no federal standards)	6 hours annually
Home Health Aides	75 hours, including 16 hours of practical training supervised by a Registered Nurse, of which 8 hours are in classroom/lab and 8 hours are with a client/patient at home or in an appropriate health care facility (federal standard also 75 hours)	12 hours annually
CNAs	100 hours, 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 (federal standard 75 hours, at least 16 of which are supervised practical training)	6 hours every 6 months

Sources: 1) “Home Care Curriculum,” January, 2007, New York State Department of Health and DAL:DHCBC 06-02, April 13, 2006 at http://www.nyhealth.gov/professionals/home_care/.

2) “Home Health Aide Scope of Tasks; Guide to Home Health Aide Training & Competency Evaluation,” March 2009, New York State Department of Health

3) “Nursing Home Nurse Aide Training Program for Nurse Aide Certification,” January 2006, New York State Department of Health at: http://www.nyhealth.gov/professionals/nursing_home_administrator/

Required training hours for home care aides in New York do not compare favorably with other occupations. For example, a licensed cosmetologist in New York must complete 1000 hours of training and a pet groomer must complete 150 hours of training.

Training Content

The New York Department of Health publishes the *Home Care Curriculum*, a guide to the required 40-hour personal care aide training. The curriculum introduces trainees to the different types of home care clients as well as basic caregiving skills. Of the 40 hours of training, 16 are designated

The curriculum introduces trainees to the different types of home care clients as well as basic caregiving skills.

as Core Basics, which include: personal care skills (e.g., pain management, toileting, bathing, grooming, dressing, toileting); taking care of the client’s environment; infection control; and transferring, turning and positioning the client.

Home health aide training builds on the 40-hour *Home Care Curriculum*, with an additional 35 hours focused on health-related tasks. These 75 hours of training are designed to cover all federally mandated content and to include mandated clinical skills practice and competency assessment.

The 35-hour health-related skills training is compiled in a DOH guide titled *Home Care Health-Related Tasks Curriculum*. The training covers a broad range of topics, including: an orientation to health-related tasks, performing simple measurements and tests, preparing food for complex modified diets, assisting with prescribed exercise programs, assisting with medical equipment,

assisting with special skin care, assisting with dressing changes, and ostomy care. The 35 hours of training are divided between 19 hours of classroom education and 16 hours of practical skills training in a lab or patient-care setting where a nurse must assess the trainee's competency to perform all clinical-related tasks.

Training Delivery

Most home care training programs are employer-based—i.e., the training is provided by home care agencies licensed by the New York State Department of Health. These employer-based programs train their employees to serve as home health aides, personal care aides, or both—thereby certifying the aide to work in either capacity. The state has approximately 332 home health aide training sites operated by 157 agencies and 341 personal care aide training sites operated by 159 agencies (exact numbers and types are difficult to ascertain).³⁵

Most home care training programs are employer-based.

and home health aide training. These programs are licensed by the State Education Department (SED) Bureau of Proprietary School Supervision.³⁶ In upstate New York, aides may also be trained through programs operated by secondary or post-secondary schools as well as community colleges. However, employers are the predominant trainers there as well.

Training instructors for home health aides must be Registered Nurses with at least two years of nursing experience, at least one year of which must be as a provider of home care services. Instructors are not required to have any training or experience in teaching. As a result, many of the state's trainers are not familiar with the adult learner-centered training techniques that have been shown to be most effective in job training programs for adults with limited language and literacy skills.³⁷ Adult learner-centered techniques are also better designed than traditional didactic education to teach the critical communication and problem-solving skills that help home care aides succeed.

Upstate New York is struggling most with developing sufficient workforce capacity.

Upstate New York is struggling most with developing sufficient workforce capacity to fill the home care needs of residents. Existing programs are not attracting sufficient numbers of trainees who can complete the programs within the required 60-day period. Many trainees attend programs that meet on a part-time basis, while also trying to hold down a paying job. If they miss one or two classes, they may not be able to finish in the required time. In addition, there are insufficient numbers of nurses who meet the requirements that trainers be RNs with a minimum of two years of experience, one year of which must have been in home care.

Training Costs

No current data is available on the cost of training for home health aides or personal care aides industry-wide throughout New York State.

The costs of turnover and differences in outcomes make training an area open to examination.

The costs of turnover and differences in outcomes—reported as placement in a job and retention over time—make training an area open to examination and possibly reform. Training is an allowable cost within the publicly funded home care reimbursement formulae, but since most reimbursement agreements are not cost-based, the

rate does not increase or decrease based on an employer's training expenses.

Training Program Quality

New York has struggled with monitoring the quality of home care training programs. The current system allows for hundreds of training programs to operate, making it difficult to assess performance or value beyond minimal paper compliance. In addition, the workforce development system is poorly coordinated (see below), with potential workers unable to identify the higher quality employers. This has enabled a culture of poor quality and fraud to occur within the home care training system.

In 2007, the Medicaid Fraud Control Unit of the state Attorney General's Office initiated "Operation Home Alone," an investigation focused on home health aide training and billing. Several individuals—including aides, owners of agencies and training programs, and patients—were convicted of Medicaid fraud for falsely certifying that aides had appropriate training, and home health aide training programs without an up-to-date license were closed.

As a result of the investigation, a list of licensed training programs has been made publicly available on the New York State Department of Health's website (www.nyhealth.gov). In addition, a comprehensive aide registry was established to allow employers and those contracting for services to check for valid credentials (e.g., completion of a licensed training program, employment history). While the public has access to the registry and the list of licensed training programs, neither provides much information regarding the quality of training.

Career Advancement

Few Advancement Opportunities

Like most states, New York lacks a coherent approach to training-based advancement strategies for home care workers. With no clear career path, home care aides have limited opportunity to be recognized for their knowledge and experience. Furthermore, because training requirements are inconsistent and not necessarily aligned with wages, "advancement" at best results in small incremental wage increases that do not translate into a real improvement in earnings.

The career ladder most often mentioned for home care workers is to aspire to become either a

Home care aides have limited opportunity to be recognized for their knowledge and experience.

certified nursing aide (CNA) or Licensed Practical Nurse (LPN) and from there, possibly a registered nurse (RN). However, *this career ladder moves home care workers out of home and community-based settings into clinical settings such as nursing facilities and hospitals. Only if they rise to the level of RN can they return to the home care setting.*

Additionally, home care workers and CNAs have very similar responsibilities, yet a worker who is trained as a home health aide must take the complete CNA course of study—regardless of the fact that three-quarters of the CNA training is nearly identical to the home health aide training that the aide has already completed.

Senior Aide Demonstrations

Home care agencies have long conferred the title of “Senior Aide” to some of their aides, though usually as a sign of longevity with the agency rather than for new levels of competency attained. Recently, however, several New York organizations developed specific curricula to train aides for more advanced competencies, such as caring for clients with chronic diseases and conditions that are prevalent in the home care population (e.g., dementia, diabetes, cardiac or pulmonary disease, stroke) (see Table 8).

Table 8: Types of “Senior Aide” Training

Advanced Training	Developing Organization or Person	Amount of Training
Alzheimer’s and Dementia	New York City Chapter of the Alzheimer’s Association	45 hours
Learning Collaborative: Promoting independence in self-care in patients with diabetes, cardiac or pulmonary illness, and rehabilitation	Visiting Nurse Service of New York	5 days
Challenging behaviors	Margaret Walsh, M.S., R.N.,C.S., Human Resources Administration, New York City	1–2 days
Berman Peer Mentor Home Health Aides Project: cultural awareness, dementia care, psychiatric disturbances and behavioral disorders, palliative care, mentoring and group leadership	Jewish Life Care System	12-hour course consisting of four 3-hour classes
Serving individuals with Multiple Sclerosis	Independence Care System	Minimum of 12 hours

For the most part, however, these initiatives have tended to remain isolated and idiosyncratic, with little systemic replication. With modest increases in levels of competency, the resulting wage enhancements are also modest—perhaps 50- or 75-cent per hour increases. Even these small

For the most part these initiatives have tended to remain isolated and idiosyncratic, with little systemic replication.

increases are typically not incorporated into the reimbursement formulae, and thus providers are left to fund these increases out of their existing rates or through fundraising and grants. The result is that many programs fail to survive once the initial demonstration funding ends, and those that do typically remain confined to the program or care delivery system within which they originated.

Medication Aide

Another career ladder step that most states have adopted is a new occupation titled “Medication Aide.” The medication aide is trained to deliver, and in some cases, administer medications. State Boards of Nursing have approved this occupation and the attendant curriculum in recognition of a shortage of nurses as well as an ongoing need for elders to have better control of their medica-

tions. However, New York remains one of a handful of states without this rung on a potential career ladder.

Fears that the Medication Aide position would compromise the quality of care have been proven unfounded. Studies show that the performance of Medication Aides compares favorably with that of conventional licensed personnel. In one study, medication error rates in assisted living facilities with Medication Aides administering the medications were 3.6 percent as compared with 19 percent in the hospital sample.³⁸

Part IV: Workforce Development Policy

Public Workforce Development System Discounts Home Care Industry

The public workforce development system, authorized by the federal Workforce Investment Act (WIA), is a partnership between state, local and federal stakeholders that gives states and localities authority to implement workforce investment strategies to address the needs of the labor market. Within each state, there is a state Workforce Investment Board (WIB) and local workforce areas, each of which has a local WIB that administers local workforce development activities.

Despite the size of the home care workforce, the WIBs have been largely uninterested in funding training for home health aide and personal care positions.

Despite the size of the home care workforce, the WIBs have been largely uninterested in funding training for home health aide and personal care positions because wages are low and advancement opportunities are limited. In addition, tuition assistance in the form of Individual Training Grants (ITGs) can only be applied to training programs operated by the proprietary training schools, and in some cases community colleges,³⁹ approved by the New York State Education Department.

The vast majority of training for home care workers is provided by employers. Since there is no “tuition” for these programs (i.e., the employer trains the worker as part of the employment agreement), employers cannot access these training funds.

In comparison, New York’s nursing homes and hospitals have had far more involvement and interaction with the WIBs. The WIBs have been more supportive of training of Certified Nursing Assistants (CNAs), largely because entry-level wages for CNAs are higher than those paid to home care workers.

Poor Coordination across Agencies Prevents Coherent Workforce Strategy

Fragmented Approach

Many state agencies and departments—Health, Persons with Developmental Disabilities, Mental Health, and Aging—rely heavily on the home and community-based workforce to deliver services and, therefore, are affected by current and future capacity issues. Nonetheless, among

the commissioners of these departments, there is little cabinet-level coordination specifically focused on this workforce. Individual agency and department budgets and categorical funding streams, particularly workforce recruitment and retention initiatives that add dollars to provider rates, contribute to fragmentation rather than to a coherent workforce development strategy.

Among the state agencies that rely on—and regulate—home care services, only the Office of Persons with Developmental Disabilities (OPWDD) has established a task force that is charged with studying the problem and developing strategies for improving retention and increasing capacity. The OPWDD task force has set the following targets for statewide improvements in direct support workforce recruitment, stability, and quality:

- 10 percent reduction in direct support professional turnover rates;
- 20 percent reduction in direct support professional vacancy rates;
- 90 percent individual and family satisfaction rates as measured by surveys; and
- 85 percent staff satisfaction as measured by surveys.⁴⁰

These are admirable goals, but they apply to only one segment of the home-care workforce—those that serve the needs of people with intellectual and developmental disabilities.

The Department of Health has not specifically developed similar goals to meet the expanding needs of elders and people with physical disabilities.

The Department of Health has not specifically developed similar goals to meet the expanding needs of elders and people with physical disabilities. Moreover, although there are instances in which aides who work on cases regulated by the Department of Health move to a case in the OPWDD system, there is little examination of the differences in the training and competencies required or how to smooth the transition from serving one clientele to another. For example,

because aides in the OPWDD system are able to dispense medications, they find it difficult to move to personal care cases in the DOH system where medication comes under much stricter regulations.

State Investments in Recruitment and Retention Poorly Monitored

In recognition of workforce shortages in health care, New York has made significant investments towards health workforce recruitment and retention since 2000. These investments came first from tobacco settlement funding and have been continued through a special add-on to the Medicaid reimbursement formula.

The only conditions placed on providers for receiving these dollars are that they be spent on personnel with direct patient care responsibilities. The recruitment and retention funding can be used to fund hourly wage increases or bonuses, training, or additional benefits. The only form of monitoring is a written attestation stating that the additional dollars received are used for the stated purpose.

In addition to the funding for recruitment and retention, the state has continued funding for the workforce retraining initiative, designed as part of the Health Care Reform Act of 1996 to prepare the workforce for new skills and tasks required to use new technologies or to adapt to

new job responsibilities proposed by providers. With respect to these training program funds, there are reports of the number of trainings and individuals trained. However, there has been no data collected that reflects the workforce outcomes of these efforts such as reduction in vacancy rates, lower turnover, or higher worker satisfaction.

Despite multi-year funding New York has very little knowledge as to how these dollars have been spent or what difference these investments have made.

Therefore, despite multi-year funding that totals over \$2 billion for workforce recruitment and retention and worker retraining in a variety of health care settings, New York has very little knowledge as to how these dollars have been spent or what difference these investments have made. There is no accurate and comprehensive

data as to the entry-level wages for home health aides, the turnover and vacancy rates, or how much public money goes to profit and overhead. New York has made one of the largest investments of any state in the country in its health care workforce, and yet has no ability to report accurately the return on that investment to the public.

Data Collection Necessary to Strengthen Workforce

New York does not collect adequate data to accurately monitor the size, stability, or compensation of the home care workforce.

The Center for Health Workforce Studies at the School of Public Health, State University of New York (SUNY) at Albany, provides annual reports on the supply and demand and employment projections for the health workforce in New York. Their report is based on primary and secondary data sources, including a survey of human resource directors in health care. Although the report is extremely useful for examining the trends, it cannot, nor does it intend to, give a unified picture of the home care workforce. Without such data, it is difficult to have a clear understanding of the current reality or to develop plans to address future needs.

Part V: System Challenges and Policy Options

New York's home care system is critical to families and communities across the state. Home and community-based services are essential to meeting health care and support needs of elders and people with disabilities—and to helping families survive what can feel like crushing obligations for caregiving, wage earning, and child raising.

The home care system is essential to New York's economy.

In addition, the home care system is essential to New York's economy, providing hundreds of thousands of jobs. In low-income communities, these jobs are providing wages for one in seven workers.

This paper lays out the factors that have come to shape New York's home care workforce,

particularly how home care aides are employed, trained, and compensated. The complex system of financing, regulation, and delivery is a product of historical decision-making, federal and state rules for the delivery of Medicare and Medicaid services, labor market forces, regional differences in the state, improvements in health care, and ongoing demographic changes.

Challenges

Our examination of the home care workforce exposes numerous challenges that are likely to be exacerbated by a future of tight federal and state budgets. These include:

Changing Demographics

- A rapidly growing elder population and growing numbers of people living with disabilities that will put increased demand on the home care system.
- In the upstate region, a diminished pool of potential workers to meet rising demand, particularly for consumer-directed home care services.

Complex Service Delivery System

- Many different programs, mostly reliant on public resources, leading to inefficiencies and lack of quality control.
- An overabundance of licensed agencies competing for home care aide contracts and, as a result, accepting prices that are too low to pay aides a living wage.

Inadequate Compensation for Home Care Aides

- Low wages and part-time hours that keep workers in poverty.
- Twice as many home care workers as other New York workers without access to health coverage.

Poor Quality Training System

- A fragmented, poorly monitored training system that leaves workers ill prepared for their jobs and undermines quality of care.
- A certification system that undermines the ability of aides to move between similar occupations.
- No articulated pathways for skill-based career advancement.

No Workforce Development Policy

- Lack of a coherent home care workforce development strategy across the many agencies that rely on these services to serve elder and disabled clients.

Setting clear goals for a workforce that will soon number 300,000 home care aides is essential to the development of an effective state system of home care services.

- A workforce development system that neglects the state's fastest-growing occupations because they pay so poorly.

Setting clear goals for a workforce that will soon number 300,000 home care aides—and will be paid primarily with public dollars—is essential to the development of an effective state system of home care services. To build an adequate and

stable home care workforce to meet future demand, New York policymakers must look at policies that will impact payment systems and subcontracting relationships, worker compensation and benefits, and training and career advancement opportunities. There also must be increased accountability to ensure that public funds are being used efficiently and effectively to provide quality care for consumers and quality jobs for workers.

Policy Options

New York needs a set of home care workforce policies that span the health, aging and labor sectors and will sustain the weight of the state's long-term care policy goals. The solutions must

The solutions must be flexible enough to address the realities of very different upstate and downstate regions.

be flexible enough to address the realities of very different upstate and downstate regions, to support different roles for family caregivers, and to provide for as much consumer direction as an individual desires. Most importantly, these policies must produce a cost-effective, well-trained, stable, professional home care aide workforce that can support the long-term care service and support needs of New Yorkers. Improving and profes-

sionalizing home care jobs and creating an advanced aide role will be an essential component to rebalancing the long-term care system, improving clinical outcomes, and achieving greater savings.

Systems Recommendations

- 1. Assess Workforce Capacity.** In order to meet the current and future demand for home care services, New York needs to know its workforce capacity by region and by occupational level (personal care vs. home health aide) as well as the turnover rates by employer. The Home Care Registry could help in this regard once it is fully operational.
- 2. Streamline Information Systems and Promote Interagency Collaboration.** The state should unify information on training and certification currently spread throughout four agencies (Departments of Health, Mental Health, Office of Persons with Developmental Disabilities, State Office for the Aging, State Education Department, and multiple bureaus). It should also create a working relationship between these agencies and the New York State Department of Labor to ensure the integration of workforce policy with the policy interests of the other agencies. Potential workers and employers would benefit from a consolidation of the regulations and requirements.
- 3. Implement Prudent Purchaser Policies.** New York needs to become a prudent purchaser and funder. The state spends millions of dollars on home care aide services without assessing whether it is being spent as efficiently and effectively as possible. In fact, there is data to suggest that these dollars do not get to the aides but instead subsidize overhead costs of the contractor and the subcontractor. The state must set standards for subcontractors and require reporting of aide workforce measures that will provide a progress report on improvements in wages, training and turnover. All home care programs and managed care plans that subcontract must be held accountable for procurement practices that contribute to better wages and the stabilization and improvement of this workforce.

Training Recommendations

- 1. Consolidate Training in the Best Training Programs.** New York has far more training programs than it needs in New York City and fewer than it needs upstate. However, all geographic areas of the state could benefit from the consolidation of training of home care aides in “Centers of Excellence” that would recruit and select trainees with a recognition of their learning deficits and needs, train them using adult-learner principles, and provide them with additional supports and services for at least the first year of employment.
- 2. Encourage Dual Certification.** New York should encourage the dual certification of aides as both personal care and home health aides and should review the requirements of other entities such as assisted living residences and group homes for individuals with developmental disabilities in order to streamline the transitions for workers across sites of care.
- 3. Improve Training Quality.** The health system that is being designed today will focus on chronic care and disease management. Home care clients have more complex needs than in the past, yet entry-level training content has remained almost entirely focused on specific personal care and clinical tasks. New York should update training content to include:
 - Use of remote monitoring technologies and electronic devices to record and access patient data.
 - Better preparation in the communication and interpersonal problem-solving skills that improve caregiver-client relationships and in communicating about issues such as nutrition and falls prevention.
 - Specialty content areas that meet the needs of specific populations: for example, Alzheimer’s and dementia, chronic diseases, and challenging behaviors.

It is essential to train trainers in effective adult learner-centered teaching strategies.

And to better meet the needs of trainees, many of whom face learning barriers, entry-level training programs should use adult learner-centered techniques that actively engage learners and use a variety of teaching activities that can meet diverse needs. To make this transition, it is essential to train trainers (primarily nurses) in effective adult

learner-centered teaching strategies. In addition, the transition from the classroom to the first case can be supported through the use of field assistants or peer mentors.

- 4. Define Career Ladders and Other Opportunities for Advancement.** In order to take full advantage of their experience and training, aides should be working at the top of their license. But to accomplish this, the nurses who train aides as well as delegate to them need to be engaged. There are many circumstances in which home care clients could have a well-trained aide perform permissible tasks, if the aide were appropriately trained. These instances should be reviewed as a basis for an expanded role for aides across settings.

Similarly, a number of programs have created Senior Aide positions where more experienced aides receive additional training to assist in the classroom, mentor new aides in the field, and take the most challenging assignments. These positions have been demonstrated to improve the satisfaction of the aides and the stability of the workforce. They now need to go to scale to provide aides with career steps that are meaningful beyond one workplace.

Finally, it is time for New York to evaluate the creation of a Medication Aide in home care. Aides already assist with medications in group homes that serve the developmentally disabled and assisted living residences, and there is ample experience and evidence-based evaluation from other states which have instituted a Medication Aide to demonstrate the value of this change.

Contracting and Compensation Recommendations

1. CHHAs and other home care programs must hold LHCSAs accountable for workforce outcomes. There have been several attempts to address subcontracting and to increase the amount of the Medicaid rate available for aide wages both by the legislature and the governor. For example, bills were introduced in past state legislative sessions to minimize profits by requiring CHHAs and LHCSAs to share a single overhead percentage of the rate. Most recently, the governor proposed the elimination of subcontracting between CHHAs and LHCSAs. This proposal was rejected, largely due to the legitimate argument that the costs of recruiting, hiring, training and retaining aides would simply move into the CHHAs, without any additional benefit to the system in either cost or quality.

While these efforts failed, there is an opportunity for CHHAs and other home care programs to concentrate the contracts in those LHCSAs with better performance, by measuring workforce outcomes and holding LHCSAs accountable for the quality of the workforce. With their exclusive focus on home care aides, LHCSAs are well-positioned to improve training and retention and provide opportunities for advancement; contracting entities should reward LHCSAs with proven success in these areas.

If New York wants a high quality aide workforce the state needs to hold the CHHAs and other home care programs accountable for contracting on the basis of quality.

If New York wants a high quality aide workforce, and plans to continue the practice of subcontracting, the state needs to hold the CHHAs and other home care programs accountable for contracting on the basis of quality.

2. DOH must require transparency. Since neither the state nor the locality contracts directly with the LHCSA for home health aide services, in order to improve the aide wages, the DOH will need to know what the contractor is paying, what the LHCSA is receiving, and how the home health aides are compensated. DOH now requires the CHHAs and the Long Term Home Health Care Programs to report subcontracting rates for each subcontractor in an addendum to their Medicaid cost report. The next step is to collect information from the LHCSAs on entry-level wages, differentials⁴¹ and benefits through their statistical report. These same reporting requirements must also be extended to other home care programs that subcontract.⁴² These steps will enable the state to determine whether or not the aide procurement process has been modified to reward those employers who compensate the aides at a higher level.

In addition, the adequacy of the rates for licensed personnel working in home care (RNs, physical, occupational, speech/language therapists) must be reviewed and revised as needed.

3. Implement wage parity for home health aides and personal care aides. Making the home and community-based services system more efficient requires wage parity across personal care and home health aide occupations. Without parity, there is a lack of continuity of aide services

for clients who move between home care programs, unless the aide wishes to lose both wages and benefits. Moreover, any policy changes in home care that would shift clients into models that use home health aides will create disruption in the home attendant workforce and their economic status, particularly if there are reductions in hours.

Wages for all home care aides must be improved.

While parity must be New York's first priority in order to rationalize and stabilize its home care delivery system, parity alone is not enough. Wages for *all home care aides* must be improved if we are to build a long-term care workforce that can achieve the goal of quality home and community-based

care that is readily available to meet the needs of New York's growing population of elders and people with disabilities.

- 4. Ensure health coverage for caregivers.** Home care aides, like many low-income workers, either lack access to employer-based coverage or are offered coverage they cannot afford. The home care aide workforce has been shown to "churn" or "see-saw" on and off coverage depending on the hours worked, the hourly wage, and the size and income of their household. Under the new federal health reform law, there is no guarantee that these workers will in fact receive employer-sponsored coverage. In fact, as a result of the part-time and episodic employment of these workers, the home care aides are likely to remain a large portion of the population that is uninsured. Providing a public option for these workers—or concentrating the workforce in the employers who demonstrate a willingness to invest in the aides—are two potential solutions.

Conclusion

New York has supported the development of multiple home care programs. While each of these programs differs to some degree, *they all use home care aides*, and in fact, each of these programs is

It is time that the state look at the role that the aide plays and ensure that the aide is treated with the respect that she deserves.

primarily dependent upon aide services. It is time that the state take a hard look at the role that the aide plays and ensure that the aide is treated with the respect that she deserves.

Few individuals in the policy realm realize that for thousands of our citizens, it is the aide who travels to the drugstore to get their medications or takes them to their doctor appointment. She may be the one who rides in the ambulance to the hos-

pital and stays until a physician arrives. There are aides who work with clients who cannot speak and yet learn what is being communicated and what is needed. Recognizing the competency that is needed to deliver these services is essential in order to improve the quality of training as well as to ensure appropriate wages and opportunities to be recognized as "senior" or "advanced" within the field.

Advanced aides could play a larger role in management of chronic diseases. Care-transition initiatives have brought a variety of new models and approaches that have been shown to improve care. With families and informal caregivers finally receiving the attention that they deserve as active participants in the care equation, it is time to focus on the role of the aide.

Providing opportunities for aides to play a more integral role in care teams will ensure that this role provides greater value and efficiency.

Providing opportunities for aides to play a more integral role in care teams, and ensuring a good working relationship between the aide and the family caregiver, will ensure that this role provides greater value and efficiency across the health care system.

Perhaps the most difficult challenge for the state will be the need to address the aide workforce *simultaneously* from several fronts. A wage

increase will improve stability by reducing turnover. Improving training will create a better prepared worker. Concentrating funding in a smaller number of employers that invest in the worker will save money and also improve the workforce. If all of these things are done together, the home care system will begin to “right size” and turn towards the future, developing new ways to include the aide in support of better outcomes for the home care client.

Appendix A

Reforming New York's Home and Community-Based Service Delivery: Report on Focus Group Input

In addition to compiling a comprehensive overview of New York's home care aide workforce, this project sought input on how to improve the quality and efficiency of home care aide services. The United Hospital Fund hosted two focus group meetings with selected stakeholders in order to obtain their input on critical questions and promising practices. Two groups of home care providers were asked to read a draft of *New York's Home Care Aide Workforce—A Framing Paper* (hereinafter referred to as “the framing paper”) and participate in a two-hour dialogue related to how home care services might be positioned in the future and the role of the aide in delivering services.

The first focus group, which met on March 12, 2010, was composed of administrators and nurses of Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCs), and Medicaid Managed Long Term Care Plans (MMLTCLs). Some of the programs also operated hospices or were part of health care systems with a hospice. The second focus group met on March 19, 2010, and was composed of a group of leaders in the area of home care finance, reimbursement, and business models.

Every invited participant received a draft of the framing paper as well as PHI's fact sheet, “New York City's Home Care Workforce,” a chart comparing home health aide and home attendant wages and benefits, a set of workforce reporting elements recommended as a state minimum data set, and a set of draft discussion questions. All participants were promised anonymity with respect to their responses. Rick Surpin, chairman of the PHI Board of Directors, facilitated the discussion.

At the beginning of each focus group, the facilitator reviewed the purpose of the discussion:

- To discuss the challenges and trends that are affecting home care from a provider perspective;
- To explore how to improve the role and jobs of home health aides;
- To explore the ways in which home care may change, adapt and/or reposition for the future; and
- To explore how home care may fit into a more integrated health delivery system with different forms of reimbursement and fewer resources.

General Challenges

There was remarkable consistency between both focus groups in the identification of the general challenges to home care:

- Home care providers will need to perform in an environment with less money but increasing expenses.
- What aides do across systems of care is not consistent.
- The demand for service is outpacing the capacity of the professional and paraprofessional workforce.
- Acute care is pushing people into home care sicker and sooner.
- Stakeholders (e.g., the payers, unions) see care and services in silos.

- A “prudent purchaser” needs to be defined as an organization that has procurement standards related to care and the workforce rather than achieving the cheapest rate. The Medicaid Inspector General and the Attorney General’s Medicaid Fraud Control Unit need to adopt this definition.

Exploring the Opportunities for Advanced Aide Training and Competencies

When asked whether or not there were opportunities to train the home health aide to a higher level of competency, the focus groups made the following observations:

- Complex care is more difficult to deliver than routine care and would require a number of interventions with respect to the aide (e.g., uniform assessment tool to distinguish routine from complex care, additional training).
- The integration of the aide into the clinical care team requires money for additional training and the time to train as well as develop teams.
- If they are to be used in other roles, the titles as well as the training of home care aides need to be rationalized.
- The aide’s scope of work needs to be expanded. There are many health-related tasks that an advanced aide could perform; using aides in a broader capacity would increase overall productivity and minimize the costs to the system. Medication management is an example of a place where the aide could function differently. If the nurse pre-poured the medications, the aide should be able to administer to patients, even those who are not self-directing. The medication aide needs to be utilized throughout long-term care, not just in home care.
- Providers have the knowledge and ability to create a specialty aide (e.g., rehab aide), but the financing model that is based on an hourly payment deprives these aides of income. What’s needed is a daily rate, or to salary the aide, in order that she could cover several patients, and be paid for travel as well as visit time. The use of a specialty aide will also require a different supervisor, particularly with a model that is disease- or condition-specific.
- Home care will need a different operating context in order to utilize a clinically integrated team, with vertical as well as horizontal consolidation.
- More training in mental health is needed within the workforce.

Subcontracting and Quality

Participants were asked how the practice of subcontracting for aide services affected care and what role it played with respect to quality:

- There is a difference in quality among Licensed Home Care Service Agencies (LHCSAs).
- Determining quality and limiting the number of subcontracts requires some kind of scoring system in order to evaluate performance.
- Operating a LHCSA allows a contractor to have control over quality through the training.
- There is little duplication between what a LHCSA does and what a CHHA or other contracting agency does.
- The LHCSAs are more efficient at providing aide services than the CHHA would be.
- It’s a myth that there’s additional money in the LHCSA to be freed up.
- Subcontracting will continue as a means of obtaining geographic and cultural coverage.

Other Opportunities Identified Within Home Care for Cost Savings

In addition to the opportunities created through an advanced aide position, focus group participants discussed other ways in which paraprofessional services could be allocated for savings to the system:

- Scheduling aide services throughout the day rather than solely in the morning hours would be more efficient.
- There needs to be consolidation in the downstate market, some of which has already occurred, but there is still an opportunity for consolidation in the back office.
- Greater efficiency would be achieved if Medicaid didn't pay by the hour.
- There could be two separate payments for aide services—higher rates for chronic or expanded acute care.
- There's a need to overcome the mindset of scheduling aides for a block of time as opposed to the amount needed to perform specific tasks.
- We need a uniform assessment tool in order to standardize the assessment of individuals to determine if they might be better served elsewhere.
- There are economies of scale to be realized by concentrating the training in a select number of training programs. There are also economies by identifying the best training in cultural diversity and specialty areas.
- The Workforce Investment Boards should pay more attention to home care since they have additional dollars that could be invested in training. New York should do a demonstration that integrates the aide into the clinical care team to determine if there are savings through enlargement of the aide's job description.

Endnotes

- 1 Employment estimates and occupational projections data are from New York State Department of Labor (NYS DOL), Long-Term Occupational Employment Projections 2006-16, available at: <http://www.labor.ny.gov/stats/lproj.shtm>. Projection estimates include both growth and replacement needs.
- 2 Data presented by the NYS Department of Health to the Home Health Reimbursement Workgroup using cost reports for certified home health agencies indicates that 77.28 percent of the Medicaid visits in 2008 were home health aide visits.
- 3 PHI analysis of Statehealthfacts.org (sum of total 2006 Medicaid personal care, home health, and waiver participants, including MR/DD). This number does not account for home health aide services provided through Medicare for short-term rehabilitation.
- 4 2008 ACS, 1-Year Estimates, Selected Social Characteristics in the US. Accessed at: <http://www.census.gov/acs/www/>.
- 5 PHI analysis of US Census Interim Projections, Table 5 (Population Under 18 and 65 and Older: 2000, 2010, and 2030). Accessed at: <http://www.census.gov/population/www/projections/projectionsagesex.html>.
- 6 The State of Aging and Health in America, 2004. The CDC and Merck Institute of Aging and Health. Available at: http://www.cdc.gov/aging/pdf/State_of_Aging_and_Health_in_America_2004.pdf.
- 7 CRS Report for Congress (March 2007). Long Term Care: Consumers, Providers, Payers, and Programs. Accessed at: http://assets.opencrs.com/rpts/RL33919_20070315.pdf.
- 8 New York State Department of Labor (NYS DOL), Long-Term Occupational Projections 2006–2016, available at: <http://www.labor.state.ny.us/stats/demand.asp>.
- 9 Personal care aides, while not traditionally considered *healthcare support occupations*, are instead classified as *personal care and service occupations*. These occupational numbers likely include some of New York's 60,000 direct-care staff working with people with intellectual and developmental disabilities. (*Interim Report on an Update to the OMRDD Five Year Comprehensive Plan: 2006–2010*, available at: http://www.omr.state.ny.us/507plan/hp_507plan_interimreport.jsp.)
- 10 The metropolitan area of New York City includes the five boroughs of NYC, Westchester, Nassau, and Suffolk counties—although northern Westchester and the far end of Suffolk County have workforce challenges related to the lack of transportation.
- 11 The numbers cited do not include the “gray” market—privately hired home care aides who are not counted in official workforce surveys.
- 12 New York City is defined by the five-borough area consisting of: Richmond, Kings, Queens, Bronx and New York.
- 13 Employment estimates are for 2006 and are taken from the NYS Department of Labor (NYS DOL), Occupational Employment Statistics (OES) Program, available at: <http://www.labor.ny.gov/stats/demand.asp>.
- 14 New York regulations prohibit payment to a spouse, parent, child, son-in-law or daughter-in-law. These regulations exceed the federal prohibitions, which are limited to a relative who is “legally responsible” for the consumer.
- 15 In addition, the Expanded In-Home Services for the Elderly Program (EISEP) is planning to test the use of consumer direction among its recipients, which will add to the growth of the consumer-directed model. Emergency rule making passed September 9, 2010, allows the ten NY counties currently administering the CLP grant to implement Consumer Directed EISEP immediately; the formal rule making, which will allow Consumer Directed EISEP to be implemented statewide, should be effective by the end of the year or early 2011. In SFY 2008-09, EISEP provided in-home services to over 13,540 customers, according to the NY State Office for the Aging, available at: <http://www.aging.ny.gov/NYSOFA/Programs/CommunityBased/EISEP.cfm>.
- 16 Homemaker services may be ordered through the NYC Administration for Children's Services as a prevention service. In these circumstances, they are generally short-term while an investigation of neglect or abuse is going on. Child protective services or family court may also order homemaker services if it is suspected that parenting is sub-standard. A foster care agency may also request homemaker services for a family where a child is returning to a family from foster care. In addition, homemaker services are also ordered by the HIV/AIDS Services Administration for families where children need to be cared for as a result of HIV/AIDS illness.
- 17 The RN must have at least two years of experience in home health care or a combination of education and experience specified in regulation as well as at least one year of home health experience.
- 18 The New York State Department of Social Services was folded into DOH in 1996 (according to personal communication with Mark Kissinger, Deputy Commissioner, Office of Long Term Care, New York State Department of Health).
- 19 Sparer, Michael S. *Medicaid and the Limits of State Health Reform* (Philadelphia, Temple University Press, 1996), p. 107.
- 20 Over time, New York's home health aides also began to serve Medicaid clients in need of skilled care on a long-term basis.
- 21 New York Public Health Law, Section 3605, April 1, 1986 implementation.
- 22 All LHCSAs provide in-service training, but not all provide training for certification. (See section on training.)

New York's Home Care Aide Workforce

- 23 The state currently has a moratorium on the opening of new LHCSAs through October 2010. Long considered a small business opportunity, the state more recently determined that there is no demonstrated need for new agencies. Data on LHCSAs from New York State Department of Health, 2007.
- 24 18 NYCRR, Section 505.14(h)(7)(ii)(a)(6) establishing rate finding, repealed 1/1/95.
- 25 The Living Wage ordinances vary as to the contractors covered and the wage and benefit floors, but have been enacted in New York City, Westchester, Nassau and Suffolk counties, and the cities of Albany, Rochester, Buffalo and Syracuse. Oyster Bay also has a Living Wage but it only applies to janitorial and security staff.
- 26 BLS/OES, May 2009.
- 27 PHI analysis of three years of pooled data from the Current Population Survey, 2007-2009 ASEC Supplement.
- 28 The current average entry-level wage of \$8 an hour applies to those home health aides covered by the collective bargaining agreement.
- 29 SEIU, in a personal communication, cited 25 percent turnover for the LHCSAs paying the best wages and benefits.
- 30 U.S. Department of Labor, Bureau of Labor Statistics, *Issues in Labor Statistics* (1997). "Injuries to Caregivers Working in Patients' Homes," at: <http://www.bls.gov/opub/ils/pdf/opbi11.pdf>
- 31 Duffy, N. (2004) *Job tenure of frontline healthcare workers*. Working Paper 102. JFK Jr. Institute for Worker Education. City University of New York.
- 32 PHI (2009). *Health Insurance Coverage of New York State's Home Care Aides: Findings from a 2008 Survey of Home Care Agencies Outside of New York City*.
- 33 These caps must be eliminated under the federal Patient Protection and Affordable Care Act.
- 34 PHI (2009). *Is New York Prepared to Care? A Comprehensive Coverage Solution for Home Care Workers*.
- 35 The DOH updated its list of approved HHA training providers on September 1, 2010, and PCA training providers in August 2010; accessed on September 9, 2010 at http://www.health.state.ny.us/professionals/home_care/. Of the 157 agencies offering HHA training, 89 also offer PCA training at 242 sites. There are also 206 state programs licensed for "dual certification," which means that the training program has structured their curriculum to allow the trainee to complete PCA training and then take the additional 35-hour health-related task portion of the home health training. (The main limitation in the counting of these programs is the likely duplication across programs, which is often difficult to identify. In addition, although all these programs are licensed to offer PCA training, it doesn't mean that they consistently deliver this training; the same may be said for those agencies consistently providing PCA training and only licensed for HHA training. For more information, see *Preparing New York's Home Care Aides for the 21st Century: Overcoming Fragmentation, Inadequate Training, and Limited Quality Control*, which provides more detail on the training and credentialing system.
- 36 SED programs were updated August 2, 2010; accessed on September 9, 2010 at <http://www.aewd.nysed.gov/bpss/otheragencies/>. Of the 40 active proprietary agencies, 39 offer HHA training and 28 offer PCA training; however, although all these programs are licensed to offer PCA training or HHA training, it doesn't mean that they consistently deliver the training.
- 37 PHI (2006). *Adult Learner-Centered Training: An Introduction for Educators in Home and Residential Care* at: <http://phinational.org/training/resources/alct/>
- 38 Presentation of Heather Young, Director of the John A. Hartford Center for Geriatric Nursing Excellence and Director of the Rural Health Research Development at the Oregon Health Sciences University School of Nursing. Presented on three separate research studies of nurse delegation at the National Council of State Boards of Nursing Workshop on the Regulation of Nursing Assistants at the NCSBN Meeting, July 7, 2006.
- 39 Only a program-by-program analysis of allotment of ITGs would provide definitive data, and even then, it would vary from year to year depending on funding.
- 40 OMRDD and the Direct Support Workforce (October 2008): "Progress and Direction; A Report of the Activities Undertaken with the Technical Assistance from the National Direct Service Workforce Resource Center 2006–2008," at: http://www.omr.state.ny.us/wt/publications/wt_pub_year2finalreport.pdf
- 41 Differentials are paid for nights, week-ends, difficult-to-serve clients, language needs and certain geographic areas.
- 42 Medicaid Managed Long Term Care Plans, Long Term Home Health Care Programs, Program of All-Inclusive Care for the Elderly (PACE), TBI, Nursing Home Transition and Diversion.



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