



Auerbach Consulting Inc.

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BEFORE THE HUMAN SERVICES COMMITTEE
CONNECTICUT GENERAL ASSEMBLY

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Honorable Co-Chairs and Members of the Committee,

I am Roger Auerbach, an independent consultant on long-term care issues. The focus of my consulting work is to help federal, state and local governments, providers, consumers and advocacy organizations develop systems which deliver quality, cost-effective services responsive to consumer needs and preferences. Most of my work is directed to building state capacity for home and community-based services and providing consumers and their families understandable, reliable and timely information from which to make choices for care. I am affiliated with The Lewin Group, a national health and human services consulting organization and I do a lot of work supporting state grantees of the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services. Other clients include the AARP, the Service Employees International Union, NCB Capital Impact, the New York State Office of Mental Health and Paraquad, an independent living center in Missouri. Since I began consulting in 2001, I have provided substantive advice for clients in 42 states.

The Challenge of Meeting the Demand for Quality In-Home Services

Prior to consulting, I was the Director of Oregon's Senior and Disabled Services Division, responsible for all publicly-funded long-term care programs for older adults and adults with physical disabilities. It was in this capacity that I first confronted the issues surrounding the supply and quality of home care services.

In 1981, the State of Oregon committed itself to systematically change long-term care by passing legislation that all citizens be allowed "to live independently at home or with others as long as the citizen desires without requiring inappropriate or premature institutionalization". To accomplish this goal, the state developed a variety of community-based residential care options including a popular "client-employed provider" program, funded under a Medicaid home and community-based waiver, providing personal care and other in-home services. As of June 2009, 81.6% of Medicaid beneficiaries needing long-term care were receiving those services at home and in the community and about half of them were receiving services delivered by home care agencies and independent home care providers.

My first real recognition of the challenges of recruiting and retaining a quality home care workforce came in 1997 when the State raised the minimum wage. Because the minimum

EAST COAST OFFICE
193 Longview Rd.
Staten Island, NY
10301
(718) 448-7854
rauerbach@yahoo.com

WEST COAST OFFICE
11 NW Pettygrove
Portland, OR
97210
(347) 225-2133
rauerbach@yahoo.com

wage has just been increased by .75/hour, most of our in-home care providers were now being paid about .05/hour above the minimum wage. I knew that it would be incredibly difficult recruiting and retaining a workforce being paid barely above minimum wage. In addition, the number of people receiving in-home services had grown about 25% in the past three years. Convincing policy makers to increase the wages of these workers, who had no organized provider advocacy organization, was a very difficult proposition. First, there had to be recognition of the value of and demand for these services; then, the understanding that failure to invest in these workers' wages would cause a reduction in available home care services likely leading to the need for more expensive institutional care.

In the year 2000, I was introduced to an innovative method to address the issues of maintaining a sufficient supply of quality home care providers, what in Oregon is called a home care commission. The Oregon Home Care Commission was created to provide referrals of qualified home care providers to the elderly and people with disabilities, provide training opportunities for home care workers and consumers, establish qualifications for home care workers, establish and maintain a registry of qualified home care workers and serve as the "employer of record" for purposes of collective bargaining for home care workers hired directly by a client and paid by the state. I was involved in the initial discussions of how the Commission was to be implemented and have followed its progress and that of other similar entities in 6 other states. I have also recently been involved in policy discussions about these home care commissions with the AARP and the Missouri Centers for Independent Living.

Entities such as the proposed Personal Care Attendant Quality Home Care Workforce Council can be a great benefit to a state in many ways. First, it provides a focal point for the State to address a vital issue for its citizens. Individuals needing long-term care support want those services delivered in their homes. This is a well-documented rapidly-growing trend. Almost every survey I have seen shows well over 90% of people wish to receive services at home for as long as they possibly can. Additionally, it is very clear that the cost of services is much less expensive than any other form of long-term care.

I emphasize the "focal point" aspect of a Council because of what I have seen in states around the country who have begun work on the vital issue of increasing the number of qualified home care workers. In all states, workforce development programs are operated in different government departments from long-term care programs. When the human services agency realizes how important this workforce is to citizens and containing expenditures, it then has to convince the workforce agency that it should invest its resources in this workforce to enhance the skill level and supply of these workers. This process always takes a long time, needs constant reinforcement and has not proven very successful. Workforce agencies generally have not had a great focus on low-wage workers. Thus, the single focus of a workforce council is incredibly beneficial.

Next, these Councils have provided support systems for both consumers and workers to make it easier for consumers to hire qualified workers and direct their own care. As I explain below, Councils have created worker registries which consumers can access to find a qualified worker who has been screened in many ways such as with criminal background checks, work status, personal references and skills training. In addition, many Councils also coordinate administrative functions such as processing payroll and benefits.

Councils have also very successfully implemented training programs for both the workers and the consumers. Workers are learning valuable skills from these trainings and are becoming very knowledgeable about specific issues such as dementia. Consumers are being trained to be good employers and learn communication skills that can help them further train the worker on how they best want their care delivered.

Finally, Councils have served as an employer of record for purposes of collective bargaining and many independent provider workers have chosen to organize themselves and have successfully bargained for higher wages and new health and worker's compensation benefits. While home care is still a low-wage occupation, increased wages made this more attractive work and the addition of health benefits specifically have been shown to be a positive factor in people coming to work as home care workers and staying with this profession.

Home Care Councils

As I have briefly discussed above, these Councils have similar core functions:

1. Develop and maintain a registry of qualified, independent providers
2. Provide access to training for home care workers
3. Provide access to training for consumers who self-direct their care
4. Serve as employer of record for collective bargaining

At the end of this testimony, I will provide more detail about how each of these Councils is implementing these functions. Now, I would like to address in a more general way how these entities have helped meet the goals of helping consumers remain supported and independent in their own homes by expanding the number of qualified providers.

Results

Developing a Registry of Qualified Independent Providers

All of the state and county councils have developed and maintain a registry which matches consumer needs to worker skills and availability. Most employ matchable databases and all help publicly-supported consumers to obtain the most appropriate provider. Some allow public access to this helpful tool, others do not. These registries,

except in California, are relatively new or are being developed, as in Massachusetts. As many independent providers are often recruited from family and friends, many consumers do not need registry assistance. However, many utilize the registry and find providers through this process. Conversely, providers who are not working or desire more work can also use the registry to let consumers know they are qualified and available for employment.

Consumers have been using the registries for many years and have found them very useful. Without such a registry and without knowing someone who might do the necessary work, consumers would need to advertise for a worker and have to do all the screening themselves. This is a very challenging process for anyone and even more so for many individuals with disabilities. Having the Council do the screening and refer workers who have the skills to meet the needs of the consumer makes it much more likely that the hiring process will be successful and the provider-consumer relationship will also be successful.

Training for Workers and Consumers

As noted below, most states and counties have developed extensive training programs for the home care workforce and for consumers as employers of home care workers. Generally, surveys done by these states show high satisfaction with this training and a desire for more (75% of Washington providers said they would take advanced training if available). Although I am not familiar with any studies linking this training with increased quality, consumers show very high satisfaction with their providers in these states, providers feel valued due to the investment in their skills and consumers appreciate the training that they receive as employers and that their workers have these educational opportunities.

Employer of Record for Collective Bargaining

There can sometimes be confusion about what it means that a Council is an employer of record while the consumer is, in fact, the employer. All of these Councils have very distinct employer functions that are different than those of the consumer/employer. There is no duplication or conflict. The Council supports the consumer and workers by doing administrative functions like payroll and benefits administration and can bargain with an employee organization. Consumer/employers retain the right to hire, fire, train, schedule and otherwise manage the activities of the worker.

Consumer/employers have been very satisfied with the work of the Councils with their role as employer of record. Consumers have wanted their providers to receive better wages and have health insurance and worker's compensation, but these benefits are both extremely difficult to obtain and extremely expensive to purchase on an individual basis. The Councils that have existed the longest now all provide at least some health insurance

and worker's compensation to all independent providers and have also improved the wages.

For example, the Oregon Home Care Commission has had a contract for its independent providers since 2003. It provides health insurance and worker's compensation coverage, previously not offered, paid time off, mileage for non-emergency medical transportation and a base rate of \$10.20/hr.

Washington's Home Care Quality Authority has had a contract with its independent providers since 2003 and now provides health, dental, vision and worker's compensation, in addition to paid time off and mileage reimbursement. The base rate is \$10.03/hr., but increases to \$11.07 for the most experienced workers. They also have a mentor program that compensates home care workers for mentoring new workers at a rate of an additional \$1.00/hr.

Massachusetts' PCA Quality Home Care Workforce Council signed its first contract with independent providers in 2008 and wages are now \$12.48/hr. The contract authorizes a study on health benefits and additional negotiation on a health plan after the study has been completed. The contract also provides for some paid time off and holidays.

Impact on Workforce Capacity and Quality

There has been increasing focus on in-home services over the past decade and longer. The large majority of individuals needing long-term care want to receive that care in their homes whenever possible. While family and friends have been recruited to help provide support, they are often not able to continue to provide that support over the course of many years. In addition, not everyone needing support has family and friends who are able to provide needed support. The Councils have provided some essential elements necessary to support both consumers and workers and have had a significant impact on the recruitment and retention of home care workers. Long-term care policymakers and stakeholders in the aging and disability communities understand how vital it is to have an adequate number of qualified home care providers. They understand this is what consumers want and that it is significantly more cost-effective than any other care option.

Recruitment and Retention of Home Care Workers

There are a number of reasons that individuals are attracted to home care work, but in a published study by Dr. Candace Howes in The Gerontologist 66% of workers (California) reported that commitment to a consumer was one of the top three reasons why they took the job and 50% said that either wanting a part-time job or flexible job or both was among their top three reasons. Wages and insurance benefits were also significant reasons for taking these jobs, but how important a factor depended on where people

lived, the expansiveness of coverage (35 hrs./mo. in San Francisco, 80 hrs./mo. in Los Angeles) and ethnicity of the individual. Even though family caregivers were most attracted to the work because of commitment, they were equally as interested in wages and benefits as non-family caregivers.

Los Angeles contracted for research and analysis on the impact of health benefits on worker retention at six different times since insurance was implemented. They report that the health benefits program tends to produce a larger, more stable workforce, contributes to longer worker tenure and more consistent work patterns, and further increase the provider pool (2008 Annual Report).

Washington has also studied recruitment and retention. The Authority contracted Washington State University to research the impact of wage increases and new benefits on workforce turnover. Turnover declined for both family and non-family providers, although turnover was higher among non-family providers. The decline in the number of independent providers leaving the industry was also statistically significant, according to the researchers. In an additional telephone survey of providers, 1 of 3 said they were more likely to stay because of health insurance and 21% because of new workers' compensation coverage. Only 8% said they would look for another job in the next year and stated the reasons as higher wages, more paid hours and family and friends no longer needing care.

Quality

One of the major measures of quality services is consumer satisfaction. Most states use some sampling to survey what consumers think of their services. In Washington, 72% of consumers rated their independent provider services as excellent and 22% rated them good. 97% of Massachusetts consumers felt safe and respected by their personal care attendant.

Conclusion

Home Care Councils provide an essential focal point for addressing a key issue in long-term care: attracting and maintaining a sufficient number of qualified home care workers. Consumers want to receive services in their homes. They want to have control over the way services are delivered. They want to be able to access a qualified worker when they need one. Consumers want workers who have skills training, are fairly compensated for their work and receive health and worker's compensation benefits. They want workers who will stay working with them for as long as possible. A state can do this for consumers and provide public support for this process through a Consumer Workforce Council. Supporting this concept helps the State meet the needs and

preferences of consumers while supporting services in the most cost-effective environment-one's own home.

Below is a description of how each Council is implementing the core functions of their entity.

Develop and Maintain a Registry of Qualified, Independent Providers

People Served by the Registry

The In-Home Supportive Services Public Authority of San Francisco, California serves both consumers and workers who participate in the Medicaid personal care program and those who do not. Private pay participants pay a sliding scale fee. In 2009, it reported serving over 23,400 independent providers and over 21,200 participants in the Medicaid personal care program. The registry employees can communicate in six languages in addition to English with services available in other languages.

The Personal Assistance Services Council of Los Angeles County, California serves consumers and providers in the Medicaid personal care program. In 2009, it reported serving 142,000 providers and 173,000 consumers.

Oregon Home Care Commission operates a statewide registry open to both publicly-supported and private pay in-home services consumers and providers. The registry is internet-based and available 24/7. Publicly-supported consumers also receive necessary assistance in securing services.

Washington Home Care Quality Authority operates an internet-based system for publicly-funded consumers of in-home services and pre-qualified individual providers. People access the registry by calling one of many regional centers.

Massachusetts Personal Care Attendant Quality Home Care Workforce Council has maintained a registry since September 2009 and recently upgraded it. It contracts with an entity that operates similar registries in Rhode Island, New Hampshire and other states. It appears that the registry will allow access by both participants and workers in publicly-funded services programs and private pay individuals.

Registry Screening and Operations

San Francisco providers are interviewed by registry staff and must have a valid social security card, valid photo identification, a negative tuberculosis test and at least three references. Providers must attend a 2.5 hour orientation. Consumers call the registry, staff assess care needs and solicit individual preferences, and send the consumers a list of 6-9 workers who meet their needs. The consumers are responsible for contacting the providers and arranging interviews and making the hiring decision. Registry employees will follow-up and work with consumers until the process is complete.

Los Angeles providers must provide valid photo identification, proof of work eligibility, employment history for the last five years, three (3) personal references, sign a provider agreement and clear a State of California Criminal Background Investigation. Providers must also attend a 2.5 hour orientation session. Consumers call the registry and detail their needs for particular services and skills and scheduling requirements. A referral report with up to five providers is sent to the consumer, also utilizing geographic proximity. The consumer is then responsible for contacting providers, arranging interviews and hiring.

Oregon providers must complete an application packet detailing skills, experience, availability and work preferences, pass a criminal background check, attend an orientation within 90 days, be 18 years old, be capable of providing or learning to provide necessary skills, disclose qualifications, skills and experience that can be verified, as well as submit references upon request and keep address and phone number current. Providers submit days and times they are available for work, services they are willing and able to provide, locations they are willing to work, languages spoken and gender. Anyone can access the internet-based registry and publicly-supported consumers can receive any assistance they need to hire a provider.

Washington providers must be 18 years old, successfully complete a background check, a face-to-face interview and an introductory course prior to being placed on the registry. Washington also requires seventy-five (75) hours of basic training for independent providers. Consumers access the registry by calling a regional center, where their needs are assessed, preferences are solicited and a list of providers is sent to the consumer.

Massachusetts is employing a registry that does not screen providers. The referral directory is set up to match consumer needs and preferences with provider preferences and experience, but it is the consumer's responsibility to check the references of all potential employees.

Access to Training for Home Care Workers

San Francisco has a Worker Training Program consisting of a Homecare Skills Development Training and Continuing Education Workshops. The training is a 12 day, 48 hour course

that covers basic health and safety procedures, hands-on personal care training including use of common homecare equipment and a two-year certification in CPR and First Aid. Workshops are offered twice a month on a variety of different homecare topics. Trainings are held in four languages and workers must have been working over 2 months to attend.

Los Angeles has developed a Homecare Workers Training Center where they offer a free 60 hour course in the basics of homecare work through its new Homecare Worker Training Curriculum. There are also voluntary trainings made available throughout L.A. County on topics such as health and safety, disease prevention, disability awareness and HIV prevention.

Oregon offers a variety of training courses. The Home Care Commission will cover the cost of CPR/First Aid training for actively working homecare workers who have completed two other Commission training classes. Other courses are free and workers who have worked in any of the three months prior to a training will be paid for training time. The courses offered include: bathing and grooming; blindness/ low vision; challenging behaviors; dementia and Alzheimer's; diabetes; fraud and abuse; durable medical equipment; end of life care; grief and loss; heart healthy; keeping it professional; medication safety; moneywise; protecting against sprains and strains; preventing disease transmission; ready set work; respiratory care; substance abuse awareness; stress management; taking responsibility in personal safety; and working together. Many are available in Spanish and Russian. There is also a professional development recognition award for successfully completing a certain number and variety of training classes.

Washington Home Care Quality Authority does not have responsibility for training in-home workers. That authority is delegated to the SEIU NW Healthcare Training Partnership, a joint labor-management organization. State law requires seventy-five (75) hours of entry-level training for new home care workers to be completed within one hundred twenty (120) days of employment, five of which must be completed before a worker provides any care, and twelve (12) hours of continuing education each year in advanced training. Providers who care for family members have fewer training requirements. Providers are also offered on-the-job training or peer mentorship with their first ninety (90) days of employment by a trained worker-mentor.

Massachusetts' Council sponsors free training in CPR for any working personal care attendant at their community colleges.

Access to Training for Consumers who Direct Their Care

San Francisco offers workshops on Hiring, Training, and Managing Your Home Care Worker and Assessment and Managing Your Worker. It also sponsors conferences, forums and symposia to explore and discuss issues relating to home care which have included

workshops on interviewing potential providers, managing and avoiding potential problems and handling paperwork. In addition, it provides a free consumer handbook.

Los Angeles has monthly trainings for consumers on Consumer as Employer, Communications, Understanding and Navigating IHSS (Medicaid personal care program) and other relevant topics.

Oregon provides employer skills to consumers through the State Independent Living Council and the Centers for Independent Living. The training covers three areas: Preparing to Hire Your Homecare Worker; Hiring Your Homecare Worker; and Communication and Safety in Your Home. Training is offered in groups with individual follow-up, one-on-one and is completed as a “guide on the side” for those who need more intensive training.

Washington’s Authority is not responsible for training.

Massachusetts’ Authority does not offer training at this time.

Employer of Record for Collective Bargaining

San Francisco’s Authority serves as the employer for the purpose of collective bargaining for wages and benefits with the union representing the independent provider workforce and has done so since May 1996.

Los Angeles’ Council serves as the employer of record for purposes of collective bargaining and negotiated the first contract in July 1999. The Council also administers the Health Plan for covered providers who work 80 or more hours a month for at least 2 consecutive months.

Oregon’s Commission serves as the employer of record for purposes of collective bargaining for homecare workers whose pay comes from public funds. The State conducts the negotiations on behalf of the Commission with representation from the Commission and state agencies.

Washington’s Governor is the public employer of home care workers for collective bargaining. This was a legislative change from the measure which created the Authority as the employer of record. The Authority operates the Workers’ Compensation Program and serves as the state’s Public Liaison to the Health Care Trust which provides health care insurance for independent providers and home care agency workers.

Massachusetts' PCA Quality Homecare Workforce Council is the employer of record for purposes of collective bargaining and negotiated its first contract with a union representing independent providers in November 2008.

