COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
AGING AND OLDER ADULT SERVICES COMMITTEE

IN RE: PUBLIC HEARING ON DIRECT CARE WORKFORCE ISSUES

RYAN OFFICE BUILDING
ROOM 205
THIRD AND STATE STREETS
HARRISBURG, PENNSYLVANIA

WEDNESDAY, APRIL 2, 2008, 9:00 A.M.

BEFORE:
HONORABLE PHYLLIS MUNDY, CHAIRWOMAN
HONORABLE TIM HENNESSEY, CHAIRMAN
HONORABLE EUGENE DePASQUALE
HONORABLE DEBORAH KULA
HONORABLE EDDIE DAY PASHINSKI
HONORABLE KAREN BOBACK
HONORABLE JIM COX
HONORABLE RANDY VULAKOVICH

SUSAN O'HARA MOORE, RMR
NOTARY PUBLIC

I N D E X

CHAIRWOMAN MUNDY: Good morning, everyone. Thank you for being here. Welcome to the House Aging and Older Adult Services Committee public hearing on direct-care workforce issues. We're fortunate to have a group of testifiers representing various segments of the direct-care field as well as Dr. Robert Garraty, executive director of the Pennsylvania Workforce Investment Board.

I'd like to thank Mr. Joseph Angelelli, who is the gentleman over here taping this, for working with my staff to coordinate this hearing. He's with PHI Pennsylvania.

It's rare, I think, that we get to hear from the people who are actually in the field working with the people that we advocate for. So we wanted to take this opportunity to hear directly from those who are on the frontline caring for older Pennsylvanians.

So we very much appreciate all the help and cooperation that we've received from SEIU and from the various agencies who are represented here today.

I'd like to ask Representative Hennessey if he has any comments.

Chairman Hennessey.

CHAIRMAN HENNESSEY: Thank you, Madam Chair.

Good morning, everyone. It's, I think, important for us to take a bird's-eye view of the industry to see if we can learn of any problems that might be developing or might be on the horizon to see if we can head them off, to try to develop some sort of legislative solutions to those problems if they do indeed exist or might be developing.

We're not crazy enough to think we have legislative solutions for everything. Frankly, by the time we get some of our legislations through, some of the problems have resolved themselves already without our help.

It is, I think, a good idea as a committee to take a look at the industry to find out if there is anything we can do to be helpful, to prod you along, to point in a particular direction, or to change direction if we have to.

So thanks for being here. We're here to listen. You should know -- and I'll apologize for our cohorts on the committee -- there's a ton of different meetings this morning, and they've all sadly been scheduled for 9:00 or 9:30.

So a lot of our people had to choose between other meetings. Some are voting meetings that they really were required to be at.

So we might have some people dropping in occasionally during the course of the hearing this morning. Please understand it's not a lack of interest, and it's really not the early hour because 9:00 is not too early even for somebody like me.

CHAIRWOMAN MUNDY: Who was just complaining to me about having a meeting at 9:00.

CHAIRMAN HENNESSEY: I was complaining about having one yesterday at 9:00. Be that as it may, we're glad to have you here, and we want to listen attentively. And for those who can't make it, it's nice to have Mr. Angelelli up here to record these statements for posterity.

Thank you. Again, welcome here.

CHAIRWOMAN MUNDY: And just so that you know, we do have a stenographer here. There will be a transcript of the hearing on the internet, as required by our rules. And copies of the testimony will be available to members who would like a copy of it. So thank you all for bringing copies.

At this time I'd like to introduce the members who are here starting on my right.

REPRESENTATIVE KULA: Debra Kula, Fayette and Westmoreland Counties, District 52.

MR. QUINNAN: Chuck Quinnan, democratic

executive director for the committee.

CHAIRWOMAN MUNDY: I'm Representative Phyllis Mundy, chairman of the committee, from Luzerne County.

CHAIRMAN HENNESSEY: Tim Hennessey, chairman of the committee on the republican side from western Chester County.

MS. SCHWARTZ: Sharon Schwartz. I'm the republican committee director.

REPRESENTATIVE VULAKOVICH: I'm Representative Randy Vulakovich, 30th District, Allegheny County.

CHAIRWOMAN MUNDY: Thank you, Members, for coming this morning.

I think it's time to call up our first panel. At this time would Brenda Nachtway, Sandy LaCroix, and Josie Johnson please come forward and take seats.

I'm going to ask you each to introduce yourselves and just give us your affiliation if there is one. We'll start with you, my friend.

MS. NACHTWAY: Thank you. My name is Brenda Nachtway, nurse's aide from Evangelical Community Hospital hospice program.

MS. LACROIX: Sandy LaCroix, Golden Living Center, Scranton, SEIU Healthcare Pennsylvania.

CHAIRWOMAN MUNDY: I think you're going to have to use the microphones and make sure the green light is on on the front, And make sure it's nice and close to your mouth so we can hear you.

MS. JOHNSON: I'm Josie Johnson from the VNA of the Wyoming Valley Health Care System in Wilkes-Barre.

CHAIRWOMAN MUNDY: Thank you all for being here.

And we'll start with you, Ms. Nachtway.

MS. NACHTWAY: Good morning. My name is Brenda Nachtway. I have been a professional direct-care worker for 25 years and now serve as the co-chair of the 700-member -- and growing -- Pennsylvania direct-care workers Association.

Currently, I work as a nurse's aide with a hospital-based hospice in Lewisburg, where I have been employed for over 20 years.

I was a nurse's aide in a long-term care facility for six years before that. I have done private duty nurse's aide work on and off for the last 25 years. I now do private duty for two seniors after my full-time job Monday through Friday until 8 p.m. every evening.

I am thankful for this opportunity to be here to discuss why the health and well-being of

direct-care workers is so critical to the health and well-being of older Pennsylvanians and younger persons living with disabilities.

Direct-care workers provide an estimated 80 percent of the hands-on long-term care and professional assistance received by Pennsylvanians. We help consumers bathe, dress, and eat, among other daily tasks. We are a lifeline for consumers as well as families struggling to provide quality care.

Last year, thanks to the assistance of CARIE, I and another board member of our association visited with Senator Casey in his Washington office to speak about our concerns for direct-care workers in Pennsylvania and how their training and well-being affects our seniors.

Then, in June of 2007, Senator Casey spent a day with me visiting my clients and witnessing firsthand the importance of well-trained direct-care workers.

Senator Casey's interest in this topic from Washington is welcomed and appreciated, but long-term care is mostly a state and local issue. So we need local interest as well.

I want to take this opportunity to invite anyone on this committee to spend time with me on

any of my jobs to experience for yourself the challenges of this work and to gain your support for action to invest in Pennsylvanian's direct-care workforce.

I'd like to share a personal story with you, if I may. Thelma was raised on a farm during the depression with her own team of horses that she plowed the fields with. She had a milk cow that she milked for her mom and grandparents. She has experienced a lot of giving, pain, and hard times in her life.

Over the years Thelma would experience even more pain; two broken hips, broken arms, a fractured pelvis, breast cancer, and many other health issues. Each time she would call me to help rehabilitate her in my own home. This took place over 12 years.

On December 29th of 2006, I once again received a phone call from the emergency room to come and pick up Thelma. She had fallen and broken her shoulder.

Thelma is a frail, 87-year-old woman with dementia, who now lives with me permanently. Because of her failing health, she now is a hospice patient as well in my home. She receives wonderful care in my home by a group of dedicated direct-care

workers, all of whom are employed in long-term care facilities and are in need of additional work.

My concern about the care that Thelma would not receive in a nursing home is why we chose to make her home in my home.

The Pennsylvania direct-care workers association would like to see an investment in the right kind of training for direct-care workers, training that is relationship based, adult-learner centered, and focused on how to communicate with and respond to the individual needs of elders.

Pay and benefits are so very important to all direct-care workers. Most direct-care workers will say that they don't do this for the pay. We do it because we love our jobs. We love the seniors. We are caring and compassionate people, but we also need to be valued, respected, and, yes, paid what we are worth.

Many direct-care workers have second and third jobs because the pay is so low. We are just like everyone else. We have the American dream; to own and call something our own, to be able to send our children to college, to be able to take our child to the doctor, and not look at something and have to decide which item to give up to buy the

medication that we need for our child.

I am fortunate that my employer offers health insurance, but when two out of five direct-care workers don't have health insurance, how can we be expected to return day in and day out to care for those seniors that need us so much.

We are in a crisis point in Pennsylvania. We need to make this profession look and feel like the career that it is that others want to pursue.

How many Pennsylvanians are aware of the huge care gap that we are facing. The number of available caregivers is expected to decrease just as the number of elders begin to increase dramatically in the next few years.

We are in the red zone now. The time is to act and to invest in the direct-care workforce is now, not five or ten years in the future when it will be too late.

I'm sure each and everyone of you sitting in front of me today wants a well trained, well paid, well respected, healthy direct-care worker caring for you or your loved one in your final days of your life. This is what you all deserve. But it's not going to just happen because we wish for it.

We need to act, to invest in new training for direct-care workers that offers them an opportunity for a career lattice, and to work with our employers in home care, assisted living, and nursing homes to invest in direct-care workers, to reimburse those employers in such a way that they get rewarded for the right kind of training and workplace support for their direct-care workers.

In closing, I would like to thank all of you for your time and to say that I do this because I have a big heart. I care for the seniors, but I care just as much for my co-workers and those who are looking to come into this profession. We need your help to invest in the direct-care workforce, however that may be.

The Pennsylvania direct-care workers Association will be at your side helping you in any way that we can.

One final statement -- and this is the saying I live by every day, and I hope after today you will join me as well. The world needs dreamers and the world needs doers, but above all the world needs dreamers who do. Thank you.

CHAIRWOMAN MUNDY: Thank you.

Ms. LaCroix.

MS. LACROIX: Good morning, my name is Sandy LaCroix, and I'm a caregiver at Golden Living Center in Scranton. I'm a member of SEIU Healthcare Pennsylvania, the state's largest healthcare union.

I thank Representative Mundy and the Aging Committee for this opportunity to talk about the challenges that Pennsylvania's direct-care workers face. These challenges, I believe, must be addressed if we are ever to build a long-term care system that gives seniors the quality they deserve.

In long-term care, quality is not about high-tech equipment, fancy procedures or heroic interventions; it's about hands-on care. Caregivers bathe, dress, feed, transport, and befriend the residents. We notice and report changes in residents' physical and emotional conditions. We arrange and act as social contacts for our residents.

We compromise our own safety and health to be with our residents every day when family and friends cannot do the job. This is why the problems that workers face are the problems that seniors face and why it is in everyone's interest to address direct-care workforce issues.

Today, Pennsylvania does not have enough

caregivers to deliver what seniors need. In 2005 Pennsylvania's estimated shortage of direct-care workers was about 10,000. With the aging of the boomers, this so-called caregiver gap threatens to become a cataclysm.

The Pennsylvania Department of Labor and Industry projects an increase of 41,950 job openings for direct-care workers in the next decade, the decade in which the senior population will grow about 40 percent.

The state's traditional caregiving population -- woman between the ages of 25 and 54 -- is expected to shrink by 12 percent over the same timeframe.

In nursing homes, turnover rates are 50 to 75 percent, exceeding the vacancy rates, and showing that retention is a bigger problem than improvement. Turnover rates for nursing home health-care workers are even higher than the nursing homes.

High turnover rates reduce the continuity and stability of care, lead to miscommunication, result in patient safety problems, as well as worker injuries and poor morale.

Turnover also means that we spend far too much on recruitment and training. The cost of

nursing aide turnover in the U.S. is estimated at over $4 billion per year in the U.S. I'm sure we can think of a better way to spend our healthcare dollars.

Why do we have such a big problem, and what can we do? My own experience confirms what researchers show: Pennsylvania's inability to create top-notch long-term care workforce comes down to a few basic, even obvious, causes.

At the root of the problem: Poor wages and benefits, inadequate and inconsistent training, high injury rates, and a difficulty of making a career in long-term care, and, finally, the discouragement we feel when employers and legislators make it plain that our work is not respected, our jobs are not respected.

Jesse Jackson, a resident I took care of for years -- I dressed her, I bathed her, I fed her when she could no longer do that for herself. When she got very sick and was dying, I and another co-worker stayed with her. We held her hand, we rubbed her arms. We told her we weren't going to leave her alone. There were no family members, no friends, we were her family. We stayed with her until she passed. We wouldn't have left her.

I thought Jesse came into this world loved and with family and she passed the same. We bathed her and put a clean gown on her. We came out of the room and someone had said to us, "I hope you have time to finish your assignment." I looked at the clock. We were only in Jesse's room 20 minutes. Somebody thought that was too much time.

Personal care workers make about $8.25 an hour. They have no health insurance, no pension, no sick days. If they get sick, no pay; their clients won't be seen. So they show up anyway. Wages in nursing homes are a little bit better, but by no means adequate.

Direct-care workers know perfectly well that the training we are given is inadequate, inconsistent, and sometimes skipped altogether. We know when we are thrust into situations that we have no preparation for and told by management to wing it, or when we compare notes with other workers trained somewhere else and discover our standards are very different and contradictory.

Inadequate training has a dramatic impact on our ability to retain direct-care workers. Many new employees find their work so challenging and bewildering that they don't even make the probation

period. Seasoned staff rarely have time to shadow or coach new workers by treating peer mentoring as extra duty.

We believe that it is the responsibility of the Commonwealth to ensure that workers are adequately prepared to do the job. We can do better. My union has partnered with Golden Living to create Pennsylvanians United for Quality Care, PUQC, an education center for all Golden Living's direct-care workers.

By consolidating our training, we were able to free up resources and invest in giving front-line workers what they need, including peer-to-peer mentoring and support.

Such concentration has really paid off. In 2005, the first year of the partnership, turnover at the company was 72 percent.

By 2006, participating facilities had reduced overall turnover to 52 percent. And last year, turnover among these facilities was only 40 percent.

But, more impressive is the drop in turnover among students of PUQC courses. In 2006, turnover among direct caregivers who attended the trainings was cut to 13 percent compared to 21

percent companywide.

By 2007, only ten percent of the caregivers who did the training left Golden Living, compared to 52 percent companywide.

We believe that the state should learn from our experience and move in similar directions. The Commonwealth should establish a credentialing body to determine standards and create appropriate credentials for direct-care workers.

More direct-care work training should be conducted peer-to-peer. Pennsylvania should consolidate training sites and staff them with dedicated teachers and mentors whose job it is to prepare workers well.

It cannot be argued that direct-care workers are paid poorly and treated poorly because their jobs are unskilled or carry little responsibility and risk.

The truth is that long-term care workers have dangerous, poorly paid jobs because our system has the wrong priorities and because workers and consumers have too little voice in setting those priorities.

As the need for care expands, the Commonwealth, providers, and direct-care workers

will all need to make additional investments in improving job quality, not in just compensation but training and career opportunities and respect for workers' rights.

Last year Pennsylvania spent $1.7 trillion on long-term care. About 65 percent of patient care days in nursing homes are paid for by Medicaid, another ten percent by Medicare.

The portion of public finance in home care is similarly great. Taxpayers and voters finance this system, and through our courageous government we have the ability to create the system that we need and deserve. Thank you.

CHAIRWOMAN MUNDY: Thank you.

Miss Johnson?

MS. JOHNSON: Good morning, ladies and gentlemen, and thank you for allowing me to speak before you today.

My name is Josie Johnson. I work as a health care professional. I have worked as a health care professional for over 30 years. I am employed by the Wyoming Valley Health Care System.

When I took my first hospice case with the VNA, I thought I had seen everything, but it was merely the tip of the iceberg.

Going into homes to assist our elderly with everyday living and personal care was, in the beginning, very overwhelming to me. I have been asked to count briefs and place a pad inside them in hopes to get them through another shift and probably get them through until the next day.

I have been asked to turn the thermostat down for the night to try to save on the heat bill because she couldn't afford to go over the reimbursement provided. When, in reality, you know in your mind she was lying there counting the hours until you returned; only to return in the morning to raise the thermostat, to provide her with a warm towel, and wait until she was warm enough to give her her bath.

Food shopping. This really hit me when I had been given a list of on-sale frozen dinners, a box of Mother's Oats, and a carton of milk in hopes that it would get her until the next check day because of her cost of medications had exceeded her budget for the month, but yet she was still left with enough pride to try to give a dollar to the delivery man at the door.

Do you know what it is to prepare one cup of Mother's Oats, knowing your client is going to

divide it into three and try to get three breakfasts out of it?

I find myself giving more than all of me in hopes of being able to go home and say, yes, another job well done. Sometimes I just can't. I go home, and I tell myself, you have done everything you can for them.

They are in a position where they will not ask nor will they tell because of the fear of long-care facilities. If they fall, you can bet it will take everything you have and then some to get them to a hospital to be checked. Why? Because in their mind that would be it. You'll never let them go home.

There is no experience more devastating than placing an 85-year-old in a room with someone that does not have all their faculties. It's not familiar to them, nor is it something that they want to see. They want pride. They want dignity.

Our elders have experienced war, flood, depression, but nothing comes close to what they experience today. Our economy makes it harder and harder for our elders to get through each day.

We forget one factor. And that is we are where we are today because of their hard work, their

ambition, and their dedication in every project they have achieved in their younger days. And a lot of those projects contribute to the ailments they struggle with today.

Born and raised a Roman Catholic, I have been taught to never question, but yet I still find myself asking why. Why must they live like this day after day?

I would like to ask each of you, upon your departure today, put yourself in their shoes or those of a loved one and write a list of wants, needs, and goals. Then sit down and really ask yourself, can I fulfill this list to its fullest each and every day, or will I have to scratch off the extras, as my patients do every day.

As I leave you today, my hopes, my wants, my goals, none of which are of great expense, are just to have your support in entirety to help our elders get through the day without struggle, without fear, without depriving themselves in any way; providing them with a sense of pride in just knowing they will not be forced to leave their home before their dying day.

Thank you all for your time and concerns, and may you have a great day.

CHAIRWOMAN MUNDY: Thank you. Good job.

Are there questions from the panel members?

I should announce that we've been joined by Representative Eugene DePasquale from York County, Representative Bill Keller from Philadelphia County, Representative Jim Cox from Berks County.

If no one else has questions, I have questions and comments. Tim will, too.

First of all, thank you all so much for your very personal testimony. It's clear that you care very much about the work that you do and the people that you serve. And I can assure you that we, too, care very deeply for the people that you serve and for you as professionals.

I would be remiss if I didn't talk for a minute about budget. We can't raise taxes in Pennsylvania. We don't have the votes to do it even if we wanted to.

Every year federal cuts in Medicaid put additional pressures on our state budget. And I really do fear in the coming months additional budget pressures as a result of this recession.

So what we do here is very much dependent on the state budget, what kinds of new programs we institute, what kinds of additional money we provide

for both in-home community-based service to people in personal care homes or in their own homes as well as in nursing homes. And that is a problem that we face each and every year, and I don't see that changing any time soon.

So to the extent that people want less government and lower taxes, both the people you serve and you yourselves as professionals are impacted.

So that's why I think it's important to have meetings like this to discuss what the needs are, and maybe people's attitudes will change when they realize that less government means you get less services when you need them. And certainly the people that you care for need them, and you yourselves need them. So, you know, I just wanted to make that comment about budget and the pressures that we face every year during budget season.

My mother was in a nursing home in Florida for four years. And it was very painful to watch her quality of life deteriorate. The only bright spot was the wonderful people who cared for her. Obviously, I couldn't be there except, you know, a week or two I would go visit her every day when I would go visit my father. But just to know that

people truly cared for her -- and when she died last September, all of the workers in the nursing home who had cared for her came in to say good-bye. That's how much they cared and cared for her as though she were part of their own family.

So I have tremendous respect for the work that you do. I don't think I could do it, honestly.

One thing that really struck me with my mother and would strike me even more if she had been at home relying on a personal-care or a home-health agency was the kind of -- changing her diaper. How personal can you get. And when you have the same person coming in day after day that you have a relationship with, it's a little more dignified than when you have a string of people, turnover, person after person coming in to provide that service. I can't imagine how traumatic that would be for an individual who needs those services to not know the person who's going to come in to bathe you and change your diaper.

It just really struck me that we need to do better with the issue of direct-care workers and retention and training. Let's face it. Training is a big part of that, and you want to do that kind of work in the most dignified way for the patient.

I was also struck by the testimony, and actually it's at the end of -- I think it's Ms. Nachtway's testimony. At the end there is a chart. Nine out of ten direct-care workers are women. Do you think maybe that's why we're not paid very well? Sometimes I wonder. I'm not going to make a judgment at this point, but sometimes I wonder.

And the issue with health care, how ironic that people who work in health care don't have health care -- health insurance. And honestly, I mean, it's no secret to anyone that I prefer a national single-payer system, which I believe would alleviate a lot of the strain on both the cost of health care and the fact that some people have it and some don't.

You know, I just -- relying on an employer-based health care system in this day and age just isn't working. It just is not working, and you are living testimony to that fact. It just is not working. We need to do something, something better.

I have a question -- and anyone of the three of you can answer it -- having to do with training. What is the current status?

Now, Ms. LaCroix, you work -- you are a

member of SEIU, and you referred directly to the kinds of training that they were doing in Golden Living. Was that the name of the -- is that a facility, Golden Living?

MS. LACROIX: Where I work? Yes.

CHAIRWOMAN MUNDY: So SEIU -- who provided that training?

MS. LACROIX: SEIU got together with Golden Living centers to provide the training facilities that they could train CNAs.

CHAIRWOMAN MUNDY: So you are trained as a CNA. Is everyone at Golden Living a direct-care worker trained at least at that level?

MS. LACROIX: Yes.

CHAIRWOMAN MUNDY: Okay. So you get that training and that background before you go into the facility. And then what kind of training was offered through this program that you referenced?

MS. LACROIX: We haven't started in our area yet, but I think it's Pittsburgh. They have training areas that they had set up. We don't have one around here yet, but that's what we're working on.

But I think also, too, that along with the training, when they see what kind of situations

they're going to face and what kind of work it is and what you have to do for good patient care -- you also have to realize, too, that sometimes people come in, they're hired, and their patient load is so big.

You know, if you're asked to take care of 10 to 12 residents a day, that's a lot of residents a day. How much quality care can you give each of those residents when you don't have time to really sit down and talk to them and do extra things? You know, you're trying to get done.

I think whatever the ratio is, that whoever makes those decisions on how many aides per resident should really look at what kind of care is given when you give such a heavy workload.

And I think new workers that come in get so overwhelmed that they have so many residents to take care of. They want to do a good job. It's just too big of a job.

CHAIRWOMAN MUNDY: You're saying the training was prior to being employed or sort of an internship kind of thing where you come in to see what the job is like first?

MS. LACROIX: You have your CNA training to be a CNA, and they're setting up these workshops. And

then those CNAs will actually go from their facility to go to these trainings instead of going to work that day. They will be going there to have extra training.

CHAIRWOMAN MUNDY: I see. Okay. So just -- Ms. Nachtway, in your experience at the Evangelical Community Hospital in Lewisburg, what kinds of training do your staff members get?

MS. NACHTWAY: I think I need to start back 26 years ago when I first started this profession going into a nursing home. I had no experience whatsoever. They trained you on the job. There were no official classes.

And then as I went on to Evangelical Hospice, there, again, was no official training other than we had to have 20 hours of inservice computer work, and I had three days of training on the job, and I am not a CNA.

CHAIRWOMAN MUNDY: Okay.

And, Ms. Johnson, what was your training like?

MS. JOHNSON: Well, I chose on my own to go and get my certification. But presently with the VNA in Wilkes-Barre, you do not need certification to work in personal care.

What you need to do is most of our girls have experience in transporting, ambulating, giving baths. You must come in with experience.

A lot of our girls are single moms, and they're trying to juggle schedules and juggle jobs. As the girls said, they do call off a lot. And trying to juggle schedules, they find it hard that we're given a task and when we give a one-hour service, in that one-hour service we have to go in; we have to give a bath; we have to make their bed; we have to be sure they have breakfast; we have to clean the bathtub out after we've given them a bath; and, if we have time, run the vacuum. And that's in a one-hour service.

CHAIRWOMAN MUNDY: Okay. So am I understanding correctly that people just need experience? They need no credentials whatsoever?

MS. JOHNSON: Not for personal care.

CHAIRWOMAN MUNDY: No official type of training at all to work?

MS. JOHNSON: Not for the personal care side of it. For the home health side of it you do need to have your certification. But for the personal care side of it, just to go in and vacuum for them and give them a bath or give them breakfast or prepare a

meal, no, you do not have to have a certification.

Unfortunately, we're dwindling down. We're getting less and less workers, and the workers we are getting are not reliable.

CHAIRWOMAN MUNDY: Can I ask you about -- Ms. Johnson and I had a -- I should tell you we had a conversation in my district office, which is how she got here. And you had mentioned that you were forced to dig into your own pocket to pay for gas to get back and forth because of the high gas. You're not getting reimbursed at the rate that you should be for gas.

MS. JOHNSON: Well, we get reimbursed 42 cents a mile. After I finished my income tax this year, what I was paid and what I spent -- I was $200 short from what I actually spent in my own gas mileage. So, no, we're not anywhere near reimbursed to what we spend as far as gas milage.

We also find ourselves giving more than our requirements require. There are a couple homes -- we feel so sorry for the people because they're struggling with their budgets for food, and we're bringing leftovers and taking little baked goods just to give them little treats to get them to the end of the month.

CHAIRWOMAN MUNDY: Representative Hennessey.

CHAIRMAN HENNESSEY: Thank you, Phyllis.

Sandy, I think you had mentioned the nursing shortage and the caregiver gap.

I remember when I was in high school, which is a generation ago or even longer perhaps, nursing was a very popular profession; at least that was my recollection of it.

But today we hear time and time again that despite whatever the state might do to try to interest people to getting into the nursing profession that the numbers are dwindling.

It would seem to me that supply and demand in that kind of situation would answer some of the problems you're describing to us, and yet it doesn't seem to have done that.

I'm wondering if you can tell us, you know, in your view why aren't people going into the nursing profession, especially out of college -- or high school or college and getting an early start in it?

I mean, we have a shortage, I guess, throughout the entire spectrum, the age spectrum. So what's causing that in your own minds and what can we do to change any of that?

MS. LACROIX: Are you talking about nurses or nurse's aides?

CHAIRMAN HENNESSEY: We have shortages of nurse's aides as well nurses, I believe.

MS. LACROIX: I think with the nurses it's the same -- similar. The workload is heavy, the pay, the benefits. I think you go in thinking -- I know when I went into it, I just thought it was -- being a nurse's aide was great.

I remember back -- and that was years ago -- the workload was lighter. It just seems now the workload is so heavy that if you're not -- if you haven't been a CNA for years and just kind of gradually got used to it, it's like when somebody tells you to do one job and a week later you're doing three jobs. You know, pile it on.

When new people come, young people from high school and stuff, I don't -- I think they go in thinking this is very good. But once they get there and they find out how heavy the workload is, what you actually have to do, what the residents' care is, it's overwhelming. And a lot of them we have in our nursing home do not last the probation period. And I think it's the same for nurses. We have a lot of nurses that don't last the probation period

either.

CHAIRMAN HENNESSEY: Because of the attitude that the work is too hard or they don't get --

MS. LACROIX: The workload is very heavy. You're not very respected. It's just like I told you when I was in with the resident, 20 minutes isn't a long time. Someone should have never even said that. That's part of my job. It's a -- it's what I should be allowed to do with no questions asked.

Not that if I was going to -- there are people in this building. They're not boxes. You just can't leave them and come back to them tomorrow. You have to care for them. And I think people -- our employers are looking at -- as not being people, as just getting done. There's a lot to just getting done.

CHAIRWOMAN MUNDY: Can I follow up on that question just for a minute?

Do you think maybe -- you know, going back to the fact that, if this statistic is accurate, nine out of ten direct-care workers are women. Women today have numerous job opportunities open to them, and many of them pay a lot better than what you direct-care workers are getting.

Why would you go into -- and I see my friend from NASW back there. Why would you go into a low-paying job that is so demanding and that is so emotionally wrenching which, let's face it, it's --

MS. LACROIX: Because it's very gratifying.

CHAIRWOMAN MUNDY: For some people.

MS. LACROIX: Very gratifying.

CHAIRWOMAN MUNDY: But, again, it's a hard job, and it's not very well paid. So, I guess my point is, you know, women have a lot -- women are most of the workforce. Women have a lot of other job opportunities.

Do you think maybe that in order to maintain a quality workforce, you're going to have to beef up the remuneration, the benefits, you know, fix the working conditions? Otherwise you're going to have very few people.

MS. LACROIX: And you have low morale when it's like that.

CHAIRWOMAN MUNDY: Exactly.

MS. LACROIX: When you're appreciated, you can see when morale goes up and down.

CHAIRWOMAN MUNDY: So, I mean, you know, from my perspective when I see young women coming out of high school and college, they have a lot of job

opportunities. You have to be a special kind of a person to even want to do this kind of work, and then to overcome the low pay and the tremendous working conditions and the difficulties of them, I would think it would have to be really trying.

MS. JOHNSON: Before I took this job I had been a certified pharmacy technician, and I was a pharmacy technician for three years retail and 23 years hospital. And I decided to try mail-order pharmacy because we had a new firm come in, and they said this is the job for the lifetime.

I gave up those 23 years to try out mail-order pharmacy. I was there four years. And that job was so demanding and so stressful that it began to affect my health. And it came to the point of do I want to do this for the rest of my life, or do I want to do something else.

We were having management struggles. We were having -- the higher you got your production, the higher they raised it. And it was more or less getting to be like you were in a shoe factory. So the more you did, the more they wanted.

So there was management struggles; there were lead struggles. And one day I just said I can't do this anymore. I walked out. I went down

to Career Links, and I said, "What are my options?" He said, "We can send you to nursing school."

Nursing school in our area is 15 months to go to the Wilkes-Barre vo-tech. To go to the vo-tech and work is impossible because the course is so hard. You can't work and go to school at the same time. It's too demanding.

So my option was to get my certification, work as a personal caregiver and to take evening classes to become a nurse. That was my option.

As you say, it is a low-paid job. I have no benefits. I get $9.40 an hour because I chose not to take benefits. If I take benefits, if I'm part-time with benefits, they'll pay me $8.40 an hour. So I work two jobs. I work part-time with VNA because to get a full-time status job is impossible. The waiting list is astronomical because there are so many girls before me. So I work two jobs, and I take evening classes to become a nurse.

In my experience, being in a hospital environment, the nurses are not respected. They're overworked. They're not appreciated. And it's gotten worse instead of getting better.

When I returned to the Wyoming Valley

Health Care system I returned not knowing anyone, and I spent 23 years there. The turnover was astronomical.

CHAIRWOMAN MUNDY: And yet you said -- was there a waiting list?

MS. JOHNSON: There are a lot of girls that are ahead of me. I believe there are five girls ahead of me right now waiting for full-time positions. There were only so many full-time positions that they will give out with benefits.

CHAIRWOMAN MUNDY: Okay. I get it. So everybody is part-time.

MS. JOHNSON: Exactly.

CHAIRWOMAN MUNDY: With no benefits.

MS. JOHNSON: And they work the crap out of you, putting it lightly, but that's exactly what happens.

MS. SCHWARTZ: Sandy, I just want to follow up on your comment, just a personal experience.

My son had to do hours of observing in order to get into a physical therapy program. And he had a choice of the settings to go to, and I made him do 30 hours in a Manor Care -- in a nursing home setting.

And he came home after the first day, and he said, "Mom," he said, "I can't believe the jobs

those people do."

And I said, "Well, is that something that you think you would be interested in?" He said, "You know," he said, "it's so stressful." He said, "It just amazes me." He said, "You're right." He said, "But I think if more people my age would be aware of the value of what they do." And I said, "Well, maybe what we need to do is start at that generation level."

And Vicky Hoke is sitting back there. She and I have talked about this for years. When they have job fairs at high schools, I never see anybody there representing human services; child care, home health, nursing. There's never anyone there.

And I think that maybe a lot of kids who have -- especially if they have relationships with grandparents, with elderly people and they have an appreciation for the needs that they have, I think if they became more familiar with what's out there and what the opportunities are, maybe there would be, you know, some attractiveness to it.

I just think a lot of kids are really shying away from it because they really don't have an understanding of what the need is. And this new generation of kids I think really have that desire

to give back. I really do.

So it's just a thought because I -- personally I've seen it, and I think that there is the opportunity out there. Because I think this generation, us, it's lost. But you're going to have to go back to the kids that are in high school, the kids that are going into the workforce eventually and thinking of choices, of careers, and maybe start to work at that level and try to give them opportunities.

MS. JOHNSON: The only thing that would concern me is, you know, when you're going into someone's home, the first challenge is gaining their trust. I think by sending someone in there that's in their early 20s versus someone that's in their 40s -- I don't know if an 85-year-old woman will trust that 20-year-old versus that 40-year-old to give them a bath. She'll probably trust them to run the vacuum, to give her breakfast, to make her lunch, or to make her bed. But I don't know that you'll get an 85-year-old to trust her to put her in the bathtub and get her back out without her falling.

CHAIRWOMAN MUNDY: Thank you.

We've been joined by Representative Karen Boback from Luzerne County.

I think we're going to have to move on to our next panel to stay on topic and on track with our time here.

Thank you all very much for being here today and for sharing your stories with us. I guess we're sharing a few of our stories, too.

The next panel is Terri McClinton, Linda Bettinazzi, and Robert Garraty. I'm going to ask you to introduce yourself once again for the stenographer and tell us your affiliation.

MS. KULP: My name is Karen Kulp. I'm president of Home Care Associates in Philadelphia. I'm here today actually to introduce Terri McClinton, who is one of our senior peer mentors and has been an aide I guess for 14 years and is on our board of directors.

We are a little bit of a different model for home care in that we are a worker-owned company. And as an employer we feel very strongly in training and also benefits. So Terri is going to talk a little bit about that.

CHAIRWOMAN MUNDY: It's nice to see you again.

MS. KULP: You, too. You, too, Representative Mundy.

CHAIRWOMAN MUNDY: It's been a while.

MS. KULP: Yes, it has.

CHAIRWOMAN MUNDY: Well, now I know where you are.

MS. KULP: That's where I am.

CHAIRWOMAN MUNDY: Great.

Would you like to introduce yourself, Ms. McClinton?

MS. MCCLINTON: Yes. My name is Terri McClinton. I'm from Home Care Associates and, as Karen said, I've been here for like 14 years. Started out as a home health aide and now I'm a senior mentor. I'm support for the home health aides out there, too.

CHAIRWOMAN MUNDY: Okay. Thank you.

MS. BETTINAZZI: Good morning. My name is Linda Bettinazzi. I'm CEO of the Visiting Nurse Association and the VNA Extended HomeCare of Indiana County.

CHAIRWOMAN MUNDY: Before you go on, let's finish the introductions.

MS. BETTINAZZI: Oh, I apologize.

CHAIRWOMAN MUNDY: Okay.

DR. GARRATY: I'm Bob Garraty, and I'm the executive director of the Pennsylvania Workforce Investment Board.

CHAIRWOMAN MUNDY: Thank you all for being here. I think we'll start with Ms. McClinton's testimony.

MS. MCCLINTON: My position is being a senior mentor. As had been said, a lot of young folks don't like to get into this job as being a home health aide. Or the ones that we do have out there don't stay with us either because of the pay or they're scared, they're not sure of themselves, of being out there with somebody who's elderly due to the fact of the training they did.

And my job is to go out there and to help them be secure, even with the patients that they're taking care of. Like someone mentioned that they look too young and the patient don't want the pain pills 'cause they're not. Where my job will come in, and I will secure both of them. You know, give her a chance. I'm going to be right here with the both of y'all, and it's going to work. But we need more of us. There's not that many mentors out there. We have a wonderful training.

CHAIRWOMAN MUNDY: That sounds like a really interesting model. We need to hear more about that.

MS. MCCLINTON: Our training -- well, everyone goes out, and we get people to come into our company. We tell them how great our company is

because it's like a family thing, which it is, and they come in, they in there for four weeks. They get training from hospice to just everyday living or companionship with one another. And then they graduate, and then they go out into the field.

And me, myself and others like me, we go out and help support them and get them over the edge of the first-time meeting with a client or someone for the first time. And we try to educate them about our program, that it's a worker-owned program.

You know, after your probation is over with, it's something you can invest in for the future, because the young folks -- they want money. They want money. $5 and $6 ain't going to get it. To go to a job fair -- because we are at job fairs. But when I tell them that the job only pays $6 dollars an hour -- no, not when somebody's sitting right there that's going to get them $20 an hour. No, they're not going to come to this.

So with our company, you know, it gives them the sense of knowing what it is to own something, to be a part of how to run something other than just working for that dollar, you know. That's pretty much about what we do.

CHAIRWOMAN MUNDY: Okay. Thank you.

Ms. Bettinazzi.

MS. BETTINAZZI: The mission of the Visiting Nurse Association is to serve the people of Indiana and surrounding areas by providing compassionate, high quality, cost-effective home care and other related health services.

Currently we have 115 full-time and 66 part-time positions. Full-time status guarantees the employee a minimum of 35 hours per workweek, as well as health insurance benefits, sick and vacation leave, as well as 401(k).

We provide care and services to over 4,000 Pennsylvanians each year, consisting of about 88,000 home visits and traveling over 500,000 miles to bring care to individuals in their own homes.

In 2007, the VNA was rated among the top 50 places to work by the Pittsburgh Post-Gazette. We believe our product is our people.

High turnover rates among direct-care workers are too often regarded as simply a cost of doing business in long-term care. But we have seen firsthand how investing in direct-care workers improves both the health and well-being of those we care for as well as the health and well-being of our workers themselves.

As a result of pioneering many new recruitment and retention initiatives, VNA Extended Home Care was also honored in 2006 by the Greater Pittsburgh Human Resource Council as a rising star.

I have come here today to urge this committee to consider new policy options for investing in our direct-care workforce so that much needed and valued care will always be available to older and disabled Pennsylvanians so that they can live as independently as possible.

But I'm also here to sound an alarm that unless there is sufficient state reimbursement for direct in-home care, home care agencies such as the VNA will not be able to continue to provide the training and other valuable employee benefits that we enjoy today.

For the past several years we have participated in a variety of promising return-on-investment initiatives focused on recruitment and retention of qualified, motivated direct-care staff.

Our agency and others like us have learned a great deal from these efforts, and I hope the state will act now to replicate some of them throughout the long-term living system and create

more opportunities for providers to invest in our direct-care workforce.

Devising and implementing a direct-care worker investment strategy has involved our agency drawing on a patchwork of different resources. We have received nearly $50,000 in funding from the local Area Agency on Aging through their direct-care worker initiative over the last seven years. These dollars have been used for various training initiatives.

In 2002, VNA Extended Care played a leadership role in creating the Indiana County Health Care Career Consortium, which is a regional alliance of 22 stakeholders focused on leveraging our individual resources to promote healthcare careers in Indiana County.

Our consortium, just for your information, consists of nursing homes, hospital, home health, aging services, long-term living, educators, and our workforce investment board.

The consortium has been a driving force in championing direct-care worker issues and finding real-life solutions to local issues.

In recent years this consortium has participated in forward-looking training grants

administered through the Tri-County Workforce Investment Board to help local providers initiate and sustain programs focused on communication and problem solving for direct-care workers.

Participation in these collaborative initiatives has helped our agency and all of the other participants to create and maintain a culture of retention among direct-care workers. We have proven that collaboration does work.

Our agency was also involved in the Better Jobs Better Care project, along with our state trade association, the Pennsylvania HomeCare Association.

This foundation-funded demonstration, administered by the Center for Advocacy for the Rights and Interests of the Elderly, provided our consortium with more than $120,000 over three years to infuse creative methods for improving retention rates and establishing a culture of respect and dignity.

One comment that I would like to add that you don't have in your written testimony is that the ability to leverage the foundation money along with our state-funded WIB money has produced much greater benefits than trying to use one or the other. I think we're looking at ways of doing some

public/private partnerships that have really been beneficial.

Today, as a result of these initiatives, which are costly but absolutely worth our investment, our turnover rates are lower, our direct-care workers' morale is higher, and we have a much more qualified staff. Breaking it down further, here is what we have done.

Our direct-care workers' salaries have been increased three percent each year, as well as giving a one to two percent annual bonus. This is over the last six years.

Our full-time employees also receive health care benefits with no employee contribution, plus six and vacation leave.

On top of that, our agency pays at the IRS rate for travel, which is currently 50.5 cents a mile. Last year our entire agency's staff drove over 500,000 miles, costs will approach $400,000 in our current fiscal year.

This year our health insurance premiums increased eight percent as well as our workers' compensation. Everything about our employee benefit package has increased. However, our third-party reimbursement, such as our Medicaid Aging waiver,

has remained stagnant or decreased.

For the past six years our agency has committed to doing all we can to have a highly trained competent workforce. We implemented a peer mentoring program, held sessions on communication, especially between frontline workers and supervisors. Some of our aides are now certified in hospice and palliative care.

Research has shown that direct-care workers do not leave their jobs; they leave their supervisors. So we are now participating in another grant-funded project to implement a coaching supervision with our nurse supervisors and field staff.

We have even initiated a peer-to-peer training within the VNA extended care where two of our direct-care workers have worked with two of our skilled nursing facilities to provide teaching among their peers.

All of these strategies have worked. The VNA's turnover rate has declined from 54 percent to 11 percent in four years. However, for all of our recent success, the future outlook is very troubling.

The average age of our frontline worker is

46. Ten of our most seasoned employees are currently above 60 years of age. Retention has been excellent, but recruitment of new hires is becoming increasingly challenging.

What is to be done? I'm sure I don't need to tell any of you that there are no simple answers. However, one thing is very clear to me. Our organization has followed the complete equation for what researchers and experts tell us will be successful in retaining workers. We have increased salaries; we have improved benefits; we have adopted a culture of mutual respect; we have committed to an aggressive training program. And guess what? It does work. But, without additional resources, our organization will have to roll back the clock.

There is now a proposal to adopt a standardized training for direct-care workers. Again, the home care industry absolutely agrees. However, without a recognition that this type of health care -- in-home care -- is deserving of a raise just like other healthcare providers have received for years, we will not be able to sustain these added costs.

The broad recommendations outlined in the report of the direct-care workforce Group are a good

place to start. The report calls for the state to create a comprehensive system of training and credentialing for direct-care workers, one that exists both within and outside the workforce development system and rewards employer-based training initiatives.

However, I once again urge these recommendations address the economic realities faced by all healthcare providers. Investing in direct-care workers is both a health care priority as well as a workforce development priority.

Home is where people want to be, and it is the most cost effective. If Pennsylvania believes that every person has the right to be cared for in the least restricted environment, such as my home, then we must invest in the workforce that's going to enable a person to do that.

The VNA has done that. But wouldn't it be a tragedy if I am forced to go back in time to a model where all employees are part-time minimum wage with no benefits? That model did not work then. It doesn't work now. It doesn't work for employees, and it certainly does not work for consumers.

I look forward to continuing to work with you and other stakeholders to develop a true

training program that enhances our ability to provide high quality care, while recognizing the financial commitment that must support such efforts.

When analyzing return on investments, a much broader view needs to be taken, a view which incorporates the cost of investing in our workforce versus the cost to all of us if we do not.

Thank you for this opportunity.

CHAIRWOMAN MUNDY: Mr. Garraty.

DR. GARRATY: Thank you.

The Pennsylvania Workforce Investment Board is the Governor's principal private sector policy advisor on building a strong workforce development system that is aligned with state education policies and economic development goals.

All of its members are appointed by the Governor and represent a diverse cross-section of business executives, labor officials, education leaders, economic development practitioners, and local elected officials.

In addition, the cabinet secretaries of five state agencies as well as four members of the legislature serve on the board. The chairman is Mr. David Malone, the principal and CFO of Gateway Financial Group.

The board's mission is to ensure that Pennsylvania's entire workforce system, covering many programs in multiple departments and agencies, meets employers' needs for skilled workers and workers' needs for career and economic advancement.

In addition, the board is responsible for providing policy guidance and direction, evaluating performance and recommending continuous improvements.

In 2004, the Pennsylvania Center for Health Careers, a public/private initiative, was put together by Governor Rendell, led by a leadership council of more than 25 employers, Commonwealth agencies, industry associations, labor unions, professional associations, and educational institutions.

Since its inception the center has become a catalyst for developing an action agenda in response to Pennsylvania's health care workforce challenges. The center, which is housed within the Pennsylvania Workforce Investment Board, serves as an organizational catalyst to develop an action agenda to address critical workforce shortages in health care, promote the best human resource practices in the industry that improve retention and career

advancement, and provide policy options to state government.

Addressing the nursing shortage was the Center's first initiative, which resulted in key strategies to increase nursing educational capacity, increase completion rates of nursing students, and recruit and retain non-traditional nursing students, including men and minorities.

And let me just add, because there was some previous discussion about this, since 2003, the number of RN graduates has increased dramatically from 2,939 graduates to an estimated 5,937 during 2006. There's a lot of reasons for that; not because of the work we were doing. Additionally, the number of LPN graduates has increased significantly from 1,236 to an estimated 2,017 during 2006.

So I wanted you to know that, you know, some positive things are going on, but there's additional problems down the road, which we can address.

In 2005 the Center directed a direct-care workforce workgroup to focus on how to best improve the recruitment and retention of direct-care workers in the long-term living system.

The workgroup consisted of providers, labor representatives, consumers, and other advocates. Its goal is to articulate the primary issues facing the direct-care workforce, research possible solutions, and make recommendations for action.

Pennsylvania's direct-care workforce includes more than 130,000 women and men, mostly women, who provide daily, hands-on support to elderly and younger consumers with physical or developmental disabilities.

These direct-care workers go by many names; nursing assistants, home health aides, home care workers, personal care aides and attendants, and direct support professionals. These occupational designations vary according to levels of training, the setting in which the direct-care workers are employed, as well as the community of consumers they serve.

Projections are that by the year 2014, Pennsylvania will need an additional 24,610 direct-care workers -- or a 19 percent increase from 2004 -- or a rate of growth nearly three times the state average for all occupations.

While regulatory and training requirements for direct-care workers vary, all these professional

caregivers operate at the vital point where the long-term living system touches the individual consumer, and thus where the essential caregiving relationship between the consumer and the paid caregiver is formed.

In 2007, the Center For Health Careers and the Governor's Office of Health Care Reform issued a report titled, "Addressing Pennsylvania's direct-care workforce Capacity: Primary Recommendations for Quality Jobs and Quality Care."

The report outlines a series of recommendations by the direct-care workforce workgroup about how best to support and grow the direct-care workforce.

The recommendations include greater access to affordable health insurance, a higher minimum wage for direct-care workers, and improved access to full-time work opportunities.

One recommendation involves raising the training standards for direct-care workers. Doing so would require a new training and credentialing system for direct-care workers, one that is competency based and built on the principles of person-centered care and consumer direction.

And let me just say that there is a

training committee that is trying to finalize these recommendations for these training standards.

Importantly, there is broad stakeholder agreement that you've heard today that such a system must take into consideration the cost to employers for enhanced direct-care worker training.

Along these lines, a related recommendation in the report focuses on addressing Pennsylvania's payment system for nursing homes and home and community-based care providers and creating financial rewards or incentives for higher training standards and superior performance with respect to direct-care staffing adequacy, stability, and care quality.

Approaches could vary in the degree and manner to which payments are linked to performance measures, but the basic premise is to foster a return on investment mindset about improved direct-care worker training and supervision across the long-term living system.

Now, because of your support in the Pennsylvania Legislature, the Commonwealth does have a beginning, we think, of a promising infrastructure through which to build out an employer-friendly training and credentialing system for direct-care

workers.

The State Workforce Investment Board has several years of experience working with local WIBs, they're called -- Workforce Investment Boards; there's 22 around the state -- on the industry partnership approach to direct-care worker investment.

Let me just say these industry partnerships are not just in the health industry. They're across all the important industry clusters in Pennsylvania. About 20 percent of the 86 industry partnerships across the state that are supported through funding from the Pennsylvania Legislature and one-to-one match from the employers involved in the industry partnerships are in health care. So there is a significant number of health care employers who have stepped up to the plate.

These industry partnerships are collaborative efforts, as was explained here, that bring together management, labor, and educational entities around a common purpose of improving the competitiveness of a cluster of companies or organizations producing similar products or services.

Our health industry partnerships have

focused on the retention and recruitment of direct-care workers with great success, and they now offer a promising model for future investment.

I thought it was so cool when you talked about direct-care workers leaving a supervisor as opposed to leaving a job. That's exactly what's happening. And I think a lot of the consortiums and industry partnerships are directing that as an issue in the first-line supervisor.

In closing, I want to reiterate the shared consensus among stakeholders in the long-term living system. All agree about the crucial link between the quality of jobs held by direct-care workers and the quality of services provided to the full range of direct-care consumers.

A rapidly aging demographic in our Commonwealth, combined with a fundamental policy shift designed to serve greater numbers of people in in-home and community-based settings is now placing critical direct-care workforce demands on our long-term living system.

The challenge before us is to devise creative policy options for meeting those demands, and to do so in a way that ensures the provision of person-center care to Pennsylvania's seniors and

other adults living with disabilities.

Thank you very much.

CHAIRWOMAN MUNDY: Thank you.

I appreciate your testimony, all of you.

I just have one question and perhaps each of you could address it. What can we do legislatively or within the public policy purview as legislators to address these issues? What should we be doing?

Now, obviously the budget issues are key. If you're going to grow the infrastructure and home- and community-based health care, you have to pay people appropriately. You have both providers and workers.

So in my testimony to the Appropriations Committee I tried to make that point that we can talk about balancing, you know, rebalancing, keeping people out of nursing homes, letting them age in place and live in their own homes as long as they can, but, without the infrastructure and the appropriate payment of people to do that, it's just not going to happen.

So what should we be doing -- obviously apart and aside from paying more to providers. What should we be doing to move this issue forward?

MS. BETTINAZZI: I just wanted to say that one of the things that I think really needs to be addressed is the fact that we have such a diverse workforce when it comes to our direct-care workers. It is not a homogeneous group. We have everyone from someone hired the woman next door to come in to our highly trained now specialty certified aides that we have moved through a career ladder from companion to as far as they can go.

So then we enter into the system when we're working with aging services with our waiver clients, for example, where the quality of the worker is not taken into any account. And I think that absolutely has to change. And there was something in my testimony as well as Dr. Garraty's that mentioned rewarding employers who invest in their workers and who provide a high quality worker. I think that's just absolutely an issue that we have to look at because that's not happening right now.

In fact, in many ways we're penalized because when consumers are given a choice of an agency to provide their direct-care services, they're given a list. And the only thing on the list is cost.

So if we're charging 75 cents an hour more

than the one across the street that has no certified aides, the clients don't know that. And, as an example, we just had a case this week where a man -- patients, they like to shop. And they'll stay with one agency for a while, and then maybe they'll go with another. We just had a phone call from a gentleman who said, I really want your agency to come back. I was with such and such agency, and they sent someone to my home. They sent a woman to my home to bathe my wife and she did not know the first thing about giving a bath.

Now, we can't look at us as being a homogeneous group. We're not. And then you look at -- you know, when we're talking about the training and education, we have everything from personal care homes, assisted living, home care skilled, non-skilled. The whole thing. Well, if we're going to have a standardized training, again, no one will be able to afford the same level. And the reason we have been --

CHAIRWOMAN MUNDY: And you probably don't need the same level.

MS. BETTINAZZI: And you don't need the same level.

And the reason that we've been able to do

the things that we've been doing, again it was the pooling on all these different resources that are out there, which I realize would be difficult to replicate for many.

But I also have to say that we have worked with the Workforce Investment Board for many years. I think we were probably the first -- we actually were a consortium before all this started. We were a model in many ways for this. And it has been wonderful. And the best part of it has been the collaborating. I think this is something else that can be addressed is people need to work collaboratively.

We don't need every nursing home and every hospital and every home care agency doing diabetic training. We need everyone to pull their resources. And now what we do is have a full day. We bring in a national speaker, and we have a full day, and we invite all consortium members to come to that training.

It sounds like a small thing, but it's really a big thing because we duplicate in some areas, and we miss the boat in other areas, and we have to, you know, maximize our funding.

I don't know if that answers your question,

but --

CHAIRWOMAN MUNDY: Yes.

MS. KULP: I think there is also one thing, which is really important, on reimbursement which is for waiver services through the Department of Agency. The AAA's decide on the rates independently. So, for example, in Philadelphia they pay $14.50, $15. In Montgomery County, which is right next door, it's $25.

So I think if the Legislature could even out some of those rates so that they were more even, you would get people. So we've decided, for example, we can't work for PCA because we can't support our workers, provide benefits, training, for that amount of money. To me, that's something that the state can do to rebalance the system.

And then the second thing is really providing resources for training. And that's done through the WIBs. It's also done through the Department of Public Welfare, which we work with, to actually train people who have been on welfare to become home health aides. So it's a win/win because you're getting people off of welfare, but you're also getting a well trained workforce. So to continue to support those programs is really

important. Again, it's not a lot of money.

DR. GARRATY: If I could say, I'm a real believer that government shouldn't do anything in the market unless there's something broken in the market or something going on. And a labor market is just like any other market. And I think there are some things that are happening within the labor market that government should look at.

I think one of the things that you have been doing through your support of a lot of these industry partnerships is creating an infrastructure who are aware of these different players that come together and to address common problems.

CHAIRWOMAN MUNDY: Through the Workforce Investment Boards?

DR. GARRATY: Well, yes. Well, through the funding that you're providing the Workforce Investment Boards to create these structures. And the funding that you're providing, it's not a lot. Overall, I think, it's $20 million, but $15 million of that is used to put on the table for employers to come and match on a one-to-one basis for training for incumbent workers.

A lot of money comes into Pennsylvania from the federal government for workforce development,

but it's for certain population groups. It has all kinds of strings to it. And very rarely can we use that funding to train existing workers. And that's what the money from you folks provides. It makes it much more flexible to train those incumbent workers.

Real quick, let me give you an example of what was happening in south central Pennsylvania while I was executive director up until recently taking this job.

We had a partnership. These folks sitting around the table. All the Summits, you know, large health facilities. And we asked them a question. We said, "What is the biggest problem in health care in south central Pennsylvania?" And we were really shocked when they came back with was the turnover rate in long-term care facilities is the biggest problem. All right. So what do we do about it?

Well, when they drilled down into it, what they found is they think a big part of the reason for that turnover was poor first-line supervision, as was mentioned before.

So what they did is they put together a training course, and they ended up training 600 first-line supervisors in the smaller long-term health care facilities in the eight counties in

south central.

One really neat thing that happened -- the training was very positively received, but the only negative was when we asked them, what didn't you like about this training, they said, well, the problem is that when we go back to our facilities, we don't think the next line up in terms of management will allow us to implement some of these things you're teaching us like generational, how to get together, you know, cultural issues between supervisors and their employers, generational differences. So the next line up probably wouldn't allow us to implement some of this stuff.

So the next training group that is getting together is focused towards that group. So it's that kind of -- where you have people who normally don't get around the table because they're competing a lot of times, they sit down and realize they have to address these issues, I think is something you can do, you have done, and we continue to work on.

CHAIRWOMAN MUNDY: You know, as I'm sitting here thinking, you talked about reimbursing for quality, you know, paying a little more for higher quality. And it reminded me of the Keystone Star's program in the childcare world, which I have advocated for a

long time.

And then as I think about it more, that's doable because the provider gets reimbursed directly for -- they get a star for improving their quality, and they get reimbursed more for their childcare.

But in this case it's not -- it's the AAA paying the provider. So I'm not sure how we could massage that to make it work properly. But I think it's worth looking at.

MS. BETTINAZZI: We definitely need standardization in our AAA. They should not each be allowed to do their own --

CHAIRWOMAN MUNDY: Well, I think having participated in the meetings around the state about the state plan, that's one thing that Mike Hall of the Office of Long Term Living has stressed is that CMS will not allow us to continue to have so many different programs and qualities in all the different counties where AAAs exist, that it needs to be one long-term care system and each service needs to be provided uniformly.

MS. BETTINAZZI: And one other thing that we haven't mentioned is not just the health care issue. Employers such as us cannot continue -- for those full-time employees to which we provide health care,

it's $2.54 an hour. So we have employees who are earning $9.90, and then we're adding another $2.54 an hour, plus the other benefits that we pay. And I'm operating in the red right now. And I have a wonderful board of directors. We're governed by -- you know, we're non-profit, community owned, run by a board of directors. They have been very forward thinking. I've told them for six years we're investing in infrastructure. Keep doing this. It's going to get better.

Well, they're pretty much saying to me we're to the point where we can't keep absorbing losses on this program. And, like I said, I don't want to roll back the clock. When we had all this part-time, minimum wage, no benefit workers, it was a constant revolving door. And our HR department -- all they did -- every single day we were interviewing and hiring. And the next week we were losing those people because there was no reason for them to work there.

So the health care issue is tremendous, and everybody knows that in every business. But for the health care workers who don't have health care is a travesty.

CHAIRWOMAN MUNDY: Was it your agency that said

that -- yes, your premiums increased 8 percent.

MS. BETTINAZZI: Yes. I just got my new premiums for next year. We're getting decreases on all of our reimbursements or they're stagnant, and health care alone is going up 8 percent. Well, where does that 8 percent come from? So how can you help your employees at the risk of going out of business?

CHAIRWOMAN MUNDY: Well, thank you all.

Representative Vulakovich.

REPRESENTATIVE VULAKOVICH: What I think I've heard over and over from today is training, certification, work environment, full-time positions with health care.

Is that pretty much where we're at? As far as the training goes, who is in the process of putting some type of -- are they going to put a curriculum together for training so it's standardized?

DR. GARRATY: What's happening in training from the standpoint of the Center for Health Careers, which is within the Workforce Investment Board, there is a series of committees, one of which is the Direct-Care Worker Committee.

There is a subcommittee of that that's just

focusing on training that is in the process of putting together recommendations to include a curriculum to include hospital certification that we would take to the pool Workforce Investment Board for approval and then work for, you know, folks to try to implement that.

REPRESENTATIVE VULAKOVICH: Now, as far as certification, which I heard from the group before you which they thought was important, your curriculum, how would you -- there are certain people that need certain training, not everybody would need diet training in diabetes. How would you approach that? So if you had some type of curriculum offering --

DR. GARRATY: I think what they're talking about, Representative, is probably two levels, a level one and a level two. And, you know, certain core would be handled in level one, and level two would be focused maybe in different areas.

REPRESENTATIVE VULAKOVICH: So there you would have to have different certifications.

DR. GARRATY: Again, that has not been finalized yet. I don't want to say definitely there's going to be different certifications. You know, everybody is not going to be trained exactly the same way in a

pool training.

You're going to have to have different certifications because you can't give a certification out for someone who hasn't been trained in some of the trainings in all these different areas and others have it. You're going to run into a problem, especially if you want to give credibility to that accreditation.

MS. BETTINAZZI: It's my understanding that there will be a standardized training that everyone will have, but then you can go beyond that and have higher levels. For example, when I mentioned that we have aides that are now certified in hospice and palliative care, others have been certified in dementia, special dementia trainings. And not everyone has to have that, but they all have to have the basic. They would have to have the basic, entry level, if you will. And it's sort of a career ladder within a career ladder.

Then the issue is if you have an aide that has gone through all the training it could possibly go through and now getting specialty certifications, you need to reward that. So we have aides that have done all that, but they're still making the same salaries as their peers who haven't done it.

REPRESENTATIVE VULAKOVICH: Are you focussing your training to be done on site, or are you looking at a bigger scope where you're looking to possibly get into community colleges.

DR. GARRATY: Well, a couple things. In terms of, number one, is recruitment for folks for this training. We're looking at using the career-link system to get the folks to come in. In terms of where the actual training would be held, I don't think that's firmed down yet.

MS. KULP: Excuse me. From my point of view, employer-based training is really effective. So if you can somehow give employers resources to do their own training -- you know, they know what their population is; they know what their needs are. I think it's -- people are more committed if they get the training from the employer.

REPRESENTATIVE VULAKOVICH: I agree with that. You've run out of aides in the future. Well, we're going to need thousands of more people in this field. And that's why I'm suggesting that maybe as far as long-term planning for this, that you consider possibly community colleges where you offer this thing. If you're talking about a workforce that you're going to have to pound out here, I mean,

you have to draw those people from someplace.

You know, and not everybody has in their mind, oh, I think I'll go work at a personal care home or do this, or when they look down at the college curriculum, they can see, oh, well, maybe what about this. So I think there has to be a long-range plan made at the time for the community colleges.

MS. BETTINAZZI: And currently our community colleges are providing the nurse's aide training. And out of our recumbent worker training money, we offer scholarships to our companions to go forward and receive at least -- I think we have 15 people who have been entry-level companions who are now certified nursing assistants through the programs. And they have done it through the community colleges.

DR. GARRATY: One of the questions you folks raised earlier: Was now you have a lot of people interested in getting into nursing. Why aren't the numbers going up?

Part of the problem is an aspect of nurses' training is clinicals. You have to be in clinical settings. And we don't have clinical settings.

MS. BETTINAZZI: And we don't have enough

nursing instructors.

DR. GARRATY: So the leadership council or the Center for Health Careers is looking at both the clinical situation and looking at the instructor situation. If I'm a nurse and I can make $100,000 in a hospital and I go to the school to teach and they can only pay me $80,000, what am I going to do. So we have to create some incentives and other ways to attract those folks to go into teaching.

REPRESENTATIVE VULAKOVICH: The question of morale, anybody who deals -- who's dealing with public service, especially when you're on a one-to-one basis with people that you -- what you do is so emotional, and you take it home with you. And at the end of the day you not only are physically tired but you're emotionally tired.

So when you talk about training your people who are your supervisors, they are the key to morale. And, believe me, being a member of a police force for 27 years, I can tell you that morale is established by your leadership. If your leadership is bad, you're going to have bad morale. It's that simple.

So I think you need very special people in those positions who understand it. I think a lot of

people want to go up a ladder and they forget where they came from. That's what's important with your supervision.

So I think the idea that you have recognized this, you must have put a lot of thought into this, just realizing at the supervisory level how important all this is for morale to be good. That's such an emotional job. I mean, I've done this stuff. I took care of an uncle, and bathing and cleaning and everything else.

To get back to what Miss Madam Chairman said, as far as women being in this line of work, I think women and men are different in a lot of ways. And the one way I like to say is they're very special. They are stronger than men in many different ways. That's why they do that kind of work. You're stronger.

Thank you.

CHAIRWOMAN MUNDY: Representative Pashinski has a question.

REPRESENTATIVE PASHINSKI: Thank you, Madam Chairwoman.

I'm sorry I may have missed a lot of the testimony here, but I hear the same kind of things that Representative Vulakovich has mentioned.

It seems to me that -- first of all, let me ask the question: What is the emergency timeframe that we need in order to train people to deal with the needs of home health care? Is there a timeframe that you're looking at? Within two years?

MS. BETTINAZZI: It's probably passed. We are at a critical stage. As I said, with our aging population of caregivers, we're having a doubling of the 85 population -- a doubling of the 65 population, our 85-year-olds and older are the fastest growing segment of our society. They have all these needs. They want to stay home.

Our current population of workers -- the average age in my agency is 46, with ten above 60, and they're -- they need help.

We have had -- in the last month we have on-site job fairs where we bring people in, we screen them, we test them, we hire them right on the site, and we do that periodically. We have had three in the last month. Out of the three we've had, about 20 people -- and this is for companions, home health aides and LPNs. Out of the three job fairs that we've had, we've only had one apply as a nurse aide. So we are in a very critical situation, and we have more and more demand for our services.

Our private-pay population has increased by about 25 percent over the last year; our private pay needing private duty services of aides and companions. So we are in a very critical situation. This has to be done sooner than later, any help that we're able to receive.

REPRESENTATIVE PASHINSKI: What's the standard amount of money that an aide like that would make?

MS. BETTINAZZI: Our average currently is $9.90 for our non-skilled. Our skilled side, which is our Medicare home health aides, they're averaging $12-something because they have all been there forever.

With benefits, the average aide -- full-time aide with benefits is earning $15.60 an hour, plus 50 and a half cents a mile for mileage.

REPRESENTATIVE PASHINSKI: I have the same feeling about the training. I'm concerned about making sure that it becomes standardized. I think by using the community colleges, you would first of all acquire people that would choose a course and select this vocation rather than being -- rather than selecting a job just because they need some money until they can find something else.

By utilizing the community colleges, first

of all, it's inexpensive. It's the most inexpensive forum. So you could attract folks that don't have a lot of dollars and may want to get involved in this industry.

And I think to develop the education levels would be standard. So that you know when someone would graduate from that course that they would qualify to do X job.

And this is no slight on your training, because on-the-job training is fantastic when you have a quality operation. And we've seen all different levels of that, haven't we?

So I would strongly urge you to consider that and come back to us again with a yea or nay, because I think since we need this so desperately, there is no time to waste. And I would engage in conversation with the community colleges immediately to see what kind of curriculum needs to be developed so that we might be able to attract people into this system.

DR. GARRATY: Representative, I will take that back to the training committee looking at this right now of both your concerns.

MS. BETTINAZZI: I just wanted to say that in regard to the community colleges, one of the best

part of our consortium -- it's really a mini think tank. We're all volunteers. We get together once a month and brainstorm. What do we need to do to put workers in the pipeline.

And there was an example where the nursing homes needed feeding assistants, and we didn't have any feeding assistants. So the community college people that were sitting at the table said, "Well, that's no problem. We'll develop a feeding assistant's class," which they did. It's a very simple four-hour class. And all of the nursing homes have been able to utilize that.

And it's just -- again, it's a little thing, but it was a need, an unmet need that was able to be corrected because of this type of collaboration. And it happened immediately. It wasn't -- we didn't go through some big -- you know, we were sitting there, we decided it, they did it, and that was it. And we're still continuing to do it anytime anyone needs that.

REPRESENTATIVE PASHINSKI: And the other thing I share with you is we've talked about the idea that you're talking about $60,000, basically, in a nursing home as opposed to $20,000 in home health care. How are we going to able to make that shift?

And will there be less use of nursing homes and more use of home health care?

There's a lot of money in the system that maybe can be balanced differently. And I think we have to be as creative as we can. Look outside the box. But, you know, certainly the need is there. And I appreciate your testimony today. Thank you.

CHAIRWOMAN MUNDY: Chairman Hennessey.

CHAIRMAN HENNESSEY: Thank you, Madam Chairman.

Ms. Bettinazzi, I listened to you when you said you had received -- or your agency had received $50,000 from the AAAs in your county, I guess, and that you've developed a program.

And I had written in my notes that you didn't want the state to do the training. We should let the training be done by the providers, which sounded like, "Send the money to us, and we can make the program really responsive to the local needs." And yet later in your testimony you talked about this report that came out and said that the state needs to do the training, and that sounds like what Dr. Garraty is saying. So we're talking about two different approaches.

MS. BETTINAZZI: We are talking about two different things.

CHAIRMAN HENNESSEY: Should we be doing them in tandem? I mean, should we --

MS. BETTINAZZI: Probably, because --

CHAIRMAN HENNESSEY: Each would have benefits.

MS. BETTINAZZI: Right, because there are different types. Training is so all-encompassing for one thing. And with the AAA, that started -- I'm thinking the first grant was maybe in 2001, and this is all agencies across the state could apply for this, and it was a direct-care worker initiative. And the reason for the grant was to receive extra money to put back into your direct-care workers. And it was very liberal as to how you could utilize that money.

So we've used it -- you couldn't use it for salaries, but we've used it for -- excuse me -- training, some recognition events. We've used it just in various ways to help the retention of our direct-care workers. And, again, that $50,000 is over seven years. You reapply for it each year.

The new training initiative that Dr. Garraty is speaking of is coming out of the center, and they are trying to look at a more uniformed standardized -- and, again, it goes back to my prior point about because we're all so different. We're

not a homogeneous group. That standardized training, although wonderful I think for baseline, you can't expect that personal care home that is only able to pay their people $5 an hour -- they're not going to do the same training that perhaps we are or the nursing home is going to. So that has to all be taken into account.

DR. GARRATY: That's what this training subcommittee is struggling with right now is just looking at the whole picture.

CHAIRMAN HENNESSEY: It seems we'll be setting up a situation where the agencies will be squabbling with you about where we should send money. Should we send 30 percent to you and 70 to the agency, vice versa; that kind of thing.

One other question, and I think it's a quick one. I'll direct it to you if I can. Who pays for all this stuff? I mean, the Feds funnel the money to us; we funnel it to the counties and the AAAs -- I guess you have private insurers, people who have bought long-term insurance. You probably are getting paid by them.

Is there anybody out there who pays out of pocket? And to the extent that we -- everything we do that is going to raise the cost eventually.

MS. BETTINAZZI: And that's one point.

CHAIRMAN HENNESSEY: The actual private payer, the guy who reaches in his pocket who pays for his wife's care or his own care, aren't we going to price them right out of the market?

MS. BETTINAZZI: Excellent point and one that we're struggling with currently, again, because of the high costs. And we're a hybrid. We receive money from -- we have a AAA piece where we take care of the Medicaid population. We do have some commercial insurance. I'm not talking about a private duty company. I'm not talking about Medicare or hospice. I'm talking about the direct care worker people. For that, we have commercial insurance.

But we do have a large and growing private pay piece, and I'm continuously juggling because there's certainly a ceiling. I can't price us out of the market place. So there's a ceiling. And we did an analysis a couple weeks ago, and we were below state and national averages on what our charges for our services were. So I just had to increase them. But today a letter is going out to all our private pay consumers due to the increase in the cost of gasoline, due to the health insurance --

CHAIRMAN HENNESSEY: I'm glad you're saying that.

MS. BETTINAZZI: Everything is going up. This is a new tax. We are taxing people. You know, they need this care.

CHAIRWOMAN MUNDY: This is a user fee, some would say.

MS. BETTINAZZI: Whatever we want to call it, they're going to pay more. And all of the things we implement to make a direct-care worker -- whatever it needs to be; somebody has to pay for it.

CHAIRWOMAN MUNDY: Well, and I would argue that they'll pay for it until they no longer can pay for it.

MS. BETTINAZZI: Exactly.

CHAIRWOMAN MUNDY: And then they'll be on Medicaid, which goes directly to my point. Less government means only until -- I want less government and lower taxes until I need a service, and then I want that service.

MS. BETTINAZZI: Yes, it's got to come from somewhere. And that's why we are seeing some success.

I alluded to the private foundation payment, which was the better jobs/better care, in

conjunction with some of the state monies has helped a lot. But how do you replicate that? I don't know.

I mean, Pennsylvania has probably more foundations -- more foundation money than any state in the United States. How do we leverage some of that? We give grants out for all kind of things? How do we leverage that to give better long-term care. Maybe that's where you can help us as well.

CHAIRMAN HENNESSEY: What percentage of your client list, patients, however you describe them -- what percentage actually pay out of pocket?

MS. BETTINAZZI: We're running about 50/50 currently.

CHAIRMAN HENNESSEY: With no insurance at all.

MS. BETTINAZZI: Yes.

CHAIRMAN HENNESSEY: That's much higher than I would have guessed.

MS. BETTINAZZI: We formerly were about 75 public to 25 private pay. Aging Services has taken so many hours of service away. We have begun losing a thousand hours of services through our agent waiver.

Over the last year, each month we're losing a thousand hours of service, which we don't know

why. And our private pay is increasing exponentially. So, yes, they are paying out of pocket. And it is very expensive.

If someone that needs -- even though it's so much less than a nursing home, if you have someone that's sick for two or three years and you need long periods of service, you don't need just a couple of hours here and there, maybe you need 12 hours a day, maybe you need 24 hours a day, then it's more expensive than a nursing home. Yeah. So it's huge, and it's going to affect every single person.

CHAIRMAN HENNESSEY: Is the percentage of private pay increasing because you're cutting back on the stuff that's -- the services to other patients that were previously paid by the AAA's.

MS. BETTINAZZI: No. These are people that are not eligible for AAA. This is just happening concurrently. These are people that do not meet the requirements. They're hiring us privately to care for. These are a lot of times someone that lives out of state. Mom and dad still live in Indiana; we want to keep them that at home. So it's all private pay. They don't meet the requirements of the state. But at the same time we are losing, we're

decreasing -- finding a decrease in our hours for AAA.

CHAIRMAN HENNESSEY: Thank you very much for your answers.

CHAIRWOMAN MUNDY: Thank you all. And thank you to the prior panel for your appearance here today. There's a lot of work to be done, I think. We're going to the floor right now. So thank you again. Appreciate your being here.

I hereby certify that the proceedings and evidence are contained fully and accurately to the best of my ability in the notes taken by me on the within proceedings and that this is a correct transcript of the same.

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Susan O'Hara Moore, RMR
Notary Public