Addressing the Crisis in the Long-term Care Workforce

Report and Findings of the Senate Committees on Aging, Health, and Labor

Senators Rachel May, Gustavo Rivera, and Jessica Ramos, Chairs

July 27, 2021

Table of Contents

A. Executive Summary 1

B. Key Findings 2

C. Facts and Figures About Long-Term Care in New York State 4

1. Demographics
2. Workforce Trends
3. Skilled Nursing Facilities (Nursing Homes)
    a. The Skilled Nursing Facility Workforce
    b. Impact of Staffing Shortage
    c. Impact of the Pandemic on Skilled Nursing Facilities
4. Assisted Living Facilities
5. Home Care
    a. The Home Care Model
    b. The Home Care Workforce
    c. Pandemic Impacts on Home Care
6. Family Caregivers

D. Stories from Witness Testimony 9

1. Workers
    a. Skilled Nursing Facility Workers
    b. Home Care Workers
2. Employers
    a. Skilled Nursing Facility Industry
    b. Assisted Living Industry
    c. Home Care Industry
3. Care Recipients, Family, and Advocates

E. Solutions 17

1. Pay and Benefits
2. Workforce Development and Career Advancement
    a. Training and Mentoring
    b. Opportunities for Advancement
    c. Other Incentives
3. Sustainable Financing and Support for Employers
4. Oversight and Quality Control in Skilled Nursing Facilities
5. Supporting Family Caregivers
6. Reforming the Long-Term Care System
7. Additional Research Needs

F. Witness List and Testimony 25

A. EXECUTIVE SUMMARY

Chairs and members of the Standing Committees on Aging, Health, and Labor of the New York State Senate received spoken and written testimony from stakeholders affected by the long-term care workforce shortage on July 27, 2021. The eight-hour hearing included more than forty witnesses, including front-line workers, care recipients and their family members, employee unions, managerial and clinical staff, professional and trade associations, senior advocacy groups and grassroots coalitions, legal and academic experts, operators of skilled nursing facilities and assisted living facilities, and home care providers. Fifty written documents were submitted in addition to spoken testimony highlighting the enormous impact of long-term care workforce challenges and offering solutions.

3.5 million New Yorkers are currently aged 65 or over, and this is by far the most rapidly growing segment of the population. Over half of people aged 65 and older will need some kind of long-term care in their lifetime, as well as over a million New Yorkers with disabilities, chronic illnesses, or other functional complications. The state's long-term care system is insufficient to meet the needs of New Yorkers now, and the problem gets worse each year. The COVID-19 pandemic has only exacerbated a workforce shortage that has been dire for many years.

Caregiving is the most rapidly growing industry in New York State, but it cannot keep pace with demand. The reason for the chronic shortage is clear: New York State has failed to make the needed investments to support a living wage and benefits for long-term care workers. Years of austerity measures, including an across-the-board cut at the outset of the pandemic, have squeezed the Medicaid budget to the point where reimbursements to providers do not cover costs, and wages have failed to keep up not only with inflation but with minimum wage standards and median pay in sectors that compete for the workers, like fast food.

We heard powerful stories from workers about inadequate pay and benefits, stressful working conditions, wage theft, inconsistent and unpredictable hours, and limited opportunities for career advancement. One witness admitted he had just come from working three back-to-back shifts, because that was the only way he could make ends meet.

We also heard compelling testimony from nursing homes and assisted living operators and home care agencies. One witness reported turnover rates as high as 94% in skilled nursing facilities, even before the pandemic. Others spoke to the issue of retroactive rate-setting by the Department of the Budget, whereby facilities and agencies would not learn their reimbursement rates for as much as a full year after they had hired the labor and provided the care. And they all had been stretched to the breaking point by pandemic-related costs and time-consuming protocols that further stressed their limited staff. High turnover among managerial staff made all the other stresses worse.

Care recipients, family members, and their advocates made emotional pleas for policy action to address the workforce shortage and high turnover rates. They stressed the need for reliable, consistent care as not only optimal for them but cost-efficient to the Medicaid budget, as it helps keep people out of emergency rooms or skilled nursing facilities unnecessarily. Without reliable home care, family members often have to leave their own jobs to care for a loved one, which further hurts the economy.

The good news is that a robust investment in the long-term care sector promises to yield excellent returns. The recent City University of New York (CUNY) report, "The Case for Public Investment in Higher Pay for NYS Home Care Workers," shows that investing $4 billion in a living wage for direct care workers results in a $7.6 billion return from savings to state and local budgets by lifting the workers off public assistance and keeping seniors in their homes, and increased tax revenue due to the higher wages and spending and more family members being able to work outside the home.

With new leadership at the state level and added resources from the Federal government and the recovering economy, New York State has an opportunity and an obligation to build a thriving caregiving economy. Every New Yorker has the right to live a healthy and independent life in the least restrictive setting. This report offers an analysis of ways the current system is broken or inadequate and a host of recommendations for action the state can take to invest in models of care that enable people to live safely and independently, reduce costs and unnecessary hospitalizations, and provide a living wage and economic security to long-term care workers.

B. KEY FINDINGS

1. Workers

For workers, the most pressing issue is **inadequate pay and lack of benefits** *(see section D.1.).* Many workers rely on public assistance and lack health insurance despite working full-time or multiple jobs. Other worker issues include:

- Stressful, complex, and high-risk work environments. Compensation does not reflect the skill and occupational risk associated with their roles, and higher wages and hazard pay are warranted.
- Failure to receive full pay for all hours worked. The "24-hour rule" allows workers to be paid for only 13 hours in a 24-hour shift. We also heard reports of wage theft.
- Gaps in employment after a client dies or is hospitalized, resulting in inconsistent hours and fluctuating income.
- A lack of opportunities for career advancement, promotions or raises.
- Excessive caseloads and understaffing in skilled nursing facilities.
- Women, people of color, and immigrants make up the majority of this workforce, so addressing long-term care workforce issues will support gender and racial equity.

2. Employers

For employers, the key issue is **New York State's low Medicaid reimbursement rates** *(see section D.2))*

- New York State Medicaid reimbursement falls well below the cost to provide long-term care.
- Inadequate reimbursement has reduced providers' ability to offer higher wages for direct care workers. While long-term care worker wages remain at or near minimum wage, wages have increased in other sectors such as fast food that compete with the long-term care sector for workers.
- Responsible budgeting is extremely challenging, as the Medicaid reimbursement rate is set retroactively, sometimes a year late.
- Staffing shortages in home care agencies mean they must turn away as many as 30% of new cases.
- High turnover is costly and time-consuming. Average staff turnover in 2017 and 2018 was 94%; many nursing homes exceed 100% turnover in a one-year period. This requires rehiring and training the entire direct care workforce, including CNAs, LPNs and RNs.
- Many providers reported difficulty retaining managers due to the challenges of navigating shifting COVID-19 guidance, burdensome reporting requirements, and strict enforcement of fines for bureaucratic issues.

3. Care Recipients, Family, and Patient Advocates

For families and patient/resident advocates, the key issue is **the need for consistent, reliable care with low turnover** (see section D.3.)

- Consistency of care is instrumental to care recipients' health, quality of life, and independent living, and services.
- The need to find or recruit new caregivers is time-consuming and highly stressful for care recipients and family members.
- Inadequate home care services resulted in preventable health crises for individuals and produced strain for family members required to balance their job or school responsibilities with intensive caregiving roles.
- High turnover among long-term care workers impedes effective communication and collaboration with families.

- Underpaid home care workers are more likely to miss shifts due to transportation or child care issues.
- The fact that many home care workers have to work multiple jobs means they are more likely to contract COVID-19 or other illness and pass on the infection to their clients.
- The Consumer-Directed Personal Assistance Program (CDPAP) is a valuable and effective model for staffing home care
- Training guidelines for long-term care workers are outdated and inconsistent; they do not meet Core Competencies developed by CMS for the direct care workforce.
- Foreign language skills and cultural competencies are needed for long-term care workers to best serve diverse populations across the state.
- The Long-Term Care Ombudsman Program is an important tool for residents and families to register complaints about care at skilled nursing facilities, but it is primarily staffed by a dwindling number of volunteers and needs greater visibility.

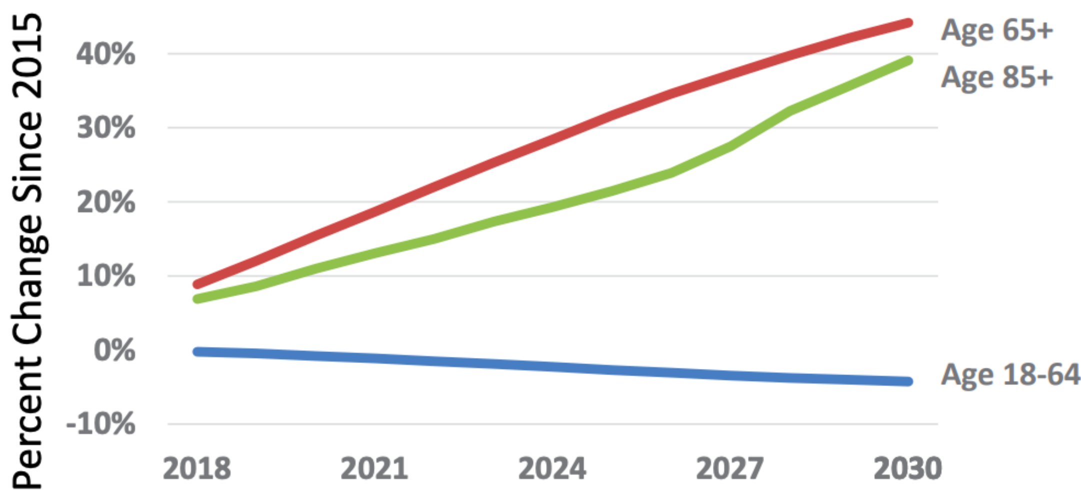
C. Facts and Figures About Long-Term Care in New York State

1. Demographics

Over 3.5 million adults aged 65 and older, representing 16 percent of our state's population, make New York their home. The oldest members of the Baby Boom generation are now in their 70s; they will soon reach their 80s, when long-term care needs become more common. Between 2015 and 2040, the number of New Yorkers aged 65 and over is projected to increase by 50 percent, while the population aged 85 and older is projected to more than double. Over half of people aged 65 and older will need some kind of long-term care in their lifetime, as well as over a million New Yorkers with disabilities, chronic illnesses, or other functional complications.

As New York's older adult population grows, projections indicate that the state's working-age population (ages 18 to 64) will decline, reducing the potential workforce available to care for an expanding older adult population. By 2040, the number of working-age adults for every state resident 65 or older will decline from 4 to 3, and the number of working-age New Yorkers per resident 85 or older will go from 29 to 15. According to Ami Schnauber of LeadingAge NY, these demographic trends will magnify existing shortages of working-age adults to provide both paid long-term care and unpaid family care to address the care needs of an aging population.

Figure 1 - Percent Change in New York Population by Age Group



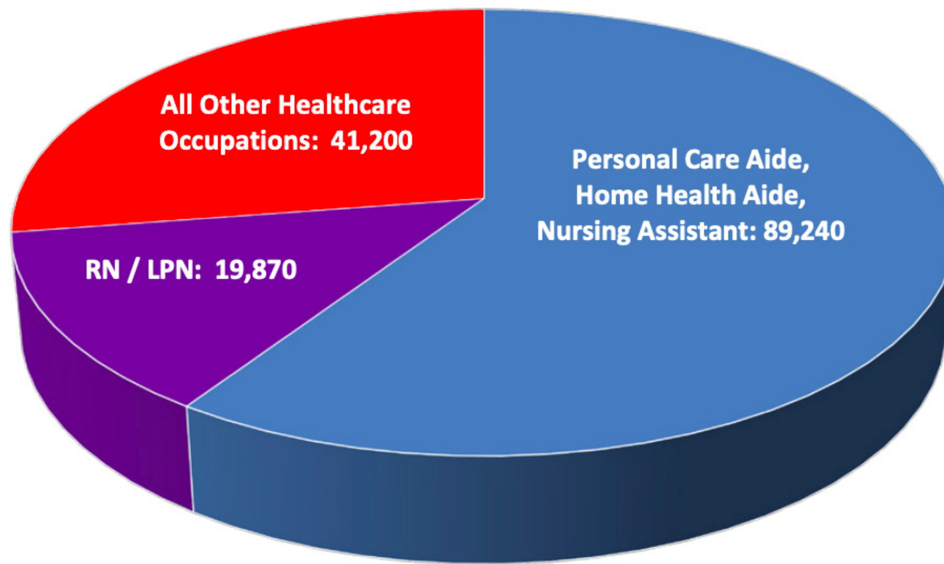
Source: LeadingAge NY testimony

2. Workforce Trends

Health care job growth in New York State exceeds job growth in every other sector. Most new health care jobs are in long-term care, according to testimony from LeadingAge and a 2018 report by the SUNY Albany Center for Health Workforce Studies. Of the 150,000 health care job openings anticipated annually, 89,000 (60 percent) are for personal care aides (PCAs), home health aides (HHAs), and nursing assistants (Figure 2, LeadingAge). Between 2016 and 2026, annual openings for HHAs and PCAs are projected to grow by 52 percent and 41 percent respectively, while openings for registered nurses (RNs) are projected to grow by 20 percent and for nurse aides by 16 percent.

The supply of workers has fallen so far below demand that skilled nursing facilities, assisted living facilities, home care agencies, and hospice programs are frequently unable to fill existing job openings. Workforce shortages present challenges for the stability of the long-term care sector, increase stress on workers, and have resulted in preventable health crises and injuries and intolerable living conditions for older adults in need of care.

Figure 2 - New York State Department of Labor Employment Projections



Source: LeadingAge NY testimony. Data from New York State Department of Labor Employment Projections

3. Skilled Nursing Facilities (Nursing Homes)

New York's 619 skilled nursing facilities serve 109,000 residents. Over the past decade, the share of skilled nursing facilities run by counties or not-for-profit mission-driven organizations has declined. More than 65% of facilities are currently owned and operated by for-profit companies. In New York State in 2017, Medicaid reimbursement rates are $243.33 per resident per day for skilled nursing facilities, while the actual cost of providing care is $307.51, resulting in a shortfall of $64.18 per resident per day, according to a report commissioned by the American Health Care Association. Compounded, this adds to a $1.5 billion dollar shortfall for facilities across the state (for 2017), the greatest loss compared to 28 states surveyed. Over 70% of New York's skilled nursing facility resident care is paid for through Medicaid.

<u>a. The Skilled Nursing Facility Workforce</u>

Skilled nursing facility workers often do not receive benefits, and low wages mean that 36% of nursing home workers qualify for public assistance. Also, relative to the typical U.S. worker, nursing assistants are three times more likely to be injured on the job. When workers take time off due to their injuries, 63% do not receive pay while they are away from work.

Jim Clancy of the Healthcare Association of New York State (HANYS) testified that even before the pandemic, turnover rates in skilled nursing facilities were as high as 94%. A published report by Gandhi, et al., indicates that this number includes average turnover rates exceeding 100% across the three most common direct care nursing home providers: registered nurses (140.7%), certified nursing aides (129.1%) and licensed practical nurses (114.1%). Grace Bognadove of 1199SEIU reported that turnover of Certified Nurse Aides (CNAs) in a typical nursing home in New York State was 25 percent, but regional median turnover rates vary from a low of 9 percent in New York City to a high of 52 percent in the Buffalo region. She also noted that skilled nursing facilities with the highest median turnover rates had the lowest CMS overall star ratings, while turnover was lowest at highest-rated facilities. High turnover is costly to the facilities and a threat to continuity of care for residents.

Nursing assistant graduation rates in New York have decreased in recent years, contributing to a shortage of qualified workers. Nursing homes across New York State reported the greatest difficulty recruiting experienced registered nurses (RNs),

and the greatest difficulty retaining certified nurse aides (CNAs), newly licensed RNs, and licensed practical nurses (LPNs), according to a 2018 Center for Health Workforce Studies (CHWS) report. The median age of working nurses is rising, and a growing number of nurses retiring in the coming years is expected to exacerbate already severe workforce shortages. Low wages and poor working conditions are the leading factors the CHWS report identified as contributing to recruitment and retention issues for CNAs and LPNs.

b. Impact of Staffing Shortages

According to the New York State Nursing Association (NYSNA) testimony, there is a direct correlation between poor staffing and higher death rates for skilled nursing facility residents. Mortality rates were 44% higher in nursing homes with poor staffing, according to the 2021 Attorney General's report. Federal law requires nursing home inspections at a minimum of every 15 months with an overall average every 12 months. While facilities with violations receive more frequent inspections, gaps between inspections often last for months, leaving vulnerable residents subject to inconsistent or inadequate care in facilities with chronic violations. Accorda ing to NYSNA, while 67% of nursing homes currently are operated by for-profit providers, not-for-profit nursing homes make up 88% of the highest rated, 5-star facilities, while the for-profits account for 81% of the lowest rated (1 and 2 star) facilities.

Recent legislation in New York requires skilled nursing facilities to direct a minimum of 70% of their revenue toward direct resident care and to provide a minimum of 3.5 hours of nursing care per resident (S.6346 [Rivera]). Advocates argue that 4.1 hours is the minimum standard recommended by the federal government and falls short of the amount of care required. While many facilities satisfied these minimum standards at the time the legislation was enacted in April 2021, witnesses expressed concern about the continued ability of skilled nursing facilities to staff up to these levels, given worsening workforce shortages.

c. Impact of the Pandemic on Skilled Nursing Facilities

The COVID-19 crisis took a devastating toll on skilled nursing facility residents and staff. An estimated 14,000 residents in New York died from the virus. Not only did the virus target older adults and those with weakened immune systems, it also affected many nursing home workers, causing staffing disruptions, shortages, and burnout among those who were able to work. The pandemic also cost many workers their lives and losing co-workers to COVID-19 also led many skilled nursing facility workers to leave the workforce to protect their health. Skilled nursing facilities faced additional challenges that strained both staff time and the bottom line: rapidly changing and often unclear guidance from DOH on infection control, development and implementation of new protocols, increased reporting procedures, the need to secure and provide PPE, and providing additional training to support the ongoing changes. The fact that DOH was not reporting accurate data about nursing home fatalities, and that this became a highly charged political issue, also increased the stress on skilled nursing facility operators, staff, residents, and families.

4. Assisted Living Facilities

Assisted Living Facilities are non-medical residential communities for older adults who need some care for activities of daily living (ADLs). There are currently 547 Assisted Living Facilities serving more than 50,000 older adults in New York State. Assisted Living Facilities rely on what is often referred to as "private pay," or self-pay for long-term care services. Many families utilize their life savings to maintain a place for their loved one to live safely. While Assisted Living Facilities are less impacted by Medicaid caps, they did not receive any of the relief funds provided to skilled nursing facilities despite the high costs of ongoing pandemic-related expenses.

5. Home Care

The vast majority of older adults prefer to age in place rather than in an institutional setting, as long as there is a support system in place to assist with any everyday activities that are challenging. Aging in place is also normally far less costly than in an institution, both to the individual or family, and to taxpayers, who foot the bill for Medicaid, which covers most skilled nursing facility residents. "With the demand for homecare increasing, and with the nursing home crisis that escalated during the pandemic, it is clear that the home care model should be preserved and elevated if New York is to remain dedicated to healthy aging and keeping older adults in their communities," said Tara Klein of United Neighborhood Houses.

a. The Home Care Model

Home care workers provide assistance to address a wide range of support needs. These range from relatively low-intensity support for "independent activities of daily living" such as cooking and shopping, to more intensive support for "activities of daily living" such as bathing and toileting. Some

home care worker roles provide in-home skilled nursing services for medically complex patients requiring a tracheostomy tube or ventilator care. Health impacts of a shortage of home care workers include increasing the risk of injury, malnutrition, and preventable hospitalizations. Home health care is especially important for immigrant seniors and families because language-accessible and culturally competent home care options are available, while these options are lacking in institutional settings, as Carlyn Cowen from Chinese American Planning Council (CPC) discussed.

New York's home care sector is made up of a variety of organizational models. These include certified home health agencies (CHHAs); licensed home care services agencies (LHCSAs); hospices; Programs of All-Inclusive Care for the Elderly (PACE); long term home health care programs (LTHHCPs); consumer directed personal assistance program fiscal intermediaries (CDPAP FIs), independent living centers, and community support organizations, among others. The Expanded In-home Services for the Elderly program (EISEP), administered by the New York State Office For Aging (NYSOFA) via the state's county-based Area Agencies on Aging, supports non-medical in-home services for older adults who want to remain at home but who need help with everyday activities and do not qualify for Medicaid. Managed Long Term Care (MLTC) plans are insurance plans that are paid a monthly premium by the New York State Medicaid program to approve and provide home care and other long term care services. Services may include nutrition, meals, physical therapy, medical equipment and/or transportation, depending upon the specific services authorized for an individual.

Medicaid is the primary funder for home care services in New York state, representing 87% of home care and personal care services. Many non-profit home care programs are 100% Medicaid funded.

b. The Home Care Workforce

New York has 250,000-400,000 home care workers and 530,000 direct care workers, according to testimony from Al Cardillo of the Home Care Association of New York State and Hannah Diamond of PHI. About 100,000 new home care workers are needed each year, including about 27,000 to meet rising demand and 72,000 to replace departing workers. Ilana Berger of the Caring Majority Panel noted that the number of exits from home care far exceed those in any other sector. Tara Klein from United Neighborhood Houses said 33% growth in the home care sector was expected by 2025, and Bryan O'Malley from the Consumer Directed Personal Assistance Association of NYS said a recent report from Mercer Consulting predicted a shortage of over 83,000 home care workers in New York by 2025.

Data from the U.S Census Bureau and the Bureau of Labor Statistics indicate that nine in ten homecare workers are women, more than half are persons of color, the median age is 45, and 39% earn below 200% of the federal poverty line. Mr. Cardillo estimated a poverty rate closer to 50%. According to LiveOn NY's testimony, New York's home care workers' median annual salary is only $22,000, while the median salary for fast food workers has grown to $24,429. Over one in seven low-wage workers in New York City is a home care worker, one in four workers live below the federal poverty line, and more than half rely on public assistance. Home care workers who have the advantage of being in a union typically have health insurance, but one in five are uninsured. Many homecare workers also lack access to reliable transportation and childcare, resulting in difficulty accessing clients and responding to unpredictable schedule changes.

An October 2020 survey of home care and hospice providers conducted by the Home Care Association found that 85% of agencies reported structural workforce shortages, especially among nurses and health and personal care aides. Dana Arnone of Reliance Home Senior Services discussed findings of a recent statewide survey of home health-care agencies, which found that 23% positions were left unfilled due to staff shortages, meaning that agencies were unable to accept nearly 30% of new cases.

c. Pandemic Impacts on Home Care

The COVID-19 pandemic accelerated the rebalancing of services from skilled nursing facilities to the community that was already underway prior to the pandemic. The increase in demand for home care services coincided with unprecedented workforce challenges in the home care sector, as many home care workers left the workforce due to COVID-related parental/family responsibilities, or their own COVID-19 illness or exposure and isolation requirements. The result has been a significant gap between need for services and available workforce supply, with negative impacts on clients, families, workers, and providers. However, severe home care workforce shortages were projected before COVID-related workforce disruptions and increases in demand.

During the pandemic, home care providers received a rising number of referrals for more complex, intensive and earlier discharges from hospitals. Several providers described facing obstacles to admitting patients authorized and approved for home care due to workforce shortages. Al Cardillo from the Home Care Association of NYS reported that 65% of the state's home care agencies saw an increase in referrals to home care during the pandemic, and 76% of agencies reported challenges in accepting these new referrals.

6. Family caregivers

According to testimony from Maggie Ornstein of New York Caring Majority, as many as 10% of family caregivers leave the workforce in order to provide care at some point in their careers. An AARP report on New York's family caregivers estimated that in 2017 there were 2.5 million unpaid caregivers in the state, providing an estimated value of $31 million annually. Many women left the workforce during the pandemic to provide care for young and old family members due to reduced access to home care and childcare services, both reducing economic activity and widening gender inequality.

D. Stories from Witness Testimony

1. Workers

> *"The work is undervalued and underpaid, and it creates hardship for the aides who stick with the work and makes it harder to find new workers."* Lilieth Clacken, home health aide

Despite the fact that long-term care is the most rapidly growing industry in New York State, chronic underinvestment has resulted in a diminished and undervalued long-term care workforce, with negative impacts for millions of New Yorkers such as inadequate care options and lower-quality care for those that do receive services. Inadequate pay and benefits are the most pressing issues for long-term care workers. Long-term care workers described wages insufficient to cover basic living expenses. Many direct care workers rely on public assistance and lack health insurance despite working full time. Workers report feeling ill-equipped for a demanding, volatile workplace. High-risk work environments, stressful working conditions, inconsistent hours, and limited opportunities for advancement are chronic challenges. The staff that have remained working at the facilities are now being asked to do more jobs and duties than one person can accomplish. They are overworked, burnt out, and stressed, according to written testimony from Rhonda Butler of Interfaith Works.

a. Skilled Nursing Facility Workers

> *"So instead of a worker shortage, the reality is that inadequate pay and benefits, poor working conditions, and the inability to have a seat at the table on matters concerning resident care are driving caregivers from the bed-side."* Grace Bogdanove, 1199 SEIU

Pay inequities: In their testimony, skilled nursing facility workers repeatedly expressed a passion for their work, knowing that it provides a valuable, much-needed service to support the health and wellbeing of facility residents. Workers who testified implored legislators to acknowledge the complexity of the work and support a system which would pay long-term care workers accordingly. William Roe, who left a job as a stockbroker on Wall Street after the 9/11 attack to go into nursing care, said,

> "Dignity can't be paid. It cannot. Can't pay for my dignity. But you can meet it with a proper wage. You can meet it with proper PPE equipment. You can meet it with respect and dignity... We have to pay workers a wage that recognizes the dignity and importance of the work we do every day. If we can keep them safe and pay them the wages that reflect the importance of the work, they will come into the facility."

As nursing home workers are predominantly female and racial/ethnic minorities, the poor working conditions and inadequate pay for skilled nursing facility workers perpetuate long-standing gender and racial/ethnic inequities. Workers described the exhaustion and demoralization of intense work demands coupled with the financial stress of low wages. As Tonya Blackshear, nursing home worker, put it,

> "I know it takes a special person to work in a nursing home. But it shouldn't just be that way. Employers need to value the work we do. Employers have to start paying wages that are well above fast food if they want to keep people who are coming in the door."

Several skilled nursing facility workers discussed the complexity of skilled nursing facility residents' medical issues and the skill required to manage resident treatment to maintain and improve health. While skilled nursing care is intensive and requires skill and time to manage all the psycho-social, emotional and medical variables involved in supporting residents' holistic needs, Medicaid reimbursement rates are not scaled to the level of skill required. Deirdre Gilkes of the New York State Nurses Association described that the acuity of patient needs in facilities far exceeded the capacity of nursing staff, though she noted facilities were not attuned to the impact of patient acuity on nursing workload. She described, ***"it's a disaster waiting to happen... we are burnt out, the nurses. But the acuity is much higher. You know, we need more staff."***

Many noted the higher minimum wage for fast food workers as a discouragement to continuing with long-term care work. Some reported that they themselves lacked health insurance. The pandemic led many managerial staff and direct care workers to retire early or change careers, resulting in knowledge gaps and excessive burdens on the remaining staff. Workers also emphasized that low wages for skilled nursing facility workers likely did little to produce meaningful savings in the overall cost of care, as facilities use temp agencies to recruit workers to fill staffing gaps when positions remain unfilled, and staff sourced from these agencies are paid significantly more than the prevailing wage. Seeing facilities pay excessively for staffing through temp agencies at the same time as denying workers modest raises added to workers' frustrations.

Job hazards: Nursing home and assisted living facility workers have an increased risk for injury compared to other direct care workers because they are constantly on their feet, responsible for many residents at a time, and often called upon to move, turn, or lift those in their care.

When skilled nursing facilities have too few workers serving residents with complex care needs, quality of care suffers and the consequences can be deadly. As Deidre Gilkes from New York State Nurses Association described, skilled nursing facilities' staffing ratios are directly correlated with quality of care, and cuts in Medicaid funding and state reimbursement rates are therefore directly responsible for worsening quality of care in New York skilled nursing facilities. She also noted that the lack of registered nurses made it difficult or impossible for skilled nursing facilities to implement effective infection control, contributing to the extremely high COVID-19 impacts on New York's nursing home population.

Pandemic impacts: Several workers described their fears related to COVID-19. ***"When workers saw their co-workers get sick or die, many left. And today they are still afraid to come back, particularly with all the news of the Delta variant,"*** said William Roe, a NYC nursing home worker. Dr. Dallas Nelson of the New York Medical Directors Association noted that the rate of deaths among skilled nursing facility workers during the pandemic made it one of the most dangerous jobs in America. Adding insult to injury, most long-term care workers did not receive hazard pay or "hero pay" made available to other health-care providers who worked during COVID-19 response. One worker described receiving a t-shirt and a pen as a thank you for continuing to work throughout the pandemic, noting that more substantive support and compensation were warranted, given the health risks and sacrifices of front-line workers in nursing homes. The issue of chronic lack of childcare access was a problem for skilled nursing facility workers pre-pandemic and was exacerbated due to COVID-19 school closures.

b. Home Care Workers

> *"We can't be forced to always search for more hours to get a paycheck big enough to take care of our needs. We can't be forced to work for agencies that provide no health benefits. We shouldn't have to look at our paycheck every two weeks to see if the agency is paying us correctly. We're human beings taking care of human beings."* Jason Brooks, home health aide
>
> *"Home care work is one of the nation's fastest-growing occupations, yet pay, benefits and working conditions remain exploitative."* Jeanette Zoeckler (Upstate Occupational Health Clinical Center)

Witnesses repeatedly emphasized that chronic low wages are the cause of the home care workforce shortage. While home care workers made 150% of NY state minimum wage in 2006, wages have stagnated and today they make minimum wage or slightly higher, often earning less than fast food and retail employees while performing skilled and emotionally intensive work.

Workers indicated that receiving a living wage would enable them to transition off of public assistance programs, therefore reducing strain on state budgets. In addition to low pay, workers frequently reported being underpaid by agencies for the hours they worked and having to fight to be fairly compensated. Given that 90% of the home care workforce are women and 60% belong to a racial or ethnic minority group, the devaluation of care work embodied by home care workers' low wages is also a racial and gender equity issue.

In addition to low wages, home care workers face additional financial challenges due to inconsistent schedules, part-time hours, and a lack of advancement opportunities. As many consumers are only authorized to receive care for a few hours a day, workers often travel between multiple clients in a day to get full-time hours. Home health aide Jason Brooks described the difficulty that arose when a long-time client would die or go into the hospital, and he would suddenly be out of work until a new client was assigned to him. He added that, as a male, he was sometimes harder to place with new clients, which could lead to even longer gaps in employment. Home care workers are also twice as likely to be uninsured compared to the overall population. Mr. Brooks said, ***"It's been a struggle for six years for me. I've worked for a lot of agencies, and all of them, non-union. ... I've never had health insurance through my job in all these years. Really, it's just hard to get."***

Several witnesses focused on the "24 hour rule," in which home care workers work 24 hour shifts to support clients with round the clock care needs, but are paid for only 13 hours of work. Carlyn Cowen of CPC provided an in-depth analysis of the issue, and described a 2019 New York state court ruling determining that if a home care worker receives less than five hours of uninterrupted sleep, then the home care agency must compensate the attendant for the full 24 hours. Workers emphasized that uninterrupted breaks and sleeping hours were not possible when clients required care through the night, and that working 24 hour shifts was harmful to workers' health and family relationships. Mary Lister from the Ain't I a Woman campaign noted that worker mistakes are more likely when shifts are longer than 12 hours, and continuing to require 24 hour shifts could result in mistakes that harm the client or cause an injury to the worker themselves.

In many parts of the state, workers are expected to have reliable transportation to access clients' homes. However, workers often are not reimbursed for time on the road, and many workers must travel between multiple clients daily, which is stressful and costly for workers. In rural areas this is especially challenging given long travel times between clients.

Workers report feeling that they lacked the skills necessary for the intensity of the work while expressing an eagerness to learn if more learning opportunities were made available through employer-provided programs. Training practices described were static and requirement-driven rather than dynamic and ongoing, and in some cases training was provided exclusively online. The desire for coaching from an experienced staff member was expressed to build skills and confidence in the work environment.

Pandemic impacts:

> *"The agency I worked for never provided us with PPE. We had to buy our own masks, gloves, and even gowns... Right now I'm getting ready to go back to work, but I'm still terrified of getting sick. I feel the agencies we work for need to do a better job of taking care of the workers and the clients."* Martha Davila, home care worker

Lilieth Clacken of 1199SEIU United Healthcare Workers East described the experience of home care workers during COVID-19, saying, "There are lots of reasons why home care workers left during the pandemic, but the biggest reason is the pay did not justify the risks they faced. Fortunately, most stayed because they are incredibly dedicated to the people they care for." Sadly,

Martha Davila described contracting COVID-19 after her agency Preferred Home Care sent her to a client's home without informing her the client was sick. The agency pressured her to continue working when she was sick and failed to provide workers with any PPE. She was severely sick with COVID and was still recovering and unable to work six months later. Both she and Jason Brooks described lacking health insurance, working under very stressful conditions, and consistently being underpaid by their agencies. Martha Davila described her experience, saying, "It was a miracle if my paycheck was ever correct. It was always missing days and hours and I always had to push to get my full hours paid. This happened to most of the aides at this agency."

2. Employers

a. Skilled Nursing Facility Industry

Nursing home operators expressed deep concern about the difficulty of recruiting and retaining staff. High staff turnover, they pointed out, has adverse effects on the health and safety of staff and residents. This results in missed opportunities to notice and address changes in residents' health before health issues escalate and are more difficult and costly to address. Grace Bogdanove from 1199SEIU cited the direct cost of turnover for a nurse aide as at least $2,500. She also noted that high turnover is associated with higher injury-related medical costs for workers and increased healthcare costs for residents due to poorly managed health issues, so the true cost of skilled nursing facility staff turnover is likely much higher.

Rather than working as a smooth health-care continuum, long-term care providers described themselves as in competition with hospitals and medical practices for workers. Long-term care providers rely heavily on Medicaid funding, in contrast with hospitals whose patients are mostly covered by Medicare and private insurance. As a result, hospitals have more resources and are better able to attract and retain skilled workers than long-term care providers. This resource imbalance creates a gap in the long-term care component of the health delivery system evidenced by worker shortages, low morale, and extremely high turnover.

According to Jim Clancy of the Healthcare Association of New York State (HANYS), roughly two-thirds of private and non-profit skilled nursing facilities are delivering care on negative operating margins, and the median operating margin in these homes is negative 2.9 percent. Sarah Daly of LeadingAge NY testified that since the beginning of the COVID-19 pandemic, a number of LeadingAge's non-profit nursing homes across the state have closed or are for sale due to the continuing financial stresses of the pandemic and rising staffing costs. Roxanne Tena-Nelson of the Greater New York Hospital Association also reported that loss of non-profit long-term care providers is a growing concern for New York, and in recent years there has been an annual loss of nearly 5% of the state's non-profit nursing homes.

Workforce recruitment and training: Individuals who testified stressed the importance of a well-functioning long-term care sector as a critical component of the health delivery system. Dr. Dallas Nelson of the New York State Medical Directors Association discussed a need for more geriatrics specialists to provide quality and person-centered health care to older patients. The long-term care sector has become increasingly strained due to funding issues and worker shortages across all levels of care, including skilled nursing, assisted living and home care services. Gaps in one area of service availability put stress on the entire system, ultimately resulting in costly and preventable hospitalizations for individuals who lack access to high-quality long-term care to support their health and autonomy.

A lack of career ladders, programs to begin equipping future workers in high school with apprenticeships, and ongoing workforce development for the long-term care workforce was voiced throughout the hearing. Doris Fischer of HANYS discussed the need for apprenticeship and career-ladder programs, saying "the key difference between a job at McDonald's and a job at a nursing home should be a career; that you are beginning a career. And so we believe that we need to build that infrastructure."

One particular issue the operators noted relates to the training of certified nurse assistants (CNAs). Dr. Tara Cortes of the Hartford Institute for Geriatric Nursing provided written testimony that the minimum training standards for CNAs were established in 1987. Over the past 34 years resident complexity has increased dramatically without changes to the amount or type of training required. CNAs are typically trained at skilled nursing facilities, who then draw on their CNA classes to staff the

facility. Industry witnesses described that facilities facing sanctions or penalties from DOH are not allowed to hold CNA training. This restriction on training impairs their ability to equip new workers and makes it difficult for facilities to address the underlying problems for which they were cited, and a mechanism for these facilities to reach appropriate staffing levels is needed.

Witnesses made it clear that providers are looking to the legislature for solutions to long-term care workforce issues that have historically received minimal attention from policymakers. The word "crisis" was spoken during the LTC workforce hearing forty-nine times. In addition, the need for a more collaborative relationship between providers and the Department of Health (DOH) was mentioned by several witnesses.

Oversight: Several witnesses expressed doubt as to the Department of Health's ability to hold chronically poor-performing skilled nursing facilities accountable and preserve resident's rights and safety. Heckler (CELJ) suggested that residents of poorly performing facilities should be given priority on waiting lists for better-performing facilities. Some witnesses indicated that fines for violations at skilled nursing facilities were often insufficient to change behavior, and management simply considered these fines part of the cost of doing business.

Pandemic impacts: Staff and financial losses in nursing homes and assisted living facilities have been greater during the pandemic due to additional unreimbursed costs. These additional costs include procuring personal protective equipment, COVID-19 testing for residents and staff, enhanced cleaning protocols, additional reporting requirements, and the cost of recruiting and training staff who have left the workforce out of fear of contracting COVID-19. Industry testimony also described frustration with the Department of Health, describing a lack of responsiveness and clarification when seeking guidance, and a desire for a supportive working relationship with the Department.

b. Assisted Living Industry

Assisted Living facilities have needed additional staff to meet infection control protocols established by New York State. Staff are required to continue to follow COVID-19 safety protocols, ensure proper visitation, and to conduct health screenings for every person who enters a facility. These staffing increases have resulted in higher unreimbursed overtime costs for Assisted Living Facilities. Sarah Daly from LeadingAge noted that Enhanced Assisted Living Facilities have the option to assist a resident with self-medication but do not have a Medication Technician (Med Tech) role. The Office for People With Developmental Disabilities (OPWDD) has Med Techs in their settings, and Daly suggested that the Med Tech role has been tested in other states successfully and has the potential to alleviate some of the workload of LPN and RNs in Assisted Living facilities. Insufficient training course availability slows down assisted living facilities' ability to prepare potential new workers. According to Lisa Newcomb of Empire State Association of Assisted Living (ESAAL), ***"there is an extreme shortage of training programs for certified home health aides and personal care aides,"*** creating additional strain on the existing workforce.

c. Home Care Industry

Home care providers and associations universally pointed to inadequate Medicaid reimbursement rates underlying lower wages for home care workers and perpetuating the workforce shortage. Nonprofit agencies are particularly beholden to Medicaid rates and negatively impacted by inadequate reimbursement and unfunded regulatory mandates, as Tara Klein of United Neighborhood Houses and Carlyn Cowen of CPC discussed in their testimony. While several agencies testified in support of raising the minimum wage for home care workers, they heavily emphasized that raising the minimum wage without corresponding increases in Medicaid reimbursement would create a gap between expenses and reimbursements that hurts both providers and workers. Adria Powell of Cooperative Home Care Associates explained, ***"for the home care sector overall, these restrictive policies fuel staff shortages, prolong HCBS waitlists, undermine the capacity of the workforce to meet clients' increasingly complex care needs, and ultimately compromise care quality."***

Medicaid long-term care reimbursement rates have stagnated for over a decade. This trend is the result of the elimination of adjustments for inflation in Medicaid rates, cuts by the Medicaid Redesign Team (MRT and MRT II) including over $1 billion in cuts during the COVID-19 pandemic, and the 2011 introduction of the Medicaid Global Spending Cap which caps the annual percentage growth of the state's Medicaid spending and does not allow spending to respond to the growing number of people

supported by Medicaid. Medicaid does not adequately account for home care costs when setting rates for Managed Long Term Care Plans, which leads Managed Long-term Care Plans to inadequately reimburse home care agencies to cover their costs.

Inadequate Medicaid reimbursement produces pressure for agencies to reduce costs by paying minimum wage and offering few if any benefits for home care workers. Home care agencies discussed an increase in labor costs in recent years, citing local minimum wage, Fair Labor Standards Act Final Rule, wage parity law, overtime and sick pay, new technology and PPE during COVID as reasons for rising costs and a need for increased Medicaid support to cover them. High overtime costs that agencies pay due to worker shortages are especially challenging for small agencies, as Medicaid reimbursements do not support overtime pay, as Dana Arnone of Reliance Home Senior Services described.

Providers also discussed the high cost of staff turnover for agencies: ARISE estimated that the cost of onboarding new staff ranges between $4,000-$6,000, meaning that the 30% annual turnover the agency experiences costs them at least $675,000 a year. Several witnesses described agencies operating at a loss due to restricted Medicaid funding. COVID-19 costs further exacerbated losses. Adria Powell of Cooperative Homecare Associates (CHA) reported that they were able to reduce the turnover rate to 24% when they were able to fund 4 weeks of paid training and provide certification and advancement opportunities for their workers. Due to Medicaid caps and lower provider reimbursement rates and distributions, they are no longer able to do so. Providers consistently emphasized that increasing Medicaid spending was central to addressing the home care workforce shortage and stabilizing the home care industry. According to Kevin Muir of Riseboro Homecare Services, improving quality of care involves costly workforce training, adequate staffing levels with appropriate skills and a reliance on technology, data and information, costs which must be fully supported either through enhanced rates or government grants.

Insufficient state funding for programs provided through the state's aging network, including home-delivered meals and in-home care programs, was also discussed as an issue during the hearing. Evidence supports that investing in these services prevents Medicaid spend-down, where people qualify for Medicaid by paying out of pocket for long-term care until their resources are below the limit for Medicaid eligibility, and also reduces preventable nursing home admissions. However, while demand for these community-based services increased dramatically during COVID, funding has remained flat and insufficient to support the demand for services, resulting in long waitlists and limited service for those that do receive in-home care. As Tara Klein of United Neighborhood Houses put it, ***"these programs have soared in demand during the COVID-19 pandemic, with homebound older adults discovering they can receive high-quality food delivered straight to their doors along with case management support and regular wellness checks."***

Industry witnesses universally acknowledged the need for action to address the home care workforce shortage; Christy Johnson of Premier Home Care described home care workforce shortages as a "full-fledged staffing crisis." Many pointed to increasing financial and social support for workers as a key strategy for improving recruitment and retention. Several home care agencies explicitly supported Fair Pay for Home Care to increase the minimum wage for home care workers but stressed that increasing Medicaid reimbursements must be paired with requirements for higher wages for workers.

Several industry witnesses voiced concerns with wage mandates. Concerns included skepticism that increased Medicaid compensation to support wage mandates would be provided, given past experiences of inadequate Medicaid support for home care. Industry witnesses also argued that even if Medicaid funding was increased, agencies would face unsupported cost increases for home care funded through non-Medicaid payers and out-of-pocket payments. Concern was expressed that this would require agencies to increase hourly rates for private pay consumers, and this may drive more consumers to turn to unlicensed caregivers. Testimony from Jeanne Chirico of the Hospice and Palliative Care Association of New York State also noted that increasing the home care minimum wage without simultaneously increasing wages for more experienced workers would create a compression factor, and agencies would need additional resources to provide raises for all workers. Lastly, industry testimony discussed home care workers' high rates of enrollment in public assistance programs such as SNAP and Medicaid and noted that increasing wages could cause workers to lose eligibility for benefits. Testimony from Becky Preve noted that careful planning using a regionally based pay structure would help to avert the issue of "benefit cliffs" which could

force some workers to reduce hours to avoid exceeding the income threshold for Medicaid eligibility or from receiving material benefits from wage increases.

Duplicative annual training for workers employed by multiple agencies was identified as an inefficiency in the home care sector. Matt Hetterich of Gurwin Home Care recommended a statewide aide registry to track home care worker training completion, avoid duplicative annual training requirements, reduce training time demands for homecare workers, and simplify the process for overseeing training.

Providers also testified on the disruptive impact of workforce shortages on consumers and their families. Dana Arnone of Reliance Home Care Senior Services testified that the workforce shortage forced her agency to shift care responsibilities back onto unpaid family members when formal services are not available, which she noted puts many families in an impossible position of managing both their own paid employment and providing intensive care for their loved ones. Neil Heyman of New York State Association of HealthCare Providers (NYSAHCP) highlighted that the current system of delivery of community-based health care services places a disproportionate amount of the burden on families and loved ones who do not get paid to perform these duties.

3. Care Recipients, Family, and Advocates

> *"You have people in bed all day. So it's an accelerated decline. Bed sores. Escalating potential for blood clots. It's a disaster."* - Marcella Goheen, advocate and family member of a nursing home resident

Speaking about the nursing home staff shortage, Marcella Goheen expressed her concern that caregiver shortages make it impossible to provide complex care including the specialized care her husband needed. She reported seeing one nurse for forty-five patients and two aides for a floor of thirty people, and noted that staffing levels were inadequate to even get all facility residents out of bed.

Home care providers and consumers described the disruption, stress, expense, and health risks associated with losing home care due to worker shortages. Tania Anderson from ARISE described a Consumer-Directed Personal Assistance Program (CDPAP) consumer who was approved for 80 hours of support, but due to COVID workforce disruptions, he was left without services for a week. He had a health crisis prompting a hospital stay, ultimately resulting in his admission to a nursing home. Agnes McCray, ARISE board president and home care consumer, described the difficulty and expense of her own experience finding home care, and noted that her son had delayed college to provide care until she was able to hire new staff. Sandra Moore Giles testified that in spite of receiving a prescription for 20 hours a week of home care, she was not able to hire an aide due to the worker shortage and attributed a current health crisis as a consequence of going without necessary care.

Bryan O'Malley of Consumer Directed Personal Assistance Association of NYS discussed how workforce shortages also limit choices for consumers, and that Medicaid recipients are often the most restricted in their service options. Witnesses emphasized that families should be in the position of overseeing home or nursing aides rather than performing the actual care for hours on end. As Keith Gurgui, a homecare recipient, described, ***"my parents are aging and I should not have to rely on family members and unpaid volunteers to help me for weeks when an agency exists with a current contract to fill my case. I want to be independent in my own home."***

Both Meghan Parker of Independent Living and Claire Pendergrast of the Lerner Center highlighted the difficult issue of providing home care services to people in rural communities. Meghan said that when staff earned 150% of the prevailing minimum wage, it was easier to hire staff, but the current uncompetitive wages combined with smaller working-age populations in rural areas produced significant staffing issues. She noted that rates for "hard to staff" locations no longer exist, compounding the challenge of rural staffing.

Carlyn Cowen from the Chinese-American Planning Council (CPC) noted that the Fair Labor Standards Act (FLSA) has not been fully implemented in New York even though it was extended to home care workers in 2013. Lack of FLSA implementation makes scheduling and labor issues difficult for workers and providers to manage, and also makes workers vulnerable to situations like the 24-hour rule where they do not receive full pay for hours worked.

Many witnesses discussed the negative economic impact when families with children and/or parents needing care, are faced with the struggle to maintain employment to support their family. Maria Alvarez of the Senior Action Council spoke of family members who have exhausted FMLA leave who are forced to opt out of the workplace to care for a loved one when a caregiver is not available. The family is impacted financially, no longer contributing economically and have reduced spending power. They may require additional public benefits as a result of income loss, placing greater demand on assistance programs. Several witnesses stressed that this common scenario is not sustainable as it leads to increased costs for New York State, economic loss for families and a reduced tax base for state and local communities.

Melissa Wendland of Common Ground Health pointed out that older adults are staying in their homes longer, delaying institutional care and increasingly relying on home and community services. The growing need for more skilled and home-health-care nurses/aides to meet the needs of home and community service delivery exist, in addition to institutional care. Workforce shortages contribute to long waiting lists for older adults with home care needs, creating long-term stress for family members who are obligated to provide unpaid care for months while waiting for home care services to become available, if at all. Several home care providers discussed the frustration of having to tell clients and their families that they were unable to provide the services they were authorized to receive due to workforce shortages. As Rebecca Preve of the Association on Aging in New York explained, ***"we really need to facilitate some type of change, not only because of the economic cost, but because of the human cost to these individuals who are told, 'You're authorized for this service, but, we're sorry, we can't serve you.'"***

E. Solutions

> *Now is the time to invest in the people of New York State and to ensure all individuals have the ability to age with independence and dignity. This means investing in the long-term care workforce, while at the same time reforming the delivery of long-term care services and supports. Lindsay Heckler - Center for Elder Law and Justice*

Witnesses presented a range of solutions to long-term care workforce challenges. The hearing included nearly universal acknowledgement that efforts to identify and **implement holistic solutions to long-term care workforce issues** were long overdue. **Ending the global Medicaid cap (introduced in legislation as S.5255 [Rivera]) and raising Medicaid reimbursement rates for long-term care** is an essential first step to rescuing nursing homes and home care agencies. Raising wages for long-term care workers is essential to recruiting and retaining them in the numbers required. Witnesses also discussed the need to strengthen training opportunities and develop career pathways or ladders for diverse long-term care roles, support promising models of community-based care, and expand research to inform data-driven policy solutions.

1. Reforming the Long-Term Care System as a Whole

Lindsay Heckler of the Center for Elder Law Justice (CELJ) described a skilled nursing facility called Safire South as an example of the health risks insufficient nurse staffing presents to skilled nursing facility residents. She described Safire South residents developing severe pressure ulcers and receiving delayed wound treatments because of the facility's consistent short-staffing and high use of contract staffing. She and other advocates ask the legislature to **work holistically on long-term care system reform** rather than thinking in silos when working to address the challenges faced.

The range of long-term care options, from skilled nursing facility to occasional in-home meal delivery, is not a constellation of separate entities but a continuum. Individuals may transition from one care setting to another, depending on care needs and preferences, and direct care workers may work in multiple settings. Long-term care employers may operate a nursing and rehab facility, an assisted living facility, a PACE center, and a home care agency. If reimbursement rates fall short in one, there is only so much they can do to make up the difference at others. Similarly, an acute workforce shortage at one point on the spectrum may have cascading impacts: rehab facilities cannot release residents to go home unless there is adequate home care for their needs, and hospitals cannot release patients into rehab if the beds are full of people waiting to go home. The result is that people don't receive the optimal level of care, and taxpayers are on the hook for unnecessarily expensive hospital and rehab beds.

Many witnesses spoke up in favor of the **Reimagining Long Term Care Task Force Act (S.598B [May])**, to bring stakeholders together from the entire continuum of care to look at best practices from a holistic, statewide standpoint. The task force, if implemented, should consider workforce supply and demand at each level on the continuum, as well as career advancement among the different levels.

2. Pay and Benefits

Workers emphatically endorsed **S.5374 - Fair Pay for Home Care (May)** to increase the minimum wage of home care workers to 150% of the minimum wage in the region. A living wage is projected to create 20,000 new homecare jobs per year and create an additional 18,000 jobs with local businesses due to the workers' own increased spending capacity. Employers are supportive of this change, provided that they receive correspondingly higher Medicaid reimbursement rates, including at the institutional facilities that must compete for the same labor force.

Table 1. Recommended Wage Increases in New York State's Three Economic Zones

	Target Level 1 Hourly	Target Level 1 Annually	Target Level 2 Hourly	Target Level 2 Annually
New York City	$22.00	$40,000	$27.50	$50,000
Long Island and Westchester	$19.25	$30,000	$24.75	$45,000
Remainder of NYS	$16.50	$35,000	$22.00	$40,000

Source: The Case for Public Investment in Higher Pay for NY State Home Care Workers - Estimated Costs and Savings - CUNY School of Labor Studies (submitted as testimony by Rebecca Preve, Association on Aging in New York)

These investments in higher home care wages are projected to yield significant returns to the state and across the economy. This is achieved, in addition to lifting workers off of public assistance and giving them buying power, by helping seniors avoid unnecessary stays in nursing homes and spending down all their savings, keeping them spending money in their communities and paying property taxes, and allowing family members to stay in the workforce rather than leaving their jobs to care for their loved ones themselves. See S.4256 Investing in Care Act (May).

Table 2. Costs and Economic Benefits of Home Care Wage Increases

	Target Level 1	Target Level 2
Costs	$3,965,014,000	$6,255,178,000
Economic Benefits	$7,632,870,000	$12,863,856,000
Net Economic Gain	**$3,667,856,000**	**$6,608,678,000**

Source: The Case for Public Investment in Higher Pay for NY State Home Care Workers - Estimated Costs and Savings - CUNY School of Labor Studies (submitted as testimony by Rebecca Preve, Association on Aging in New York)

Workers and providers emphasized the need for a **legislative solution for the 24-hour rule issue,** in which many home care workers are assigned 24-hour shifts but are paid for only 13 hours. **S.359 (Persaud)** requires providers to cover 24-hour care with two non-sequential split shifts of twelve hours each rather than one 24-hour shift. Several witnesses cautioned that an increase in the home care minimum wage without such a rule, and without instituting Medicaid reimbursements for 12-hour shifts, would provide an incentive for agencies to implement more 24-hour shifts.

Many long-term care workers described how they make ends meet by working multiple shifts or overtime. Across-the-board wage increases would ease this problem. Often overtime is involuntary, as in the case where no one shows up to relieve a home care worker caring for someone who needs continual care. **S.359 (Persaud)** would address this by **limiting the number of overtime hours a worker can be required to work** without consent.

Workers who testified mentioned repeatedly the importance of being treated with dignity and respect. It is difficult to achieve this goal through policy, other than ensuring adequate pay and benefits, but it points to the importance of according due respect to the work we all now agree is "essential." Lindsay Heckler (CELJ) emphasized that skilled nursing facilities' house-

keeping, dietary, social work, and therapy employees play a key role in residents' physical, social, and psychosocial well-being and deserve adequate pay for their hard work. Hanse (NYSHFA/NYSCAL) suggested expanding the model of healthcare to include scribes, patient navigators and expanded care coordinators. There was also discussion at the hearing of **encouraging nursing homes to develop on-site child care** for their workers, as both an incentive to attract workers and a way to improve their morale and work lives.

Matt Hetterick of Gurwin Health Services described a "Resident Care Assistant" role they utilized in skilled nursing facilities to provide non-clinical needs such as delivering food or answering call bells from residents. According to Lindsay Heckler of CELJ, teamwork, respect and organizational culture are key to recruitment and retention for skilled nursing facility workers. Bogdanove of 1199 SEIU noted that including workers in management activities such as mentoring new staff also improves worker engagement and investment in the workplace.

Individuals with more complex needs require more care hours to meet those demands. Worker stress can be reduced by **allocating an appropriate number of hours for more complex cases (accuity).** Workers expressed a desire for involvement in the care decision-making process. They are witnesses to subtle changes in the individuals they care for. They expressed a desire to share their observations and contribute to discussions about care. A workplace culture where ideas are heard, that is welcoming and supportive, where staff feel respected and appreciated leads to greater levels of retention (Heckler).

It is a scandalous fact that many long-term care workers do not themselves have health insurance, in spite of working in high-stress jobs that can expose them to deadly diseases. Witnesses proposed two solutions: **more unionization** of the long-term care workforce, and **passage of the New York Health Act (S.5474 [Rivera]),** which would cover all New Yorkers regardless of employment status or income.

3. Workforce Development and Career Advancement

> *"Current training standards and programs do not, for the most part, sufficiently prepare nursing assistants, residential care aides, and home care workers for their complex and challenging roles... While better compensation is needed to attract workers to the long-term care industry, adequate training and advancement opportunities are critical for job satisfaction, workforce retention, and high-quality care."* - Hannah Diamond, PHI

a. Professional Standards and Systems of Support

Throughout the testimony we heard about the need to reduce turnover, improve worker safety, and support the long-term care workforce with paid training, information, and advancement opportunities. To realize these gains, New York State needs a **well-constructed long-term care workforce support system** that begins with clearly defined professional standards with mechanisms designed to achieve those standards. Doris Fischer (HANYS) referred to this as a need to build the infrastructure.

A workforce system designed to address the recommendations made in testimony would bring together all the recommended components. It includes a career roadmap, methods for recruiting students into the profession such as apprenticeships, identified pathways for advancement, role definitions consistent with skills required, updated training and certification standards, development of comprehensive training and standardized curriculum, along with enhanced and specialized learning opportunities. Addressing the need for updated professional standards and a workforce support system could be initiated by the Reimagining Long Term Care Task Force (S598B [May]).

We heard many recommendations for improving the training and certification process and incentivizing recruitment and retention of long-term care workers. Funding the infrastructure to support regional collaboration **to benchmark effective pilot programs, assess effectiveness, share best practices,** and conduct workforce research and tracking is also recommended. Jeanne Chirico of PHCANYS suggested the creation of a **New York State Community Health-Direct Care Workforce Center of Excellence** to secure and dispense grants on behalf of regional and statewide initiatives to address transportation,

career paths, and support programs such as childcare. It would also bring together stakeholders in regional coalitions to address issues such as workforce deserts and produce recommendations to DOH and regulatory bodies.

Hanse (NYSHFA/NYSCAL) stressed the need for **"more robust and broader training on geriatrics skills across the health workforce,"** that would provide "quality and effective care to cover the unique needs and challenges related to older adults." Legislation that would provide tuition support, stipends or loan forgiveness for nursing programs, geriatric studies and credentialing is highly recommended to expand the pool of candidates able to enter and grow the long-term care workforce. **S.6201 (May) would create a loan repayment program for people choosing to specialize in geriatrics.** Tuition support for adult learning/certification and enhanced financial aid for nursing programs at community colleges and/or BOCES was also recommended.

The **existing pathways to training and certification of CNAs, HHAs, and PCAs is in need of reform.** Current required hours for CNAs are 100, PCAs are 40 and HHAs are 95. In addition to addressing the overarching systems issues, specific recommendations include:

- Establishing new DOH skill classifications that reflect the acuity of care required
- Updating certification and training standards developed decades ago, to align with skills required
- Allowing multi-certification training for universal workers; eliminating duplicative training requirements
- Offering high school or technical school pre-apprenticeship programs
- Supplementing classroom training with opportunities to practice skills with an experienced trainer or mentor
- Adjusting Home Health Aide Training Program (HHATP) requirements to allow flexibility in rural areas
- Increasing the availability of enhanced skills training in areas such as mental health, Alzheimer's, diabetes, renal disease, hospice and palliative care, and worker safety
- Allowing LPNs to conduct training under general supervision of an RN, as provided for in Federal guidelines
- Streamlining the application process for employers/agencies to provide training. providing training for culturally competent and trauma-informed caregiving at all levels

There are some specific **efforts in place in New York State** to recruit, train, and mentor long-term care workers.

- Jim Clancy of HANYS described apprenticeship programs for home care workers that include mentoring and college credits. He noted that these programs are proven to be effective and asked the state to support the development of additional apprenticeship opportunities.
- The Greater NY Hospital Association (GHNYHA) has a *Certified Nurse Assistant Apprentice Program* to recruit people not typically exposed to the healthcare field and provide targeted educational opportunities combined with experiential learning at a nursing home.
- Grace Bogdanove (1199 SEIU) spoke about LPN apprenticeships in Syracuse and Buffalo, NY. With this model CNAs continue work while they attend school to become an LPN. This effort is a collaboration between union and management with support from the 1199 training fund. The union hopes more employers will partner with them to expand this model.
- *The Creating a Legacy of Care © Mentorship Program* (New York State Association of HealthCare Providers) was described as increasing caregiver satisfaction. This mentorship model improved cohesiveness and a sense of connection between the home office and the home care aides who often feel isolated in their work. The pilot program findings showed that caregiver turnover rates (pilot vs. non-pilot agencies) for agencies without mentorship programs, had a 170% higher caregiver turnover rate in the first 90 days of employment compared with pilot agencies

using the program during the research period.

- Rona Shapiro of SEIU 1199 described the HUGS Aide program the union created in partnership with Healthfirst, to create a career ladder and train home health aides to provide health coaching services for clients.

Witnesses also recommended several **promising training and recruitment models in other states** that may warrant replication in New York.

- California has a senior care workforce development model that seeks to reach potential long-term care workers at an earlier age. Partners include schools, career centers and vocational schools with programs appropriate to senior care development. A certificate that includes rotation in assisted living residences is currently under development.
- An Ohio-based, grant-funded program, *Nurse Leadership Training Program* operated from 2018 to 2020. The program helped nurses build skills in team-building and leadership. It included effective communication, managing expectations, accountability, delegation and mentorship. Based on information available, the program decreased staff turnover by 53%, increased resident satisfaction by 17%, and increased family satisfaction by 10%.
- *The Healthcare Northwest Partnership* is a collaboration in Washington state between SEIU and private health-care industries. Grace Bogdanove of 1199 characterizes it as **"the nation's first large-scale career pathway program for home care aides."** While designed for home care, she said it applies to the aides who work in nursing homes as well. 3,000 new apprentices have completed this program over the last five years.

b. Opportunities for Advancement

Workers, employers, and advocates alike spoke to the need for career ladders and opportunities for advancement. According to Diamond (PHI), while better compensation is needed to attract workers to the long-term care industry, adequate training and advancement opportunities impact whether they stay.

The Centers for Medicare and Medicaid Services (CMS) developed a set of twelve competency areas named **the Direct Service Workforce Core Competencies** (Appendix A). These competencies are partially but not completely covered in the Home Care Curriculum developed in New York State, according to an assessment done by PHI. They recommend development of core competencies and standard curricula for all roles, as well as an overarching Long Term Care career roadmap. This could be addressed by the **Reimagining Long Term Care Task Force (S.598B [May]).**

According to several individuals providing testimony, the recently ended **Workforce Investment (WIO) program** is an example of the type of program providers and workers need. Febraio (NYSAHCP) highlighted the success of a Peer-to-Peer mentorship program funded through the WIO. Michele O'Connor of Argentum noted that the Advanced Home Health Care Aide role had been created but not staffed due to regulatory barriers and funding. Hannah Diamond of PHI stated, "career advancement opportunities within direct-care are also critical for retaining workers, for amplifying their contribution to care, and achieving quality outcomes and cost-savings. To develop advanced roles, PHI recommends that the legislature enact and fully fund the **Home Care Jobs Innovation Fund (S4222 [May])."**

c. Other Incentives

We heard support for maintaining and expanding upon the executive order to allow nurses from Canada and other states to continue to work in New York State. Witnesses recommended recognizing out-of-state credentialing or participating in multi-state credentialing to reduce redundant training requirements and expand the available workforce. Expanding loan forgiveness for nursing programs, allowing and funding bonuses for staff, implementing incentives and tax credits based upon length of employment were all recommended to encourage continuous learning and retention in the profession.

4. Sustainable Financing and Support for Employers

> *"During budget discussions HCP and other stakeholders made clear, and we reemphasize this in the strongest terms possible today, that any such proposal to increase wages must include minimum hourly reimbursement rates that include wages, benefits and provider costs."* – Febraio, NYSHCP.

Employers need reimbursement to cover workforce costs, including worker recruitment, training, benefits, overtime when needed, continuing development, safety measures including PPE and service provision. Witnesses also argued that given the emotionally and physically demanding nature of direct care work, **incentives for longevity** were also recommended to retain the skilled workforce.

Provider organizations and the Geriatrics Task Force of the NY state chapter of American College of Physicians requested better collaboration with DOH and the Legislature to assist with improving long-term care delivery and to **address the punitive workplace culture** seen in many nursing home environments, noting that this approach has been successful in other states.

Recommendations specific to assisted living facilities are designed to support workforce flexibility. **S.1593 (Rivera)** authorizes nurses to practice incidental nursing services in assisted living facilities to avoid transfers to nursing homes and hospitals. To resolve the issue of excessive workloads for medical directors, develop legislation **to allow Nurse Practitioners and Physician's Assistants to conduct medical evaluations for Assisted Living Facility residents.**

Lindsay Heckler of Center for Elder Law and Justice (CELJ) suggested better **utilization of Civil Money Penalty Reinvestment Funds to fund some skilled nursing facility workforce development efforts.** The federal Civil Money Penalty (CMP) is a monetary penalty that CMS imposes against nursing homes for violations of federal regulatory requirements. Once CMS collects the CMP, a portion of it is sent back to the state and must be reinvested to support projects that benefit nursing home residents or improve their quality of care and quality of life. These funds are available through DOH-issued grants. However, nursing home operators must apply for grants to gain access to CMP funds, and Heckler advocated for increased use of these funds for workforce development. Since CNA certification standards haven't been updated since 1987, there is also room for change there.

As one means of assisting home care providers, **S.2117 (Rivera)** directs the Commissioner of Health to designate episodic payments at a 10% higher rate, and to establish minimums for individual home care services paid by Medicaid. It also provides authorization for subsequent increases to ensure that services are reimbursed adequately, which would allow home care operators to remain viable and to provide needed services now and in the future. The **Consumer-Directed Personal Assistance Program,** or CDPAP, is a Medicaid-funded program that provides chronically ill or physically disabled New Yorkers with services from a home care worker by allowing individuals the flexibility to choose their caregiver, including hiring, training, and supervising workers. This **is a very effective model that deserves robust support** in the budget and could be emulated for senior care as well.

5. Oversight and Quality Control in Skilled Nursing Facilities

Industry witnesses also repeatedly called for simplification of the complicated process for care qualification and delivery in skilled nursing facilities, referencing the highly regulated nature of the industry. The **Washington State long-term care trust act** offers a funding approach provided by Common Ground Health.

Worker and resident advocates called for **higher levels of transparency** by making information about individual nursing home performance, such as salaries, turnover rates, outcomes, violations, etc. available to the public. They recommended restricting referrals of patients from hospitals to poor or underperforming facilities and those with insufficient staffing levels.

One suggestion to improve transparency at Assisted Living Facilities is to require DOH to collect and publish staffing

schedules.

6. Supporting family caregivers

The need for greater support for family caregivers who provide significant long-term care support to their loved ones and reduce strain on formal long-term care providers was also discussed throughout the hearing. **The Family Caregiver Tax Credit - S.620 (May)** provides a middle-class family caregiver tax credit to reduce the burden of caring for a loved one. The tax credit can be claimed by an individual with a gross annual income of $75,000 or less and a couple with a gross annual income of $150,000 or less. The proposed credit would not exceed $3,500, or fifty percent, of the total amount expended. These bills are currently in committee.

7. Additional Research Needs

Many witnesses discussed the need for **more robust data collection and research** on the long-term care workforce. Diamond (PHI) stated that more precise data on the state's long-term care workforce is needed to support policymakers' ability to quantify workforce shortages, monitor workforce trends over time, and evaluate the impact of changes in long-term care policy and practice on the workforce. She recommended a survey of all relevant departments and agencies to catalog existing long-term care workforce-related data collection mechanisms and to identify gaps and inconsistencies. Tara Klein (UNH) noted that while industry trade associations and think tanks could support data collection and analysis of workforce trends, state agencies such as the Department of Health and the Department of Labor are likely best suited to lead these efforts, as they already have access to many relevant data sources. We heard wide ranges in estimates of basic data points: 250,000-400,000 long-term care workers, for example, or home care salaries ranging from $20,000 to $28,750 annually.

Klein also identified **specific home care-related data needs,** including number of clients served, number of employees, number and percent of 24-hour cases, changes in these numbers over time, employee retention and turnover rates by role, average length of staff vacancies, and disaggregated data by nonprofit and for-profit agencies and size of agencies. Other specific data requests from witnesses included surveying direct care workers across occupations, care settings, and regions **to document workers' experiences and recommendations for improving job quality,** assessing staff turnover in skilled nursing facilities to identify characteristics of facilities with high turnover and its impacts, and assessing the number of individuals who have been approved to receive home care services but did not receive services due to workforce shortages.

More research on home care safety concerns was also discussed. Testimony from Tara Klein (UNH) noted that more systematic home care workforce data collection would support efforts by home care providers, the Department of Health, and the legislature to develop a successful policy solution to the 24-hour rule. Jeannette Zoeckler of SUNY Upstate Occupational Health Clinical Center also supported **funding mechanisms to support research on health and safety issues for home care workers.**

Witnesses also discussed a need for more research on a variety of models for long-term care service provision. Zoeckler of SUNY Upstate pointed to **home care unions and worker-owned cooperatives** as promising strategies for improving outcomes for home care workers. She called for further research on **challenges unions face in organizing home care workers,** including worker non-co-location and institutional hierarchies. She also noted that research is needed to understand the conditions of the private pay home care workforce, who she noted are an understudied group in comparison to publicly funded home care workers.

The importance of building an evidence base to inform efforts to improve worker training and career development was also discussed. Zoeckler of SUNY Upstate called for further research on the potential of enhanced service delivery, such as nutritional counseling or mild exercise programs, for creating career pathways for home care workers. Hannah Diamond of PHI also recommended building in **home care "advanced role" demonstration projects** into New York's Medicaid Waiver and including provisions for thorough evaluation of these demonstration projects to build the evidence base for the impact and value of supporting home care workers' career advancement into roles such as "transition specialists", "peer mentors", and "care integration senior aides."

Witnesses also identified several specific research projects needed to inform long-term care workforce policies. Given the potential for increased home care wages to reduce eligibility for or generosity of public assistance for home care workers, future analyses should examine how overall take-home pay would be affected by increases in the home care minimum wage. Hannah Diamond of PHI also recommended that the Department of Health should **evaluate the impact for worker wages, benefits, and job quality of the recent requirement that 70% of nursing home revenue be spent on direct resident care** and at least 40% on frontline staff. Sarah Daly of LeadingAge recommended that a **"workforce impact analysis"** be conducted for proposed long-term care regulations to assess if the proposed requirement would divert staffing resources away from resident care. Jeannette Zoeckler of SUNY Upstate called for cost-effectiveness analyses assessing savings due to avoided hospitalizations, Medicare/Medicaid expenditures, and the financial impacts of unpaid family caregiving associated with investments in home care. Maria Alvarez of Statewide Senior Action Council recommended that researchers **assess the true cost of unpaid caregiving** that results from inadequate home care access.

F. WITNESS LIST AND TESTIMONY

A transcript and recording of all spoken testimony can be found on the Senate Events website, in addition to all written testimony. In addition, all submitted written testimonies are also available. To access this information go to - https://www.nysenate.gov/calendar/public-hearings/july-27-2021/joint-public-hearing-nursing-home-assisted-living-and-homecare

List of Witnesses

Part I: Nursing Homes and Assisted Living

Panel 1

Meghan Parker - New York Association on Independent Living
Dora Fisher - Healthcare Association of New York State (HANYS)
Jim Clancy - Healthcare Association of New York State (HANYS)
Lisa Newcomb - Empire State Association of Assisted Living (ESAAL)

Panel 2

Stephen B. Hanse, ESQ. - NYS Health Facilities Association
Tarrah Quinlan - NYS Health Facilities Association
Lisa Volk - NYS Health Facilities Association

Panel 3

Gene Hickey - UFCW, Local # 2013 (replaced Louis Mark Carotenuto - illness)
Francine Streich UFCW, Local # 2013 (late addition)

Panel 4

Grace Bogdanove - 1199SEIU United Healthcare Workers East
William Roe, LPN, - 1199SEIU United Healthcare Workers East
Tonya Blackshear, CNA - 1199SEIU United Healthcare Workers East

Panel 5

Sarah Daly - LeadingAge New York (replaced Jim Clyne)
Michele O'Connor - Argentum/Argentum NY
Doug Wissman - Greater New York Health Care Facilities Association

Panel 6

Dallas Nelson, MD - New York Medical Directors Association
Diedre Gilkes, RN - New York State Nurses Association

Panel 7

Hannah Diamond - PHI
Maria Alvarez - Statewide Senior Action Council
Lindsay Heckler - Supervising Attorney, Center for Elder Law & Justice

Panel 8

Agnes McCray - Board President of ARISE, Human Rights Advocate & home care consumer
Marcella Goheen - Founder, Essential Care Visitor
Ian Magerkurth - Alzheimer's Association (unable to testify due to illness)

Part 2: Home Care

Panel 1

Rona Shapiro - 1199SEIU United Healthcare Workers East
Lilieth Clacken - 1199SEIU United Healthcare Workers East
Jason Brooks, PCA, Healthcare Workers Rising
Martha Davila, Home Care Attendant

Panel 2

Ilana Berger - Caring Majority Panel
A reader for Sandra Moore Giles - Senior Home Care Consumer
Sandra Abramson - Family Caregiver
Mildred Garcia Gallery - Ageless Companions

Panel 3

Mary Lister - Ain't I a Woman?! Campaign, Queen City Workers Center, Buffalo, New York
Ignacia Reyes - National Mobilization Against SweatShops (NMASS)
JoAnn Lum - Ain't I a Woman?! Campaign

Panel 4

Rebecca Preve - The Association on Aging in New York
Tara Klein - United Neighborhood Houses (UNH)
Carlyn Cowen - Chinese-American Planning Council (CPC)

Panel 5

Claire Pendergrast, MPH - Syracuse University Lerner Center for Public Health Promotion
Melissa Wendland - Common Ground Health
Jean Moore - Center for Health Workforce Studies, UAlbany School of Public Health - unable to testify

Panel 6

Bryan O'Malley - Consumer Directed Personal Assistance Association of NYS
Tania Anderson - ARISE
Heidi Siegfried - Center for Independence of the Disabled, NY

Panel 7

Jeanne Chirico - Hospice and Palliative Care
Katelyn Andrews - LiveOn
Kathy Febraio - NYS Association of Health Care Providers
Al Cardillo - Home Care Association of NYS (in place of Alyssa Lovelace)

Panel 8

Dana Arnone, RN - Reliance Home Senior Services
Hon. Christine Pellegrino - All Things Home Care, Inc. (501c3)
Faigie Horowitz - Caring Professionals, Inc.
Jim Hurley - Home Instead Senior Care

Panel 9

Christy Johnston - NY Coalition of Downstate Homecare Agencies/Premier Home Health Care
Matt Hetterich - Gurwin Certified Home Health Agency
Veronica Charles - Maxim Healthcare

List of Written Testimony

- Bryan O'Malley, Consumer Directed Personal Assistance Assn of New York State (CDPAANYS)
- CIPA Capstone Report Office of the Aging
- Honorable Christine Pellegrino, Civil Service Employee Association (CSEA)
- Lindsay Heckler, Supervising Attorney, Center for Elder Law and Justice (CELJ)
- Melissa Wendland, Common Ground Health
- CUNY Homecare Report
- Dr. Tara Cortes, Hartford Institute of Geriatric Nursing (HIGN), (NYU)
- Grace Bagdanove, 1199 SEIU
- Greater New York Healthcare Facilities Association (GNYHCFA)
- Greater New York Hospital Association (GNYHA)
- Matt Hetterich, Gurwin Home Health Agency
- Healthcare Association of New York State (HANYS)
- Homecare Association of New York State (HCA)
- Hospice and Palliative Care Association of New York State (HPCANYS)
- Rhonda M. Butler, EdD., Interfaith Works
- Jeanette Zoeckler, Ph.D., MPH Occupational Health Clinic Centers (OHCC) Upstate Medical University
- Amy J. Schnauber, LeadingAge New York
- Lilieth Clacken, Home Health Aide, NYC
- LiveOn NY New York State Home Care
- Long Term Care Community Coalition (LTCCC)
- Maggie Ornstein, Ph.D., MPH, caregiver and Caring Majority Member
- Martha Davilla, home care aide NYC
- Veronica Charles, Maxim Homecare Services
- Neil Heyman, Southern New York Association, Inc.
- New York Providers Alliance (NYPA)
- Colleen Downs, North Country Center for Independence
- New York Health Facilities Association/New York Assisted Living Facilities (NYHSA/NYSCAL)
- Diedre Gilkes, R.N., New York State Nurses Association (NYSNA)
- Maria Alvarez, New York Statewide Senior Action Council
- Paula E. Lester, MD, FACP, CMD Metropolitan Area Geriatrics Society (MAGS)
- Claire Pendergrast, Lerner Center at Syracuse University
- Rebecca Preve, Association on Aging in NY
- Keith Gurgui, Resource Center for Accessible Living
- Rona Shapiro, 1199 SEIU
- St. Nick's Alliance Home Care
- Tonya Blackshear, CNA, Utica, NY
- UFCW Local #2013
- United Neighborhood Houses (UNH)
- William Roe, LPN NYC
- NY Coalition of Downstate Homecare Agencies

- Andrea Thomas, Sunnyside Community Services
- Margaret Lee, Ain't I a Woman Campaign?!
- Kevin Muir, Riseboro Community Partnership and Riseboro Homecare
- New York State Association of Healthcare Providers (HCP)
- Carlyn Cowen, Chinese Planning Council (CPC)
- New York Medical Directors Association (NYMDA)
- Mary Lister, Queen City Worker Center, Ain't I a Woman?! Campaign
- Adria Powell, Cooperative Home Care Associates (CHCA)
- PHI/Hannah Diamond Testimony

Appendix A - Centers for Medicare and Medicaid Services (CMS) Direct Service Workforce Core Competencies

CMS generated an initial list of direct care competencies through a comprehensive inventory of common competency lists from across settings in long-term care. Next, CMS solicited input from consumers, family members, direct service workers, state representatives, provider agencies, and training development experts to develop the following set of core competencies.

- Communication: use strong communication to build relationships with consumers and team members
- Person-centered practices: assist consumers to make choices and plan goals and support them in achieving those goals
- Evaluation and Observation: Gather information on a consumer's physical and emotional health and communicate observations to care teams and supervisors.
- Crisis Prevention and Intervention: Identify factors that can lead to a crisis and use effective strategies to prevent or intervene in the crisis.
- Safety: Prevent and respond to signs of abuse, neglect or exploitation and help consumers avoid unsafe situations and keep them safe during emergencies.
- Professionalism and Ethics: Provide supports professionally and ethically, maintaining confidentiality and respecting consumer and family rights.
- Empowerment and advocacy: assist consumers in advocating for themselves and achieving their goals.
- Health and Wellness: Support consumers in achieving and maintaining good mental and physical health.
- Community living skills and supports: Help individuals manage the day-to-day tasks that form the basis of independence in the community.
- Community Inclusion and Networking: Help consumers maintain and expand their roles and relationships in the community and assist individuals with major transitions that occur in community life.
- Cultural competency: Respect cultural differences and provide services and supports in line with consumer preferences.
- Education, Training, and Self-Development: Obtain necessary training, and seek opportunities to improve skills and work practices through ongoing learning opportunities.

Appendix B - Glossary of Acronyms Used in the Report

BOCES Boards of Cooperative Educational Services
CDPAP Consumer Directed Personal Assistance Program
CMP Civil Money Penalty
CNA Certified Nursing Assistant
DSRP Delivery System Reform Incentive Payment
EISEP Expanded In-Home Services for the Elderly
FLSA Fair Labor Standards Act
HCBS Home and Community-Based Services
HHA Home Health Aide
LPN Licensed Practical Nurse
MLTC Managed Long-Term Care
MRT Medicaid Redesign Team
PACE Program for All-inclusive Care for the Elderly

PCA Personal Care Assistant
RN Registered Nurse

Appendix C: Models of Care

Several promising models of care offer opportunities to support older adults across a continuum of care needs and enable more older New Yorkers to receive appropriate services and remain independent in their homes and communities as long as possible. Investing in access to quality models of care that align with older adults' preferences and reduce preventable hospitalizations and nursing home admissions benefits individuals, their families, and ultimately reduces strain on the state's Medicaid budget.

The Program of All-Inclusive Care for the Elderly, or PACE, is a comprehensive care model that coordinates access to health care, services and community supports for dual Medicare- and Medicaid- eligible older adults who may otherwise be placed in a nursing home. While PACE programs are a less costly option than nursing home care and are proven to be effective at providing quality care, they are not available in all parts of the state and eligibility requirements restrict access to PACE for some older adults. S6664 (May) aims to correct that.

The Expanded In-home Services for the Elderly Program, or EISEP, administered through the New York State Office for Aging (NYSOFA), provides non-medical in-home services for older adults who are not eligible for Medicaid. It is far less costly than Medicaid-funded long-term care services, provides holistic person-centered care, and does not require recipients to spend down their assets. EISEP has a long waiting list and needs increased funding in the state budget.

New York's network of 59 county-based Area Agencies on Aging and over 1,000 local aging services providers offers a diversity of community-based services and supports to enable older adults to age in place and avoid preventable hospitalizations or nursing home placements. Services include home-delivered meals, medical transportation, home repairs, caregiver supports, legal services, case management, and more. Several witnesses emphasized the value of these services in addressing older adults' social determinants of health, reducing food insecurity, and providing social connection and supports that address unmet needs for older adults who have less intensive care needs. While cost-effective and popular, home-delivered meals and other aging services have been chronically underfunded.

Kevin Muir of Riseboro and Tara Klein of United Neighborhood Houses discussed the value of "settlement houses," or neighborhood-based multi-service nonprofits that offer a continuum of culturally competent social and clinical care options for older adults, including home care, adult literacy classes, and senior centers. This model leverages additional resources such as eviction prevention services and meal delivery to address emergent needs in an integrated and cost-effective manner.

The federal Coronavirus Aid Relief, and Economic Security Act (CARES Act) made permanent changes to federal statute permitting non-physician providers, such as physician assistants and nurse practitioners, to order home care services. While this flexibility was permitted at the federal level, state law and regulations limited applicability of non-physician practitioners' (NPP) ordering permissions across New York home care providers and services. This created confusion for referral sources and perpetuated access-to-care burdens. As a result, the Department of Health proposed changes to address this longstanding issue to allow NPPs to broadly order home care services in New York State. Organizations such as the Home Care Association of New York continue to advocate for changes to the rules for practitioner orders for home care.

Katelyn Andrews (LiveOn NY) discussed the importance of ensuring older adults are stably and affordably housed, as well as offering "light-touch" supports through a service coordinator. This may include assisting residents with accessing benefits programs or scheduling and traveling to medical appointments.

Sources referenced in testimony:

Center for Health Workforce Studies (2018). "The Health Care Workforce in New York: Trends in the Supply of and Demand for Health Workers."
https://www.chwsny.org/wp-content/uploads/2018/04/Full_CHWS_NY_Tracking_Report-2018b-1.pdf

Community Health Care Services Foundation. Creating a Legacy of Care Mentorship Program. Creating a Legacy of Care Mentorship Program (nyshcp.org)

Cornell Program on Applied Demographics. County Projections Explorer. https://pad.human.cornell.edu/counties/projections.cfm

Cromer, T. et al. (2021). "Modernizing Long-Term Services and Supports and Valuing the Caregiver Workforce", Health Affairs
https://www.healthaffairs.org/do/10.1377/hblog20210409.424254/full/

Farrell, C. (2021). "How Helping America's Caregiving Workforce Can Address Diversity, Equity, and Inclusion." Forbes. https://www.forbes.com/sites/nextavenue/2021/05/21/how-helping-americascaregiving-workforce-can-address-diversity-equity-and-inclusion/?sh=7c38e51d533

Gandhi, A. et al. (2021). "High Nursing Staff Turnover in Nursing Homes Offers Important Quality Information." Health Affairs.
https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00957

Hansen Hunter & Company (2018). "Report on Shortfalls in Medicaid Funding for Nursing Center Care." https://www.ahcancal.org/Reimbursement/Medicaid/Documents/2017%20Shortfall%20Methodology%20Summary.pdf

Jabola-Carolus, I. et al. (2021). "The Case for Public Investment in Higher Pay for New York State Home Care Workers: Estimated Costs and Savings." City University of New York.
https://slu.cuny.edu/wp-content/uploads/2021/03/The-Case-for-Public-Investment-in-Higher-Pay-for-New-York-State-H.pdf

PHI (2021). "Direct Care Workers in the United States: Key Facts." https://phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2/

PHI (2021). "PHI Urges New York State to Renew the Medicaid Managed Long Term Care Workforce Investment Program."
https://phinational.org/wp-content/uploads/2021/06/Discussion-Paper-April-2021.pdf

PHI Workforce Data Center
Workforce Data Center (phinational.org)

Spanko, A. (2021). "Nursing Homes Have 94% Staff Turnover Rate — With Even Higher Churn at Low-Rated Facilities." Skilled Nursing News. https://skillednursingnews.com/2021/03/nursing-homes-have-94-staff-turnover-rate-with-even-higher-churn-at-low-rated-facilities/

Supplemental resources

AARP (2020). “Caregiving in the U.S.”
https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf

Association for Talent Development (2015). “What’s Happening in Healthcare Talent Development.”
https://www.td.org/insights/whats-happening-in-healthcare-talent-development

Association for Talent Development (2015). “Measuring Training Success in Healthcare.”
https://www.td.org/insights/measuring-training-success-in-healthcare

Commonwealth Fund (2021). “Placing a Higher Value on Direct Care Workers.” https://www.commonwealthfund.org/publications/2021/jul/placing-higher-value-direct-care-workers

HRSG (2018). “What’s the Difference Between Skills and Competencies?”
https://resources.hrsg.ca/blog/what-s-the-difference-between-skills-and-competencies

National Direct Service Workforce Core Competencies. (2014). CMS Direct Care Workers Core Competency
DSW Core Final Competency Set, Appendix E (mykapp.org)

PHI (2018). “Workplace Injuries and the Direct Care Workforce.”
http://phinational.org/wp-content/uploads/2018/04/Workplace-Injuries-and-DCW-PHI-2018.pdf

Preceden. Career Roadmap
https://www.preceden.com/roadmap/career

Regional Centers for Workforce Transformation (OPWDD)
https://www.workforcetransformation.org/

SHRM. Career Paths and Ladders
https://www.shrm.org/resourcesandtools/tools-and-samples/toolkits/pages/developingemployeecareerpathsandladders.aspx

NOTES

NOTES

Rachel May

New York State Senator

District 53

SYRACUSE DISTRICT OFFICE:
State Office Building
333 E. Washington Street, Suite 805
Syracuse, NY 13202
Phone: (315) 478-8745

MADISON COUNTY DISTRICT OFFICE:
Cornell Cooperative Ext. of Madison Co.
100 Eaton Street
Morrisville, NY 13408
Phone: (315) 684-3331

ALBANY OFFICE:
Legislative Office Building
198 State Street, Suite 803
Albany, NY 12247
Phone: (518) 455-2838

EMAIL: may@nysenate.gov
WEB: may.nysenate.gov