Caring in America

A Comprehensive Analysis of the Nation's Fastest-Growing Jobs: Home Health and Personal Care Aides

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December 2011

PHI
Quality Care THROUGH Quality Jobs

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www.phinational.org/policy

Foreword

Home care aides represent one of the nation's largest and fastest growing occupations. We see them every day: carefully guiding a wheelchair down a city sidewalk, accompanying an older woman waiting to see her doctor, or alongside a man with a spinal cord injury at work so that he can provide for his family. And there are millions more we don't see—in people's homes and apartments, fixing dinner, helping with bathing and dressing, doing laundry. This is caring in America.

Although our times are marked by technological innovation, caregiving remains an inherently human function. It is a high-touch, time-intensive, and intimate part of human life. And while many aides take great personal satisfaction from helping elders and people with disabilities, caregiving is also a real job, a fact too often overlooked.

Home care work can be tough and demanding. It requires skill, patience, and endurance. And yet, these jobs are among our nation's most poorly paid and supported. This is also caring in America.

Despite its size, and the essential services it provides, the home care workforce remains largely invisible. We invest too little in the preparation, compensation, and support of those who enter this field, leading to high turnover and recruitment challenges. The infrastructure for providing in-home services is underdeveloped and uneven. So at a time when our society is experiencing profound demographic, economic, and social upheavals, we stand unprepared to meet the rapidly growing demand for care.

The purpose of this report is to bring this workforce into sharp focus. By using the best data and research evidence available, it provides the most complete picture of America's home care and personal assistance workforce ever presented. Our hope is that this resource will promote a better and broader understanding of the workforce, as well as the large and growing eldercare/disability services industry it supports. We also hope that it will facilitate a more informed public discussion of key issues shaping the future of in-home services, aiding the development of both effective policy solutions and a targeted industry response.

For all of us, our family members, our businesses, and our economy, it is time to prepare America to care.

Steven Edelstein
National Policy Director

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APPENDICES

Section 1 Introduction

In an era of nearly constant technological innovation and change, ironically the economy's largest, fastest-growing workforce is charged with providing basic hands-on, caregiving services to millions of elders and persons with disabilities needing assistance with everyday activities and tasks.

Numbering on the order of 2.5 million workers, the home care and personal assistance workforce in the United States has reached historic proportions. Expected to increase at rates four to five times that of jobs overall in the economy, the tremendous growth of this workforce is being fueled by profound structural changes in our society that are fundamentally reshaping long-term services and supports.

Chief among these changes is the aging of our population and significant increases in life expectancy due to medical advances that allow individuals with chronic conditions and severe disabilities to live longer. People's preference for receiving supports and services in their own homes as opposed to institutional settings is also amplifying demand for home care and personal assistance workers, bolstered by various legal decisions supporting the right to receive care in the least restrictive settings possible. State and federal policies show a similar trend, increasingly supporting home and community-based services as alternatives to traditional, more costly institutional care.

Finally, public and private payers are beginning to insist on more cost-efficient treatment options with better alignment between acute care and eldercare and disability services. This trend opens up new opportunities for direct-care workers who could, with additional training, provide more value to the health care system. For example, these workers are well positioned to assist with transitions from one care setting to another, prevent hospital readmissions, participate in team approaches to chronic disease management, and provide information and support to family caregivers.

Notwithstanding this confluence of structural forces, the home care and personal assistance workforce has yet to receive the policy and practice attention that would allow its potential value for the health care system, for communities, and for workers to be realized. The development of this workforce is fundamental to ensuring the capacity of our service delivery systems to provide care — both the volume required but also the quality we expect. It is also crucial to stabilizing an overburdened family caregiving system made up of millions of family members and relatives who work tirelessly to support the well-being and independence of their loved ones.

Relying on the most recent data and research available, the purpose of this report is to provide a comprehensive analysis of the home care and personal assistance workforce. We begin in the next section by presenting basic facts on the size of the home care and personal assistance workforce and its demographic characteristics along with a description of job titles and tasks performed. In Sections 3 and 4, we step back to analyze the employers in the in-home care industry sector as well as the complex of service delivery systems that provide daily services and supports to millions of people living in their homes.

Returning to the workforce, Sections 5 and 6 investigate the state of training for home care and personal assistance workers, and the job hazards that accompany this work. The following three chapters (Sections 7 through 9) treat three closely-related topics: workforce compensation, the employment patterns of aides (*e.g.,* hours worked), and evidence of workforce instability (*e.g.,* high turnover). Low wages and part-time hours are factors that directly impact our ability to attract and retain a stable, skilled workforce that will be capable of providing the quality home and community-based services individuals, families, and policymakers desire.

The final section of this report (Section 10) addresses the current status of federal and state wage and hour protection for this workforce, a subject that has received growing attention over the last few years. Because of an exemption to the Fair Labor Standards Act passed by Congress in 1975, untold numbers of home care and personal assistance workers are excluded from federal minimum wage and hour protection on the grounds that the work they perform is casual and confined to "fellowship and protection." In light of significant changes that have taken place in the home care industry, the U.S. Department of Labor is currently reviewing the regulations that interpret this statute. We hope the comprehensive data and analysis provided in this report contributes to an informed debate and appropriate regulatory reform.

A Note on Terminology Used in This Report

The state of terminology for both the workforce and industry that are the subject of this report are in flux, resulting in multiple terms that are either overlapping or roughly equivalent. Throughout this report, we use the following terms interchangeably: in-home services and supports AND in-home care AND home care; home health and personal care aides AND home care and personal assistance aides or workers AND home care aides or workers.

In general, the term "home care" is used as an umbrella term that includes all the non-medical and paramedical services that can be provided in people's homes, including home health aide services, personal care, homemaker services, and companionship services. However, increasingly the term "in-home services and supports" is being used in lieu of "home care."

A capitalized job title of an aide in this report indicates that we are referring to an official job classification used in the 2010 Standard Occupational Classification (SOS) system, such as Home Health Aide (SOC 31–1011) and Personal Care Aide (SOC 39–9021). The SOC system is used by federal and state statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data.

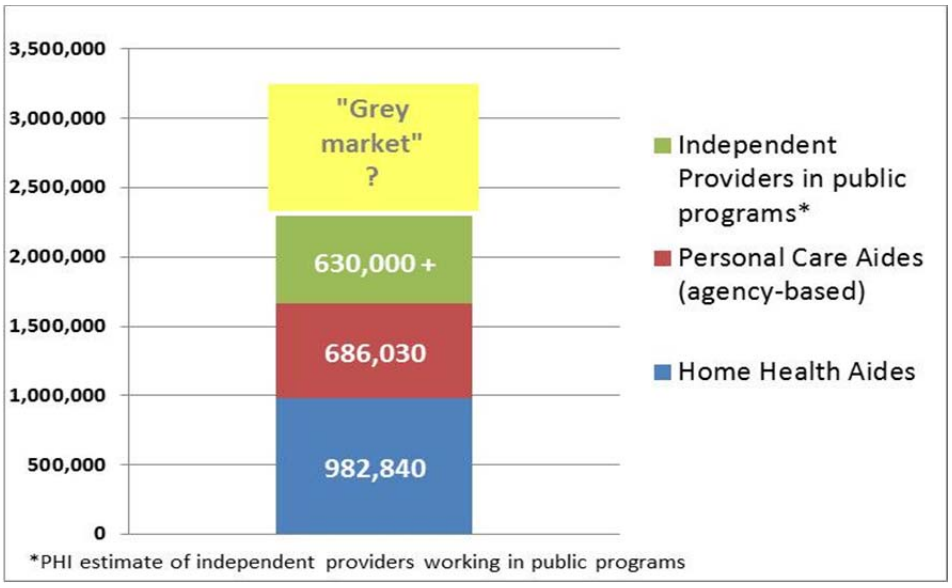
Section 2 The Workforce

Home care and personal assistance workers provide essential daily supports and services to millions of Americans living with functional limitations and needs due to aging-related impairments, chronic disease, and other disabilities. Much of this work is difficult, physically taxing, and requires ongoing responsibility and judgment as well as emotional commitment and flexibility.

Home care and personal assistance workers now constitute one of the largest and fastest growing occupational groups in the United States, fueled by sweeping increases in the demand for home and community-based long-term services and supports. This workforce today conservatively totals nearly 2.3 million[1] and may reasonably approach 2.5 million.

Official counts of this workforce include Personal Care Aides and Home Health Aides who are largely employed by organizations or agencies that deliver in-home services and supports. In addition, large numbers of aides are directly employed by consumers under publicly-financed programs that allow program participants to hire their own personal care worker ("independent providers in public programs" in Figure 2.1 below). Beyond that, hundreds of thousands of additional aides are thought to work

Figure 2.1: Size of the Home Care and Personal Assistance Workforce, 2010

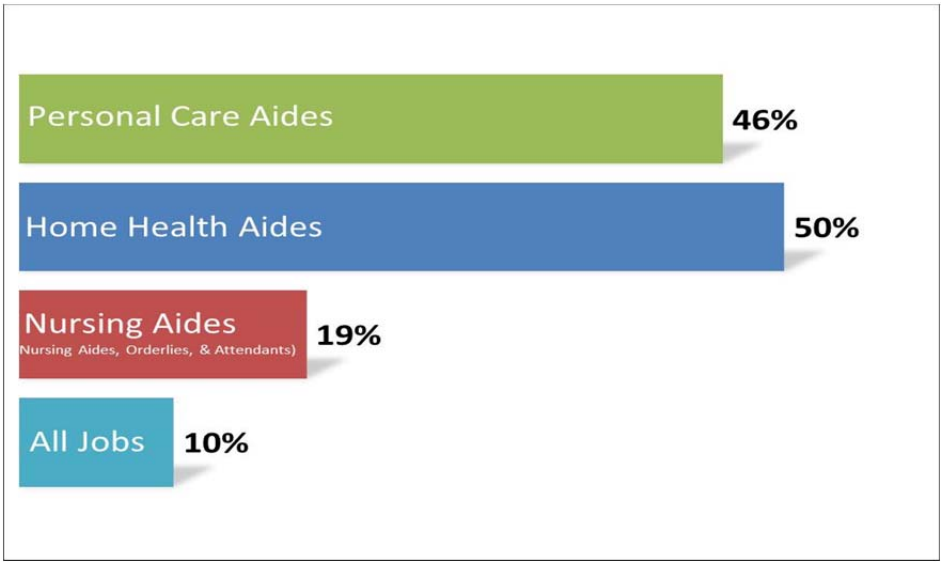


Source: Counts of Home Health and Personal Care Aides are from U.S. Bureau of Labor Statistics, Occupational Employment Statistics Program; counts of independent providers in public programs are from PHI State Data Center (http://phinational.org/policy/states)

directly for individuals and their families under private arrangements. This segment is often referred to as the "grey market," an acknowledgement of the unknown scale of these arrangements.

The home care and personal assistance workforce has been and is expected to continue to be one of the fastest growing in the country. The Bureau of Labor Statistics projects that Home Health Aides and Personal Care Aides will be the third- and fourth-fastest growing occupations in the country between 2008 and 2018, increasing by 50 percent and 46 percent, respectively, and generating over 830,000 new jobs due to growth alone. (For state-by-state statistics on projected demand for direct-care workers, see Appendix 2.)

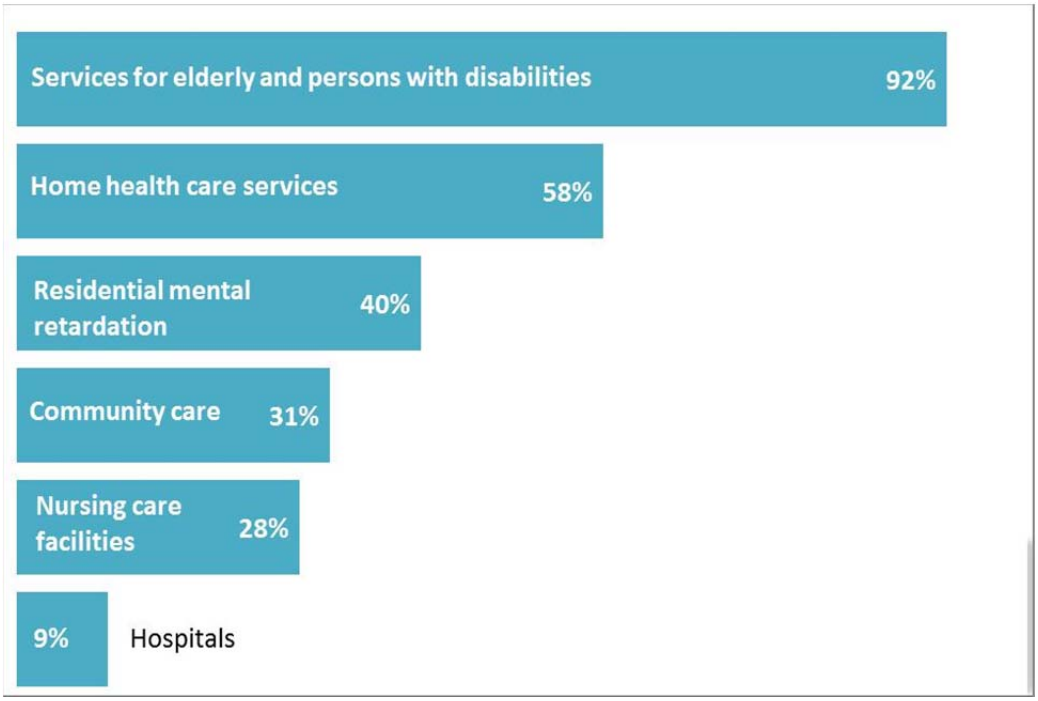
Figure 2.2: Projected Growth in U.S. Direct-Care Jobs, 2008-2018



Source: PHI (February 2010). Occupational Projections for Direct-Care Workers, 2008-2018, FACTS 1. Available at: http://directcareclearinghouse.org/download/PHI%20FactSheet1Update_singles%20(2).pdf

Furthermore, the two industries that provide the vast majority of home care and personal assistance services — Home Health Care Services and Services for the Elderly and Persons with Disabilities — are expected to be among the fastest growing industries in the economy. Employment of aides in the former industry is projected to increase by 58 percent from 2008 to 2018 and the latter by 92 percent (see Figure 2.3 below). Striking as they are, these numbers do not include the vast majority of home care and personal assistance workers who are employed directly by private households (*i.e.*, non-agency employed independent providers).

Figure 2.3: Projected Growth in Direct-Care Employment by Selected Industries, 2008-2018



Source: PHI (February 2010) Occupational Projections for Direct-Care Workers, 2008-2018, FACTS 1. Available at: http://directcareclearinghouse.org/download/PHI%20FactSheet1Update_singles%20(2).pdf

Job Titles and Tasks Performed

A variety of job titles are used in the home care and personal assistance industry to identify paraprofessional workers who assist their clients with self-care tasks, everyday tasks, some medically-related tasks, and also with social supports. These job titles include: home health aides, home care aides, personal care aides, personal assistants, home attendants, homemakers, companions, personal care staff (used in Adult Care Facilities), and resident care aide (used in Assisted Living Residences). Another common job title is "direct support professional," a term which refers to a person providing assistance to persons with intellectual and developmental disabilities.[2]

Official U.S. occupational codes recognize two job titles within the home care and personal assistance industry: **Personal Care Aides** (SOC 39-9021) and **Home Health Aides** (31-1011).[3] Home Health Aides are categorized as a "Healthcare Support" Occupation whereas Personal Care Aides are designated as a "Personal Care and Service" Occupation.

As noted in Section 4 of this report, public programs—Medicaid and Medicare, in particular—finance over 80 percent of home care and personal assistance services in the United States, according to federal national expenditure accounting. As the largest purchaser of in-home services and supports, federal and state governments exercise considerable influence over the definition and categorization of home care services and tasks, and play a crucial role in shaping the overall home care and personal assistance industry.

The tasks that these aides perform are largely defined by the parameters of public long-term care programs, since it is these programs which are the largest payors of in-home services and supports. Tasks performed can be sorted into three main categories:

- Paramedical tasks
- Assistance with self-care tasks (also known as Activities of Daily Living (ADLs)) and with everyday tasks (also called Instrumental Activities of Daily Living (IADLs))
- Social supports related to ADLs and IADLs

Paramedical tasks are health care tasks that usually are performed by home care workers who are certified as home health aides.[4] These tasks may include: ostomy hygiene, catheter hygiene, bowel hygiene, changing aseptic dressings, and administering non-injectable medications.

ADLs generally refer to the following activities: eating and drinking, activities related to personal hygiene (*e.g.*, bathing, oral, hair, skin care, and nail care), dressing, transferring (getting in or out of a bed or chair), using the toilet and maintaining continence, and ambulation.

IADLs refer to tasks that enable a person to live independently at home. They can include: preparing meals, shopping for groceries or personal items, performing light housework (*e.g.*, keeping living areas neat and clean, laundry, changing bed linens), taking medications, using the telephone, escorting outside the home (*e.g.*, accompanying the consumer to medical service appointments or to the store to buy food), and managing money (*e.g.*, paying bills).

Social Supports are services that enable the consumer to take an active part in his or her family and community through such means as providing a personal attendant to accompany a consumer to regular religious services or other social gatherings [5] or ensuring that a consumer's cognitive state does not deteriorate due to social isolation

(particularly if the consumer lacks an active social network). Social supports also consist of supervision and assistance provided to persons with cognitive impairments, including persons with mental illness or mental retardation as well as persons who have Alzheimer's disease and other forms of dementia.

For examples of Plans of Care for in-home services from several states, see Appendix 7.

Changes in Home Care and Personal Assistance Duties and Practices

Over the past 25 years, the locus of care and support for people in need of long-term services has increasingly shifted to home and community based settings and away from institutional settings. National industry employment projections indicate that by 2018, home and community-based direct-care workers will outnumber facility workers by nearly two to one.[6] Several states already exceed these proportions. For example, three-quarters of California's direct-care workforce is employed in home- and community based settings.[7]

As the tasks performed have evolved to require more extensive and demanding duties—and often greater autonomy, responsibility and skill—the challenges faced by home care and personal assistance aides in fulfilling their roles have grown. Furthermore, changes in the acuity of the consumer population mean that these workers are now providing services to an increasing number of nursing home-eligible consumers in home and community-based settings. Whether they are persons with physical, developmental, and intellectual disabilities, or people with chronic or terminal illnesses and conditions, many of these consumers are older, frailer, and more impaired than the consumer population served even a decade ago. Additionally, homecare workers must practice their caregiving skills with far less direct supervision and access to on-site consultation from professionals than nursing assistants in institutional settings.

Role of Fellowship and Protection

The simple provision of "fellowship and protection" is not the service for which the vast majority of home care and personal assistance workers are being engaged. Rather the home care and personal assistance workers are primarily hired to assist with paramedical tasks, ADLS, and IADLs as described above. Indeed, home care services are only financed by Medicaid if the supervision and assistance are directly related to the performance of ADLs and IADLs, and do not include simple companionship or custodial observation of an individual. According to the Medicaid Manual of the U.S. Department of Health and Human Services:

> *A state may now extend such services to include supervision and assistance to persons with cognitive impairments, which can include persons with mental illness or mental retardation as well as persons who have Alzheimer's disease and other forms of dementia. However, this supervision and assistance must be related directly to performance of ADLs and IADLs. Simple companionship or custodial observation of an individual, absent hands-on or cueing assistance that is necessary and directly related to ADLs or IADLs, is not a Medicaid personal care service.*[8]

The U.S. Department of Labor currently defines "companionship services" as: "those services which provide fellowship, care, and protection for a person who, because of advanced age or physical or mental infirmity, cannot care for his or her own needs. Such services may include household work related to the care of the aged or infirm person such as meal preparation, bed making, washing of clothes, and other similar services."[9]

Fellowship is further defined as 'the condition of being together, friendship and coming together in a congenial atmosphere. Fellowship might involve reading a book or a newspaper to the person, chatting with him or her about family or other events, playing cards, watching television or going for a walk.'[10] Protection refers to 'being present in the home of the individual to ensure the safety and well-being of that individual.'[11]

Under Medicaid, some states reimburse for "protection" explicitly for consumers living with mental disabilities. "Fellowship" is not a reimbursable service under Medicaid and is distinct from the area of social supports and socialization described above. The latter activities tend to be authorized only when they are connected to ADL and IADL assistance.

Some states, however, may use the term "Companionship Services" to refer to Social Supports activities even though the Social Support activities are not defined as fellowship and protection but rather relate to socialization and goal-oriented teaching, which can be reimbursable activities.

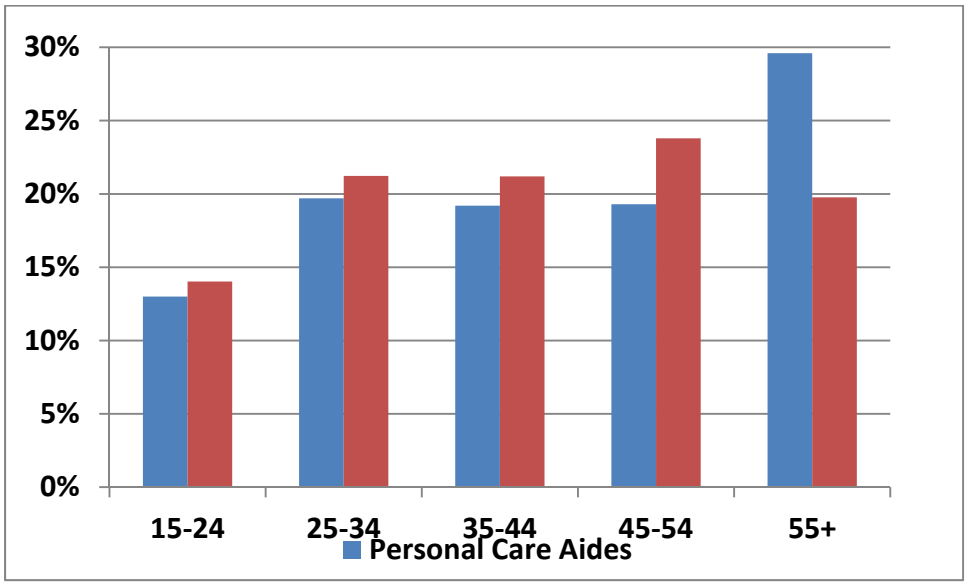
Demographics

A basic demographic picture of the home care and personal assistance workforce can be gleaned from the Current Population Survey for Personal Care Aides[12] and the National Home Health Aide Survey for Home Health Aides.[13]

Like the direct-care workforce in general, home health and personal care workers are overwhelmingly female—on the order of 90 percent.[14] The data also suggest that when men do work in this field, they are more likely to be Personal Care Aides than Home Health Aides.

The average age of Home Health Aides and Personal Care Aides is mid-forties, older than women in general in the civilian labor force.[15] As shown in Figure 2.4, in 2009, nearly 29 percent of Personal Care Aides were age 55 and older, while only 19 percent of females in the civilian workforce were in this age cohort.[16] [17] And, at least for Personal Care Aides, it is clear that this workforce is aging: women 55 and older constitute an increasing share of these workers, and by 2018 about a third of Personal Care Aides can be expected to be ages 55 and older, up from 22 percent in 2008.[18]

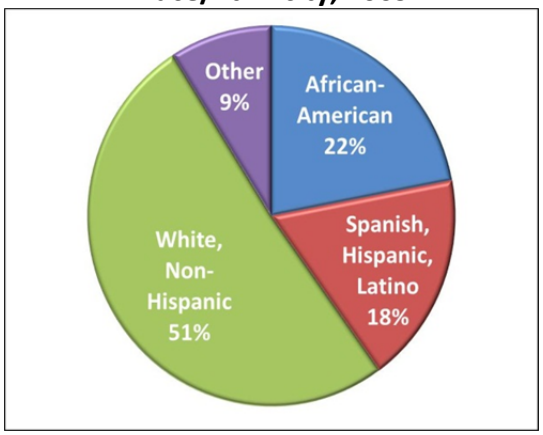
Figure 2.4: Age Distribution of Personal Care Aides and Overall Female Workforce Compared, 2009



Source: PHI, (April 2010). *Older Direct-Care Workers: Key Facts and Trends*, available at: http://phinational.org/policy/about-the-workforce/an-aging-direct-care-workforce/

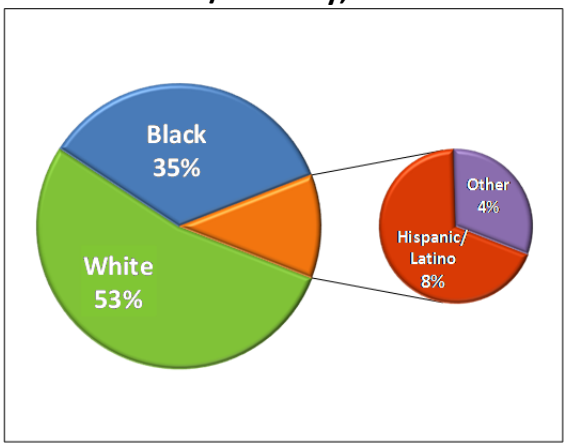
The home care and personal assistance workforce is disproportionately minority: roughly half of aides are non-white. The data suggest that, of home care and personal assistance workers, Hispanics are more likely to be Personal Care Aides than Home Health Aides, whereas the reverse is true for African Americans (see Figures 2.5 and 2.6 below).

Figure 2.5: Personal Care Aides: Race/Ethnicity, 2009



Source: PHI, (February 2011). FACTS 3: Who are Direct-Care Workers? Available at: http://www.directcareclearinghouse.org/download/PHI%20Facts%203.pdf

Figure 2.6: Home Health Aides: Race/Ethnicity, 2007



Source: PHI analysis of public use data files for the National Home Health Aide Survey, 2007, National Center for Health Statistics, Center for Disease Control and Prevention. Compiled data from two questions.

Of Personal Care Aides, 23 percent are foreign-born. However, in some regions of the country, such as the Pacific and Mid-Atlantic regions, this percentage is considerably higher (42 and 30 percent, respectively). In California and New York, over 45 percent of Personal Care Aides are foreign born.

Among Personal Care Aides, 55 percent report having a high school diploma or less. Of Home Health Aides, 60 percent report having a high school diploma or less.

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[1] Occupational employment estimate for the Direct-Care Workforce is from the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics (OES) Program, 2010. Plus PHI estimate of IPs employed in 18 states. Plus PHI estimate of IPs employed in 18 states. See: http://phinational.org/policy/states/data-sources-definitions/

[2] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2010-11 Edition*, Home Health Aides and Personal and Home Care Aides, on the Internet at http://www.bls.gov/oco/ocos326.htm (visited *July 31, 2010*).

[3] For the official definitions of these two occupations, see U.S. Bureau of Labor Statistics (Feb 2010). 2010 SOC Definitions (available at: http://www.bls.gov/soc/soc_2010_definitions.pdf).

SOC 39-9021 Personal Care Aides Assist the elderly, convalescents, or persons with disabilities with daily living activities at the person's home or in a care facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide assistance at non-residential care facilities. May advise families, the elderly, convalescents, and persons with disabilities regarding such things as nutrition, cleanliness, and household activities. [Note "Personal Care Aide" is a new occupational title in the 2010 SOC, changed from "Personal and Home Care Aide."]

31-1011 Home Health Aide: Provide routine individualized healthcare such as changing bandages and dressing wounds, and applying topical medications to the elderly, convalescents, or persons with disabilities at the patient's home or in a care facility. Monitor or report changes in health status. May also provide personal care such as bathing, dressing, and grooming of patient.

[4] Some states allow non-certified personnel to provide paramedical services. For instance, Missouri allows ostomy hygiene, catheter hygiene, bowel hygiene, the changing of aseptic dressings, and the administering of non-injectable medications to be performed by uncertified homecare workers. See: http://www.dhss.mo.gov/HCBS/103.20DA-3cForm.doc) and http://www.dhss.mo.gov/HCBS/InHomeProposalPackets.html.

[5] "Social supports are intended to help individuals take an active part in both their family and community. Such supports help avoid social isolation. Social supports such as companion services, for example, provide assistance so that individuals can participate in community activities (e.g., by providing a personal attendant to enable the individual to attend church)." U.S. Department of Health and Human Services (November 2000) *Understanding Medicaid Home and Community Services: A Primer*, p. 57. Available at: http://aspe.hhs.gov/daltcp/reports/primer.pdf.

[6] PHI (February 2010) "FACTS 1: Occupational Projections for Direct-Care Workers 2008-2018." Available at: http://directcareclearinghouse.org/download/PHI%20FactSheet1Update_singles%20(2).pdf.

[7] PHI (December 2010) "State Facts: California's Direct-Care Workforce." Available at: http://www.directcareclearinghouse.org/download/CA%20Fact%20Sheet-%2011-04-10.pdf.

[8] U.S. Department of Health and Human Services (November 2000) *Understanding Medicaid Home and Community Services: A Primer*, p. 61. Available at: http://aspe.hhs.gov/daltcp/reports/primer.pdf.

[9] 28 C.F.R.§552.6

[10] Code of Federal Regulations 2/20/1975: http://www.dol.gov/dol/allcfr/title_29/Part_552/29CFR552.6.htm. The "Senior Companion Program" contains a looser definition: http://law.justia.com/us/cfr/title45/45-4.1.9.11.34.html#45:4.1.9.11.34.1.22.2 Referred to in 1/19/2001 proposed companionship rule. 29 CFR Part 552, Federal Register, Vol. 66, No 13, January 19, 2001 "Application of the Fair Labor Standards Act to Domestic Service.

[11] Code of Federal Regulations 2/20/1975: http://www.dol.gov/dol/allcfr/title_29/Part_552/29CFR552.6.htm. The "Senior Companion Program" contains a looser definition:

http://law.justia.com/us/cfr/title45/45-4.1.9.11.34.html#45:4.1.9.11.34.1.22.2 Referred to in 1/19/2001 proposed companionship rule. 29 CFR Part 552, Federal Register, Vol. 66, No. 13, January 19, 2001 "Application of the Fair Labor Standards Act to Domestic Service. Some states also define *protection* using above language with regard to their Intellectual/ developmental disabilities program services.

[12] PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic (ASEC) Supplement, with statistical programming and data analysis provided by Carlos Figueiredo. Data for PCAs are for 2009. While data on Home Health Aides is also collected in CPS, numbers specific to this occupation alone cannot be ascertained as Home Health Aides are combined with Nursing Aides in this survey.

[13] PHI analysis of the Centers for Disease Control, National Home Health Aide Survey, 2007, with statistical programming by Tiffany Mason. The downloadable public use data files of the NHHAS are available at: http://www.cdc.gov/nchs/nhhas.htm. The weighted sample of workers in the NNHAS consists of 160,720 aides.

[14] 95% of Home Health Aides are women, 88% of Personal Care Aides are women.

[15] The mean age of Home Health Aides is 46, and of Personal Care Aides is 44.

[16] PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic (ASEC) Supplement, with statistical programming and data analysis provided by Carlos Figueiredo.

[17] PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic (ASEC) Supplement, with statistical programming and data analysis provided by Carlos Figueiredo.

[18] PHI (April 2010). "Older Direct-Care Workers: Key Facts and Trends", available at: http://www.directcareclearinghouse.org/download/PHI%20Older%20DCW%20Analysis%20April%202010.pdf

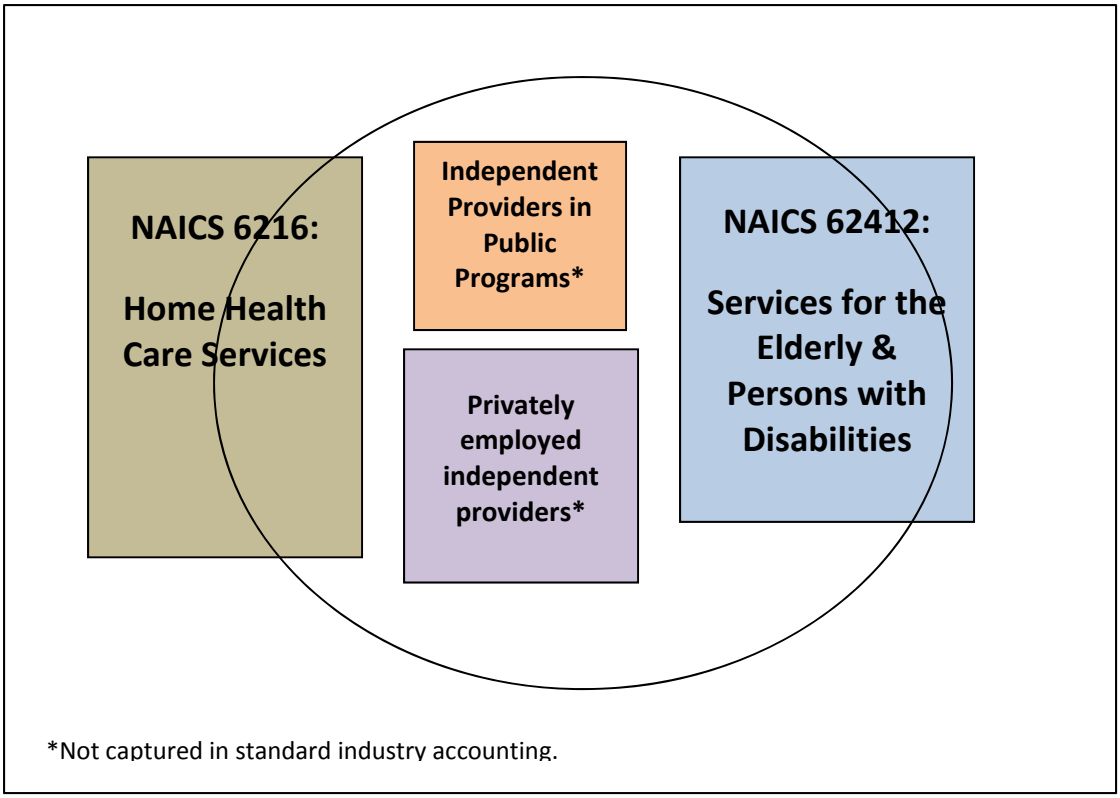
Section 3 The Industry Sector

While what is meant by the "home care workforce" is fairly straightforward, the establishments and service providers that make up the "home care industry" are less well defined. It is often assumed that the formal industry called "Home Health Care Services" (NAICS 6216) is synonymous with the "home care industry," but as this section explains, there are other equally important groups of providers that make up this sector.

Types of In-Home Care Providers

Figure 3.1 below provides a schematic of the in-home services and supports industry sector, Note that, as defined by the circle in the diagram, the in-home care sector includes parts of two formally defined industries[19] — Home Health Care Services and Services for the Elderly and Persons with Disabilities — but does not fully include them.

Figure 3.1: Schematic of the In-Home Services & Supports Industry Sector



In addition to parts of these two important industries, the sector also includes two groups of non-agency based providers: independent providers in public program and privately employed independent providers. These four groupings of providers are described more fully below.

In-home care providers are primarily engaged in providing non-medical and paramedical assistance to elders and persons with intellectual, developmental, or physical disabilities. These entities provide services and supports related to living and functioning independently in the workplace or a home or community setting. Many, but far from all of these services are provided within publicly-financed medical assistance programs, such as Medicaid, Medicare, and various state-only financed programs.

Across the two industries—Home Health Aide Services and Services for the Elderly and Persons with Disabilities, some of the main employers include: home health care services companies, non-medical home care companies, private households directly employing home care and personal assistance aides.

Home health care services companies. These refer to traditional companies that provide medically-oriented home health care services and sometimes also non-medical home care or personal assistance services. Examples of traditional types of home health care companies include: for-profit home care agencies, Visiting Nurse Associations (voluntary non-profits), private not-for-profit home care agencies, and facility-based home care agencies that are attached to hospitals, rehabilitation facilities, or skilled nursing facilities. Some home health care companies also provide in-home hospice and palliative care services.

Home health care companies may participate in publicly-financed programs or operate independently. Over 9,000 home health care companies are Medicare-certified. Agencies that remain outside of Medicare often do so primarily because they choose not to offer the breadth of services that Medicare requires, such as skilled nursing care.

The services that home health care companies provide are broader than just home care and personal assistance. For example, these companies also provide: skilled nursing, physical therapy, occupational therapy, speech therapy, audiology, occupational therapy, medical social services, dietary and nutritional services, and bereavement counseling. In addition, some providers derive substantial revenue from the provision of durable medical equipment, infusion services and equipment, and telehealth equipment.[20]

As the demand for home care and personal assistance services has increased, traditional home health care services have expanded their capacity to provide non-medical services. One consequence is that increasing numbers of Personal Care Aides, in addition to Home Health Aides, are now employed in the Home Health Care Services industry. According to estimates from the Employment Projections Program of the Bureau of Labor Statistics, in 2008, 40 percent of direct-care workers in the Home Health Care Services industry were Personal Care Aides. Another 52 percent were Home Health Aides, and the remaining 8 percent were Nursing Aides.[21]

Non-medical home care agencies in Services for the Elderly and Persons with Disabilities. Market research studies of the "home care industry" tend to be confined to the companies and organizations that make up Home Health Care Services (HHCS). Very little attention has been paid to Services for the Elderly and Persons with Disabilities (SEPD) and, as a result, these studies lack a complete picture of the range of providers that make up this industry. Services for the Elderly and Persons with Disabilities is defined as encompassing:[22]

> *[E]stablishments primarily engaged in providing nonresidential social assistance services to improve the quality of life for the elderly, persons diagnosed with mental retardation, or persons with disabilities. These establishments provide for the welfare of these individuals in such areas as day care, nonmedical home care or homemaker services, social activities, group support, and companionship.*

For-profit franchise chains. A growing number of non-medical companies are chain-affiliated. In fact, one of the fastest growing players in the in-home care sector is for-profit franchise chains that provide non-medical personal assistance services. This sector is highly fragmented with over 35 different franchise brands.[23] Among the most well-known brands are: Comfort Keepers, Home Instead Senior Care, and Visiting Angels. With just a couple of exceptions, most of these companies have been franchising for less than a decade.

The niche positioning of many franchises is the "senior care industry" which is described as "a vibrantly growing, multi-billion dollar segment of the U.S. economy"[24] with vast market opportunity. Even during the current recession, this industry has been performing solidly: from 2007 to 2009, the number of franchise "units" (locations) increased 9.4 percent (compound annual growth rate) and corporate revenues (from franchise fees and royalties) increased by 11.6 percent.[25]

This industry segment has relatively low barriers to entry because of low start-up costs—under $100,000 including franchise fees and initial cash requirements—and state

licensing requirements that are in many states either non-existent or very modest (see below). Many new franchisees begin operations out of a home office, with prospects of gross margins on the order of 30 to 40 percent.[26]

Underlying these margins are significant spreads between the billing rates for services, on the one hand, and the wages paid to aides, on the other. Based on findings from a recent member survey conducted by the National Private Duty Association, Table 3.1 below compares recent national average billing rates for different types of home health and personal care services with starting pay received by aides. The national average hourly cost of services ranged from $18.75 per hour for companionship services to $22.37 for home health services. Reported hourly pay rates for aides make up approximately 50 percent of the rates charged.

Table 3.1: Comparing Cost of Home Care Services and Caregiver Pay, 2008

Type of Service	National Average Cost of Services (per hour)	National Average Starting Pay for Caregivers (per hour)
Companionship	$18.75	$8.92
Homemaker services	$18.90	$9.10
Personal care	$19.82	$9.69
Home health Services	$22.37	$11.78

Source: National Private Duty Association (2009) State of Caregiving Industry Survey, Executive Summary. Available at: NPDA State of Caregiving Industry

Currently, the leading franchises in terms of number of locations or "units" are Home Instead, Comfort Keepers, Home Helpers, and Visiting Angels. These four brands account for about 2,400 locations. The largest franchises in terms of corporate revenue are Home Instead, Interim HealthCare, Visiting Angels and Comfort Keepers.[27] Some of these organizations have expanded their networks internationally.

Home Instead is considered to be not only the leading senior care franchise but also the largest franchise system period in the U.S. And in 2010, Comfort Keepers made it onto the Inc. 5000 list of the top 5000 fastest-growing companies in the U.S. with a three-year sales growth of 32 percent.[28]

The number of home care and personal assistance aides employed by the franchise sector is unknown. Home Instead has reported that it employs "nearly 65,000 trained CAREGivers℠,"[29] and Interim Health reports employing 75,000 aides. It would not be surprising if employment in this sector approached 500,000 aides.

Non-chain affiliated private-duty home care companies specialize in the provision of **non-medical home care**.[30] According to the trade association representing these companies—the National Private Duty Association—these companies provide "personal care services, errands and housekeeping services, and other related services in the home of Americans over the age of 65, people with disabilities, and children with special medical needs."[31] The Association has 1,200 members, some of which are franchise companies.

Home care and personal assistance aides working directly for private households. There are hundreds of thousands of households that directly hire home care and personal assistance workers ("independent providers"), rather than engage the services of an agency. These independent providers can be divided into two categories:

- **Independent providers serving individuals who participate in public programs that allow them to hire their own home care or personal assistance aide.** These programs are often called consumer- or participant-directed programs. The consumer/participant (or their surrogate) employs the aide either on their own, jointly with an agency, with a Fiscal Management Service (FMS) that is responsible for performing fiscal and business services, or with the state.(See Section 4 for more information on the structure of this service delivery system.)
- **Independent providers hired privately by individuals or their family members.** Most of these employment arrangements are unreported and unregulated, and constitute a vast "grey market" that helps to meet the growing demand for in-home services and supports. The consumer may or may not meet basic employment standards or pay required employer taxes on behalf of the worker, such as Social Security, unemployment compensation, and workers' compensation.

Although independent providers represent a fast-growing segment of the home care and personal assistance industry, standard surveys of workers and establishments conducted by state and federal government fail to fully capture the size of this workforce. As a result, it is nearly impossible to quantify the industry's full economic and financial dimensions.

For example, the BLS Employment Projections Program (EPP), in its national employment matrix for 2008, estimates that nearly a quarter of Personal Care Aides (PCAs) work directly for a household.[32] According to EPP, Personal Care Aides in the year who worked directly for private households numbered approximately 190,000, but we know that this is a *substantial* underestimate. Indeed, across the eleven states that

allow independent providers within their public home care and personal assistance programs to engage in collective bargaining (CA, IL, IA, MA, MD, MI, MO, OH, OR, WA, and WI), there are over 500,000 Personal Care Aides who reportedly work as independent providers. (See Section 4 for more information on this undercounting problem.)

Uneven State of Licensure for In-Home Care Providers

For a home health care company to receive reimbursement from Medicare, that agency must be certified as a Medicare home health provider to ensure that it meets federal health and safety requirements. State survey agencies are responsible for inspecting and certifying Medicare home health agencies for the Centers for Medicare and Medicaid Services (CMS). There is no federal requirement that an agency delivering intensive home health services be certified for Medicare; any business can forego Medicare funding.

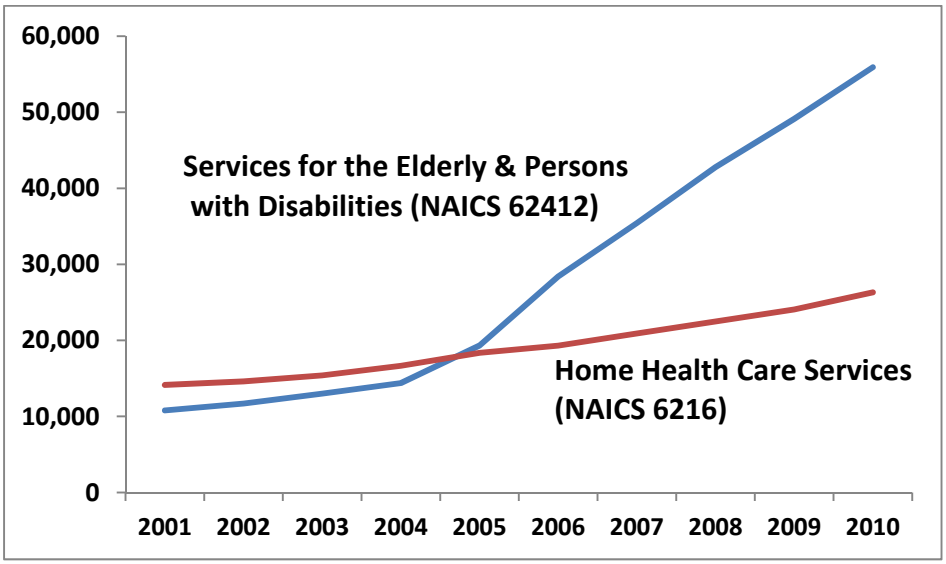
States are left to set standards for agencies that will deliver non-medical in-home services, including non-medical home care paid for by Medicaid. At the same time, states can set licensing requirements for certified Medicare home health agencies and any and all other businesses who want to deliver in-home services at any level of intensity. Licensure requirements in some states extend to independent providers and often provide for criminal background checks for the employees of home care agencies. Some include minimum education and training requirements for aides.

States without licensure requirements for non-medical or custodial services are particularly low barrier-to-entry states for agencies that want to deliver intensive or non-medical home care services. Currently, 19 states do not require licensure of non-medical in-home care agencies. An additional three states have a licensure bill in progress (California, Hawaii, and Michigan). For a listing of states with and without licensure requirements, see Appendix 5.

Numbers of Agency Providers

The number of agency providers in both HHCS and SEPD has skyrocketed in recent years. As shown in Figure 3.2, the number of home health care "establishments"[33] grew from 14,133 in 2001 to over 26,000 in 2010, a 7 percent increase per year. Establishments captured in SEPD increased 20 percent per year, from 10,789 to 56,000, and now far eclipse the number of home health care establishments.

Figure 3.2: Number of Establishments by Industry, 2001 - 2010



Source: US Bureau of Labor Statistics, Quarterly Census of Employment and Wages.

Home Health Care Services Industry

As indicated in Figure 3.2 above, the home health care industry includes an estimated 23,826 home health agency establishments nationwide. According to the most recent National Home and Hospice Care Survey, these establishments are operated by some 14,500 home health and hospice care agencies.[34] This number represents an extraordinary increase from 1963, when only 1,100 home care providers were in operation. The home health care industry burgeoned after the enactment of the Medicare program in 1965. Hospices now constitute an important segment of the home health care industry and they have also experienced widespread growth since the mid-1980s. Hospices have increased from just 31 Medicare-certified facilities in 1984 to well over 3,000 by the end of the 2000s.[35]

While there has been a trend toward consolidation, the Home Health Care Services industry remains highly fragmented with the 50 largest companies generating less than 25 percent of the revenue, and no industry player accounting for more than 3 percent of industry receipts.[36] Major companies include: Apria Healthcare Group, Gentiva Health Services, and Lincare Holdings.

The vast majority of Medicare-certified agencies are privately owned. Eighteen percent of certified agencies are facility-based, mostly operating in conjunction with a hospital system.[37] The remainder is free-standing, and of these agencies, 70 percent are for-profit. In sharp contrast, in 1980 only 7 percent of free-standing agencies were proprietary.

According to the 2007 National Home and Hospice Care Survey, roughly a third of home health care only agencies were part of a chain in 2007 which was significantly lower than the percentage reported in 1996 (51 percent) and 2000 (47 percent).[38]

Services for the Elderly and Persons with Disabilities

The explosive growth in the number of establishments in this industry parallels other aspects of the industry's growth. The BLS Employment Projections Program projects a 74 percent increase in position openings over the period 2008 to 2018, with employment topping a million towards the end of the decade.

Between 2001 and 2010, estimated employment in SEPD more than doubled, increasing from 326,582 to 723,429, according to the Quarterly Census of Employment and Wages. This industry is thought to have very low barriers to entry, and until recently it has been dominated by a plethora of mom-and-pop outfits. In the last five years, with the growth of the for-profit franchise chains discussed above, there has been some increased consolidation.

Estimated Revenues

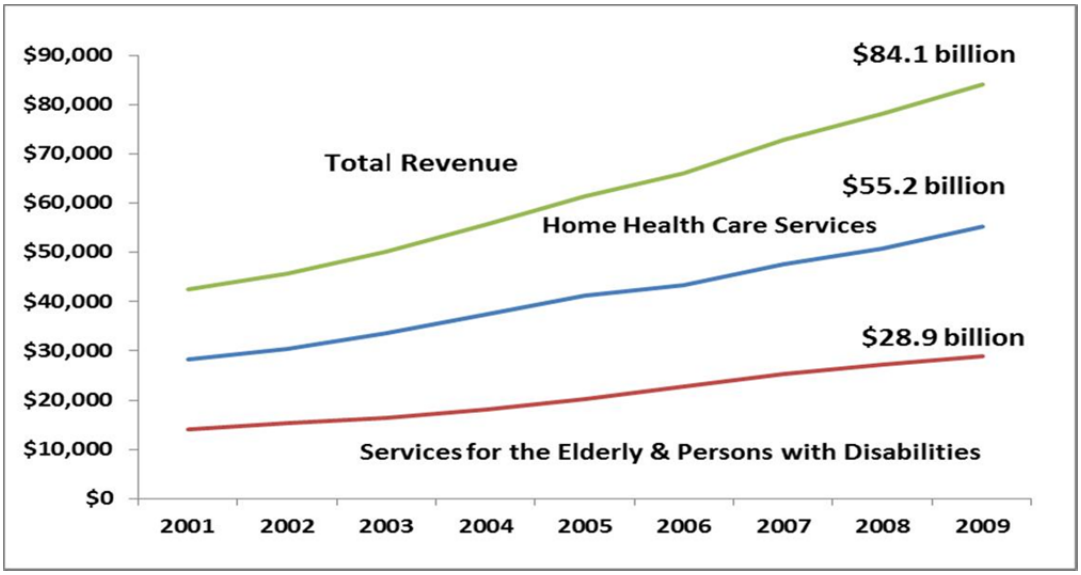
According to the Service Annual Survey Data of the U.S. Census Bureau, in 2009 the combined revenues of the two key industries providing home care and personal assistance totaled over $84 billion (see Figure 3.3 below). With annual revenue of approximately $30 billion, SEPD is now more than half the size of HHCS. Both industries have been growing at a phenomenal pace over the last decade, with revenue increasing at an average annual rate of 9 percent per year, over the period 2001 to 2009.

Industry analysts foresee that the home health care services industry will evolve to focus more on chronic disease management. This will position the industry to spur new demand and allow it to compete effectively with institutional care providers such as hospitals. According to one forecast, industry revenue will grow at an average annual rate of 5 percent during the five years to 2016 and reach $84.3 billion by the end of the period.[39] The Bureau of Labor Statistics projects that home health care services will be the fourth fastest growing industry employer through 2018.[40]

Non-profits dominate SEPD while for-profits dominate HHCS. In HHCS, 69 percent of revenue in 2009 was earned by taxable entities, compared to 31 percent of SEPD revenue. However, the percent of revenue from taxable SEPD entities has nearly tripled across the decade, a trend that reflects rapidly growing business activity in the

provision of non-medical care. This market is described as "virtually untapped and limitless"[41] due to increasing demand, and low barriers to entry.

Figure 3.3: Estimated Industry Revenue, 2001-2009
in millions of dollars

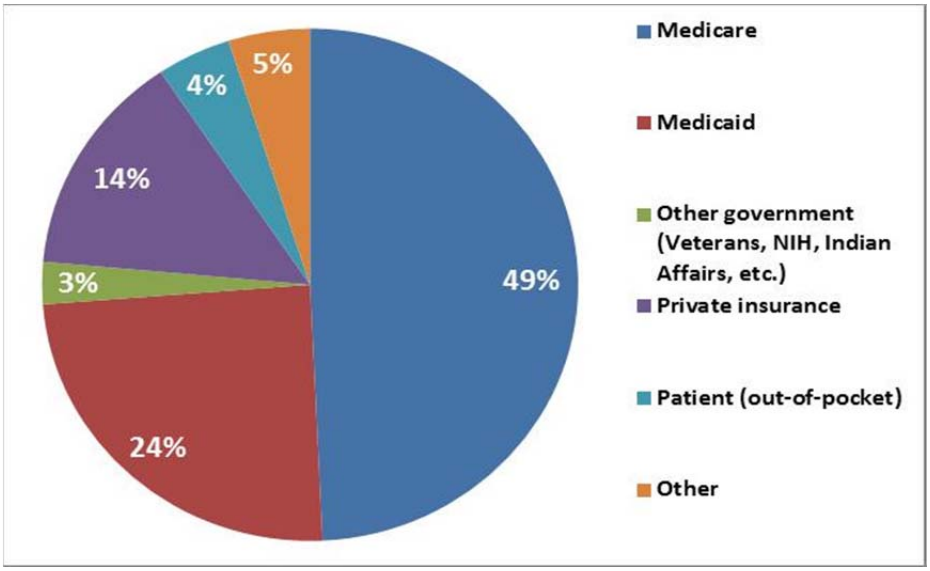


Source: U.S. Census Bureau, Health Care and Social Assistance, 2009 Service Annual Survey Data for Health Care and Social Assistance. Available at: http://www.census.gov/services/sas_data.html.

Preponderant Role of Public Reimbursement in the Home Health Care Services Industry

As shown in Figure 3.4, the Census Bureau estimates that, in 2009 **public reimbursement (Medicare, Medicaid, and other government spending) accounted for three-quarters of the revenue received by employers in the Home Health Care Services industry.** [A similar breakdown of patient revenue for SEPD is not available from the Census Bureau.] Private insurance and private out-of-pocket revenue contributed just under a fifth of the total (18 percent).

Figure 3.4: Home Health Care Services Industry (NAICS 6216)
Estimated Revenue By Source, 2009



Source: US Census Bureau, Service Annual Survey Data, Table 8.9. Available at: http://www.census.gov/services/sas_data.html

The dominant role of public reimbursement means that the prices of services in the home health care services industry are primarily determined by Medicare and Medicaid payment rates. Despite strong growth in overall revenue, industry operating profit has been under pressure since 2008 due to declining federal and state budgets, and resulting payment reductions to providers.

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[19] NAICS refers to the 2007 North American Industry Classification System (NAICS), specified by the U.S. Office of Management and Budget. The NAICS replaced the Standard Industrial Classification (SIC) system beginning in 1997.

[20] Ongoing treatments include: respiratory therapy programs, delivery of nutrients either intravenously or through feeding tubes, intravenous infusion of antibiotics to treat infectious diseases, and infusion therapies for patients with fully or partially dysfunctional digestive tracts. Since the majority of companies in the home infusion and respiratory markets are privately held companies, definitive revenue figures are difficult to ascertain. However, the National Home Infusion Association estimates that there are between 700 and 1,000 home infusion companies in operation today, bringing in revenue of $9 to $11 billion annually. This is up from $4 billion a decade ago, according to the Association's president (from http://pharmaceuticalcommerce.com/frontEnd/1285-Home_Infusion_Providers_Struggle_With_Unfriendly_Reimbursement_Policies_.html). The home respiratory market (including home oxygen equipment and respiratory therapy services) conservatively represents another $5 billion in annual sales.

[21] PHI analysis of 2008 industry/occupation matrices for SOC31-1012, 31-1011, and 39-9021. Available at: http://www.bls.gov/emp/.

[22] See http://www.naics.com/censusfiles/ND624120.HTM.

[23] See various sources at http://www.privatedutytoday.com/survey/.

[24] [24] Franchise Business Review (December 2010) *Senior Care and Home Healthcare Franchises*, Special Report. Available at: http://www.franchisebusinessreview.com/content/files/FBR_Senior_Care_Report2010.pdf

[25] Franchise Business Review (December 2010) *Senior Care and Home Healthcare Franchises*, Special Report. Available at: http://www.franchisebusinessreview.com/content/files/FBR_Senior_Care_Report2010.pdf

[26] Franchise Business Review (December 2010) *Senior Care and Home Healthcare Franchises*, Special Report. Available at: http://www.franchisebusinessreview.com/content/files/FBR_Senior_Care_Report2010.pdf

[27] Tabulations by PHI during August 2011 based on search of information available at corporate franchise websites.

[28] See http://franchise.comfortkeepers.com/news/

[29] Home Instead Senior Care (2010), *Paid In-Home Care: Offering Substantial Economic Savings*, White Paper, Omaha, NE: Home Instead. Available at: www.homeinstead.com.

[30] The trade association for private duty companies is called the National Private Duty Association. It says these companies are an "emerging industry." The NPDA currently has about 1200 members.

[31] See www.privatedutytoday.com/survey.

[32] U.S. Department of Labor (DOL), Bureau of Labor Statistics (BLS), *National Employment Matrix, 2008 and projected 2018* for SOC 31-1011, 31-1012, and 39-9021.

[33] "Establishment" refers to an individual worksite or a single business location of a company which is engaged in a single activity. Establishments are classified into industries based on their principal product or activity.

[34] E.Y. Park-Lee and F.H. Decker (November 2010) *Comparison of Home Health and Hospice Care Agencies by Organizational Characteristics and Services Provided: United States, 2007*, National Health Statistics Reports Number 30, National Center for Health Statistics, Center for Disease Control and Prevention, U.S. Department of Health and Human Services. Available at: http://www.cdc.gov/nchs/data/nhsr/nhsr030.pdf

[35] *Encyclopedia of American Industries* (2010 edition) "Home Health Care Services," Farmington Hills, Michigan: Gale Group.

[36] S. Snyder (April 2011), Home Care Providers in the US, IBISWorld Industry Report 62161, p. 28.

[37] National Association for Home Care and Hospice (2008 update) *Basic Statistics About Home Care*. Available at: www.nahc.org/facts/08HC_stats.pdf.

[38] E.Y. Park-Lee and F.H. Decker (November 2010) *Comparison of Home Health and Hospice Care Agencies by Organizational Characteristics and Services Provided: United States, 2007*, National Health Statistics Reports Number 30, National Center for Health Statistics, Center for Disease Control and Prevention, U.S. Department of Health and Human Services. Available at: http://www.cdc.gov/nchs/data/nhsr/nhsr030.pdf

[39] S. Snyder (April 2011), Home Care Providers in the US, IBISWorld Industry Report 62161.

[40] R.A. Woods (2009) "Industry output and employment projections to 2018," **Monthly Labor Review**, Table 3. Available at: http://bls.gov/opub/mlr/2009/11/art4full.pdf

[41] Francine Russo (September 14, 2009) "Franchising the Care and Feeding of Grandma," *Time*, Vol. 174. Available at: http://www.time.com/time/magazine/article/0,9171,1920298,00.html; Kerry Pipes (December 7, 2006) "Aging U.S. Population Is Driving Growth in Elderly Franchising," from http://www.franchising.com/articles/154/.

Section 4 Service Delivery Systems

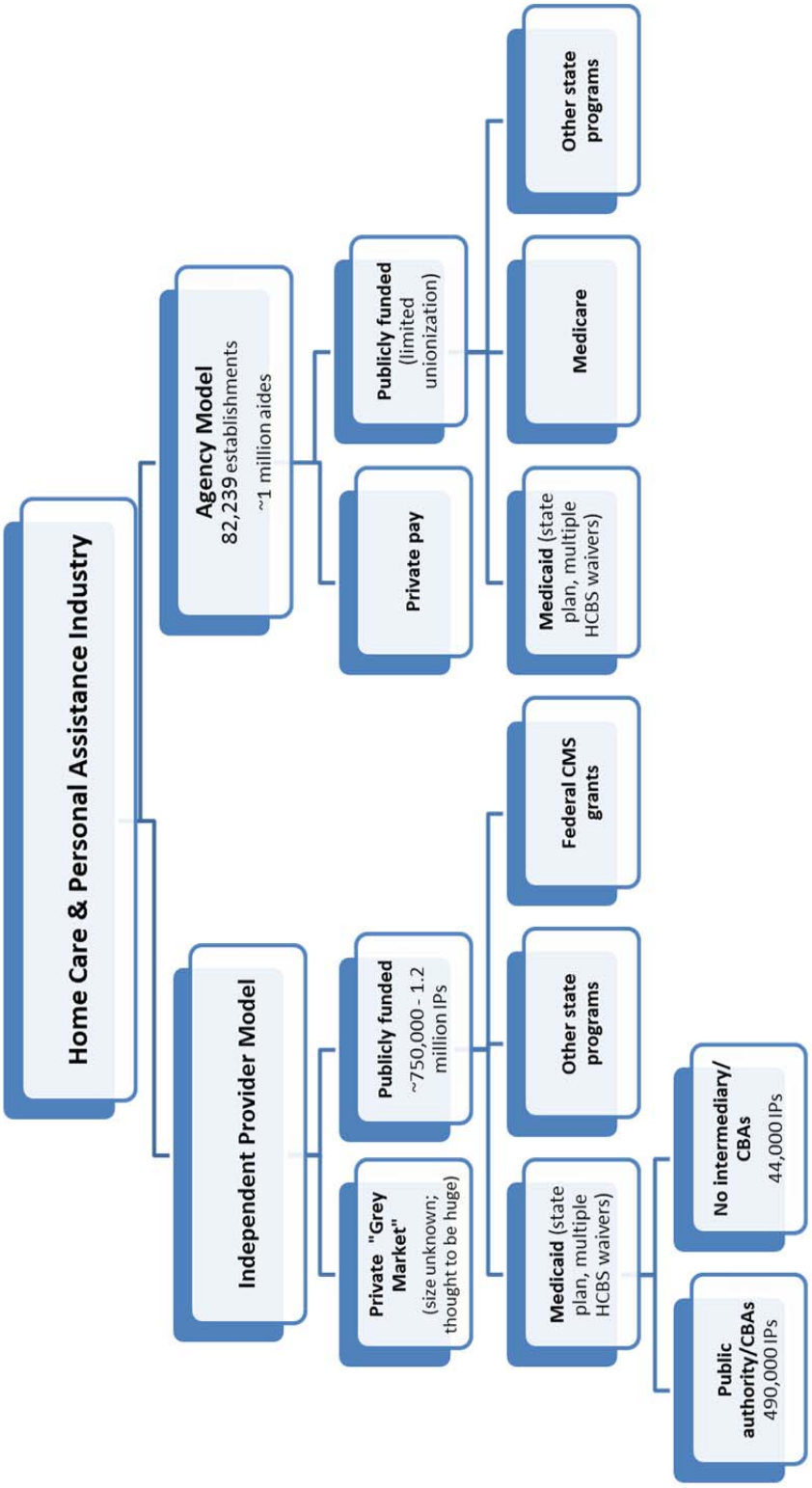
There are two basic models for delivering in-home services and supports in the United States today: an agency model and an independent provider model. Under the agency model, a third-party provider such as a home care organization is responsible for service delivery whereas under the independent provider model, the consumer or family directly hires a home care or personal assistance aide (an "independent provider"). This section begins by describing these two models. It then focuses on publicly-funded service delivery systems, first reviewing the general procedures for determining need and services authorized and, then, presenting nationwide information on expenditures and numbers of participants.

Agency and Independent Provider Models

The schematic on the following page depicts the current organization of service delivery systems for in-home care. Within the **agency model**, in 2010, more than 1 million aides were employed across a universe of 82,239 agency-based establishments that provided services related to in-home services and supports. These agencies employed and assigned these aides and were responsible for monitoring the delivery of services in the consumer's residence.

Under the **independent provider (IP) model**, the consumer assumes a range of employer responsibilities and is responsible for hiring, scheduling, supervising, and terminating the PCA. Because of the consumer's responsibility for exercising workplace authority, he or she is considered to be either the sole employer or a joint employer (with another entity or intermediary).

The IP model in turn has two broad variants: private and public. The *private* strand of the IP model, or "grey market," is fairly invisible. It is made up of households that hire aides under private arrangements, most of which are thought to be unreported and unregulated. The *public* strand operates within a plethora of state-based consumer-directed programs funded either by Medicaid, directly by states, or through programs or grants administered by the Centers for Medicare and Medicaid Services (CMS). All states offer some kind of a consumer-directed option that provides for employer authority. In addition, many states also have programs that provide participants with budget authority, meaning that the participant is provided with a fixed monthly allowance determined by a professional needs assessment and a formula that converts the case manager's assessment into a budget allocation. The allowance is then managed and spent by the participants on purchases related to personal care.[42]


Home Care & Personal Assistance Industry
Agency Model
82,239 establishments
~1 million aides
Publicly funded
(limited unionization)
Private pay
Other state programs
Medicare
Medicaid (state plan, multiple HCBS waivers)
Independent Provider Model
Publicly funded
~750,000 - 1.2 million IPs
Private "Grey Market"
(size unknown; thought to be huge)
Federal CMS grants
Other state programs
Medicaid (state plan, multiple HCBS waivers)
No intermediary/ CBAs
44,000 IPs
Public authority/CBAs
490,000 IPs

Comprehensive counts of aides employed under public and/or private IP arrangements are unfortunately not available. Staffing models developed and utilized by the Employment Projections Program of the Bureau of Labor Statistics assume that about a quarter of direct-care workers are employed directly by private households.[43] PHI has a multi-year project to gather a state-by-state count of independent providers employed in public programs providing in-home care. Counts conducted to date for 18 states reveal a total of 626,000 independent providers, suggesting that the total size of the public IP workforce is substantial.[44]

The agency and IP models differ significantly in their structures and functions, and in the responsibilities they place on both consumers and workers. Under the agency model, the home care organization is responsible for service fulfillment: it directly employs a pool of available workers and carries out the matching function of assigning a particular worker to a particular consumer. Under the IP model, there is no inherent fulfillment platform. Usually, as a result, consumers are responsible for recruiting and hiring their PCAs and workers must search for their own consumer-employer. In other words, consumers and workers must fend for themselves in locating each other and determining workable "matches."[45]

Variants of the Independent Provider Model under Public Programs

Under publicly funded programs, the IP model is usually referred to as "consumer" or "participant" -directed." In 2010:[46]

- 38 states offered consumer-directed options under one or more Medicaid Waivers
- 7 states offered consumer-directed options under their Medicaid Home Health programs
- 12 states offered consumer-directed options under their Medicaid Personal Care Option

According to preliminary findings from the National Survey of Publically Funded Participant-Directed Services Programs, every state reports having at least one employer-authority program that allows participants to select and hire their own worker.[47]

Within state public assistance programs providing in-home services and supports, the IP model can take several distinct forms. One variant is a **"public authority" model.** In this model, a "public authority," or some other governmental or quasi-governmental entity, plays a role in setting compensation and other employment terms for the IP home care worker whose remuneration comes from public funds. This entity also

assumes responsibility for the payment process and, along with the consumer, serves as the "employer-of-record" for the workers. The public authority may also provide supports such as training for consumers and/or providers, and often creates and maintains registries of individual home care provider candidates in order to improve the access of beneficiaries to individual providers. Under the public authority model, IP home care workers, if they choose to, have generally been permitted to designate representatives, pursuant to the state's public sector collective bargaining system, in order to collectively bargain with the governmental entity over home care workers terms and conditions of employment.

Six states have fully implemented some form of the public authority model (CA, MA, MI, OR, WA, WI), and one other state (MO) is in the process of doing so. In each case, IP home care workers have selected the Service Employees International Union (SEIU) or the American Federation of State, County and Municipal Employees (AFSCME) to collectively bargain with the public authority on their behalf.[48]

The number of IPs providing home care and personal assistance services under the public authority model conservatively totals 490,000. Approximately, three quarters of these IPs are based in California and the majority are paid family caregivers.[49]

Four other states—Illinois, Iowa, Maryland, and Ohio—have elected to play a similar role in setting the compensation and other employment terms of IP home care workers, but without creating a separate "public authority" entity. In these states, IP workers providing services under designated public programs have been allowed to designate a representative for collective bargaining with the state. Approximately 44,000 IP homecare workers in these four states have selected either SEIU or AFSCME as their representative to collectively bargain with the state.

In sum, there are approximately 535,000 aides working in public IP programs across the country covered under collective bargaining agreements. Two-thirds of these aides are based in California and the majority are paid family caregivers. In addition to this count of over half a million aides, based on only a partial count of all states (18), we have identified an additional 100,000 IPs who are employed in public programs.

Another home care model utilizing independent providers is the **Cash & Counseling** program. In this model, frail elders and adults with disabilities have the option to manage a flexible budget and to decide the mix of goods and services that best meets their personal care needs.[50] In some states, children with developmental disabilities are also served. Cash & Counseling participants may use their budgets to hire their own personal care aides, and frequently are given significant discretion to negotiate these

aides' compensation terms. Currently, about 17,500 participants across 15 states are receiving assistance through Cash & Counseling programs.[51]

Cash & Counseling participants must otherwise be eligible for state-plan personal care or home and community-based services waiver services. Enrollment caps are permitted. The budget authority for this program was created under the Deficit Reduction Act of 2005. According to the National Resource Center for Participant-Directed Services, as of 2010-11, all states but three provide for at least one program that grants participants budget authority, and states have expanded budget authority arrangements to participants in programs besides Cash & Counseling.[52]

Determination of Need for Home Care & Personal Assistance Services

Home health care is a mandatory service under Medicaid for individuals entitled to Medicaid nursing facility care. The application process for receipt of these services is initiated by a physician's order documenting an individual's need for in-home care. A plan of care is contingent on an assessment performed by a Medicaid-authorized physician who determines the level-of-care required and authorizes a set number of allowed hours of care.[53]

Because the provision of **personal care services** is optional under state Medicaid programs, states have more leeway in how they determine eligibility for these services. Many states require nursing and social assessments performed by RNs and case-managers. These assessments determine the level of care and authorized hours for any one individual.[54]

In the case of **consumer-directed** Medicaid home care services, the same eligibility and assessment criteria apply but with the additional criterion that the consumer or representative be able to direct his or her caregiver. The plan of care, level of service, and authorized hours of service are determined by the same processes. However, instead of then being assigned to a home health or personal care agency, the consumer or representative is allowed to independently hire his or her own care provider. Although the number of hours of service is limited in any given month, the consumer can schedule the receipt of these hours as he or she sees fit. Qualifying for consumer-directed services does not give the consumer the authority to determine the *quantity* of services received.[55]

Public Expenditures on Home Care and Personal Assistance Services

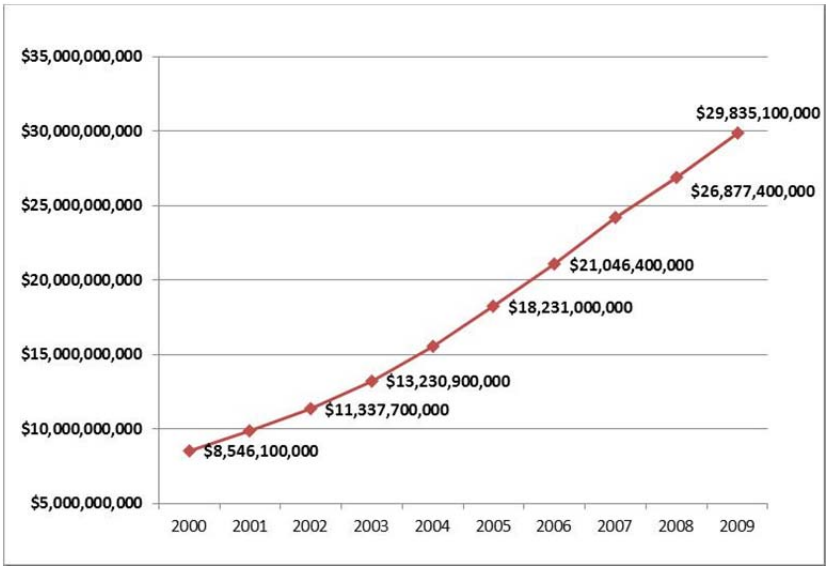
Basic information on the main sources of public expenditures on home care and personal assistance services is publicly available on the following (see Appendix 6 for information on state-by-state expenditures on Medicaid in-home services):

- Medicare Home Health
- Medicaid Home Health
- Medicaid State-Plan Personal Care Services benefit
- Medicaid Home and Community-Based Services Waivers (1915(c), 1915(j), 1915(i)—home care and personal assistance portion

Each of these sources of public expenditures has shown tremendous growth over the last decade.

Medicare Home Health expenditures have tripled, increasing from $8.5 billion to $29.8 billion over the period 2000 to 2009 (Figure 4.1).

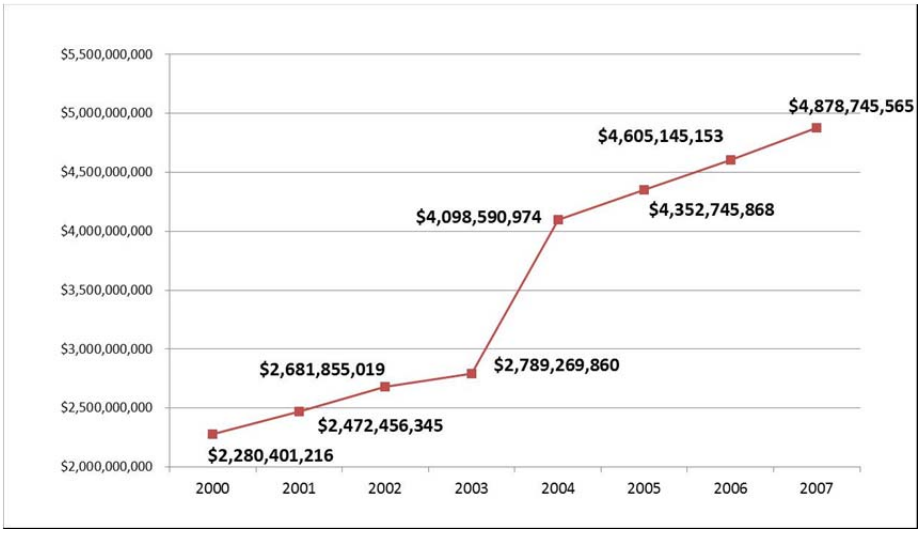
Figure 4.1: Medicare Home Health Expenditures, 2000-2009



Source: Centers for Medicare & Medicaid Services, National Health Expenditures, "Type of Service and Source of Funds, Calendar Years 2009 to 1960".

Medicaid Home Health expenditures doubled over the period 2000 to 2007, increasing from $2.2 billion to $4.9 billion (Figure 4.2). Over the same period, recipients grew by 16 percent, from 703,908 to 813,848.

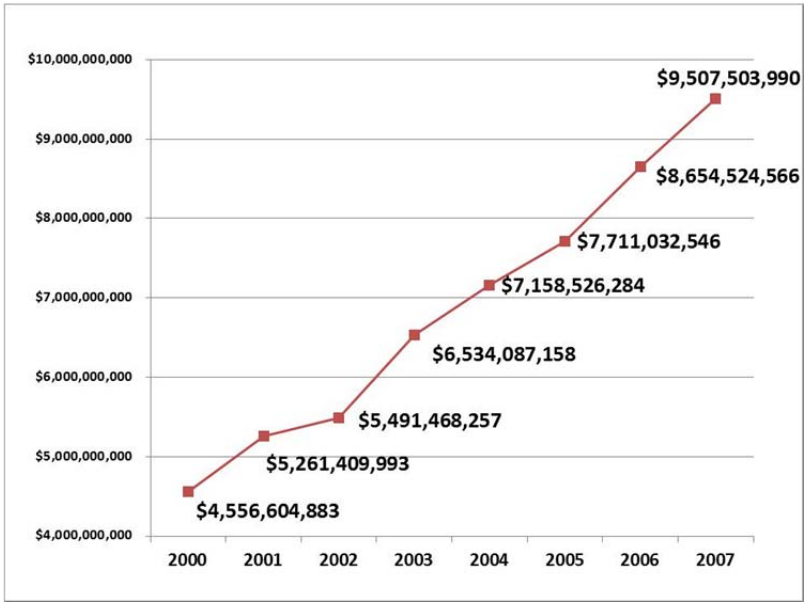
Figure 4.2: Medicaid Home Health Expenditures, 2000-2007



Source: Kaiser Family Foundation, State Health Facts, "Medicaid Home Health Expenditures, 1999-2007."

Medicaid Personal Care expenditures under the State Plan Personal Care Option have more than doubled, increasing from $4.6 billion to $9.5 billion, from 2000 to 2007 (Figure 4.3). Recipients have increased by nearly 50 percent, growing from 578,207 to 826,251.

Figure 4.3: Medicaid Personal Care Expenditures, 2000-2007



Source: Kaiser Family Foundation, State Health Facts, "Medicaid Personal Care Expenditures, 1999-2007."

Medicaid Waivers

In 2007, total Medicaid Waiver spending across all waivers and for all services totaled $27 billion. Total beneficiaries numbered 1.1 million. Table 4.1 breaks out the different categories of waivers, and details expenditures and recipients for 2007.

Table 4.1: U.S. Medicaid HCBS Waivers 1915(c) Participants and Expenditures, 2007

Type of Waiver	Expenditures (in 1,000s)	Participants
MR/DD	$19,758,745	471,033
Aged	$1,185,296	133,983
Aged & Disabled	$4,412,081	447,878
Physically Disabled	$1,148,864	70,017
Children	$244,788	24,423
HIV/AIDS	$46,047	12,766
Mental Health	$15,498	2,177
TBI/SCI	$401,273	12,942
Total	**$27,212,593**	**1,175,220**

Source: Kaiser Family Foundation, State Health Facts

Waiver spending covers a wide range of services, only one of which is personal care. Personal care spending under the above waivers may only amount to about 18 percent of total 1915(c) waiver spending.

Service and cost limits on publicly-provided in-home services

Cost controls, such as formal hourly limits, other service limits, or expenditure caps, are common throughout Medicaid long-term services and supports programs. According to the latest update on HCBS from the Kaiser Commission on Medicaid and the Uninsured,[56] in 2010 more than half of all states (51 percent or 26 states) utilized either expenditure or service limits or both in their **home health** programs.

With respect to the **personal care optional State plan benefit**, 56 percent or 19 states in 2010 reported enforcing limits on participants by using service/hourly limits or cost caps (ceilings). Of the 19 states, 18 had service/hourly limits, 3 had cost caps, and two had both. Of course, the existence of hourly limits within a program does not imply that any particular percentage of consumers utilize these services at or near the limitations, but only that none utilize the services above the level of the limit.

All **HCBS waivers** have a federal requirement of cost neutrality with respect to traditional institutional care. In addition to these aggregate cost caps, most states enforce individual expenditure limits, hourly limits, or geographic limits for personal care participants. In 2010, 42 states (82 percent) imposed some combination of cost control limits: hourly limits (22 states), individual cost limits (30 states), or geographic limits (10 states). Full information is not available concerning which of these limits apply to personal care participants as opposed to non-personal care participants.[57]

Since the beginning of the recession in 2008, there has been a significant increase in the number of people on **waiting lists for waiver services**, highlighting the unmet demand for services. According to the Kaiser report:

> *In 2010, 39 states reported waiver wait lists totaling 428,571 individuals. This reflects a 17 percent increase from the previous year. Additionally, the average time on a waiting list for waiver services was almost 2 years, with wide variations among programs. The average length of time an individual spent on a waiting list ranged from 6 months for mental health waivers to 36 months for MR/DD waivers.*

Persons on MR/DD waiver waiting lists made up 63 percent of the total persons on waiver waiting lists while persons on aged and aged/disabled waivers made up 28 percent of total persons on waiting lists.

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[42] I. Selkow (November 2011) Growth and Prevalence of Participant Direction: Findings from the National Survey of Publically Funded Participant-Directed Services Programs, GSA Presentation 2011. Available at: http://www.bc.edu/schools/gssw/nrcpds

[43] U.S. Department of Labor, Bureau of Labor Statistics, Employment Projections Program, 2008-18 National Employment Matrix, available at: http://www.bls.gov/emp/empiols.htm

[44] See information on counts of independent providers employed in public programs available at the Data Sources and Definitions pages of the **PHI State Data Center** at http://phinational.org/policy/states/data-sources-definitions/

[45] For an analysis of the need for improved service fulfillment platforms to support the independent provider model, see D. Seavey and A. Marquand (Spring 2011) *Building Infrastructure to Support CLASS: The Potential of Matching Service Registries*, SCAN Technical Assistance Brief Series, No. 16. Available at: http://www.directcareclearinghouse.org/download/scan-classact-20110415.pdf

[46] Kaiser Commission on Medicaid and the Uninsured (December 2011) *Medicaid Home and Community-Based Service Programs: Data Update*, Issue Paper, Table 9 presents UCSF analysis of Medicaid 1915(c) Waiver, Home Health and Personal Care Services Policy Survey.

[47] I. Selkow (November 2011) Growth and Prevalence of Participant Direction: Findings from the National Survey of Publically Funded Participant-Directed Services Programs, GSA Presentation 2011. Available at: http://www.bc.edu/schools/gssw/nrcpds

[48] As a general matter, once the legislature sets the overall reimbursement rate for Personal Care Services, these negotiations determine the amounts for wages and benefits that get incorporated into the payment rates.

[49] PHI (December 2010) California's Direct-Care Workforce, endnote 2. Available at: http://www.directcareclearinghouse.org/download/CA%20Fact%20Sheet-%2011-04-10.pdf

[50] P. Doty, K.J. Mahoney, and M. Sciegaj (January 2010) "New State Strategies To Meet Long-Term Care Needs," *Health Affairs* Vo. 29, No. 1, pp. 49-56. For more information on Cash & Counseling, also visit: http://www.cashandcounseling.org.

[51] L. Simon-Rusinowitz, D. Loughlin, and K. Mahoney (Spring 2011) How Did Cash and Counseling Participants Spend Their Budgets, and Why Does that Matter for CLASS? The SCAN Foundation, CLASS Technical Assistance Brief Series No. 8, p. 2. Available at: http://www.thescanfoundation.org/sites/default/files/TSF_CLASS_TA_No_8_Spending_Cash_and_Counseling_FINAL.pdf

[52] I. Selkow (November 2011) Growth and Prevalence of Participant Direction: Findings from the National Survey of Publically Funded Participant-Directed Services Programs, GSA Presentation 2011. Available at: http://www.bc.edu/schools/gssw/nrcpds

[53] U.S. Department of Health and Human Services (November 2000) *Understanding Medicaid Home and Community Services: A Primer*, Available at: http://aspe.hhs.gov/daltcp/reports/primer.pdf.

[54] For example: New York, http://wnylc.com/health/entry/7/

[55] U.S. Department of Health and Human Services (November 2000) *Understanding Medicaid Home and Community Services: A Primer*, Available at: http://aspe.hhs.gov/daltcp/reports/primer.pdf.

[56] J. Howard, T. Ng and C. Harrington (December 2011) *Medicaid Home and Community-Based Service Programs: Data Update*, Report prepared for the Kaiser Commission on Medicaid and the Insured, Table 9, Available at: http://www.kff.org/medicaid/upload/7720-05.pdf

[57] J. Howard, T. Ng and C. Harrington (December 2011) *Medicaid Home and Community-Based Service Programs: Data Update*, Report prepared for the Kaiser Commission on Medicaid and the Insured, Table 9, Available at: http://www.kff.org/medicaid/upload/7720-05.pdf.

Section 5 Training

The state of home care and personal assistance training is tenuous. The federal government sets minimum training requirements for Home Health Aides and Certified Nursing Assistants who work for Medicare-certified agencies (75 hours for each occupation of which 16 hours must be clinical).[58] However, these requirements have not changed in over 20 years. For Personal Care Aides, the situation is different still: there are no federal training requirements for this occupation.[59]

In its 2008 report on the adequacy of the health care workforce for older Americans, the Institute of Medicine (IOM) recommends that "Federal requirements for the minimum training of certified nursing assistants (CNAs) and home health aides should be raised to at least 120 hours and should include demonstration of competence in the care of older adults as a criterion for certification" (Recommendation 5-1).[60] These changes have yet to be made at the federal level,[61] although a handful of states have instituted training standards that exceed the current federal level. The IOM also recommended that state establish minimum training requirements for Personal Care Aides.

FEDERAL TRAINING REQUIREMENTS FOR DIRECT-CARE WORKERS

Certified Nurse Aides: 75 hours (16 supervised clinical) (42 CFR 484.36)

Home Health Aides: 75 hours (16 supervised clinical) (42 CFR 483.152)

Personal Care Aides: None

Training Requirements for Home Health Aides

Federal legislation (42 CFR 484.36) requires that Medicare-certified home health agencies employ Home Health Aides who are trained and evaluated through training programs approved by their state. Federal regulations require that these training programs consist of at least 75 hours, including at least 16 hours of supervised practical or clinical training and 12 hours of continuing education per year. The federal government also lists the subject areas and skills to be taught, outlines the qualifications for approved trainers, and defines the competency evaluation process.

An inventory and analysis of state-by-state training requirements of Home Health Aides conducted by PHI in 2011 found that:[62]

- Of all states, 35 and the District of Columbia do not require more than the minimum federal standard of 75 hours.
- Though 15 states exceed the federal minimum for training hours, only 5 of those meet the standard suggested by the IOM of 120 hours.
- Federal standards for Certified Nurse Aide training have also remained at 75 hours for the past 20 years. However, 30 states and the District of Columbia have exceeded these minimum standards for Certified Nurse Aide training hours. By comparison, relatively little progress has been made towards meeting the improved standards for Home Health Aide training recommended in the IOM report.

Training Requirements for Personal Care Aides

Unlike Home Health Aides, Personal Care Aides have no federal standards for training or certification. This has left state governments with the task of overseeing training standards for direct-care workers who work outside a nursing home or home health agency. Not surprisingly, standards vary widely across states. When service providers receive Medicaid reimbursements, federal law provides that states may conduct checks on the background, training, supervision, age, health, and literacy of direct-care workers.[63]

Further complicating the picture is the sheer number of programs in which Personal Care Aides are employed. In terms of Medicaid-funded programs, these aides may be employed in a state's Medicaid State Plan Personal Care Option or in one of various home and community-based waiver programs serving different populations. Within each program, aides may be agency-employed or directly employed by consumers. There is no requirement that the job titles, job descriptions, or employment requirements be uniform across these programs, and in practice, they rarely are.

State of PCA Training Research

PHI is engaged in a multi-year project to catalog, assess, and highlight training requirements for Personal Care Aides across the 50 states and the District of Columbia.[64] While more states are moving toward establishing formal requirements, most states do not have well-defined training standards and instead leave the determination and assurance of personal care aide competency to the agencies that employ them. In addition, within a given state, there is usually little uniformity across programs even when the tasks performed by Personal Care Aides are very similar.

More specifically, **of the 25 states examined so far, in one or more programs**:

- 60 percent of states have no Personal Care Aide training requirements of any kind. This drops to 30 percent if consumer-direction programs are excluded.
- 56 percent of states leave training sufficiency to provider agencies.
- A fifth of states have state-sponsored curriculum and/or require certification.

When examining state training requirements more closely, programs fall between two extremes – from having no formal standards to requiring formal certification. Most state programs that specify requirements fall short of formal certification, instead requiring CPR and First Aid training, specifying required skills or number of hours of training, or offering a state-sponsored curriculum for agencies to utilize for training.

Generally, the largest discrepancies in personal care aide training requirements within states are between consumer-directed and agency-employed Personal Care Aides, with consumer-directed aides usually having few, if any, formal requirements. In these cases, consumers are often responsible for training their workers in the tasks necessary to fulfill the plan of care. Additionally, there tend to be differences between waiver programs that serve aging populations and those that serve individuals with intellectual and developmental disabilities, as these programs are usually overseen by different state agencies.

State Initiatives

The shift towards increased utilization of home and community-based services and consumer-direction is encouraging state policy initiatives that streamline training requirements for all entry-level direct-care workers, regardless of setting or population serviced. It also has encouraged attention to the development of consistent standards regarding the basic skills and knowledge required for providing services and supports safely, effectively, and consistent with consumer preferences.

Table 5.1 below presents a brief summary of recent state legislative initiatives in the area of training for Personal Care Aides.

Table 5.1: Recent State Legislative Initiatives on PCA Training

Arizona	Arizona's Direct Care Workforce Initiative has overseen the development of a model training curriculum for PCAs, "Principles of Caregiving." From this curriculum, the AZ Direct Care Workforce Committee and other stakeholders drafted competencies and standards for direct-care workers as well as a standardized competency evaluation. Throughout 2011, Arizona's Medicaid department has implemented the new training and testing requirements for Direct Care Workers (DCW) who work in home care settings under DES or AHCCCS Medicaid Programs. Full roll-out will be completed by October 2012.
Iowa	A 2008 report from the Iowa Direct Care Worker Task Force recommended classification of direct care workers into three levels based on function, drafting of competencies as a basis for a core curriculum, development of in-service requirements, standards for instructors, and outreach and educational strategies. 2010 legislation made appropriations to establish a board of directors to report on the size of the workforce and any pilot results, and to launch an independent statewide association of direct care workers for education and outreach.
Maine	House Paper 954 signed into law on March 25, 2010 is titled "An Act to Stimulate the Economy by Expanding Opportunities for Direct Support Aides." The legislation calls for the Commissioner of Health and Human Services to establish a workgroup to report on establishing a statewide job classification system of direct-care job titles and develop logical sequences of employment tiers and training links between these tiers. While the legislation does not specifically call for implementation of a core curriculum, it does recognize fragmentation in personal care job titles across programs and seeks to streamline this.
Minnesota	Legislation enacted in May 2009 established mandatory Department of Health Services-administered training for PCAs in Minnesota as part of a "comprehensive reform of PCA services." Beginning in 2010, PCA provider agencies must use 72.5% of PCA revenue towards PCA salaries and benefits, and all PCAs must complete the training program. The online training/testing must be completed before agency employment or enrolling as an independent PCA provider. The 9-part DHS training program is available online in six languages.
New Mexico	In March 2010, New Mexico adopted House Memorial 56, a bill requesting the establishment of a task force to examine a strategy for consolidating and coordinating training programs for direct support professionals across disability programs. The task force will examine the economic savings associated with consolidated training requirements and research direct-care training initiatives in other states.
Pennsylvania	In 2007, Pennsylvania's Direct Care Workforce Workgroup issued a report recommending the development of a state-wide training system to certify direct-care workers using a set of core competencies including both "hands-on" and "soft" skills. In 2008, a 77-hour entry-level competency-based PCA curriculum, developed by the PA Department of Labor and Industry under a contract with PHI, was introduced for field-testing. This pilot-training program will train over 300 PCAs in southwestern Pennsylvania.
Washington	Following recommendations of the Home and Community-Based Long-Term Care Workforce Development Workgroup, SEIU initiative 1029 passed in 2008. This initiative called for 75 hours of mandatory training and a certification test for long-term care workers. In 2011, a budget shortfall delayed implementation of these requirements until 2014. However, in November 2011, initiative 1163 passed moving the implementation up to 2012. The training must be conducted using the DSHS curriculum or approved comparable curricula, and very few workers will be exempted.

Source: Research conducted for PHI Project on *PCA Training across the States*, with funding from the National Institute on Disability and Rehabilitation Research (Grant No. H133B080002) through the Center for Personal Assistance Services.

Additionally, states are experimenting with providing standardized training that is recognized across eldercare and disability service settings and programs. A handful of states have expressed interest in a **core-competency based approach** to personal care aide training.[65] These advances reflect early signs of a trend towards recognition and professionalization of the home care and personal assistance workforce at the state-level. See Appendix 3 for an example of an analysis of the core competencies required to perform the tasks and duties of a personal care aide who assists elders and persons with disabilities.

Federal Initiatives

The **Affordable Care Act (ACA) of 2010** included the first-ever federal initiatives to improve training for home care and personal assistance workers, and to assess the future needed capacity of the personal care workforce. The ACA training initiative—PHCAST (see below)—was complemented with a provision that established the **Personal Care Attendant Workforce Advisory Panel** (Title VIII, Section 8002) for the purpose of evaluating and advising on workforce issues for personal care attendants, including wages, benefits, and training. The panel was established as part of the CLASS Program (Community Living Assistance Services and Supports Program) which the Secretary of Department of Health and Human Services recently determined is not financially viable, leaving the future of the panel unclear. This statutory provision includes an examination of service needs under Medicaid, Title XIX of the Social Security Act.

Personal and Home Care Aide State Training Program (PHCAST)

The Affordable Care Act created a training demonstration program called the **Personal and Home Care Aide State Training (PHCAST) Program** (Title V, Subtitle F, Section 5507(a)). This program is funding six states to develop core competencies, pilot training curricula, and create certification programs for personal and home care aides. Funding for these demonstrations totals $15 million over three years. According to the federal agency in charge of administering the grant program—the Health Resources and Services Administration (HRSA) — "It is expected that the training standards established under these State grants would be utilized as a "Gold Standard" for future training of personal and home care." [66]

In 2010, six states were awarded grants: California, Iowa, Maine, Massachusetts, Michigan, and North Carolina. These six states are expected to train over 5,100 personal care aides by 2013.

Grantees have been directed to emphasize "learner-centered" teaching methods shown to be effective for adults with multiple learning barriers, and to focus on building communication and problem-solving skills essential to direct-care workers success. States are encouraged to consult and collaborate with community and vocational colleges regarding the development of curricula to implement the project. The training programs currently underway are different across states. Some training is focused on programs serving nursing home-eligible populations, while others serve a less acute demographic. In Michigan, the PHCAST training program is focused on a single Medicaid HCBS waiver, serving the elderly and adults with physical disabilities, while in Maine, the PHCAST grant is targeting direct care workers serving elders, people with cognitive disabilities, and those with serious and persistent mental illness. The goal in Maine is to create a common curriculum with specialized modules thereby improving the supply and mobility of the workforce across service populations and programs.

DOL Registered Apprenticeship Programs

Since 2001, the Employment and Training Administration of the U.S. Department of Labor (DOL) has invested in two federally sponsored Registered Apprenticeship Programs pertaining to home care and personal assistance workers: Direct Support Specialist and Home Health Aide (see Table 5.2). These programs were designed to support employers in recruiting and retaining skilled employees. For workers, the Registered Apprenticeship programs provide opportunities to receive training and learn while on the job and to advance their careers.

Table 5.2: U.S. Department of Labor Registered Apprenticeship Programs for Home Care & Personal Assistance Workers

	Setting	Description	Competencies
Direct Support Specialist	Residential homes, home care	Provides support to individuals with disabilities and others who need assistance with basic services and information to lead self-directed lives, contribute to their society, and support behaviors that enhance inclusion in their communities.	• Direct-support role and work environment • Contemporary and best practices in community support • Advocacy, supporting empowerment and recognition • Prevention and reporting of abuse, neglect, and exploitation • Wellness issues • Communication • Teaching and supporting others • Crisis management
Home Health Aide	Home care	Includes completing initial minimum 75 hours of training required to work for a	• Role of home health aide • Client rights and confidentiality • Communication and problem-solving skills • Personal care skills

		Medicare- or Medicaid-certified agency. Offers additional advanced entry-level training in specific demands of home care, and opportunity to obtain specialties in at least two areas.	• Health-related tasks • In-home and nutritional support • Infection control • Safety • Understanding the needs of various groups of clients *Additional Competencies for specialty areas are available for: mentoring, dementia care, hospice and palliative care, physical disabilities, mental illness.

Source: U.S. Department of Labor, Employment and Training Administration, Office of Apprenticeship. (http://www.doleta.gov/oa) and competency-related instruction outlines available at: http://phinational.org/training/resources/apprenticeships/

It is worth noting that, in several of the states where these programs are being implemented, aides who achieve Apprentice status under these voluntary industry-driven training programs fall under the companionship exemption and are not necessarily entitled to federal wage and hour protections.

Most recently, the Office of Workforce Investment at the DOL Employment and Training Administration has initiated the development of a **Long-Term Supports, Care, and Services Competency Model**. Notable features of this initiative include: reframing long-term care as encompassing not only health services but also social and human services; focusing on the core competency resources **across** sectors; and including **core** competencies such as person-centered services and cultural sensitivity.

[58] 42 CFR 484.36, 42 CFR 483.152

[59] Note: For states that offer Medicaid-funded personal care services, the State Medicaid Manual (Chapter 4, Section 4480, paragraph E) requires states to develop provider qualifications for PCAs. The manual does not list specific qualifications, but rather offers examples of areas where states may establish requirements including: criminal background checks or screens for attendants before they are employed; training for attendants; use of case managers to monitor the competency of personal care providers; and establishment of minimum requirements related to age, health status, and/or education.

[60] Institute of Medicine (2008) *Retooling for an Aging America: Building the Healthcare Workforce*. www.iom.edu/Reports/2008/Retooling-for-an-Aging-American-Building-the-Health-Care-Workforce.aspx.

[61] Section 6121 of the Affordable Care Act of 2010 mandates enhanced nurse aide training in nursing homes. The enhanced training focuses on two areas: 1) how to care for residents with dementia, and 2) how to prevent resident abuse. CMS is developing a regulation to mandate in-service training on these two topics (as part of each nurse aide's yearly training program). See: http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_35.pdf

[62] PHI (posted December 2011) Home Health Aide Training Requirements by State. Available at: http://phinational.org/policy/home-health-aide-training-requirements-by-state/

[63] U.S. Department of Health and Human Services (December 2006) *States' Requirements for Medicaid-Funded Personal Care Service Attendants*, Office of the Inspector General, OEI-07-05-00250**.** The OIG report found that that 75 percent of Medicaid-funded personal care programs included some training requirements for workers.[63] Twenty-six percent of training requirements could be completed after employment had begun, ranging from 30 days after the start of employment to 18 months. Less than half of the programs with training requirements specified the number of hours of training required. The OIG report is limited in that it included in its counts programs that require *only* First Aid and CPR training.

[64] PHI Project on *PCA Training across the States*, with funding from the National Institute on Disability and Rehabilitation Research (Grant No. H133B080002) through the Center for Personal Assistance Services.

[65] A competency model for home care training describes clearly what a worker needs to know and be able to do in order to be successful on the job and to provide high quality care to consumers. The focus is on acquiring knowledge, skills, and abilities- known as competencies.

[66] See grant application for PHCAST issued by U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). Available at: https://grants.hrsa.gov/webExternal/FundingOppDetails.asp?FundingCycleId=93B61192-C2D7-4C55-8CDE-6EF1FD6D055A&ViewMode=EU&GoBack=&PrintMode=&OnlineAvailabilityFlag=&pageNumber=&version=&NC=&Popup=

Section 6 Job Hazards

Home care and personal assistance workers are charged with supporting the well-being of others yet, according to a recent National Institute for Occupational Safety and Health (NIOSH) report, they face a myriad of workplace hazards that place their own personal safety and health at risk.[67] As a result of the nature and diversity of the tasks that have become expected in the contemporary home care industry, these risks are potentially serious or and can even be life-threatening.

One set of risks have to do with **performing personal care tasks**. These dangers include: musculoskeletal disorders caused by lifting, transferring, and overexertion; infectious disease acquired through needlesticks or bloodborne pathogens; and latex sensitivity. In addition, home care and personal assistance workers frequently work with clients who have cognitive impairments or mental health issues and may display difficult or violent behaviors.

Home care and personal assistance workers also provide a range of **household tasks** such as laundry, housekeeping, shopping, and meal preparation, all of which pose risks of physical injury. In fact, a study of personal care assistants in California concluded that "housekeeping activities are as physically demanding to HCWs [home care workers] as personal care activities."[68] Workers in that study reported experiencing pain or discomfort when cleaning bathrooms, carrying groceries, cleaning floors, or moving boxes or furniture for cleaning, for example. Because of the low-income status of many of the consumers they serve, workers may lack access to the appropriate housekeeping equipment and supplies they need to perform their tasks safely (for example, lightweight long-handled mops and hand scrubbers).

Another significant job hazard associated with the modern home care industry relates to **transportation**. Often serving more than one client in a day, home care workers typically are required by their employers to commute between their clients' homes, often driving substantial distances in their own vehicles, and thus exposing themselves to risks of vehicular injury or even fatality. A 2008 study conducted by the National Association for Home Care and Hospice revealed that home care nurses, aides, and therapists travel close to 5 billion miles each year.[69] In addition to driving risks, falls may occur when an aide is walking on ice- and snow-covered streets, driveways, sidewalks, and paths to the homes of their clients. These workday travel patterns, which be so hazardous to home care workers, may be made more onerous by the application of the Companionship Exemption. This is because employers have far less incentive to

minimize or otherwise manage travel requirements for individual workers, as they are far less likely to compensate for travel time given the exemption.

In addition to the risks associated with carrying out personal care tasks and the hazards associated with the travel demands of the job, home care and personal assistance jobs are often accompanied by a high level of **job stress**. NIOSH categorizes job stress as "the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker."[70,71] A recent NIOSH Hazard Review identifies "work overload, time pressure, lack of task control and role ambiguity; and organizational factors, such as poor interpersonal relations, lack of support from supervisors and coworkers, and unfair management practices" as key causes of occupational stress for home care workers.

When workers are unable to comfortably report incidents like injuries and other issues in home care environments, occupational stress and job dissatisfaction are increased. Unaddressed injuries on the part of aides can worsen through continued overexertion and physical and emotional stress, ultimately worsening the quality of care delivered to clients.

The demanding nature of home care work is presumably reflected in a recent report from the Substance Abuse and Mental Health Services Administration which found that, among all workers in the United States, personal care workers experience the highest rates of depression lasting two weeks or longer.[72]

Finally, **additional occupational stressors and health risks** can occur in home-settings, such as temperature extremes, cigarette smoke, unsanitary conditions, lack of water, and the presence of guns and other weapons, illegal drugs, or violence in the home or community. These factors may stem from working conditions that are not under the control of either the employer or the employee.

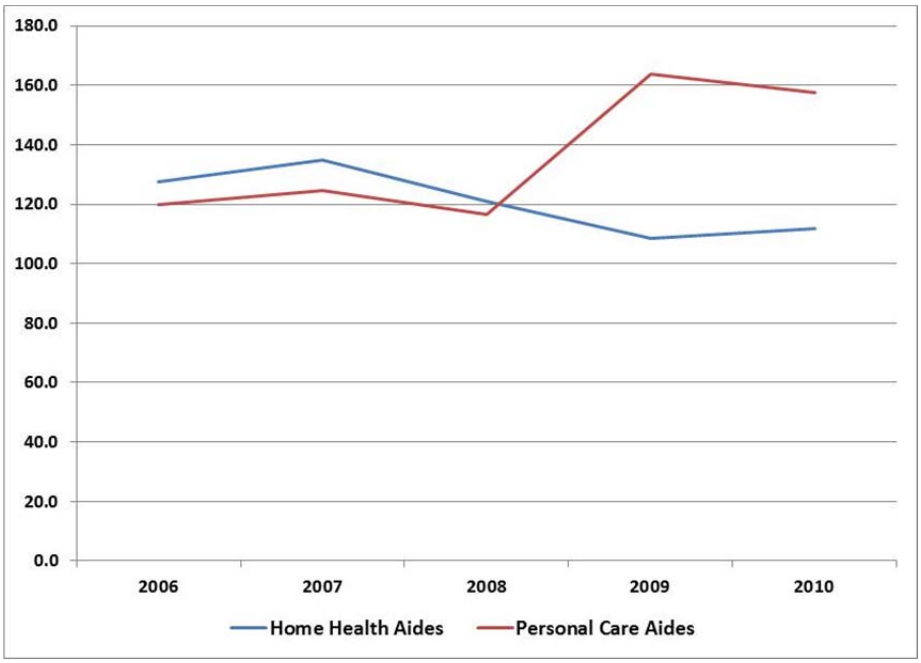
Information from the Injuries, Illnesses, and Fatalities (IIF) Program at the Bureau of Labor Statistics

According to the latest data from Injury, Illnesses, and Fatalities (IIF) Program at the Bureau of Labor Statistics, during 2010 alone 48,400 recorded injuries and illnesses occurred among workers employed in the two key industries providing the bulk of home care and personal assistance services in the United States, Home Health Care Services (NAICS 6216) and Services for the Elderly and Persons with Disabilities (NAICS 62412).

As shown in Fig8ure 6.1 below, over the period 2006 to 2010 the injury/illness rate for Personal Care Aides increased by nearly a third (31.3 percent), while that for Home Health Aides declined by 12 percent.

Figure 6.1: Rate of Injury/Illnesses for Home Health Aides and Personal Care Aides, 2006-2010

(incidence rate for nonfatal occupational injuries and illnesses involving days away from work, per 10,000 FT workers)



Source: U.S. Department of Labor, Bureau of Labor Statistics, Injury, Illnesses, and Fatalities Program.

IIF statistics for 2010 show that for Home Health Care Services (private industry only), the incidence rate for lost workdays from injuries caused by overexertion – resulting from such tasks as the lifting and turning associated with personal care as well as from household chores – was twice that of general industry workers (54.3 per 10,000 workers compared to 25.8 per 10,000 workers). Assaults were also more than twice as high for home health care workers as they were for general industry workers (6.7 and 2.7 per 10,000 respectively). Most strikingly, however, transportation incidents were more than 13 times higher for home health care workers than for hospital workers at 20.4 and 1.5 per 10,000 workers, respectively.[73]

In 2010, as a result of injuries, Home Health Aides took more days away from work in 2010 (median of 12) compared to nursing home staff (median of 6) and all workers in general (median of 8). One-third of injured workers were away from work for 31 days or more because of injuries, compared to 20 percent for Nursing Aides, Orderlies, and

Attendants and 28 percent for all workers. Such long periods of time away from work suggest that for many Home Health Aides, the injuries are quite severe. They represent lost revenue for these workers and diminished quality for the clients they serve.

During 2010, 12 fatalities were reported under the industry Home Health Care Services. Five of these fatalities were due to transportation accidents; three were due to homicides.[74]

Other Research Literature Findings

It is likely that official injury statistics underestimate the actual injury incidence among home care and personal assistance workers because they only capture injuries that are actually reported by employers to the government. Underreporting may occur when an employee fails to report an injury out of fear of losing her job. Undercounts may also result if an employer files no injury report out of concern that their agency will undergo inspection or that reporting the incident will raise the cost of their workmen's compensation.[75]

Friedman and Forst find that changes in OSHA reporting processes and requirements have contributed to a decrease in the number of recorded workforce injuries.[76] Injuries that are progressive or result from repetitive injury may not be as easily counted in the official injury statistics as those resulting from a traumatic event.[77] Additionally, **Newcomer and Scherzer** remind us that injury rates for independent home care workers, consumer-directed caregivers, and those in the "grey market" are not included in official counts and would be difficult to ascertain.[78]

A study by **Gershon and colleagues** reveals that neighborhood violence/crime, threat of physical harm from clients, pets or neighbors, and drugs or guns in the home are also potential safety hazards.[79] Of home health care workers in that study, 65 percent reported that they had refused an assignment in the past; it is unknown what effect their decision had on either their employment or the care they provided.

Myers and colleagues studied lower back injuries among home health aides and hospital nurse aides and found the rates of low-back injury to be nearly three times as high for home health aides as for nursing aides. Of injured home health aides, 80 percent were alone when injured compared to less than 40 percent of nursing aides.[80] Home care workers lift and transfer clients who, in many cases, may be bigger and heavier than the aide. They lean over and twist to bathe residents; bend down to put on peoples' shoes; lift their limbs to dress them; push, pull, and lift wheelchairs; and

support clients while they walk and catch them when they fall. The physical toll on home care workers is exacerbated by the fact that homes are rarely designed as safe workplaces and often lack appropriate assistive devices for lifting, carrying, and supporting clients. Additionally, home care and personal assistance workers typically perform duties like transporting and transferring patients alone, thus increasing their risk of musculoskeletal disorders, ergonomic injuries, and overexertion.

Meyers and Mutaner argue that, while home care workers report fewer injuries overall, studies suggest that they are experiencing more injuries related to overexertion relative to workers in other health care settings and that the injuries they sustain may be particularly serious and difficult to resolve.[81,82] Their examination of workers' compensation claims revealed that the mean number of days away from work was significantly higher for home health care workers (44) compared to nursing home workers (18) and hospital workers (14), suggesting that injuries among home-based workers may be more severe and disabling.[83]

Project SHARRP (Safe Home Care and Risk Reduction for Providers), associated with the University of Massachusetts, investigated the risk of exposure of home care workers to bloodborne pathogens such as HIV and hepatitis when "sharps" (*i.e.,* hypodermic needles, suture needles, intravenous blood collection devices, phlebotomy devices, and scalpels) are reused or improperly disposed.[84] Researchers found that: "Over their entire career in home healthcare, 35% of nurses and 6% of aides had at least one sharps injury (SI). In the 12 months prior to the survey, 4.3% of nurses and 0.7% of aides sustained at least one SI."[85] The study explains that the incidence rate appears low for home health aides, but when the size of the workforce is considered, the public health impact is quite high. In fact, consideration of rates and workforce size reveals that home health aides experience approximately 10,000 sharps injury incidences each year, while incidence among nurses is estimated at 8,000 per year.[86]

Exposure to infectious disease becomes a serious threat when home care workers have not obtained adequate immunizations and preventive care. **Gershon and colleagues** found that "self-reported hepatitis B virus (HBV) vaccine rates were suboptimal; only 57% of study participants reported that they had received all three doses."[88] Furthermore, home health aide safety hazards place them at risk of exposure to bloodborne pathogens, according to the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standard.[87,88] This standard requires that employers offer training and the hepatitis B vaccine to employees at no cost. Though helpful, this requirement does not ensure coverage for those working independently or part-time, which is the case for many home health aides.[89]

In their recent work, **Markkanen and colleagues** describe access to the hepatitis B vaccine as being imperative, given that the connection between bloodborne pathogens and contagion is clear. Furthermore, although between 385,000 and 800,000 sharps injuries occur every year, only half of these are reported. As potential hindrances to reporting, home care workers cite time-consuming reporting processes, resultant anxiety for sharps injuries they have experienced, fear of blame for "careless" behavior, disease history of the patient (*i.e.*, patient is not recorded as an infection risk), or concern about the incident's influence on present or future job opportunities.[90]

The isolated nature of home care work and the generally poor state of training and supervisory support for these workers (see Section 5 of this report) provides few opportunities for workers to learn safe workplace practices either before they begin employment or on-the-job.[91] In a 2008 study, **Alamgir and colleagues** linked the lack of training and supervision to an increased likelihood of injury for this workforce.[92] In their analysis of the 2007 National Home Health Aide survey, **McCaughey and colleagues** found an increased risk of injury among Home Health Aides who reported their training did not adequately prepare them for their jobs. In addition, they found a greater risk of injury among Home Health Aides who reported that they had poor supervisory support, compared to those reporting that they had good supervisory support.[93]

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[70] Center for Disease Control and Prevention, National Institute for Occupational Safety and Health (January 2010) "Occupational Hazards in Home Healthcare," *NIOSH Hazard Review*. Available at: http://www.cdc.gov/niosh/docs/2010-125/pdfs/2010-125.pdf.

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industry and selected events or exposures leading to injury or illness, 2010" Washington, DC. http://www.bls.gov/iif/oshwc/osh/case/ostb2832.pdf.

[74] U.S. Department of Labor, Bureau of Labor Statistics (2008) Census of Fatal Occupational Injuries (CFOI) Current and Revised Data, "TABLE A-1. Fatal occupational injuries by industry and event or exposure, All United States, 2008." Available at: http://www.bls.gov/iif/oshwc/cfoi/cftb0232.pdf.

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[77] US Bureau of Labor Statistics. "Frequently Asked Questions: Does the BLS 'Undercount' Workplace Injuries?" http://www.bls.gov/iif/oshfaq1.htm#q02, accessed January 4, 2010.

[78] R. Newcomer & T. Scherzer (November 2006) *Who counts? On (not) counting occupational injuries in homecare.* Presented at the American Public Health Association 134th Annual Meeting and Exposition hosted by APHA.

[79] R. Gershon *et al*. (2008) "Home Health Care Patients and Safety Hazards in the Home: Preliminary Findings."

[80] A. Myers, R. Jensen, D. Nestor, and J. Rattiner (1993) "Low-back injuries among home health aides compared with hospital nursing aides." *Home Health Care Services Quarterly 14(2-3)*: 149-155.

[81] For a review of this literature see: K. Parsons, T. Galinsky, and T. Waters (March 2006) "Preventing Musculoskeletal Disorders in Home Healthcare Workers" *Home Health Care Nurse 24(3)*. Or see: National Institute for Occupational Safety and Health (January 2010) NIOSH Hazard Review Occupational Hazards in Home Healthcare. Available at: http://www.cdc.gov/niosh/docs/2010-125/pdfs/2010-125.pdf.

[82] A. Myers, R. Jensen, D. Nestor, and J. Rattiner (1993) "Low-back injuries among home health aides compared with hospital nursing aides." *Home Health Care Services Quarterly 14(2-3)*: 149-155.

[83] J. Meyers and C. Muntaner (1999) "Injuries in home health care workers: An analysis of occupational morbidity from a state compensation database," *American Journal of Industrial Medicine 3 (3):* 295-301.

[84] University of Massachusetts. Project SHARRP (Safe Home Care and Risk Reduction for Providers). Summary 2004-2009.

[85] University of Massachusetts. Project SHARRP (Safe Home Care and Risk Reduction for Providers). Summary 2004-2009.

[86] University of Massachusetts. Project SHARRP (Safe Home Care and Risk Reduction for Providers). Summary 2004-2009.

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[89] R. Gershon *et al*. (2008) "Home Health Care Patients and Safety Hazards in the Home: Preliminary Findings."

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[93] D. McCaughey, J. Kim, J., G.E. McGhan, R.A. Jablonski, and D. Brannon, D. (2010). Who Needs Caring? We Do! Workplace Injury and Its Effect on Home Health Aides. In the Best Paper Proceedings of the 2010 Academy of Management Meeting, Montreal, Canada.

Section 7 Workforce Compensation

In its recent national study of the health care workforce, the Institute of Medicine concluded that "[a] major factor in the deficit of direct-care workers is the poor quality of these types of jobs. Direct-care workers typically receive very low salaries, garner few benefits, and work under high levels of physical and emotional stress."[94] The IOM additionally determined that the wages of direct-care workers are so low that they "do not appear to adequately support the recruitment and retention of these workers."

Of all frontline, direct-care jobs, home care and personal assistance jobs are the lowest paying. This reflects the fact that frontline workers employed in institutional settings, such as nursing care facilities and hospitals, have benefited from: greater upward pressure on their wages due to more rational rate setting with built-in cost-of-living adjustments; the need to compete with hospitals for Certified Nurse Assistants; and relatively powerful lobby groups that exert influence on state legislatures.

We review here the current information available about national compensation levels and practices within the home care and personal assistance industry. Research studies investigating the role of adequate wages and affordable and accessible health insurance in recruiting and retaining a competent and stable frontline workforce are reviewed elsewhere.[95]

Wages

In 2010, the two official occupations making up the home care and personal assistance workforce—Personal Care Aides and Home Health Aides—both earned under $10 per hour (median wages of $9.44 and $9.89, respectively). Nurse Aides, Orderlies and Attendants earned $11.54 per hour, and the median wage for all U.S. workers in 2010 was $16.27.[96]

Table 7.1 shows the national mean and median wages earned by HHAs and PCAs who work in the two main industries that provide home care services: Home Health Care Services (NAICS 621600) and Services for the Elderly and Persons with Disabilities (NAICS 624120). These industry-specific wages are lower than the overall occupational wages which are calculated across all industries.

These calculations indicate that **the median hourly wage earned by home and care and personal assistance workers working in the home health care industry was $9.40.**

TABLE 7.1: National Mean and Median Wages for Home Health Aides & Personal Care Aides by Industry, 2010

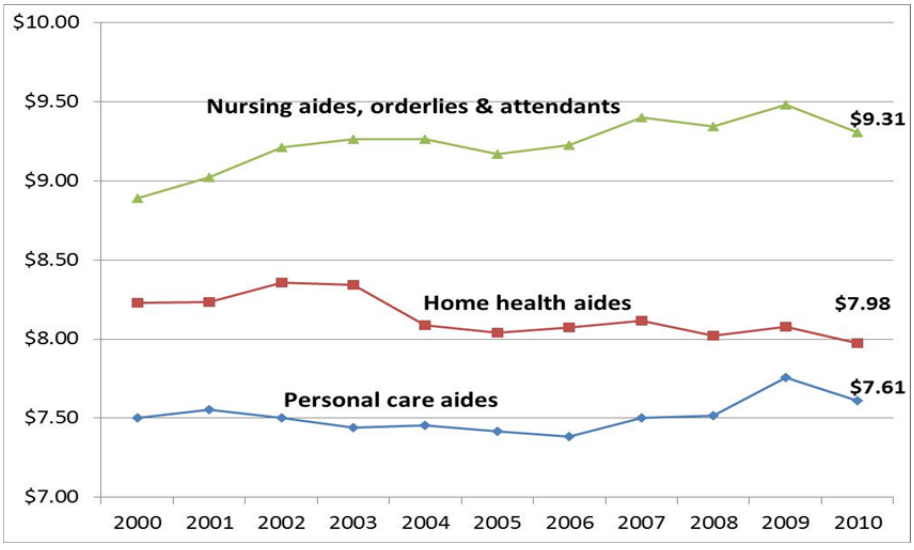
	Median wage		Mean Wage	
Industry/Occupation	**Home Health Care Services** *NAICS 621600*	**Services for Elderly & Persons with Disabilities** *NAICS 624120*	**Home Health Care Services** *NAICS 621600*	**Services for Elderly & Persons with Disabilities** *NAICS 624120*
Home Health Aide	$9.56	$9.25	$10.25	$9.74
Personal & Home Care Aide	$8.79	$9.75	$9.14	$9.88
	Both industries and occupations combined			
Weighted average	**$9.40**		**$9.82**	

Source: PHI analysis of wage data available from the US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics Program.[97]

Wage Trends

Over the past ten years, while Nursing Aides, Orderlies and Attendants have seen a modest increase in their real (inflation-adjusted) median wages to $9.31 an hour (measured in 2000 dollars), **Home Health Aides and Personal Care Aides have both seen their wages stagnate at under $8.00 an hour (in 2000 dollars)** (see Figure 7.1).

Figure 7.1: United States Median Wages for Direct-Care Workers, Adjusted for Inflation (2000 dollars)



Source: PHI analysis of median hourly wage data reported by the Occupational Employment Statistics (OES) Program, Bureau of Labor Statistics (BLS), and the Consumer Price Index for urban wage earners and clerical workers (1982-84=100), also from BLS.

For state-level estimates of median wages for home health aide and personal care aide wages, see **Appendix 4**.

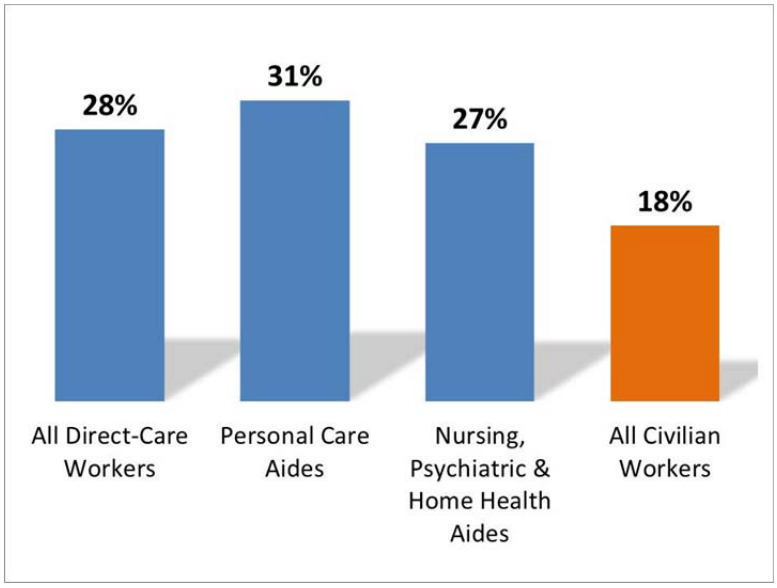
Health Insurance

Inadequate health insurance jeopardizes the health of hundreds of thousands of direct-care workers. In particular, low rates of health coverage means that direct-care workers are less likely to access preventive and therapeutic care, thereby increasing their risk of poor health.[98] An estimated 900,000 direct-care workers went without health insurance coverage in 2009.[99]

By Occupation

Personal care aides have higher rates of uninsurance compared to the direct-care workforce as a whole, and compared to Americans in general (see Figure 7.2). According to the AESC Supplement of the Current Population Survey, approximately 31 percent of Personal Care Aides reported having no health insurance in 2009, compared to 28 percent of direct-care workers generally, and 18 percent of Americans under age 65.

Figure 7.2: Direct-Care Workers Without Health Coverage By Occupation, 2009



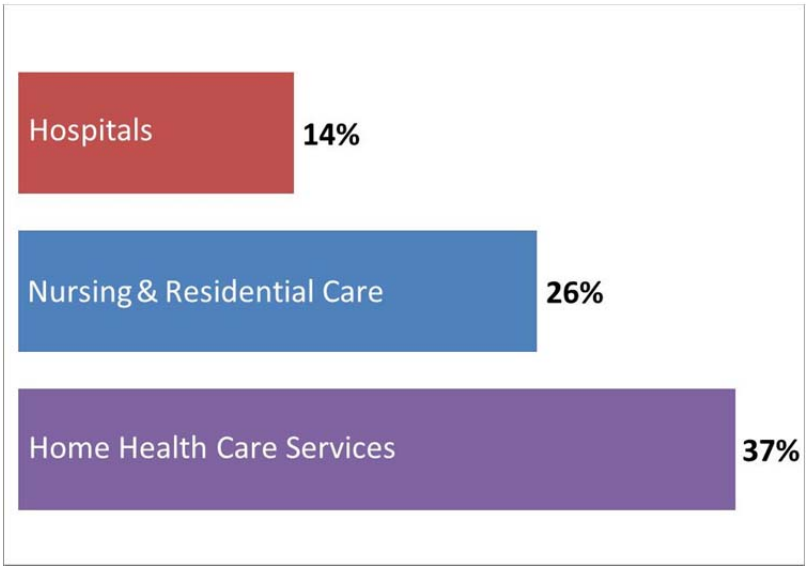
Source: PHI analysis of 2010 Annual Social and Economic (ASEC) Supplement, Current Population Survey.

By Industry/Setting

When analyzed by work setting, Figure 7.3 indicates that uninsurance rates for direct-care workers vary widely. For instance, in 2009, 37 percent of direct-care workers employed by agencies in the home health care services industry lacked health care coverage compared to only 14 percent of those working in hospitals.

The nationwide trend towards "self-direction," where workers are employed directly by households, leaves many independent providers of direct- care services without access to employer-based coverage. In 2008, 45 percent of direct-care workers employed directly by households were uninsured.[100] An important exception, however, is independent providers covered by collective-bargaining agreements that provide access to health coverage.

Figure 7.3: Direct-Care Workers without Health Coverage by Setting, 2009



Source: PHI analysis of 2010 Annual Social and Economic (ASEC) Supplement, Current Population Survey.

Sources of Coverage for Direct-Care Workers

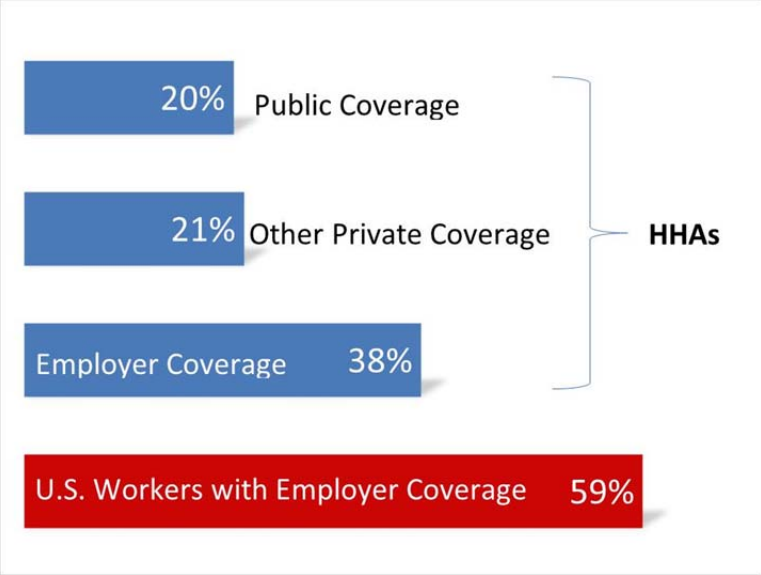
Like other workers, direct-care workers rely on employer-sponsored policies or other private sources, or alternatively they rely on publicly funded insurance programs such as Medicaid or Medicare. Mirroring larger national trends, the latest data indicate that employer-provided coverage for direct-care workers has declined while public coverage has increased.

Employer-Based Insurance. Overall, 47 percent of direct-care workers reported having employer-sponsored insurance — a significantly lower rate than for U.S. workers generally (68 percent). Furthermore, employer-based insurance for direct-care workers

declined by 6 percentage points from 2008 to 2009.[101] While 78 percent of hospital aides reported employer insurance at some point in 2009, only 32 percent of aides working for agencies in the home health care services industry were covered by their employers.

The 2007 National Home Health Aide Survey demonstrated that far fewer home health aides purchased employer-sponsored health insurance than the working-age American public in general. This may be the result of two factors: health insurance is less likely to be made available by home health employers, and health insurance deductibles and premiums are relatively unaffordable to home health aides given their low wages.[102] (See Figure 7.4)

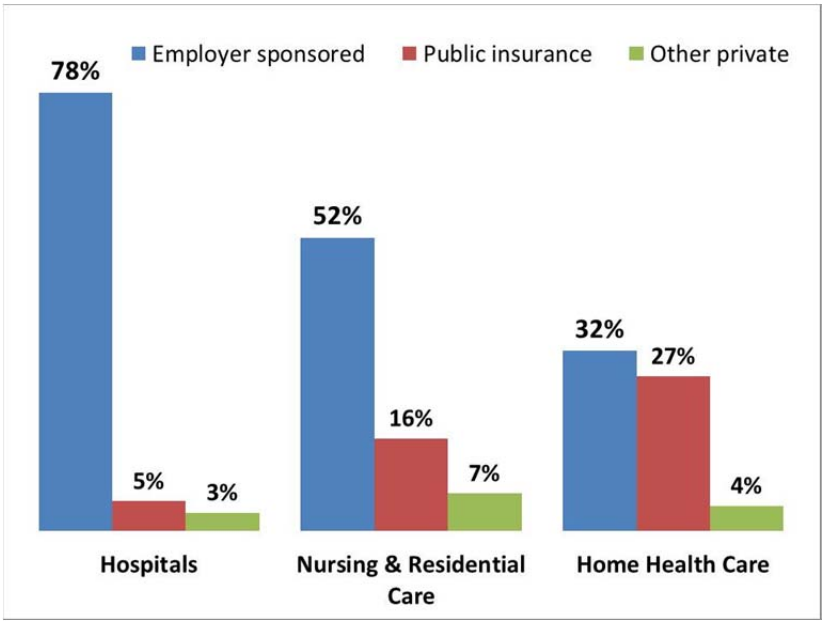
Figure 7.4: Home Health Aide Health Insurance Coverage, 2007



Source: PHI Analysis of National Home Health Aide Survey, 2007 and U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the U.S., 2007.

Employer-sponsored insurance tends to be less available in home and community-settings for several reasons. Home care agencies do not always offer coverage, or only offer it to full-time workers. Less than half of home care workers work full-time, full-year. Additionally, when home care agencies offer employer coverage, many direct-care staff cannot afford the premiums and co-payments. In 2010, the national median hourly wage for aides employed in the home health care services industry was $9.40, and annual median earnings in 2009 were $12,000. Finally, with few exceptions, rate-setting for publicly provided in-home services and supports (other than Medicare) does not allow for building wages or health insurance costs for direct-care staff directly into the reimbursement rate.[103]

Figure7.5: Sources of Health Coverage for Direct-Care Workers by Setting, 2009



Source: PHI analysis of 2010 Annual Social and Economic (ASEC) Supplement, Current Population Survey.

Public Insurance. Medicaid and other public insurance programs constitute an important source of health care coverage for direct-care workers. In 2009, nearly one in five (18 percent) direct-care workers received health coverage under public insurance programs.

Public coverage is particularly important for low-wage direct-care workers employed in settings like home health care where employer-sponsored coverage is limited. During 2009, 27 percent of aides working in the home health care services industry reported relying on public health coverage.

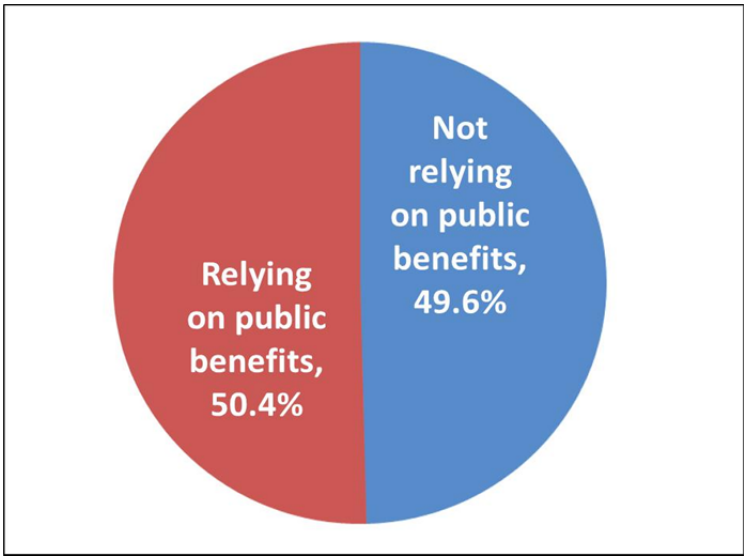
Household Economic Self-Sufficiency

A recent analysis by PHI of state-level wages from 2010 found that, **in over two-thirds of states (34 states), average hourly wages for Personal Care Aides were below 200 percent of the federal poverty level wage ($10.42) for individuals in *one-person* households working full time.**[104] These wages are low enough to qualify workers for many state and public assistance programs.

More disconcerting, 2009 to 2010 marked the first year-to-year decline in Personal Care Aides wages on record since the federal government began reporting these wage estimates in 1998. The national wage for these aides was pulled down by a drop in wages for Personal Care Aides in 17 states from 2009 to 2010.

PCA households show a high level of reliance on public assistance. Half of these households report receiving benefits such as: Medicaid, food and nutrition assistance, cash welfare, or assistance with housing, energy, or transportation.[105]

Figure 7.6: Personal Care Households Relying on Public Assistance, 2009



Source: PHI (February 2011) *FACTS 3: Who are Direct-Care Workers?* Available at: http://www.directcareclearinghouse.org/download/PHI%20Facts%203.pdf

A comparatively high percentage of home health aides report relying on public assistance at some point. In the 2007 National Home Health Aide Survey, conducted by the U.S. Department of Health and Human Services, nearly one in four home health aides reported ever receiving cash assistance, and over 40 percent have received food stamps or WIC.[106]

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[94] Institute of Medicine (2008) *Retooling for an Aging America: Building the Health Care Workforce*, Prepared by the Committee on the Future Health Care Workforce for Older Americans, Board of Health Care Services, Washington, DC: The National Academies Press, p. 200,

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[96] PHI, (July 2011). *State Chart Book on Wages for Personal and Home Care Aides, 2000-2010*. Available at: http://www.directcareclearinghouse.org/download/PCAwages-2000to2010.pdf Occupational Employment Statistics (OES) program, available at: http://www.bls.gov/oes/#tables.

[97] http://www.bls.gov/oes/current/naics4_621600.htm and http://www.bls.gov/oes/current/naics5_624120.htm

[98] C. Chou et al. (December 2009) "Health Care Coverage and the Health Care Industry." *American Journal of Public Health* 99 (12): 2282-2288.

[99] PHI (March 2011) Facts 4: Health Care Coverage for Direct-Care Workers, 2009 Data Update. Available at: http://www.directcareclearinghouse.org/download/facts4-20110328.pdf

[100] In 2009, unlike earlier years, the unweighted count of direct-care workers employed by households was too small to permit reliable statistical analysis. Therefore, this fact sheet reports the uninsurance estimate from prior year.

[101] Significant at the 90% confidence level.

[102] The downloadable public use data files are available at: http://www.cdc.gov/nchs/nhhas.htm. To date, no reports or articles have been completed that analyze the survey data. The estimates and statistical analysis presented in this section were conducted by PHI for this report. The weighted sample of workers in the NNHAS consists of 160,720 aides.

[103] D. Seavey and V. Salter (October 2006) *Paying for Quality Care.* AARP Public Policy Institute Report #2006-18. http://*directcareclearinghouse.org/l_art_det.jsp?res_id=217110*

[104] PHI, (July 2011). *State Chart Book on Wages for Personal and Home Care Aides, 2000-2010*. Available at: http://www.directcareclearinghouse.org/download/PCAwages-2000to2010.pdf

[105] PHI analysis of U.S. Census Bureau, Current Population Survey, 2010 Annual Social & Economic (ASEC) Supplement, with statistical programming and data analysis provided by Carlos Figueiredo.

[106] The downloadable public use data files are available at: http://www.cdc.gov/nchs/nhhas.htm. To date, no reports or articles have been completed that analyze the survey data. The estimates and statistical analysis presented in this section were conducted by PHI for this report. The weighted sample of workers in the NNHAS consists of 160,720 aides.

Section 8 Hours Worked

The staffing and scheduling practices of home care and personal assistance employers have a dramatic effect on the job and income stability of aides. These practices—which typically rely on low hourly wages, part time and per diem work, and few other supports and benefits—make it difficult for aides to amass full-time hours on a regular basis.

The same factors often make it difficult for home care and personal assistance workers to obtain consistent income, and dependable work schedules and assignments. Furthermore, for many of these workers, stable hours last only until their current client dies or is hospitalized. Frontline aides typically bear the entire risk of lost hours and income due to changes in consumer status resulting from events such as hospitalization, death, client refusal, or care reduction.

Unreliable schedules and irregular hours for home care and personal assistance workers are correlated with lower rates of job satisfaction and intent to leave. Studies have found lower wages, fewer hours, and lack of travel cost reimbursement to be the strongest predictors of turnover for home care aides. [107]

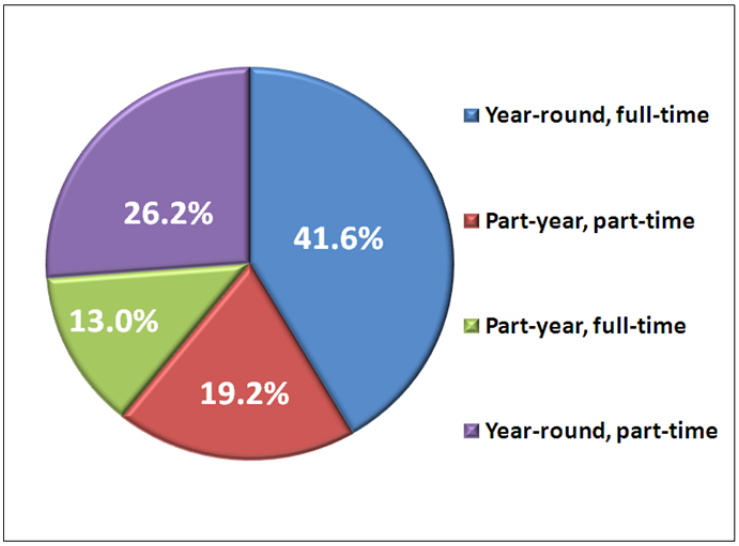
Some home care and personal assistance employers have developed scheduling practices that provide steady work and even guaranteed hours as part of an arrangement, in which, for example, the aide agrees to accept case assignments on alternating weekends and substitute assignments.[108]

In this section, preliminary information is presented on average hours worked and the incidence of overtime obtained from two nationally representative surveys of aides—one for home health aides and the other for personal care aides. We know of no other research studies that address the issue of hours worked and overtime in a comprehensive way.

Labor Force Patterns of Aides in Home Health Care Services[109]

As indicated in Figure 8.1 below, in 2009, 42 percent of all aides working in the Home Health Care Services industry (NAICS 6216) reported that they worked full-time, year round.

Figure 8.1: Labor Force Patterns of Direct-Care Workers in Home Health Care Services, 2009

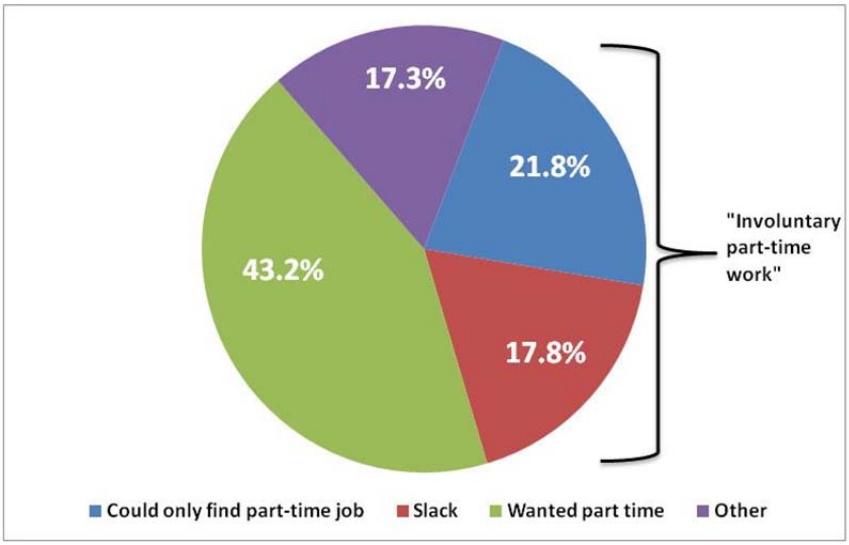


Source: PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 ASEC Supplement.

Another quarter (26.2 percent) worked year-round, part-time, and the remainder reported working part of the year, either part time or full time.

In response to the question, "what was the main reason you worked less than 35 hours per week?" 22 percent of aides working in the Home Health Care Services industry reported that they could only find part-time work, and an additional 18 percent

Figure 8.2: Reasons for Part-Time Work by Aides in the Home Health Care Services Industry, 2009



Source: PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 ASEC Supplement.

reported that they worked fewer than 35 hours because of slack work or business conditions. This suggests that approximately 40 percent of aides in the Home Health Care Services industry who worked less than 35 hours were *involuntary* part-time workers in 2009. A slightly larger proportion of aides reported working part time because they wanted to work part time (43 percent).

Home Health Aides in the NHHAS (2007): Average Hours Worked and Overtime[110]

Sponsored by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services, the National Home Health Aide Survey (NHHAS) was designed to provide national estimates of home health aides employed by agencies that provide home health or hospice care. NHHAS utilized a multistage probability sample survey, and was conducted as a supplement to the 2007 National Home Health Care Survey (NHHCS).

Agencies providing home health or hospice care were sampled into NHHCS, and then no more than six home health aides were sampled from each eligible participating NHHCS agency. Home health aides were considered eligible to participate in NHHAS if they were: directly employed by the sampled agency; and provided assistance in activities of daily living (ADLs), including bathing, dressing, transferring, eating, and toileting.

A preliminary analysis by PHI indicates that the vast majority of aides sampled considered themselves to be "home health aides" (62 percent). About a quarter identified as CNAs (23 percent). Less than 10 percent identified as a "home care aide/personal care attendant" (7 percent), and 4 percent worked as "hospice aides."

Eighty-one percent of aides reported working in patient homes only.[111] Sixteen percent responded that they worked in both patient homes and facilities, and only 3 percent reported working in one or more inpatient facilities.

NHHAS data indicate that **home health aides worked 31 hours per week on average.** Ninety-two percent of respondent aides reported working 40 hours or less in an average week for their employer or agency in their primary job. This means that **just 8 percent of aides worked more than 40 hours**. Nearly all of the respondents (98 percent) worked 50 hours or less.

Personal Care Aides and the Home Health Care Services Industry in the 2010 ASEC: Average Hours Worked and Overtime[112]

The Annual Social and Economic (ASEC) Supplement of the Current Population Survey tracks two occupational titles for direct-care workers: Personal Care Aides (SOC 39-9021), and Nursing, Psychiatric and Home Health Aides (SOC 31-1012, 31-1013, 31-1011). The latter category does not allow for a distinction between Home Health Aides—who are more likely to work in home-based settings—and those direct-care workers who are more likely to work in facility-based settings only.

Average Hours Worked

As indicated in Table 8.1 below, in the longest position they held in 2009, **Personal Care Aides (PCAs) reported working 34 hours per week.**

Table 8.1: Average Hours Worked by Occupation, 2009

Occupation	Mean hours worked per week in longest job (HRSWK)
Personal Care Aides	33.9
Nursing, Psychiatric & Home Health Aides	35.4

Source: PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic (ASEC) Supplement.

As shown in Table 8.2, mean hours worked for all direct-care workers varied somewhat by setting, ranging from 32-33 hours per week in both Home Health Care Services and Individual and Family Services, to 36-37 hours in Nursing Care Facilities, Residential Care (no nursing), and Hospitals.

Table 8.2: Average Hours Worked by Industry/Setting, 2009

All DCWs	Home Health Services	Nursing Care Facilities	Residential Care (no nursing)	Individual & Family Services	Hospitals
Mean hours worked per week	32.6	36.3	37.4	32.3	37.3

Source: PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic (ASEC) Supplement.

Overtime

As indicated in Table 8.3, **88 percent of Personal Care Aides reported working 40 hours or less in 2009.**[113] Looking across all industries and settings, 12 percent of PCAs

reported working more than 40 hours per week,[114] or a weighted national count of 109,268 aides. One in four of these aides, however, reported working part-time, thereby circumscribing their contribution to total overtime hours worked by PCAs.[115] **PCAs who worked full time, full year and who reported working overtime constituted 9.4 percent of total PCAs.**

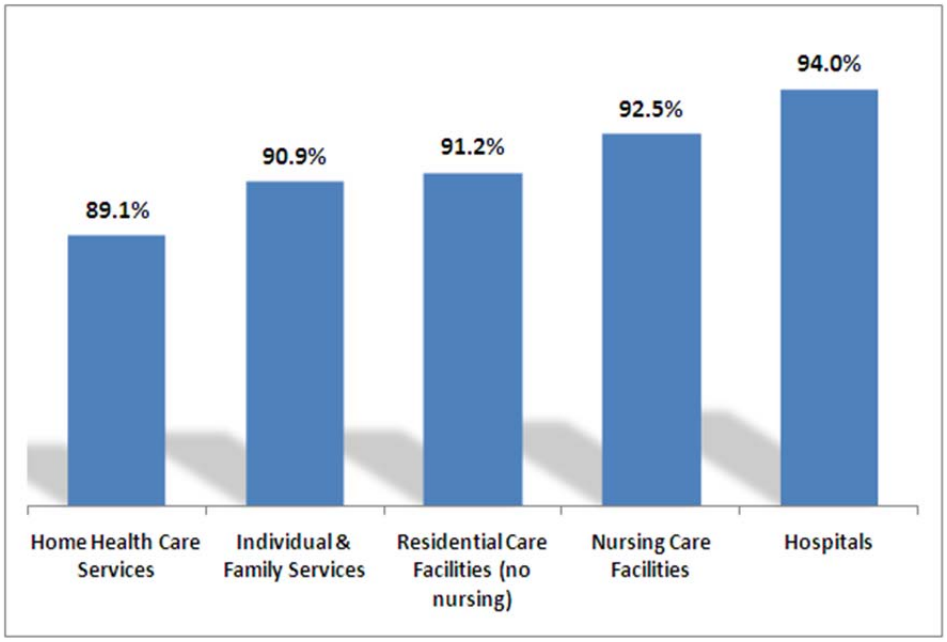
Table 8.3: Overtime by Occupation, 2009

Occupation	Percent working 40 hrs/wk or less in longest job	Percent working full year, full time& working more than 40 hrs/wk
Personal Care Aides	12.4%	9.4%
Nursing, Psychiatric & Home Health Aides	7.7%	7.1%

Source: PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic (ASEC) Supplement.

Figure 8.3, below, shows the variation by setting/industry in the percentage of direct-care workers working 40 hours or less per week in their longest job. Hours worked at 40 hours or less per week ranged from 89 percent for aides in the Home Health Care Services industry to 94 percent in Hospitals.

Figure 8.3: Percent of direct-care workers by industry working 40 hours/week or less in their longest job, 2009



Source: PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic (ASEC) Supplement.

The Home Health Care Services industry had a weighted national count of 783,386 aides in 2009. Of these aides, 10.9 percent reported working overtime: 77,141 aides who worked full year, full time and 8,627 aides who worked part time (see Table 8.4).

Table 8.4: Overtime in the Home Health Care Services Industry, 2009

Occupation	Percent of aides working 40 hrs/wk or less in longest job	Percent of aides working full year, full time& working more than 40 hrs/wk
All Aides	10.9%	9.8%
Weighted national count	85,768	77,141

Source: PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic (ASEC) Supplement.

As for the PCA occupation as a whole, the incidence of overtime among full-year, full-time aides employed in the Home Health Care Services industry was less than 10 percent in 2009.

Characteristics of PCAs Working Overtime vs. Part Time

Table 8.5 below presents some summary demographic and economic characteristics of PCAs who report working overtime and then those who report working part time.

In 2009, a quarter of "part-time PCAs" lived in families with income under the Federal Poverty Level compared to 12 percent of "overtime PCAs." Furthermore, a higher percentage of part-time PCAs lived in households receiving Medicaid and/or food and nutrition assistance compared to PCAs who reported working overtime. Finally, four in ten part-time PCAs received other income such as Social Security, child support and alimony compared to one out of three overtime PCAs.

Table 8.5: Selected Characteristics of PCAs Working Overtime and Part Time, 2009

Characteristic	Overtime Workers	Part-Time Workers
Age (mean years)	47	44
High school education or less	45.1%	55.1%
Native born	80.0%	79.6%
Received employer-sponsored insurance	39.7%	27.4%
Received income from other	24.5%	11.4%

work		
Received income from Social Security, alimony, child support, etc.	33.5%	44.1%
Family income less than 100% of Federal Poverty Level	12.1%	23.9%
In a household receiving public assistance	50.6%	52.5%
In a household receiving Medicaid	39.9%	43.5%
In a household receiving food/nutrition assistance	27.8%	36.1%

Source: PHI analysis of the U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic (ASEC) Supplement.

Summary

The two nationally representative surveys examined in this analysis indicate that overtime for the nation's home care and personal assistance workforce—measured as working more than 40 hours per week— is very modest. Roughly 8 to 9 percent of aides report working more than 40 hours per week. A similar overtime prevalence rate is observed for aides employed in the Home Health Care Services industry: approximately 10 percent of aides in that industry who are employed full time, full year report working overtime.

Compared to the number of aides employed full year, full time who report working overtime in the Home Health Care Services industry, a far greater number of direct-care staff—nearly two and a half times more—report *involuntary* part-time work, meaning that these aides would have liked to have worked more hours than they did.

While home care and personal assistance occupations constitute *bona fide* forms of employment that by and large are not performed on a casual basis, it is also true that the home care industry has structured employment so that it is heavily part time. In 2009, 58 percent of aides in the Home Health Care Services industry reported working part time. Mean hours worked per week in this industry totaled 32.6. In sharp contrast, in the Hospital industry, aides worked 37.3 hours per week and only 28 percent worked part-time.

Part-time hours combined with generally low hourly wages result in very low earnings for many home care and personal assistance workers. As detailed in the chapter on compensation in this report, average median wages received by aides in the Home Health Care Services industry were just $9.34 in 2009, and annual median earnings totaled only $12,000. As a result of these low earnings, 56.2 percent of aides employed in the Home Health Care Services industry in 2009 lived in households that relied on one or more public assistance programs such as Medicaid and food stamps.

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[107] See research literature reviewed in Section 9 of this report.

[108] PHI (July 2007) *The Guaranteed Hours Program: Ensuring Stable, Full-Time Direct-Care Employment*, Workforce Strategies No. 4, Bronx: PHI. Available at: http://www.directcareclearinghouse.org/l_art_det.jsp?res_id=247310.

[109] Analysis of work patterns in the industry Services for the Elderly and Persons with Disabilities is not possible because it is not broken out as a separate industry but rather is included in a larger industry grouping called Individual and Family Services.

[110] The NHHAS public use data files are available at: http://www.cdc.gov/nchs/nhhas.htm. NHHAS estimates and statistical analysis presented in this section were conducted by PHI for this report. The NHHAS weighted sample of consists of 160,720 aides.

[111] In response to the question "Did you work at an in-patient facility at your job with {AGENCY} or care for patients in their homes.

[112] Statistics in this section are based on PHI analysis of the U.S. Census Bureau, Current Population Survey (CPS), 2010 Annual Social and Economic (ASEC) Supplement, with statistical programming and data analysis provided by Carlos Figueiredo.

[113] The variable **HRSWK** in the AESC is defined by the following question: "(For your longest job held in 2009), in weeks that you worked, how many hours did you usually work?"

[114] The corresponding estimate for 2008 was 15 percent.

[115] In 2009, out of total estimated count of 882,007 PCAs nationwide, 82,823 aides reported working more than 40 hours a week in full year, full time positions (9.4% of all PCAs). An additional 26,445 aides in part-time arrangements reported working overtime.

Section 9 Workforce Instability & Labor Shortages

The direct-care workforce is characterized by **chronically high rates of workforce instability.** Some turnover is inevitable in every enterprise and not all turnover is "bad." However, across most of the country, evidence suggests the existence of high turnover and vacancy rates for direct-care workers, shortages of qualified staff, and difficulties recruiting and retaining workers.[116] The current economic recession has inevitably reduced turnover in these frontline occupations, but projected demand for in-home supports and services is extremely strong.

The consequences of workforce instability due to persistent turnover and vacancies are serious. They include: diminished quality of care, compromised access to services, and greater unmet need among the full population that could benefit from in-home supports and services. Staff instability and turnover can also result in major financial burdens for both agency-based long-term care providers, and the state and federal agencies that foot a large part of the bill for these services.[117] A 2004 report investigating these costs concluded that "turnover among frontline workers is a critical cost driver for the long-term care industry," and that "the costs of turnover to the public sector are tantamount to an implicit tax on reimbursement rates paid to public-financed providers—a hidden tax which ultimately is paid by taxpayers for high industry turnover costs."[118]

Concerns about high turnover rates and difficulties in workforce recruitment have informed several notable federal and state initiatives to improve recruitment and retention. For example:

- The Centers for Medicare and Medicaid Services created the **National Direct Service Workforce Resource Center** in 2006 to respond to the large and growing shortage of workers who provide direct care and personal assistance to individuals who need long-term supports and services. The Resource Center supports efforts to improve recruitment and retention of workers who assist people with disabilities and older adults to live independently and with dignity in the community.

- In 2002, the Robert Wood Johnson Foundation and The Atlantic Philanthropies launched **Better Jobs Better Care**, a 4-year, $15.5 million multi-state applied research and demonstration program that sought to achieve changes in long-term care policy and practice that help to reduce high vacancy and turnover rates among direct care staff across the spectrum of long-term care settings and contribute to improved workforce quality.

- Since 2001, CMS has awarded over 330 **Real Choice System Change (RCSC) Grants** totaling $270.3 million to states and other agencies working to improve state long-term care infrastructures. Many of the grantees have undertaken initiatives aimed at improving recruitment and retention of direct-care workers. [119]

- In 2008, the **Institute of Medicine** issued a major report on the adequacy of the health care workforce for aging Americans. The direct-care workforce was featured and the recruitment and retention challenges of this workforce were detailed and analyzed. The IOM concluded that "the recruitment and retention of sufficient numbers of these workers is challenging due to serious financial disincentives and job dissatisfaction as well as high rates of turnover and severe shortages of available workers."[120]

- The Affordable Care Act of 2010 creates a **Personal Care Attendant Workforce Advisory Panel** (Title VIII, Section 8002) for the purpose of evaluating and advising on workforce issues for personal care attendants, including wages, benefits, and training. The Panel was established as part of the CLASS Program (Community Living Assistance Services and Supports Program) which the Secretary of Department of Health and Human Services recently determined is not financially viable. This statutory provision includes an examination of service needs under Medicaid, Title XIX of the Social Security Act.

Evidence on home care aide turnover and intent to leave

Although the problem has been widely observed "on the ground," there is a paucity of comparable and consistent data documenting actual home care aide turnover.[121] A handful of small-scale studies have demonstrated high rates of aide turnover ranging from 44 to 65 percent.[122] In addition, a literature exists that examines "intent to leave" and the factors correlated with it.[123]

Research has shown that a direct-care worker's expressed intent to leave his or her job is strongly associated with his or her level of "job satisfaction." In turn, job satisfaction has been found to be strongly linked to wages and compensation, workloads, and working conditions. High job satisfaction is associated with positions where workloads are balanced, and the work environment promotes respect, independence, and positive relationships with supervisors.

PHI's analysis of the 2007 National Home Health Aide Survey indicates that nationally, **35 percent of home health aides who are working for home care agencies intended to leave their job in the next year**. The weighted sample of this nationally representative survey consists of 160,720 home health aides, meaning that over 56,000 aides were at risk of leaving in the year following the survey.[124]

Brannon and colleagues (2007) studied how the job perceptions of the direct-care workers participating in the BJBC demonstration projects related to their intent to leave their job. A total of 3,039 workers from 50 nursing homes, 39 home care agencies, 40 assisted living facilities and 10 adult day services in five states participated in the survey. Researchers found that the perceived lack of opportunity for advancement along with the perception of work overload were significantly related to intent to leave, particularly among home care agency and skilled nursing home staff.[125] This study determined that 39 percent of home care workers said that they were likely to leave their jobs in the following year.

Turnover endemic to home health and personal care jobs

- Small-scale studies show PCA turnover ~ 44 - 65%
- 2007 National Home Health Aide Survey: 35% of home health aides intend to quit in next year (~56,000 workers)
- Turnover "predictors"
  - **Low wages**
  - **Not enough hours**
  - **No reimbursement for travel costs**

One of the only *state-wide* studies of home care workers to investigate job quality and turnover was conducted by Morris of the Muskie School of Public Service at the University of Southern Maine. Over 600 Maine home care workers were surveyed in 2005 and again in 2007. Morris found that 47 percent of the aides intended to leave their jobs over the following two years. Actual turnover over the two year period was 46 percent. Lower wages, fewer hours, and lack of travel cost reimbursement were identified as the strongest predictors of turnover.[126]

Relationship of direct-care worker turnover to wage levels and other factors

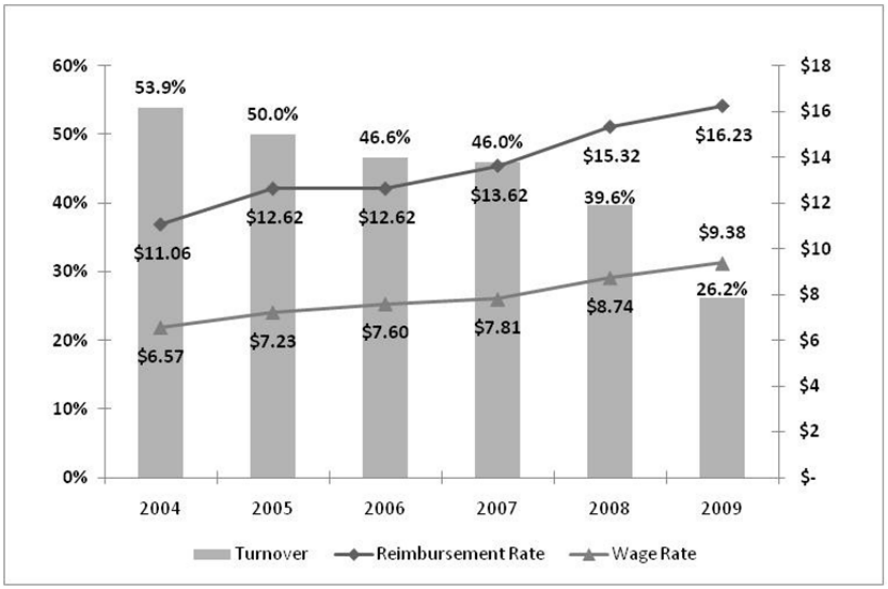
According to a variety of studies, wages play a critical role in determining the adequacy and stability of the home care workforce. **Lower wages are associated with higher turnover and lower quality of care.**

Research findings consistently support the notion that higher wages lead to lower rates of turnover for direct-care workers. For example:

- In **Michigan**, a $1 per hour wage increase in turn reduced the odds that a paraprofessional worker would leave by 15%, and for nursing home workers, in particular, by 27 percent.[127]
- A near doubling of wages for homecare workers in **San Francisco County** over a 52-month period was associated with an increase in the annual retention rate of new workers from 39 percent to 74 percent. This improved retention translated into a 57 percent decrease in the turnover rate for new workers.[128]
- In **Wyoming**, the average wage of experienced direct-support workers increased from $7.38 to $10.74 over a three-year period beginning in 2001. Over the same period, full-time staff turnover declined from 52 percent to 32 percent. The wage increase was funded by a 28 percent increase in appropriations for the adult developmental disabilities waiver to improve staff reimbursement and retention, followed by two cost-of-living increases for workers.[129]
- In **Maine**, a 20 percent wage increase for agency-employed home care workers can be expected to reduce turnover by 28 percent.[130]
- In **Illinois**, the turnover rate among field staff employed by Addus HealthCare, Inc.[131] fell by half—from 54 percent in 2004 to 26 percent in 2009—as the Illinois Department of Aging increased its hourly reimbursement rate for Medicaid home care services from $11.06 to $16.23, or by 47 percent (see Figure 9.1). This rate increase led to a 43 percent increase in the hourly wage rate paid to home care workers by Addus. State regulations require that a minimum percentage of the revenues paid to a provider be expended on direct care worker costs, including wages.[132]

In addition to the negative correlation between simple wages rates and turnover, research also corroborates a similar correlation between turnover and **reimbursement for home care workers' work-related travel costs**. Specifically, Maine home care worker study concluded that reimbursing workers for travel costs had a similar effect on turnover as nearly a $4 increase in hourly wages.[133] The Maine study also suggests an important relationship between turnover and the scheduling practices of agencies: ensuring **full-time hours** reduced aide turnover by 21 percent.

Figure 9.1: Relationship between reimbursement rates, wages, and turnover in home care programs funded by the Illinois Department of Aging, 2004-2009



Source: Addus HealthCare, Inc. (with permission). Turnover rates are for Addus field staff providing home care and personal assistance services.

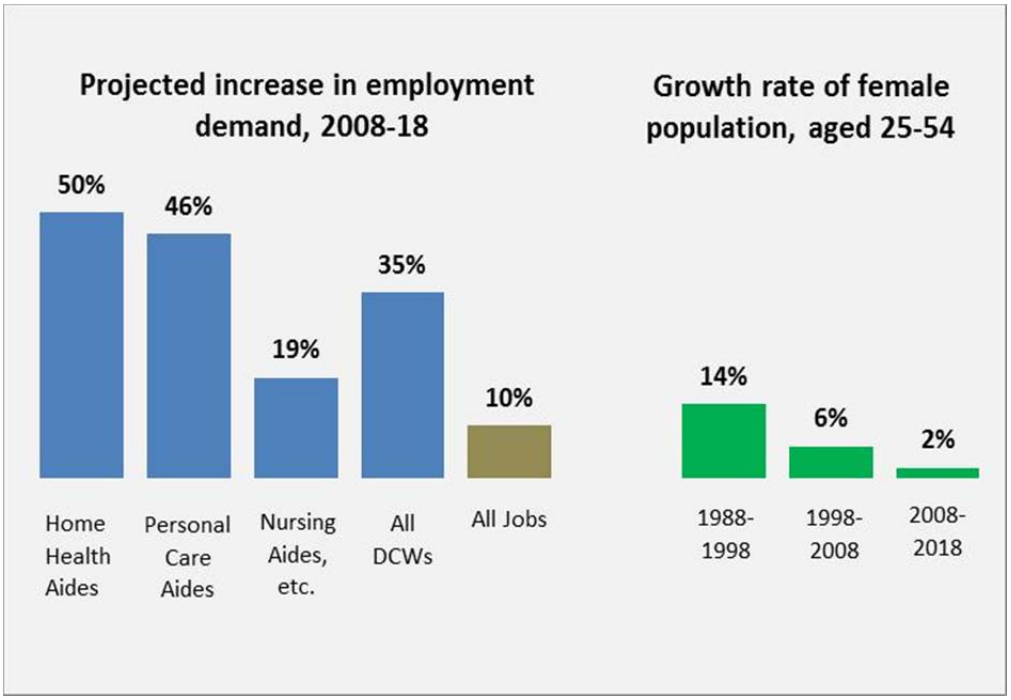
Although no specific data is available with regard to the home care industry, several studies of nursing care facilities find that turnover rates of aides have a strong negative correlation with **care quality**. For example:

- Increases in nursing aide and LPN turnover are associated with decreases in the quality of care experienced by nursing home residents, as measured by rates of physical restraint use, catheter use, contractures, pressure ulcers, psychoactive drug use, and certification survey quality-of-care deficiencies.[134,135]
- In **Wisconsin**, nursing homes with higher turnover have lower quality of care as measured by the average numbers of complaints, violations, and deficiencies.[136]

Building Demographic Pressure for Labor Shortages

Today's demographics are strikingly different from the labor supply conditions that existed from the 1960s to the early 1990s when increasing numbers of females were entering the labor force. Service delivery systems for in-home services and supports in the United States can no longer continue to rely on steady supply of women with few other employment opportunities.

Figure 9.2: Demand for Direct-Care Workers vs. Growth of Core Female Labor Supply



Sources: PHI (February 2010), FACTS 1: Occupational Projections for Direct-Care Workers 2008-2018"; and M. Toossi (November 2009) "Labor force projections to 2018," Monthly Labor Review.

Figure 9.2 shows that, at the same time that overall demand for direct-care workers is projected to increase by 35 percent over the next decade, adding one million new openings by 2018, the number of women aged 25-54 – the main labor pool from which these workers are drawn – is projected to increase by less than 2 percent, down from over 14 percent just two decades ago.

The old workforce paradigm viewed the direct-care workforce as largely disposable, and turnover as an unavoidable cost of doing business. But at the beginning of the current decade, the absolute size of the female labor force aged 25 to 54 began to contract. The structural "supply" change underway argues for shifting the workforce calculus to a focus on retention and a consideration of the costs that turnover exacts in terms of replacement, additional training, lost productivity, and even lost revenues.

[116] For six years now, the National Survey of State Initiatives on the Long-Term Care Direct Care Workforce has found that the vast majority of states consider direct-care turnover and vacancies to be a serious issue. The percentage of states has varied from 88 percent in 1999 to 97% in 2007. For the latest survey, see the National Clearinghouse on the Direct Care Workforce and the Direct Care Workers

Association of North Carolina (December 2009), *The 2007 National Survey of State Initiatives on the Direct Care Workforce*. Prior years surveys can be found at: http://www.phinational.org/clearinghouse.

[117] D. Seavey (October 2004) *The Cost of Frontline Turnover in Long-Term Care*, Better Jobs Better Care Report, Washington, DC: Institute for the Future of Aging Services, American Association of Homes and Services for the Aging; U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy (January 2006) *The Supply of Direct Support Professionals Serving Individuals with Intellectual Disabilities and Other Developmental Disabilities: Report to Congress*. Available at: http://aspe.hhs.gov/daltcp/reports/2006/DSPsupply.htm#changing.

[118] D. Seavey (October 2004) *The Cost of Frontline Turnover in Long-Term Care*, Better Jobs Better Care Report, Washington, DC: Institute for the Future of Aging Services, American Association of Homes and Services for the Aging.

[119] In its evaluation final report on the grantees' workforce initiatives, RTI International finds that "[l]ong-term care providers currently report high job vacancies and turnover rates. Increasingly, federal and state policy makers, and the long-term care industry are acknowledging a labor shortage crisis with potentially negative consequences for the quality of care and quality of life for people with disabilities and their informal caregivers. These shortages are likely to get worse over time as the demand for services increases." RTI International (2004) Direct Service Workforce Activities of the Systems Change Grantees, Prepared for Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Research Triangle Park, NC: RTI International, p. 5.

[120] Institute of Medicine (2008) *Retooling for an Aging America: Building the Health Care Workforce*, Prepared by the Committee on the Future Health Care Workforce for Older Americans, Board of Health Care Services, Washington, DC: The National Academies Press, p. 232.

[121] Barry, Kemper, and Brannon provide important cautions when comparing different turnover rates since there is currently no standardized method of measuring turnover, and differences in definitions of turnover and the data elements used to construct the measure can have large effects on turnover rates. Barry, T.T., Kemper, P., Brannon, S.D. (2008) "Measuring worker turnover in long-term care: Lessons from the Better Jobs Better Care Demonstration," *The Gerontologist* 48 (3): 394-400.

[122] A survey of home care agency staff in Pennsylvania found a turnover rate of 44% (University of Pittsburgh (2007) *The State of the Homecare Industry in Pennsylvania*, Prepared for the PA Homecare Association); a review of 13 state and 2 national studies of in-home care for persons with intellectual and developmental disabilities found an average turnover rate of 65% (Hewitt and Larson (2007); a study of agency-employed home care workers in Maine found a turnover rate of 46% (L. Morris (2009) "Quits and Job Changes Among Home Care Workers in Maine," *The Gerontologist*, 49(5): 635-50).

[123] While intent to leave is not a proxy for turnover, it has been shown to be highly correlated with it, and it has been found to be the strongest predictor of individual turnover (Brannon *et al*., 2008).

[124] The downloadable public use data files are available at: http://www.cdc.gov/nchs/nhhas.htm. To date, no reports or articles have been completed that analyze the survey data. The estimates and statistical analysis presented in this section were conducted by PHI for this report. The weighted sample of workers in the NNHAS consists of 160,720 aides. *Intent to leave* combines "very likely" and "somewhat likely" to leave.

[125] T.T. Barry, P. Kemper, S.D. Brannon (2008) "Measuring worker turnover in long-term care: Lessons from the Better Jobs Better Care Demonstration," *The Gerontologist* 48 (3): 394-400.

[126] L. Morris (2009) "Quits and Job Changes Among Home Care Workers in Maine," *The Gerontologist*, 49(5): 635-50.

[127] M. Mickus, C.C. Luz, A. Hogan (2004) *Voices from the Front: Recruitment and Retention of Direct Care Workers in Long Term Care Across Michigan*, Michigan State University.

[128] C. Howes (2005) "Living Wages and Retention of Homecare Workers in San Francisco," *Industrial Relations,* 44(1): 139-163.

[129] B.D. Sherard (2002) *Report to the Joint Appropriations Committee on the Impact of Funding for Direct Staff Salary Increases in Adult Developmental Disabilities Community-Based Programs,* Wyoming Department of Health.

[130] L. Morris (2009) Quits and Job Changes Among Home Care Workers in Maine. *The Gerontologist*, 49(5): 635-50.

[131] Addus is a national home care company that provides personal care and assistance with activities of daily living, skilled nursing and rehabilitative therapies, and adult day care. Addus has over 12,000 employees that provide services through more than 120 locations across 16 states to over 23,000 consumers.

[132] According to state regulations, a provider agency delivering services under the Community Care or Home Services Program must submit an annual cost report demonstrating that it has expended a minimum of 73 percent and 77 percent, respectively, of the total revenues due from either the Departments on Aging or Human Services for allowable direct service worker costs.

[133] L. Morris (2009) "Quits and Job Changes Among Home Care Workers in Maine," *The Gerontologist*, 49(5): 635-50.

[134] N. Castle (2005) "Turnover begets Turnover," *The Gerontologist*, 45 (2): 186-195.

[135] N. Castle, J. Enberg, R. Anderson, A. Men (2007) "Job Satisfaction of Nurse Aides in Nursing Homes: Intent to Leave and Turnover," *The Gerontologist*, 47(2): 193-204.

[136] E. Hatton, L. Dresser (2003) *Caring About Caregivers: Reducing Turnover of Frontline Health Care Workers in South Central Wisconsin*, Jobs with a Future Partnerships, The Center for Wisconsin Strategy.

Section 10 Status of Wage & Hour Protection

Home care and personal assistance workers now constitute one of the largest and fastest-growing occupational groups in the United States, fueled by sweeping increases in the demand for home and community-based services. The role that this workforce plays in our nation's daily capacity to provide in-home services and supports to millions of Americans with functional impairments stands in sharp contrast to the lack of basic workforce protections that these workers are accorded. Chief among these is the Companionship Exemption of the federal Fair Labor Standards Act (FLSA), which exempts the vast majority of home care and personal assistance workers from basic federal wage and hour protection.

Background on the Companionship Exemption

FLSA was enacted by Congress in1938 to ensure a minimum standard of living for workers through the provision of a minimum wage, overtime pay and other protections. It excluded domestic workers. In 1974 the FLSA was amended to include domestic employees such as housekeepers, full-time nannies, chauffeurs, and cleaners.

However, a narrow exception was retained for babysitters and for employees who provide "companionship services to individuals who because of age or disability are unable to care for themselves" — an exemption colloquially referred to as the "babysitter exemption." The definitions of what constitute "companionship" duties and "domestic service employment" have been argued ever since, particularly in light of the enormous changes that have occurred in the provision of home-based services and supports in the past three decades.

In January 2001, the Clinton Administration's Department of Labor issued a notice of proposed rulemaking that offered several ways of modernizing the Companionship Exemption. These updates were required, the Department argued, in order to reflect "significant changes in the home care industry over the last 25 years" and because the regulations "exempt types of employees far beyond those whom Congress intended to exempt."[137] However, before the revision process could be concluded, it was terminated by the incoming Bush Administration.

The Department of Labor continued to interpret the exemption to apply to the vast majority of home care workers, even workers employed by an agency (as distinct from directly employed by a family member, for example) and who perform duties beyond those of "companionship" as specified in the Code of Federal Regulations. In 2007, in a case brought by New York home care attendant Evelyn Coke — *Evelyn Coke v. Long*

Island Care at Home — the U.S. Supreme Court ruled that the Department of Labor acted within its authority in interpreting the Companionship Exemption broadly.

In 2007, the Fair Home Health Care Act was introduced in both the Senate and House, with then-Sen. Barack Obama as a co-sponsor. This proposed Act would have reworded the 1974 amendment to extend federal wage and hour protection to home care aides, retaining the exemption for "live-in" workers, and also maintaining the minimum wage exclusion for "casual" companions who work less than 20 hours/week. The legislation was not reported out of committee.

In July 2010, the Direct Care Workforce Empowerment Act was introduced in Congress by Representative Sanchez and Senator Casey. This bill would have eliminated the exemption for all but live-in aides. In June 2011, a revamped bill, the Direct Care Job Quality Improvement Act (H.R.23411/S.1273) was reintroduced with the support of 33 cosponsors in the House and 7 in the Senate.

Additionally, under the Obama Administration, the Department of Labor has indicated its intention to update its companionship services "in order to clarify when domestic service employees, who provide companionship services to the aged or infirm, are exempt from the minimum wage and overtime provisions of the FLSA."[138] A notice of proposed rulemaking is expected in late 2011.

Current Status of Wage and Hour Protection across the States

In a number of states, state wage and hour protection laws and regulations either specifically cover home care work or cover domestic service employment *without* exempting companions. In these cases, home care and personal assistance workers have rights equal to those of employees in other industries. Also, in many of these states, the minimum wage rate exceeds the federal minimum wage.

As detailed in Table 10.1 below, 21 states and the District of Columbia require that home care workers be paid the state minimum wage for all hours worked. Moreover, 16 of those states also provide for overtime pay at time and a half to some or all home care and personal assistance workers who work over 40 hours in a workweek.

Table 10.1: State minimum wage and overtime coverage for home care & personal assistance workers

(Compiled by National Employment Law Project, August 2011 and reprinted with permission)

States that provide minimum wage and overtime coverage	
Colorado*	Minimum Wage Act exempts companions[139] and domestic employees employed by households or family members to perform duties in private residences. CO Wage Order 26 Sec. 5; 7 CO ADC 1103-1:5.
Hawaii*	"Employee" excludes any individual employed in domestic service in the employer's home. Haw. Rev. Stat. § 387-1.
Illinois*	Minimum wage and overtime coverage. No relevant exemptions. "Employee" excludes any individual employed by an employer employing fewer than four employees. 820 Il. Comp. Stat. § 105/3 (d).
Maine	Minimum wage and overtime coverage. No relevant exemptions. 26 M.R.S.A. §§ 663, 664.
Maryland	Companions may be required to work a longer workweek before the state overtime pay requirements apply. Md. Code Ann. § 3-420(c)(2). Companions employed by non-profit agencies are exempt from overtime. Md. Code Ann. § 3-415.
Massachusetts	Minimum wage and overtime coverage. No relevant exemptions. MA St. Ch.151, § 1.
Michigan*	Minimum wage law provides minimum wage and overtime coverage to employees employed in domestic service employment to provide companionship services as defined in 29 CFR 552.6, but exempts live-in domestic workers as described in 29 CFR 552.102. Mich. Comp. Laws § 408.394(2)(a).
Minnesota	Minimum wage and overtime laws exclude nighttime hours worked by companions if employee is available to provide services but does not actually do so. Minn. State. § 177.23(11).
Montana*	Minimum wage and overtime laws exempt companions (as defined in federal law) when the person providing the service is employed directly by the family. Mont. Code. § 39-3-406(p).
Nevada	Minimum wage law exempts domestic service employees residing in the household. Nev. Rev. Stat. § 608.250(2)(b).
New Jersey	Minimum wage and overtime coverage. No relevant exemptions. NJSA 34:11-56a *et seq.*
New York	"Employee" does not include any individual who lives in the home of an employer for the purpose of serving as a companion and whose principal duties do not include housekeeping. NY Lab Law § 651, 12 NYCRR § 142-2.14(a)(iii). Overtime compensation for companions is limited to 150% of the state minimum wage rate for each hour worked over 40 in a workweek. 12 NYCRR § 142-2.2.
North Dakota	Minimum wage law exempts employees who provide companionship services between 10 pm and 9 am. N.D. Cent. Code § 34-06-03.1. Overtime law exempts live-in domestic service employees. N.D. Admin. Code § 46-02-07-02(4)(d).
Pennsylvania*	Minimum wage and overtime laws exempt domestic services in or about the employer's private home. 43 Pa. Const. Stat. § 333.105(a)(2).
Washington	Minimum wage and overtime laws exempt any individual whose duties require that she reside at the place of employment. Wash. Rev. Code § 49.46.010(5)(j).
Wisconsin*	Companions are exempted if they reside in the employer's household and spend less than 15 hours a week on general household work. Wis. Admin. Code §272.06(2). Overtime law exempts companions who are employed directly by the client's household. Wis. Admin. Code § 274.015. Overtime law provides a limited exemption for employees of nonprofit organizations. Wis. Admin. Code §§274.015, 274.01.
States that provide minimum wage but no overtime coverage	
Arizona	Minimum wage but no overtime coverage. No state overtime law. Ariz. Rev. Stat. Ann. §§ 23-362, 23-363. *See also*, Op. Att'y Gen. 2007 Ariz. AG LEXIS 2 (Feb. 7, 2007).
California	Minimum wage coverage but no overtime coverage. "Personal attendants" exempt from overtime. Industrial Wage Order 5-2001.
D.C.	Minimum wage but no overtime coverage. D.C. Ann. Code 902.5(b).
Nebraska	Minimum wage but no overtime coverage. No state overtime law. Neb. Rev. St. §§ 48-1202, 1203.
Ohio	Minimum wage but no overtime coverage. Overtime law adopts FLSA exemptions. OH. Rev. Code § 4111.03(A). Overtime law also exempts live-in companions. Id. (D)(3)(d).
South Dakota	Minimum wage but no overtime coverage. No state overtime law. SDCL §§ 60-11-3, 60-11-5.
* Likely covers only agency-employed workers under one or more laws, due to exclusion of workers employed solely by the recipient or family.	

Source: P.K. Sonn, C.K. Ruckelshaus, and S. Leberstein (August 2011) Fair Pay for Home Care Workers, National Employment Law Project. Available at: http://www.nelp.org/page/-/Justice/2011/FairPayforHomeCareWorkers.pdf?nocdn=1

In some of these states, overtime coverage is partial. For example, Illinois, Michigan and Pennsylvania extend overtime coverage to agency employees, but exempt those employed solely by individual consumers. However, seven states (IL, ME, MA, MN, MT, NJ, and NV) extend minimum wage and overtime either to all home care aides, or to all aides except night-time aides, live-in aides, and/or paid family members.

Reassessing the Companionship Exemption

Changes in the Industry

Dramatic changes in the provision of home-based services and supports have rendered the Companionship Exemption a vestige of a prior era. The debates surrounding the 1974 amendments to FLSA characterized the "companion" to be exempted as an occasional adult sitter hired by a private household to watch over an elderly or infirm person in the same way that a babysitter watches over children. This notion of "companion" has little relevance in today's world where home care and personal assistance aides typically deliver a range of in-home services and supports that far exceed the provision of "fellowship" and "protection" under the formal definition of companionship. Moreover, home care workers today usually pursue this work as a primary vocation under formal employment relationships made either with an agency, directly with the consumer/household, or by way of a joint employment relationship between the consumer and an agency.

Unintended Consequences

Maintaining the Companionship Exemption has a number of negative consequences that may not be initially apparent. From a ***workforce development*** standpoint, the exemption deters employment in the home care industry by acting as a barrier to the overall status of this occupation relative to other low-wage jobs. Other domestic occupations such as housekeeper, cook, and gardener offer the advantage of basic wage and hour protections as do virtually all other jobs that require similar levels of education and training as home care jobs.

From a ***labor market*** point of view, maintaining the current exemption in only one segment of the long-term care labor market (home care as opposed to facility-based nursing aides) creates distortions in and artificial segmentation of caregiver labor markets across the entire system. By supporting this kind of disparity, the exemption impedes the normal functioning of markets and serves to undermine the development of a stable, adequate workforce of paid caregivers to provide home- and community-based services.

Finally, from a ***federal policy*** perspective, the exemption works to send mixed message from the federal government concerning the future direction of publicly-reimbursed long-term services and supports. The exemption in its present form subverts the government's encouragement of "**rebalancing**"—that is, the expansion of home and community- based services relative to those provided in more facility-based settings, such as nursing homes. It also is inconsistent with efforts by the Department of Labor to support innovative training and credentialing programs for home care and personal assistance workers that help professionalize these occupations.

Costs and Benefits of Narrowing the Exemption

It is likely that low wages actually impose significant costs on the Medicaid system – costs that a narrowing of the Companionship Exemption would help to mitigate. As reviewed in Section 9 of this report, studies show turnover rates for agency-employed personal assistance workers of between 44 and 65 percent. A 2007 National Home Health Aide Survey found that 35 percent of home health aides intended to quit in the next year. The primary causes of high turnover rates are low wages, insufficient hours, and a lack of reimbursement for travel costs. High turnover imposes a significant financial burden on employers in the form of recruitment, retraining, and administrative costs. Additionally, because workers' annual earnings are so low, many workers rely on public assistance programs – potentially a huge financial burden on state budgets. Raising wages modestly could therefore result in an overall costs savings to Medicaid home care programs and state budgets.

Several factors suggest that extending basic employment protections to non-live-in homecare and personal assistance workers is unlikely to increase dramatically the nationwide cost of services or seriously disrupt service delivery systems—so long as steps are taken to adjust service delivery management accordingly.[140]

1. Since virtually all homecare and personal assistance workers already are receiving at least the federal minimum wage, extending the minimum hourly wage requirement is unlikely to have tangible cost consequences, except in so far as workers have not been paid for travel time between clients as well as time spent in any required training.

2. The available evidence at the national level suggests that the vast majority of homecare and personal assistance workers do not work over 40 hours per week, and thus extension of overtime protection would likely have only modest financial impact. Furthermore, aides in many states are already eligible for overtime, because state hour and wage laws exceed the federal standard.

Therefore, from a cost perspective, the universe of workers who may be impacted by narrowing the exemption is ***not*** the entire universe of homecare workers, but rather the subset of non-live-in homecare and personal assistance workers who are: (i) employed for more than 40 hours a week, and (ii) reside in states that have not already taken steps to override fully the federal companionship exemption. Furthermore, predictions that massive dislocations of care would result from narrowing the exemption are inconsistent with the experience of many states with wage and hour laws that cover companions.

3. Overtime in this industry is not always voluntary. Rather it is often due to understaffing, worker shortages, and inadequate backup service delivery systems to cover no-shows, illness, or other excused absences.[141] Continuing to diminish the profile of this occupation through the denial of basic wage and hour protection only exacerbates this kind of problematic overtime. Instead, what is needed is to make these occupations more attractive relative to other low-wage jobs through better compensation, improved training and supervision, the creation of career advancement opportunities, and scheduling that allows for full-time work, if desired, and stable work schedules with balanced workloads.[142]

4. From an employer/agency perspective, overtime and service delivery disruptions can be managed by improving scheduling and workforce management practices, including using information technology to get real time data that can be used to monitor and track workers' hours.[143] These dynamic practices can keep overtime costs to a minimum, while better managing workers' hours in order to spread them more evenly, creating balanced workloads while preserving continuity of care.

The argument that the exemption should be maintained because it lowers the cost of services for elderly and disabled persons, and thus enables people to receive needed services that might otherwise be unaffordable is fundamentally flawed. Under-compensating labor in order to keep the cost of services down creates a labor market distortion that depresses the supply of labor, and also distorts the demand for services. Quality is also compromised by a limited labor pool, high turnover, and burnout among over-stressed and over-worked aides.

With the Companionship Exemption as it now stands, we are essentially asking the home care and personal assistance workforce—workers who are crucial to maintaining the health and independence of millions of Americans—to sacrifice their wages to keep costs down for their employers, clients, and taxpayers. Neither the structure of their

work nor the duties they perform provide a rationale for excluding them from basic wage and hour protections.

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[137] http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2001_register&docid=01-1590-filed.pdf

[138] See: http://www.dol.gov/regulations/factsheets/whd-fs-flsa-companionship.htm

[139] Note that this chart uses the terms "companion" and "domestic employee" as they are used in the statutes and regulations cited.

[140] The costs of narrowing the exemption need to be carefully and thoroughly explored on a state-by-state basis. It is possible that in some states, the costs could have significant budgetary and service delivery implications that would require adjustments in federal and state funding—at least during a transitional period.

[141] D. Seavey and V. Salter (October 2006). *Bridging the Gaps: State and Local Strategies for Ensuring Backup Personal Care Services*, Policy Report #2006-19, Washington, DC: AARP Public Policy Institute. Available at: http://assets.aarp.org/rgcenter/il/2006_19_pcs.pdf.

[142] S. Dawson (June 2007) *IOM Presentation: Recruitment and Retention of Paraprofessionals*. Bronx, NY: PHI. Available at: http://www.directcareclearinghouse.org/download/Dawson_IOM_6-28-07_bkmk.pdf.

[143] : P.K. Sonn, C.K. Ruckelshaus, and S. Leberstein (August 2011) Fair Pay for Home Care Workers, National Employment Law Project. Available at: http://www.nelp.org/page/-/Justice/2011/FairPayforHomeCareWorkers.pdf?nocdn=1

Section 11 Conclusions

Charged with providing basic hands-on caregiving services to millions of elders and persons with disabilities, home care and personal assistance workers struggle with basic conditions of employment, as this report demonstrates. Although the intrinsic rewards of this work can be quite high, these in-home workers typically receive low wages and few benefits, and work under demanding physical and emotional conditions. Injury rates are high, and in general, formal training requirements are quite limited. Many workers receive no training at all.

Over half of the workforce works part-time, some by choice but a significant portion would prefer to work more hours. Unfortunately for those workers, their jobs are structured as part-time employment, often with erratic or unpredictable hours.

As a result of their low wages, part-time hours, and lack of benefits, approximately 50 percent of home care and personal assistance aides live in households that rely on one or more public benefits such as food stamps or Medicaid. That is, over 1 million American workers, providing crucial services to families across the nation, are consigned to near-poverty because of the structure of their employment.

Basic workforce facts for home care & personal assistance workers

- Among the country's **lowest paying** jobs
- Inconsistent **training** requirements **poorly aligned with wages**
- Inadequate **health care** coverage
- High injury rates
- **Unpredictable** hours, often **part time**
- Heavy reliance on **public benefits**

A consequence of these problematic employment conditions is high turnover that in turn undermines workforce stability and continuity of care. Agencies with resulting gaps in staffing or worker shortages often compensate by employing a mere handful of

aides to work overtime. These aides then suffer from stress and burnout, compromising the quality of care they can deliver.

There are many reasons that direct-care jobs have evolved as low-wage, poor-quality jobs. Chief among these is *who* does this work — women, often women of color. These women have long faced wage discrimination when it comes to "domestic" employment. The skills women bring to these jobs are inherently undervalued by our society. But the most singular deterrent to the improvement of home care and personal assistance jobs in recent years has been the misconception that they constitute a poor investment for public workforce development and training dollars because the jobs are, by and large, low-quality and dead-end. As we argue below, this view is short-sighted because the underlying calculus for the value of these jobs has changed.

Reconfigured Value Proposition for Home Care and Personal Assistance Jobs

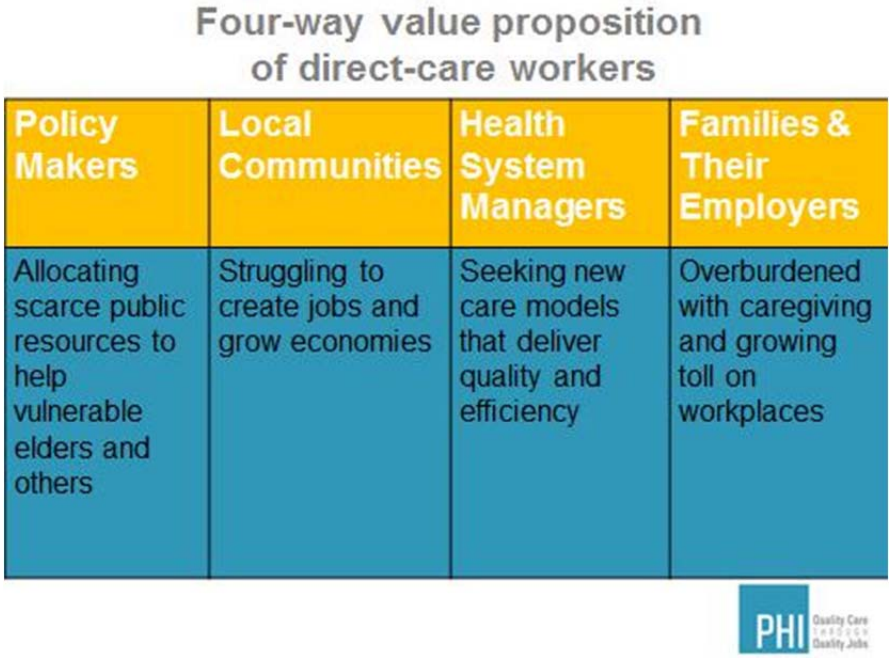
Home care workers are uniquely imbedded in the lives of their clients and often their families. This has always been true. Their value stems from the fact that:

- They are deployed every day in several million homes and in hundreds of thousands of facilities and day programs around the country.
- Eight of every ten hours of paid services delivered to elders and people with disabilities are provided, not by a doctor or nurse, but by a direct-care worker.
- They are extremely well situated for observing and reporting changes in their clients' conditions and for catching problems early.
- They are ideally positioned to work in care teams, to interface with family caregivers, and to support positive health-related behaviors.

What has changed are the underlying demographic and economic fundamentals, thereby reconfiguring the value proposition of direct-care jobs to policy makers, local communities and regions, health system managers, and families and their employers.

Now at the cusp of the largest generation to reach retirement age[144] — the "Baby Boomers" — we are beginning to see and understand the magnitude of the need for organized caregiving at the far end of life. The population of adults over age 65 is growing at three times the rate of the population of family members available to care for them, primarily spouses and adult children aged 45 to 64 years. As these informal caregivers age, they are at increasing risk of needing supports themselves, and are less likely to be able to provide unpaid care at the same rate as they have in recent decades.

According to health experts, the adverse health impacts of overburdened caregivers now constitute an emergent public health issue.[145]



Additionally, the challenges of caregiving in America are quickly eroding employee productivity and therefore becoming a business problem. At one time, family caregivers might have left the workforce to provide daily support for aging parents. Today, in a fragile economy, working women cannot afford to leave the workforce and must instead struggle to manage the competing demands of eldercare and work responsibilities. An estimated 16 million workers are trying to balance full-time employment with caregiving for a family member over age 18. The problem is so severe, that some areas of the country are even treating the demands of caregiving as a regional economic development challenge.[146] The lost productivity of family caregivers who are also employed is estimated to cost their employers upwards of $34 billion annually.[147]

Home care and personal assistance workers are core to the caregiving infrastructure that we are challenged to develop, an infrastructure that arguably is as essential to a well-functioning economy as roads and bridges.

A Forward-Looking Agenda for the Home Care and Personal Assistance Workforce

Carework in America is at a cross roads. We can continue the status quo, adding direct-care positions that are poorly supported and poorly compensated, then backfilling them with public assistance. Or we can leverage the enormous potential of this workforce as

both an underutilized asset in our health care/health assistance system, *and* as one of the strongest job growth engines that our economy has to offer.

A forward-looking agenda will require federal and state policy development in four key areas. The first is implementing **effective payment and procurement policies** that encourage minimum compensation standards for direct care workers providing services through public programs. A critical starting place is to extend federal minimum wage and hour protection to these jobs so that they have the same subfloor as all other jobs.

The second area is **training.** Our country's approach to direct-care worker training needs to be modernized by:

- Enhancing training content using competency-based curricula to support the delivery of person-centered care
- Setting consistent standards across occupations requiring similar skills
- Extending federal training hour requirements
- Investing in state training infrastructure designed for excellence in education

Third, we need to design and promote **new models of care** that expand the roles of direct-care workers who care for older adults. For example, there are nascent models under development for continuing care workers or advanced aides with deeper clinical skills and knowledge who can move across settings and work in interdisciplinary teams. Through enhanced training in health education and system navigation, these aides can improve the health experience and outcomes of consumers while addressing the needs and concerns of family caregivers.

Finally we need to advance **caregiving infrastructure innovations** to support consumers, their families, and also workers. This is of particular necessity in models of service delivery where consumers self-manage their care and hire their own direct-care workers. For example, web-based matching service registries can support consumers and workers to find each other and can be linked to other intermediaries that provide access to things like training, respite, and emergency back-up services. Developing such resources and supports can help address the challenges inherit in these decentralized models of care.

At a time when states are grappling with high unemployment rates and the need to move unemployed individuals into economic sectors with strong job growth potential, it should not be forgotten that the industry sector in which home care and personal assistance workers are employed constitutes one of the most powerful "job creation

machines" in the American economy. These jobs are plentiful and are among the fastest growing; in addition, they do not require higher education. These are jobs that can fuel local economies in low-income communities, where employment barriers are high. Better quality direct-care jobs will bring more stable employment and more cash directly into communities that need them most, thereby spurring the virtuous cycle of consumer spending and economic growth. Investing in this workforce is a win-win for all of America's families, businesses, and communities.

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[144] The first of the nation's 78 million baby boomers begin turning 65 in 2011, and by 2025 some 72 million Americans will be seniors.

[145] C. Chou *et al.* (December 2009) "Health Care Coverage and the Health Care Industry." *American Journal of Public Health* 99 (12): 2282-2288.

[146] For a treatment of this issue in Oregon and Washington, see: M. Gallelli et al. (January 2011) *Boomers, Technology and Health: Consumers Taking Charge!* MIT Enterprise Forum of the Northwest, Cambridge, MA.

[147] The MetLife Caregiving Cost Study: Productivity Losses to U.S. Business, July 2006, MetLife Mature Market Institute and the National Alliance for Caregiving, available at: http://www.caregiving.org/pdf/research/Caregiver%20Cost%20Study.pdf

Appendix 1

Demographic and Employment/Income Characteristics of Personal Care Aides, 2009

Demographic Characteristics	
Median age(years)	43
Gender	
Female	88.4%
Male	11.6%
Race	
White only, non-Hispanic	51.3%
Black only, non-Hispanic	21.7%
Spanish, Hispanic, or Latino	18.3%
Other or mixed, non-Hispanic	8.7%
Single parent, grandparent, or caretaker	19.2%
Citizenship/Foreign Born	
Native	78.0%
Foreign born	22.0%
Education: High school or less	55.0%
Employment & Income Characteristics	
Labor force participation in home & personal care	
Year round, full time	42.0%
Year round, part time	22.0%
Part year, full time	15.9%
Part year, part time	20.1%
Individual annual earnings, mean	$15,611
Individual annual earnings if full time, full year	$23,064
Family poverty status	
<1.00	19.5%
<2.00	51.7%
Health insurance	
Uninsured	30.9%
Employer provided, private	34.5%
Other private	10.1%
Public insurance	24.5%
Household public assistance	
Any	50.4%
Medicaid	41.5%
Food and nutrition assistance	33.5%
Housing, energy, transportation, TANF/AFDC	11.5%

Source: PHI analysis of March Supplement data from 2010 Current Population Survey.

Appendix 2

State Projected Demand for Direct-Care Workers, 2008-2018

State/Occupation Title	2008 Estimated Employment	2018 Projected Employment	Percent Change 2008-2018	New Openings Over Decade*
UNITED STATES (see note 1)				
Home Health Aides	921,700	1,382,600	50%	**552,700**
Nursing Aides, Orderlies, & Attendants	1,469,800	1,745,800	19%	**422,300**
Personal & Home Care Aides	817,200	1,193,000	46%	**477,800**
All DCWS	**3,271,200**	**4,387,500**	**34%**	**1,462,600**
All Occupations			**10%**	
ALASKA				
Home Health Aides	1,887	2,780	47%	**1,214**
Nursing Aides, Orderlies, & Attendants	1,999	2,450	23%	**737**
Personal & Home Care Aides	2,472	3,350	36%	**1,374**
All DCWS	**6,358**	**8,580**	**35%**	**3,325**
All Occupations			**10%**	
ALABAMA				
Home Health Aides	10,530	14,430	37%	**4,850**
Nursing Aides, Orderlies, & Attendants	23,300	26,710	15%	**5,500**
Personal & Home Care Aides	3,440	4,780	39%	**1,950**
All DCWS	**37,270**	**45,920**	**23%**	**12,300**
All Occupations			**11%**	
ARKANSAS				
Home Health Aides	4,213	5,420	29%	**1,590**
Nursing Aides, Orderlies, & Attendants	18,626	22,330	20%	**5,370**
Personal & Home Care Aides	8,607	10,965	27%	**3,820**
All DCWS	**31,446**	**38,715**	**23%**	**10,780**
All Occupations			**7%**	
ARIZONA				
Home Health Aides	17,987	24,982	39%	**8,786**
Nursing Aides, Orderlies, & Attendants	19,401	22,749	17%	**5,280**
Personal & Home Care Aides	13,314	16,980	28%	**5,328**
All DCWS	**50,702**	**64,711**	**28%**	**19,394**
All Occupations			**6%**	
CALIFORNIA				
Home Health Aides	54,300	78,000	44%	**29,100**
Nursing Aides, Orderlies, & Attendants	108,100	130,800	21%	**33,600**
Personal & Home Care Aides	346,500	504,700	46%	**201,500**
All DCWS	**508,900**	**713,500**	**40%**	**264,200**

All Occupations			**10%**	
COLORADO (see note 2)				
Home Health Aides	**	**	**	**
Nursing Aides, Orderlies, & Attendants	19,361	23,530	22%	**5,790**
Personal & Home Care Aides	10,489	15,092	44%	**6,090**
All DCWS	**	**	**	**
All Occupations			**8%**	
CONNECTICUT				
Home Health Aides	13,600	18,248	34%	**6,000**
Nursing Aides, Orderlies, & Attendants	25,835	27,767	7%	**4,500**
Personal & Home Care Aides	12,364	17,774	44%	**6,950**
All DCWS	**51,799**	**63,789**	**23%**	**17,450**
All Occupations			**5%**	
DISTRICT OF COLUMBIA (see note 3)				
Home Health Aides	914	1,239	36%	**410**
Nursing Aides, Orderlies, & Attendants	3,409	3,717	9%	**620**
Personal & Home Care Aides	1,266	1,708	35%	**660**
All DCWS	**5,589**	**6,664**	**19%**	**1,690**
All Occupations			**9%**	
DELAWARE				
Home Health Aides	**	**	**	
Nursing Aides, Orderlies, & Attendants	5,395	6,744	25%	**
Personal & Home Care Aides	658	979	49%	**400**
All DCWS	**	**	**	**
All Occupations			**8%**	
FLORIDA (see note 4)				
Home Health Aides	32,862	46,353	41%	**19,990**
Nursing Aides, Orderlies, & Attendants	90,339	106,970	18%	**29,400**
Personal & Home Care Aides	14,489	19,067	32%	**7,460**
All DCWS	**137,690**	**172,390**	**25%**	**56,850**
All Occupations			**14%**	
GEORGIA (see note 3)				
Home Health Aides	7,720	11,780	53%	**4,800**
Nursing Aides, Orderlies, & Attendants	38,510	48,900	27%	**13,900**
Personal & Home Care Aides	13,210	17,630	33%	**6,600**
All DCWS	**59,440**	**78,310**	**32%**	**25,300**
All Occupations			**14%**	
HAWAII				
Home Health Aides	720	1,070	49%	**500**
Nursing Aides, Orderlies, & Attendants	4,970	6,160	24%	**1,700**
Personal & Home Care Aides	5,110	7,840	53%	**3,300**
All DCWS	**10,800**	**15,070**	**40%**	**5,500**

All Occupations			**7%**	
IOWA				
Home health aides	10,420	14,890	43%	**5,500**
Nursing aides, orderlies, & attendants	23,385	27,865	19%	**6,850**
Personal & home care aides	5,700	7,955	40%	**2,950**
All DCWS	**39,505**	**50,710**	**28%**	**15,300**
All Occupations			**10%**	
IDAHO				
Home Health Aides	3,904	5,929	52%	**2,420**
Nursing Aides, Orderlies, & Attendants	7,196	9,301	29%	**2,830**
Personal & Home Care Aides	3,492	5,749	65%	**2,700**
All DCWS	**14,592**	**20,979**	**44%**	**7,950**
All Occupations			**16%**	
ILLINOIS				
Home Health Aides	26,331	39,270	49%	**15,560**
Nursing Aides, Orderlies, & Attendants	60,488	73,162	21%	**18,690**
Personal & Home Care Aides	25,711	34,464	34%	**11,960**
All DCWS	**112,530**	**146,896**	**31%**	**46,210**
All Occupations			**9%**	
INDIANA				
Home Health Aides	12,903	19,728	53%	**8,120**
Nursing Aides, Orderlies, & Attendants	32,152	38,712	20%	**9,760**
Personal & Home Care Aides	12,783	18,442	44%	**7,260**
All DCWS	**58,583**	**77,652**	**33%**	**25,240**
All Occupations			**9%**	
KANSAS (see note 2)				
Home Health Aides	**8,334**	**12,299**	48%	**4,711**
Nursing Aides, Orderlies, & Attendants	**19,772**	**22,570**	14%	**4,567**
Personal & Home Care Aides	**11,914**	**17,745**	49%	**7,850**
All DCWS	**40,020**	**52,614**	**31%**	**17,128**
All Occupations			**12%**	
KENTUCKY				
Home Health Aides	4,662	6,859	47%	**2,660**
Nursing Aides, Orderlies, & Attendants	25,936	31,621	22%	**8,270**
Personal & Home Care Aides	3,864	5,856	52%	**2,470**
All DCWS	**34,462**	**44,336**	**29%**	**13,400**
All Occupations			**7%**	
LOUISIANA				
Home Health Aides	11,340	16,560	46%	**6,200**
Nursing Aides, Orderlies, & Attendants	25,560	30,640	20%	**7,400**
Personal & Home Care Aides	13,700	19,680	44%	**8,300**
All DCWS	**50,600**	**66,880**	**32%**	**21,900**

All Occupations			**8%**	
MASSACHUSETTS (see note 3)				
Home Health Aides	17,330	23,150	34%	**7,380**
Nursing Aides, Orderlies, & Attendants	41,620	47,210	13%	**9,320**
Personal & Home Care Aides	11,190	15,200	36%	**5,910**
All DCWS	**70,140**	**85,560**	**22%**	**22,610**
All Occupations			**6%**	
MARYLAND				
Home Health Aides	10,385	15,150	46%	**5,795**
Nursing Aides, Orderlies, & Attendants	30,640	36,320	19%	**8,730**
Personal & Home Care Aides	5,890	8,605	46%	**3,450**
All DCWS	**46,915**	**60,075**	**28%**	**17,975**
All Occupations			**9%**	
MAINE				
Home Health Aides	5,536	6,966	26%	**1,980**
Nursing Aides, Orderlies, & Attendants	10,158	10,506	3%	**1,360**
Personal & Home Care Aides	6,201	7,800	26%	**2,370**
All DCWS	**21,895**	**25,272**	**15%**	**5,710**
All Occupations			**2%**	
MICHIGAN				
Home Health Aides	32,580	47,050	44%	**17,710**
Nursing Aides, Orderlies, & Attendants	49,520	58,240	18%	**13,640**
Personal & Home Care Aides	19,330	23,200	20%	**6,270**
All DCWS	**101,430**	**128,490**	**27%**	**37,620**
All Occupations			**6%**	
MINNESOTA (see note 2)				
Home Health Aides	37,908	53,834	42%	**19,696**
Nursing Aides, Orderlies, & Attendants	31,298	35,605	14%	**7,427**
Personal & Home Care Aides	38,122	59,369	56%	**26,007**
All DCWS	**107,328**	**148,808**	**39%**	**53,130**
All Occupations			**9%**	
MISSOURI				
Home Health Aides	12,960	19,400	50%	**7,720**
Nursing Aides, Orderlies, & Attendants	39,470	43,310	10%	**7,770**
Personal & Home Care Aides	18,140	25,220	39%	**9,340**
All DCWS	**70,570**	**87,930**	**25%**	**24,830**
All Occupations			**3%**	
MISSISSIPPI				
Home Health Aides	4,290	6,430	50%	**2,550**
Nursing Aides, Orderlies, & Attendants	21,020	25,430	21%	**6,500**
Personal & Home Care Aides	4,340	5,380	24%	**1,600**

All DCWS	**29,650**	**37,240**	**26%**	**10,650**
All Occupations			**13%**	
MONTANA				
Home Health Aides	3,267	4,048	24%	**1,070**
Nursing Aides, Orderlies, & Attendants	5,668	6,486	14%	**1,330**
Personal & Home Care Aides	2,651	3,228	22%	**1,030**
All DCWS	**11,586**	**13,762**	**19%**	**3,430**
All Occupations			**11%**	
NORTH CAROLINA (see note 3)				
Home Health Aides	72,130	99,990	39%	**34,400**
Nursing Aides, Orderlies, & Attendants	21,780	28,360	30%	**8,600**
Personal & Home Care Aides	18,350	32,250	76%	**17,000**
All DCWS	**112,260**	**160,600**	**43%**	**60,000**
All Occupations			**	
NORTH DAKOTA				
Home Health Aides	2,077	2,748	32%	**880**
Nursing Aides, Orderlies, & Attendants	6,719	7,705	15%	**1,660**
Personal & Home Care Aides	1,513	1,906	26%	**580**
All DCWS	**10,309**	**12,359**	**20%**	**3,120**
All Occupations			**9%**	
NEBRASKA				
Home Health Aides	**	**	**	**
Nursing Aides, Orderlies, & Attendants	14,904	17,464	17%	**4,040**
Personal & Home Care Aides	1,469	2,076	41%	**790**
All DCWS	**	**	**	**
All Occupations			**10%**	
NEW HAMPSHIRE				
Home Health Aides	2,864	4,318	51%	**1,740**
Nursing Aides, Orderlies, & Attendants	8,012	9,648	20%	**2,440**
Personal & Home Care Aides	3,472	5,154	48%	**2,110**
All DCWS	**14,348**	**19,120**	**33%**	**6,290**
All Occupations			**9%**	
NEW JERSEY				
Home Health Aides	28,700	40,600	41%	**14,800**
Nursing Aides, Orderlies, & Attendants	51,250	58,500	14%	**12,300**
Personal & Home Care Aides	8,850	11,550	31%	**3,800**
All DCWS	**88,900**	**110,650**	**24%**	**30,900**
All Occupations			**3%**	
NEW MEXICO				
Home Health Aides	7,390	10,600	43%	**3,900**
Nursing Aides, Orderlies, & Attendants	8,670	10,100	16%	**2,200**
Personal & Home Care Aides	12,430	19,140	54%	**8,800**

All DCWS	**28,490**	**39,840**	**40%**	**14,900**
All Occupations			**13%**	
NEVADA				
Home Health Aides	4,945	6,344	28%	**2,050**
Nursing Aides, Orderlies, & Attendants	4,992	5,902	18%	**1,560**
Personal & Home Care Aides	3,514	4,542	29%	**1,590**
All DCWS	**13,451**	**16,788**	**25%**	**5,270**
All Occupations			**7%**	
NEW YORK				
Home Health Aides	129,870	178,190	37%	**61,200**
Nursing Aides, Orderlies, & Attendants	100,580	114,270	14%	**23,700**
Personal & Home Care Aides	117,540	169,890	45%	**67,100**
All DCWS	**347,990**	**462,350**	**33%**	**152,000**
All Occupations			**3%**	
OHIO				
Home Health Aides	60,280	89,150	48%	**34,870**
Nursing Aides, Orderlies, & Attendants	75,910	87,840	16%	**19,490**
Personal & Home Care Aides	13,820	19,990	45%	**7,900**
All DCWS	**150,010**	**196,980**	**31%**	**62,260**
All Occupations			**4%**	
OKLAHOMA				
Home Health Aides	8.440	11,630	38%	**4,000**
Nursing Aides, Orderlies, & Attendants	19,000	20,830	10%	**3,700**
Personal & Home Care Aides	9,180	12,110	32%	**4,100**
All DCWS	**36,620**	**44,570**	**22%**	**11,800**
All Occupations			**10%**	
OREGON				
Home Health Aides	8,599	10,775	25%	**3,150**
Nursing Aides, Orderlies, & Attendants	12,842	15,950	24%	**4,540**
Personal & Home Care Aides	6,285	7,732	23%	**2,330**
All DCWS	**27,726**	**34,457**	**24%**	**10,020**
All Occupations			**9%**	
PENNSYLVANIA				
Home Health Aides	54,110	66,380	23%	**17,110**
Nursing Aides, Orderlies, & Attendants	80,590	88,440	10%	**15,060**
Personal & Home Care Aides	37,190	45,570	23%	**14,680**
All DCWS	**171,890**	**200,390**	**17%**	**46,850**
All Occupations			**2%**	
RHODE ISLAND				
Home Health Aides	5,582	7,304	31%	**2,222**
Nursing Aides, Orderlies, & Attendants	8,123	9,129	12%	**1,733**
Personal & Home Care Aides	1,343	1,915	43%	**800**

All DCWS	**15,048**	**18,348**	**22%**	**4,755**
All Occupations			**8%**	
SOUTH CAROLINA				
Home Health Aides	**	**	**	**
Nursing Aides, Orderlies, & Attendants	20,094	23,395	16%	**5,300**
Personal & Home Care Aides	5,631	7,558	34%	**2,630**
All DCWS	**	**	**	**
All Occupations			**8%**	
SOUTH DAKOTA				
Home Health Aides	1,110	1,370	23%	**370**
Nursing Aides, Orderlies, & Attendants	6,365	7,175	13%	**1,440**
Personal & Home Care Aides	1,635	2,150	31%	**720**
All DCWS	**9,110**	**10,695**	**17%**	**2,530**
All Occupations			**9%**	
TENNESSEE				
Home Health Aides	13,700	21,800	59%	**9,450**
Nursing Aides, Orderlies, & Attendants	30,710	35,800	17%	**8,150**
Personal & Home Care Aides	14,070	18,950	35%	**6,650**
All DCWS	**58,480**	**76,550**	**31%**	**24,250**
All Occupations			**6%**	
TEXAS				
Home Health Aides	92,660	143,720	55%	**60,300**
Nursing Aides, Orderlies, & Attendants	99,320	126,160	27%	**36,750**
Personal & Home Care Aides	94,530	138,530	47%	**55,800**
All DCWS	**286,510**	**408,410**	**43%**	**152,850**
All Occupations			**17%**	
UTAH				
Home Health Aides	6,080	10,670	75%	**5,200**
Nursing Aides, Orderlies, & Attendants	9,330	13,260	42%	**4,800**
Personal & Home Care Aides	1,900	2,860	51%	**1,300**
All DCWS	**17,310**	**26,790**	**55%**	**11,300**
			21%	
VERMONT				
Home Health Aides	**	**	**	**
Nursing Aides, Orderlies, & Attendants	2,893	3,452	19%	**850**
Personal & Home Care Aides	7,222	10,585	47%	**4,260**
All DCWS	**	**	**	**
All Occupations			**9%**	
VIRGINIA				
Home Health Aides	16,430	29,536	80%	**14,746**
Nursing Aides, Orderlies, & Attendants	33,629	45,056	34%	**14,777**
Personal & Home Care Aides	14,435	24,418	69%	**11,833**

All DCWS	**64,494**	**99,010**	**54%**	**41,356**
All Occupations			**15%**	
WASHINGTON				
Home Health Aides	12,937	19,401	50%	**8,050**
Nursing Aides, Orderlies, & Attendants	22,318	27,133	22%	**7,275**
Personal & Home Care Aides	27,268	36,393	33%	**13,050**
All DCWS	**62,523**	**82,927**	**33%**	**28,375**
All Occupations			**9%**	
WISCONSIN				
Home Health Aides	20,730	28,670	38%	**10,000**
Nursing Aides, Orderlies, & Attendants	36,960	42,050	14%	**8,800**
Personal & Home Care Aides	21,720	29,100	34%	**10,100**
All DCWS	**79,410**	**99,820**	**26%**	**28,900**
All Occupations			**3%**	
WEST VIRGINIA				
Home Health Aides	**	**	**	**
Nursing Aides, Orderlies, & Attendants	9,243	10,553	14%	**2,230**
Personal & Home Care Aides	6,177	7,973	29%	**2,570**
All DCWS	**	**	**	**
All Occupations			**5%**	
WYOMING				
Home Health Aides	1,356	2,054	51%	**700**
Nursing Aides, Orderlies, & Attendants	3,265	3,896	19%	**630**
Personal & Home Care Aides	905	1,482	64%	**580**
All DCWS	**5,526**	**7,432**	**34%**	**1,910**
All Occupations			**9%**	

* New openings include openings due to growth and replacement, and are a measure of the total number of workers who will be needed to meet demand for a particular occupation.

Notes
1. U.S. and state projections are from different sources; total state projections will not equal U.S. numbers.
2. CO and MN projections are for 2009-2019.
3. DC, GA, KS, MA, NC projections are for 2006-2016.
4. FL projections are for 2010-2018.

Sources: PHI analysis of 2008-18 occupational employment projections available from each state labor department. The U.S. projections are from the U.S. Department of Labor/Bureau of Labor Statistics, Employment Projections Program, 2008-18 National Employment Matrix.

Appendix 3

Competencies for Personal Care Workers Providing Personal Care Services To Elders and People with Disabilities

From: PHI (2009). *Providing Personal Care Services to Elders and People with Disabilities: A Model Curriculum for Direct-Care Worker*. Available at: http://phinational.org/training/resources/pcsc/

Role of the Direct-Care Worker	
1.1	Explain the importance of the relationship between the consumer and the direct-care worker for quality of care
1.2	Define the role of the direct-care worker in relation to other members of the service team in various long-term care settings
1.3	Explain the role of the direct-care worker in relation to the consumer receiving services in various long-term care settings
1.4	Demonstrate professionalism and responsibility, including in timeliness and appearance
1.5	Explain the purpose of the service or care plan
1.6	Explain the role of the direct-care worker in supporting the consumer's engagement in community activities
Consumer Rights, Ethics, and Confidentiality	
2.2	Listen to and observe the preferences of the consumer
2.2	Respect the consumer's right to privacy, respect, and dignity
2.3	Demonstrate ways of promoting the consumer's independence
2.4	Explain the philosophies of consumer-direction and independent living
2.5	Facilitate the consumer's desire to express his or her personal faith and observe religious practices as requested
2.6	Respect the confidentiality of consumer information, adhere to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and follow employer confidentiality guidelines
2.7	Explain the direct-care worker's responsibility to identify, prevent, and report abuse, exploitation, and neglect
2.8	Describe the rights of consumers as addressed in the Americans with Disabilities Act (ADA)
Communication, Problem Solving, and Relationship Skills	
3.1	Explain the term "communication," including the difference between verbal and non-verbal communication
3.2	Demonstrate effective communication, including listening, paraphrasing, and asking open-ended questions
3.3	Demonstrate ability to resolve conflict
3.4	Demonstrate respect and cultural sensitivity in communicating with others
3.5	Demonstrate the use of effective problem-solving skills
3.6	Demonstrate respectful and professional interaction with the consumer, significant other(s), and family members
3.7	Demonstrate basic language, reading, and written communication skills

Individualized Personal Care Skills According to Consumer Preference and Service Plan	
4.1	Assist with tub bath and shower
4.2	Provide bed baths
4.3	Shampoo hair in bed
4.4	Assist with oral hygiene
4.5	Assist with fingernail and toenail care
4.6	Shave consumer
4.7	Turn and/or position consumer in bed and wheelchair
4.8	Transfer consumer from bed to wheelchair
4.9	Provide consumer with back rubs, foot rubs, leg rubs, arm/hand rubs
4.10	Assist with routine skin care
4.11	Assist with eating and drinking
4.12	Assist with dressing, including using elastic support stockings
4.13	Assist with walking
4.14	Make an occupied and unoccupied bed
4.15	Assist with basic toileting needs, including using a bathroom or commode.
4.16	Demonstrate proper use of bedpan, urinal, and commode
4.17	Provide perineal care (cleaning of genital and anal areas)
4.18	Clean and ensure appropriate function and care of appliances such as glasses, hearing aids, orthotics, prostheses, and assist with their use
4.19	Observe, record, and report as appropriate
Individualized Health Care Support According to Consumer Preference and Service Plan	
5.1	Assist consumers with self-administered medications
In-Home and Nutritional Support According to Consumer Preference and Service Plan	
6.1	Assist with meal planning, food preparation and serving, food shopping, storage, and handling
6.2	Assist with the preparation of simple modified diets
6.3	Assist consumers with care of the home and/or personal belongings
6.4	Support a safe, clean, and comfortable living environment
Infection Control	
7.1	Demonstrate proper hand washing procedures
7.2	Demonstrate application of the principles of infection control in all activities
7.3	Demonstrate the use of standard precautions as indicated
7.4	Prepare soiled linen for laundry
Safety and Emergencies	
8.1	Use proper body mechanics at all times and demonstrate safe transfer techniques
8.2	Explain procedures in case of emergencies
Apply Knowledge to the Needs of Specific Consumers	
9.1	Describe basic anatomy and physiology of body systems
9.2	Recognize and report abnormal signs and symptoms of common diseases and conditions of body systems
9.3	Describe the normal aging process and its effects
9.4	Identify the specific needs of a person with Alzheimer's disease and related

	dementia
9.5	Identify the needs of people with various physical disabilities
9.6	Identify the specific needs of and demonstrate the ability to care for a sensory deprived consumer
9.7	Describe how age, illness, and disability affect sexuality
9.8	Identify the special needs of a consumer with mental illness
9.9	Identify the special needs of a consumer with intellectual and developmental disabilities
Self Care	
10.1	Recognize signs of burnout in self and others, and identify stress reduction techniques
10.2	Demonstrate use of time-management and organizational skills
10.3	Identify resources to maintain personal health and well-being
10.4	Identify options and strategies to respond to abusive behavior directed toward direct-care workers by consumers

Appendix 4
State Median Wages for Home Health Aides & Personal Care Aides, 2010

State	Median Wage, 2010	
	Home Health Aide	Personal Care Aide
Alabama	$8.80	$8.35
Alaska	$14.56	$14.38
Arizona	$10.36	$10.05
Arkansas	$8.30	$8.30
California	$10.13	$10.23
Colorado	$10.38	$9.63
Connecticut	$13.33	$10.37
Delaware	$11.34	$9.82
District of Columbia	$10.64	$12.53
Florida	$10.00	$8.96
Georgia	$8.94	$8.63
Hawaii	$10.84	$8.77
Idaho	$8.88	$9.22
Illinois	$10.13	$9.69
Indiana	$9.90	$9.40
Iowa	$10.18	$9.80
Kansas	$9.92	$8.87
Kentucky	$10.14	$8.67
Louisiana	$8.81	$8.41
Maine	$10.52	$9.82
Maryland	$11.24	$10.37
Massachusetts	$12.54	$11.90
Michigan	$9.48	$9.55
Minnesota	$10.97	$10.92
Mississippi	$8.53	$8.37
Missouri	$9.15	$8.75
Montana	$10.06	$9.65
Nebraska	$10.30	$10.28
Nevada	$10.58	$10.41
New Hampshire	$10.84	$10.49
New Jersey	$10.61	$11.24
New Mexico	$8.90	$8.84
New York	$10.36	$10.29
North Carolina	$9.25	$9.03
North Dakota	$11.05	
Ohio	$9.36	$9.48
Oklahoma	$9.69	$8.52
Oregon	$9.85	$10.52
Pennsylvania	$9.96	$10.08
Rhode Island	$12.16	$10.70
South Carolina	$9.80	$8.91
South Dakota	$11.21	$9.22
Tennessee	$9.67	$8.65
Texas	$8.64	$8.16
Utah	$10.17	$9.03
Vermont	$12.13	$10.40
Virginia	$8.94	$8.62
Washington	$10.88	$10.85
West Virginia	$8.45	$8.14
Wisconsin	$10.35	$9.62
Wyoming	$11.16	$10.56

Source: U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment and Statistics (OES), May 2010, available at: http://www.bls.gov/oes/current/oessrcst.htm

Appendix 4 (cont'd)

State Mean Wages for Personal Care Aides Compared to Federal Poverty Level (FPL) Mean Wage for a One-Person Household, 2010

State	Mean wage, 2010	State	Mean wage, 2010	State	Mean wage, 2010
100% US FPL 2010	**$5.21**	IN	$9.51	PA	$10.54
150% US FPL 2010	**$7.82**	SD	$9.60	VT	$10.55
WV	$8.15	MT	$9.61	NH	$10.56
MS	$8.28	UT	$9.64	MD	$10.64
TX	$8.36	WI	$9.69	OR	$10.77
AR	$8.49	MI	$9.77	RI	$10.87
LA	$8.49	ND	*	WA	$11.11
AL	$8.50	OH	$9.93	MN	$11.11
OK	$8.66	AZ	$9.97	CT	$11.37
KY	$8.80	DE	$10.03	MA	$12.30
TN	$8.86	IA	$10.08	DC	$12.70
GA	$8.91	IL	$10.17	NJ	$12.73
VA	$8.94	ME	$10.22	**250% US FPL 2010**	**$13.03**
MO	$9.01	NY	$10.22		
KS	$9.07	NV	$10.32		
SC	$9.09	NE	$10.37	HI*	$9.33
NM	$9.15	CO	$10.38	AK*	$14.27
ID	$9.29	**200% US FPL**	**$10.42**		
NC	$9.38	WY	$10.48		
FL	$9.42	CA	$10.53		

* Because of their higher living costs, Hawaii and Alaska have separately specified federal poverty guidelines that are different from those for the 48 contiguous states and the District of Columbia. In 2010, the mean wage for PHCAs in Hawaii fell between 150% and 200% of Hawaii's poverty guidelines; the mean wage for PHCAs in Alaska fell between 200% and 250% of Alaska's poverty guidelines.

Appendix 5

Status of State Licensure for Private Duty Home Care, 2011

Licensure Required	No Licensure Required	Bill in Process
Alaska	Alabama	California
Colorado	Arizona	Hawaii
Connecticut	Arkansas	Michigan
District of Columbia	Idaho	
Delaware	Iowa	
Florida	Kansas	
Georgia	Massachusetts	
Illinois	Mississippi	
Indiana	Missouri	
Kentucky	Montana	
Louisiana	Nebraska	
Maine	New Mexico	
Maryland	North Dakota	
Minnesota	Ohio	
Nevada	South Dakota	
New Hampshire	Vermont	
New Jersey	West Virginia	
New York	Wisconsin	
North Carolina	Wyoming	
Oklahoma		
Oregon		
Pennsylvania		
Rhode Island		
South Carolina		
Tennessee		
Texas		
Utah		
Virginia		
Washington		

Sources: PHI compilation based on: state searches; Private Duty Homecare Association (2011), *Private Duty/Private Pay: Licensure Information*; and P. Notarstefano (2010) *Non-Medical Homecare: A First Step to Providing Home and Community-Based Services*, AAHSA.

Appendix 6

State Expenditures on Medicaid In-Home Services, 2006

	Medicaid Home Health 2006		State Medicaid Personal Care 2006		Medicaid Waiver Program Totals 2006	
State	Participants	Expenditures	Participants	Expenditures	Participants	Expenditures (in thousands)
AL	6,389	$16,500,000	NA	NA	14,428	$280,805
AK	246	$596,425	4,807	$40,326,532	3,755	$125,137
AZ	32,358	$694,692,383	NA	NA	NA	NA
AR	6,505	$13,199,366	15,160	$59,891,616	12,894	$163,033
CA	87,656	$161,459,361	329,893	$3,403,108,000	75,766	$1,429,634
CO	9,430	$90,877,099	NA	NA	27,101	$383,720
CT	22,217	$194,779,575	NA	NA	13,588	$142,127
DE	1,467	$4,269,654	0	$0	2,757	$82,517
DC	3,406	$13,316,435	2,498	$10,123,663	1,675	$26,601
FL	21,149	$73,248,266	12,253	$29,285,951	66,455	$1,009,222
GA	8,731	$6,861,224	NA	NA	24,236	$386,790
HI	1,469	$2,659,653	NA	NA	4,591	$125,971
ID	3,321	$7,504,200	4,134	$24,005,454	9,906	$120,714
IL	72,934	$51,670,312	NA	NA	71,022	$841,044
IN	8,307	$84,227,444	NA	NA	13,964	$411,856
IA	26,439	$80,632,161	NA	NA	23,424	$318,410
KS	5,364	$16,359,837	NA	NA	25,205	$381,719
KY	22,948	$54,985,680	NA	NA	14,557	$538,933
LA	11,442	$287,191,362	8,324	$38,169,072	9,204	$283,784
ME	3,695	$6,932,165	8,362	$50,365,311	4,034	$248,270
MD	4,176	$2,590,535	4,474	$21,475,374	14,466	$508,706
MA	17,591	$64,745,167	14,834	$267,991,192	20,302	$701,180
MI	6,551	$4,738,409	56,210	$218,774,776		$443,889
MN	5,965	$8,132,662	10,236	$186,421,251	48,802	$1,312,866
MS	9,036	$12,392,854	NA	NA	13,943	$112,023
MO	7,033	$6,640,760	47,435	$242,194,935	31,951	$387,394
MT	414	$446,627	3,117	$25,306,327	4,028	$85,746
NE	7,700	$32,985,484	1,680	$10,538,996	8,562	$183,117
NV	1,108	$2,969,842	5,738	$70,917,452	4,241	$70,762
NH	2,694	$3,323,130	21	$472,197	5,113	$165,289
NJ	12,653	$42,633,878	21,198	$254,337,493	17,366	$468,061
NM	447	$451,038	10,477	$167,269,434	6,016	$280,295

NY	111,698	$1,496,560,322	82,038	$2,124,420,834	81,101	$3,822,364
NC	40,313	$116,213,659	53,141	$311,068,834	24,013	$564,364
ND	813	$5,255,508	1,896	$10,949,487	3,692	$66,439
OH	32,215	$98,578,936	NA	NA	56,651	$1,147,208
OK	5,233	$8,994,437	4,559	$30,368,879	24,228	$369,707
OR	650	$965,301	4,915	$5,366,121	36,520	$594,972
PA	10,679	$59,399,984	NA	NA	52,958	$1,666,701
RI	1,546	$3,426,523	0	$0	6,151	$257,209
SC	7,598	$22,659,632	NA	NA	19,655	$260,235
SD	5,036	$3,956,523	936	$1,569,845	3,698	$83,125
TN	11,875	$195,438,503	NA	NA	7,945	$439,380
TX	192,421	$481,608,537	126,952	$482,079,361	62,940	$1,103,452
UT	1,976	$9,556,659	1,674	$1,204,294	5,140	$123,992
VT	3,842	$8,136,526	2,116	$17,698,983	NA	NA
VA	4,055	$5,018,912	NA	NA	20,466	$524,154
WA	3,702	$4,609,343	23,988	$222,685,553	41,331	$702,137
WV	1,803	$2,563,231	5,441	$32,136,558	8,264	$297,666
WI	6,742	$18,653,224	13,255	$136,936,461	38,053	$910,448
WY	569	$1,463,258	NA	NA	3,761	$93,768

Source: Kaiser Family Foundation, State Health Facts, available at http://www.statehealthfacts.org.

Appendix 7

State Plan of Care Examples for In-Home Services

STATE OF MARYLAND MEDICAL ASSISTANCE
DEPARTMENT OF HEALTH AND MENTAL HYGIENE PERSONAL CARE SERVICES PROGRAM
PERSONAL CARE PLAN OF CARE AND PROVIDER INSTRUCTIONS

RECIPIENT'S NAME: _____ DATE: _____

√	Activities of Daily Living	Frequency	Specific Instructions
	Bathing		□ sink □ tub □ shower □ bed bath as tolerated
	Care of Teeth		□ give/set-up equipment □ rinse mouth □ brush □ teeth/dentures
	Care of Skin		□ lotion after bath □ check skin for redness/breaks □ foot care
	Care of Hair		□ brush/comb hair □ shampoo hair ___x week □ assist w/shampoo
	Care of Nails (Do not clip)		□ clean under nails □ file only □ soak feet
	Dressing		□ assist as needed with clothing □ buttons □ hooks □ shoelaces □ zippers
	Meal Preparation		□ assist/prepare/serve □ follow prescribed diet □ follow restrictions
	Eating		□ cut food □ spoon feed □ encourage
	Medications (Do not administer)		□ remind □ prompt □ open bottle/container for recipient
	Toileting		□ remind □ assist □ bed pan □ diaper □ empty foley bag
	Transferring		□ assist as needed □ hoyer lift □ two persons only
	Ambulation		□ Encourage (use of cane, walker) □ wheelchair □ braces □ assist
	Straightening Area		□ keep living area neat and clean □ refrigerator □ dishes □ bathroom
	Laundry		□ wash recipient's personal clothing □ linen and towels
	Changing Bed		□ change bed linen as needed □ remake bed
	Food Shopping/Pharmacy		obtain receipts and return to recipient
	Escort		□ accompany to medical services □ accompany to workplace
	Infection Control		follow Personal Care Services Program guidelines and/or Universal Precautions Administrative Protocol

Administrative Protocol			
	Emergency		In case of an emergency provider will Call 911, notify the Case Monitor at, notify responsible guardian and/or emergency contact, at .
	Admission to Hospital or Nursing Home		Immediately report to the Case Monitor/Program Coordinator any admission of recipient to a nursing home or hospital.
	Eligibility		Call EVS 1-866-710-1447, the first of each month
	Provider is to contact Case Monitor		When absences, vacations occur for provider or recipient and if health status changes.
	Other protocols if necessary		

I have reviewed and understand the contents of this document. These are the only functions to be performed unless otherwise instructed by the Case Monitor. I understand that I will not be paid as a provider during the time of hospitalization/nursing home stay except for the day of admission and discharge if services were provided.

_____

Provider's Signature

I have reviewed and understand the contents of this document. These are the only functions to be performed by this provider unless otherwise instructed by the Case Monitor. I understand that my provider will not be paid for any services during my inpatient stay at a hospital or nursing home facility.

_____ _____

Recipient's Signature Case Monitor's Signature

DHMH 310 REVISED 07/08

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES												
	DIVISION OF SENIOR AND DISABILITY SERVICES											
	CARE PLAN SUPPLEMENT FOR IN-HOME SERVICES											
Participant Name:							**DCN:**			**Referral number (HCS only):**		**CDS**
Provider Name:										**Provider Phone:**		
SERVICE			**SUGGGESTED TIME**		**SUGGESTED FREQ**		**#MIN/ VISIT**	**#VISIT / WK**	**#MIN/ WK**	**# DAY/ MO**	**TOTAL UNITS**	**TOTAL COST**
PERSONAL CARE												
			10-60 MIN		1-7 X WK							
			15 MIN		DAYS w/o BATH							
			30-60 MIN		1-7 X WK							
			5-10 MIN		AS NEEDED							
			5-10 MIN		AS NEEDED							
			3-5 MIN		AS NEEDED							
			USE HC SECTION FOR TASKS/TIMES									
MIN/WK	÷ 15=	UNIT/WK÷	DAY/WEEK=		UNITS/DAY		× MAX DAYS/MO=					
ADVANCED PERSONAL CARE												
			15 MIN		1-7 X WK							
			15 MIN		1-7 X WK							
			15 MIN		AS ORDERED							
			15 MIN		AS ORDERED							
			15 MIN		AS ORDERED							
			15 MIN		AS ORDERED							
			15 MIN		PER TRANSFER							
MIN/WK	÷ 15=	UNIT/WK÷	DAY/WEEK=		UNITS/DAY		× MAX DAYS/MO=					
HOMEMAKER OR MEDICALLY RELATED HOUSEHOLD TASKS												
			10-60 MIN		1-7 X WK							

			30-45 MIN	1-7 X WK					
			30-45 MIN	1 X WK					
			10-45 MIN	1 X WK					
			10 MIN	AS NEEDED					
			30-150 MIN	1 X WK					
			10-15 MIN	1 X WK					
			10-15 MIN	1 X WK					
			5 MIN	1 X WK					
			60-120 MIN	1-2 X WK					
			30 MIN	1 X WK					
MIN/WK	÷ 15=	UNIT/WK÷	DAY/WEEK=	UNITS/DAY	× MAX DAYS/MO=				
AUTHORIZED NURSE VISITS									
NURSE COMMENTS									
RESPITE CARE									
BASIC:									
				UNITS/VISIT:					
ADVANCED:									
				UNITS/VISIT:					
HOME DELIVERED MEALS				**MEALS/DAY:**					
ADULT DAY HEALTH CARE				**UNITS/VISIT:**					
				UNITS/VISIT:					
CHORE SERVICES	None								
								TOTAL	
COMMENTS:									

NURSE/OTHER SIGNATURE:	DATE:	CLINICAL SUPERVISOR SIGNATURE:	DATE:
HCS WORKER SIGNATURE:	DATE:	EMERGENCY CONTACT/PHONE:	

MO 580-2510 (07-08)	**DISTRIBUTION:PROVIDER, CLIENT, CASE RECORD, PHYSICIAN**	DA-3a

Maryland Medicaid Home and Community-Based Services Waiver Programs

Caregiver Service Plan (use only for people at home)

Participant: **Date of Plan:**

Nurse Monitor: **Signature:**

The Nurse Monitor - Develop a Caregiver Service Plan (CSP) that documents services or tasks the caregivers are required to perform for the participant. The nurse monitor must: ask the case manager for a copy of the Plan of Care/Plan of Service (POC/POS), use the POC/POS with appropriate input from the participant and caregivers to help develop the CSP, ensure that caregivers understand all CSP tasks and expectations, complete a new CSP when adding services or tasks, add additional pages as needed and give a CSP copy to both case manager and caregivers. Immediately contact the case manager and other appropriate professionals to report suspected health and safety concerns. (Adult Protective Services at 1-800-917-7383, emergency Personnel, Police, etc.)

Task	Frequency	Tasks: Please note all special instructions and precautions	Note and Comments
Personal Hygiene (i.e. bathing, hair, oral, nail, and skin care)			
Toileting (i.e. bladder, bowel, and bed pan routines; movement to/from bathroom)			
Dressing & Changing Clothes			
Mobility & Transfers			
Eating & Drinking			
Medications		(Place a check next to each required item) Medication reminder___ Assist to self-medicate___ CMA ____MAR____ (Medication Admin. Record)	
Light Housekeeping			
Errands			
Other			

DHMH 4658 B (N - CSP) Approved 07/01/06

White Copy - Case manager Yellow Copy - Nurse Monitor Pink Copy - Participant/Representative Goldenrod Copy - Caregiver

Iowa Department of Human Services

HCBS Consumer-Directed Attendant Care Agreement

This is an agreement between a consumer of services under a Medicaid home- and community-based services waiver and a consumer-directed attendant care (CDAC) provider.

Name of Consumer	Name of CDAC Provider

The Iowa Medicaid program will reimburse for CDAC services provided under this agreement when consumer-directed attendant care is part of the consumer's comprehensive service plan and the DHS service worker or case manager has determined that the prior training and experience of the CDAC provider are sufficient to meet the consumer's needs noted in this agreement. However, the consumer agrees not to hold the service worker or case manager responsible for any problems resulting from any deficiency in the provider's training or experience. The CDAC provider must report any health, safety or welfare concerns to the DHS service worker or case manager.

Instructions:

The consumer or the consumer's legal representative must complete this form by entering information describing how the CDAC provider will meet the standards and responsibilities and the agreed-upon rate of payment. **Before the CDAC provider begins providing the CDAC service and receives payment, all the following must occur:**

1	The consumer and/or the consumer's legal representative, and the CDAC provider will decide which services are needed, the number of hours to be provided, and the rate of payment to the CDAC provider.
2	This CDAC agreement must be filled out completely and signed by both the consumer or consumer's legal representative and the CDAC provider to show they approve all the information in the agreement and shall abide by all requirements in the agreement.
3	The original copy of the CDAC agreement is kept by the service worker/case manager and attached to the comprehensive service plan. A copy of the CDAC agreement must be given to and maintained by the consumer, the consumer's legal representative if applicable, the CDAC provider, and to the nurse or therapist supervising the provision of skilled services, if any.
4	The service worker/case manager shall distribute a *Notice of Decision* to the consumer, the consumer's legal representative if applicable, and the CDAC provider showing that the service worker/case manager has approved the CDAC services, the CDAC provider, and the rate of payment.
5	The CDAC provider must provide only the CDAC services as described and approved in the service worker/case manager's comprehensive service plan. The CDAC provider must document the CDAC activities performed on the designated clinical/ medical record form 470-4389 and form 470-4390 for each unit of service prior to submitting a claim for payment. The record must show that the service is necessary due to the consumer's complaint, needs or goals as reflected in the comprehensive service plan. The record must state the CDAC provider's specific actions or activities and the consumer's response to the services rendered, including any observed changes in the consumer's physical or mental health, mood or behavior.

470-3372 (Rev. 3/09)

6	The CDAC provider cannot disclose protected health information (PHI). The HIPAA Privacy Rule protects all "*individually identifiable health information*" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. "Individually identifiable health information" is information, including demographic data, that relates to:				
	§ The individual's past, present or future physical or mental health or condition,				
	§ The provision of health care to the individual, or				
	§ The past, present, or future payment for the provision of health care to the individual, and				
	§ That identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.				
	Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).				
	Civil and criminal penalties may be imposed for failure to comply with the Privacy Rule. Civil penalties of $100 per incident, not to exceed $25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year. Criminal penalties with fines of $50,000 and up to one-year imprisonment can be imposed for an individual who knowingly obtains or discloses individually identifiable health information. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm.				
Agreement:					
The consumer and the CDAC provider agree that:					
1	The CDAC provider, as an agency or individual, is not an agent, employee, or servant of the state of Iowa, the Department of Human Services, or any of its employees. It is the CDAC provider's responsibility to determine employment status in regards to income tax and social security. Providers of CDAC service have no recourse to the Department of Human Services to collect payments performed outside of the provisions of this agreement.				
2	This agreement will be reviewed annually and when there are significant changes in the consumer's condition or situation.				
3	This agreement must be amended and approved by the service worker/case manager whenever there is a change:				
	(a)	Of a CDAC provider,			
	(b)	In the service components to be provided,			
	(c)	In the description of provider activity, or			
	(d)	In the rate of payment			
470-3372 (Rev. 10/08)					

Responsibility: To be completed by the consumer or consumer's legal representative.
Describe the plan for emergencies, including instructions in calling 911 first in all life-threatening situations. What supports are available to you in case of an emergency or crisis situation? Describe the back-up plan if CDAC services are interrupted or delayed.
Describe in detail all the CDAC provider's prior training and experience and how you evaluated it.
Describe how you will manage the CDAC provider's services.
Describe how you will measure and evaluate the services you receive from your CDAC provider.

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Standards for the CDAC provider: To be completed by the consumer or consumer's legal representative regarding information about your CDAC provider.	**Confirmation of Standard – Please print clearly**
1. Age (must be at least 18 years old as verified by driver's license, state identification card, passport, or other government-issued document) and a citizen of the United States or legal alien (green card or ID 9).	
2. Does the CDAC provider have the necessary skills needed to perform the CDAC services as identified and approved in this agreement? Yes/No	
3. The CDAC provider must be able to document and maintain the fiscal and clinical/medical records he/she provides per Iowa Administrative Code 441 79.3. List evidence of basic math, reading, and writing skills (e.g., high school diploma, GED, etc.).	
4. Insurance or bond for the activities provided	**Please fill out 1 and 2 or circle 3**
upon consumer request	1) Insurance or bonding company:_____

	2) Policy Limit Policy Number:_____
	3) Requirement is waived:_____

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Describe the service activities provided by the CDAC provider. Enter ther amount of time per day and the number of days per week or month required to provide the activity. Enter "Not applicable" (NA) fo components of the CDAC service that will not be provided.

Documentation Service Code	**Non-Skilled Service Components To be completed by the consumer or consumer's legal representative.**	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
N1	**Dressing**		0	0	0
N2	**Bathing, grooming, personal hygiene** – includes shaving, hair care, make-up, and oral hygiene		0	0	0
N3	**Meal preparation and feeding** – includes cooking, eating, and feeding assistance (but not the cost of meals themselves)		0	0	0
N4	**Toileting** – includes bowel, bladder and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter)		0	0	0

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Documentation Service Code	Non-Skilled Service Components To be completed by the consumer or consumer's legal representative.	Describe CDAC Provider Activity	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
N5	**Transferring, ambulation, mobility** – includes access to and from bed or a wheelchair, repositioning, exercising, and mobility in general.		0	0	0
N6	**Essential housekeeping** – activities which are necessary for the health and welfare of the consumer such as grocery shopping, laundry, general cleaning, and routine home maintenance.		0	0	0
N7	**Minor wound care** – includes foot care, skin care, nail care, and skin/nail observation and inspection.		0	0	0

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Documentation Service Code	Non-Skilled Service Components To be completed by the consumer or consumer's legal representative.	Describe CDAC Provider Activity	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line

N8	**Financial and scheduling assistance** – includes money management, cognitive tasks, and scheduling personal business matters.		0	0	0
N9	**Assistance in the workplace** – assistance with self-care tasks, environmental tasks, and medical supports necessary for the consumer to perform a job. Assistance with understanding and completing essential job functions is not included.		0	0	0
N10	**Communication** – includes interpreting, reading services, assistance with communication devices, and supports that address the consumer's unique communication needs.		0	0	0

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Documentation Service Code	**Non-Skilled Service Components To be completed by the consumer or consumer's legal representative.**	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
N11	**Essential transportation** – assisting or accompanying the consumer in using transportation essential to the health and welfare of the consumer. *			0	0

*Transportation may be provided for consumers to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation and to travel to and from pwrk or day programs. Note: Transportation costs and waiting time are not reimbursable costs

Documentation Service Code	**Non-Skilled Service Components To be completed by the consumer or consumer's legal representative.**	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
N12	**Medication assistance** – includes assisting the consumer in sorting, storing, organizing, and taking medications ordinarily self-administered. It also includes medication equipment maintenance and medication administration. *			0	0

* If medication is administered, documentation on the name of the medication, the dosage, and the route of administration must be maintained of the service record form or MAR (medication administration record). (A medication aid course id available through the area community colleges.

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Skilled service activities include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The cost of this supervision shall be paid from private insurance and other third party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program. The nurse or therapist must retain accountability for actions that are delegated and ensure appropriate assessment, planning, implementation, and evaluation. The nurse or therapist shall make on-site supervisory visits every two weeks. This nurse or therapist agrees to supervise these service components delivered by this CDAC provider:

Name and telephone number of supervising nurse or therapist:

Documentation Service Code	**Skilled Service Components** To be completed by the consumer, consumer's legal guardian, nurse/therapist, and CDAC provider.	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line

S1	Tube feedings if a consumer is unable to eat solid foods.		0	0	0
S2	Assistance with intravenous therapy administered by a licensed nurse.			0	0
470-3372 (Rev. 3/09)					
Documentation Service Code	**Skilled Service Components** To be completed by the consumer, consumer's legal guardian, nurse/therapist, and CDAC provider.	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
S3	Parenteral injections required more than once a week.		0	0	0
S4	Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.		0	0	0
S5	Respiratory care, including inhalation therapy, tracheotomy care, and ventilator.	0	0	0	0
S6	Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.		0	0	0
S7	Rehabilitation services *		0	0	0

*Rehabilitation services include Bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, re-teaching the activity of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, re-motivation, and behavior modification.					
470-3372 (Rev. 3/09)					
Documentation Service Code	**Skilled Service Components** To be completed by the consumer, consumer's legal guardian, nurse/therapist, and CDAC provider.	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
S8	Colostomy care.		0	0	0
S9	Care of medical conditions out of control (includes brittle diabetes and comfort care of terminal conditions).		0	0	0
S10	Post-surgical nurse delegated activities under the supervision of the licensed nurse.		0	0	0
S11	Monitoring reactions to medications requiring close supervision because of a fluctuating physical or psychological condition.		0	0	0
S12	Preparing and monitoring responses to therapeutic diets.		0	0	0
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Documentation Service Code	Skilled Service Components To be completed by the consumer, consumer's legal guardian, nurse/therapist, and CDAC provider.	Describe CDAC Provider Activity	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
S13	Recording and reporting of changes in vital signs to the nurse or therapist.			0	0

					Total Units
					0

Enter the number in the 'Total Units' box into the Total Units Per Month box below:

		Total Units Per Month			
		0			

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The consumer/consumer's legal representative, the CDAC provider, and the service worker/case manager determine the CDAC provider's rate of pay. The payment of CDAC services must not exceed the fee limits allowed in the CDAC program. The rate of service multiplied by the number of approved units of CDAC services per month cannot exceed the consumer's total monthly budget amount allowed in the consumer's comprehensive service plan. Complete the waiver type and agreed upon reimbursement rate to the provider as follows *(one HCPCS code only)*:

Waiver type: (check one)					
0	Ill & Handicapped	Brain Injury	Mental Retardation	Elderly	Physically Disabled

HCPCS Code	Provider Type	Fee Per Unit	Maximum Units
W1265	Agency CDAC provider. Not an assisted living CDAC provider.	$ per hour (up to 8 hours per day)	

W1266	Agency CDAC provider. Not an assisted living CDAC provider.	$ per hour (defined as 8 or more hours per day)
W1267	Individual CDAC provider	$ per hour (up to 8 hours per day)
W1268	Individual CDAC provider	$ per hour (defined as 8 or more hours per day)
W2517	Assisted living CDAC provider	$ per month

470-3372 (Rev. 3/09)

I agree to abide by all the requirements in this CDAC agreement including the following:

¨ That my criminal and abuse records will be checked for reported or confirmed criminal history or abuse.

¨ To hold the Department of Human Services harmless against all claims, damages, losses, costs, and expenses, including attorney fees, arising out of the performance of this CDAC agreement by any and all persons.

¨ To keep both fiscal and designated clinical/medical documentation records of all CDAC services provided which are charged to the medical assistance program and to maintain these CDAC records for at least five years from the date of claims submission. Documentation shall include the following information for each unit of CDAC service provided and billed:

	1	Full name of the consumer receiving the CDAC service as it appears on their medical assistance card.
	2	Consumer's date of birth.
	3	Medical assistance identification number.
	4	Full name of the person providing the service. If the provider functions under a professional license or is certified to perform certain tasks, list the title after the provider's name. If the provider does not have a title, enter "CDAC Worker."
	5	Agency name (if applicable).
	6	Specific date of the CDAC service provided including the day, month, and year.
	7	Total units billed for the date of service.
	8	Waiver type and service procedure code as identified in this agreement.
	9	Duration of the CDAC service provided including the start and end time.
	10	The number of units as computed from the start and end time.
	11	Specific service activity provided as described in this agreement.
	12	Location in which the service was provided.
	13	Description of the CDAC service provided as described in this agreement and as authorized in the service worker/case manager comprehensive service

		plan.			
	14	Description of the provider's interventions and supports provided and the consumer's response to those interventions and supports.			
	15	Identification of any health, safety, and welfare concerns.			
	16	Consumer's signature, provider's signature, and the date.			
I hereby confirm that all information provided by me on this form is true and correct to the best of my knowledge.					
CDAC Provider Signature		Date	Consumer Signature		Date
ADDITIONAL INFORMATION ON BILLING:					
Submit claim forms for all consumer-directed attendant care to Iowa Medicaid Enterprise (IME) Provider Services on form 470‑2486, Claim for Targeted Medical Care. Both the consumer and the CDAC provider must sign and date the Claim for Targeted Medical Care. CDAC services must be billed in whole units. Obtain copies of this form from IME Provider Services at 1-800-338-7909 or (515) 725-1004 (Des Moines local number only) or at the IME website: www. ime.state.ia.us. Please refer to your CDAC provider manual for directions on completing the CDAC claim form. Questions may be directed to the Iowa Medicaid Enterprise Provider Services telephone number listed above. Submit claims to IME on a monthly basis on or after the first day of the following month to facilitate payment in a timely manner. To receive payment, submit the claim for an entire month's service. IME has 30 days to process a claim. If a submitted claim contains errors, the payment to the provider may be delayed.					
470-3372 (Rev. 3/09)					