

JULY 2017

**ROUNDTABLE REPORT**

# **New York Home Care: Leaders Reflect on the Changing Landscape**

BY ALLISON COOK

Home care is a vital component of New York’s health care system, providing the services and supports that enable older adults and other individuals with disabilities or chronic conditions to remain in their communities. These services can get expensive—the average monthly cost for a home care aide in New York is estimated to be \$4,385<sup>i</sup>—and most people receive coverage through Medicaid. According to a 2015 estimate, there were almost 200,000 people in New York State receiving Medicaid-funded home care services,<sup>ii</sup> and that number continues to grow.



The clear majority of this hands-on care is provided by home care aides, who therefore have an enormous influence on the quality of care and quality of life for their clients. As of 2015, there were more than 300,000 home care aides in New York State, making home care one of the largest occupational groups.<sup>iii</sup> Despite the size and importance of this workforce, home care aides have historically been underpaid, inadequately trained, and undervalued.

Recent labor law changes represent a critical step toward remedying these issues. Within the past five years, for example, home care in New York has been redefined by the move to Medicaid managed long-term care, increased labor costs, and the growing chasm between costs and reimbursement rates. As the field continues to grow and evolve, it is critically important to consider the implications for home care quality and the role of the home care aide. To identify challenges and opportunities presented by this changing landscape, PHI sought the input of home care agencies and policy experts. This report outlines the issues they identified.

## Convening the Experts

In May 2017, PHI convened leaders from seven home care agencies and related nonprofit organizations for a roundtable discussion on the changing home care field in New York. The key themes, ideas, and questions arising from this roundtable discussion are presented in this brief. To deepen the insights developed during the convening, PHI also drew on the expertise of other

“The critically important world of home care, which can provide a lifeline for older adults and people with disabilities, is too often overlooked, ignored, or misunderstood. Convening home care agencies for thoughtful, wide-ranging discussions such as this one is necessary to call attention to the major issues affecting this vital sector.”

Bruce Vladeck  
Senior Advisor,  
Greater New York Hospital Association

leaders in the field, representing Medicaid managed long-term care plans, advocates, and others. Their insights are included in boxes throughout the brief.

It is important to note that this discussion focused on the Medicaid-funded system of long-term services and supports since, as noted above, this program is the largest payer for home care in New York State. Furthermore, Medicaid policies trickle down and influence the private-pay market.

Four themes emerged from this roundtable discussion of home care leaders, listed below:

1. Home care leaders have a strong sense of what it means to provide “quality” home care, yet they struggle to achieve common definitions and measures across the health care system.
2. Home care leaders are challenged with maximizing the evolving role of the home care aide while improving job quality and complying with new rules and regulations.
3. Technology can dramatically change both home care delivery and home care jobs, yet providers are unable to fund new innovations.
4. Home care leaders are eager for more solution-oriented conversations on how to improve home care jobs and care delivery.

### Home Care Leader Roundtable Participants

- Marki Flannery – Executive Vice President and Chief of Provider Operations, Visiting Nurse Service of New York
- Gloria Garan – Vice President of Clinical Services, Cooperative Home Care Associates
- Kathryn Haslanger – Chief Executive Officer, JASA
- Russell Lusak – Senior Vice President, Selfhelp Community Services
- Osarhiemen Okpeseji – Director of Patient Services, Montefiore Home Care
- Lenard L. Parisi – Vice President Quality Management, Metropolitan Jewish Health System
- Adria Powell – President, Cooperative Home Care Associates
- Lorette Shea – Director of Professional Practice and Outcomes Management, Metropolitan Jewish Health System
- Amy Thomas – Vice President, Best Choice Home Health Care

*PHI would like to thank the Altman Foundation and Senior Program Officer Rachael Pine for their generous support of the roundtable and this report.*

## Theme 1: Home care leaders have a strong sense of what it means to provide "quality" home care, yet they struggle to achieve common definitions and measures across the health care system.

When asked to define “quality home care,” home care leaders in the room identified several components, including continuity of care, positive client outcomes, and a strong relationship between the client and the home care aide. One important distinction was that “quality” includes both clinical outcomes, such as effectively managing chronic conditions and preventing unnecessary hospitalization, and quality of life outcomes, such as ensuring that clients can participate in their communities. At the national level, considerable progress has been made in defining these dual aspects of care (see *Home Care Quality Measurement*, below), yet adopting a uniform set of comprehensive measures has lagged. Participants described how clinical outcomes, particularly rehospitalization rates, continue to be prioritized within the payment system (including the state Department of Health and Medicaid managed care plans), even though they represent an incomplete picture of the value of home care. It is also important to note that different quality measures might better serve the Medicaid Consumer Directed Personal Assistance Program, a program that allows clients to recruit, train, and schedule their own home care aides.

Home care leaders also suggested that, in certain circumstances, the payment system has defined quality as reducing costs. The result can be cutbacks to non-mandatory expenditures, such as training, which can have an adverse effect on quality of care. If a client has Alzheimer’s disease but their home care aide has never received dementia care training due to funding cuts, for example, the client’s quality of care will suffer.

Participants believe that home care quality discussions are complicated by the lack of recognition afforded to home care. One explanation, according to the roundtable’s participants, is the mistaken reputation of home care as “unskilled” work that is rife with fraud (due to the lack of direct oversight that is more readily offered in residential settings). Participants also pointed out that the individuals affected by home care, both workers and clients, are predominantly older people, people with disabilities, women of color, and immigrants. These populations have a long history of marginalization and have often struggled to see their contributions validated.

### HOME CARE QUALITY MEASUREMENT

The National Quality Forum recently released a report<sup>1</sup> that provides a framework for defining and measuring quality home and community based services, including home care, across the following domains:

- Service delivery and effectiveness
- Person-centered planning and coordination
- Client choice and control
- Community inclusion
- Family caregiver support
- Adequacy, availability, and appropriateness of the paid workforce
- Human and legal rights
- Equity in access to care
- Holistic health and functioning
- System performance and accountability
- Consumer leadership in system development

<sup>1</sup> National Quality Forum. September 2016. *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*.  
[http://www.qualityforum.org/Publications/2016/09/Quality\\_in\\_Home\\_and\\_Community-Based\\_Services\\_to\\_Support\\_Community\\_Living\\_\\_Addressing\\_Gaps\\_in\\_Performance\\_Measurement.aspx](http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx)

However, home care leaders are hopeful that a clear and consistent definition of quality home care that values both quality of care and quality of life will be established, for the benefit of clients, workers, and home care agencies. This could lead to better recognition of the importance of home care and enhance the inclusion of home care in broader health system conversations.

## Theme 2: Home care leaders are challenged with maximizing the evolving role of the home care aide while improving job quality and complying with new rules and regulations.

Home care leaders in the room agreed that the key functions of a home care aide's role have generally remained the same over the last five years: home care aides still provide the majority of hands-on care that clients receive, focusing on assistance with the activities of daily living that contribute to clients' overall health and wellbeing.

However, participants stated that home care aides' responsibility to observe, record, and report the status of their clients has significantly increased. This enhanced responsibility is partly driven by the broader emphasis—reinforced through the payment system—on monitoring and addressing changes in a client's condition to prevent the risk of adverse outcomes, such as rehospitalizations. Additionally, enhanced recording and reporting is used to monitor home care aides' fulfillment of client care plans, to ensure their compliance with regulations and allay concerns about fraudulent reimbursement claims. Nonetheless, participants noted that skills development related to observing, recording, and reporting are not always adequately covered in entry-level training for home care aides.

“We will truly leverage the full value of home care aides when we figure out how to ensure that the information they hold about their clients' health needs and preferences is communicated in a consistent and effective way to nurses, physicians, and care managers.”

Rick Surpin

President, Independence Care System

### NEW WAGE AND LABOR RULES

- **Wage Parity** – Mandates an annually-adjusted base wage and benefit package for home care aides in New York City, Westchester, and Long Island.<sup>1</sup>
- **Fair Labor Standards Act (FLSA)** – Requires employers to pay aides 1.5 times their base wage (rather than minimum wage in NYS) for overtime hours and to compensate them for travel time between clients.<sup>2</sup>
- **Minimum Wage Increase** – Raises the minimum wage to \$15 per hour in New York City and surrounding areas, and to \$12.50 in the rest of the state, by 2021.<sup>3</sup>

<sup>1</sup> PHI. 2014. *Wage Parity for Home Care Aides*. <https://phinational.org/sites/default/files/research-report/medicaid-redesign-watch-1.pdf>

<sup>2</sup> PHI. 2015. *FLSA Facts*. <https://phinational.org/sites/default/files/flsafaacts-20131206.pdf>

<sup>3</sup> NYS Department of Labor. “Minimum Wage.” <http://www.labor.ny.gov/workerprotection/laborstandards/workprot/minwage.shtm>. Accessed June 1, 2017.



Participants also noted they have seen an increase in the acuity of clients. Clients leave the hospital sooner and receive care in the community rather than transferring to nursing homes. Additionally, training standards for home care aides do not adequately account for increased client acuity.

Additionally, home care leaders agreed that new wage and labor rules have provided important rights and protections to home care aides, such as increased base wages and equitable overtime protections (see *New Wage and Labor Rules*, p. 5). Overall, participants were supportive of these policy changes, yet universally agreed that many of the new mandates are unfunded or underfunded by Medicaid. As a result, agencies have struggled to cover new labor costs and have had to implement policies such as minimizing overtime and reducing non-mandatory training.

Home care leaders suggested that these cost-cutting measures have had unintended negative repercussions on job quality. While the new wage and labor protections have increased home care aides' hourly wages, the reduction in hours means that their overall annual income has not necessarily increased. Consequently, it has become more common for home care aides to work for two or more agencies to make ends meet, with participants estimating that roughly 60 percent of their home care aides work for multiple agencies. This trend puts additional burdens on the home care aide. For example, home care aides may experience unstable schedules when required to divide their time among multiple employers in order to compensate for fewer hours with a single agency.

## **SPOTLIGHT – NEW MODELS**

PHI worked with their affiliated Medicaid Managed Long-Term Care Plan (Independence Care System) and three home care agencies (Cooperative Home Care Associates, JASA, and Sunnyside) to create an advanced role for home care workers that is designed to maximize the value of home care in improving care transitions, reducing emergency department usage, and preventing rehospitalizations. With lead funding from the New York State Department of Health over 18 months, the project involved the design and roll-out of an advanced home care training curriculum, training of 14 home care workers, and deployment of eight full-time “Senior Aides” across the three agencies. This new model of care was successful in optimizing caregiving resources, implementing best practices in care transitions, and using technology to support communication between home care aides and registered nurses, thus facilitating an immediate response to changes in clients' conditions and reducing the incidence of costly health outcomes. It has also created a pathway to advancement in a field that does not traditionally offer career growth.

Home care leaders also reported that the new labor rules have generated scheduling challenges within their agencies. One home care leader stated that scheduling home care aides has become “a logistics game” where they “need the same software as Uber” to coordinate all the details. Participants remarked that minimizing overtime and travel time between cases has become essential in an environment where home care agencies do not have the Medicaid funding to cover additional costs. Since scheduling is such a challenge, coordinators no longer have the capacity to match home care aides and clients based on experience and personality, and instead must match based on schedules, which can negatively impact the continuity and quality of care. Leaders in the room agreed that sufficient reimbursement for the new rules will be essential for easing some of these challenges.

Finally, participants noted the opportunity to design advanced roles for home care aides in New York. A 2016 bill established an Advanced Home Health Aide occupation with an expanded scope of practice,<sup>iv</sup> but most of the home care

leaders' focus has been on models that maximize the role of the home care aide within the existing scope of practice. For example, the care transitions model developed by PHI and affiliates and partner agencies (see *Spotlight – New Models*, left), provides additional support to clients who are discharged home from the hospital through an enhanced and better-supported role for home care aides.<sup>9</sup> Participants provided other examples of models they have piloted where home care aides have an enhanced role in care management as key members of the health care team. These innovative models have the potential to create sustainable changes across the system, but only with adequate funds to cover the costs of training and compensation. Providers were hopeful that both the state and managed care plans will express more interest in enhanced roles for home care aides over time—which could lead to higher reimbursement to cover the costs involved—given the trend toward reimbursement for care quality outcomes such as reduced rehospitalizations.

### **Theme 3: Technology could dramatically change both home care delivery and home care jobs, yet providers are unable to fund new innovations.**

Participants agreed that technological advances have significant potential for home care. According to one home care leader, “technology might be the key” to the future of the field. The discussion identified several interconnected functions of home care technology, including tools for direct care, communication, data collection, and administration.

When discussing technology-based tools for direct care, participants believed that the near future holds great possibilities. One participant described how home care aides could use smartphones to access “on-the-go” courses on health-related issues facing their clients. Another participant noted how sensors that monitor a client’s movement and health status could be installed in the home, supporting client care. Home care leaders in the room agreed that the potential of new technology in home care is not matched by funding to support the pilot-testing of new technological tools.

Communication technologies can be used to share information. PHI has worked with partners and affiliates to develop and pilot advanced roles for home care aides in helping clients transition from hospital to the community; in such roles, technology can be used to facilitate consistent and efficient information transfer between home care aides and clinical staff. Leaders in the room reasoned that communication technologies can also help home care aides feel less isolated and more supported, as they receive more immediate feedback and support when client issues arise.

Closely related to direct care and communication technologies, data collection technology helps gather information on care tasks and client status. Currently, telephonic systems typically track the home care aides’ time and attendance only. More advanced technology, such as dedicated apps that automatically ask the home care aides about clients’ status and whether care plan tasks have been completed, is being pilot-tested by several home care agencies. Participants noted that this data has direct implications for improving care and could be particularly useful in the Medicaid system’s move to value-based payment (see *Value-Based Payment*, right), but only insofar as there is sufficient

#### **VALUE-BASED PAYMENT**

Value-based payment is a health care reimbursement framework that seeks to reward providers for the quality rather than quantity of services they provide. To that end, payment to providers is based on care outcomes, as defined through quality indicators. New York State has set a goal of having 80 to 90 percent of its Medicaid payments be value-based by 2020.<sup>1</sup>

<sup>1</sup> NYS DOH. June 2016. *A Path Toward Value Based Payment: Annual Update*. [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/2017/docs/2016-06\\_vbp\\_roadmap\\_final.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2017/docs/2016-06_vbp_roadmap_final.pdf)

infrastructure to deal with the data once it has been captured. They also indicated a need for better alignment between technology systems across care settings. For example, a managed care plan’s data system does not always communicate well with the home care agency’s system, making it difficult to efficiently share client information, including acute care data, with clinical staff. One participant remarked that their agency currently receives such data long after it was collected, so they cannot efficiently use the data to monitor and improve individual care or address broader trends across the client population. New technology might improve data capture and usage, especially with effective integration of acute and long-term care data systems, but evidence about the most cost- and clinically-effective options is still required.

Finally, technology has implications for the administration of home care agencies. Software for scheduling, tracking time and attendance, and monitoring regulatory compliance is being used by many home care agencies. Home care leaders indicated there was room to improve this type of software, as the systems have not kept pace with new requirements of wage and labor rules.

Overall, home care leaders in the room were hopeful about the potential of technology for the field. Technological advances could alleviate the increasing burden of administrative documentation, improve the quality of care for clients, evolve the role of the home care aide to better support clients, and create more fulfilling home care jobs. However, leaders believed that a significant financial investment in technology is needed to realize these goals.

## **Theme 4: Home care leaders are eager for more solution-oriented conversations on how to improve home care jobs and care delivery.**

Participants concurred that the profound changes in the home care field during the past five years—and the corresponding new requirements—necessitate careful reflection and strategic action. However, they also noted that home care agencies tend to get “bogged down” by the daily challenges of keeping pace with these changes. They are eager for more opportunities to reflect on current trends, such as agency consolidation or increased labor costs, and to prepare for the future.

As one example, home care leaders noted that the New York Medicaid system’s upcoming move to value-based payment (see *Value-Based Payment*, p. 7) could potentially benefit home care if quality

metrics are designed to include quality of life indicators, as well as clinical ones.

To develop this expanded quality framework, and leverage the value of home care, home care leaders would need to be included in discussions about key quality indicators. The new framework would also require technology that properly captures and quantifies quality indicators, as well as creating the infrastructure to share data across care settings. If these components are integrated into the new value-based payment system, leaders believe that the

“Future conversation should also examine what additional training and supports are needed by both family caregivers and home care aides – the people who spend the most time with home care clients – to work together to provide high-quality care.”

Carol Levine

Director of Families and Health Care Project,  
United Hospital Fund



value of home care would be better quantified and demonstrated.

Another important policy topic for home care leaders is the complex landscape of home care regulations. Home care leaders noted the protective value of regulations, in that they require providers to meet a threshold of knowledge and skills to provide quality care in the home. Equally, they have found that regulations can stifle innovation, limiting opportunities to integrate home care with other essential care to promote efficiency. Participants expressed an interest in discussing how to structure a system that balances protecting the clients and the industry with sufficient opportunity for innovation. Leaders in the room were hopeful that New York State’s recent efforts to reexamine licensing rules will serve as a starting place to achieve this balance.

Participants were also interested in discussing innovation in home care aides’ roles and responsibilities. Leaders noted that several promising models exist that provide higher quality care and a career ladder for home care aides, but the limited funding hinders widespread dissemination. One participant described a self-defeating cycle: because agencies lack the capacity to secure grants to implement evidence-based interventions, they cannot demonstrate outcomes—yet without outcomes, New York’s managed care plans will not provide funding to adopt such interventions in a sustainable way. The leaders agreed that more incentives are needed for the payment system to invest in innovative home care aide models. As described above, the advanced roles that PHI and its affiliates and partner agencies are developing provide a promising example of how advanced home care aides, and the implementation of technology, can work together with clinical staff and care managers to help clients transition from the hospital to the community more successfully. Such approaches maximize the valuable role of the home care aide while helping reduce costs related to hospitalizations or institutionalization.

Finally, participants would like more designated opportunities to address issues arising from changes to the long-term services and supports system. For example, home care leaders want a forum to explore how to alleviate the burden on both home care aides and agencies when a home care aide works for multiple agencies. The duplicative requirement to complete in-service training through each employer might be avoided, one participant suggested, through better use of the home care aide registry. Leaders also noted the increased administrative costs they face related to, for example, scheduling and monitoring regulatory compliance. Given that the new wage and labor rules described above have increased direct costs in home care, there are less funds available to cover these administrative costs. The leaders thought that these types of issues could be more proactively managed through regular conversations with policy-makers.

“In order to meet the challenges of our changing health care landscape, we must invest in new skills training models that bring together partner organizations in a truly integrated way and thereby support system redesign.”

William D. Myhre, MPA

Senior Director of Workforce Transformation/HR,  
Staten Island Performing Provider System

## Conclusion

PHI’s conversations with home care leaders and other experts in the field have illuminated several opportunities and challenges facing the home care field in New York. The ideas raised—and the type

of discussions that bring them to light—are essential for creating a home care system that provides both quality care to clients and quality jobs for home care aides. It is clear that home care leaders must be directly involved in efforts to redesign the health care system so that home care is appropriately valued, integrated with other levels of care, and reimbursed. Moreover, additional system-design conversations are needed to incentivize quality home care jobs. Finally, advances in technology, coupled with a large-scale investment that matches the historical investments in institutional and physician-led care, may substantially advance the field. Change can be exciting—yet without careful management, it can be overwhelming. The roundtable discussion summarized here aimed to help home care leaders work together amid ongoing change to create a vision for a quality home care system for New York.

---

*Allison Cook is PHI New York Policy Manager.*

---

## Notes

<sup>i</sup> Genworth. 2016. “Cost of Care: New York.” <https://www.genworth.com/services/servlets/pdf/coc2016>.

<sup>ii</sup> Home Care Associates. 2015. *Home Care: What it Is, Why it Matters*. <https://hca-nys.org/wp-content/uploads/2015/01/HomeCareWhatItIsWhyItMatters.pdf>.

<sup>iii</sup> PHI analysis of U.S. Bureau of Labor Statistics (BLS), Division of Occupational Employment Statistics, 2015. *Occupational Employment Statistics*. <https://www.bls.gov/oes/current/oessrcst.htm>. Last updated March 30, 2016.

<sup>iv</sup> Cook, Allison. 2016. “New York Legislature Passes Advanced Home Health Aide Legislation.” *PHI Policyworks Blog*. June 21. <https://phinational.org/blogs/new-york-legislature-passes-advanced-home-health-aide-legislation>.

<sup>v</sup> Working Nation. May 11, 2017. *One Company’s Solution for Filling the Coming Demand for Home Care Providers*. <https://workingnation.com/one-companys-solution-filling-coming-demand-home-care-providers/>.

---

## About PHI

PHI works to transform eldercare and disability services. We foster dignity, respect, and independence for all who receive care, and all who provide it. As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.

Drawing on 25 years of experience working side-by-side with direct care workers and their clients in cities, suburbs, and small towns across America, PHI offers all the tools necessary to create quality jobs and provide quality care. PHI's trainers, researchers, and policy experts work together to:

- Learn what works and what doesn't in meeting the needs of direct care workers and their clients, in a variety of long-term care settings;
- Implement best practices through hands-on coaching, training, and consulting, to help long-term care providers deliver high-quality care;
- Support policymakers and advocates in crafting evidence-based policies to advance quality care

For more information, visit us at [PHInational.org](http://PHInational.org) or [60caregiverissues.org](http://60caregiverissues.org)

© PHI 2017