JOINT SENATE PUBLIC HEARING

ON THE SUBJECT OF:

NURSING HOME, ASSISTED LIVING, AND HOMECARE WORKFORCE: CHALLENGES AND SOLUTIONS

JULY 27, 2021

Testimony of
Hospice and Palliative Care Association of New York State (HPCANYS)

Presented by:
JEANNE CHIRICO, PRESIDENT/ CEO

Hospice & Palliative Care Association of New York State
119 Washington Ave., Ste. 302
Albany, N.Y. 12210
(518) 446- 1483
HPCANYS.org

Thank you to Chair May, Chair Rivera, Chair Ramos, and members of the Committees for providing me with an opportunity to provide testimony at this public hearing regarding the challenges the hospice and palliative care workforce continues to face and the meaningful reform that will offer much-needed solutions.

My name is Jeanne Chirico and I am president and CEO of the Hospice and Palliative Care Association of New York State. Our Association represents the vast majority of hospice and palliative care providers throughout New York State who care for patients with a life-limiting illness through a holistic, team-oriented approach. Please note that on behalf of the association's members, we will be providing comprehensive written testimony to the Committees after the hearing.

Before assuming my current role as the President of the association, I worked for over twenty years in the healthcare arena, most recently as a Hospice Administrator. As a Licensed Home Care Service Agency ("LHCSA") administrator I held responsibility for overseeing hundreds of home health aides. I understand the Certified Home Health Agency position and regulations as I was responsible for meeting the needs of three hundred patients a day under a CHHA palliative care program.

The shortage of clinicians in home care and hospice is dire. However, today I want to stress the critical shortage of direct care personnel and their role in helping keep disabled and seriously ill New Yorkers at home. The interventions required to support this workforce requires its own consideration.

I am grateful that our New York State representatives desire to discuss what can be done at the state level. However, as you have heard today, addressing this issue will require a comprehensive solution. For example, earlier this month the New York State Department of Health produced their "Spending Plan for Implementation of American Rescue Plan Act of 2021," which addresses certain sectors of home and community based services but leaves a gaping hole in support to the direct care workers serving hospices and CHHAs.

It is important to note that the majority of those receiving hospice and home care services receive them under the Medicare benefit. There are over 60,000 New Yorkers who die every year on hospice under Medicare, and tens of thousands more individuals with serious and often life-limiting conditions receiving home care via their Medicare benefit. If the personal care and daily living needs of the individual on Medicare cannot be met while they live in the community, the consequence will most likely be an increase in the use of nursing home beds funded by Medicaid.

It would appear that an increase in wages would help incentivize new applicants. However, with all due respect for well-intended proposals, I believe that any proposal that solely looks at increasing the minimum wage for home health aides and personal care aides is not sustainable, nor is it the comprehensive approach needed to face this workforce crisis. All aspects of direct

care workforce need to be realized and understood if there is going to be a true increase in the pool of direct care workers. Without additional considerations, minimum wage increases alone may usher in unintended consequences.

Craig Richardson of Center for The Study for Economic Mobility (CSEM) at Winston-Salem University offers support for this position in his article, **"The minimum wage paradox."** According to PHI, 45% of the direct care workforce live below 200% of the federal poverty level and 47% rely on public assistance. The "paradox" and the CSEM Social Mobility calculator show that a boost in the minimum wage may barely change the lives of low-wage workers who are currently drawing social benefits such as food stamps (SNAP benefits) or child care, or housing assistance. The increased salary may push individuals over income thresholds and result in reduced benefits as well as increased taxes leaving little left of the salary boost.

Furthermore, New York State hospices and home care agencies would not be able to manage the significant compression factor that would occur as HHA's entering the field would be making as much as aides having worked a decade in the field. In order to raise the salary and maintain an experienced workforce, hundreds of thousands of dollars per year would have to be found and budgeted for by not-for-profit organizations that can least afford to. The way hospice and home care shifts are scheduled would require all aides to get this pay lift, not just those serving Medicaid patients.

As the administrator for a LHCSA, I oversaw the implementation of various staff benefits including full health insurance, additional bereavement days, personal days, life insurance, tuition assistance, and a paid training program in an effort to increase the number diminishing employees. Despite these workforce initiatives, month after month I would hear from frustrated human resource personnel that only three to six viable candidates would result from every two hundred applicants.

Once hired and trained, retention becomes the next hurdle. I could spend more time than I have allotted talking about the barriers to attaining and sustaining a healthy direct care workforce. It is due to the complexity of the multifaceted issues involved and the unintended consequences of well-intentioned proposals that I recommend the creation of the **New York State Community Health-Direct Care Workforce Center of Excellence**. It is now time to bring together all the community stakeholders to discuss and implement strategies utilizing collaboration, cooperation, and innovation across lines of payment streams and regulations. It is time for the state to consider additional interventions along with minimum wage increases, which have historically on their own had minimal effect on increasing the pool of available workers.

1. Center members would include a bringing together of organizations and individuals that can provide significant contributions to education, data, information, and stakeholder support. Members might include:
    - State DOH
    - OHIP

- PHI
- Center for Health Workforce Studies (CHWS) at SUNY Albany
- Office for the Aging
- Hospice and Palliative Care Association and other Associations representing home care, hospice, DD/ID
- 1199 and other applicable Unions
- Hospice and home care Providers
- Educational Representatives

2. After initial New York State funding, the Center would be required to secure and dispense innovative grants on behalf of Regional and Statewide initiatives to address:
   - Transportation
   - Career Paths across the health care sector
   - Social-Environmental Support Programs (i.e. childcare)

3. The Center would bring together Stakeholders in Regional Coalitions to determine the current workforce "deserts" with the most critical needs. Working together stakeholders will create short and long term goals and interventions to address these Direct Care Workforce issues. Members of the Regional Coalition's would include:
   - Local DSS
   - Local Public Health
   - Regional OFA
   - Providers
   - Educational Institutions
   - Interfaith Coalition Leaders
   - Associations

4. The Center would produce recommendations to DOH and other regulatory bodies for consideration of waivers and regulatory changes which might include:
   - Public Assistance reductions in the "countable Income", or an increase in income limits for essential workers to assure the employees continued eligibility in these programs and remove the regulatory barriers no longer in the best interest of the people being served.
   - Expand access points for criminal history record checks and expedite the clearance process. In difficult-to-serve areas, utilize current technologies to enable fingerprinting onsite or at mobile locations, thereby eliminating the need for a prospective employee to travel up to an hour to get fingerprinted.
   - Create consistency in the scope of practice across service lines (i.e. PCA, HHA, CDPAP, Provider, CNA.)

Only through a comprehensive long term multifaceted workforce development plan with a significant commitment of Medicaid and non-Medicaid dollars will New York begin to see a rise in the number of direct care workers. It is with this commitment that those being asked to give the most care can themselves receive the care needed to have their own health care social determinants of health needs addressed.

I thank you for the opportunity to provide these comments and I am happy to answer your questions.