

Service Employees International Union's Comments on Workforce Issues for the National Commission for Quality Long-Term Care

January 2007

The National Commission has identified three critical changes that are required to sustain and expand the current long term care workforce: improved wages and benefits; better working conditions; and greater opportunities for training and advancement.¹ The Service Employees International Union (SEIU) fully supports these goals and generally agrees with the specific recommendations contained in *Out of the Shadows: Envisioning a Brighter Future for Long-Term Care in America*, the Brown University report to the Commission. In particular, we support the recommendations in Chapter V, "Investing in the Long-Term Care Workforce," and endorse the recognition in Chapter IV that to reduce turnover and provide higher quality care, "Effective leadership and management are critical, along with a work environment that values and respects direct care workers and the people they care for – and gives them decision-making authority."² We generally agree with these findings and, rather than simply repeat information already known to the Commission, we want to highlight several workforce issues not yet addressed by the Commission that we believe have a disproportionate influence on the delivery of quality long-term care.

Wages and Benefits: Ensuring Adequate Wages and Benefits in Consumer-Directed Care

It cannot be overemphasized that the current shortage of long-term care workers is in large part caused by extremely low compensation rates. The decision to leave the field is a rational economic response: the national average for home care workers is \$8/hour and less than 10 percent earned more than \$11/hour. Since 70% of home health aides are able to secure only part-time work, annual incomes are particularly low – around \$17,340 in 2005. Nursing home aides are paid slightly better, but overall, almost a fifth of direct-care workers earn incomes below the poverty level and between 30 to 35 percent are single parents receiving Food Stamps. As the Commission has noted, improving the economic circumstances of direct care workers is crucial to developing a better long-term care system.

One concern is whether changes in the delivery of long-term care are reducing or reinforcing the poverty in which so many direct care workers find themselves trapped. In recent years, we have seen the expanded use of consumer-directed home care, an innovative alternative to agency-directed care that accords consumers greater autonomy and control over how and when they receive care. It is a model that SEIU has embraced as a matter of principle, although our experience has been that such programs often requires modification to ensure compliance with state and federal labor law and payment of adequate wages and benefits. Our experience

¹ *Out of Isolation: A Vision of Long-Term Care in America*, National Commission for Quality Long-Term Care, September 2006, at 7.

² *Out of the Shadows: Envisioning a Brighter Future for Long-Term Care in America*, Miller, Edward Alan, and Mor, Vincent, Brown University, 2006, at 46.

has been that consumer-directed care works best when it is structured to ensure that direct care workers have an employer with the means to provide adequate wages and benefits.

SEIU has worked in six states to redesign the long-term care system to support consumer-directed care in ways that work for both consumers and workers, but California offers perhaps the clearest example of this work. California's In-Home Supportive Services (IHSS) program was created in 1973 to provide housecleaning, meal preparation, laundry, grocery shopping, and personal care services to more than 380,000 low-income consumers who are elderly, blind, or living with disabilities, and who are unable to live safely at home without assistance. IHSS currently employs more than 300,000 home care workers across California.

However, for many years, the IHSS program in California was not functioning well. Consumers were not able to find direct care workers who, making minimum wage, would stick with the work. Usage of the program was sporadic and its reputation was not good. The poor quality of care and the turnover among workers led many seniors to opt for institutionalization, even though it was not medically necessary.

The key reason for this dysfunction was the nature of the employer-employee relationship. Wages were set by the recipient of services, and not by the public entity that paid for services and would traditionally be considered the employer. Indeed, around the country in traditional forms of consumer-directed care, the consumer, and not the state, is considered the employer of record, even though the services provided are paid for by the state through a public program (Medicaid).

Having the consumer serve as the employer is a mixed blessing because although consumers are best situated to direct care, they do not have the financial resources to provide adequate compensation. There is no doubt that consumers are capable of and should be able to select workers, train the worker hired, determine when care is provided and, if necessary, dismiss the worker. As the disability community has taught us, control over who provides intimate care and when that care is offered is the essence of consumer-directed care and a basic civil right.

But when the caregiver must negotiate wage rates directly with the consumer, there are significant problems that are exacerbated by nature of the Medicaid program. Consumers are given a limited budget, so there is a trade-off between wages and hours of service, particularly as an individual beneficiary's physical condition worsens over time. Since this is a means-tested public program, consumers are indigent individuals who lack the resources to provide training or benefits like health insurance; in some cases, they may not even provide worker's compensation benefits should the worker get hurt. Having the consumer serve as the employer with respect to wages and benefits means having an employer that lacks the resources to provide workers with an economic opportunity that is attractive over a long period of time.

To correct this situation, in 1992, the California legislature enacted SB 485 authorizing the creation of county-level home care commissions (called "public authorities") to oversee and manage IHSS delivery issues in the counties. The legislation did not change the ability of consumers to determine who would be the caregiver or how care would be provided. Rather it made the state the co-employer for purposes of collective bargaining over wages and benefits.

Workers participating in the program would have two employers: the consumer, who determined hiring and firing and how the work was done, and the state, which set wages through collective bargaining.³

The public authorities were also empowered to maintain caregiver registries, provide IHSS consumers with caregiver referrals, and provide training for both consumers and caregivers. Once the public authorities were established, SEIU negotiated significant wage and benefit increases that have stabilized the IHSS workforce and allowed it to expand to meet growing demand for in home services.

These structural changes in the IHSS program have been resoundingly successful. A study of the San Francisco Public Authority, where the hourly wage increased 74% between 1996 and 2003, found:

- A 54 percent increase in the number of Medicaid-funded personal care workers in the state's IHSS program over the four-year period of the study.
- A 47 percent increase in the number of consumers, possibly because the wage increase and/or the addition of health benefits made it easier for consumers to hire an acceptable provider.
- A 30 percent decrease in the annual turnover rate of the workforce.⁴

Follow up work by the same researcher that looked at a broader cross-section of counties in California confirmed the importance of wages and benefits in stabilizing the workforce. According to the later study, individuals will start working in consumer-directed home care because they feel a personal commitment to a particular consumer, but they will not remain in the job if they do not get paid a living wage with benefits.⁵

In contrast, we believe that variations on consumer-directed programs, like Cash & Counseling, are flawed because workers continue to be employed by the recipient of services, and not by the public entity that pays for services and would traditionally be considered the employer. With Cash & Counseling, there is no ability for the employer to provide meaningful training opportunities or a living wage; the fundamentals of the labor market for home care do not change.⁶ Such an arrangement where the caregiver negotiates a wage rate directly with the consumer is perhaps not surprising in the private pay market, but the consequences are significant in a means-tested public program like Medicaid where consumers are indigent.

SEIU supports consumer-directed care that provides workers with a co-employer and a mechanism to bargain for better wages and working conditions. Where there are already public

³ Home care workers would not have access to the state's pension program or the state's health care coverage.

⁴ *The Impact Of A Large Wage Increase On The Workforce Stability Of IHSS Home Care Workers In San Francisco County*, Candace Howes Connecticut College.

⁵ *For Love, Money or Flexibility: Why People Choose to Work in Consumer-Directed Home Care*, presentation by Candace Howes at the Academy Health meetings, June 26, 2006.

⁶ Ironically, one evaluation of the Cash & Counseling program suggested the need for some kind of list of available workers for consumers who were unable to hire family members or friends. According to the evaluation, such a list would also help with respite/no-shows. Of course that is what a public authority does.

authorities providing consumer-directed care, we support measures that produce greater consumer choice and autonomy within that framework.

Working Conditions: Labor-Management Partnerships to Promote Culture Change

One of the major reasons for high turnover and low retention rates in long-term care is a management culture that does not value direct care workers. The Better Jobs, Better Care project notes that “direct care workers often do not feel valued or respected by their employers and supervisors,” and that “despite having more interaction with patients than many other members of the care team, these workers are often excluded from decision-making involving patient care.”⁷ This finding is consistent with polling and focus groups we have conducted with our members.

We believe that reforming the workplace culture can best be achieved in unionized nursing homes, because the presence of the union ensures that direct care workers will feel empowered and be given a meaningful voice in decisions that directly affect their working conditions. But we also recognize that not all nursing homes will be unionized and in those that are, it is important that programs promoting team-based decision making not be imposed by management as yet another top-down solution to the current corporate culture. Programs that foster team-based decision-making, such as culture change or resident-centered care, offer the promise of increased worker satisfaction and improved retention rates when they empower workers and are built around worker input and worker participation. For most direct care workers, the remedy for a general sense of lack of respect for their views and experience is not a plan that is solely devised by and unilaterally imposed by management.

Recognizing the potential benefits for workers, two SEIU Locals have developed creative programs to promote culture change in the nursing homes they represent. The Quality Care Committee, a program developed by Local 1199SEIU based in New York City, is a unique addition to the national “Culture Change” movement. It is the only entity committed to the equal recognition and involvement of direct-care staff in the design, leadership and implementation of its programs. In less than three years, the QCC (Quality Care Committee) has actively engaged more than 500 staff from 40 nursing homes in organizational change efforts.

The Quality Care Committee was established in 2001, as part of the collective bargaining agreement negotiated between the Association of Voluntary Nursing Homes and 1199SEIU, which represents over 50,000 nursing home workers. A Planning Committee comprised of leadership of the Nursing Home Division of 1199SEIU and the Continuing Care Leadership Coalition, the trade association representing approximately 100 voluntary not-for-profit long-term care facilities, held a series of meetings to discuss their concerns about nursing home care. They discovered that they shared many areas of common interest and quickly identified opportunities for joint work.

This Planning Committee modeled the joint labor-management approach that characterizes all of the work of the QCC. In rejecting the image of “labor” and “management” as natural enemies, each group reserved their right to disagree on some issues while focusing

⁷ Background: The Long-Term Care Workforce Crisis, available at <http://www.bjbc.org/Page.asp?PgID=31>.

collective energies and actions on areas of mutual agreement. The Planning Committee quickly agreed to an action plan, which included a combination of education, organizational development and advocacy.

Five large-scale conferences were envisioned as a way to efficiently and effectively engage large numbers of people in the program. The initial group of 25 New York City area nursing homes quickly grew to 40. Each nursing home was asked to identify five management and five union staff who would comprise a facility team and commit to attending all five conferences. By having facility teams attend the conferences together, the intention was to strengthen team development and deepen learning simultaneously.

Although each of the 40 nursing homes that have participated in the QCC is in a different place in its culture change journey, all have experienced profound changes that have improved conditions for residents and workers alike. The program has attracted the attention of the Commonwealth Fund, which is currently supporting a 15-month study of the QCC experience. In addition, a research team from Brandeis University and Boston College will study the impetus for this initiative, how the usual barriers to cooperation between labor and management were addressed, and how the QCC nursing homes implemented their plans for culture change. These findings will inform efforts to involve other New York nursing homes in the partnership and serve as a model for other unions, associations representing direct-care workers, quality improvement organizations and other stakeholders interested in promoting culture change.

SEIU Local 1199NE in Connecticut has more recently embarked on a culture change program that offers a different model from the Quality Care Committee. The program is supported by a grant from the state as part of a career ladder initiative. In the first year, the program was piloted at a nonprofit nursing home represented by the Local. Labor and management were given training first on a monthly basis and later on a bimonthly basis by Barbara Frank and Cathie Brady, experts on culture change who were instrumental in developing the QIOs' culture change program. The initial focus of the training was exercises designed to help workers and managers get to know each other and develop better relationships. Interestingly, when the time came to decide on the career ladder portion of the program, workers objected to management's proposal for team leaders and asked for an ESL program instead. Management listened and the ESL program trained 60 workers during twice weekly two hour classes that were conducted by instructors paid by the Local Training Fund. Management gave workers one hour of paid release time to attend the classes, which were held from 2:00 to 4:00 p.m. to straddle first and second shifts,⁸ and the profound transformation that has taken place in the workplace environment is perhaps best illustrated by the fact that co-workers and management willingly pitched in to cover for workers who were attending the classes. Although there is no hard data yet, there is a sense that retention is up and turnover is down.

Now in its second year, the program is currently working with three union facilities in Hartford and New Haven. The Local hopes that culture change will become a permanent project of the Training Fund and eventually expand to all or most of the nursing homes the Local represents.

⁸ For example, a worker on first shift, 7:00 a.m. to 3:00 p.m., would leave work an hour early at 2:00 and would attend the first hour of the class on paid time and the second hour on her own time.

Training and Advancement: Jointly-Trusted Taft-Hartley Training Funds

Both the Local 1199SEIU⁹ and Local 1199NE culture change programs have been developed and supported by jointly-trusted Taft-Hartley training funds.¹⁰ This is an innovation for the funds, which, like other union training funds, are more typically involved in providing job-related vocational training that focuses directly on opportunities for career advancement.

When multiple employers participate in and contribute to training funds, as with the SEIU funds, these funds have the advantages of economies of scale and increased leverage to secure public and private grants to support their programs. A relatively small contribution (typically ½% of payroll) can enable a participating employer to provide its workers with access to meaningful opportunities for career advancement. In contrast, a single employer is likely to lack the financial and other resources needed to develop and secure funding for a sophisticated training program and may also fear that workers will use their new skills to secure jobs elsewhere.

The largest SEIU training fund in the health care sector is the Training and Upgrading Fund (TUF) sponsored by Local 1199SEIU, which is based in New York City. The size of the fund, and the considerable grant funding secured by the TUF has enabled it to offer an impressive array of training and career advancement programs. Although other local union funds do not currently operate on the same scale, the 1199SEIU TUF illustrates the enormous potential for expanded programs.

The mission of the Training and Upgrading Fund is to provide education and training benefits to covered employees, which in many cases enables them to move from service and clerical positions into higher paying professional and technical jobs. Through grant funds, the TUF supports hundreds of work-site specific programs that help workers and institutions meet the unique needs of their communities. Foreign language, team building and computer training are just a few of the programs offered through grant funds. The TUF also collaborates with education and training organizations to develop innovative education programs that address health care industry shortages as well as meet members' needs as working adults. In one recent year (2003), the TUF reported the following accomplishments:

- The Fund was awarded over \$32.2 million in grant funds.
- Collective bargaining contributions totaled \$16.1 million.
- 20,000 members completed one or more training programs.
- More than 15,000 members participated in workplace skills training programs.
- Over 2,000 members pursued a nursing degree in Fund-sponsored programs.
- 4,000 members were sponsored in basic education and pre-college programs.

⁹ Local 1199SEIU's Employment, Training and Job Security Program is comprised of nine jointly-trusted Taft-Hartley funds. The Quality Care Committee is supported by the Planning and Placement Fund.

¹⁰ Union benefit funds, also known as "Taft-Hartley Funds," are named after the 1948 legislation that gave them legal status. They are also known as labor-management or jointly-trusted funds, meaning they are managed jointly by unions and employers.

- During the 2002-03 school year, the Fund processed 8,673 Tuition Assistance applications.

Although many programs are conducted in the workplace, other classes are given at 1199SEIU's Healthcare Training Center, which is located in the Bronx at a major transportation hub. A collaborative effort with City University of New York, the Center trains workers in state of the art nursing and computer labs. It serves over 1,500 members a year and provides free child-care while members study.¹¹

* * *

SEIU commends the Commission for highlighting the importance of workforce issues by placing them first on its agenda for 2007. Long-term care reform tends to focus on financing and methods of delivering care, but a reformed long-term care system cannot function effectively without a stable and expanded workforce. There is increasing recognition among policymakers that ultimately quality care requires a well-trained, respected, and adequately compensated workforce.

¹¹ More information about the Funds is available on their website, www.1199etjisp.org.