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**Comments submitted July 21, 2008 by:**

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### COMMENTS SUMMARY

In response to the request for comments by the Standard Occupational Classification Policy Committee (SOCPC), PHI respectfully submits the following comments addressing the SOCPC's recommended changes to titles and codes of occupation from the 2000 SOC. Specifically, we ask that you consider changes to the following three occupations:

- Nursing Aides, Orderlies and Attendants (SOC 31-1012)
- Home Health Aides (SOC 31-1011)
- Personal and Home Care Aides (SOC 39-9021)

In addition, we use this opportunity to bring your attention to a problem with the sampling frame used in federal surveys including the BLS Occupational Employment Survey, due to the fact that it leads to a serious undercount of workers counted as Personal and Home Care Aides.

Our comments are presented below in two sections: A. Proposed Changes and B. Background and Rationale for Proposed Changes.

#### A. PROPOSED CHANGES

##### 1. Nursing Aides, Orderlies and Attendants (SOC 31-1012)

Current description: Provide basic patient care under the direction of nursing staff. Perform duties such as feeding, bathing, dressing and grooming, moving patients or changing linens. This occupation includes nursing aides who provide "hands-on" patient care under the direction of licensed nurses as well as people who do not provide such direct care.

Proposed Change: We propose splitting this into two occupations to separate those who provide hands-on patient care under the direction of nursing staff, and those who do not provide such direct care. The two proposed occupations are as follows:

- New Title: **Nursing Aides**
- New Description: Provide or assist with basic care or support under the direction of on-site licensed nursing staff. Perform duties such as monitoring of health status, feeding, bathing, dressing, grooming, toileting, or ambulation of patients in a health or nursing facility. May include medication administration and health-related tasks such as assisting with ileostomy, colostomy and gastrostomy care.
- New Title: **Orderlies and Attendants**
- New Description: Provide services such as transporting patients to areas such as operating rooms or x-ray rooms using wheelchairs, stretchers or moveable beds, maintaining stocks of supplies, cleaning and transporting equipment, cleaning rooms and other duties.

## 2. Home Health Aides (SOC 31-1011)

Current description: Provide routine personal health care such as bathing, dressing or grooming, to elderly, convalescent, or disabled persons at patient's home or residential care facilities.

Proposed Change: A change is recommended in this definition to reflect the increased responsibilities of home health aides with advances in in-home technology.

- New Description: Provide or assist older adults, people living with intellectual, developmental, and physical disabilities, people with chronic illnesses, and persons who are convalescing with routine personal health care or support such as monitoring of health status, feeding, bathing, dressing, grooming, toileting, ambulation, medication management and administration, and other health-related tasks under the direction of off-site or intermittent on-site licensed nursing staff in a person's home or a residential care facility. Duties also may include non-health care related tasks such as preparing meals, housekeeping, and laundry.

## 3. Personal and Home Care Aides (SOC 39-9021)

Current description: Assist elderly or disabled adults with daily living activities at person's home or daytime non-residential facilities. Duties include keeping house or preparing meals. May also provide meals and perform supervised activities at non-residential care facilities. May advise families, the elderly, and disabled on such things as nutrition, cleanliness, and household utilities.

Proposed Change: A change in the description of personal and home care aides is proposed to reflect the broader range of tasks actually performed by Personal and Home Care Aides as they support elders and people with disabilities to lead independent lives. An inclusive reference to the range of populations receiving services and supports from these aides is also recommended. Finally, a slight rewording of the occupational title is proposed in order to make it more current with the terminology that is developing within the long-term care industry.

- **New Title: Personal Care Assistants**

New Description: Assist older adults, people living with intellectual, developmental, and physical disabilities, and people with chronic illnesses with daily living activities at the person’s home, place of work, while engaged in the community, or at a daytime non-residential facility as directed either by the care recipient or other supervisor. Duties may include assistance with bathing, dressing, grooming, transferring and ambulation, eating, medication support, implementing behavior plans, teaching new self-care skills, supporting friendships and self-determination, providing employment supports, and a homemaking tasks such as meal preparation, light housekeeping, transportation, or other support activities as requested.

#### **4. Updating the Sampling Frame of Federal Surveys for Long-Term Care Employers**

A substantial number of Personal and Home Care Aides are currently excluded from federal employer surveys including the Occupational Employment Statistics survey, due to the fact that many of these workers are not affiliated with traditional long term care facilities or agencies, but rather are directly employed by the individual or family required services and supports. These workers (and their clients), and the public authorities and other intermediaries that sometimes operate as fiscal agents between these workers and their employers in some states, represent a growing consumer-directed care segment in long term care and their exclusion has resulted in a serious undercount of workers in the Personal and Home Care Aides occupation. We strongly recommend that future federal employer surveys utilizing the Standard Occupational Codes take this important trend into consideration.

## **B. BACKGROUND & RATIONALE FOR RECOMMENDED CHANGES**

### **1. Employment and growth in the three occupations**

Taken together, the three occupations for which we are recommending changes are widely considered to constitute the nation’s direct-care workforce—that is, our nation’s “frontline” paid caregivers, most of whom provide long-term care services and supports to the elderly and people with disabilities (physical, intellectual and developmental) and with chronic illness. The majority of these staff work in the consumer’s own home, in institutional settings such as

nursing homes, or in residential care settings such as assisted living facilities and group homes. A smaller portion of these staff work in acute care settings, such as hospitals and clinics.

The size of this workforce is substantial and growing. The latest 2006 employment estimate for the direct-care workforce surpasses the 3 million mark and projected demand calls for an additional 1 million new positions by 2016 (see **Table 1**). At 4 million, the size of this workforce will exceed: registered nurses (3.1 million), teachers from kindergarten through high school (3.8 million), cooks and food prep workers (3.3 million), fast food and counter workers (3.5 million), waiters and waitresses (2.6 million), and cashiers (3.4 million).

Further, according to the most recent occupational projections of the Bureau of Labor Statistics (BLS) at the U.S. Department of Labor, Personal and Home Care Aides and Home Health Aides are expected to be the second and third fastest-growing occupations in the country between 2006 and 2016, increasing by 51% and 49%, respectively. Nursing Aides, Orderlies and Attendants are expected to increase by 18%. All three occupations are on the list of top ten occupations projected to register the largest numeric growth across the entire economy.

<b>Table 1: Employment and Employment Growth for Direct Care Workers, 2006 -2016</b>				
<b>Occupation</b>	<b>Employment 2006</b>	<b>Employment 2016</b>	<b>Numeric growth</b>	<b>Rate of growth</b>
Nursing Aides, Orderlies & Attendants (SOC 32-1021)	1,447,233	1,710,876	263,643	18%
Home Health Aides (soc: 31-1011)	787,315	1,170,935	383,620	49%
Personal and Home Care Aides (SOC 39-9021)	767,257	1,155,795	388,538	51%
<b>Total</b>	<b>3,001,805</b>	<b>4,037,606</b>	<b>1,035,801</b>	<b>35%</b>
Source: A. Dohm & L. Shniper (Nov. 2007) "Occupational employment projections to 2016," <i>Monthly Labor Review</i> (Washington, DC: Bureau of Labor Statistics, U.S. Department of Labor.				

## 2. Employment settings

Direct care workers are employed in a range of settings that either deliver long-term care services and supports or are simply where people with disabilities or chronic illnesses live and work. The chart below depicts our best understanding of the settings in which direct-care workers are employed in the delivery of long-term care services.

## The Continuum of Long-Term Care Settings

INSTITUTIONAL SETTINGS		HOME AND COMMUNITY-BASED SETTINGS						
		Community Residential		Supports to Individuals and Families			Non-Residential Community Supports	
<b>Nursing facility &amp; residential rehabilitation</b>  <i>(e.g., Skilled Nursing Facilities, Nursing Facilities, Intermediate Care Facilities)</i>	<b>State operated institutions &amp; large private institutions</b>  <i>(e.g., ICF-MR, residences with 16 or more people)</i>	<b>24-hr residential supports &amp; services</b>  <i>(e.g., group home, supported living arrangement, supervised living facility, assisted living)</i>	<b>Less than 24-hr residential supports &amp; services</b>  <i>(e.g., semi-independent living services)</i>	<b>Home health care services</b>	<b>Personal care services (agency-directed)</b>	<b>Personal care services (consumer directed)</b>	<b>Day programs, &amp; rehabilitative or medical supports</b>  <i>(e.g., day services for seniors, MH day services, rehabilitation for working age adults)</i>	<b>Job or vocational services</b>  <i>(e.g., supported employment, work crews, sheltered workshops, job training)</i>

**From:** National Direct Service Workforce Resource Center (Draft for Review 4-28-08) State Long-Term Care Reform: The Need for Monitoring the Direct Service Workforce and Recommendations for Data Collection. Available at: [http://www.dswresourcecenter.org/index.php/dsw/dsw\\_symposium/agenda\\_and\\_materials/improving\\_the\\_evidence\\_base\\_for\\_policy\\_initiatives\\_to\\_strengthen\\_the\\_direct\\_service\\_workforce](http://www.dswresourcecenter.org/index.php/dsw/dsw_symposium/agenda_and_materials/improving_the_evidence_base_for_policy_initiatives_to_strengthen_the_direct_service_workforce).

Data from the BLS's latest National Employment Matrix suggests that the majority of direct-care workers are now employed in home- and community-based settings, and not in institutional settings such as nursing facilities. Moreover, the proportion of home- and community-based workers relative to facility-based workers can be expected to increase over the next decade. In fact, PHI estimates that, by 2016, home- and community-based direct-care workers are likely to outnumber facility workers by nearly two to one.

Using information from the BLS's 2006 National Employment Matrix, **Table 2** presents information about the main industries or sectors in which the different types of direct-care workers are employed.

Table 2: Employment of Direct-Care Workers by Industry Setting, 2006								
Industry Setting	SOC: 31-1012 Nursing aides, orderlies and attendants	% of total	SOC: 31-1011 Home health aides	% of total	SOC: 39-9021 Personal and Home care aides	% of total	Total in Industry	% of total
Total employment	1,447,233	100%	787, 315	100%	767,257	100%	3,001,807	100%
Employment services	52,420	3.6%	23,280	3.0%	13,937	1.8%	89,637	3.0%
Home healthcare services	34,197	2.4%	241,409	30.7%	216,941	28.3%	492,547	16.4%
Hospitals	418,882	28.9%	19,489	2.5%	5,057	0.7%	443,428	14.8%
Nursing care facilities	588,648	40.7%	58,711	7.5%	7,315	1.0%	654,674	21.8%

Residential care facilities	163,937	11.3%	253,815	32.2%	72,746	9.5%	490,498	16.3%
Individual, family, community and vocational rehab based services	13,989	1.0%	122,878	15.6%	233,415	30.4%	370,282	12.3%
Private households, self employed and unpaid family care givers	43,318	3.0%	18,573	2.4%	168,874	22.0%	230,765	7.7%
Other, calculated as remainder	131,842	9.1%	49,160	6.2%	48,972	6.4%	229,974	7.7%
Source: <a href="http://ftp.bls.gov/pub/special.requests/ep/ind-occ.matrix/occ_pdf/occ_31-1011.pdf">ftp://ftp.bls.gov/pub/special.requests/ep/ind-occ.matrix/occ_pdf/occ_31-1011.pdf</a> <a href="http://ftp.bls.gov/pub/special.requests/ep/ind-occ.matrix/occ_pdf/occ_31-1013.pdf">ftp://ftp.bls.gov/pub/special.requests/ep/ind-occ.matrix/occ_pdf/occ_31-1013.pdf</a> <a href="http://ftp.bls.gov/pub/special.requests/ep/ind-occ.matrix/occ_pdf/occ_39-9021.pdf">ftp://ftp.bls.gov/pub/special.requests/ep/ind-occ.matrix/occ_pdf/occ_39-9021.pdf</a>								

Among other things, this employment/industry data indicates the following concerning the three occupations under consideration:

***Nursing Aides, Orderlies and Attendants***

- 40% percent are employed in nursing care facilities.
- 29% percent are employed in hospitals.
- 11% are employed in a broad industry category called “residential care facilities.” This wide-ranging industry classification includes intermediate care facilities for individuals with mental retardation, non-hospital facilities for persons with substance abuse and mental health problems, assisted living facilities for the elderly, and small congregate homes for people with people with any kind of disability.

***Home Health Aides***

- 31% are employed in the home health care services sector.
- Just under a third work (32%) work in the broad industry grouping called “residential care facilities” (see definition of this industry provided in above bullet).
- An additional 16% of home health aides work in an industry called “Individual, family, community, and vocational rehabilitation services.” These services are primarily non-residential and are further defined in the attached footnote.<sup>1</sup>

***Personal and Home Care Aides***

- Nearly a quarter of these aides are estimated to be either directly employed by private households as caregivers or self-employed (*i.e.*, the aide contracts directly with their client). This is consistent with the growing numbers of consumers who are directly hiring their own direct-care workers under Medicaid consumer-directed programs or privately, without the assistance of personal/home care agencies.
- An additional 30% of these aides work in Individual and Family Services (see industry definition in footnote 1).
- Another 28% are employed in the home health care services sector.

### 3. Required occupational training and certification for these occupations

Federal training and certification requirements exist for Certified Nurse Aides and Home Health Aides working in Medicare-certified nursing facilities, home health care agencies, and hospice agencies. State training requirements for these two occupations and settings sometimes exceed the federal requirements. The situation for personal care attendants is quite different: there are no federal requirements for this occupation and, while most states have at least one set of training requirements for Personal and Home Care Aides in at least one public program, there is minimal consistency and uniformity across long-term care settings and the various public programs that deliver these services.

A more detailed overview of training and certification for each of the three occupations is as follows:

**Nurse Aides.** Nursing facilities must meet federal statutory requirements for the training and competency levels of certified nurse aides (CNAs) working in facilities that participate in Medicare and/or Medicaid.<sup>ii</sup> According to these requirements, CNAs are nurse aides that provide nursing or nursing-related services to residents and who are not licensed health professionals, registered dietitians, paid feeding assistants, or volunteers providing services without pay.<sup>iii</sup> As specified in federal regulation, a state-approved nurse aide training program must consist of a minimum of 75 hours of training, which includes at least 16 hours of supervised practical or clinical training.<sup>iv</sup> Some states have chosen to require additional hours of classroom and clinical training.<sup>v</sup>

**Home Health Aides.** Home health agencies participating in Medicare and/or Medicaid must meet federal statutory requirements for conditions of participation as specified in Medicare statute (Medicaid defers to Medicare for conditions of participation for home health agencies).<sup>vi</sup> Home Health Aide training programs must consist of a minimum of 75 hours of training, which includes at least 16 hours of supervised practical training. Agencies providing long-term care services and supports under home- and community based Medicaid waivers do not have to be certified and their aides do not have to meet these standards, even if they are serving consumers who qualify for nursing-facility level of care. This means that there is no minimal training requirement or certification that can be used to help specify the description of SOC 31-1011.

**Personal and Home Care Aides.** There are no federal requirements related to training Personal and Home Care Aides. The Medicare program does not cover personal care attendant services, but states may choose to offer personal care services through their Medicaid state plan and/or Medicaid waiver programs. For states that offer Medicaid-funded personal care services, the State Medicaid Manual requires them to develop provider qualifications for these aides. A U.S. DHHS OIG (2006) report that examined state requirements for Medicaid-funded personal care services found 301 sets of requirements for Personal and Home Care Aides across Medicaid programs in all 50

states and the District of Columbia. Training requirements for Personal and Home Care Aides were included in 75 percent of the 301 requirement sets identified in the study, translating into 46 states that incorporated training requirements in at least one Medicaid program offering personal care services. However, these requirements were found to vary by program, even within the same state, in terms of the content, duration, and time necessary to complete training. The median number of required training hours was only 28, but nearly half of the requirements did not specify the required training hours.

#### **4. Changes that have occurred that necessitate revisions to occupational descriptions and classifications**

*It is our assessment that the 2000 SOC occupational definitions for the three occupations at issue could usefully be updated with more accurate and expanded task definitions as well as more inclusive reference to the types of populations receiving long-term care supports and services.* In large part, these proposed updates reflect the enormous expansion of the long-term care industry in the United States, and in particular, dramatic changes in the size and structure of the home care/personal assistance industry, and in the community residential sector. These structural shifts have been accompanied by important changes in the tasks performed by Home Health Aides and Personal and Home Care Aides.

- **Changes in the size and structure of the home care/personal assistance industry and the community residential sector**

Two sectors of the long term care industry that have witnessed substantial growth are the multi-billion dollar homecare industry and the community residential sector. Both are fueled in large part by significant increases in life expectancy and medical advances that allow individuals with chronic conditions to live longer. In the very near future, care giving for baby-boomers will become a rapidly growing source of demand: over the next two decades there will be more than 70 million people over the age of 65. The growth in the demand for in-home services is further promoted by the availability of public funding assistance for in-home care under Medicaid and Medicare, and also by the rising cost of traditional institutional care combined with a growing preference for receiving supports and services in the home as opposed to in institutional settings.

The formal provision of homecare/personal assistance services in the United States now occurs within a rapidly expanding, and complex industry composed of a diverse array of providers that includes: long-standing voluntary nonprofit organizations such as the Visiting Nurse Association; public agencies operated by state, county, and city governments; proprietary for-profit homecare agencies (including rapidly growing chains of elder care franchises); and private non-for-profit private duty agencies. The fastest growing sector of Medicare-certified homecare agencies is the for-profit sector, which increased from 7.3 percent of freestanding agencies in 1980 to 69 percent in 2006. Public health agencies,

which constituted half of Medicare-certified agencies in 1980, now represent only 16 percent.<sup>vii</sup>

The community residential sector refers to residential care settings for individuals who generally can't live alone but who do not require the skilled level of care that nursing facilities provide. Examples include: group homes, adult foster care homes, adult family care homes, board and care homes, and assisted living facilities. In 2007, states reported 38,373 licensed residential care facilities with 974,585 units/beds (Mollica *et al.*, 2007). These numbers do not include facilities licensed separately as adult foster/family care or facilities licensed by state departments of mental retardation and other developmental disabilities or mental health. In general, these settings provide supported living arrangements on either a 24-hour basis or on less than a 24-hour basis.

There is also a booming consumer-directed market, financed primarily by Medicaid, in which consumers serve as the employer of record or as joint employers with agencies. Various kinds of intermediary support organizations sometimes serve as fiscal agents under this model. Workers in this sector are known as consumer-directed workers, or "independent providers." PHI estimates that over 400,000 of these independent providers now rely on public authorities and collective bargaining agreements to stabilize their employment conditions.<sup>viii</sup>

Finally, there is an admittedly huge private-pay "grey market" operating "off the books," where private individuals hire aides on their own and may or may not pay required employer taxes on behalf of the worker, such as Social Security, unemployment compensation, and workers' compensation. This segment of the industry is completely unregulated and, although it is thought to be sizeable, little is known about it except on an anecdotal basis.

- **Changes in tasks performed by the nation's home- and community-based direct-care workforce**

The increasing use of in-home services translates, on the workforce side, into a much greater need for skill, judgment and personal accountability on the part of Home Health Aides and Personal and Home Care Aides, whether they are assisting older individuals, persons with physical disabilities, or persons living with intellectual and developmental disabilities or with chronic disease.

Furthermore, changes in the acuity of the consumer population mean that Home Health Aides and Personal and Home Care Aides are now providing services to nursing home-eligible consumers in home- and community-based settings. Many of these consumers are older, frailer, and more impaired than the consumer population served even a decade ago.

Additionally, Personal and Home Care Aides must practice their care giving skills with far less direct supervision and access to on-site consultation from professionals. Much of this

work is difficult, physically taxing, and requires responsibility and judgment as well as emotional commitment and flexibility.

## 5. Rationale for the proposed changes

**Nurse Aides, Orderlies and Attendants (SOC 31-1012).** This occupational category currently mixes two categories of workers who are performing tasks that could and should be functionally distinguished: namely, workers who provide hands-on care to persons with disabilities under the supervision of on-site licensed nursing staff and those who perform non-hands on care. Hands-on care under nurse supervision includes tasks such as feeding, bathing, dressing and grooming, health status monitoring, and medications administration. Non-hands on tasks refer duties such as transporting patients, maintaining supplies, changing linen, and cleaning rooms. These two sets of tasks require different sets of skills and training, which leads us to suggest that SOC 31-1012 should be re-categorized into two groups: **Nurse Aides** and then **Orderlies and Attendants**.

**Home Health Aides (SOC 31-1011).** The tasks performed by Home Health Aides have expanded significantly beyond the tasks specified in the current description for SOC 31-1011. We propose updating the specification of tasks performed to expand beyond bathing, dressing, and grooming (current definition) to also include: monitoring of health status, feeding, toileting, ambulation, medication management and administration, and also sometimes non-health care related tasks such as preparing meals, housekeeping, and laundry.

**Personal and Home Care Aides SOC 39-9021.** The changes we propose address the need to adjust the current definition to accommodate the expanded duties and tasks that are actually performed by workers who can be coded as SOC 39-9021. In addition, critical tasks performed by these aides when working with individuals with intellectual and developmental disabilities are specified, such as implementing behavior plans, teaching new self-care skills, and supporting friendships and self-determination. A more inclusive reference to the range of populations receiving services and supports from these aides is also recommended. This is particularly important if SOC 39-9021 is to be of greater relevance to policy makers and workforce experts concerned with non-aging populations (e.g., persons with physical disabilities, and persons living with intellectual and developmental disabilities). Finally, a slight rewording of the occupational title is proposed to strengthen the distinction between SOC 31-1011 and SOC 39-9021, and because the trend across the states is for use the term “personal care” or “personal assistance” services rather than “home care” services.

**Sampling Frame Problem.** Given that BLS matrix data show that roughly a quarter of Personal and Home Care Aides are either self-employed or directly employed by households, ***we would like to bring to the attention of the SOCP a substantial problem with the current sampling frame of BLS employer surveys such as the Occupational Employment Statistics (OES) survey.*** Today, thousands of direct-care workers are directly employed by individuals and, therefore, are not affiliated with (or payrolled by) a facility or agency. In many states, Personal and Home

Care Aides who are employed by individuals have mistakenly been characterized as "self-employed" or "independent contractors" because they are not affiliated with a traditional employer such as a home care agency that payrolls them or organizes and supervises their work (including specifying their assignments and the services they should provide). However, there is a definite employer-employee relationship, and these aides should be correctly categorized as support service employees of individual employers. But, because of this non-traditional employment relationship, literally hundreds of thousands of direct-care workers who work as independent providers for private-pay consumers or under state Medicaid programs and waivers, are excluded from the OES survey, leading to a serious undercount of these workers.

We have evidence of this undercount in publicly funded programs. For example, in California there were 280,000 such workers in 2005,<sup>ix</sup> yet California BLS 2005 numbers identified 32,600 personal and home care aides. Further, under Medicaid programs, independent providers are often jointly employed by consumers and a provider agency, and often, the employer-related fiscal and administrative responsibilities are handled by "Fiscal Agents" or "Employer Agents" and sometimes by public authorities. Public authorities for Personal and Home Care Aides who are employed as independent providers now exist in 5 states: California (where there is a county-based authority system), Michigan, Washington, Oregon, and Massachusetts. Together, these five authorities report covering more than 400,000 personal care workers.

***As a result of the dramatic expansion of non-agency based employment arrangements for personal care workers, and in order to address the serious undercount of Personal and Home Care Aides that is built into the current sampling frame of federal employer surveys, we strongly recommend that Fiscal/Employer agents and Public Authorities be sampled when BLS and other related federal surveys are fielded.***

## **6. Expected benefits of the recommended changes**

Those of us who work in the field of workforce development for the long-term care industry are often confronted with considerable confusion on the part of workers, consumers, employers and policy makers concerning just which workers are captured by each of the three SOC codes that are the subject of our comments. A significant amount of the confusion is attributable to the fact that states have different approaches to the training and certification for these workers, and in many states the same worker who must be trained and certified under one program does not have to be trained and certified in the same way in another program, even though he or she is delivering the same supports and services.

While the changes we have proposed will not eliminate all of the resulting "greyness" in these classifications, we believe they will reduce the overlap between the classifications for Home Health Aides and Personal and Home Care Aides, and, therefore, make the occupational definitions more reflective of how people in the field actually experience the actual groupings of and distinctions between workers and the tasks and duties they perform.

In sum, we think that the recommended changes would allow for a more precise and accurate count of the workers who perform frontline caregiving tasks for individuals who have disabilities due to aging, developmental and intellectual disabilities, physical injuries, or chronic illness. They would also provide occupational titles and task descriptions that correspond more closely with the jobs that workers actually perform. As a result, employers of these workers will be able to complete federal surveys and requests for information in a way that more accurately reflects the job titles that they use in their own agencies and organizations. It is also important to get these SOC codes “right” because they impact the job titles used to classify workers who participate in the Current Population Survey and the American Community Survey.

The resulting occupational estimates and related wage estimates in turn will provide a more realistic picture to federal and state policymakers who currently find themselves hampered by a lack of ongoing, reliable state-based information about their direct care workforce. The National Center for Health Workforce Analyses (2004), which is part of the Health Resources and Services Administration at the U.S. Department of Health and Human Services, recently undertook a comprehensive examination of nursing aides, home health aides, and related health care occupations and associated data needs. In its final report, the Center concluded that “state planners and policymakers do not have adequate data and information with which to assess the adequacy of the long-term care paraprofessional workforce” because “existing data systems—which were designed for other purposes—cannot support systematic assessments of any [long-term care] industry component: individual workers, individual facilities, classes of workers, classes of facilities, people receiving services, people needing services, organizations financing services, or policymakers overseeing the various systems.” Revised and updated SOC codes for the three main occupations making up the direct-care workforce could be a useful step on the part of the federal government to address the need for better data on this rapidly growing part of our economy.

## **7. Conclusion**

Given the enormous growth that is projected to occur over the next decade in demand for the direct-care workforce, we strongly suggest to the SOCP this is a propitious time to update the title and task definitions of SOC 31-1012, SOC 31-1011, and SOC 31-9021 so that they better correspond to the actual tasks performed by these workers. By updating these three occupational categories to reflect the important changes that have occurred in the provision of long-term care services and supports, the SOCP could substantially enhance the value of the workforce-related data that is generated using these classifications.

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### **Description of PHI**

*PHI (www.PHInational.org) is a national non-profit based in the Bronx, NY that works to improve the lives of people who need home and residential care—and the lives of the workers who provide that care. Using our workplace and policy expertise, we help consumers, workers*

*and employers improve long-term services and supports by creating quality direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect, and independence. With nearly 50 staff, PHI works to strengthen our nation's direct-care workforce, which includes nearly three million home health aides, certified nurse aides, and personal care attendants. We develop recruitment, training, supervision, and person-centered caregiving practices—and the public policies necessary to support them.*

## **Sources**

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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.

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<sup>1</sup> This industry group includes: a) Services for the elderly and persons with disabilities (2002 NAICS 624120); b) Child and youth services (2002 NAICS 624110); c) Other individual and family services (2002 NAICS 624190); d) Community food services (2002 NAICS 624210); e) Community housing services (2002 NAICS 62422); f) Other community housing services (2002 NAICS 624229); g) Emergency and other relief services.

Industry (a) refers to establishments primarily engaged in providing nonresidential social assistance services to improve the quality of life for the elderly, persons with MR, or persons with disabilities and includes day care, nonmedical home care or homemaker services, social activities, group support, and companionship. (b) refers to establishments primarily engaged in providing nonresidential social assistance services for children and youth and includes adoption and foster care, drug prevention, life skills training, and positive social development. (c) refers to other establishments primarily engaged in providing nonresidential individual and family social assistance services, except those specifically directed toward children, the elderly, persons diagnosed with mental retardation, or persons with disabilities (includes alcoholism and drug addiction self-help organizations, counseling services, ex-offender rehab agencies, family welfare services, hotline centers, marriage counseling, private probation offices, suicide crisis agencies, rape crisis centers).

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<sup>ii</sup> Sec. 1919 of the Social Security Act.

<sup>iii</sup> Sec. 1919(b)(5)(F) of the Social Security Act.

<sup>iv</sup> 42 CFR 483.152; Supervised practical training means training in a laboratory or other setting where the trainee demonstrates knowledge while performing tasks on an individual and under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

<sup>v</sup> An up-to-date list of additional state requirements can be found at:

[http://www.directcareclearinghouse.org/download/StateNA\\_Training\\_Requirements07.pdf](http://www.directcareclearinghouse.org/download/StateNA_Training_Requirements07.pdf).

<sup>vi</sup> Sec. 1891 of the Social Security Act.

<sup>vii</sup> National Association of Home Care (2007) *Basic Statistics About Home Care*, Table 1. Available at:

[http://www.nahc.org/facts/07HC\\_Stats.pdf](http://www.nahc.org/facts/07HC_Stats.pdf).

<sup>viii</sup> Dorie Seavey and Vera Salter (October 2006) *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants*. Policy Report #2006-18, Washington, DC: AARP Public Policy Institute, pp. 17-19. Available at: [http://assets.aarp.org/rgcenter/il/2006\\_18\\_care.pdf](http://assets.aarp.org/rgcenter/il/2006_18_care.pdf).

<sup>ix</sup> RTZ Associates, Inc. (May 2005) *The State of IHSS Health Benefits in California: A Survey of Counties*. RTZ Associates, Inc.