~AARP NATIONAL CONFERENCE ~

Paraprofessionals on the Front Lines: Improving Their Jobs — Improving the Quality of Long Term Care

PRESENTATION: "Confronting the Decline of Paraprofessional Care"
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Steven L. Dawson
President
Paraprofessional Healthcare Institute, Inc.

INTRODUCTION

In my remarks this morning, I ask that you picture in your mind two individuals: a long term care client, and her direct-care worker.

Now, I ask that you keep that image in mind, because at the heart of our work at the Paraprofessional Healthcare Institute lies a core premise. We believe that:

> **A direct link exists between the quality of the paraprofessional's job, and the quality of care her client receives.**

That is, we believe that the paraprofessional is the face, voice and hands of healthcare for literally millions of Americans—but particularly long-term care consumers.

And yet—and this is the most important information I can bring to you from working directly with paraprofessional agencies across the country—our full-employment economy, combined with a re-structured welfare system, is already colliding with America's expanding long term care needs.

Increasingly, our welfare system is directing women away from healthcare jobs, and in a full-employment economy, low-income women are increasingly finding job alternatives outside of healthcare.

What this means is that—with only a few courageous exceptions—the quality of both long term care and paraprofessional jobs is, at this moment, deteriorating across the country. In turn this means that we can no longer presume an endless supply of caring, competent women willing to feed and bathe our loved ones for low pay and few benefits.

In this afternoon's sessions, we will have the opportunity to talk about these issues—something I have been looking forward to since the AARP first decided to host this conference. For I know that all of you here—not just on these panels, but those of you in the audience as well—have worked long and hard on these issues.

It would be a great credit to the AARP if, upon leaving *this* conference, we —as providers, consumer advocates and worker advocates—find new common ground.

Because unless we begin to speak with one voice—and create a new mechanism to carry that voice—the quality of life for both long term care clients and their caregivers will *continue* to deteriorate across the country. …Even within our supposedly "perfect" economy …deteriorating even in this, the wealthiest country the world has ever known.

So let me briefly introduce our work at PHI, the Paraprofessional Healthcare Institute. Then, I will:

- Describe some of the nationwide *forces* currently shaping paraprofessional jobs; and

- Close with specific *suggestions for action*.

THE PHI EXPERIENCE

PHI is a nonprofit organization, based in the South Bronx, that focuses exclusively on the recruitment, training and supervision of paraprofessional healthcare workers. PHI links a small system of worker-owned, paraprofessional service agencies and training programs across the country. What we call the "Cooperative Healthcare Network" currently employs about 600 para-

professionals—more than 70 percent of whom were formerly dependent on welfare.

By far the largest of these worker-owned agencies is Cooperative Home Care Associates, which is also based in the South Bronx and is now 13 years old. CHCA's success is due in very large part to its relationship with the Visiting Nurse Service of New York, which is CHCA's largest contractor. The VNS provides the full range of home care services throughout New York City, and contracts with agencies like CHCA for paraprofessional-only services.

PHI's other inner-city affiliates, in Boston, Philadelphia and Waterbury (Connecticut), and its rural affiliates in Arkansas and New Hampshire, share a similar strategy of concentrating exclusively on *paraprofessional* services. Recently, PHI joined in partnership with the VNA of Southeast Michigan, in Detroit, to establish a paraprofessional training institute. And most recently, the Catholic Campaign for Human Development and the Catholic Health Association have asked PHI to assist in their collaborative to create worker-owned paraprofessional healthcare agencies in cooperation with local Catholic health systems.

We maintain this exclusive focus, not only to convince the healthcare system to value the paraprofessional more highly, but also to help ensure that the paraprofessional brings more value to the healthcare system.

Later this morning, you will meet Peggy Powell, Executive Administrator of PHI, and Denise Clark, a home health aide and recent corporate board member of Cooperative Home Care in the Bronx. They will provide you an inside look into our largest employee-owned agency.

THE FORCES SHAPING PARAPROFESSIONAL JOBS

We see three major forces shaping the future of paraprofessional healthcare jobs:

The first factor…

…is a significantly re-structured, low-income labor market. Our economy—which is now desperate for entry-level workers, to serve us food and to clerk our counters—is beginning to confront a growing demand for community-based care. While this is a relatively positive trend for low-income women, it should be extremely troubling for those concerned with long term care consumers.

For the familiar "zero sum" argument—that investing in better job quality for paraprofessionals will only mean less care available to consumers—presumes an endless supply of saintly, low-income women. We believe that argument will soon be rendered moot: Other jobs, with better hours and easier work—and sometimes even better pay—are now plentiful in many parts of the country.

(In Boston, we lost one excellent home health aide to a job at Starbucks that offered a full 40 hour week, plus 20 hours at time-and-a-half.) And surprisingly, this labor shortage is occurring *despite* the current disruption in the home health care industry under Medicare's Interim Payment System—which, at least temporarily, is reducing the demand for home care workers.

Clearly, this change is deeper than the now recognizable, cyclical phenomenon of a labor shortage among direct care givers occurring whenever our economy is strong. It is that, but more: It is also a *structural* shortage reflecting the twin demographic realities of the "baby boom": The "bulge" in our elderly population is being followed by a "flat" number of younger workers—too many elders needing long term care with far too few young workers available to care for them. This new reality will not fundamentally change, even when the economy next softens.

And therefore, it seems clear to us that, if we want *qualified, competent,* and *trustworthy individuals* to show up at our bedside in the future, <u>we will have no choice but to improve these jobs</u>.

The second factor…

…is the rise of the <u>market-based healthcare system</u> in America, which has created a phenomenal degree of instability, not only for healthcare consumers, but for healthcare workers as well.

Change is good; competition is healthy… Yet the speed of change and the degree of instability that has accompanied this hyper-market orientation has clearly been destructive: In Philadelphia, eight hospital systems merged into three within a three-year period, and then, just last month, one of those three systems, the Allegheny Health System, declared bankruptcy. The result has been layoffs, client referral disruptions and in general, a sense of chaos within the Philadelphia healthcare market.

And the instability is far from over: More than 60 percent of the HMOs in the United States reported losses in 1997—this *without* the passage of legislation allowing consumers to sue their HMO for failure to cover services. That breadth of loss means our nation's healthcare system has yet to find a formula for

financial stability …let alone the stability required to pay attention to the paraprofessional workforce …let alone the stability required to build a *high-quality* paraprofessional workforce.

And the final factor is public policy.

At the crossroads of healthcare policy and welfare policy stands the direct-care worker.

Healthcare Policy

Now, what is remarkable about healthcare regulations governing paraprofessional jobs is this: They simply don't exist. Other than requirements for training, which we know to be minimal, Medicare and Medicaid regulations are silent on issues of wages, benefits and hours of work. Tellingly, when HCFA issues new regulations on Medicaid, for example, it is required to assess the impact on consumers, on states, and on providers—but not on workers.

And the logical result is that the paraprofessional bears much of the brunt of budget cuts: Due to the public policy combination of Medicare's home care Interim Payment System and government's continued encouragement of managed care—with the exception of New York—we have witnessed a marked decrease in the quality of direct-care jobs across the country: Cases are fewer, visits are far shorter —and therefore average hours per week are less, paychecks are smaller and paraprofessional jobs even more unstable than before.

Simply stated, the Federal government is the single largest funder of health care, and has therefore in essence created an entire labor market of para-professional healthcare workers—a labor market that would not exist without its funding, a labor market that keeps low-income women "working, but poor." And yet clearly, our government has yet to accept any responsibility for creating—and maintaining—literally hundreds of thousands of poverty-level jobs. For we know from research conducted by Dr. Himmelstein of Harvard Medical School that more than 600,000 workers who are employed by our healthcare system go home at night to families living below the poverty line.

Welfare Reform

And when welfare reform crosses the path of healthcare re-structuring, the ironies really begin to mount—particularly when you recall that both healthcare and welfare policies are managed within the same Federal Department of Health and Human Services. For example:

- **Congress and the Clinton Administration recently created a $3 billion program to encourage welfare recipients to secure jobs.**

  PHI applied for a grant under this initiative, and, while the quality of the program was praised, the reviewers concluded that the paraprofessional jobs our cooperatives were offering *paid too little for welfare recipients*—even though our cooperatives pay above the average market and offer health benefits.

  …This from the *same* Federal government that pays us to provide these paraprofessional services.

- **And a second irony: the central tenet of welfare-to-work reform is the concept of "work first."**

  That is, welfare recipients are encouraged to find a job, any job, rather than seek preparatory training. Therefore, no welfare-to-work funds are available even for even the short-term skills training—four weeks in length—that PHI's affiliates provide their entry-level workers.

  …Yet this is the same Federal department that *requires* that home health aides and certified nurse aides receive skills training before they are allowed to care for a client.

But the most important change is that, for many low-income women, welfare is disappearing altogether—due to time limited benefits, plus a much more aggressive approach to denying support from the very beginning. This bodes ill for home care and other health services that rely on women working part time, because the reality has been that for years many poor women have worked part-time jobs, *and* collected welfare— sometimes legally, sometimes not.

Now, however, as low-income women find themselves cut off completely from welfare, they will need something approaching full-time work—and if the healthcare system doesn't offer it, they will find it elsewhere. In short, we will no longer be able to rely on the welfare system to subsidize our part-time healthcare employment.

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A CALL TO ACTION

In my last few minutes, I would like to talk about us… I believe all three of us:

- Consumers
- High-Quality Providers
- Workers

essentially face the same risk. Each of us is harmed by the current system, and each will be hurt even more as the system continues to deteriorate. And yet, we have to date not spoken with one voice on the future of paraprofessional care.

To begin, I hope that all three of us might agree on two core principles:

- Direct care workers must *be more highly valued by* the healthcare system: They deserve a livable wage—which includes decent pay, healthcare benefits, and a stable number of hours of work; and at the same time,

- Direct care workers must *bring more value to* the healthcare system: They must be better trained, better supervised, and better supported.

I know this is far easier said than done. But for this afternoon's discussion, I want to offer a few suggestions based within those two principles:

1] **Educate the public:** We must aggressively project the positive, essential role that paraprofessionals play within our healthcare system—otherwise, all we will read in the newspapers will be more stories of nursing home aides beating their clients, and home care aides stealing the life savings of widowers.

2] **Encourage industry "effective practice":** Despite my gloomy report, examples of excellent paraprofessional-oriented practice do exist. These should be examined, promoted and given incentives within the provider, consumer and labor communities.

3] **Collect data:** And in this case, I mean the Federal government should collect labor data directly from the providers that it funds. For, dry as it may sound, we know far too little about how our public tax dollars are used in the perpetuation of poor-quality healthcare jobs. The first

step in making the Federal government responsible for this labor market… is to ask that it measure it.

4] **Introduce government to itself:** We must encourage the people inside HHS responsible for healthcare policy to talk with the people inside HHS responsible for welfare policy. Both must understand that welfare policy has a profound impact on healthcare, and that healthcare policy has an equally profound "labor impact."

5] Finally, rather than fighting the inevitable, we **should make use of market forces**. Reward in the market place those agencies that create decent paraprofessional jobs and provide high-quality paraprofessional services. This can be done by requiring that consumers be informed—through the use of a "quality scorecard" —about each providers' employment practices (including turnover rates, health insurance benefits, and wage rates for different classes of workers).

For example, if I as a family member know that one nursing home has a paraprofessional staff turnover of 100 percent and provides no health benefits, while a second has a staff turnover of just 20 percent and provides their employees health benefits—then I would be pre-disposed to entrust my mother to the latter.

CONCLUSION

These are just initial ideas—but if not these ideas, then others. For our long term care system is now fraying dangerously thin.

The Paraprofessional Healthcare Institute stands ready to work with the AARP, and each of you, to create a new coalition of **consumers**, **high-quality providers** and **workers**—to strengthen that essential link between quality jobs and quality care.

Thank you.