



**Sectoral
Employment
Development
Learning
Project**

**The
Cooperative
Home Care
Associates**

**A Case Study
of a Sectoral
Employment
Development
Approach**

Cooperative Home Care Associates

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of a Sectoral Employment
Development Approach**

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The Sectoral Studies

This is the sixth and final sectoral case study published by the Sectoral Employment Development Learning Project (SEDLP), a project of the Economic Opportunities Program of the Aspen Institute. The purpose of these case studies is to provide an in-depth look at individual sectoral employment development programs and their interaction within distinct economic and industry environments. The sectoral studies offer policy makers and practitioners insights into issues involved in operating a sectoral intervention.

Although each case study explores a particular program in a specific industry sector and regional context, all answer the same key research questions and use a common research format. The methodology relied on primary data collection through key informant and focus group interviews with program staff, program participants and other key actors such as industry and trade association leaders. In addition, this case study used primary data collected through the SEDLP survey of program participants, an independent survey conducted by the Aspen Institute collects longitudinal data on program participants. That information was supplemented by analysis of internal program documents and financial statements, SEDLP self-reported program monitoring profile data and some secondary source materials. The sectoral studies were made possible through the support of the Charles Stewart Mott, Ford and Annie E. Casey foundations.

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“If the family isn’t going to take care of someone, and the system isn’t going to take care of someone, we are the ones nursing them back to health.”

— CHCA aide¹

As CHCA became more deeply involved in the home health care arena, the organization’s perspective changed from that of an outsider advocating for change in the home health sector, to that of an insider within the sector.

Cooperative Home Care Associates (CHCA) is a worker-owned cooperative and employer-based training program that provides home health aide services in New York City’s South Bronx. The cooperative was launched in 1985 as part of a strategy to improve the low-wage occupation of the home health aide and create employment opportunities for low-income women. As CHCA developed, the intention became to establish an enterprise model to demonstrate how the home care job could be improved, and then diffuse those practices by becoming a “yardstick” corporation for the industry. As CHCA became more deeply involved in the home health care arena, the organization’s perspective changed from that of an outsider advocating for change in the home health sector, to that of an insider within the sector. CHCA became concerned with many issues involved in providing quality home health services, including — but no longer limited to — the quality of the home health aide’s job. The quality of the job, however, remains a leading issue for CHCA and, increasingly, the industry. CHCA contributes to the debate by highlighting the relationship between quality home care jobs for workers and quality service for patients, and by testing effective practices.

As CHCA refined its approach during the years, the training program and business expanded significantly. The cooperative has been able to offer its employees better benefits, increased working hours and modestly higher pay, as well as an unusually supportive working environment. In addition, the organization has had some influence on industry practice and public policy in the New York market. CHCA’s accomplishments encouraged philanthropic investors to back the organization’s leadership in an attempt to replicate the model in other cities, and to experiment with new approaches and programs. Today, CHCA is part of a network of affiliated businesses and training programs all founded with a similar mission. In addition, CHCA has an important nonprofit affiliate, Paraprofessional Healthcare Institute (PHI), which extends CHCA’s

¹ Focus group interview by authors, 16 March 2000.

sectoral approach by explicitly addressing the policy and regulatory issues that determine what is possible in the long-term care industry. CHCA is one of the leading examples of a sectoral employment development strategy. The box below shows how CHCA meets the defining characteristics of a sectoral initiative.²

Cooperative Home Care Associates as a Sectoral Initiative

- **Targets a particular occupation or set of occupations within an industry.** CHCA targets the home health care industry, and the specific occupation of home health aide within it.
- **Intervenes by becoming a valued participant within the industry that employs the occupation.** CHCA directly participates in the home health industry as a business, and has become well known as a quality service provider. CHCA leaders are recognized and respected advocates involved in industry associations and in policy and reform efforts.
- **Exists for the primary purpose of assisting low-income people to obtain decent employment.** CHCA provides training and jobs for low-income women in an inner city area. Most CHCA applicants receive public assistance, and they often have multiple barriers to employment such as limited work histories and low education levels. The majority of home health aides at CHCA are from minority ethnic or racial groups.
- **Eventually creates systemic change within that occupation's labor market.** By modeling best practices in its own business and disseminating information through involvement in industry organizations and policy reform efforts, CHCA has gained influence within the New York City home health sector. CHCA is identified as a yardstick company that is respected by clients, other providers and regulatory agencies. Other home health care providers have adopted some of CHCA's practices. In addition, CHCA has built on its success in New York to develop initiatives for sectoral change in other cities and states. CHCA and its affiliates also have been active in debates concerning the policy and regulatory structure affecting the home care industry.

² Peggy Clark and Steven L. Dawson, *Jobs and the Urban Poor: Privately Initiated Sectoral Strategies*, (Washington, DC: The Aspen Institute, 1995).



Outline of the Case Study

- **Section 1:** The case study begins with a description of the key features of the home care industry environment in which CHCA operates. Details on the nature and conditions of home care work are presented, as well as the way the home care industry is set up and operated in New York City.
- **Section 2:** This section provides a brief history of the development of Cooperative Home Care Associates and some affiliated organizations. It presents key organizational features and relationships that have been important in CHCA's evolution.
- **Section 3:** Important aspects of CHCA's sectoral approach are described in more detail. The Quality Jobs/Quality Care strategy is described, as well as CHCA's involvement in regulatory reform efforts. Information is presented on CHCA's experience in trying to develop career advancement strategies. Finally, this section analyzes the broader influence of Cooperative Home Care Associates on the home care sector.
- **Section 4:** This section provides a more detailed analysis of the training program. The main elements of the content and training approach are described. CHCA's effective intake and recruitment strategy also is covered in some detail.
- **Section 5:** This section addresses training costs and outcomes, and describes how CHCA internally assesses its progress toward achieving its goals.
- **Section 6:** The final section summarizes lessons learned from CHCA's experience. The points are drawn from issues that emerged during interviews and in the course of other research conducted for the case study.

Health care is strikingly different from other economic sectors in the intimacy of its services, the emotional involvement of its “customers,” the complexity of its financing and the degree of governmental involvement in every aspect of its direction and day-to-day functioning.

One dollar out of every \$7 spent in the national economy goes to health care. Both the absolute dollar amount and the proportion of gross domestic product (GDP) spent on health care have grown rapidly during the past several decades, and both are projected to continue growing. In 1980, national health expenditures were about \$247 billion, or \$1,052 per capita. By 1998, national health expenditures had risen to about \$1,149 billion, or \$4,094 per capita. Of that \$1,149 billion in 1998, approximately \$29.3 billion was spent on home health care.³

When most of us think of health care, the first things that come to mind are visits to a doctor and, in an emergency, to a hospital. These two aspects of the health care enterprise encompass about 60 percent of national health care spending. The success of these two services during the past four decades, along with significant advances in pharmaceuticals, means that greater numbers of people are surviving into old age and living with disability. However, many of these elderly and disabled individuals require continued treatment and ongoing assistance with the routines of daily life. This assistance has come to be called “long-term” (chronic) care. Formal long-term care is provided primarily in nursing homes and at home, and it has been increasing. In 1980, nursing home care made up about 7.1 percent of national health expenses, and formal home health care was about 1 percent. By 1998, they had risen to 8.6 and 2.9 percent, respectively. Because these figures do not include nursing home and home health services provided by hospitals, they are actually understated.⁴

Home health care covers a wide array of services that enable patients to function at home, in a community setting. These include medical services such as nursing, rehabilitation, respiratory and physical therapies. Beyond health care, patients often require a wide range of personal care, social, homemaker and housing services. For example, patients may require assistance with basic activities such as shopping, fixing meals, bathing, dressing, toileting and housecleaning.

³ Katherine Levit, Cathy Cowan, Helen Lazenby, Arthur Sensenig, Patricia McDonnell, Jean Stiller, Anne Martin and the Health Accounts Team, “Health Spending in 1998: Signals of Change,” *Health Affairs* 19, no. 1 (January/February 2000): 124-138.

⁴ Levit et al, 125.



The job of the aide requires technical skills as well as emotional sensitivity. Doing the job well requires initiative.

However, some long-term care patients require technologically intensive medical care. Advances during the past few years have enabled the use of some of these technologies at home. They may include ventilator-assisted breathing, intravenous therapy and nutritional tube feeding.



Photo by Rick Smith Studios

Home health aides help patients with a variety of tasks, including personal grooming.

Acute and Long-term Care

Home health care is typically provided to two broad (and often overlapping) types of patients. First are those recovering and being rehabilitated at home following an acute illness or injury. Typically, this is immediately after being hospitalized. An example might include an elderly patient who has returned home following hospitalization for a broken hip. This patient might require assistance with meals, bathing and walking during the course of recovery, but care stops once recovery is complete. The second type of patient has a condition that can be managed over the long term, but from which there is typically no recovery. These patients suffer from chronic conditions such as Alzheimer's disease, chronic obstructive pulmonary disease and many cardiovascular conditions.

Most assistance provided to long-term care patients at home is actually provided informally by family members, friends and neighbors. Many people receive a combination of informal care, such as that provided by family members, along with formal care provided by home care agencies. Some estimates indicate that only a relatively small number of patients rely solely on formal care.

The Nature of Home Health Care Work

The home health aide workforce is overwhelmingly female and typically low income. It often includes former welfare clients, especially in New York City. It is disproportionately made up of immigrants.

The work of the home health aide involves such functions as assisting patients with dressing, bathing and toileting. It also involves feeding patients and may include food preparation. The work is physically demanding. Aides must regularly lift patients who cannot assist in any way, and who are often frail. Although aides are intimately involved in caring for patients, they may not perform certain medical tasks. For example, aides typically may not administer medication. In home health care, that role is left to nurses, the patients themselves and patients' family members.

As with many jobs in the arena of human services, there are ironies in the home health aide's job. On one hand, the jobs typically:

- Are contingent, meaning that the availability of work for an individual aide depends on whether there is a patient. When an aide's patient is hospitalized or – as is often the case – dies, the aide is temporarily out of work
- Pay relatively little
- Provide less than full-time hours
- Offer limited or no fringe benefits, particularly health insurance or pension contributions
- Are attributed low status within the hierarchy of health care providers, which includes doctors and nurses

At the same time, much is expected of the home health aide. She must be able to function independently. Most of the hours an aide spends with the patient are not directly supervised. For certain types of conditions, the home health aide spends more time with the patient than any other health caregiver. The job of the aide requires technical skills as well as emotional sensitivity. Doing the job well requires initiative. The rewards and challenges of home health aide work are captured in comments made by CHCA aides:

- "My favorite thing is to walk in and be greeted with a smile. I make a cup of coffee for my patient and we talk."
- "I love to go to Bingo with my client. We win and the other elderly folks get mad. I love taking clients dancing; to the recreation center. ... (My) least favorite aspect is dealing with family members of clients. They come into the house and

order you around, say you have to do this or that. They think you are there for them.”

- “(You) have to do everything for some patients – the quadriplegics. There are so many different personalities you have to learn to work with. Some are prejudiced – I’ve been called the N-word. You have to learn to count to 10 and say the Lord’s Prayer. So many times! But it’s because people can’t do the things they used to do and they are frustrated. They take it out on you. You get tough and they don’t want you to leave, but they still take it out on you.
- “I enjoy giving the bath, the grooming and skin care. ...It’s hard sometimes knowing what to cook for a patient when there isn’t much food available.”
- “The job as a home health aide is hard and not well-paid. The satisfaction does not come from the money, but from the well-being of the patients.”

— CHCA aides and staff⁵

The Role of Government in Health Care

Government plays a much more substantial role in health care than in most other sectors of the economy. Government involvement consists of three primary functions: the traditional role of overseeing public health, which is not central to understanding CHCA; the role of insurer; and the role of regulator. In the government’s role as insurer, it pays for approximately 45 percent of health care expenses in the United States. It does this primarily through three programs: Medicare, Medicaid and State Child Health Insurance Programs, the latter of which will not be discussed here. Government pays for an even larger share of home health care expenses than is the case for the rest of health care. Private insurance usually covers at least a minimum of home health care services and it pays for about 11 percent of national home care expenditures. Many people pay for such services out of their own pockets for themselves or family members, and these payments make up about 21 percent of total home care expenditures. Other private payments total about 12 percent. The government pays for the bulk of home health care, however, most notably via the Medicare and Medicaid programs. Medicare pays for just under two-fifths (39.5 percent) of

⁵ All comments from focus groups on 16 March 2000, except for the last comment, which was from a CHCA aide on 11 January 2001. The comment came from an independent survey conducted by the Economic Opportunities Program of the Aspen Institute, as part of the Sectoral Employment Learning Development Project.

home health care and Medicaid pays for about 15 percent. Thus, government pays for almost 55 percent of all home health care expenditures.⁶

Medicare and Medicaid add an overlay of regulation not found in every economic sector. With government involvement comes a high degree of politicization. This sometimes produces rather abrupt swings in the fortunes of those dependent on public programs. Some of it is arbitrary. Much of it feels arbitrary to those involved, especially patients waiting at the end of a long chain of administrative processes. The volatility that results from the politicization of health care has made planning difficult. Operating in this environment requires tenacity, resilience and flexibility from organizations, as well as a high level of political sophistication.

Medicare

Medicare is the federal government's health insurance program for the elderly (and a very limited number of younger disabled persons). It is entirely paid for, overseen and administered by the federal government. Direct administration, especially payments to health care organizations and professionals, is contracted to fiscal intermediaries, which are generally private health insurers. Their interpretation of federal law, regulation and policy sometimes varies, creating confusion and inconsistencies in the actual operation of the program. Three separate intermediaries deal with home health care in New York.

Originally designed during the early 1960s and enacted into law in 1965, Medicare coverage is still focused on acute hospital and physician services. Medicare does cover home health services, but its benefits are generally limited to acute episodes. It does not cover chronic care. Medicare's rules and procedures are complex both for patients and for those providing health services to them. To be eligible for home health benefits, the patient must meet all three of these conditions:

- 1) The patient must be considered homebound, meaning he or she must have a condition because of illness or injury that makes it very hard to leave home.
- 2) The patient must require the services of a skilled nurse or a speech, physical or occupational therapist on an intermittent or part-time basis.

⁶ Health Care Financing Administration, Office of the Actuary.

- 3) The patient must receive care in accordance with a physician-approved plan from a Medicare-certified home health agency.

Medicaid

Medicaid is the federal/state government health insurance program for the poor. Medicaid also covers home health care services. Medicaid is overseen by the federal government and is administered by the states. It is paid for by both federal and state funds. Within broad federal guidelines, states have considerable latitude to determine who is eligible, what services are covered and to what degree, and how much medical organizations and professionals will be paid for services. Furthermore, certain states, including New York, choose to extend some forms of coverage that do not operate under the federal umbrella and are not supported financially by the federal government. In the state of New York, the New York City government and counties outside the city also play major administrative and financial roles in the program. This means that home care agencies must deal with three levels of government to provide Medicaid-covered services. Medicaid covers some — but not all — poor patients. To be eligible for Medicaid, one's income and assets must not only be low enough; one must fit into a statutory category. The categories are primarily aged, blind, disabled or a member of a family in which there is a dependent child. The processes that states or localities develop for determining whether an individual is Medicaid-eligible often are protracted and highly complex, deterring many eligible individuals from seeking Medicaid coverage. Not surprisingly, there are many elderly and disabled poor individuals who are covered by both Medicare and Medicaid. Billing for these dually eligible patients further increases the administrative complexity of operating a health care agency.

Unlike Medicare, Medicaid does provide long-term home care for chronically ill patients. However, it does this only for those who are poor enough. Many people, especially elderly individuals with significant extended illness, do not start out poor, but go through a process called "spending-down," in which they exhaust enough of their own money on health care until they become poor enough to be Medicaid-eligible. This is especially so for nursing home patients who often use up their assets very quickly. Among the elderly covered by New York's Medicaid program, 22 percent, or

nearly 100,000 elderly people, used some form of non-institutional, long-term care in fiscal 1997-98. Another 80,000 non-elderly Medicaid clients also received home care services.

How Home Health Care is Organized

Except for government agencies, virtually all home care agencies are incorporated. They may be established as voluntary, not-for-profit organizations or as for-profit stock companies. To get a sense of the national distribution of home care agencies by type of organization, one can look at the distribution of the subset of home care agencies that serves the Medicare population, as shown in Table 2.1. Note that not all home care agencies serve Medicare enrollees. Cooperative Home Care Associates is unusual, with its structure as a worker-owned, for-profit cooperative.

Table 2.1:

Number and Percent of Certified Home Health Care Agencies Used by Medicare Enrollees, U.S., Calendar Year 1997, by Type of Control

Type of Control	Number of Agencies	Percent
Voluntary nonprofit	1,923	54.1%
Proprietary	1,313	36.9%
Government	321	9.0%
Total	3,557	100.0%

Source: *Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1999*, U.S. DHHS, Health Care Financing Administration, Table 49, Persons Using Medicare Home Health Agency Services, Visits and Charges, by Type of Visit, Type of Agency and Type of Control: Calendar Year 1997, 204

A home health agency must have a state-issued certificate to do business directly with Medicare. New York has a unique structure in that it differentiates between certified and licensed agencies. While most states provide both nursing and aide services under one organizational umbrella, in New York City the typical arrangement is that nursing services and supervision are provided directly by a certified agency and aide services are provided by a licensed agency. Certified agencies must go through a much more rigorous process to be established, and must adhere to more extensive operational requirements.

In New York City, licensed agencies providing home care services are divided into two main segments: home health aide services and personal care aide services.⁷ Some licensed agencies, such as CHCA, focus their attention and business strategies on providing home health aide services through subcontracts with certified agencies. Other licensed agencies, called home attendant agencies, contract with city or county agencies to provide personal care aide services. Many provide services to private-pay patients in addition to their contract work.

Use of Home Health Care Services

There is considerable variation in the use and costs of all types of health services, including home health care. Marked differences among states can be seen in the usage of home care services, as financed through both Medicaid and Medicare.

New York spends proportionately more than other states on home care spending under Medicaid. In 1997, New York was the highest-ranking state in per capita Medicaid spending for home care, at \$192.63. It was substantially ahead of other states, with the second highest-ranking state, Rhode Island, spending only \$126.69 per capita for home care.⁸

Under Medicare, New York's pattern is closer to the national average. In 1997, the national average number of persons receiving home health care for every 1,000 Medicare enrollees was 109. In Massachusetts and Mississippi, however, the numbers of persons per 1,000 receiving home health services were 152 and 153, respectively. In contrast, the rate in New York was 94, and in Wisconsin, the rate was 69. Federal intervention since 1997 may have reduced this variation somewhat, but substantial differences remain. Not only is there variation in the number of people who receive home care, there is variation in the degree to which they receive it. Medicare enrollees who receive home health care in Mississippi receive almost four times as many home care visits per year as those in Wisconsin (120 vs. 43).⁹

⁷ Personal care aides provide assistance with daily living to generally stable, chronic patients who do not have acute medical conditions. Home health aides may perform all of the functions that personal care aides do, plus health-related tasks such as checking blood pressure and respiration, catheter care and monitoring of blood sugar levels. Thus, home health aides are qualified to care for patients with active or acute medical conditions.

⁸ AARP, "Trends in Medicaid Long-Term Care Spending," AARP Webplace (home page online); available from http://research.aarp.org/health/dd38_trends.html; Internet, accessed 12 February 2002.

⁹ *Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1999*, Table 48, Persons Served, Total Charges, Visit Charges and Program Payments for Medicare Home Health Agency Visits, by Area of Residence: Calendar Year 1997, 202.

There also is considerable variation in service use within states, including New York. This is particularly so for aide visits. For example, aide visits to Medicaid patients in New York City may be as much as four times more likely than aide visits to Medicaid patients in other parts of the state.

This high rate of spending on home care in combination with its large population makes New York City one of the largest markets for home care services in the country. While still affected by the volatility in public home care spending described earlier, CHCA leadership believes the sheer size of the New York market provides greater stability than do other markets around the country, allowing the system to better weather funding cutbacks and other

challenges. Furthermore, leaders believe this stability has provided the necessary latitude for CHCA to test and demonstrate innovative approaches to practice.

Trends in Spending on Home Health Care

Spending on home health care grew very rapidly during the late 1980s and through the mid-'90s. Especially in New York, this was partly an attempt to substitute for more expensive nursing home care. It also was partly a response to hospitals' need to discharge

patients more rapidly, as the Medicare payment system for hospital services changed from cost-based reimbursement to prospective payment. Under the prospective payment system, hospitals receive a flat rate from Medicare for services delivered, based on diagnosis-



Photo by Marilyn Humphries

Home health care covers a wide array of services for a variety of clients, including those with disabilities.

related groups. Because the amount a hospital receives for any given diagnosis is fixed, hospitals must respond by limiting costs with accelerated discharges. However, these speedier hospital discharges not only increased demand for home care services, they increased the frailty of patients newly discharged from hospitals to home care.

In 1997, the Congressional Budget Office projected that during the next five years, per capita Medicare home health expenditures would grow at an annual rate of 12 percent, more rapidly than any other type of service covered. In response to these projections, which came after already significant increases in Medicare spending, the federal government reversed direction and cut spending dramatically through the Balanced Budget Act. Medicare spending on home care fell from \$17.5 billion in fiscal year 1997 to \$14.9 billion in 1998 and \$9.7 billion in 1999, an overall reduction of 45 percent. From 1997 to 1998, the number of Medicare home health patients in New York dropped from 211,000 to 194,000, and the total number of visits dropped from 10.8 million to 7.8 million. Nationally, the declines were even larger. In one year, total Medicare home care patients fell from more than 3.5 million to just more than 3 million. Total visits fell from nearly 258 million to 155 million. Visits per patient dropped by about one-third, from 73 to about 50 in the U.S. overall. In New York they dropped by about one-fifth, from 53 to about 40.¹⁰

While every home care agency struggled, only those that were sufficiently robust to begin with survived. There was a modest increase in spending for the Medicaid personal care program in New York City, but total payments to certified agencies fell. In particular, spending on aide services fell more than 3 percent from 1998 to 1999. The possibility of continued cuts looms over the industry, and if they are enacted, many agencies are not expected to survive.

Labor Market for Home Health Care

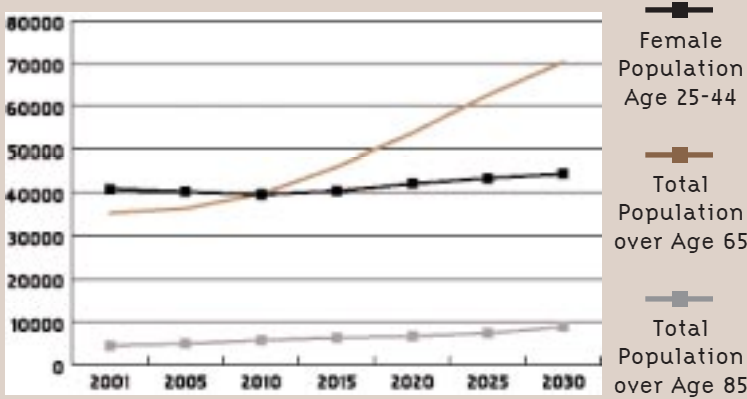
The defining characteristic of home health care is the one-on-one relationship between the caregiver and the patient, and the fact that this relationship is based in the patient's home. By its intrinsic nature, home health care is very labor-intensive and there has been relatively little success in increasing productivity. This restrains pay and, as other economic sectors become more productive, puts

¹⁰*Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1999, Table 48, Persons Served, Total Charges, Visit Charges and Program Payments for Medicare Home Health Agency Visits, by Area of Residence: Calendar Year 1997, 202.*

financial pressure on agencies attempting to retain their workforce.

Another question is whether there will be enough workers to perform the work. The elderly population, which is most likely to require home care services, is projected to grow much more quickly than other age groups in the next 25 years. By 2030, the number of individuals over age 85 is projected to nearly double, as is the number of individuals over age 65. Home health workers, however, are typically women between the ages of 25 and 44. This population is projected to grow by only 8 percent during the same period. The ratio of individuals over 85 years to women between the ages of 25 and 44 declines from approximately 1-to-10 to 1-to-5 in that 30-year period. The implication is that it will become twice as difficult to find enough workers to meet the care needs of the elderly. Figure 2.1 charts the projected growth for these three population groups.

Figure 2.1
Projected U.S. Population Growth,
by Selected Age Groups*



*Source: Population Projections Program, U.S. Census Bureau

As their numbers relative to the elderly diminish, the price of home health aides' services should logically be bid up. This could potentially lead to resumption in the actual delivery of services and at least a partial restoration of financial health to the industry. However, given the current budget situation and the regulatory ceil-

ings on health care spending and reimbursement rates for home care agencies, there are reasons to doubt the long-term prospects, as will be discussed in the section on Implementing a Sectoral Approach. There seems to be at least some probability that either there will not be sufficient numbers of people to provide the services, or that the services (especially publicly funded ones) will become too expensive for most people.

In the meantime, the home care industry continues to be characterized by low salaries and high employee turnover rates. In expectation of these high turnover rates, most agencies make only minimal investments in training and retaining workers. Home health aides typically receive only the minimum training required by regulation. The resulting situation is in some respects like a self-fulfilling prophecy: A home health agency does not invest much in training, support and compensation for its home health aides because management expects that employees are likely to leave in the short term; and home health aides frequently leave their jobs because the pay and other conditions are not attractive enough. This is the pattern that CHCA has attempted to reverse with its alternative model based on the rationale that improving the job of the home health aide can result in a win-win situation for workers, patients and home care provider agencies.

Mission

During its 17-year history, Cooperative Home Care Associates has worked to improve the quality of the job for home health care workers. Improving the conditions of home health aide work is promoted as a means for also improving the quality of patient care. This Quality Jobs/Quality Care philosophy, described in more detail in the next chapter, is the foundation for the sectoral employment approach CHCA uses.

The quest for practical ways to implement this mission led CHCA's founders to develop new program areas, form new institutions to address specific challenges and extend the approach to new locations across the U.S. These initiatives have experimented with approaches to solving the problems facing the long-term health care system from a fundamentally humanistic perspective based on concern for the welfare of workers in a demanding, low-paying profession, as well as concern for the well being of the patients.

Target Group Served

Cooperative Home Care Associates tries to create decent jobs for economically disadvantaged women. Women who enter the CHCA training program are low income, and most have previously been on public assistance. Nearly all are from minority ethnic or racial groups, with the largest percentage being Latina, followed by African American. Many participants who enter the training program have multiple employment barriers, including limited work experience and poor educational backgrounds. According to data collected in an independent survey sponsored by The Aspen Institute's SEDLP project, 66 percent of CHCA trainees were single heads of households with children, and 42 percent lacked a high school diploma or equivalent. Fifty-six percent did not work at all in the year before coming to CHCA, and 15 percent had never worked in their lives. Among those who did work, average earnings were less than \$5,000. A more detailed description of the target population served by CHCA is presented in the Training Program chapter.

Isabel's Story

When Isabel came to CHCA in November of 1998, she was a 37-year-old single mother who had been laid off two months earlier from her job as a waitress/cashier. During the four years she waited tables, she also received housing assistance and food stamps. Isabel's native language is Spanish, and her English language skills are limited. She explained that she came to CHCA because she likes to help people and because she needed a job to support her daughter.

Isabel began working for CHCA in December 1998, after completing the entry-level training course. A year later, she was earning more than what she was making at the restaurant. (She had earned \$210 per week at the restaurant, and was earning \$275 per week as a home health aide.) Two years after completing the training, Isabel was still a home health aide with CHCA, working 35 hours a week. She had received a raise and was now earning \$6.75 an hour. Despite this, however, Isabel still found it difficult to make ends meet, and described having a place to live and paying the monthly bills as immediate concerns. She no longer received housing assistance, but she was still receiving food stamps.

Despite these worries, Isabel reported that she was generally satisfied with her job at CHCA. She found the work schedule, number of hours worked, job flexibility, level of responsibility and her treatment by superiors and co-workers all to be satisfactory. She also had received additional training from CHCA, and believed her career prospects were better because of it.¹¹

CHCA's Early Years — Establishment and Stabilization

Cooperative Home Care Associates was established in 1985 in the South Bronx as a worker-owned cooperative and employer-based training program. In the early 1980s, Community Service Society (CSS), a social service organization in New York City, sponsored a community

¹¹Compiled from responses of a CHCA aide who was interviewed several times between November 1998 and January 2001 as part of an independent longitudinal survey of sectoral training participants undertaken by the Economic Opportunities Program.

economic development program based on creating jobs through the formation of worker-owned firms. Rick Surpin, whose background was in community development, was head of the CSS Center for Community Economic Development. The goal of the program was to create decent jobs for low-income individuals, preferably in an industry that offered a socially useful product or service. The worker-ownership structure was emphasized as a way to maximize wages and benefits in businesses with low profit margins, and to ensure that workers' interests would receive priority in the business strategy of the firm. The CSS program identified the home health aide industry for the new project and launched CHCA. The logic was that achieving even modest improvements in this low-wage occupation would be worthwhile, given that it employs large numbers of low-income individuals.

Cooperative Home Care Associates' first contract was with Montefiore Hospital, which shared an interest in improving the quality of home health services and providing more full-time work for home health aides. CHCA began operations in early 1985 with a dozen experienced home health aides. The Montefiore Hospital contract grew during the course of 1985 to include 60 aides. Despite the expansion, however, CHCA ended the year with a loss far greater than had been anticipated (\$187,000), in addition to serious cash flow problems. The quality of the job for CHCA's home health aides had not significantly improved, either. While CHCA aides received a slightly higher wage and an allowance for uniforms, worker schedules continued to be dominated mostly by part-time work.

Key staff at the CSS Center for Community Economic Development and at the Industrial Cooperative Association (which provided financial advice and assistance to the program) perceived that the fledgling CHCA was facing a severe management crisis. CHCA's original CEO was replaced. Rick Surpin and another CSS staff member, Peggy Powell, became much more involved in the day-to-day management of Cooperative Home Care Associates.

In 1986, CHCA launched an entry-level training program. Instruction was contracted to a local community college, while CHCA recruited and screened candidates. Despite the addition of two small contracts and an increase in the number of employed home health aides to 116, Cooperative Home Care Associates continued to experience losses in 1986. It also faced problems with worker morale and a

resulting decline in the quality of services. The percentage of aides with full-time work increased to 50 percent. While this exceeded norms for the home health care industry, it fell short of CHCA's job-improvement goals.¹²

Things began to turn around in 1987, when Cooperative Home Care Associates achieved profits for the first time.¹³ That year, Surpin formally stepped in as CEO, and the company's management and administrative systems were reorganized. Dissatisfied with the training its aides were receiving from the community college, CHCA developed its own training program. Worker morale improved as the company expanded its business, and the quality of the job improved. Workers received a life insurance benefit as well as five paid personal days per year. An impressive 70 percent of positions were now full time.¹⁴ Five workers were elected to the board of directors, which meant that for the first time, the company was majority controlled by employees. The company was becoming more widely known for providing a quality service, and it received few complaints from its clients.

Cooperative Home Care Associates continued to grow and become more stable throughout the late 1980s. In 1989, the company reached its goal of 50-percent worker ownership. Limited health insurance for aides also was added that year, making CHCA the first licensed home health agency to offer this benefit. Surpin had some success in negotiating higher reimbursement rates from CHCA contractors, which allowed for wage improvements. In particular, CHCA introduced the innovation of a modest differential wage increase for more difficult jobs and for weekend work. The training program continued to expand and to be revised and improved. Staff members also began to get more involved in policy and advocacy work in the late 1980s, notably through organizing and leading the Home Care Work Group, a group of consumer advocates, providers and labor union representatives.

As Cooperative Home Care Associates entered the 1990s, it had achieved the status of a stable, profitable, worker-owned company. In 1990 it employed 200 workers, and profits were \$170,000.¹⁵ That year the Ford Foundation funded a strategic planning process for CHCA. One of the changes that followed was the establishment of departments and a more formal management structure.

¹²Steven Dawson and Sherman Kreiner, "Cooperative Home Care Associates: History and Lessons," (Bronx, NY: Home Care Associates Training Institute, 1993), 12.

¹³Profits for 1987 are reported as \$98,000. However, salaries of several key CHCA staff people were still subsidized by Community Service Society.

¹⁴Dawson and Kreiner, 15.

¹⁵Dawson and Kreiner, 9, 14.

Despite the generally upward trend, CHCA's progress was not always uniform. In 1991, for example, a lower profit margin resulted in a smaller and delayed dividend distribution to employees.¹⁶ This caused some discontent among worker-owners. Overall, however, worker confidence in the company evidently remained strong, as indicated by the fact that worker ownership continued to increase, from 56 percent in 1991 to 69 percent in 1992.

Figure 3.1

Timeline: Major Events In the History of CHCA

1985	Cooperative Home Care Associates (CHCA) opens for business.	1992	
1986	CHCA starts training program with community college providing training. CHCA receives first contract from Visiting Nurse Service of New York.	1993	Home Care Associates (HCA) Philadelphia opens.
1987	Rick Surpin becomes CEO of CHCA. CHCA achieves profits for first time. CHCA's training program moves in-house. CHCA board is majority controlled by employees.	1994	Cooperative Home Care of Boston opens.
1988		1995	
1989	CHCA becomes the first licensed home health agency to offer aides health insurance. CHCA achieves 50% worker ownership.	1996	
1990	Medicaid reimbursement rate wage pass through achieved. CHCA employs 200 home health aides.	1997	Balanced Budget Act results in severe cuts for home care funding.
1991	Home Care Associates Training Institute (HCATI) is established.	1998	HCATI is renamed Paraprofessional Healthcare Institute (PHI). Visiting Nurse Associates Training Institute (VNATI) of SE Michigan starts.
		1999	Cooperative Home Care of Boston closes due to changes in state funding of home care. Quality Care Partners (QCP) in Manchester, New Hampshire starts.
		2000	Independence Care System is launched. The Direct Care Alliance is started. The National Clearinghouse on the Direct Care Workforce is established. CHCA employs 600 home health aides.

Expansion and CHCA Affiliated Organizations

In 1992, CHCA achieved a 15-percent growth rate, which was higher than the 10-percent growth rate prevalent in the rest of the New York City home health care sector. A three-tier wage system was introduced that included pay differentials based on the years of experience a home health aide had with CHCA. CHCA achieved an incredibly low 11-percent employee turnover rate that year, which compared very favorably with industry averages ranging from 45 percent to 60 percent.¹⁷

Beginning to Diversify

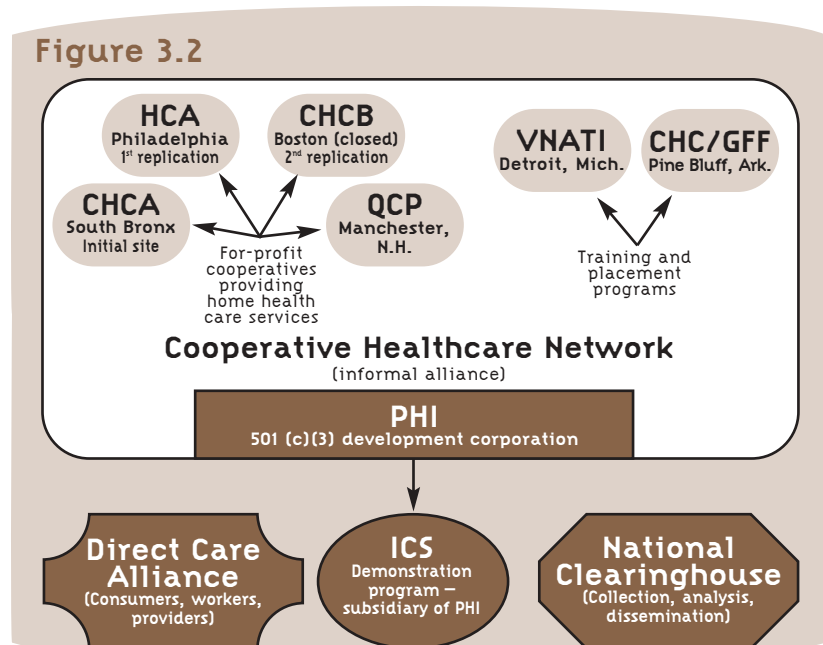
In 1991, the first of the affiliated organizations to spin off from Cooperative Home Care Associates was formed. The Home Care Associates Training Institute (HCATI) was initially established

¹⁶One factor that contributed to lower profits that year was the fact that one of CHCA's largest contractors declined to raise its payment rate. This provided an impetus for CHCA to try to redirect a greater proportion of its business to Visiting Nurse Service of New York, which paid higher rates.

¹⁷Dawson and Kreiner, 21-22.

to manage the training programs for CHCA. As a nonprofit affiliate, HCATI could receive grants from foundations that were used to subsidize the training program. Gradually, HCATI also became involved in replicating programs in other cities. By facilitating and nurturing new programs, HCATI played a role similar to the one that Community Service Society played in helping to establish Cooperative Home Care Associates. HCATI helped develop business plans for the new enterprises, and recruited key staff. It also provided equity and training funds for replication sites. In 1997, HCATI changed its name to the Paraprofessional Healthcare Institute (PHI).

The first replication program was Home Care Associates of Philadelphia (HCA), which opened in 1993. The new company reached the break-even point within 18 months, and in three years had become the largest Medicare-funded subcontractor for home care in inner-city Philadelphia.¹⁸ The second replication program was Cooperative Home Care of Boston (CHCB), formed in 1994. CHCB also got off to an excellent start. The company broke even within 18 months, and achieved profits every year after that until 1997. The three for-profit, worker-owned cooperatives (the two replication programs plus CHCA in the South Bronx) joined together to create an informal alliance called the Cooperative Healthcare Network.



¹⁸Steven Dawson, Peggy Powell and Rick Surpin, "The Cooperative Health Care Federation: Lessons Learned – The Replication Program 1993-1997," in *Jobs and Economic Development: Strategies and Practice*, ed. Robert Giloth (Thousand Oaks, Calif.: Sage Publications, 1998), 5.

1997 – Difficulties for Home Health Care

As described in the previous chapter, the home care market in New York City expanded rapidly during the middle and late 1980s as a result of policy and regulatory changes in the publicly funded health care system that encouraged hospitals to release patients earlier and favored the use of home care – rather than institutional — services for long-term care needs. This growth was accompanied by an increase in the Medicare and Medicaid reimbursement rates affecting home care in 1990, thanks in part to reform efforts of groups such as the Home Care Work Group, in which CHCA staff played a major leadership role. (The next chapter on CHCA’s sectoral strategy contains a more detailed discussion of the rate increase and CHCA’s involvement in policy reform more generally.)

In the early 1990s, however, efforts at federal, state and local levels to reduce publicly funded health care costs were beginning to constrain the industry. Certified home health care agencies found that payment for Medicare claims for home care was delayed and sometimes denied altogether. This contributed to some consolidation among certified home care agencies in New York City, as well as efforts on their part to cut costs by paying less to the licensed agencies with which they subcontracted for home care services.¹⁹

As explained in the Industry Context chapter, publicly funded health care costs were significantly cut in 1997 as part of the Balanced Budget Act, in part through a strategy of reducing utilization of home health care services. The number and length of home care visits covered by Medicare and Medicaid were effectively reduced by limiting home health care visits to 1994 levels. In 1997, the federal Medicare home care benefit was cut by 25 percent. Between 1997 and 2000, home care funding nationwide was cut 40 percent. According to a February 2000 CHCA report, the cuts caused turmoil in the home health care industry and led to the closure of more than 20 percent of provider agencies and the merger of others. Many proprietary home care agencies had trouble meeting their investors’ expectations.

The 1997 budget cuts directly affected Cooperative Home Care Network members. In Philadelphia, the cuts forced Home Care Associates to diversify and reduce its dependence on the Medicare market alone. HCA aggressively sought new contracts and currently

¹⁹Jeremy Brecher and Ruth Glasser, “We Are The Roots: An Analysis of Cooperative Home Care Associates’ Organizational Culture,” (New York, NY: Paraprofessional Healthcare Institute, 1998), 21-23.

has a mix of about 15 of them. The effects of the budget cuts on the Boston replication program were disastrous. Cooperative Home Care Boston did not survive the Medicare home care cuts and closed.

CHCA and the Visiting Nurse Service of New York

Fortunately, CHCA was somewhat protected from the effects of the 1997 cuts because it had developed a special relationship with the Visiting Nurse Service of New York (VNSNY). VNSNY is a certified home health agency that accounts for about 60 percent of the New York City home health care market.²⁰ VNSNY has always had a strong commitment to providing high quality home health care to patients. As such, the agency has required more of the licensed agencies with which it subcontracts, and has been willing to pay more than other certified agencies to obtain higher quality services. According to CHCA staff, VNSNY pays about \$2 per hour more for home health aide services than hospital-based agencies. CHCA's commitment to providing high-quality services made it a natural ally of VNS. According to Barbara Lyon, director of contract administration for Visiting Nurse Service of New York, CHCA's worker-ownership model also appealed to VNSNY, which originated in community and public health efforts. VNSNY became CHCA's second contractor in 1986, and by the early 1990s had become the cooperative's largest customer. CHCA leaders have attributed the company's ability to survive the severe Medicare and Medicaid home health care rate cuts of 1997 to VNSNY's commitment to the "high road" approach of quality care and higher wages for health aides.

Visiting Nurse Service of New York cases currently account for 75 percent of CHCA's business, and in previous years have accounted for an even higher percentage.²¹ CHCA deliberately chose to develop a very deep relationship with one major contractor that paid the higher rates that enabled it to fulfill its business and social goals. The dependence on VNSNY has recently begun to diminish, as CHCA's newest affiliated program, Independence Care System, has begun to generate business for CHCA. ICS clients accounted for 13 percent of CHCA's business in January and February 2001.

Organizational Features and Assets

Organizational Structure and Culture

In the CHCA cooperative model, a majority of the members of the board of directors are employees who are elected by CHCA

²⁰ Visiting Nurse Service of New York is the largest home health care agency in New York City, and currently handles more than 11,000 cases per week. As a certified agency, VNSNY directly provides nursing services to patients at home, and supervises accompanying care by home health aides through subcontracts with a number of licensed home health agencies, including CHCA.

²¹ As of March 2000, VNSNY accounted for 95 percent of CHCA's business.

An employee becomes eligible to become a cooperative member after performing satisfactorily on the job for the three-month probationary period. The total cost of a share is \$1,000.

worker-members. An employee becomes eligible to become a cooperative member after performing satisfactorily on the job for the three-month probationary period. The total cost of a share is \$1,000. An initial deposit of only \$50 is needed, and then weekly payments of \$3.65 are deducted from the employee's paycheck. A member has full voting rights on all major company decisions as soon as the initial deposit is made. According to company sources, typical annual dividends have ranged from \$200 to \$400.

The first employee representation was achieved when Community Service Society appointed two CHCA workers to the board in 1986. In 1987, workers voted for board members and filled five slots, making the company majority-controlled by employees. That same year, the initial goal of having more than 50 percent of the employees become owners was achieved. Worker-ownership percentages for CHCA have gradually increased during the years and today, more than 65 percent of the employees own shares in the company.

CHCA's employees, most of whom come from economically disadvantaged backgrounds, clearly value the opportunity to become shareholders. One home health aide explained it this way:

"I never thought in my 37 years that I would own a piece of a company! I was proud to have something. I say, 'I own it. I have a say-so.'"

Another stated that it was *"hard to believe I own part of a company – especially coming from public assistance."*²²

CHCA's unique organizational culture is based on a vision of employee empowerment that forms the underlying rationale for the Quality Jobs/Quality Care model. The premise is that empowering workers and providing them with superior training will result in excellent service, which will benefit customers and, in turn, generate more business for the company. The values of the original founders and senior staff have greatly influenced the development of CHCA and its affiliates. Rick Surpin and Peggy Powell, along with an important group of senior managers, desired to create not just a new company that would provide decent employment for low-income women, but also a real sense of an alternative communi-

²²Focus group, 16 March 2000.

ty. They wanted to create an atmosphere in which an individual could develop her potential. Watch words included “personal growth,” “mutual respect” and “community.”

The values of participation and employee empowerment have been built into the formal business structure and strategy. As an employee-owned cooperative, the company’s basic structure is democratic. Employees also have been encouraged over time to participate more in running Cooperative Home Care Associates. An elected Worker Council was instituted to provide a mechanism for informing workers about key management issues and soliciting their feedback.

Surpin exemplified these ideals by instilling a management style and structure that were informal, open and accessible. All staff, including home care workers, had relatively direct access to the CEO, certainly for many years. As one longtime CHCA home health aide put it:

“One thing that is great and different is our president. He knows us. He respects us. ... When there is a problem, you can go straight to the president and he will try to solve the problem. I don’t know of any other company where you can go straight to the top – no channels. We’ve got real support here all the way up. It’s like family.”

Staffing

Extraordinarily talented and dedicated individuals have nurtured Cooperative Home Care Associates, Paraprofessional Healthcare Institute and their affiliated organizations. Surpin has been a driving force behind CHCA from the earliest days, responsible for launching it from within CSS, and intensively managing CHCA as CEO for many years. In 2000 he left CHCA to run Independence Care System, but he continues to chair the CHCA board. Surpin has been described as a social entrepreneur whose vision, skills and dedication were vital to the development and survival of CHCA. Sustained leadership also was provided by a number of other key staff members. Peggy Powell was one of the original founders of CHCA, and played a pivotal role in framing and developing its organizational culture. Over time she focused on managing the training programs, which are so important as the

entry point for introducing recruits to the CHCA community and maintaining the institutional culture of the organization. When the replication programs began under HCATI, she became executive director, and now is director of workforce strategies at the Paraprofessional Healthcare Institute.

Steve Dawson, currently president of PHI, had a long consulting relationship with CHCA dating back to the early 1980s, when he was executive director of the Industrial Cooperative Association. He played a major role in transforming HCATI into the nationally recognized Paraprofessional Healthcare Institute, ran the replication program at PHI, and broadened the policy advocacy activities. CHCA was fortunate to have Michael Elsas take over as CEO when Surpin left to establish ICS. He has 30 years of experience in the home care sector with a variety of types of organizations. Elsas also has a deep understanding of the policy issues, and is extremely dedicated to the social mission of CHCA. Frances Sadler, vice president of ICS, has played an important role in developing ICS' emerging operations and organizational culture. Many other dedicated individuals also played critical roles in developing CHCA and its later affiliates.

Relationships with Key Organizations

Cooperative Home Care Associates has had some very important relationships with organizations outside of the Cooperative Healthcare Network that have shaped its development. The special relationship with the Visiting Nurse Service of New York was described earlier. Community Service Society played a critical role in launching and supporting CHCA in its early years by providing key staff, equity and loans. Another major influence was that of the Industrial Cooperative Association (of Boston) and its Revolving Loan Fund Program. ICA provided and secured critical financing for CHCA, and monitored its fledgling financial situation. The United Hospital Fund, a New York City health care philanthropic organization, gave CHCA its first grant, and during the years has supported and promoted CHCA's Quality Jobs/Quality Care model.

The Charles Stewart Mott Foundation has generously supported CHCA, the replication program and the launch of ICS. The Mott Foundation has been the lead donor since 1986, and has helped

advocate for additional funding from other donors. The Ford Foundation has been another important donor, and has funded the Nurses' Education Program, the strategic planning process and the replication efforts. The Robin Hood Foundation has provided extensive philanthropic support for CHCA's training activities. Cooperative Home Care Associates also has had an ongoing relationship with Local 1199 of the Service Employees International Union (SEIU). CHCA has cooperated with the union on policy reform issues, and SEIU participates in Direct Care Alliance activities.

Recent Developments for Cooperative Home Care Associates

Cooperative Home Care Associates has continued to grow and expand. By 2001, it employed about 600 home health aides. According to internal documents, 69 percent of eligible employees chose to become worker-owners by the end of 2001 and on average, CHCA aides worked 36 hours per week during 2001. CHCA has been profitable every year since 1987. Sales in 2001 totaled \$13 million, and revenues in 2002 are expected to be \$16 million. Looking to the future, CHCA management believes it will need to continue expansion and achieve greater economies of scale to cope with the reimbursement rate ceilings on publicly funded home care services. The organization's leaders estimate that the CHCA workforce eventually will need to grow to 1,000.

Affiliated Organizations

One of the most impressive features of Cooperative Home Care Associates is the array of affiliated programs that have been developed during the years in response to specific opportunities and problems. Funding from the Charles Stewart Mott and Ford foundations was used for a program designed to try to re-create the CHCA model in other parts of the country. HCA in Philadelphia and CHCB in Boston, which were described earlier, were the first two such efforts. CHCA also has fostered the development of some entirely new entities, such as PHI and ICS. All of the affiliated programs have shared the original goals of trying to create quality jobs for low-income individuals while producing better quality health care. This creativity and willingness to experiment is what truly makes CHCA a flexible, learning organization. The box below con-

tains brief descriptions of all the programs and organizations that have grown from CHCA.

SUMMARY OF PROGRAMS

Cooperative Home Care Associates (CHCA) – The initial worker-owned cooperative and employer-based training program, launched in the South Bronx in 1985. CHCA is a licensed home health care agency and a member of the Cooperative Healthcare Network.

Paraprofessional Healthcare Institute (PHI) – A national 501 (c)(3) nonprofit health care employment and advocacy organization. Originally formed in 1991 as the Home Care Associates Training Institute (HCATI), its name was changed to PHI in 1997. PHI’s main functions are to support employer-based training and placement programs, support the replication of CHCA through the creation of sites in other cities, and advocate for improved public policy and health care industry practice.

Cooperative Healthcare Network (CHN) – An alliance of the home health care programs, including CHCA in New York, HCA Philadelphia, QCP New Hampshire, the VNA Training Institute of Southeast Michigan, Careers in Health Care in Arkansas, and the former CHCB of Boston. The network links the agencies for mutual support and sharing lessons and information.

Home Care Associates (HCA) Philadelphia – A worker-owned cooperative and employer-based training program in the health care aide industry. Launched in 1993, it was the first replication of the CHCA program model, and belongs to the Cooperative Healthcare Network.

Cooperative Home Care of Boston (CHCB) – The second replication program of the CHCA model. This worker-owned cooperative and training program opened in 1994, and closed in 1999.



Quality Care Partners (QCP) New Hampshire – This cooperative was launched in Manchester with the sponsorship of the New Hampshire Community Loan Fund. The cooperative now belongs to the Cooperative Healthcare Network, and received start-up assistance from PHI.

Visiting Nurse Association Training Institute (VNATI) of Southeast Michigan – A training and placement program for home care aides in Detroit that PHI helped launch. The training institute is housed within a VNA private pay subsidiary that employs the graduates of the training course. It is also a member of the Cooperative Healthcare Network.

Careers in Health Care Arkansas – A training and placement program for certified nursing assistants located in Pine Bluff, Ark., and run by the Good Faith Fund. PHI provided design assistance for this training program, which also is a member of the Cooperative Healthcare Network.

Direct Care Alliance – A national coalition of consumers, workers and providers concerned about issues affecting employment for health care aides. PHI helped launch the alliance at a conference in Washington, D.C. in June 2000.

National Clearinghouse on the Direct Care Workforce – An information clearinghouse for health care providers, consumers, workers and policy makers concerned about labor shortage issues facing the long-term care system. The clearinghouse collects, analyzes and disseminates information, and conducts surveys and studies of workforce issues affecting the long-term care sector. PHI and the Direct Care Alliance launched the project in 2000.

Independence Care System – A 501 (c)(3) nonprofit organization providing managed long-term care services for people living with physical disabilities. The organization, developed by the leadership of CHCA and PHI, and located in New York City, started operations in April 2000.

Paraprofessional Healthcare Institute (PHI)

In 1997, the Home Care Associates Training Institute (HCATI) was renamed the Paraprofessional Healthcare Institute (PHI). PHI is a national health care employment and advocacy organization that serves as the nonprofit arm of the for-profit businesses in the Cooperative Healthcare Network. PHI and Cooperative Home Care Associates are closely linked in terms of leadership, history, structure, staffing and activities. PHI has similar connections to the other programs under its umbrella that are described below. The various organizations share formal affiliations, have overlapping membership on their boards of directors and work together on projects.

PHI has a two-part mission. It seeks to create decent jobs for low-income individuals, with an emphasis on women who are unemployed or transitioning from welfare to work. It also promotes high-quality health care for elderly, chronically ill or disabled individuals. PHI sponsors demonstration programs and research, does policy and advocacy work at both state and federal levels, sponsors training activities and undertakes education on health care issues. PHI has played a key role in the establishment and ongoing support of CHCA replication and other affiliated programs.

Replication Programs

Cooperative Home Care Associates and PHI sponsored the development of a number of replication programs of the CHCA model. As described earlier, **Home Care Associates of Philadelphia** was the first replication site. The program was launched in 1993, and grew rapidly for the first few years. Dramatic cuts in Medicare funding for home health care that followed the Balanced Budget Act contributed to three years of losses. HCA tried to address the problem by diversifying its services, obtaining a greater variety of contracts and expanding into the suburbs. By 2000, HCA Philadelphia had achieved modest profits again. According to an April 2001 program report, HCA had 15 different contracts and employed 105 active home health aides in early 2001. Growth in 2001 was expected to be slower because of high worker turnover and retention problems.

As described earlier, the second replication program was launched in Boston in 1994. **Cooperative Home Care of Boston** also

achieved profits in its early years. By 1997, CHCB employed 70 people working an average of 33 hours per week, had launched its worker-ownership program, and was building a reputation for quality service.²³ Unfortunately, the 1997 welfare reform had a devastating effect on the home care industry in Massachusetts. When CHCB was formally shut down at the end of 1999, it was the 26th home care agency to do so in Massachusetts within two years. Before closing, however, CHCB successfully helped its home health aides find jobs with other licensed home care agencies that paid at least the wage they were receiving from CHCB.

The three worker-owned cooperatives of CHCA in the South Bronx, HCA Philadelphia and Cooperative Home Care of Boston were joined in an informal alliance called the **Cooperative Healthcare Network**. PHI's goal in working with the network was to provide assistance to a variety of community-based agencies across the U.S. to experiment with programs involving health care aides' services, and ultimately link them in a "training and employment network for information exchange and policy advocacy."²⁴ The network today includes three additional programs: Quality Care Partners in New Hampshire, the VNA Training Institute of Southeast Michigan and Careers in Health Care in Arkansas.

Quality Care Partners (QCP) is a health care cooperative established in Manchester, N.H., in 1999 under the sponsorship of the New Hampshire Community Loan Fund and with assistance from PHI. As of early 2001, QCP was still quite small, employing only 23 aides working an average range of 27 to 32 hours per week. QCP has had difficulties including monthly losses, and problems with recruitment and retention.²⁵ PHI and another sponsor have been working intensively with QCP to try to resolve the problems.

PHI partnered with the Visiting Nurse Association of Southeast Michigan to establish the **VNA Training Institute (VNATI)** in Detroit in 1998. The institute is located within a VNA private pay subsidiary that employs the graduates of the training course. The goal has been to try to restructure home care jobs from contingent work to more stable employment with guaranteed hours and benefits. However, to date, the program has been addressing significant challenges such as insufficient working hours, training class sizes and transportation problems.²⁶ As of December 2001, the total num-

²³Dawson et al, 6.

²⁴Internal PHI report, "Pre-Final Interim Report, Jan. 1-Dec. 31, 1999," January 2000.

²⁵PHI and CHCA managers, interview by Maureen Conway and Anne Inserra, New York, NY, 11 April 2001.

²⁶PHI and CHCA manager interviews, Conway and Inserra.

ber of VNATI graduates working for the Detroit VNA was 94. PHI staff has been working intensively with VNATI to try to address the various problems and now believes the program is on much more solid footing.

Careers in Health Care is a training and placement program for nursing assistants in Pine Bluff, Ark., that is run by the Good Faith Fund. The certified nursing assistant (CNA) program is one of two career tracks in a workforce development program that includes optional basic skills training. PHI provided significant assistance to design the training program.

In addition to trying to improve the state of practice in home health care by supporting replications and other innovative provider programs, the Paraprofessional Healthcare Institute sponsors broader research, education and advocacy. PHI was instrumental in starting the **Direct Care Alliance**, a coalition of consumers, workers and providers concerned about issues affecting employment for health care aides. The organization, launched at a major conference in June 2000 in Washington D.C., undertakes education and advocacy. PHI and the Direct Care Alliance together developed an additional project in 2001 called the **National Clearinghouse on the Direct Care Workforce**. The clearinghouse collects, analyzes and disseminates information relevant to the labor shortage issues facing the long-term health care system.

In addition to the specific programs described above, PHI has worked with quite a few other organizations on various projects related to issues affecting the health care aide industry. One of PHI's most significant consulting initiatives is its work in developing career ladders for health aides within nursing homes through the **Massachusetts Career Ladders Initiative**, which is described in the next chapter.

Looking to the Future – Independence Care System

In early 2000, CHCA and PHI helped launch Independence Care System, an ambitious, managed long-term care demonstration program for people living with physical disabilities. The new initiative arose from the same values and convictions that had inspired the creation of both CHCA and PHI, and presented an opportunity to gain even greater influence within the long-term health care sector. Ever since the 1997 budget cuts, prospects for federal funding

for home care (through Medicare and Medicaid) were looking bleak. The trend toward fewer and shorter home visits under the fee-for-service payment system was making it more difficult for home health care providers to operate. At the same time, managed care approaches were gaining popularity. The leadership of CHCA and PHI believed that Cooperative Home Care Associates, operating under a payment system that appeared to be at long-term risk and dependent on so few customer organizations, might have to adopt new strategies to survive in the longer term.

Independence Care System was created to provide quality services to a special population of clients with severe disabilities whose needs, it was believed, were not being met by the existing health system.

The target group consists of adults eligible for Medicaid who have severe physical disabilities.²⁷ The founders of ICS wanted to create an alternative approach that would avoid some of the potential drawbacks of managed care, such as depersonalized care and excessive focus on cost containment. The ICS model was intended to improve coordination and quality of care for individuals with disabilities and give them a greater voice in decisions about their own care.

At the same time, ICS offered the opportunity to have greater influence on the long-term care industry in New York, and as such represented a further evolution of CHCA's sectoral strategy. Because other companies will subcontract with ICS to provide patient services, ICS will have opportunities to influence how its



Photo by Wild Bill Studios

Warmth, compassion and caring are so essential in the makeup of a good home health aide that CHCA screens applicants for those qualities.

²⁷Many severely disabled patients suffer from spinal cord injuries or degenerative neurological conditions such as multiple sclerosis or cerebral palsy. Patients are classified as severely disabled if they are eligible for a nursing home level of care, as determined by assessments of their level of functional disability.

subcontractors do business. For example, ICS requires other providers of home health services to pass on 75 percent of the fee they receive from ICS to the aides in the form of wages and benefits. ICS knows this is possible to do, since ICS provides relatively high reimbursements to its subcontractors as compared to VNS. CHCA regularly meets or exceeds this goal.

Independence Care System, like CHCA, was viewed as a high-risk initiative with the potential to yield great benefits. ICS was expected to generate significant new business for Cooperative Home Care Associates. Home health aide services would constitute a major part of the benefits package provided to ICS members (estimated at 50 percent of total expenditures), and it was hoped that ICS would subcontract with CHCA for 50 percent of its home health aide services.²⁸ It was hoped that this increased business would contribute to CHCA's goals in the area of generating full-time work for home health aides. ICS is committed to the CHCA Quality Jobs/Quality Care model, and to striving for better wages and benefits for aides. There were initial hopes that ICS would provide modest career ladder opportunities for CHCA home health aides, although this has not occurred to a significant extent. Also, as a managed long-term care program authorized to receive Medicaid payments directly, it was expected that ICS would have greater ability to influence terms and conditions affecting the sector, and hopefully greater policy leverage. The founders hoped that ICS would prove to be a successful alternative model that could have far-reaching impact in the emerging managed long-term care sector.

The launch of Independence Care System, initially planned for 1998, was delayed by legislative, administrative and fund-raising bottlenecks.²⁹ ICS finally signed a contract in February 2000. It was established as a nonprofit subsidiary of the Paraprofessional Healthcare Institute. Both PHI and Cooperative Home Care Associates are represented on the ICS Board of Directors, along with consumer advocates and public representatives.

As of January 2002, ICS had 318 members and was growing by about 20 new members a month. Home care aides' services represented about 65 percent of its medical costs, and approximately 30 percent of the aides were contracted from Cooperative Home Care Associates.

²⁸If an enrolling member does not have a preference to keep working with her or his existing home health aide when joining ICS, an aide from CHCA is assigned.

²⁹The legislation that authorized the creation of up to 37 managed long-term care demonstration programs in the state of New York was passed in 1997. Shortly afterward, however, dramatic changes were made in the state Medicaid apparatus, which delayed implementation.

However, ICS is still a start-up, and like CHCA in its early years, is learning how to develop its model against the grain of the existing industry. In this case, the industry is managed long-term care, a broader, more complex and more capital-intensive sector than paraprofessional services alone. Further, ICS' niche is serving younger disabled individuals, not the elderly. The ICS target population has complex medical and social issues and is often inappropriately served or under-served in the fee-for-service health system. It has been very difficult to establish appropriate capitation rates in this context. ICS began to suffer significant monthly losses (ranging as high as \$350,000) during its initial year of operation. A retroactive rate increase, cuts in administrative costs and increased philanthropic support, particularly from the Charles Stewart Mott Foundation, enabled the program to continue. ICS is now undergoing a major transformation of its internal operations, focused on maximizing consumer-member direction and satisfaction, as it continues to explore how to be paid adequate capitation rates from the state. Ultimately, it seems that Independence Care System's ability to succeed will depend on whether it can both adjust its model while retaining its key principles, and obtain adequate rates on an ongoing basis. It is too early to know whether this will happen.

Cooperative Home Care Associates has pursued a sectoral employment strategy since it began in 1985. During the years, CHCA has explored different ways to improve the pay and other aspects of the demanding job of the home health aide. To achieve these goals, CHCA became deeply engaged in the home health care sector, and has intervened on both the supply and demand sides of the labor market in the industry. On the supply side, CHCA developed a training program to improve the skills of home care aides. On the demand side, CHCA operates a worker-owned cooperative business that employs home health aides at wage and benefit rates consistently above the industry norm. By providing an example of a profitable company that successfully operates on these principles, CHCA has had some influence on other service providers in the New York City area to raise the standard of care and jobs.

CHCA's strategy, based on the Quality Jobs/Quality Care approach, is designed to improve conditions in the sector in ways that benefit both workers and consumers. Cooperative Home Care Associates has continually experimented with new program approaches to address specific problems and opportunities. In addition, CHCA has responded to opportunities to replicate its model in other cities. In reality, these organizations operating in new markets are quite distinct from CHCA, and each has developed some unique features to best respond to local market conditions and dynamics. CHCA also has contributed to systemic change by influencing policy makers and opinion leaders regarding the policy and regulatory framework governing home care services.

Improving the Job of the Home Health Aide

Cooperative Home Care Associates' business strategy developed from what was essentially a workforce strategy. Business decisions were made with the goal of improving the job of the home health aide, a position that has traditionally been accessible to low-income women.

Increased Wages

One of the most difficult aspects of working as a home health aide has been historically low wages. Many women working as home health aides concurrently depend on one or more forms of



Important elements of CHCA's strategy for improving the quality of home care services its aides provide are its rigorous recruitment and screening process and intensive entry-level training program ...

public assistance, such as food stamps or housing subsidies. While CHCA has worked very hard during the years, significantly increasing the wages for aides has been one of the most difficult challenges. In an independent longitudinal survey of CHCA aides, many respondents commented that, while they were satisfied with many aspects of the job, wages were not high enough, and they continued to experience difficulties in meeting their monthly expenses.³⁰

Quality Jobs/Quality Care

Since its inception, Cooperative Home Care Associates has sought to increase wages for its workers and has pursued various strategies to accomplish this goal.³¹ One of the most important elements of its approach has been development of its Quality Jobs/Quality Care philosophy. The premise of this strategy is that if the conditions of the home health aide job are improved, home health aides will provide higher quality services. Higher quality services will result in more satisfied patients as well as more satisfied nurse managers in the certified agencies. This will then generate more business for CHCA, and also should enable CHCA to command a higher price for its services in the marketplace. If CHCA does a higher volume of business it can hire more aides, and if it can get the certified agencies with which it contracts to pay higher rates, CHCA can then pass the benefit on to the home care aides in the form of improved wages and job conditions.

Important elements of CHCA's strategy for improving the quality of home care services its aides provide are its rigorous recruitment and screening process and intensive entry-level training program, described in more detail in the Training chapter. Careful recruitment and high-quality training help ensure that able, qualified home health aides work for the company and that resulting services are of high quality.

The Quality Jobs/Quality Care strategy has enabled CHCA to secure payment rates that are at the upper end of the range. Visiting Nurse Service of New York has been CHCA's dominant customer, and CHCA staff note that its reimbursement rate, at \$12.68 per hour, is about \$2 per hour more than the rates paid by hospital-based agencies. In 1997, the wages and benefits paid by CHCA (and the other organizations in the Cooperative Healthcare Network) were between 10 percent and 20 percent higher than the norm in

³⁰Open-ended responses to longitudinal survey by EOP of sectoral training participants, interviews conducted from 1999-2000.

³¹CHCA's opening business plan in 1985 called for payment of wages that were 50 cents more per hour than the average industry wage in New York City at the time, Dawson and Kreiner, 8.

their respective markets.³² In the spring of 2001, the average CHCA wage of just under \$8 per hour was among the highest in New York City. (This wage was equivalent to \$9.65 with cash benefits.) After raises were instituted in July 2001, CHCA's wage rate scale included six tiers that ranged from \$6.40 to \$8 per hour, not including benefits. Workers also receive a higher rate for overtime work. A higher percentage of workers at CHCA also have full-time and more stable employment, thanks to the guaranteed hours program, which is described in the next chapter. This is important in terms of improved annual incomes.

It should be noted that while CHCA pays wages that are relatively higher than that of the average home health aide in New York City, the resulting income is still modest. This means that many women still depend on various forms of public assistance to make ends meet, even after they start working for CHCA.³³

Moving into Policy Reform

Despite the successes it has been able to achieve in terms of relatively higher wages and better benefits, the policy/regulatory framework governing the home health care industry has limited the effectiveness of CHCA's Quality Jobs/Quality Care strategy. As explained in the Industry Context chapter, the Medicare- and Medicaid-funded reimbursement rates paid to certified health agencies are set by federal and state regulations, with considerable regional variation. For many years, reimbursement rates under the system have not been enough to pay decent wages to home health aides. Because rates are set by regulation, the price of labor in the home care market is not completely negotiable. This constrains the effectiveness of a strategy designed to command a higher price by offering a superior quality service.

This reality led CHCA's founders to get involved in policy and regulatory reform efforts, and to advocate for wage increases and long-term systemic change in the home health aide labor market. As early as 1988, Rick Surpin, CHCA's founder and then-CEO, was invited to consult on home health aide issues for a New York state task force on personnel shortages in health care occupations. The group did some work on policy options affecting the creation of good jobs. In 1989, CHCA staff organized the New York City Home Care Work Group, which consisted of representatives of consumers,

³²Dawson et al, 4.

³³Jackie Sarantis, interview by Maureen Conway and others, New York, NY, 15 March 2000.

unions/workers and home care providers. The work group played an important policy and advocacy function in the New York home health care industry. It conducted research and developed recommendations for improving the home care system that emphasized higher reimbursement rates and better services.

According to a representative of the United Hospital Fund, Surpin and Cooperative Home Care Associates played an influential role in the home care industry in the late 1980s. He was instrumental in helping to articulate a common agenda that united the formerly divergent interests of home care consumers and providers around the Quality Jobs/Quality Care approach.³⁴ To understand how events unfolded with regard to wage increases in home health care, it is helpful to understand a few more details about the New York City home care labor market. As mentioned in the Industry chapter, one of the two main segments consists of personal care services. Under a New York City program, Medicaid funds are used to contract for personal care services provided by home attendant agencies. Most personal care workers are unionized. Cooperative Home Care Associates operates in the other major segment of the New York home care market. In this segment, Certified Home Health Agencies (CHHAs) and Long-Term Home Health Care Programs (LTHHCPs) receive Medicaid and Medicare funds to provide a spectrum of services to individuals, including nursing and physical therapy, in addition to home care. These certified agencies generally subcontract with licensed agencies such as CHCA to provide the needed home care services. Workers in this segment are generally not unionized.³⁵

In 1987, unions organized a successful public rally in favor of raising wage rates for personal care workers under the city program. After negotiations, the city and state ultimately agreed to support worker wage and benefit rate increases paid by home attendant agencies by 42 percent over a three-year period. This victory generated momentum that also helped the non-unionized sector of the market where CHCA operated. In 1989, the state approved a Medicaid labor adjustment tied directly to home health aides' wages and benefits in the CHHA/LTHHCP sector. This wage pass-through was incorporated into the Medicaid reimbursement rate for this sector. CHCA, through the Home Care Work Group, was very active in advocating for the increases.³⁶

³⁴Kathryn Haslanger, interview with Maureen Conway and John Rodat, New York, NY, 16 March 2000.

³⁵Rick Surpin, Kathryn Haslanger and Steven Dawson, "Better Jobs, Better Care: Building the Home Care Work Force," (New York, NY: United Hospital Fund, 1994), 29.

³⁶Surpin et al, 30, 43.

Unfortunately, a significant portion of the rate increases wound up being absorbed at the level of the certified agency in some cases, and/or at the level of the licensed home care agency in others. The exception to this practice is VNS, and the rate increase achieved in 1989 accounts for much of the differential between the rate paid by VNS for home health services and that paid by other agencies. The absorption of the rate increase by most agencies effectively meant that the pass-through did not translate completely into wage increases for home health aides. Neither have there been further dramatic increases in the reimbursement rates for home health services.³⁷ In fact, Medicare and Medicaid funding for home care services were dramatically cut after the Balanced Budget Act was passed in 1997, as described earlier.

These regulatory dynamics have kept CHCA active in the policy arena during the years, even while it has continued to experiment with different business strategies to try to maximize wages and benefits within the existing regulatory framework. Much of the involvement in policy issues has been implemented through the Paraprofessional Healthcare Institute. PHI has an active policy department with staff who cover policy issues affecting the home care sector in several states, including New York, Pennsylvania, Massachusetts and Michigan.

CHCA staff also collaborated with other organizations on policy and advocacy issues during the years. CHCA did some work on the home care sector with the United Hospital Fund's (UHF) research and demonstration program. Rick Surpin and Steve Dawson co-authored with Kathryn Haslanger of UHF an influential 1994 report called "Better Jobs, Better Care: Building the Home Care Work Force." Surpin also was asked to join the board of the Home Care Association of New York State in the early 1990s, and he is currently the chairperson. His participation has helped raise the prominence of home care aide and workforce shortage issues within the agenda of the trade association, and has gained exposure for CHCA's alternative model within the industry. Michael Elsas, CHCA's current CEO, also has served on various committees and has been active for years in the Home Care Association.

As described in the Program chapter, the Paraprofessional Healthcare Institute recently helped launch the Direct Care Alliance

³⁷Surpin et al, 31, 43, 44.

In an industry where turnover for home health aides typically has ranged from 40 percent to 60 percent per year or even higher, CHCA has consistently experienced turnover rates below that.

and the National Clearinghouse on the Direct Care Workforce. These two organizations are active in research and advocacy concerning various issues affecting the labor force in the long-term health care system. CHCA and PHI also continue to be active in policy reform efforts. In May 2001, Elsas testified in a U.S. Senate Health Education, Labor and Pensions Committee hearing on addressing direct-care staffing shortages. His presentation included policy recommendations to address the nationwide shortage of long-term care workers.

PHI has made policy work a large part of its current agenda. The agency has helped develop coalitions of stakeholders — including industry representatives, consumer groups and/or organized labor — in several states, and continues to work to develop coalitions that can set and then advocate for a common health care policy agenda. For example, through working with such coalitions, PHI staff played an active role in shaping health care demonstration programs in Massachusetts and New Hampshire. PHI continues to build its capacity to engage in policy work, and has recently hired full-time policy directors to work in Pennsylvania and Michigan.

Growth and Efficiency

Another aspect of CHCA's business strategy for improving wages has involved growth and seeking greater efficiency. As described above, reimbursement rate ceilings on publicly funded health services limit the strategy of improving the quality of services to get a premium price for a premium product. Within the existing environment of the New York City home care market, CHCA believed that increasing the volume of business and seeking greater efficiency through economies of scale could free up some revenue to increase wages and benefits. As described in the previous chapter, CHCA has grown dramatically since its first contract with 12 aides in 1985, to nearly 600 workers and \$13 million in revenues in 2001. While growth has created some strains and challenges for the organization's unique culture, management staff members report that the aide's job is now better than it was a few years ago in terms of fundamentals such as wages, hours and benefits.³⁸

CHCA's careful recruitment and screening procedures contribute to remarkably low staff turnover rates that, in turn, improve efficiency. In an industry where turnover for home health aides typi-

³⁸Rick Surpin, interview by Maureen Conway and others, New York, NY, 15 March 2000.

cally has ranged from 40 percent to 60 percent per year or even higher, CHCA has consistently experienced turnover rates below that. The current rate ranges between 20 percent and 30 percent. High turnover entails extra costs for service providers, who have to recruit and train scores of new candidates just to replace aides who leave.

Focus on the Workers

The well being of its workforce has always been a central concern of CHCA's business strategy. Rick Surpin summed up how the interests of employees have guided CHCA's business decisions:

"The major thing is the focus on workers ... building the organization based on workers and what workers want. ... Worker-ownership ... has its own financial logic. ... Workers don't care if we make huge profits. They care about having a good job and having a good company that lasts over time and having enough money ... retained each year ... (to) survive a bad year or two. The worker-owner structure allows you to maximize wages and benefits. ... At the board level and at the council level, managers ... can't forget about workers, whereas on a typical board you can easily do that." ³⁹

This focus on the employee has guided the efforts to increase wages and benefits. From the beginning, CHCA has tried to maximize the percentage of revenues funneled to workers in the form of wages and benefits. Currently, it is estimated that 80 cents on the dollar goes in employees' pockets in the form of wages and benefits.⁴⁰ CHCA leadership estimate that in most other agencies, the percentage of revenue dedicated to compensating aides ranges from 65 percent to 75 percent.

Becoming a worker-owner in the cooperative business structure of CHCA brings with it monetary rewards in the form of annual dividends, as well as opportunities to participate more in the management of the company through representation on the board of directors and in the worker councils. CHCA home health aides who decide to become shareholders receive annual dividends. These have tended to range from \$200 to \$400 per year. Shareholders also own a stake in the company and thus ultimately benefit from any future profits that result from investment of retained earnings in the business.

³⁹Rick Surpin, interview by Maureen Conway and others, New York, NY, 15 March 2000.

⁴⁰CHCA and PHI managers, interview by Maureen Conway and Anne Inserra, New York, NY, 11 April 2001.

Beyond this financial advantage, employees have benefited from the special participatory and empowering atmosphere that results from the worker-centered philosophy. CHCA has tried to upgrade the status of the aide within the team that provides care to the homebound patient, by raising awareness of the importance of the work that home health aides do. One practice that has contributed to this is the use of geographically based nurse-aide teams, which helps develop stronger relationships between nurse supervisors and the home health aides working under their direction.

These advantages are less tangible but have been extremely important to CHCA's success. Higher morale resulting from all these efforts has contributed to the higher quality services that CHCA health aides provide, reinforcing the Quality Jobs/Quality Care approach. As one CHCA home health aide put it:

*"Here I love my job, my co-workers. ... We are like a family."*⁴¹

Better Benefits

In addition to paying higher wages, Cooperative Home Care Associates provides superior benefits for its home health aides. The company tried to offer improved benefits from the time it first opened in 1985. That first year, CHCA was able to offer an allowance for uniforms for aides, which was unusual in the industry. In 1987, a life insurance benefit and five paid personal days were offered to employees. By 1989, CHCA became the first licensed home health agency in New York City to offer limited health insurance to its workers. Ironically, the normal practice in the industry at the time was that home health aides, whose livelihoods involved caring for the health of others, did not have access to employer-sponsored health insurance. CHCA added more benefits during the years, including sick leave and vacation time. In 2001, CHCA added a 401(k) retirement savings plan.

Improved Work Hours

One of the problematic aspects of the home health care industry has traditionally been the difficulty of scheduling full-time work. The publicly funded reimbursement systems for home care specify how long each home visit for a specific medical condition

may take. Most home care sessions are limited to a few hours or less per visit.⁴² To work close to full-time hours, a health aide must usually try to fit more than one home visit into any given work day. Scheduling multiple visits in a day is difficult because an aide must travel to each individual patient's home and is not compensated for time spent traveling between assignments. In addition, patients most often request home care visits in the morning (to help them start their day) and tend to resist scheduling afternoon visits. All of these factors have contributed to the prevalence of part-time work in the home health aide field.

Cooperative Home Care Associates has consistently tried to find ways to increase the average number of weekly hours home care aides work, with a goal of providing full-time work to all who desire it. CHCA pursued a multi-pronged approach to increasing weekly hours for its workers. On one front, CHCA staff lobbied hard with certified agencies to get them to persuade their patients to accept home visits in the afternoons. Another element of the strategy involved restricting the geographic spread of CHCA's cases to certain areas of New York City, namely the South Bronx and northern Manhattan. By accepting work only in these areas, CHCA managed to reduce the amount of time aides spent traveling between cases. Although certified agencies such as Visiting Nurse Service of New York tended to group caseloads for nursing staff by geographic areas, the principle had not generally been extended to organizing the work for home health aides.

The result of these efforts has been a steady increase in the number and percentage of CHCA home health aides working full-time schedules. In 1985, approximately 70 percent of CHCA's aides had only part-time work, comparable to the overall industry average. In 1987, the first profitable year for the company, CHCA reached its original goal of having 70 percent of its workforce on full-time schedules.⁴³ According to program data, CHCA aides worked an average 36 hours a week during 2001.

Replication sites also succeeded in increasing the amount of work available to home health aides. In 1997, Cooperative Home Care of Boston averaged 33 hours per week per aide, and Home Care Associates in Philadelphia averaged 31 hours per week.⁴⁴ The

⁴²Under Medicaid and Medicare, the number of home visits and the length of each visit are specified according to the patient's medical condition and other characteristics. There is a great deal of regional variation. For example, a medical condition that might be authorized for a four-hour visit in New York might be authorized for only 90 minutes in Philadelphia.

⁴³Dawson and Kreiner, 7-15.

⁴⁴Dawson et al, 4.

The main focus of CHCA's sectoral employment strategy has involved improving the conditions of an entry-level job that was already accessible to low-income women.

increases in weekly hours of work have had a great effect in terms of increasing the overall amount and predictability of income for home health aides employed within the Cooperative Healthcare Network. The eagerness of employees to accept increased hours also has helped refute a common assumption within the home care industry that most aides were interested only in part-time work. In this way, CHCA and its affiliates have had an influence on the broader home care sector.

In 1993, Cooperative Home Care Associates received funding from the United Hospital Fund and the New York Community Trust to experiment with a guaranteed hours program. Under this program, an aide who had at least three years of experience with CHCA could be paid a guaranteed minimum of 30 hours of work a week in exchange for agreeing to accept cases on alternating weekends and any substitute assignments offered. Workers who participated appeared to appreciate having a more secure income. The guaranteed hours program is still in place and is generally considered a good way to provide stability to the job, and to promote long-term retention of home health aides at little extra cost per participant.⁴⁵

Career Advancement Strategies

The main focus of CHCA's sectoral employment strategy has involved improving the conditions of an entry-level job that was already accessible to low-income women. At the same time, however, Cooperative Home Care Associates also has experimented with strategies designed to help home health aides gain access to better quality jobs. The different strategies for developing career ladders, or paths, for home health aides have varied in their effectiveness.

In 1991, CHCA introduced wage rate tiers to provide a modest career path for employee advancement within the company. In this system, there are three levels of the home health aide position. Each successive level requires additional training and receives a higher wage. In addition, slightly higher rates are offered to employees who stay with the company longer. As mentioned above, CHCA also offers a wage differential for assignments that involve weekend hours or more difficult patient cases.

The Senior Home Care Aide Pilot Project provided two years of funding for four upgraded aide positions within CHCA in

⁴⁵The cost of the entire guaranteed hours program in 2001 was \$21,000. About half of the workers participated in the program that year, so this works out to an estimated annual cost of between \$60 and \$70 per participant (based on figures provided by Peggy Powell to Anne Inserra in a telephone interview, 24 January 2002).



Photo by Marilyn Humphries

The work of a home health aide can be quite physically demanding, often requiring them to move or lift patients that are unable to assist.

1992. The positions were for individuals who continued to provide home health care, but also assumed new responsibilities such as helping with training or coordinating patient services.

A number of home health aides have been successfully promoted into positions in training or administration within CHCA. Forty percent of CHCA's administrative staff positions are filled by former home health aides. Some aides have been upgraded to competency instructors or assistants who help with the training program, and others work in administrative support positions.

CHCA also has experimented with strategies designed to help aides acquire the training and credentials needed to advance beyond the home health aide occupation altogether. The Nursing Education Assistance Program was started in 1989 under Peggy Powell's leadership. This program offered training to 15 CHCA aides to help them qualify to become nurses. The program was disbanded in 1992 because of a lack of funding. A significant number of candidates dropped out because they had difficulties meeting the science course requirements for the nursing degree. Five aides ultimately became nurses, with two becoming licensed practical nurses (LPNs) and three becoming registered nurses (RNs). Three of these graduates were employed at CHCA, and one became a supervisory teaching nurse for CHCA.

Another approach was the Home Care Certificate Program, launched in 1996 in collaboration with the Lehman College School

of Adult and Continuing Education and the John F. Kennedy Jr. Center for Worker Education at City University of New York. The program was designed to offer accredited college-level courses to working home health aides, and was intended to serve as a bridge to college for these individuals. Cooperative Home Care Associates employees were encouraged to attend. To make it easier for them to attend, courses were offered on site at CHCA in the evenings. Tuition was paid through a grant from the United Hospital Fund. Students had to pay only registration fees at Lehman College. Tutorial assistance was available to help students succeed. Four semester-long courses were offered on different health care topics including gerontology, rehabilitation, disabilities and the home care system. More than 60 individuals completed at least one course and 35 completed all four classes and earned the certificate. Twenty percent of those who completed all four courses and received the certificate continued on to college. A repeat cycle of two courses was offered at CHCA in 1999, but the CHCA site-specific course cycle was interrupted when Lehman decided to offer the courses at several central city locations so that home care workers from multiple agencies could attend.⁴⁶

Affiliated organizations within the Cooperative Healthcare Network also have experimented with career advancement paths for home health aides. Home Care Associates in Philadelphia created a mentor program for senior aides, and has upgraded some aides to administrative positions within the company. The Careers in Health Care program run by the Good Faith Fund in Arkansas trains health care aides to become certified nursing assistants. They have found that 20 percent to 25 percent of the CNA training program graduates do ultimately move on to licensed practical nurse or registered nurse training programs.

A recent development is the Paraprofessional Healthcare Institute's work with the Massachusetts Career Ladders Initiative. PHI participated in an alliance of stakeholders in Massachusetts that successfully lobbied for an extensive, \$42-million nursing home staffing legislative reform package. The package included a wage pass-through for certified nursing assistants, and a \$5-million demonstration project called the Extended Care Career Ladder Initiative (ECCLI). PHI's role in ECCLI has been to provide techni-

⁴⁶This information on the certificate program comes mostly from e-mail correspondence from MaryAnn Wilner of PHI, who taught the courses at CHCA.

cal assistance and education to participating nursing homes, which receive grant funding to experiment with restructuring the ways that aides are trained, supervised and supported.

The results of the various career advancement strategies that have been tried within the Cooperative Healthcare Network appear to be somewhat mixed. Employment at CHCA seems to provide an initial boost to employees' earnings — an independent survey of participants found that, among those who worked during the year before coming to CHCA, average annual earnings increased from \$4,735 in the year before training to \$10,098 in the year after training.⁴⁷ However, after a year or two, employees have few viable options for continuing to improve their earning power while remaining in occupations related to the home health care sector. CHCA's system of wage rate increases for greater length of service, weekend work, guaranteed hours and more difficult cases seems to be popular among employees. A relatively small number of home health aides have successfully transitioned into administrative or teaching work within the cooperatives. Very few home health aides, however, have managed to move up the health care career ladder in any significant way. Some CHCA and PHI managers believe that the qualifications gap between the home health aide job and the next higher position within the health care profession — nurse — is probably too large for many individuals. Also, it is not legally possible within current regulations to allow a health care aide to perform more advanced medical procedures with patients. *All of these factors have contributed to CHCA and PHI's decision to place so much emphasis on trying to improve the pay and conditions of the health care aide job as a longer-term occupation in its own right.*

Independence Care System as a Sectoral Initiative

Independence Care System, the new demonstration program sponsored by CHCA and PHI, extends CHCA's sectoral employment strategy. As described in the Program chapter, ICS is a managed long-term care program designed to provide better care to severely disabled adults whose needs have not been adequately met by the existing health care system. ICS has the potential to contribute to the sectoral strategy both by making CHCA a stronger and more effective organization in its own right and by reaching and

⁴⁷This survey was conducted as part of the Sectoral Employment Development Learning Project. Further information and publications are available from the Economic Opportunities Program at the Aspen Institute.

Because ICS buys higher quality home health aide services only from organizations that give their workers higher wages and more benefits, ICS has some influence on the broader market for home care services in New York City.

influencing a broader range of actors within the health care arena. While ICS is an integral part of the sectoral strategy, it is important to note that establishing ICS also is a calculated business decision. ICS' ability to contribute to the vision of sectoral change that originated with CHCA will be contingent upon its surviving and thriving in a very difficult business environment.

The founders of ICS expect that being a managed long-term care program that receives payments directly from Medicaid will give it more ability to influence the terms of contracts and the operating environment. (Because CHCA and the other replication sites are licensed agencies, they operate at the bottom of the reimbursement payment system, which gives them less ability to influence prices and other factors in the labor market.) ICS shares the Quality Jobs/Quality Care strategy of providing higher wages and better benefits to home health care workers, and superior services to clients. ICS currently pays rates similar to the Visiting Nurse Service of New York rate for home health aide services, the highest in New York City. However, ICS also requires that the licensed agencies with which it contracts for home health aide services pass through at least 75 percent of the reimbursement rates directly to wages and benefits for aides.

Independence Care System can be described as a sectoral employment approach in several respects. ICS tries to improve wages and conditions for the low-wage occupation of home health aide. By contracting for the services of home health aides from licensed agencies, ICS operates on the demand side of the home health aide labor market. Because ICS buys higher quality home health aide services only from organizations that give their workers higher wages and more benefits, ICS has some influence on the broader market for home care services in New York City. This influence should increase as ICS grows in size and volume of service. The emphasis on superior quality home health aide services creates more demand for the type of quality training for aides that CHCA supports. ICS believes that by operating as a managed long-term care program that receives Medicaid payments directly, it will potentially have greater ability to improve conditions of the home health aide job. As a managed long-term care demonstration program, ICS hopes to influence wider practices within the industry.

Finally, ICS is expected to need some upgraded aide positions, which would provide increased career advancement opportunities for home health aides.

Broader Influence of CHCA's Sectoral Approach

"CHCA has been one of the more forward-thinking licensed agencies in terms of benefits. ...By providing a successful example (of offering improved benefits), CHCA served as a sort of leader among other agencies."

— Barbara Lyon, director of contract administration for the Visiting Nurse Service of New York⁴⁸

The founders of Cooperative Home Care Associates created a yardstick company that has gained respect from industry associations, consumer groups, policy makers and entry-level workers. As a model company, CHCA has demonstrated that an emphasis on improved job conditions and investment in workers can result in better quality home care services, and still meet profitability standards. There also has been some success with replicating the CHCA model in other cities. Over time, CHCA and its affiliates have moved toward the broader goal of trying to influence the entire home care system in New York City and beyond. The Paraprofessional Healthcare Institute is nationally regarded as a unique and valuable player in direct care policy and research arenas.

Within the New York City home care market, CHCA has had some influence on industry practice, partly through its involvement with Visiting Nurse Service of New York. In 1997, VNSNY formed a Licensed Agencies Leadership Group on a pilot basis with six agencies, including CHCA. The goal was to try to develop more of a partnership relationship between VNSNY as the certified agency (buyer of home health aide services) and the licensed agencies (suppliers of services), and to disseminate best practices among the agencies.

According to Barbara Lyon of VNSNY, CHCA shared with the group its successful experience with certain improved practices, such as guaranteed hours and better benefits. CHCA demonstrated that it was possible to implement measures that improved the quality

⁴⁸Barbara Lyon, telephone interview by Anne Inserra, 12 October 2001.

of the job while still operating successfully as a business, and this example helped put some degree of peer pressure on other members of the group to adopt similar measures. Another contribution to the group was CHCA's novel scheduling solution for patients requiring 12 hours of care, seven days a week. The typical approach among licensed agencies was to assign one aide to the patient for five weekdays, and then scramble to find weekend coverage from other aides. CHCA's innovation was to create two full-time jobs for aides by splitting the seven-day week at the midpoint, giving each aide 42 hours of work and improving consistency and weekend coverage for the patient. In addition, Cooperative Home Care Associates was one of only two licensed agencies at that time using a geographic approach to assign home health aides (the other was Sunnyside in Queens). While VNSNY had always assigned its nurses according to geographic areas, it now extended geographic-based assignment to home care services from the licensed agencies it worked with, persuaded by advantages of reduced travel time between cases and improved continuity and relationships between supervising nurses and home health aides. Finally, when VNS decided to reduce the number of licensed home care agencies it worked with from 24 to 13 in 1999, Cooperative Home Care Associates remained a valued partner.⁴⁹

Cooperative Home Care Associates has influenced the home care sector in other ways. The United Hospital Fund has promoted CHCA as a model of the Quality Jobs/Quality Care approach. CHCA has won various awards, such as the Business Enterprise Trust Award for courage, integrity and social vision in 1992, and the Corporate Conscience Award for employee relations from the Council on Economic Priorities in 1997. The president of the Home Care Association of New York State described how CHCA is currently cited as a promising model for future practices in the home care industry at most major presentations and events on long-term care that take place at the federal or state level.⁵⁰ Industry observers have described Rick Surpin as a visionary leader who helped create new organizations, such as CHCA and ICS, that could serve as laboratories for experimenting with the basic structure and operating terms of the home care industry.⁵¹ Surpin, Steve Dawson, Peggy Powell and other key leaders of CHCA and its affiliated organizations have stood out in their thinking about issues affecting home

⁴⁹Barbara Lyon, telephone interview by Anne Inserra, 12 October 2001.

⁵⁰Carol Rodat, Home Care Association of New York State, telephone interview by Anne Inserra, 9 October 2001.

⁵¹Kathryn Haslanger and Carol Rodat, telephone interviews by Anne Inserra, 16 March 2000 and 9 October 2001.

care in systemic and policy terms. According to Kathryn Haslanger of the United Hospital Fund, Surpin “had an influence that went ... far beyond ... this little paraprofessional agency ... Rick’s voice was a lot bigger than his 200-aide agency.”⁵² PHI and CHCA have become active, valued players in the policy arena, and are expected to continue to help shape policy surrounding the home health care industry in the future.

⁵²Kathryn Haslanger, telephone interview by Anne Inserra, 16 March 2000.



“It is intense training. Lots of information. It was excellent. It prepared you for practically everything – dealing with bed-bound patients, etc. ... The training prepared me for any situation I might have.”

— CHCA aide⁵³

Cooperative Home Care Associates’ entry-level training program for home health aides reflects the values and philosophy of the organization, and is a critical part of its strategy for running a successful business. CHCA leadership describe the training program as being, in essence, a second business line that can contribute to shared overhead costs with the home care agency, improving efficiencies for both. The business lines are highly complementary and often require a similar set of knowledge and skills among staff. In particular, this increased efficiency enhances CHCA’s ability to pass on wages and benefits to workers.

Like other aspects of CHCA’s operations, the training program has evolved during the years as training staff experimented with various ideas and approaches. In addition to the entry-level training, CHCA offers different advanced training classes, described more fully in the previous chapter. All of the replication sites in the Cooperative Healthcare Network have developed training programs based on the CHCA experience, adapted to their particular needs. This section focuses on the entry-level training program for home health aides as it operates at Cooperative Home Care Associates in the South Bronx. In addition, the methods CHCA uses to support trainees as they transition to work also are discussed.

Participants

The entry-level training program at Cooperative Home Care Associates recruits low-income women, most of whom have limited work histories and face multiple employment barriers. Most of the applicants have children in their households. An independent survey conducted by The Aspen Institute found that 83 percent of trainees had children living with them, and 42 percent had children under the age of 6. In addition, 56 percent had not worked at all during the year before coming to CHCA, and 15 percent had never worked at all. Education levels were generally low; 42 percent did not have a high school diploma or equivalent, and only 5 percent

reported any education beyond high school. The survey also found that 51 percent of participants received public cash assistance, and 71 percent were receiving food stamps or other publicly funded food program benefits. CHCA staff estimate that typically 65 percent to 70 percent of the applicants for the entry-level training are on some form of public assistance.⁵⁴

Many applicants have quite limited work histories, and their earnings and overall household income are very low. According to an independent survey in 1998, 80 percent of respondents had been unemployed six months or longer during the 12 months before enrolling in the CHCA entry-level training program. Average personal earnings per year for entrants to the training program were \$4,960, and average personal earnings per hour were \$5.69.⁵⁵ CHCA program data for 1998 and 2000 indicate an even higher incidence of household poverty, with 95 percent of trainee households below 100 percent of the federal poverty level.⁵⁶

Joanna

When Joanna came to CHCA in July 1998, she was a single mother with four children under the age of 11, and was sharing a home with her mother and two younger sisters. Joanna was 29 and she had a GED and some work experience. Her most recent job had been as a concessionaire at Yankee stadium. While it was a union job that paid fairly well, at \$8.30 per hour, the work depended on the baseball schedule. Joanna worked only 17 weeks in the 12-month period before beginning the CHCA course. Her family was dependent on various forms of assistance, including cash benefits and food assistance, and she had been receiving welfare benefits for the past six years.

Ten years earlier, Joanna had attended — but not completed — a different, two-week home health aide training course. At the time of her enrollment in the CHCA course, she had aspirations of becoming a registered nurse. Joanna liked the quality of the instruction and the instructors of the CHCA course.

⁵⁴Betsy Smulyan, interview by Maureen Conway and others, New York, NY, 16 March 2000.

⁵⁵From the independent longitudinal survey of CHCA participants by EOP, Wave One results.

⁵⁶SEDLP Program Monitoring Profile data for 1998 and 2000. This data is self-reported by participating programs.



Immediately after completing training, CHCA hired Joanna as a home health aide. She started at \$6.25 an hour and worked an average of 32 hours a week the first year, which she did not think was enough. Two years after completing the training course, Joanna was still working for CHCA. Her hourly wage had risen to \$6.75 and she increased her average weekly hours to 40, which she felt was the right amount. Joanna was satisfied with her job at CHCA in general, including her work schedule, the level of responsibility she had, the flexibility for dealing with family needs and emergencies and the way she was treated by her supervisor and co-workers. She appreciated having the opportunity to become an owner of the business, as well as the opportunities for career advancement, and she thought her career prospects were better as a result of taking the CHCA training course. Despite the raise, however, she was still dissatisfied with her earnings and the health benefits. Having enough money to pay the monthly bills was still an immediate concern for Joanna.

Joanna's family situation appeared to be a bit better off than before she began working for CHCA. She found her own place to live with her four children, and was no longer receiving cash welfare benefits, state general assistance or public housing assistance. Her family continued to receive additional income from sources such as child support/alimony payments, and they still received food assistance.⁵⁷

One employment barrier facing many applicants to Cooperative Home Care Associates' training program is a poor educational background. Program data show that during the past few years, the percentage of participants who lacked a high school diploma or GED ranged between 36 percent and 44 percent.⁵⁸ Similarly, an independent survey found that 42 percent of participants in CHCA training lacked a high school diploma or GED.⁵⁹

The vast majority of CHCA employees belong to minority ethnic or racial groups. The proportion of Spanish-speaking participants has grown dramatically in recent years. Monitoring data collected on trainees in 2000 shows that 90 percent were Hispanic, and

⁵⁷Compiled from responses of an individual CHCA aide to the EOP longitudinal survey of sectoral training participants.

⁵⁸SEDLP Program Monitoring Profile data for 1998, 1999 and 2000.

⁵⁹EOP survey data.

that 58 percent tested as not proficient in the English language. Two years before, the percentage of Latina participants was just 44 percent, and only 3 percent of participants were identified as not proficient in the English language.⁶⁰ This movement toward more Spanish-speaking participants was to some degree pushed by changes in welfare law as described below, and was facilitated by the introduction of Spanish language training cycles in 1999.

Effects of Welfare-to-Work Reforms on Recruitment

The work first requirements that accompanied welfare reform beginning in 1996 affected CHCA's ability to recruit trainees. New York City's Work Experience Program (WEP) discouraged pre-employment training in favor of immediate employment.⁶¹ Under the WEP guidelines, a caseworker was more likely to try to place an individual who spoke English directly into a job rather than into a training program, while someone who did not speak English well was more likely to be allowed to enroll in a training program first. This trend may have contributed to an increase in the proportion of native Spanish speakers in CHCA's prospective applicant pool. However, during a similar time period, the demographic makeup of the South Bronx also changed, shifting toward a higher percentage of ethnic Hispanic individuals, and this shift also contributed toward the increase in Spanish-speaking applicants.

In CHCA's early years, when the regulatory environment was more supportive of welfare recipients entering training programs, CHCA found that a greater proportion of applicants were transitioning from welfare to work. One of the consequences of the work first policy, which was amplified by relatively low unemployment rates toward the end of the 1990s, was that individuals who remained on welfare tended to have more barriers to employment, and were the hardest to employ. CHCA found that this made recruitment efforts more difficult. For example, the law prohibits an individual with a substance abuse problem or a criminal record from becoming a certified home health aide. As a result, the proportion of CHCA entry-level training applicants coming directly from welfare decreased, and the majority of recruits shifted to unemployed women looking for more stable work.

⁶⁰SEDLP Program Monitoring Profile data for 2000 and 1998.

⁶¹CHCA's entry-level home health aide training course did not qualify as a WEP assignment for several years, although under new guidelines issued in 2000, it was included in the Human Resources Administration's list of approved training procedures.

Development of the Training Program

For its first contract in 1985, CHCA recruited a dozen trained home health aides. In 1986, in an effort to gain more ability to influence employees' standards and expectations, CHCA created its own entry-level training program under the leadership of Peggy Powell.⁶² During the first year of the training program, CHCA recruited and screened candidates, and contracted the two-week training course to a local community college. By 1987, CHCA staff had become dissatisfied with the college training course because the quality of instructors varied too much, and classroom locations shifted constantly. At this point, Powell and Kathleen Perez led an effort to develop a completely internal, on-site training program for home health aides. CHCA has continued to offer an employer-based, entry-level training program for home health aides ever since. CHCA management recognizes the importance of the training program not only for its success in teaching important technical skills, but also for introducing new recruits to the unique company policies and organizational culture of CHCA.

Outreach and Recruitment Strategy

Cooperative Home Care Associates' entry-level training course for home health aides is about double the regulatory requirement, and trainees who successfully complete the program are guaranteed a job at CHCA. Because CHCA invests so much in preparing new aides, it tries to ensure that the individuals who enter the course are likely to succeed at the job. Higher initial costs involved in recruiting and training are offset by lower staff turnover rates. The intensive recruitment and screening process is considered crucial to the success of the cooperative's business strategy. As explained in a PHI guide that describes the recruitment strategy used by CHCA and other members of the Cooperative Healthcare Network:

"Our recruitment approach emphasizes carefully screening candidates so that once trainees become employees they are more likely to stay with the company. The more stable your workforce, the easier it will be to build a cooperative and committed company culture."⁶³

Cooperative Home Care Associates' entry-level training course for home health aides is about double the regulatory requirement, and trainees who successfully complete the program are guaranteed a job at CHCA.

⁶²Dawson and Kreiner, 12.

⁶³"A Guide to Training Home Health Aides," (New York, NY: Paraprofessional Healthcare Institute, 2000), I.1.

Cooperative Home Care Associates relies mostly on targeted outreach efforts to attract potential candidates to the training program. Broader outreach efforts, such as fliers or advertisements in newspapers, also have been used but are not considered to be as successful. The largest source of applicants (50 percent) comes from informal contacts and word-of-mouth, such as existing CHCA employees referring friends. A formal Employee Referral Program provides a \$50 bonus to a CHCA employee who refers an applicant who ends up being hired and stays with the company for six months. Another 20 percent of applicants are referred to CHCA by different community-based organizations. CHCA currently works with 15 organizations in the South Bronx that provide services to low-income women, including pre-employment and job-readiness programs, and English as a Second Language centers. CHCA workforce development staff members encourage caseworkers in these programs to try to identify and refer appropriate individuals. The remaining 30 percent of applicants come from a mix of outreach efforts. An interesting example is the CHCA aide who explained how she happened to come to the building to visit the Social Security office and accidentally got off the elevator on the CHCA floor instead.⁶⁴

Attracting Candidates

Relative to industry standards, CHCA's training program and employment standards have a number of positive features. For example, at some companies, individuals pay a fee to participate in training that will certify them to become a home health aide. At others, there is no stipend to cover the cost of a uniform. The box below highlights the main positive features of CHCA's training. CHCA also emphasizes the less tangible rewards of the job, including the personal satisfaction that can be found as a caregiver. The participatory and egalitarian atmosphere that CHCA cultivates also is a draw for many individuals.

⁶⁴Focus group, 15 March 2000.

Positive Features of Training and Employment at CHCA

- Training course is free
- Guaranteed employment to those who pass the training course
- Smooth transition from training to work
- Possibility for full-time work and guaranteed hours
- Individual health insurance option after three months' employment
- Disability insurance after three months' employment
- Workers' compensation insurance after three months' employment
- Vacation pay (up to 10 days per year, with cash payout option)
- Earned leave time (up to 12 days per year, with cash payout option)
- Uniform subsidy
- Credit union membership
- Retirement plan option
- * Annual cash dividends
- * Life insurance

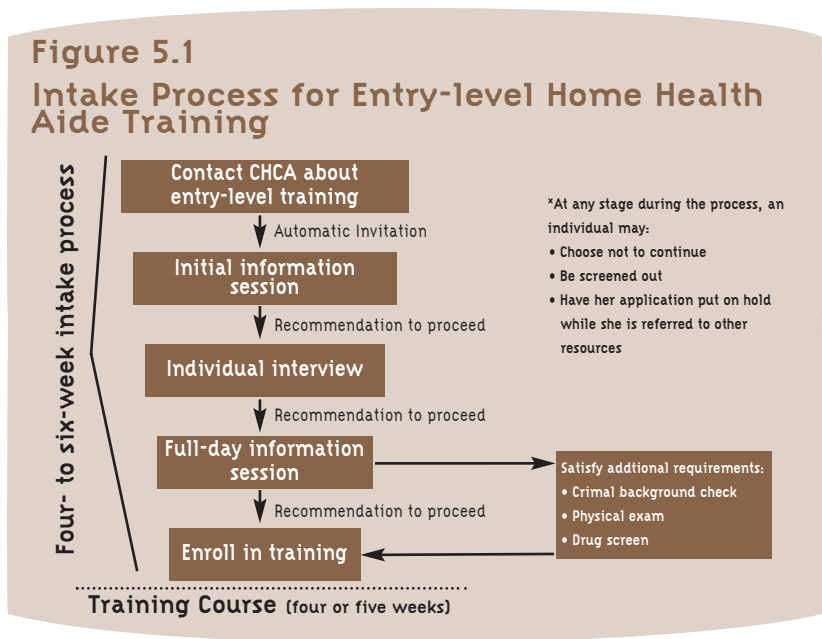
* Benefits available to workers who purchase a share and become owners of the cooperative

Application/Screening Process

CHCA employs an unusually rigorous applicant screening process. It involves multiple opportunities to assess different aspects of an applicant's personal history and living situation, basic skills and potential for success in home health care work. Attrition rates before the training begins are expected to be quite high. In fact, Cooperative Home Care Associates has estimated that for every 10 successful graduates of the entry-level course, it needs about 100 applicants to sign up for the information session, the initial step in the screening process. In other words, only one in 10 of the initial group of people who express interest in the program will actually graduate from training.⁶⁵ While this may imply that CHCA accepts only the least difficult to employ candidates, the group that it does

⁶⁵PHI, "A Guide to Training Home Health Aides," I.2.

bring into its training programs is quite disadvantaged, as described above. However, because of the nature of the work and certain legal requirements, substantial numbers of people are not accepted into the program, as described below.



When an individual inquires about the entry-level training program, she is invited to attend a group visit or information session at CHCA headquarters. At this session, an applicant fills out an intake sheet that includes some questions designed to assess her care giving experience. An overview of the job and training program is given, and CHCA staff members try to make a preliminary assessment of whether the individual seems suited to the program. If a candidate is invited to proceed to the next step, she has an individual interview. At the interview, the applicant is asked specific questions and is evaluated according to standard criteria. Tests are given to gauge reading ability, basic math skills and ability to prioritize and solve problems. CHCA staff members try to identify potential barriers that the candidate may face in terms of child care, housing or in other areas. After the interview, staff members recommend whether the candidate should proceed to the next step. If the person is recommended, she is scheduled for a more intensive information session.

A full-day information session was initiated in the late 1990s in an effort to reduce attrition in the training program. At this session, participant expectations and responsibilities are fully explained. The applicant is observed in various group activities to see how she communicates and handles problems. At the end of the day, counselors sit with each applicant individually and ask her to assess whether she thinks she is ready to begin training.

Additional enrollment requirements are that the applicant must pass a criminal background check, a drug screen and a physical. CHCA

reports that it loses many of the applicants because of the criminal background check or the drug screen. References

and proof of residency also

are checked. About four to six weeks are needed to complete the pre-training steps, assuming that the application is not put on hold for any reason.

Individuals may drop out at any point in the recruitment and orientation process. Some decide they do not wish to pursue home care work. Others fail the criminal background check or drug screening. Some miss a scheduled appointment with CHCA staff. Others are assessed as not having the desired characteristics and abilities that CHCA's experience has shown make for a successful home health aide. Low-income women in the target population group often face many difficulties in their personal and family lives that can interfere with their ability to complete the training or work steady hours. According to Zianna Ameer, CHCA's employment services manager, problems with child care and housing are the most frequent reasons candidates cite when dropping out after the training actually begins. Another problem some applicants face is domestic violence.



Photo by Marilyn Humphries

Trainees learn many practical skills, including how to change linens when the patient must remain in bed.

In some cases, CHCA recruitment staff members may decide that a candidate is very promising, despite one or more problems. The application can be put on hold while the individual is referred to other organizations for assistance. Upon resolution of the problem(s), the candidate may return to the CHCA intake process. CHCA also offers different forms of support to try to help women make it through the training program and remain successfully employed, as described below.

Desired Personal Qualities

An important goal of the recruitment strategy is to identify candidates who possess certain characteristics and abilities that CHCA believes will contribute to an individual's success in working as a home health aide for the cooperative. The idea is that a person needs to have certain innate abilities to begin with, and that the four-week training should enhance those natural abilities. Because an aide works largely on her own in clients' homes, she must be resourceful and comfortable with taking the initiative to solve problems. A home health aide needs to be honest, mature, reliable and responsible. Good communication skills are important, because the aide must regularly interact with the patient, the patient's family and the supervising nurse.

Perhaps most importantly, CHCA screens applicants for qualities of warmth, compassion and caring. An applicant must receive a score of seven out of 10 on a set of care giving questions on the intake form. An upgraded home health aide who assisted with the training course described how these qualities cannot really be taught: *"We teach them the hands-on skill. But the caring part – that you cannot teach. ...They have to really want to do it."*⁶⁶ CHCA staff members have observed that many employees apparently had some experience with taking care of sick or disabled family members before they enrolled in the training course. CHCA believes that being able to derive personal satisfaction or a sense of reward from helping others is essential in this line of work, especially given the relatively low pay. As one CHCA trainee put it: *"(It is) a spiritual sort of occupation. You don't do it for the money."*⁶⁷

In focus group interviews, individual CHCA aides and trainees were asked about what drew them to home care work, and

⁶⁶Focus group, 15 March 2000.

⁶⁷EOP survey response, 23 November 1998.

what they liked about the job. Individuals revealed inspiring qualities of caring and compassion:

- *“I knew what I wanted to do was help people.”*
- *“(I) feel good helping people. I found that this work is beautiful.”*
- *“I like it. I ... have personal experience in the home. Just don’t have professional experience. I like to help elderly people. I like to take care of them.”*
- *“I was always taking care of somebody. Always attracted elderly people to me. I can’t help it! They just come to me. ... It’s what I was doing anyway. Just decided to try to get paid for it.”*
- *“I do like helping patients and seeing improvement. I like seeing health problems get better. Both physically and mentally getting stronger, getting better. ...I feel good to be able to help them and to prevent sickness.”⁶⁸*

Training Process

Federal law requires a home health aide receive 75 hours of classroom training to become certified. Sixteen of those hours must involve practical skills training under the supervision of a registered nurse.

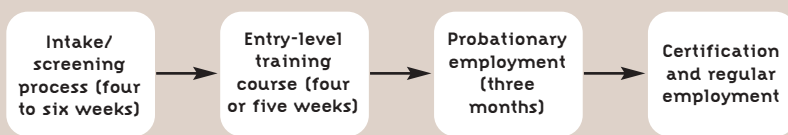
Cooperative Home Care Associates is licensed by the New York State Department of Health to conduct a home health aide certification training program. CHCA’s entry-level training course far exceeds the federal requirement. The course in English is 160 hours and lasts four weeks, while the course offered in Spanish is 200 hours and is five weeks. Classes are conducted daily from 9 a.m. to 5 p.m. After finishing the training program, an applicant must then complete eight hours of clinical work in the field under the supervision of a registered nurse.

An individual who successfully completes the entry-level training course is automatically hired by CHCA and immediately starts working. The first three months of work constitute a probationary period, during which a new employee is carefully monitored. After three months, a trainee goes through a graduation ceremony and receives her official certification as a home health aide under federal Medicare and New York state regulations.⁶⁹

⁶⁸Focus groups, 15-17 March 2000.

⁶⁹The individual also receives certification as a personal care aide. The training to become a personal care aide is subsumed within the home health aide training course.

Figure 5.2
Path to employment at CHCA



Learning Methodology

The entry-level training course for home health aides at Cooperative Home Care Associates aims to provide more than clinical competency or “hard” skills. The program also tries to strengthen “soft” skills, such as the ability to communicate effectively, solve problems and think critically.

CHCA’s training method is grounded in a pedagogical approach called adult learner-centered education.⁷⁰ A learner-centered approach tries to actively engage pupils in the learning process and help them absorb new information by integrating it with what they already know. Teaching techniques try to build critical thinking skills by using problem-based exercises, case studies and role-plays that actively involve students as participants, instead of relying mostly on passive lectures or demonstrations. Instructors demonstrate technical skills on each other, and then class members practice in small groups. Interpersonal and communication skills are strengthened through team exercises and brainstorming sessions. Job-readiness is enhanced because the content is practical and directly applicable to actual work in the field.

An important assumption in a learner-centered approach is that people assimilate new information best when they feel they are in a supportive, comfortable environment. This is particularly important for CHCA’s entry-level course, because so many candidates come from weak educational backgrounds and/or have had negative experiences with school. The training approach is designed to try to bolster individuals’ confidence and self-esteem through the use of participatory techniques and emphasis on mutual respect among trainees. Former or practicing CHCA home health aides are employed as associate instructors to help conduct the training course, which increases students’ comfort levels.

⁷⁰The information on CHCA’s teaching methods that is presented here comes mostly from a draft publication of the Paraprofessional Healthcare Institute, “A Guide to Training Home Health Aides,” written in February 2000, especially pages 20-24 and 29-30.

Many trainees appreciate the approachability of the trainers and the supportive learning environment at CHCA, as shown in these comments:

- *“I feel very comfortable here. You have to work as a team. If you don’t understand, ask them. You learn in here very good. Because they come to you and make sure you really understand.”*
- *“If there is anything you can’t do, you can refer back to them and they will help. They always stressed that spelling doesn’t count!”⁷¹*
- *“(I liked) everything (about the training. We) worked together as a group; the instructor was always available to answer questions.”⁷²*

One criticism expressed by some trainees was that the class sizes were too large to allow all of the students to fully participate.⁷³

Support for Trainees and Employees – Retention Issues

An important element of Cooperative Home Care Associates’ workforce development strategy involves providing support services to trainees and employees. Individuals receive ongoing support and assistance while they are trainees, as well as after they begin working as aides. Two different staff members provide this support.

CHCA employs a *counselor* who begins to work with candidates while they are still involved in the intake process. The counselor is an important member of the training team. The counselor helps to assess a potential applicant’s suitability for home health care work, and tries to help her with the transition to full-time work and all the accompanying responsibilities. If significant employment barriers are identified, the counselor tries to help the individual resolve those problems, if possible. The counselor works most intensively with individuals during the application and training phases, although aides are sometimes referred to the counselor for help with problems even after they begin working in the field.⁷⁴

Cooperative Home Care Associates also employs **coordinators** who manage the scheduling. A senior coordinator and


⁷¹Focus groups, 16-17 March 2000.

⁷²EOP survey response, 10 April 1999.

⁷³EOP survey responses, 18 June 1998 and 31 January 2000.

⁷⁴Zianna Ameer began working at CHCA as a home health aide more than 10 years ago. While continuing to work as an aide, she went to school part time to earn a master’s degree in social work, and the company subsequently hired her as a counselor. Her experience as a home health aide and great familiarity with CHCA gave her a unique perspective from which to advise CHCA aides. She was recently promoted to the newly created position of employment services manager.

Individuals receive ongoing support and assistance while they are trainees, as well as after they begin working as aides.



another eight coordinators match aides to home care cases arranged through contracts with certified home care agencies. Each coordinator manages the schedules of approximately 65 to 75 home health aides. Factors considered in matching an aide to a patient assignment include language, geographic location and, occasionally, specialized skills needed for a difficult or more complicated case. Another important role of the coordinator is to provide support to working home health aides. The coordinator is a link between the home health aide, who works in relative isolation in the field, and the company. A coordinator responds to any complaints received from clients or supervising nurses from VNS, and tries to help aides solve problems they may have with particular patients. A coordinator also may refer an aide to a CHCA counselor for help with issues related to public assistance benefits.

Support for Workers

As described above, after a candidate successfully completes CHCA's entry-level training course, she is offered employment with the company for a probationary period. Training staff, counselors and schedulers carefully consider the various strengths of each new aide when assigning her to her first patient. During the three-month probation interval, CHCA tries to provide new employees with extra support as they transition into the work world. During the first two weeks of work, the coordinator checks in with new employees every day by phone to see how they are doing. Each aide receives several supervisory field visits from a nurse. Biweekly worker review meetings also are held in which nurses, coordinators, counselors and training staff get together to review how each new employee is doing and identify any problems. Aides also are required to attend two or three in-service "rap" sessions during the probationary period. These sessions give aides an opportunity to discuss how they have been adjusting to work, solve any problems they might be having, brush up on technical skills and review company policies.

CHCA aides continue to receive support even after the probationary period is over. An employee may go to a coordinator or counselor for assistance at any time with a problem. To maintain certification, practicing home health aides must receive 14 hours of in-service training and four supervisory field visits by a nurse per year, as well as pass an annual competency evaluation. CHCA uses

in-service sessions to inform employees about any changes in regulations. These sessions also help reinforce the company culture, and provide opportunities for aides to connect with each other and share their perspectives on practical problems encountered on the job.

Training Staff

CHCA's current training manager is Gloria Pichardo, a registered nurse. A team that consists of nurse instructors and five associate instructors teaches the entry-level classes. To comply with New York state and federal licensing requirements, an RN must supervise the clinical part of the training. At present, five RNs work for CHCA (for an equivalent of four and a half full-time equivalent positions). The associate instructors are former CHCA home health aides who have been promoted to help conduct the training. The associate instructor position provides career advancement opportunities for senior home health aides, contributes to a more comfortable and approachable atmosphere in the classroom and helps trainees understand what it is really like working with patients in the field. Outreach and recruitment, along with the counseling functions, are integrated within training services.

Facilities

The entry-level training program is located at the Cooperative Home Care Associates' office in the South Bronx. The training facilities consist of classroom space, plus beds and sinks so that trainees can practice clinical and personal care skills as they learn them.

Student Evaluation

CHCA staff members use exams to assess the progress of individuals enrolled in the entry-level training course. Instructors and counselors also meet frequently to discuss each



Photo by Maritlyn Humphries

CHCA's home health aide certification training program includes classroom work as well as clinical work under the supervision of a registered nurse.

trainee's progress. Trainees receive written feedback from instructors, and meet individually with a trainer twice during the course. Additional assessment tools are the annual competency evaluation of home health aide skills required by Medicare, and supervisory field visits. Trainees also have opportunities to assess the effectiveness of CHCA's entry-level course. Students are asked for feedback on a daily basis during the training, and anonymously complete evaluation forms at the conclusion of the course.

Other Training Programs

Certified Aide Training (CAT)

For a few years, Cooperative Home Care Associates tried an alternative approach of recruiting already certified home care aides and providing brief training to prepare them for working specifically at CHCA. This training, the Certified Aide Training (CAT), began around 1997. The training lasted one week (40 hours). Because the trainees were already certified as home health aides, the course emphasis was not on teaching technical skills, but on immersing aides in the philosophy and values of CHCA. Retention was poor, and the program was eliminated in early 2000. Training staff concluded that, in many cases, one week simply was not sufficient for persuading an already established home health aide to embrace the particular values and approaches expected of CHCA aides.

Independence Care System

CHCA and PHI staff initially anticipated that preparing home health aides to work with the more clinically complicated ICS patients would necessitate a two-week upgrade training program. It was assumed that aides would require substantial additional technical skills to care for patients with diseases such as multiple sclerosis. Experience so far, however, has shown the content of the regular CHCA entry-level training course to be more relevant than was expected. Rather than intensive technical skills training, ICS aides seem to need more help with soft skills such as learning how to interact with special-needs patients. As a result, information relevant to ICS work has been incorporated into the regular CHCA four-week, entry-level training.

Conclusion

“The training prepared me for the job. Four weeks of intense training. It changed me as a person. I was very arrogant when I came here because I had experience. I thought no one could tell me or teach me anything I didn’t already know. It changed my attitude and I found myself growing.”⁷⁵

Cooperative Home Care Associates’ entry-level training program for home health aides is closely linked to its business strategy. The system is designed so that a recruit follows a series of incremental steps that take her through the training process and directly into employment with the company. The training and enterprise sides of the operation also share administrative and management costs, which increases efficiency.

As is true of other aspects of its operating practices, CHCA’s recruitment and training strategy has changed over time. Staff members have experimented with different recruitment venues and techniques, such as small group interviews and open houses, in an effort to try to identify the most effective practices. The structure and content of the entry-level training course have been continually evaluated and revised in response to changes in participant needs and the operating environment. Cooperative Home Care Associates also has experimented with assistance to a variety of other training programs, including different approaches to advanced training to help employees move ahead on a career path (as discussed in the previous chapter).

Cooperative Home Care Associates’ entry-level training program is successful, and not just because it provides individuals with access to knowledge and skills needed to provide quality home care services. For many low-income women, completing CHCA’s training program is an empowering experience that broadens their opportunities and expectations. As a former home health aide and current member of the CHCA training staff described it:

“My favorite thing is to see the changes in women. I interview them and see them at the beginning, just the look on their face. When they start working they feel so strong. They get (a) paycheck. It is gorgeous. ... I love to see it.”⁷⁶

⁷⁵Focus group, 16 March 2000.

⁷⁶Focus group, 15 March 2000.

This section will focus primarily on the costs of CHCA's training program and the training outcomes observed. It also will review the ways in which CHCA monitors and assesses its own performance as a company and as a provider of quality jobs. A discussion of CHCA's strategies for improving the quality of the home health aide's job and influencing industry practice, as well as the discernible results of these strategies, can be found in the section on CHCA's sectoral strategy.

Sources and Uses of Funds for Training

In fiscal year 2000, CHCA had a total training budget of just more than \$1.1 million. This included both training for entry-level aides as well as upgrade training for aides to improve their skills so that they could take on more complex cases. Table 6.1 outlines the sources of funds for this training budget, and how the money is used to implement the training program.⁷⁷

On the sources side, it is notable that only 16 percent of the training budget is covered by CHCA's earned income. Because CHCA provides much more training than the industry standard, it is not feasible for the company to cover all of the training costs through earned income. Says Michael Elsas, CHCA's current CEO: "You can't do the four weeks of training out of the rate," referring to the reimbursement rate that CHCA is paid by certified agencies for providing home health care services. He believes that it makes good business sense to develop other resources to support staff training and that other licensed agencies are starting to recognize the need to do so. (See the Sectoral Approach chapter for a detailed discussion of the regulatory limits on reimbursement rates and the effects on the industry.) The contribution from ICS also is projected to be from revenue generated by that business, bringing the total in earned revenue to 25 percent of the training budget.

This leaves 75 percent of the training budget to be covered from other sources. Interestingly, much of this appears to be covered by philanthropic rather than public sources of funds. For fiscal year 2000, only 8 percent of CHCA's training budget was covered directly from a public source. The 25 percent that is accounted for by contracts with nonprofit agencies may, however, be an indirect source of public funds. A very substantial portion of the training

⁷⁷Rough calculations were made to allocate costs between categories of funds where specifics were difficult to determine. In particular, the occupancy and office expenses have been allocated to administrative and direct program expenses, respectively, based on their relative proportion of personnel costs.

budget, 42 percent, is covered through contributions from PHI. This money is largely philanthropic in origin, and it has been raised to support CHCA/PHI’s training and workforce development activities for low-income women.

Looking at the uses of funds, the greatest expenditures are for personnel, which accounts for 76 percent of funds. These personnel are roughly divided into four specific categories. The first is executive personnel, who provide the management infrastructure for CHCA’s operations. Second is the workforce development staff – the individuals responsible for recruitment, screening and follow-up support for new aides. Third is the training staff, which provides the classroom instruction, and fourth is the clinical staff, responsible for providing trainees with supervised clinical experience after they complete classroom training.

Table 6.1

Sources			Uses		
Public	City contract	8%	Administrative	Executive personnel	11%
Nonprofit contracts	Dominican Women	3%		Occupancy and office expenses	3%
		Wildcat	22%	Direct program costs	Recruitment, screening, retention personnel
Earned income	CHCA	16%	Training personnel		28%
Network affiliates	PHI	42%		Clinical experience supervision (post-classroom)	13%
		ICS	9%	Occupancy and office expenses	14%
				Other program expenses	7%
TOTAL			100%	TOTAL 100%	

Source: CHCA training program budget for fiscal year 2000

Of the total budget that CHCA spent on training for fiscal year 2000, almost a third went to upgrade training, various kinds of in-service training and support for workers.

CHCA management staff notes that the training program is almost like a second business, and that CHCA’s recent growth has put a lot of pressure on the training program to keep expanding.

However, the funding from the training program allows CHCA to have a strong management team to handle the challenges of “two businesses.” Staff members estimate that about 25 percent of administrative salaries come from the training budget. Allocating costs between training and business operations can be difficult. For example, the above allocation shows the training program covering the costs for outreach and recruitment. All training programs have these costs. However, all businesses incur costs for recruiting employees, so whether these costs are training costs or business costs is not always clear. For the purposes of discussing a training budget, however, it was decided that these costs should be included because it provides a fuller understanding of what the training actually costs, regardless of the fact that it is affiliated with a particular employer.

Training Outcomes

During the three-year period from fiscal year 1998 through fiscal year 2000, CHCA provided training services to 673 low-income women, an average of 224 per year. Seventy-two percent of these women completed training and became CHCA employees. Table 6.2 shows the number of women accepted to CHCA’s training program, the number who completed it and the number who retained employment with CHCA for at least 90 days, as well as the associated cost ratios for the training in those years.

Table 6.2
Indicators of Training Outcomes and Costs⁷⁸

	FY 1998	FY 1999	FY 2000
Number of trainees	214	216	243
Total training budget	\$560,000	\$630,000	\$766,722
Cost per trainee	\$2,617	\$2,917	\$3,155
Number of graduates	150	140	197
Graduation rate	70%	65%	81%
Cost per graduate	\$3,733	\$4,500	\$3,892
Number retained in employment	127	133	180
Retention rate	85%	95%	91%
Cost per retained employee	\$4,409	\$4,737	\$4,260
Average hourly wage at placement*	\$6.25	\$6.25	\$6.25

* CHCA staff note that the value of wage supplements for overtime work, weekend care and complex care, plus the cash benefit for vacation/leave, bring the value of the placement wage up to \$7.05 per hour for the typical entry-level worker.

⁷⁸SEDLP Program Monitoring Profile data for 1998, 1999 and 2000. This data is self-reported by participating programs.

The cost ratios in Table 6.2 are calculated by dividing the total training budget by the number of trainees, graduates or retained employees, according to the ratio. During the three years shown in the table, CHCA's cost per trainee grew steadily, but its cost per retained employee did not increase in the same manner. The average annual cost per trainee during the period was \$2,896 and the average annual cost per retained employee was \$4,469. The wage at placement has remained steady during the period. After one year with the company, base pay rises to \$6.50 per hour, after three years to \$7 per hour, and after five years to \$7.25 per hour. In addition, aides may earn an additional 50 cents per hour for weekend, overtime, holiday or complex care work. For the last several years, all employees have received a year-end bonus equivalent to five cents an hour per hour worked. Assuming an employee works 33 hours per week all year, that would amount to roughly \$80. Worker-owners are eligible for a more substantial annual bonus, typically ranging from 10 to 40 cents per hour for hours worked that year, depending on company performance and needs for internal investment. Internal capital accounts are maintained in the names of the worker-owners that reflect their share in these investments of retained earnings.

CHCA's Measures of Success

"They've (CHCA has) been one of our quality (provider) agencies since the beginning."

— Richard Griffin, acting director of contract administration for home care services, VNS of New York⁷⁹

"CHCA is the No. 1 company in the industry. I wouldn't want to be with any other company in this industry. ...Other companies are not as good."

— CHCA aide⁸⁰

CHCA continues to aspire to set the standard for quality jobs and quality care in New York City's home health care market. The company tracks key indicators of customer and worker satisfaction, and sets goals for performance improvement along these mea-

⁷⁹Richard Griffin, telephone interview by Anne Inserra, 12 October 2001.

⁸⁰Focus group, 16 March 2000.

asures. CHCA has developed a quarterly scorecard to measure company performance that reflects the organization's Quality Jobs/Quality Care philosophy. The scorecard addresses four main topics: Quality of Service, Quality Jobs, Financial Results and Recruitment and Retention. The scorecard is purposely kept brief, with a total of 15 measures. Each indicator is tracked quarterly and is compared to a target goal for the period.

Under Quality of Service, the only measure used is the company's rating from its major customer, VNS of New York. VNSNY assesses the quality of services provided by each licensed agency it contracts with, based on the ability of the company to keep problems related to services, communication and administrative issues to a minimum, as well as the ability to achieve high patient satisfaction. Service issues cover such things as an aide's reliability in fulfilling a job and her arriving on time. Communications issues include any difficulties arising between the aide and other members of the medical team, while administrative issues have largely to do with billing. Patient satisfaction used to be assessed through surveys. As VNS began measuring companies' performance along these dimensions, however, companies began to focus on the issues more and improved their performance, leading most VNS contractors to achieve the top service quality rating. The measure thus became less helpful to VNS in monitoring the performance of its subcontractors. It also became less helpful to CHCA in determining how the quality of its service compared to that of its peers. Recently, VNS decided to reconfigure its system for quality monitoring, and CHCA is currently looking for a new measure to monitor quality.

CHCA uses seven measures to assess the quality of jobs it provides. By tracking the average wage per hour and the percentage of revenues that goes to aides in the form of wages and benefits, CHCA assesses whether it is paying aides as high a wage as it can. CHCA also has several measures to determine whether it is meeting its goal of providing full-time jobs. In 1999, for example, CHCA found that close to 50 percent of aides were working more than 35 hours per week and that on average, aides were working just more than 33 hours per week. In 2001, the average number of hours worked per week rose to 36. Finally, CHCA also tracks the percentage of aides, among those eligible, who choose worker-ownership.

Although the company has had difficult quarters now and then, it has been profitable every year since 1987.

This measure is a proxy for determining how satisfied aides are with the company, since aides who become worker-owners are making a commitment to the company. CHCA staff notes that about 80 percent of those eligible to become worker-owners have chosen to do so.

In assessing its quarterly financial performance, the scorecard reflects how CHCA has met its goals in terms of total hours billed, total net income after tax and the balance in the average line of credit. Thus, the company looks at the volume of sales, overall profitability and short-term debt. Although the company has had difficult quarters now and then, it has been profitable every year since 1987.

Given that the workers are the company, recruitment and retention of quality staff is the key to CHCA's success. The recruitment and retention section of the scorecard tracks the number of new hires (i.e., the number of individuals that graduate from the training program), the percentage of new hires retained for 90 days, the turnover rate for the period, and the number of aides working for the company at the end of the period. As seen in Table 6.2, the 90-day retention has varied, ranging between 85 percent and 95 percent. Success in recruitment and retention has positive effects on CHCA's ability to reach its main goals of providing quality service, creating quality jobs and operating a profitable company. If, for example, CHCA does not meet its recruitment and retention goals, the company cannot expand as projected and is likely to have difficulty meeting its financial performance goals, particularly targets for total hours billed. Recruitment and retention measures also provide CHCA with important information about how satisfied workers are with the company and how the company is perceived as an employer by the low-income women for whom CHCA strives to create quality jobs.

A Learning Organization

Cooperative Home Care Associates can be described as a learning organization that has consistently experimented with new programs and initiatives to address emerging problems and opportunities in the home care field. As described in *Jobs and the Urban Poor: Privately Initiated Sectoral Strategies*, establishing new programs or organizations in response to issues that emerge in the course of working more deeply in a sector is a pattern that has been seen in other sectoral programs.⁸¹ In CHCA's case, an unusual number of replications and even entirely new programs have evolved in response to events. Much of the credit for this innovation and learning can be attributed to the willingness of CHCA leaders to experiment and try new things. As described in the sector chapter, key industry actors, including representatives from the United Hospital Fund, the Home Care Association of New York State and Visiting Nurse Service of New York, have described Rick Surpin as a thoughtful, creative social entrepreneur, even a "genius." His unique contribution has been described as having the ability to "think outside the box" and help create alternative models or laboratories, such as CHCA and ICS, for demonstrating new ideas. Steve Dawson and Peggy Powell extended this process of discovery and informed learning to reach beyond New York City through their work at PHI. Surpin, Powell, Dawson and the other leaders of CHCA, PHI and ICS have been credited with helping to create environments where the basic structure and terms of the home care industry could be revisited at a fundamental level, and where more humane, community-based approaches could be tested.

Critically important to CHCA's success as a learning organization has been consistent support from philanthropic organizations. Time and again, private foundations have stepped in to provide the necessary funds to support the innovations and new programs that the management of Cooperative Home Care Associates and the affiliated organizations have sought to launch. For example, CHCA leaders cite the generous, consistent support of the Charles Stewart Mott Foundation as critical to developing the replication sites and supporting the growth of the organization, bringing it to where it is today. Other foundations, including the Ford Foundation, the United Hospital Fund and the Robin Hood

⁸¹Dawson et al, 28.



Foundation, also have provided consistent support during the years, providing flexible funds at critical times that supported organizational learning and growth.

Improving the Status of the Home Health Aide Job

“As home health aides we are at the bottom. We tell the nurse, the doctor what is going on with a patient. If the patient gets better, they credit the doctor. But it was us. We fed them, we made them feel better. We are working together. We are part of the medical team. But they never recognize us as being part of the team. We are the key person in the system. People don’t realize how important we are.”

— CHCA aide⁸²

In addition to providing increased pay, benefits and work hours, Cooperative Home Care Associates has been committed to trying to improve less tangible aspects of the home health aide job. A home care worker typically provides the vast majority of total care hours to a homebound patient, and spends more time with the client than any other caregiver, with the possible exception of family members. Despite this, a common complaint is that home health aides do not always receive appropriate respect or status within the home care establishment, particularly from supervising nurses. Traditionally, the medical community has been characterized by hierarchical structures based on professional qualifications, with doctors at the top, nurses in the middle and home health aides at the bottom.

Elevating the role and status of the home health aide within the team that provides care to the homebound patient has been an important objective for CHCA. One tactic used to pursue this has been trying to form nurse-aide teams that would work together more consistently by adopting the practice of assigning aides to cases on a geographical basis, which also results in decreased travel time for aides between cases. CHCA has tried to emphasize educating supervisory nurses on the importance of the work performed by home health aides. Finally, the design for Independence Care System included a provision for making the performance review for the entire care giving team dependent upon the extent to which the home health aide was involved in care decisions.

Career Ladders for Home Health Aides

In addition to improving the conditions of a low-wage job that was already more or less accessible to low-income individuals, Cooperative Home Care Associates has experimented with different approaches for helping home health aides advance to better occupations. One tactic has involved promoting aides to administrative and teaching assistant positions within the company. Aides have been successfully promoted in this way, but the number promoted is relatively small because this strategy is limited by the size of the company. Another tactic has involved trying to help some aides advance within the health care field by getting additional professional qualifications, such as a nursing degree. CHCA has tried a couple of approaches to help interested employees move toward gaining these credentials through advanced coursework, and has achieved some success with the Home Care Certificate Program. Ultimately, the size of the academic leap to a nursing degree appears to be prohibitively large for many home health aides, particularly non-native English speakers. Very few CHCA home health aides have gained nursing credentials.

Another strategy has involved creating an upgraded aide position, with modest wage differentials for good performance, length of service and more difficult cases. In an effort to increase the amount and predictability of hours worked and, therefore, income, CHCA also introduced the innovative guaranteed hours system, through which an employee can be assured of regular full-time work in exchange for accepting work on some weekends. However, health care regulations strictly limit the types of procedures and care that a home health aide may deliver to a patient, and this effectively restricts the extent to which it is possible to create a sort of gradual career ladder made up of smaller promotions or steps that might lead to a professional degree in nursing or beyond. In addition, wages remain low, even with the differentials. CHCA and the Paraprofessional Healthcare Institute argue that these realities underscore the critical importance of improving the wages and conditions of home health aide work through policy and regulatory changes. They stress that such important care giving work should be a viable, long-term occupation for working women.

Implications of Recruitment/Intake Process

Cooperative Home Care Associates has spent considerable effort on perfecting its recruitment and intake process for the entry-level training program. CHCA uses a rigorous, multi-step screening process to ensure that candidates who actually begin the training course are very likely to complete it and to work successfully as home health aides for the company. CHCA regards this selective, intense screening as an essential component of its success, in terms of high training completion rates, high employment retention rates and successful operation of the business.

Of the six employment programs studied in the Sectoral Employment Development Learning Project, CHCA serves the most disadvantaged population in terms of income, reliance on public assistance and level of education.⁸³ However, as a result of the selective intake process, the individuals who end up being served by the CHCA program are not necessarily the most disadvantaged from among the applicant pool in terms of personal characteristics and other potential employment barriers. As described in the Training chapter, on average, only one in 10 individuals who makes an initial inquiry ends up completing the training program and working for CHCA. While some of this attrition is due to potential applicants choosing not to proceed, most is due to job requirements – such as passing criminal background checks and drug screens – and CHCA’s selection process. CHCA screens for women who already have certain qualities and abilities, such as coping skills and maturity, as well as a natural aptitude for home care work.

CHCA staff members have debated the implications of these rigorous recruitment and screening policies. Critics have argued that by winnowing out so many candidates, only the most employable candidates are accepted into the program. Others argue that there is a limit to how much personal transformation a candidate can reasonably undergo within the four-week training window. It is noted that CHCA has developed a highly effective strategy for recruiting candidates who tend to succeed at home care work, and this recruitment strategy is critical to its ability to operate a sustainable business. While the beneficiary group may not include the most disadvantaged among the poor, it cannot be disputed that

CHCA has developed a highly effective strategy for recruiting candidates who tend to succeed at home care work, and this recruitment strategy is critical to its ability to operate a sustainable business.

⁸³The other programs participating in the SEDLP project include: Asian Neighborhood Design, the Garment Industry Development Corporation, Focus: HOPE, Jane Addams Resource Corporation and Project QUEST.

CHCA is improving the opportunities for and lives of a group of low-income people.⁸⁴

The experience of Cooperative Home Care Associates appears to be similar to that of other sectoral programs in terms of the way in which selective intake criteria and procedures have contributed to its ability to fulfill its business goals and social mission. However, the use of techniques such as careful screening and requiring candidates to take initiative and demonstrate commitment and responsibility, are not exclusive to sectoral employment programs. These appear to be characteristics shared by other market-oriented programs that involve training individuals to meet the needs of employers.⁸⁵

From Job-Creation Program to the Home Care Industry

CHCA's identity has evolved over time. CHCA originated from Community Service Society's Community Economic Development program, which sponsored creation of decent jobs for low-income people. As CHCA gained experience as a home care provider and developed its Quality Jobs/Quality Care message, it became more and more deeply engaged in the industry. CHCA also became active in policy and advocacy issues. The result, as Rick Surpin described it, is that CHCA leadership currently views the organization as primarily being in the business of home care, with a workforce development program embedded in the home care business. Due to the structure and culture that were established at the outset, however, CHCA has remained very worker-centered in its business approach.

The Challenges of Growth

As described in the Sector chapter, CHCA's business expanded far beyond initial expectations. The impetus for growth resulted from the restrictive rate ceilings that govern Medicare and Medicaid reimbursement systems for home care. The rate ceilings limited the extent to which a strategy of trying to secure higher prices for premium services could be achieved, which was the foundation of CHCA's Quality Jobs/Quality Care approach. Within the existing regulatory environment, increasing the volume of business and seeking greater efficiency appeared to be the most viable ways to achieve any further wage and benefit increases for home health aides.

⁸⁴Brecher, 45.

⁸⁵Clark, 34-35.



Operating a company with 600 employees is necessarily quite different from operating a 200-person home health agency. As Cooperative Home Care Associates grew, it had to adopt changes in its organizational structure and operations, such as introducing formal departments, and strengthening and computerizing management systems. While expansion has been viewed as necessary for the survival of the business, management and employees have expressed concern about maintaining CHCA's unique company culture and sense of community in the face of growth. An example of the type of issue that has arisen concerns the system for distributing paychecks to employees. Previously, home health aides had to come to company headquarters to pick up their paychecks. Waiting in the bank line together for their paychecks provided an informal setting for aides to see former classmates and share experiences and advice. In focus groups conducted for this case study, several staff stated that they missed the socializing opportunity that the bank line used to provide, now that it has been replaced by direct deposit. CHCA has responded to these concerns by hosting parties and other events to bring people to the office and instituting "rap sessions" to allow aides to discuss their experiences on the job. Staff members also are working to install an automated teller machine (ATM) in the office. Nonetheless, debates about the tradeoff between growth and maintaining the unique organizational culture of the company are expected to continue.

Maturing Sectoral Program

As it has evolved and become more deeply engaged in the home care sector, CHCA has followed a pattern seen in other well-established sectoral employment development programs. As the program matured, CHCA developed a more complicated organizational and legal structure involving a mix of nonprofit and for-profit entities. Like other mature sectoral programs, CHCA also expanded and diversified into new areas over time. CHCA's expansion involved replication of the original program model in other geographic areas, and diversifying into related program areas within the initial geographic operating area. While developing a more complicated mix of organizational structures and programs appears to be an inevitable result of growth and adapting to an ever-changing market environment, it can present significant challenges for management and strategic focus.

Lessons of Replication

A lesson learned in the process of trying to replicate CHCA in other cities has been that the model cannot be simply transferred without modification. Factors in the operating environment and home care market in each particular geographic location have led to changes in the program design. A sectoral program is fundamentally linked to the local market, and it seems inevitable that it should be responsive to the particular characteristics of that market. In addition, regulations and institutions vary by locale. For example, home care visits authorized under Medicare and Medicaid rules in Philadelphia are generally of shorter duration than in the New York City area. This has made it more challenging to try to schedule full-time work for home health aides, since more visits must be fit into a single day. In addition, clients in the Philadelphia program are more widely dispersed in the suburbs than are CHCA's patients, who are concentrated in the South Bronx. In response to these realities, HCA Philadelphia has tried to diversify into different types of services (such as training aides to work in home care institutions), and has a much larger number of contracts than CHCA does in New York. HCA also has tried to address the transportation difficulties of serving the different suburbs with an experimental "auto aide" program.

Peggy Powell and other managers at PHI have acknowledged that another lesson learned through the replication program has been the need for CHCA's founding leaders to let go of the original model to some degree. In addition to differences in markets and regulatory environments, the individual managers of each new program have had distinctive ideas about how to shape their businesses. To be true to the spirit of some of the values that are so important to CHCA, such as empowering staff and fostering innovative solutions to problems, each site has had to be given some latitude to modify the model as needed.⁸⁶

Factors that seem to have been especially important to the success of CHCA and HCA include having dedicated and talented staff, and access to generous funding support. It is also evident that the complex policy environment in health care can lead to quick and dramatic changes in the fortunes of the home care industry. The way in which the Boston program was forced to close after some ini-

⁸⁶Peggy Powell, Steve Dawson and Rick Surpin, interview by Maureen Conway and Anne Inserra, 11 April 2001.

tial success illustrates how political factors and the policy/regulatory environment can affect the viability of a program.

Experience to date illustrates how difficult it has been to establish a viable replication of the CHCA program. The Philadelphia program has managed to achieve some stability so far, but the Boston replication was forced to close and the enterprise in New Hampshire is struggling. The Philadelphia program is the oldest of the replication programs, and, like CHCA, took several years to get going, although this is true for many start-up businesses. All this suggests that establishing a sustainable home care business that is committed to the CHCA alternative model of paying higher wages to low-income workers and providing better quality services for patients is a difficult and time-consuming process. The successes achieved by CHCA in New York and HCA in Philadelphia are all the more impressive when considered in this light.

Cooperative Home Care Associates has created a model that has demonstrated to other providers that it is possible to provide higher wages and benefits while still operating a successful home care business.

Successes and Limitations of CHCA's Sectoral Approach

For more than 15 years, Cooperative Home Care Associates has worked to improve employment for low-income women as home health aides. CHCA's sectoral employment strategy has involved intervening on both the demand and supply sides of the labor market for home care workers. In pursuit of its goals, CHCA has developed deep roots in the home care industry. On the demand side, CHCA is a model business that directly employs home health aides under improved job conditions. It provides higher wages and benefits, along with stable, full-time work. As a worker-owned cooperative, CHCA's corporate structure and operating principles are focused on the worker as well. An egalitarian, empowering atmosphere is cultivated. Workers participate in company ownership by purchasing shares, and have a voice in company management through participation in worker councils and on the board of directors. On the supply side, CHCA operates a successful, on-site training program. CHCA produces high-quality services and has been able to secure a niche at the higher end of the home care market, to the extent that there is one. The two-sided strategy of operating a training program and a business that immediately employs training graduates creates a smooth path to employment for low-income recruits.

Beyond the company itself, CHCA has worked to influence conditions more broadly within the home care industry. It has done this by sharing information and providing successful working examples of improved practices to other home care providers through organizations of peers such as the VNSNY Licensed Agencies Leadership Group. Cooperative Home Care Associates has created a model that has demonstrated to other providers that it is possible to provide higher wages and benefits while still operating a successful home care business. CHCA and its policy/research affiliate, the Paraprofessional Healthcare Institute, also have been respected voices advocating for changes in the regulatory framework affecting home care.

CHCA has developed some improved practices in pursuit of its goals of expanding the business and building a competitive advantage for CHCA within the home care industry. At the same time, CHCA has attempted to share information and diffuse its practices with the rest of the industry regarding creation of a better work environment and improvement of a particular low-wage occupation. While it would seem that these two broader aims should conflict to at least some degree, it is interesting to observe how CHCA has been able to achieve success in both areas.

On the cautionary side, Cooperative Home Care Associates' success as a business appears to depend to a great degree on the patronage of Visiting Nurse Service of New York, which values its services and is committed to paying slightly higher reimbursement rates. In addition, home health aide work even under the improved terms offered at CHCA still provides a relatively low income that is not sufficient to lift most women out of poverty or free them from the need for various types of public assistance. The regulatory limits on Medicare and Medicaid reimbursement rates for home care are a formidable barrier that has constrained CHCA's ability to improve the job of the home health aide. In New York and in some other states, reform advocates have tried to address the problem with rate increases and wage pass-through measures that designate increases specifically for home care workers' wages. The results have been mixed, and in the case of New York, the effects of the 1990 wage pass-through were quickly eroded. Reimbursement rate

ceilings have kept wages for home health aides artificially low in the New York home care market, even during labor shortages. If public sector funding for home health care remains inadequate within the existing policy and regulatory framework, wages and incomes of home health aides will continue to be constrained, and many home health workers will continue to rely on public assistance to make ends meet. The rate ceilings also will pose challenges for efforts to provide quality services during times of increasing demand for home care services.

Nevertheless, within this difficult operating environment, CHCA has provided successful examples of specific measures that have improved the situation for both home care workers and patients. Cooperative Home Care Associates' business model has demonstrated an alternative approach to providing home care services that offers employees better working conditions, and results in improved care for patients. Another important element of CHCA's strategy has involved forward-looking experimentation with new programs and approaches, such as its recent work in developing the managed long-term care model of Independence Care System. At the same time, CHCA and its affiliated organizations have tried to address the larger policy constraints by advocating for reimbursement and regulatory reforms. While progress has been made, CHCA and its affiliates can be expected to continue to innovate in the area of industry practice and advocate for changes in public policy to move further toward the goal of quality jobs and quality care.