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The Paraprofessional Healthcare Institute is honored to deliver testimony to the Senate Committee on Health, Education, Labor and Pensions. We are pleased that you, Chairman Jeffords, Senator Kennedy and your colleagues are addressing the current crisis in the long-term care workforce.

I am Michael Elsas, CEO of Cooperative Home Care Associates, a worker-owned home-health agency in the South Bronx. We have 600 home health aides in our agency who provided services last year in 2500 cases to clients who live in their homes in Manhattan and the Bronx. We specialize exclusively in the delivery of paraprofessional services for individuals who are elderly, chronically ill or living with disabilities.

We are delighted to be here today to discuss what we believe is a matter of national security. ***Is our nation prepared to provide adequate care and services to our citizens who are elderly and disabled?*** A lack of preparedness will genuinely threaten our nation, both socially and economically.

In our comments, we will address three areas:

- Our analysis of the current factors affecting the crisis in the pararprofessional long-term care workforce,
- A description of the elements of the Cooperative Healthcare Network system to create high quality jobs, and our assessment of how other providers and systems can incorporate these elements;
- Recommendations for changes in federal and state policies that could address the current problems.

We also respectfully submit as addenda copies of several publications written by Paraprofessional Healthcare Institute:

- ***Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care,*** a report commissioned to PHI and published by the Domestic Strategy Group of the Aspen Institute, and
- ***The Conference Proceedings from The Direct Care Alliance First National Meeting.***

- A brochure describing the ***National Clearinghouse on the Direct Care Workforce***

Our comments address ***paraprofessional*** workers in the long-term care system. These are the workers who deliver eight out of every ten hours of paid care to a long-term care client. There are many names for these "direct-care" paraprofessionals— home health aide, personal care attendant, certified nurse's aide, resident assistant, personal attendant. These direct-care staff are the primary delivery system for long-term clients who are elderly, chronically ill or living with a disability at home, or in an institution.

In whichever setting direct care workers work, they assist clients with personal care activities such as feeding, bathing, dressing, and toileting, and home maintenance tasks such as shopping, cooking or light cleaning.

Introduction to Cooperative Healthcare Network and Paraprofessional Healthcare Institute

Cooperative Home Care Associates (CHCA) was created in 1985 as a licensed home health care agency to deliver high quality home health aide services while creating good jobs for low income women. We create a direct link between the quality of the job and the quality of care. For that reason we designed the business as a cooperative where every employee can own a single share of the company and earn dividends. We have built into our model intensive training, support and decisionmaking as ways to prepare our employees to deliver high quality care. More information about this model is included later in this testimony.

CHCA is one of three cooperative home health agencies affiliated with the Paraprofessional Healthcare Institute (PHI). PHI is a national nonprofit health care employment and advocacy organization, based in the South Bronx, New York. PHI's mission is two-fold:

- To create decent jobs for low-income individuals, with an emphasis on women who are unemployed or transitioning from welfare – to – work, and
- To provide high-quality health care to clients who are elderly, chronically ill or living with disabilities.

PHI has linked this twofold mission through a "Quality Jobs/Quality Care" school of thought: Creating quality jobs for low-income individuals —who comprise the majority of paraprofessional healthcare workers —is not only consistent with, but necessary to, the provision of high-quality, cost-effective care.

In addition to Cooperative Home Care Associates in the Bronx, PHI fostered the development of the Cooperative Healthcare network, a federation of largely worker-owned, paraprofessional health care providers and training programs in the states of New York, Pennsylvania, New Hampshire, Michigan and Arkansas. Over 850 employees work in the whole Cooperative Network.

Each of the network's agencies is considered a top quality service provider in its community. The focus of each agency is to delivery good care by creating good job opportunities for low-income women, often minorities and new immigrants. As many as 70 percent of the employees at these companies were at one time dependent on welfare and had sporadic job histories. Yet, employee turnover rates are significantly lower then industry averages. PHI is also a prime sponsor of Independence Care System (ICS), a nonprofit managed long-term care program for people living with physical disabilities in New York City.

At the policy level, PHI staffs the national Direct Care Alliance, an advocacy voice representing consumers, workers and concerned providers to create both quality jobs and quality care within the long-term care sector. In addition, PHI recently launched the National Clearinghouse on the Direct Care Workforce, to act as a national information center on the staffing crisis in long-term care.

PART I: THE LONG-TERM CARE SYSTEM

THREE KEY STAKEHOLDERS. The three stakeholders are those whose lives are touched each day within long-term care settings:

Paraprofessional Workers: Nationwide, paraprofessionals total more than 2.1 million workers; 86 percent are women, 30 percent are women of color, and most are between the ages of 25 and 54—more than 28 percent return from work to a family living in poverty. Since direct-care positions cannot be replaced by technology, nor moved offshore, over the next eight years they are projected to be the nation's seventh fastest-growing occupation.

Long-Term Care Consumers: The U.S. long-term care population currently numbers about 12 million. Although diverse, all require assistance with personal activities of daily living, hygiene, and household maintenance. The elderly make up approximately half of the long-term care population at 6.4 million; 5.3 million non-elderly adults and 400,000 children also require long-term care.

The need for direct-care services is expected to grow *geometrically* during the next 30 years: ◆ The population of those requiring paraprofessional care is increasing; ◆ The acuity of illness and disability of those in need is increasing; and ◆ The preference for living in home- and community-based settings (where more assistance is required than in institutional-based care)--is increasing.

Provider Agencies: Nearly 120,000 long-term care agencies—ranging from small nonprofits to massive, for-profit chains—offer care in a range of institutional, home-based and community-based settings. The financial viability of the entire industry is currently endangered, caused in part by passage of the Balanced Budget Act of 1997: Two years ago more than 20 percent of all Medicare-funded home care agencies closed and three of the four largest for-profit nursing home chains have entered Chapter 11 bankruptcy.

PRIMARY FINANCIERS. In 2000, long-term care expenditures for the elderly alone are expected to total $123 billion—60 percent from *public sources* (primarily Medicaid and Medicare), 4 percent by *private insurance*, and 36 percent by *out-of pocket* and other sources. By 2020, Medicare and Medicaid funding will likely increase over 70 percent, to $126 billion in constant year 2000 dollars, yet still remain 60 percent of the elderly long-term care finance system.

Medicaid: Funded jointly at the federal and state levels, Medicaid provides health coverage primarily for low-income citizens. The program is intentionally designed to provide certain long-term care benefits, with approximately 35 percent of all Medicaid funding flowing to long-term care needs.

Medicare: Funded solely by the federal government, Medicare is designed to provide coverage for acute care—assistance for relatively short-term, intensive medical care—to those 65 years and older and for people living with disabilities. Thus Medicare's participation in long-term care for chronic conditions has been intentionally restrained by Congress.

A DISAGGREGATED SYSTEM. The resulting structure has become a rickety system of disparate program "silos," where function follows form. These vertical structures fail to recognize that clients move *laterally* through the long-term care system and that many paraprofessionals also work across settings.

PART II: THE ENDANGERED HEALTH CARE WORKER

More than 40 states now report critical shortages of paraprofessionals and turnover rates ranging between 40 and 100 percent annually. As a result of these shortages some nursing homes have closed units and many others are relying on current workers to work overtime or manage dangerously high numbers of residents per shift. Working under these conditions puts residents at greater risk of poor care and workers at higher risk of injury and burnout, which further exacerbates worker shortages.

Home health agencies in rural areas such as upstate New York report client waiting lists of several weeks since they are unable to hire enough workers to

meet client need. Those clients who are being served are receiving fewer hours of care and fewer visits per week.

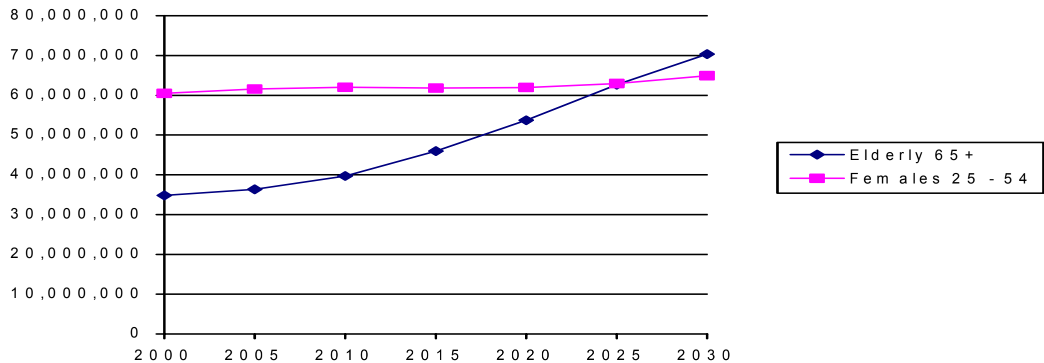
Vacancies and turnover are dangerously high for three reasons:

1] **The quality of direct-care jobs tends to be extremely poor.** Wages are low, and benefits few—in a bitter irony, most direct-care staff do not receive employer-paid health insurance.[i] Home care work typically offers only part-time hours and thus part-time pay and aides in many nursing homes are now forced to serve far too many "beds"—creating unsafe conditions for both client and worker.

2] **The full-employment economy offers better job alternatives.** With the lowest U.S. unemployment rate in 30 years, vacancies now stretch throughout the service industry. Clerical and food-counter positions offer jobs that are safer and less demanding than direct-care health positions, and yet pay as well or better. Offered the alternative of stable and safe service-sector employment, compared to the increasingly stressful demands of long-term care, even those who love to assist others are choosing to leave the health field.

3] **"Post-baby boom" demographics in the U.S. have created a "care gap" that will worsen over the next 30 years.** If staff vacancies and turnover were the result only of our full-employment economy, the health care system could simply wait, "hoping" for the next economic downturn. However, the number of those requiring paraprofessional care is growing, while those who traditionally provide that care—primarily women between the ages of 25 and 54—cannot keep pace As one dramatization of this growing mismatch between the supply and demand for direct-care services, note below that the U.S. elderly population is projected to *double* over the next 30 years, while the "traditional" female caregiving population is projected to grow *by only 7 percent*:

The Care Gap: Women of Care-Giving Age and Elderly in U.S., 2000-2030
(Females aged 25-54; individuals 65 and older)



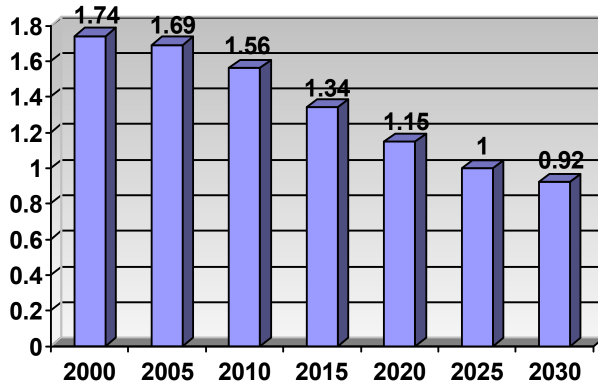
Source: U.S. Census Bureau, National Population Projections, Summary Files, "Total Population by Age, Sex, Race, and Hispanic Origin," http://www.census.gov/population/www/projections/natsum-T3.html

In short, the demographic mismatch between the demand for and supply of direct-care workers is a long-term *structural* problem that will persist, even if higher unemployment rates return.[1]

Viewed from a slightly different perspective, we can use this same data to calculate an "elderly support ratio," comparing the relative availability of caregivers over time. As the chart below shows, the U.S. population currently includes 1.74 females aged 25-54 per elderly person—at a time when we are already experiencing significant direct-care vacancies. Yet this ratio will decline steadily over the next 30 years and, by 2030, reach a point where there will be *fewer than one woman of caregiving age per elderly individual.*

[1] Given the very low population and labor force growth projected over the next several decades, a "normal" business cycle recession will likely result in only a modest increase in the number of unemployed. Dr. Richard Judy, director of the Hudson Center for Workforce Development, suggests that the United States over the next 20 years can expect unemployment rates to vary only within the narrow range of a low of 3.5 percent to a high of 6.5 percent. See testimony of Richard W. Judy to the Subcommittee on Oversight and Investigation, Committee on Education and the Workforce, U.S. House of Representatives, February 17, 2000. Hudson Institute, Indianapolis, Indiana. http://www.hudson.org

Elderly Support Ratio, 2000-2030
(Females aged 25-54 per individual aged 65 and older)



The long-term care industry has long structured itself on the presumption of a seemingly endless supply of low-income workers. Now that decades-old presumption is no longer valid, placing unprecedented pressure not only on the "formal," paid health care delivery system, but also on unpaid family caregivers.

In order to maintain a stable, competent direct-care workforce, both providers and consumers now find it in their essential self-interest to improve the quality of paraprofessional jobs.

In short, our nation—with growing numbers of those in need of assistance followed by so relatively few young available to provide that assistance—must re-frame fundamentally how long-term care for our loved ones will be delivered.

PART III: IMPACT OF THE "CARE GAP"

High rates of staff vacancies and turnover harm all three "key stakeholders" within long-term care. Although these three stakeholders have often competed with each other for long-term care resources, all three are publicly stating their common concern that vacancies and turnover are now causing our direct-care delivery system—the very point where long-term care "touches" the client[ii]—to disintegrate.

Impact on Consumers (and their families): The emerging "care gap" is causing ◆ care without continuity, ◆ inadequate and unsafe care, and ◆ in some cases, denial of care. High turnover results in staff who are relatively inexperienced, with fewer senior staff available as mentors. Remaining staff are often forced to serve relatively more clients in a rushed or unsafe manner. Constant replacement of staff disrupts the care setting and precludes the development of relationships—which are centrally important to both the client *and* the caregiver.

National organizations representing consumers are so troubled by the link between poor staffing and poor-quality care that they have identified staffing shortages as a critical issue. For example, thirteen state chapters of the national Alzheimer's Association have selected staffing issues as their top priority in the year 2000. In addition, a recent report published by The Commonwealth Fund found that inadequate staffing, a lack of individualized care, and high nurse-aide turnover are key causes of malnutrition and dehydration, affecting an estimated one-third of our nation's nursing home residents.[iii] The National Citizens Coalition for Nursing Home Reform states that "*Short staffing affects the welfare of every resident in nursing homes, and in some cases even endangers the lives of residents.*"[iv]

Impact on Providers: Staff vacancies and high turnover create: ◆ high recruitment and orientation costs, ◆ high retention costs, ◆ high separation costs, ◆ high temporary replacement costs, and ◆ foregone sales revenues.

High turnover and heated competition for workers force providers to divert financial and managerial resources toward additional advertising, hiring incentives, and orientation activities. Since providers offer relatively unattractive jobs within the current competitive environment, they are more likely to select from a pool of candidates with greater barriers to employment within the health care field—low education, poor work histories, poor health, drug or alcohol abuse, inadequate child care or transportation—than was true just two or three years ago. This means, in turn, that additional financial and managerial resources must be diverted toward oversight and disciplinary actions.

Many facility-based providers are forced to hire "temp" agency replacement staff at hourly costs of up to 100 percent more than that of regular employees. National trade associations representing long-term care providers have identified labor vacancies as among their top concerns. For example, the National Association for Home Care states: "*In all geographic regions of this country, there is an ongoing inability to hire staff to provide the most fundamental care needed. Agencies have to turn away requests for service for lack of competent, appropriately trained staff.*"[v]

Impact on Workers: "Working short" means: ◆ higher rates of injuries, ◆ higher levels of stress and frustration, and ◆ less training and supervisory support. The result is a spiral of instability: a growing exodus of direct-care staff, leaving behind a workplace that is ever less attractive to potential new staff.

Direct-care jobs have always been of such poor quality that many paraprofessional workers have long endured poverty-level wages, part-time hours, and no benefits—relegated to the bottom rung of respect within the health care workforce hierarchy.

Now, however, the shortages and high turnover are forcing a downward cycle of deteriorating job quality. Those who do show up are forced to work "short," or able to offer only "drive-by home care" as they rush from one home across town to another. The impact of these conditions on direct-care workers includes:

- **Higher rates of injuries -** Nationally, nursing home aides already experience more injuries per year than occupations such as coal mining or construction.
- **Higher levels of stress and frustration -** Pressured by administrators to "speed up," direct-care workers are less able to provide the level of care they know their clients require and deserve, making the job increasingly stressful and less personally satisfying. Home care workers are forced to spend less time *with* clients and more time traveling *between* clients (often unpaid); nursing home workers are often required to work overtime and double shifts.
- **Less training and support -** High turnover and vacancies leave new workers with fewer mentors for on-the-job learning, less time for training, and less support from supervisors who are themselves over-stretched.

PART IV: "HIGH-INVESTMENT, HIGH RETURN"

In response, policymakers can begin to pursue "win–win–win" high-investment/high-return employment strategies that provide workers with higher wages and better working conditions—benefiting all three stakeholders:

Workers would earn a livable wage, provide health insurance for their families, and become a more respected member of the care team. **Provider agencies** would direct their management and financial resources away from recruitment and disciplinary actions, and toward training, support, and retention. **Consumers** would receive consistent assistance from more highly trained, better paid caregivers who could focus their attention solely on care for their client.

PART V: HEALTH, LABOR, AND WELFARE POLICIES

The low-income, direct-care worker stands at the intersection of three public policy worlds—*health care policies*, *labor policies*, and *welfare policies*—yet coordination between these three policy worlds is absent.

Health Care Policies: Governmental procedures play the dominant role in the structuring and implementation of our long-term care system. Yet health care delivery policy has been designed without recognition of its "labor impact":

When the Health Care Financing Administration (HFCA, the manager of Medicare and Medicaid) issues proposed regulatory changes, it assesses the likely affect on clients, on states, and on providers, but not on workers.

Unfortunately, health care delivery policy has been designed without recognition of its "labor impact," particularly upon low-income workers. For example, even though direct labor constitutes the majority of expenses for long-term care, *reimbursement rates typically reflect historic, not current, labor market conditions.* When labor competition in the economy is low, this structure allows the health care system to "bargain" for workers at the lowest price possible, with little regard for the resulting quality of job. Yet when budget constraints collide with heightened labor competition, as is now the case, the result is a health care system unable to offer competitively attractive employment.

Labor Policies: The federal government invests more than $8 billion to prepare Americans for new and better jobs, yet public training programs often *preclude* the long-term health care industry—by requiring participants graduating from those programs to secure wages higher than direct-care workers typically earn. In 1999, Congress passed the new Workforce Investment Act (WIA), which may allow new flexibility at state and local levels for experimentation.

Welfare Policies: Since direct-care staff are typically low-income women, they are often supported by, and entangled in, public assistance agencies. For years the interweaving of welfare and health care employment provided a hidden employment subsidy to the health care system. Agencies could offer artificially low wages and no benefits, forcing their workers to rely, at least in part, on public assistance programs for the necessities of food, housing, and health insurance.

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), curtailing welfare as an entitlement. However, although welfare rolls have been reduced by 50 percent, many low-income health care workers are still entangled within public programs such as food stamps, support for child care and transportation.

The Gulf between the Three: Although health, labor, and welfare policies all intersect the lives of direct-care workers, none are designed with the worker in mind. Furthermore, these three centers of policy do not communicate with one another on paraprofessional workforce matters—even though the creation of a stable, well-trained workforce would serve the interests of all three.

PART VI: DYNAMICS OF THE DIRECT-CARE LABOR MARKET

If the health care labor market were functioning "perfectly," direct-care vacancies would not continue for long—the supply of workers would expand to meet demand as employers improved their "price" (wages, benefits, *and* working conditions) to attract and retain more workers. Yet several factors prevent our health care system from achieving rapid labor-market "equilibrium," including: ◆ Continually expanding pressures on the demand for health care services, ◆ limitations on the supply of additional workers, and ◆ restrictions on the ability and/or willingness of employers to increase their labor "price."

Factors of Demand: The health care labor market is driven by massive demographic and technological forces that push to *accelerate* aggregate demand for services, while simultaneously, powerful third-party payers (both public and private) attempt to *brake* that demand through regulatory constraints and cost containment. The result is likely to be continued expansion of "effective demand," but an expansion that will remain irregular and "balky," depending largely on political and financial—not simply care-related—factors.

Factors of Labor Supply: The pool of likely "entry-level" workers—women in the civilian workforce within the age range of 25 to 44—is projected to *decline by 1.4 percent during the next six years.* This new decline follows three decades of significant expansion of the equivalent labor pool—nearly tripling from 1968 through 1998. We thus face a labor supply that profoundly differs from what our long-term care system has presumed over the past 30 years.

"Price" Inflexibility: To address the labor vacancies, one realistic path remains open to long-term care providers: *competing successfully against other employers for workers*. While successful competition requires improving the "price" of labor—examining ways to increase wages, benefits, and working conditions—this path will require aggressive action by third-party payers and employers, both of whom have been slow to react to the emerging direct-care labor crisis.

Although there is some belief that these problems will be solved with a softening economy, recent data from the Bureau of Labor Statistics suggests that even if a recession occurs, high vacancy rates will continue in the long-term care industry for two reasons:

- The relatively flat supply of the traditional caregiving workforce (women aged 24 through 54), and
- The increase in demand for services from a burgeoning elderly population and the population of disabled consumers who are living longer, and thus requiring more services.

Despite the overall job loss in the economy in April employment demand within these targeted occupations and related occupation clusters (i.e., those competing for the same type of workers), remains high.

- Health services added 14,000 jobs in April
- Home care employment dropped slightly, but is still higher than one year ago
- Nursing and personal care facility employment increased in April
- Hospital employment increased in April
- Social services employment increased in April

More specifically, the unemployment rate for women aged 25 through 54 dropped in April to 3.4 percent (from 3.5 in March) and is again the lowest of any other major gender/age worker grouping. This reinforces the theory that competition for traditional caregivers in the civil labor force will remain high compared to other worker groupings.

Finally, looking at labor price: Despite the overall drop in employment demand, average hourly earnings rose by 5 cents over the month, and average weekly earnings increased by 0.4 percent. Thus, wage pressures remain upward.

PART VII: ESSENTIAL ELEMENTS OF THE DIRECT-CARE WORKFORCE

The five essential elements necessary to frame a quality health care job are:

A "family wage," health insurance, and other benefits; A reasonable hourly starting wage for a person entrusted with the care of an ill or frail human being should be at least 200 percent of the minimum wage (which currently would total $10.30 per hour. Additional compensation should be offered for weekend and off-hour shifts, which are essential in providing adequate and safe care to long-term care clients.

In addition, the health care industry should provide health insurance to its own workers and their families, as well as vacation pay, sick pay, paid holidays, retirement benefits, and family medical leave.

Balanced and safe workloads; Much of the home care industry is structured on the presumption of part-time work. For those seeking full-time employment, home care jobs should offer a minimum of 35 hours per week without overuse of off-hour shifts. Scheduling full-time home care work requires greater provider and client flexibility, as well as the geographic "clustering" of cases to ensure a minimum of time lost to transportation.

In facility-based care, "working short" frequently requires either overtime, or rushed and unsafe care, or both. Overtime should never be mandatory, and staffing levels should be increased to 4.13 hours of staff time per resident, per day, the minimum required to meet consumers' medical and psychosocial needs.[vi]

Higher training standards; Providing care to vulnerable clients requires more formal training than the federally mandated 75 hours. Paraprofessional entry-level training should be updated and expanded to reflect current care needs, clinical realities, and adult life-long learning techniques. The training should cultivate problem-solving, interpersonal, and communication abilities, and specific skills related to caring for clients with Alzheimer's disease, physical disabilities, and depression.

Opportunities for advancement and professional development;
To both attract and retain good dedicated staff within the long-term care health system, potential workers must have access to career pathways by which they can develop themselves and, over time, receive higher levels of compensation for higher levels of experience, skills, and responsibilities.

However, creating a "career lattice" that extends above the entry-level position must not be an excuse for keeping lower-rung positions at low wages. Many individuals prefer to remain as direct-care workers and should be rewarded for doing so. Otherwise, "forcing" staff up a career ladder—because it is the only way to escape poverty—will merely exacerbate rapid turnover of direct-care staff.

Employee supports, provided by both the community and the employer. The nature of direct-care jobs requires two types of support: *Externally*, paraprofessional work often entails off-hour and multi-site employment and, thus, community services such as special-hour child care and transportation must be arranged, most likely through community-based services outside the provider agency.

Internally, paraprofessionals require a job design that recognizes their skills, as well as their special knowledge of the client. One approach is to ensure that paraprofessionals are made a central member of the "care team." This in turn requires higher levels of effective supervision[2]—including "job coaching" and other approaches that emphasize problem solving over disciplinary actions—and training in the cultural differences that often divide professionals from paraprofessionals and staff from clients.

[2] Nurses are trained in clinical procedures, but are rarely schooled in effective supervision practice.

While fully implementing these five elements will be difficult to undertake within our currently ill-structured system of long-term care, many worker-centered initiatives are now being encouraged in a variety of experimental settings, one which is described below.

The Cooperative Healthcare Network

As mentioned earlier, the Cooperative Healthcare Network is a federation of largely worker-owned home health agencies. In addition to our three worker-owned enterprises, we have started two paraprofessional training institutes: one is part of the Visiting Nurse Association of Southeast Michigan and the second is a program in the Good Faith Fund in Pine Bluffs, Arkansas, a nonprofit arm of the Southern Bank Corporation which provides nursing assistant training and employment opportunities for TANF eligible individuals under the state's welfare program.

Each of our worker-owned agencies has many structural elements in common that have facilitated their becoming standard bearers in the industry. Elements of our companies include:

- Careful selection and recruitment of new employees
- A commitment to offering the highest wages possible within the reimbursement structure – our wages are higher than other providers in our market areas
- Fully paid health insurance
- Paid vacations, sick time and holidays
- 4 – 5 weeks of training, although the federal government requires only 75 hours of training for home health aides reimbursed by the Medicare program.
- Reinforcement and support to assist workers moving from training to full-time work. This includes helping trainees and new workers coordinate housing, transportation or child care assistance from local government programs.
- Upgrading commitment to build internal or external opportunities for advancement. As home health aides become more proficient in their jobs, we offer career advancement opportunities to become associate trainers (in the basic and ongoing skills programs), clerical staff, peer counselors and a soon to be developed peer mentoring program. Others become workforce development staff who guide and support new home health aides. A few have become nurses and social workers.

In each of our companies we are engaging in ongoing experimentation to improve the delivery of care by further enhancing paraprofessional jobs. Some examples include:

- A coaching method of supervision which enhances the supervisory skills of coordinators and leads to better problem solving and higher retention among direct care workers
- Paid peer mentoring training job opportunities
- New career ladder opportunities
- Guaranteed 30 hours of work after several years with the company
- Upgrading aides to become skilled in assisting clients with dementia, specific disabilities or those in hospice
- Job redesign for the direct care worker by emphasizing individualized care, team work and culture change

PART VIII: EXPERIMENTS IN DIRECT-CARE RESTRUCTURING

Experimentation to improve the quality of paraprofessional jobs is now occurring both within government and inside the long-term care industry:

Government actions include: ◆ wage and benefit "pass-through" legislation at the state level, ◆ state health insurance programs for home care workers, ◆ minimum staffing regulation initiatives at the federal and state levels, and ◆ new training and welfare resources at the state level. ***Industry practices*** include: ◆ job redesign programs, and ◆ new recruitment, training, and career pathways consortia among regional employers.

Part IX: RECOMMENDATIONS

In response to the emerging direct-care crisis, we propose the following initial steps:

1] **Create a national *"Long-Term Care Workforce Commission."*** This sectoral commission could be sponsored by one or more nationally respected foundations, modeled after the Kaiser Commission on Medicaid and the Uninsured. The charge of the commission would be to propose how the nation's long-term care system can be assured of an adequate, well-trained and stable direct-care workforce. Initial activities of the commission might include recommendations to:
Structure a cross-departmental dialogue at the federal administrative level, particularly between the departments of Health and Human Services (DHHS), Labor (DOL), and Education (DOE).

- **Research paraprofessional demographics and document paraprofessional job quality.**

- **Design a system of workforce data, reported by each publicly funded direct-care employer.**

- **Encourage further "effective practice" experimentation at the federal and state levels.**

- **Encourage further "effective practice" experimentation among employers, consumers, and organized labor.**

2] **Identify a few key states in which to create an administrative, cross-departmental "Long-Term Care Council."** Each state council would explore ways to remove inefficiencies, identify opportunities to re-build that state's direct-care workforce, and encourage further experimentation among demonstration programs.

3] **Consider promoting a single initiative across several states—*e.g.*, "health care for health care workers."** This initiative could build on the success of child care workers in Rhode Island, as well as the research and legislative initiatives undertaken by the Service Employees International Union on behalf of home care workers in California and New York State.

4] **Support cooperation and organization among the three key stakeholders.** Nationally, representatives of these three key actors within the long-term care system have formed the Direct Care Alliance (DCA). Assistance could be provided to the DCA to encourage information interchange among providers, workers, and consumers.

Our system that provides long-term care to our most vulnerable citizens is truly in danger. While the demographics are inexorable, the resulting crisis is not.

We built a system of care when labor was plentiful, and thus we could "afford" to offer poor-quality jobs. Now that labor is a scarce resource, our presumptions, and prescriptions, must change.

In this period of high competition for labor, we must create jobs that will attract workers. To do so will void the crisis. To do otherwise will be to witness the wealthiest health care system on earth perpetuate poverty-level jobs—offering to its most vulnerable citizens care that is hurried, care that is delayed, and increasingly, care that is foregone.

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[i] D.U. Himmelstein; J.P. Lewontin, and S. Woolhandler, "Medical Care Employment in the United States, 1968 to 1993: The Importance of Health Sector Jobs for African Americans and Women," *American Journal of Public Health* (April 1996, Vol. 86, No. 4).

[ii] Genevieve Gipson, Director, Career Nurse Assistant Programs, Inc.

[iii] Sarah Greene Burger et al. (June 2000) "Malnutrition and Dehydration in Nursing Homes: Key Issues in Prevention and Treatment," The Commonwealth Fund, www.cmwf.org.

[iv] Elma Holder, founder of the National Citizens' Coalition for Nursing Home Reform.

[v] Testimony of the National Association for Home Care, submitted to the House Committee on Education and the Workforce Subcommittee on Oversight and Investigations, February 17, 2000.

[vi] The National Citizens' Coalition for Nursing Home Reform (NCCNHR) endorsed this staffing ratio, which was based on the experiences of residents, families, nursing home staff and developed by professional experts convened by The John A. Hartford Institute for Geriatric Nursing at New York University in April 1998.