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HOME CARE

HOME CARE WORKERS:

A BRIEFING PAPER

SUBMITTED BY
SERVICE EMPLOYEES INTERNATIONAL UNION

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AND
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HOME CARE: THE SWEATSHOP JOB OF THE NEW MILLENNIUM

The past twenty years have seen the creation of a huge, new sub-industry in health care -- home care services. In 1977, there were virtually no options other than nursing homes for persons who required paid long-term care[1] Today, home care is the fastest growing sector of the health care industry, and many elderly and disabled are able to avoid costly institutionalization and stay at home. More and more consumers are demanding alternatives to institutionalized care to provide them with a wide range of medical and non-medical services. Based on current trends, the number of seniors depending upon long-term care will double (from 7 to 14 million) by 2020, and the greater number of people in need of chronic care[2] will expand greatly the need for personal assistance and custodial services.

As we move into the 21st century, U.S. health policy makers face a profound challenge -- to meet the needs of the rapidly growing number of Americans who will rely on home care services. Yet most of the personal care and home care aides who make home care possible still receive poverty-level wages, have no health care coverage or other benefits, receive little if any training, and frequently work in hazardous conditions. These workers care for our society's sickest and frailest members in their own homes and are paid less than workers who care for animals in zoos.[3]

Over the past decade, there has been a growing body of academic literature and public policy recommendations that calls for action to address the poor compensation and training of paid paraprofessionals in order to ensure the availability of quality long-term care. In 1993, a major Kaiser Family Foundation study stated that *"As the Clinton Administration takes a fresh look at the major issues on our national agenda, there is a critical window of opportunity for serious efforts to improve conditions in the long-term care workforce. The time is ripe for...a multidisciplinary effort for increasing reimbursement for home care aides linking heath care reform, welfare reform, and job training."*[4]

Five years later, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry identified the problems of unevenness of quality, training, and supervision in the home care sector of the industry as *"matters of some urgency."* Contributing to those problems are the poverty level wages that are generally paid to the paraprofessionals who work in the home care sector. The Commission noted that of the two million health care paraprofessionals in the United States, 600,000 are earning wages below the poverty line.[5]

These numbers do not include "independent providers" and other home care employees paid directly by states and exclude some of the workers in agencies funded solely by Medicaid, who also earn pathetically low wages.

The Administration's recently announced long-term care initiative, which would provide tax credits for family caregivers, offers needed relief for many American families. A recent report by the Alzheimer's Association found that family caregivers save the U.S. health care system $196 billion a year ($22.9 billion in California; 13.5 billion in New York). Yet, there is also a critical need to address the shortfalls in the care provided to those who must rely upon paid caregivers. The largely

publicly funded home care industry is becoming the modern day sweatshop, with caregivers working at poverty wages with no health care or other benefits and often under harsh conditions. Since the federal and State governments largely set the standards for care and performance in this industry and pay for its delivery, they must bear the responsibility for improving care for the elderly and disabled who rely upon these services and ensuring decent wages and working conditions for the workers who seek to provide it.

SEIU represents over 175,000 paraprofessionals in the home care industry, who are committed to their clients and the work, but for whom working conditions and living standards are shameful. Most of these members are paid directly by state agencies or are employed by non-profit agencies, solely funded through government aid programs. The urgency of the problems faced by the providers and the consumers who rely upon them for services calls for immediate action and the attention of both the Department of Labor and the Department of Health and Human Services to improve quality by developing a stable, well-trained workforce.
We appreciate the opportunity and challenge of working with you to address these issues.

Below we first provide general background on the nature of the services provided, the providers, the clients, and the funding mechanisms. We then look more carefully at two of the largest programs, the New York City and Los Angeles County programs. Finally, we suggest some steps and directions for improvement.

PUBLICLY FUNDED PERSONAL CARE SERVICES

Who are the Employers Home care is a multi-segmented industry, with services involving a wide range of medical complexity. Prior to 1980, home care was provided primarily by RN's employed by visiting nurses associations and public health agencies in the formal sector and by family and friends in the informal sector.[6] In the 1980's funding, regulatory and system changes resulted in enormous growth in the numbers of service providers[7], including hospital based agencies, for-profit agencies, non-profit social services agencies, and "independent provider" programs (so-called because the state agencies who pay the providers do not acknowledge an employment relationship with them).

"Custodial" services -- homemaking, bathing, feeding, shopping and assisting consumers with other activities of daily living -- are where the bulk of state and Medicaid funds are concentrated. While some agencies provide services across the entire spectrum (including skilled nursing and "high tech" care), it is the independent providers and non-profit agencies that dominate the custodial sector. For the individual providers, their employers are the recipients of services themselves and, for some purposes, the state and local agencies that pay and direct them.

Who are the Consumers Consumers of personal care services include people with physical, sensory, cognitive, and psychiatric disabilities of all ages. Those who are eligible for Medicaid financed services are generally low-income elderly and/or disabled persons. While the population that most

benefits from home care services are the elderly (over 60 years), many are younger adults with physical disabilities and some are children with special needs.

While consumers of personal care services often prefer to select, direct and dismiss their own providers and to control the delivery of services, consumer-directed services have generally lacked sufficient supports for consumers, compensation and training for workers and integration with other long term care services. Surveys of consumers done in California have found that nearly 99% support the so-called individual provider mode of delivery because consumers frequently control the selection, hiring, firing, and delivery of services. However, this model of service delivery generally lacks an effective quality control mechanism.

What are the Services The Medicaid program, which funds paraprofessionals to provide personal care services in the homes of the elderly and disabled, defines these services as "related to a patient's physical requirements, such as assistance with eating, bathing, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, and taking medications. They may also include assistance with preparation of meals, and other services which are essential to the health and welfare of the beneficiary such as housekeeping chores like bed-making, dusting, and vacuuming. HCFA describes the personal care services provided in the home of the elderly and disabled as "similar to those that would normally be performed by a nurse's aide" in a hospital or nursing home.

While the services overlap with those performed by home health aides, "skilled services that may be performed only by a health professional are not considered personal care services."[8] Personal care assistants may perform "paramedical services, which are loosely defined as activities which persons would normally perform for themselves but for their functional limitations" and could include movement to prevent atrophy, catheter care, changing of dressings, injections, administration of medication, tube feeding, and ostomy care.[9] In the real world of home care consumers and workers, these boundaries are often blurred.

Who are the Workers While doctors and nurses are involved to some extent in the delivery of home care, it is the home health aides, personal care and homemaker/choreworkers who provide the vast majority of hands-on care that is purchased by disabled persons of all ages. These front-line, unskilled paraprofessionals are central to the ability of millions of clients across the country to stay in their homes. In 1995, there were more than 875,000 home care workers nationwide, a number that has more than doubled since 1988. Today we estimate that there are nearly 1.3 million workers.[10]

No occupation will grow faster over the next ten years than home health aide, with personal care aides ranking third. Currently, the majority of these aides are female, single, and middle aged (average age 47). In larger cities, these workers tend to be minority and immigrant women. They work part-time, get little if any training, earn minimum wage or slightly higher, receive few if any benefits, have uncompensated travel time between clients, experience high turnover, and work without the protection of basic labor and employment laws. Meanwhile, home care workers' low levels of pay and benefits have contributed to the cycle of poverty and public health problems in the

inner-city neighborhoods, where these jobs have long been among the only steadily growing sources of employment.

Home care worker turnover in some parts of the nation has grown as high as 60% per year. Low unemployment rates have produced shortages of respite and replacement workers, and -- as noted by the President's Quality Commission --"unevenness of quality, training, and supervision appear to be matters of some urgency" as these caregivers serve consumers with increasingly complex needs.

Labor and employment law protections generally do not apply to personal care workers. They are generally excluded from wage and hour protections, unemployment and workers' compensation programs in most states.[11] And inadequate attention to the health and safety problems that these workers confront has resulted in a much higher risk of serious job-related injuries or illnesses than that faced by the average health care worker, who is herself at high risk of injury.

In 1994, the rate of lost-work time injuries was 4.7 per 100 workers in the home health industry, one and one-half times the corresponding rate (3.1) in all private health services. When injured, home health care workers typically missed seven workdays, two days more than the median absence from work for private health services.[12] The primary cause of lost workdays for these providers is overexertion while assisting clients. Highway accidents were also a significant cause. In addition, providers face the risk of contracting serious illnesses. For example, after the bloodborne pathogens standard was promulgated by the Occupational Safety and Health Administration, a suit by the home care industry led to the exemption of these workers from many of the mandated protections against the spread of serious bloodborne diseases among health care workers.

What is the Funding Today, there are a broad range of federal and state programs that fund home care services, including Medicare home health benefits; Medicaid home and community based services waivers, personal care services option and home health benefits; the Older Americans Act; the Social Services Block Grant; and state revenue funded programs. With the exception of Medicare, states control the vast majority of these spending decisions which has resulted in substantial variation in program design, access, availability and structure of these programs.

Though relatively small, home care is the fastest growing component of total national health care spending, with 3/4's of all such services paid for by government programs. The rapid growth in the number of home health agencies has been paralleled by a 167 percent increase in home health expenditures (mainly Medicare) from 1989 to 1993 (from $9 to $24 billion). This escalation in expenditures has been attributed to a number of factors, including the aging of the population, medical and technological advances allowing people to avoid institutional care, increased insurance coverage for post-acute home health care, pressure for earlier hospital discharge, and revisions of HCFA's home health regulations, *but not to* home care aide's wages.[13]

The Medicaid personal care option and the Social Services Block Grant (SSBG) are the largest personal care programs. Under the Medicaid program, personal care services are an optional service

which a State may choose to cover under its Medicaid plan. Most states have opted to do so. Home care purchased through Medicaid goes primarily to elderly and disabled clients, with half of that spending for those needing custodial care only (semi-skilled or non-skilled services for low-income individuals who need help with activities of daily living).

Since States have set the amount, duration and scope of coverage, there is considerable variation among them in the use of Medicaid home health care funds. California and New York consume the lion's share of all U.S. Medicaid spending on home care. The SSBG authorizes states to fund a broad range of home care community-based social services, including home care for the elderly and disabled. California receives by far the largest percentage of these funds.[14]

Since these services are funded directly by federal and state governments, and because in many instances the state is considered a joint employer of these workers, the government bears a special responsibility to improve their standards. Recent developments in the nation's two largest cities provide a unique opportunity for the administration to partner with consumers, caregivers, and state and local officials to improve the quality of in-home services.

The Los Angeles County Program

California's In-Home Supportive Services (IHSS) program has over 200,000 independent providers providing personal care services throughout the state. In Los Angeles County alone there are approximately 74,000 providers serving over 77,000 persons with serious disabilities, a majority of whom are elderly. They provide a range of non-professional, personal care services in the homes of low-income elderly and disabled individuals.

For most recipients, IHSS serves as an alternative to much most costly institutional care. The cost of the IHSS program is very low – an average of approximately $300 per client per month.[15]

Personal care providers in the IHSS program are on the whole paid the California minimum wage of $5.75 an hour with the exception of those in Alameda and San Francisco, where pursuant to collective bargaining agreements, the public authorities are obligated to pay more: $6.00 in Alameda and $7.00 in San Francisco. With the exception of workers in San Francisco, these workers are not provided health care coverage through their employment. In San Francisco, health insurance is provided through an employer-paid plan covering services offered by a network of public and safety net providers.

Although almost 75% of IHSS providers depend solely on the IHSS program as their sole employment, almost 80% work part-time, and most do not have enough clients to work the number of the hours that they would like and need to work. Approximately one-third of providers donate hours and work for more hours than they are paid in order to sustain clients whose needs exceed the hours for which the County is willing to pay.

While the IHSS program has existed since at least 1973, California included personal care services as a benefit provided through the Medicaid program only in 1993, shifting a substantial proportion of the costs of services to that program and accordingly to the federal government. Previously, the federal government had participated in the costs of the program through the Title XX program, but in much smaller amounts. Although the participation of the federal government through the Medicaid program greatly reduced county and state costs, neither the Los Angeles County or the State of California devoted funds saved from the increased federal contribution to improving services under the program or increasing provider compensation.

When the IHSS program was first established, counties were given the option of providing the services through their employees or through a contract with a private agency. Then in 1992, the state established an innovative program. In an effort to improve the delivery of services, counties were given the option of forming a public authority to administer the program with consumer direction and input. This public entity would take on the responsibility of acting as the employer of those workers, maintaining a registry of competent workers, providing training and directing them to needy clients.

Prior to the establishment of the public authority model, consumers in California had identified a range of problems in the delivery of services through the program. Consumers and providers reported that they received little assistance when coping with problems. Counties were not providing sufficient hours of assistance for the clients, resulting in providers' providing unpaid hours of service to meet their clients' basic needs. Consumers reported great difficulty in recruiting qualified providers and in retaining them since the providers needed to move on to better paying jobs. In Los Angeles County, 90% of providers had never had any formal training to prepare them to provide personal care services to disabled clients. Statewide in California's IHSS program, there are no formal training, screening or application procedures. To begin work, home care providers simply need to present their name and Social Security number.

In 1998, Los Angeles County made a commitment to improve home care services. It chose the public authority option, establishing a Personal Assistant Services Council to *"develop and implement a comprehensive approach to improving it IHSS program, including providing assistance in finding providers for the IHSS program through the establishment of a central registry, and related functions . . .."*.[16] The county faces a huge challenge given the size of its IHSS program -- approximately 80,000 clients -- and the varying needs of the population served. Los Angeles is now among six counties that have selected this option and have established public authorities: Alameda, Contra Costa, Los Angeles, San Francisco, San Mateo, and Santa Clara.

As the administration explores options for the expansion and enhancement of consumer-directed personal assistance service programs, the Los Angeles PASC presents a significant opportunity to support a momentous state and local policy initiative that places improvements in workers' wages, benefits, and training at the core of the home care quality agenda.

The New York City Medicaid Homecare Program

After a series of exposés about horrific conditions in Medicaid supported nursing homes in the late 1970s, New York State's political leadership decided to redirect its long-term policy from bricks and mortar nursing home care to home care. Rather than invest in significantly enlarging and upgrading its long-term institutional care sector, people needing long-term chronic care were offered in-home services. At the time, home care was promoted as the more humane, less expensive alternative. It remains, for most frail elderly and chronically disabled, a more humane alternative. However, since home care is by definition a labor-intensive one-on-one service, home care is less costly only if two conditions are met. The clients/patients receive a very limited number of hours of service, and workers' wages are small and benefits minimal.

As the elderly and disabled population has grown in New York, so has its home care programs. Today, New York State has the nation's second highest Medicaid expenditures on home care. The larger of the two Medicaid-funded programs -- the home attendant program -- had state expenditures in 1997 of $1.8 billion. This program paid for the care of an average of 60,000 clients per day in New York, provided by over 70,000 workers with an average cost per hour of about $14.00, including wages, benefits, administrative and other costs. An estimated one-third of the clients are so-impaired that absent the in-home program, they would pass the State's restrictive entry screen and be entitled to nursing home admission. One in ten clients is cared for 24 hours a day. While half the clients receive less than 30 hours a week of service, on average, home attendants work 43 hours a week.

Over the past fifteen years, New York City's home care unions have won the city and state funding battles necessary to establish the nation's highest standards of home care wages and benefits The 50,000 unionized NYC personal care workers are paid an average of $7.00 an hour, receive employee paid health insurance, and have a small pension.

New York City runs its program primarily through non-profit agencies, of which there are 64 community-based home attendant agencies with between 600-1200, cases each. With the exception of a few for-profit agencies which have only recently became vendors, all of the agencies are unionized. However even the collective bargained wages are barely livable by New York standards. In 1997, the average wage was $14,000. Sixty percent of workers had at least one dependent. Many are the only regularly employed wage earners in large multi-generational, immigrant families. When the health insurance plans were established in 1989-90, roughly half of the newly-enrolled plan participants were uninsured, the other half was receiving Medicaid benefits. Today, the workers' health plans are strained by the slow growth in agency rates and the pension is meager.

State budgetary pressures have substantially slowed the climb towards parity between in-home and institutional workers. In fact, in New York City there has been a net reduction in the average number of authorized hours per client. In response, many home attendant agencies are attempting to stabilize and expand their operations by increasing the scope of services they offer. In addition to providing Medicaid financed personal care, these agencies have begun to solicit home health aide

contracts from a certified home health agencies in the state. Unfortunately, few workers are prepared to adopt the same survival strategy. There is an acute shortage of people certified as home attendants and licensed as home health aides. Without further training, most workers are restricted to a diminishing number of personal care cases.

To be certified as a personal care worker, New York's home attendants must pass a literacy skills test and complete a two-three week training program before receiving a certificate. In addition, the agencies are required to provide 12 hours a year of in-service training. Many workers have noted that the training is often inadequate to help them deal with their clients' complex physical and psychological problems. An additional 24 hours of classroom work plus supervised clinical on-the-job training would be required to upgrade from home attendant to home health aide.

Sixteen thousand of the unionized home care workers are eligible to receive additional training benefits through the 1199 Home Care Education Fund. This Fund is a multi-employer benefit plan that is financed with a $.025 an hour employer contribution (virtually all employer income is Medicaid) and 32 separate agencies contribute to the Fund. Annually, the Fund receives about $800,000. The Fund has a Board of Trustees composed of half Union and half management.

The Fund's program ranges from literacy to college. Well over 1,000 people have taken advantage of Fund offerings since its inception 6 years ago. About half enrolled in ESL or GED programs. The other 500 people were enrolled in Home Health Aide training programs, college prep, LPN and college programs. The Fund has a special arrangement with Lehman College (City University of New York) whereby the College has designed a particular college level certificate program (12 credits) organized around home care workers and their experience.

However, the unions' training capacity is insufficient to prepare workers for full-time employment in a home care system increasingly dominated by fewer and larger agencies which are rapidly integrating the provision of social and medical services.

As the administration explores options for the integration of social and medical home care services under more rigorously managed models, the New York City program provides a significant opportunity to begin stabilizing the improvement of home care workers' health insurance benefits and job training as part of the core federal efforts to build a comprehensive system of quality home and community-based services.

STEPS TO IMPROVE SERVICES AND WORKING CONDITIONS

Government funding and regulatory decisions ultimately dictate home care employment standards. Whether through waivers, tax credits, pilot projects or enhanced reimbursement, the direction of federal public policy must be to encourage independent living goals, models of client-directed care, and cost-effective alternatives to institutional care while ensuring decent and appropriate standards for the home care workforce. The Los Angeles County PASC and the New York City Campaign for Quality Home Care offer unique opportunities to the develop and improve models of high quality home care under the two dominant modes of in-home service delivery.

There are both short and long-term policy objectives and possible initiatives which we are proposing for consideration by the U.S. Department of Labor and Health and Human Services. This list is not all-inclusive but intended to frame some solutions for discussion.

IMMEDIATE:

1. LA County Registry A common goal for consumers and labor advocates in Los Angeles is the creation of a full-service, county-wide registry that would ensure IHSS consumers timely access to qualified care providers, and improve the stability, competency and continuity of the workforce. The development of such a registry for Los Angeles County faces challenges beyond those encountered by other IHSS public authorities given the system is comprised of over 80,000 consumers, a comparable number of caregivers, and is spread out over 4,000 square miles of service area. It will not only be the largest registry in California, but anywhere in the U.S.

SEIU commissioned a study from the Paraprofessional Healthcare Institute which reviewed various types of registry infrastructures and provided preliminary projections about what would be needed (i.e., expertise, staff, information systems, physical plant) to develop and run such a registry.[17] From this report, we anticipate that the PASC will need financial support in the planning and design process, which must include the involvement of stakeholders. We envision an effort that phases in the various components of the registry -- recruitment, pre-screening, training, data management, basic referral and referral support, services to consumers and quality assurance -- with a full system being operational by the end of two years.

We are seeking federal demonstration funds for the planning, development and operation (for a limited time until operational funds are secured) for the registry. We believe that the successful development of a home care workers' registry in LA county will set a model for other Public Authority counties in California as well as for other states that have IP home care programs.

2. Training Assistance The type of training now needed in New York city is a massive, one-time upgrade of current workers licenses and certifications to prepare them to take on any case regardless of payor. Currently, Medicare and Medicaid pay for slightly different services and require different licenses (home attendant and home health aide). The integration of the systems is necessary. Right now, a patient discharged from the hospital might get home health aide services for 3 to 6 months

(paid by Medicare) before she is switched over to chronic care from a home attendant (paid by Medicaid).

We are seeking to give the workers the credentials to care for any patient/client who needs home health care services and to ensure continuity of care. The most efficient way to do this is to start a several year process whereby every working home attendant gets trained (with a few exceptions of people who just can not do the upgraded work). The $.025/hour made by the non profit employer contribution is not enough to undertake this one-time effort, although it is enough to prepare new workers and to underwrite the cost of in-service programs.

Five million dollars in support to supplement the current contributions of the non-profits will enable this one time, initial training of New York City's home attendants employed by non-profit agencies and ensure continuity of care to clients who rely upon these services.

3. Companionship exemption regulation When Congress amended the FLSA in 1974 to cover persons engaged in domestic service employment, it created a limited exemption for persons in domestic service employment who provided babysitting and companionship services.[18] DOL promulgated regulations defining the term companionship to include a wide range of services:

> *those services which provide fellowship, care, and protection for a person who, because of advanced age or physical or mental infirmity, cannot care for his or her own needs. Such services may include household work related to the care of the aged or infirm person such as meal preparation, bed making, washing of clothes, and other similar services. They may also include the performance of general household work: provided, however, that such work is incidental, i.e., does not exceed 20 percent of the total weekly hours worked. The term "companionship services" does not include services relating to the care and protection of the aged or infirm which require and are performed by trained personnel, such as a registered or practical nurse. 29 C.F.R. §552.6.*

Contrary to the intent of Congress in creating the companionship exemption, the regulations allows the exemption to cover workers who perform an unlimited amount of certain household work so long as the services are "related to the care of the aged or infirm person." As a result, personal care services attendants are excluded from FLSA protection although the bulk of their work is household work -- the very type of domestic service work that Congress amended the FLSA to cover.

These regulations must be revised to more loosely conform to congressional intent in providing coverage to persons engaged in domestic service and limit the exemption to workers who do no or only a small amount of household work of any kind.

4. Medicaid and CHIP outreach and expansion to cover additional families The administration should work with the States of California and New York and Los Angeles County to ensure that personal care providers and their families who qualify for Medicaid and CHIP services have been

enrolled in the program. Because of their low income and because many have children in their homes, these workers may be eligible for these services. In addition, HCFA should work with these States to consider how Medicaid and CHIP eligibility could be expanded to ensure coverage for these low wage workers so that those who provide essential health care services can themselves receive medical care.

5. Health and Safety protection for agency workers Given the high injury rates among these workers and the often hazardous settings in which they work, effort must be made to ensure that protections are afforded to them in the homes of their clients. Health and safety protections must ensure full protection for those workers in the homes of their clients.

FUNDING AND STANDARDS IMPROVEMENTS: 1999 AND BEYOND

1. Establish mechanisms for wage enhancement Since the federal and state governments in effect set the wage rates for these workers, they must establish a mechanism for wage and benefit improvements. State and local governments would be encouraged to re-assess what are reasonable levels of compensation for home care workers if they had a clearer understanding of the boundaries of federal reimbursement for wages and benefits. The federal government should delineate conditions under which it would approve increased reimbursement for homecare worker compensation. This could be done through the establishment geographic wage ranges or through recognition of acceptable procedures for state and local determination of compensation levels, such as interest arbitration or similar mechanisms. In establishing wage ranges, either level of government should look to prevailing wages for other segments of the long term care industry, such as nurse aides in institutional settings. Parity with these other parts of the industry should be recognized as the norm.

2. Encourage the establishment of living wage standards : In approving demonstration and other grant funding for programs providing home care services, the Administration should consider whether the compensation levels for workers who deliver services under the programs provide a "living wage." Only programs which do so should be provided discretionary funding.

3. Change the statutory definition of family provider The Medicaid statute currently excludes spouses and parents of children from reimbursement for home care services because of their financially responsible family members. In California, an estimated 25% of IHSS workers are family providers. The fiscal burden on the state to be the sole payer is tremendous, yet studies on the IP program[19] shows improved consumer satisfaction when family members are paid to care for relatives.

In the alternative, we propose consideration of a waiver for the California program that would allow responsible family members to be providers. This could be done in any number of ways, such as based on family income, client health status (based on activities of daily living), or a limited number of visits. Appropriate quality of care, fiscal oversight and professional standards would be included.

4. Improve clients' needs assessments: Too many clients are receiving insufficient services to provider for their needs. Needs assessment need to be refined to ensure that clients are eligible for sufficient hours of services. Workers will benefit from improved assessments since there will be less need for them to devote uncompensated hours to their clients. The federal government should use New York and California as laboratories to test out and develop needs assessment tools for this client population.

5. Mandate training and registry As with home health aides under the Medicare program, there is the need for minimum standards for personal care assistants under the Medicaid program. The administration should work with stakeholders to develop appropriate training modules for home care workers seeking to improve their abilities to meet the special physical, psychological, and cultural needs of diverse home care consumers, and to qualify themselves for employment in other paraprofessional and professional roles in health care system.

HHS

Endnotes

1. "Taking Care of Their Own: State-Funded Home and Community-based Care Programs for Older Persons", Kassner and Williams, AARP, 1997

2. According to the 1996 Robert Wood Johnson report entitled "Chronic Care in America: A 21st Century Challenge", over 40 million people are limited in their daily activities by chronic conditions, and the numbers are expected to increase dramatically in the coming decades.

3. "Union Gets the Lowly to Sign Up", The New York Times, Nov. 21, 1995, page A10

4. "Developing a Caring and Effective Workforce", Final Report to Henry J. Kaiser Family Foundation by Project Hope, Center for Health Affairs; Bayer, Stone, Friedland, June 1993.

5. "Quality First: Better Health Care for All Americans: Final Report to the President", May 1998, p. 205

6. Benjamin, A. E., 1993. "A Historical Perspective on Home Care Policy." Milbank Quarterly 71(1).

7. Changes in Medicare certification and reimbursement policies, OBRA '80 & OBRA '81 which initiated the well-documented trend in the increase of for-profit agencies in the long term care business, and OBRA '87 which redefined the "homebound" eligibility requirement of Medicare.

8. *State Medicaid Manual*, HCFA Publication 45-4, § 4480, Transmittal No. 67 (April 1995).

9. California DSS Manual, Service Program No. 7: In-Home Supportive Services 30-757.191 - .199.

10. U.S. Bureau of Labor Statistics, calculated by SEIU in "Home Care Organizer", 1996.

11. William J. Nelson, Jr., "Workers' Compensation: Coverage, Benefits, and Costs, 1990-91, 56 Social Security Bulletin 68 (1993).

12. Bureau of Labor Statistics, "Home Health Care Services: Injuries resulting in Absences from Work, USDL-96-163 (May 9, 1996)

13. "Developing a Caring and Effective Workforce", Project Hope Center for Health Affairs, Bayer, Stone and Friedland; June 1993, page 86.

14. Committee on Ways and Means, "The Green Book", 1994.

15. R.T.Z. Associates, "Bold Action For A Challenging Problem, Immediate Steps And Long Term Solutions For Improving Services For Impaired Adults In Los Angeles County, Los Angeles In-Home Supportive Services Study, Final Report" Consultant Services Contract for the Los Angeles County Auditor-Controller (November, 1996) at p. i.

16. Los Angeles County Ordinances § 3.45.030

17. The study will be released in mid-May 1999.

18. 29 U.S.C. § 213(a)(15)

19. Ted Benjamin Study