Improving Jobs and Care

A National Sector Strategy

PHI Quality Care THROUGH Quality Jobs

Authored by: Steven L. Dawson
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PHI Quality Care THROUGH Quality Jobs

PHI (**www.PHInational.org**) works to improve the lives of people who need home and residential care—and the lives of the workers who provide that care. Using our workplace and policy expertise, we help consumers, workers, employers, and policymakers improve eldercare/disability services by creating quality direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect, and independence.

THE HITACHI FOUNDATION

The Hitachi Foundation (**www.hitachifoundation.org**) is an independent nonprofit philanthropic organization established by Hitachi, Ltd. in 1985. Our mission is to forge an authentic integration of business actions and societal well-being in North America. Our strategic focus through 2013 is on discovering and expanding business practices that create tangible, enduring economic opportunities for low-wealth Americans, their families, and the communities in which they reside—while also enhancing business value.

About the Author: As its founding President, Steven Dawson has guided PHI for more than 19 years. Under his leadership, PHI has grown into an $8 million organization with a staff of 43, working to secure *Quality Care through Quality Jobs* for our nation's direct-care workforce and long-term care consumers. He serves on the Board of Cooperative Home Care Associates (CHCA), PHI's affiliated $43 million home care agency, which employs more than 1,700 paraprofessionals in New York City and is the largest worker cooperative in the country. Steven chairs Independence Care System (ICS), New York's first Medicaid-funded chronic care demonstration program for adults living in their homes with disabilities, which now coordinates care for more than 1,600 consumer members. He is also the founding co-convener of the Eldercare Workforce Alliance which, with 28 national members, is the only coalition organized to strengthen the caregiving workforce serving older adults. He has authored several landmark publications on low-wage and health care employment issues. Previously, he founded the Industrial Cooperative Association (now The ICA Group).

Photography: Cynthia August (pages i, 6, 8, 17, 24, 26); Marilyn Humphries (pages 1, 12); Hadas Thier (IFC, and pages 5, 11, 13).

Improving Jobs and Care *A National Sector Strategy*

Preface

If this document were a map, it would describe the intersection of *low-wage workforce development* and the *eldercare/disability services* sector. The map's intended users would be practitioners hailing from either territory: *workforce development practitioners* working to improve jobs for low-income people, or *eldercare/disabilities practitioners* working to improve services and support for elders and people with disabilities.

The scale and complexity of this intersection are impressive. In the United States:

- At least 4.5 million elders and people with disabilities receive paid care in order to secure a degree of health, independence, and dignity;
- At least 3.2 million direct-care workers are employed to provide those services (as well as direct-care services delivered in acute care settings), a number that will grow to 4.3 million by 2018;
- And at least 90,000 nursing homes, home care agencies, assisted living facilities and other programs, as well as countless individual households, employ those millions of workers.

Many other key actors are present as well: state and federal policymakers, government agencies, insurers, organized labor, trade associations, community-based training programs, community colleges, consulting groups, researchers, the media, and a plethora of nonprofit policy organizations—including an increasingly influential foundation community.

This is the complex territory in which PHI works. Within it, our constituents (direct-care workers, elders, and people with disabilities) want and deserve real improvements in their lives; our clients demand practical expertise; and our funders seek "systemic change." For more than 25 years, the leaders associated with PHI and its affiliates have worked to achieve all three—directly impacting thousands of lives and creating practical value for key stakeholders, while also changing the surrounding systems for the better. Admittedly, a presumptuous venture from the start.

Where to begin? From a practitioner's perspective, this document describes our history, our strategy, a few tactics, and what we have learned along the way.

Executive Summary

This paper is a brief introduction to PHI—a field-building organization standing at the intersection of *low-wage workforce development* and the *eldercare/disabilities services* sector. As the country's first and largest nonprofit organization pursuing a national "sectoral workforce development" strategy, we describe here our history, industry context, theory of change, and lessons learned.

PHI works to transform eldercare and disability services, so that all who need these services—and all who provide them, particularly direct-care workers—may live and work with dignity, respect, and independence. We enhance the quality of direct-care jobs, strengthen provider organizations, and advocate for system-wide change to ensure high-quality, cost-effective services for individuals and families.

The Direct-Care Sector

The eldercare/disabilities services sector is centrally important—both to those who rely on paid caregiving services and to those who provide that care: At least 4.5 million elders and people with disabilities receive paid care in order to secure a degree of health, independence, and dignity, employing at least 3.2 million direct-care workers. Since most direct-care staff receive low compensation, *one out of every 12 low-wage workers in this country is a direct-care worker*.

Although essential to millions of clients, these workers typically are both undervalued and underutilized.

The direct-care labor market, which PHI seeks to transform, employs Home Health Aides; Personal Care Aides; and Certified Nursing Aides, Orderlies and Attendants. Projected to grow to 4.3 million by 2018, these workers serve clients in their homes as well as in assisted living facilities, nursing homes, and other residential settings. Although essential to millions of clients, these workers typically are both undervalued and underutilized: federal law requires only 75 hours of training, and the 2009 median annual earnings averaged just $16,800. As a result of these low wages, approximately 45 percent of direct-care workers live in households earning income *below 200 percent of the federal poverty level.* Despite serving the health care industry, an estimated 900,000 direct-care workers do not themselves have health coverage.

PHI's Origins

Though now a national organization employing 43 staff and working in more than a dozen states, PHI grew out of a single "social enterprise" initiative in the heart of the South Bronx: *Cooperative Home Care Associates* (CHCA). Founded 25 years ago as an employee-owned home care agency, CHCA is now the largest worker cooperative in the United States, employing more than 1700 African American and Latina workers, and training annually more than 450 inner-city women to become home health aides.

Since CHCA is a for-profit worker cooperative, its leadership in turn created PHI in 1991 as an

affiliated nonprofit training arm, gaining access to philanthropic support. PHI's role soon broadened, initially to replicate CHCA beyond New York City, the prime result of which was the creation, in 1993, of *Home Care Associates* (HCA) of Philadelphia, now a highly successful worker cooperative and training program that today employs 200 aides in Center City.

In 2000, PHI sponsored the creation of *Independence Care System* (ICS)—a New York City Medicaid-funded Managed Long Term Care program, creating a home care-based model of care delivery for low-income adults with physical disabilities and, in turn, creating an additional employment demand for CHCA's aides. ICS is now a $100 million enterprise, coordinating services for more than 1,600 low-income individuals and directly employing more than 700 of CHCA's home health aides.

PHI offers "expertise with a point of view," and is widely considered the foremost specialist on direct-care workforce issues in the U.S.

Over the past decade, PHI has continued as the training, development, and policy arm for the home care-based CHCA, ICS, and HCA. Yet in addition, PHI has expanded both in reach and geography, consulting to more than 20 employer agencies at any one time—not only home care agencies, but nursing and other residential facilities as well—with staff based in New England, New York, Pennsylvania, and Michigan.

Finally, PHI's role dramatically broadened when it created a unique policy capacity within an advocacy frame. With national policy/research staff, regional policy directors, and a government relations office based in Washington, DC, PHI offers "expertise with a point of view," and is widely considered the foremost specialist on direct-care workforce issues in the United States.

PHI's Theory of Change

Our change strategy—based on 20 years of field experience—has positioned PHI to become a credible and valued actor at the intersection of the two fields of *eldercare/disability services* and *low-income workforce development*:

1) **School of Thought:** PHI has crafted a *Quality Care through Quality Jobs* disruptive school of thought (see page 11), advocating for a "high investment – low turnover – high return" business model that values relationship-centered care and is a direct challenge to the current eldercare/disability services system.
2) **Key Stakeholders:** The long-term care universe is shaped by the four key stakeholders—consumers, labor, employer/providers, and public policymakers—each having an essential and legitimate role within the system. PHI has positioned itself to become a valued resource to all four key actors.
3) **Systems Analysis:** PHI works with the key stakeholders to analyze the current system and recommend detailed, effective policy and practice alternatives.
4) **Demonstration:** PHI partners with stakeholders to demonstrate that well-designed and implemented skill-based interventions result in effective and efficient improvements in both job quality and care quality outcomes.

5) **Relationships Based on Expertise:** Finally, by offering expertise of real value to each key stakeholder's self-interest, PHI is developing trusted relationships with leaders among these stakeholders. We then undertake coalitional and other multi-stakeholder initiatives, providing PHI the opportunity to disseminate our disruptive school of thought throughout the system toward a shared *Quality Care through Quality Jobs* perspective.

This strategy presents PHI with a constant challenge: to "sell" our services into a marketplace that we are simultaneously advocating to change. We therefore are constantly asking ourselves how much to challenge—while still remaining "in relationship" with—our key stakeholders. Yet our strategy also helps provide an answer: The greater the value that we offer key stakeholders, the more we can advocate change while simultaneously strengthening our relationships.

Sectoral Employment Initiatives

We have forged PHI's field-building strategy within a workforce development framework that is widely known as "sectoral employment development." As a co-author with the Aspen Institute of several definitional studies on sectoral strategies, PHI has helped shape the national sectoral workforce development field. A sectoral strategy:

Sector strategies acknowledge that low-wage workers are employed within a labor market system.

- **Targets a specific industry or cluster of occupations**, developing a deep understanding of the interrelationships between business competitiveness and the workforce needs of the targeted industry.
- **Intervenes through a credible organization**, or set of organizations, crafting workforce solutions tailored to that industry and its region.
- **Supports workers** in improving their range of employment-related skills, improving their ability to compete for work opportunities of higher quality.
- **Meets the needs of employers**, improving their ability to compete in the marketplace.
- **Creates lasting change in the labor market system** to the benefit of both workers and employers.[1]

Sector strategies acknowledge that low-wage workers are employed within a *labor market system*—including not simply the supply of labor (workers) but also demand (employers). These labor-market dynamics are further influenced by a complex matrix of educational institutions, labor organizations, employment laws, and welfare policies, to name only a few.

Practitioner engagement cannot stop at "supply-side" training-related issues, but must address other essential "demand-side" elements that determine the quality of jobs for low-wage workers—ranging from wages and benefits, to supervision, to the overall management culture. Not only engaging employers, but *engaging employers in issues beyond training and education*, is required for a full-bore sectoral strategy.

Five Environmental Trends

Several major factors will influence PHI's emerging strategy over the coming decade:

1) **Demographics:** The Baby Boom generation is aging—out of the workforce and into eldercare and disability service settings. This is a tectonic demographic shift that simultaneously increases demand for eldercare/disability services while limiting the traditional supply of eldercare/disability services workers. These demographics will create social and economic tensions in the United States that will dramatically increase for at least the next 20 years.

This tectonic demographic shift will create social and economic tensions in the United States that will dramatically increase for at least the next 20 years.

2) **Public budgetary exhaustion:** The next decade and beyond, with a current federal deficit of $14 trillion and endless rivers of additional red ink, portend a profound battle over competing social investments. Advocates cannot simply demand *social justice* for workers and consumers—they now must simultaneously develop models of service delivery that generate true *efficiencies* and increased *effectiveness* within the care delivery system.

3) **Health care reform and job creation:** The historic passage of the *Patient Protection and Affordable Care Act* provides a range of opportunities to test new, efficient service delivery models. Support within the Act for emerging "care coordination teams," "transitions in care," and "accountable care organizations" offers fresh territory within which advocates can design new models of relationship-centered organizations delivering high-quality services and supports.

4) **Person-directed values:** The concept of consumers directing their own care—and even hiring their own caregivers—will be further fueled by Baby Boomers who are far more self-assured and demanding in terms of health care services than previous generations. Yet creating person-directed caregiving services—what PHI calls "relationship-centered" care—requires a set of skills quite distinct from traditional, medically oriented caregiving practices.

5) **Philanthropic re-structuring:** The philanthropic universe has been fundamentally altered in the past three years, resulting in a reduced capacity to make significant, long-term grant investments. At the same time, foundations are acting increasingly as "operating foundations"—playing a more explicit role in defining the field's strategies, and seeking explicit outcomes. The combination of the two trends—fewer resources targeted toward narrower goals—will make it increasingly difficult for field-building organizations to pursue their own mission and strategies.

Five Lessons Learned

During PHI's two decades of experience, five lessons have shaped fundamentally PHI's core organizational strategies and tactics:

1) **Positioning:** Within the retail business world, there is a famous question, "What are the three most important elements of success for a retail business?" The answer: "Location. Location. Location." The same question for the sectoral employment world, "What are the three most important elements of success for a sectoral strategy?" would find a precisely parallel answer: "Position. Position. Position."

For in order to influence an entire sector, the workforce practitioner must establish and maintain a careful organizational balance of being in relationship with each of the key stakeholders—offering *real* value to each—yet being perceived as "in the pocket" of none.

2) **Asset-Based Fundraising:** Workforce leaders should design their initiatives from the outset with the intention of *converting grant funds into assets*: At the end of the initial funding, what assets will have been created that will in turn attract additional grants and/or fee income? Such organizational assets can be quite tangible, such as new tools or systems; or less tangible but nonetheless powerful, such as staff knowledge and expertise, or even relationships with key actors within the sector. Current funding must simultaneously achieve the promised program impact and create something of future value.

3) **Building Ladders and Raising the Floor:** Two distinct paths are available to the workforce practitioner to improve jobs for low-income workers: 1) Removing barriers in order to gain access to good jobs; and 2) fundamentally re-structuring the quality of poor jobs. Yet in the current workforce development world, there exists a heavy emphasis on the first: creating ladders to "escape" poor quality jobs. The workforce development community must directly confront this bias, insisting on policies and strategies that focus equally on both "building ladders and raising the floor" for the millions of low-wage jobs in the U.S. economy.

4) **Expertise, with an Attitude:** One tension that PHI has experienced is the expectation that an organization must be either a research shop or an advocate, but not both. Our response to this presumption is two-fold: to continue to undertake our own rigorous evaluation of work in the field, and to continue to become the most informed organization in the country—so that our expertise simply cannot be ignored. We continue to believe that "expertise, with a point of view" is not only possible, but essential, in creating fundamental change.

An "enclave" strategy, in which philanthropy deepens and protects high-quality programs, rather than exhorting them toward expansion as the sole definition of success, may be more appropriate.

5) **"Going to Scale" Reconsidered:** Only a few years ago, when the economy was growing, the philanthropic community was aggressively urging nonprofit grantees to "go to scale." Now, within our current Great Job Recession, the resources of the philanthropic community are relatively constrained, and calls for scale can no longer be backed quite so boldly with commensurate amounts of funding.

This humbling reality should give the workforce development world an opportunity to pause, and question whether "going to scale" is always an appropriate strategy. For, even when scale is a shared aspiration between funder and grantee, an appropriate question to ask is *when* is it appropriate to pursue? Perhaps, in these very troubled times, an "enclave" strategy is more appropriate, in which philanthropy deepens and protects high-quality programs, rather than exhorting them toward expansion as the sole definition of success.

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Table of Contents

A Brief History 1
PHI: A Field-Building Organization 5
PHI's Statement of Strategy 8
Sectoral Employment Initiatives 12
The Eldercare/Disability Services Workforce 14
The Industry 18
Five Environmental Trends 23
Five Lessons Learned 25

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A Brief History

PHI—and its network of affiliates—began as a single employer, in the heart of the South Bronx. In 1985, the founding leaders of our work—Rick Surpin and Peggy Powell—understood that the low-income workforce development field was all too often standing on the outside looking in. By definition, it is employers who primarily determine the quality of employment for low-income people, and yet the workforce field was led almost exclusively by nonprofits and public agencies. It still is.

The Initial Enterprise: Cooperative Home Care Associates

In response, supported by the nonprofit Community Service Society of New York City, Surpin and Powell created a new for-profit company called Cooperative Home Care Associates (CHCA)—designed to be a model employer of home health aides in the South Bronx. To ensure that CHCA would always remain committed to creating the best jobs possible, they structured the agency as a worker-owned cooperative, so that the aides would own and control the company—and so that the resulting corporate culture would be truly built around the aides. CHCA started with 12 home health aides in 1985; by early 2011, the cooperative employed 1,700 aides and home attendants—nearly all Latina and African-American women. CHCA is now the largest worker cooperative in the United States.

Getting from there to here was hardly a straight path.[2] Surpin was a nonprofit manager and Powell an educational specialist; neither had ever run a for-profit business, let alone a home care agency. Instead, the forging of CHCA was driven by a powerful combination of curiosity, alignment of mission, and sheer drive to survive—resulting not only in building CHCA into a major "high road" employer and nationally respected training program, but also in the creation of several other organizations, including PHI itself.

From a workforce practitioner's perspective, this initial decision to create our own company was pivotal. By being a direct employer of low-wage workers, over the years we have been forced to "internalize the inconsistencies" of attempting to create good jobs and good care, all within a very imperfect system. The result is a depth of knowledge—of our industry, our business, our employees, and our clients—which simply could not have been achieved if we had remained on the outside looking in.

Today, the CHCA low-income training and employment program is considered one of the most successful in New York City.

Creating an Employer-Based Training Program

The founders' second pivotal decision was to create our own training program. At first, CHCA's leadership looked outside of itself, turning to a local community college. However, the college's courses proved ill-designed for the typical low-income woman whom CHCA employed—and so, out of frustration, CHCA's leadership chose to create its own, employer-based training program.

Today, CHCA trains more than 450 inner-city enrollees annually, with a successful employment

rate of 75 percent. The company's retention rate exceeds 60 percent of placements remaining employed at 365 days. As a result, the CHCA low-income training and employment program is considered one of the most successful in New York City.[3]

CHCA's decision to create its own training program presaged many that followed, all derived from a never-ending process of problem solving in order to figure out how to create better jobs and better care. Every time we bumped up against a wall that hindered progress, we pushed on every available door until one opened.

Out of that process, CHCA has become an engine of innovation. For example, when faced with aides not receiving enough regular work assignments to earn a decent paycheck, CHCA created a "Guaranteed Hours Program" that ensured a minimum of 30 hours of income for senior aides. That particular innovation in turn required another: restructuring the entire management system for allocating hourly cases to aides, in order to maximize efficiency of assignments.

Then, when faced with the unavoidable isolation of the home care job, CHCA created its own peer mentor program. That innovation in turn required that we author our own curriculum, for how to train and support peer mentors.

Internalizing Inconsistencies

If we (PHI and its affiliates, see page 4) were simply a workforce training and placement agency for home health aides, our goal would be to find, train, and place as many low-income individuals as possible.

Yet, as an employer, we must also be absolutely sure that the aides we hire are mature, capable, and caring individuals.

Therefore, when selecting recruits—and making the hard decision of whether a trainee graduates or is dismissed—we must temper our desire to help the low-income trainee with the hard question, "Would I feel good about sending this aide into *my* mother's home?"

The result is a constant, careful balancing of often conflicting goals.

This on-going process of innovation is the same process that soon created PHI. Since CHCA was a for-profit cooperative, the leadership needed a nonprofit organization, initially to solve the problem of raising philanthropic funding for the initiative and, soon thereafter, to take on two core challenges: disseminating CHCA's lessons to the field and influencing public policy.

PHI — Early Strategic Choices

In 1991, Surpin and Powell created the nonprofit that later became known as PHI.[4] Starting with three staff, PHI's initial sole purpose was to support CHCA—both as a conduit for training and workforce funds into the cooperative, and to provide technical assistance to improve the training program. Soon, however, CHCA's success had attracted two key funders, the Charles Stewart Mott Foundation and The Ford Foundation, both of which encouraged PHI to replicate CHCA in other cities. PHI's vision broadened accordingly.

The decision to influence the industry through replication proved a particularly humbling experience.

The decision to influence the industry primarily through replication proved a particularly humbling experience, for we did not fully appreciate at first how greatly home care markets differ from region to region. Before the replication initiative, we had complained often about the lack of public support for the home care industry in New York—until we began to work in other cities and found the environments there even less inviting. More importantly, during the mid- to late-1990s, just as we were in the midst of building replication sites in Philadelphia

Independence Care System

While it may appear that PHI's decisions during the past decade were an attempt to lower our degree of risk, it was instead a decision to re-direct, not reduce, our risk level: In 2000, PHI sponsored and Surpin led the creation of Independence Care System (ICS)—to build a home care-based model of care delivery for adults with physical disabilities and, thereby, essentially create our own market for CHCA's aides (see page 4). Compared to entering into new, unknown markets in other cities through our replication project, we believed we could create more value by exploring new "territory" within the systems we already knew well.

The decision to invest more deeply in our existing enterprise base, rather than broaden it geographically, eventually proved of great value: ICS itself is now a $100 million enterprise, coordinating the care for more than 1,600 low-income individuals and directly employing more than 700 of CHCA's home health aides. (ICS indirectly employs an additional 1,200 aides contracted through other home care agencies.)

and Boston, federal policy suddenly became far less generous toward home care.

The result of the ten-year replication initiative was genuinely mixed: a closing of the Boston site in 2000 after six years,[5] yet also the eventual survival of Home Care Associates of Philadelphia—now a highly successful worker cooperative and training program that today employs 200 aides in Center City. During those same years, PHI played a supporting role (in some cases significant; in some cases modest) to several other initiatives modeled after CHCA, in Connecticut, Massachusetts, New Hampshire, California, and Wisconsin. Some closed; one was sold; a few have survived.

This mixed record of success and failure taught us a great deal. The primary lessons were: creating our own enterprise base was enormously valuable, extremely difficult, and very expensive. Our conclusion: if our goal was to influence the entire sector, it was clear we could not do so by creating one or two enterprises every decade—and certainly not with only a 50/50 track record.

A Major Shift in Strategy

Therefore, PHI entered the decade of 2000 to 2009 with a significantly altered strategy composed of three core elements:

1) **Deepening investment in our existing models**, in Philadelphia and particularly New York City;
2) **Offering technical assistance** to a range of employers and training programs nationally; and
3) **Engaging directly in public policy/advocacy**, at both the state and federal levels.

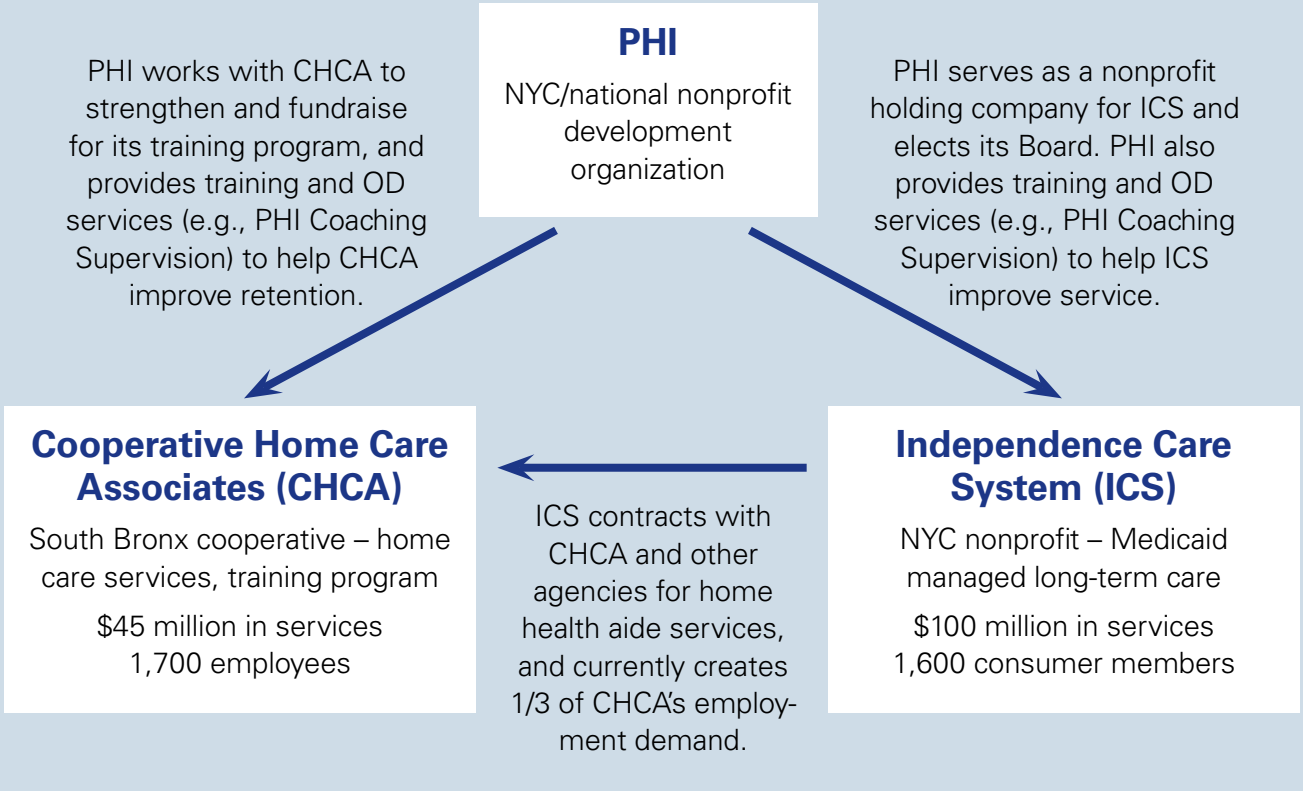
Underlying this shift in strategy was yet another critical decision: to broaden PHI's expertise—in both practice and policy—from a focus exclusively within home care to one that included a fuller range of eldercare and disability service providers, particularly nursing homes and other residential care settings. And even within the home care sector, we broadened from a focus solely on the more clinical home health care subsector to a wider set of home-based personal care programs, including consumer-directed services and supports.

This underlying shift allowed PHI to carve out a universe that now includes the entire eldercare/disability services sector, thereby stepping outside the internecine warfare that often exists between the home care industry and the nursing home industry, and even among competing models within those industries. With PHI's dual mission to create both quality jobs and quality care, we have now positioned ourselves to be in support of any part of the sector that employs low-income individuals—wherever elders and people with disabilities receive assistance and within whatever model of service delivery they choose.

PHI's Affiliated Home Care System — New York City

Over the past 25 years, PHI and its affiliates have created a $150 million "social enterprise system" in New York City to create good jobs and high-quality services and supports. Our home care system is a hybrid of nonprofit and cooperative enterprises linked through cross-board relationships, service contract responsibilities, and most importantly, a shared mission. Annually, our system provides care for more than 6,000 elders and people with disabilities; employs approximately 1,800 people; and trains annually more than 450 women to become home health aides:

- **PHI** is the nonprofit development corporation that provides training, workforce development, and organizational development support to the system. PHI also raises grant funds that support the training and innovation capacity of the system. Approximately 25 percent of PHI's time and resources are invested in New York; 75 percent is invested nationally and in other regions of the U.S.
- **Cooperative Home Care Associates** has two roles: providing home care services to elders and people with disabilities and the training of new home health aides. CHCA is the largest worker cooperative in the United States.
- **Independence Care System**, a nonprofit Medicaid managed long-term care organization, coordinates care and services for more than 1,600 low-income New York City residents who are physically disabled and nursing home eligible, yet are living independently in their homes. PHI and CHCA co-sponsored the creation of ICS, both as a model of care coordination for people with disabilities and to provide employment for CHCA's aides.



PHI: A Field-Building Organization

By pursuing such a fundamental shift in strategy over this past decade, PHI aspired to become a "field-building organization" at the intersection of the low-income workforce development and the eldercare/disability services sector.

Over the past ten years, we have significantly deepened our enterprise development model in New York (see "PHI's Affiliated Home Care System – New York City" on page 4) and continue to support our Home Care Associates affiliate in Philadelphia. For our employer-based technical assistance strategy, our workforce and organizational development staff now consult at any one time to more than 20 providers and training programs in over a dozen states. For our public policy/advocacy strategy, we employ national staff with offices in New York and Washington, DC, and regional staff headquartered in Massachusetts, New York, Pennsylvania, Michigan, and Minnesota.

We have now structured our program staff into five departments:

- **Market-Oriented Services**
  - **Training & Organizational Development** (7.63 FTE)
  - **Curriculum & Workforce Development** (3.5 FTE)
  - **Policy/Advocacy** (11.9 FTE)
- **Programmatic Support**
  - **Communications** (5 FTE)
  - **Evaluation** (2 FTE)

The first three departments deliver services to client groups, and the remaining two primarily support the activities of the three field service departments—while at the same time playing a public education role.

PHI authors curricula, designs training programs, and provides train-the-trainer services.

Each of our three field service departments have distilled a set of core competencies:

- **Curriculum and Workforce Development Services:** For employers and programs that train direct-care workers and consumers, PHI authors curricula, designs training programs, and provides train-the-trainer services—all delivered within the intersection of a low-wage workforce serving an increasingly self-directed health care consumer.

  PHI's educational pedagogy is: *competency-based* (designed around what the individual is expected to know and do); *adult learner-centered* (respecting and building upon what the individual already knows and is capable of doing); and contextualized within a *relationship-centered* environment (acknowledging that caring, stable relationships between consumers and workers are essential, so that both may live with dignity, respect, and independence).

- **Training and Organizational Development Services:** PHI has crafted a distinct *skill-based* approach to creating relationship-centered services within eldercare/disability service organizations. Most

PHI has crafted a distinct, skill-based approach to creating relationship-centered services within eldercare/disability service organizations.

eldercare/disability consultants offer prescriptions for how to design person-directed organizations. In contrast, PHI helps organizations build the necessary *foundational skills*—which we call the PHI Coaching Approach℠—that are essential for staff at all levels to implement "relationship-centered" caregiving organizations.

We focus particularly on building core *communications* and *problem-solving skills* that support positive relationships among co-workers, and between caregivers and those whom they support. Therefore, PHI does not offer a "competing model" of care delivery, but instead provides the core skills essential to make any relationship-centered service delivery model succeed.

- **Policy Services:** We have developed a unique policy capacity—ranging from research and analysis to policy development—*within an advocacy frame*. Stated in another way: PHI offers "expertise with a point of view." That expertise includes: direct-care worker compensation and training systems; service delivery program design and procurement policies; and workforce assessment and monitoring—all of which support quality and efficiency.

  Our capacity is anchored in a specific understanding of the sizeable and rapidly expanding direct-care workforce within the eldercare/disability services industry, as well as the significant impact these jobs have on both our local labor markets and our economy as a whole.

PHI threads these core competencies through the complex weave of the eldercare/disability services and workforce development worlds. A resulting strength is that we are now of value to a far wider

Defining PHI

Aspiring to play a field-building role makes PHI difficult to categorize. In fact, it is easier to state what PHI is not: We are not a professional association, nor a trade association, nor a union, nor an employer. That is, we do not *formally* represent any one constituency, not even direct-care workers or consumers (even though it is primarily from the point of view of these two constituencies that we try to understand and re-shape the eldercare/disability services system). This absence of a base of members is limiting, in that we speak only for ourselves; yet it is also freeing, in that we do not have to defend the territorial self-interests of any specific set of members or member organizations.

Nor are we strictly speaking a think tank, a research house, or a consulting firm. Instead, we consider PHI a *field-building* organization that advocates for system change—articulating a *quality-care-through-quality-jobs* framework at the policy level and building *relationship-centered caregiving* organizations at the practice level—with a fundamental emphasis on the direct-care workforce and the consumers they serve. No other such organization exists at the intersection of eldercare/disability services and low-income workforce development.

breadth of funders and client groups than many other nonprofits. PHI receives support from varying types of foundations—*e.g.*, those that value health care, elders, low-wage workers, women's issues, and social enterprise—as well as a similarly wide range of fee-for-service and public agency clients. This breadth of support has allowed PHI to remain relatively stable, despite the recent turbulence of our nation's near financial collapse.

Supporting these three field service departments are PHI's two program support departments:

PHI's **Evaluation Department** primarily provides support to our three market-oriented departments, although it also provides external services to funders and clients for the design and implementation of third-party evaluations.

Our **Communications Department** staffs all of our web-based portals and several e-newsletters as field-building services—free of charge to practitioners, advocates, policymakers, researchers, and the media. These are intended as public resources that report not just on PHI's activities, but on many other direct-care issues and initiatives that align within PHI's "quality care through quality jobs" school of thought.

Although PHI currently generates no direct income from our online information services,[6] our presence as the nation's primary online source of direct-care information and analysis—PHI websites have generated 5.5 million page views in Calendar Year 2010—continues to position PHI as an essential actor within the field and, at the same time, to drive traffic toward PHI's other income-generating services.

Finally, in working to build the intersection of low-wage workforce development and eldercare/disability services, PHI has designed and helped to establish a number of pillar institutions. In addition to forging PHI's own organizational capacity, along with the now $150 million New York City Home Care System, PHI has:

- Co-founded with the Chicago Jobs Council, and then spun off in 1998, The Workforce Alliance (now re-named the **National Skills Coalition**), the primary advocacy organization for skill development in the nation's workforce.
- Founded and then spun off in 2006 the **Direct Care Alliance**, a national advocacy voice for direct-care workers within the long-term care industry.
- Helped design and in 2009 became the founding co-convener with the American Geriatrics Society of the **Eldercare Workforce Alliance**, a coalition of 28 national organizations advocating to address the immediate and future workforce crisis in caring for an aging America.

Admittedly, the resulting field-wide complexity generates for PHI a range of management and marketing challenges. What keeps PHI focused within this complexity is an overarching systems-change sectoral strategy—one that guides our mutually reinforcing policy and practice interventions.

Our presence as the nation's primary online source of direct-care information and analysis continues to position PHI as an essential actor within the field.

PHI's Statement of Strategy

The current system of eldercare/disability service delivery in the United States is fundamentally unstable, and driven far more by financial demands than human values. The prevailing "business model"—low investment in staff, leading to high turnover, leading to low quality of care—wastes precious resources, both capital and human. We believe it will soon prove unable to bear the crush of demand from an ever-increasing number of elders and people with disabilities.

PHI has worked to articulate a positive vision of relationship-centered care.

In response, PHI has worked to articulate a positive vision of relationship-centered care, one which we have branded as *Quality Care through Quality Jobs*. While a positive vision, it is also fundamentally a "disruptive" school of thought that inverts the current business model—requiring instead an up-front and on-going investment in frontline workers, resulting in greater stability and higher quality of staff, which in turn delivers higher quality care and greater efficiencies:

High investment → **Low turnover** → **High quality/ efficiency**

Systems Change

PHI understands that eldercare/disability services in the United States exist within a jumble of *systems*—differing from program to program and from state to state—sometimes overlapping and sometimes quite distinct. What these systems share, however, are two determinative structural elements (finance and service delivery) and a set of four key stakeholders (consumer groups, organized labor, provider agencies, and government policymakers/agencies).

Our responsibility is to understand these key stakeholders—their values, their priorities, their roles within the system—as well as *how* these key stakeholders then interact with each other to shape both finance and service delivery design. That is, we must learn how the universe of eldercare/disability services works in order to identify the most effective points of leverage. The better we understand this universe, the better we can then wield a coordinated array of policy/advocacy, evaluation, practice, and communication *tools*, applying each and all in whatever combinations are necessary to create fundamental "systemic change."

Within the eldercare/disability services universe, systemic change is that which:

- Fundamentally alters **policies/laws/regulations** within governments, **structures/procedures** within organizations, or **perspective/beliefs** within individuals;

- Leading to a consistent and lasting **change of behavior**; which, in turn
- Results in **higher quality services and supports** for consumers, **higher quality jobs** for workers, **better value** for employers, and/or **greater efficiencies** for government.

To define and measure those improvements, PHI has identified "nine essential elements of a quality job" (see below) and "nine essential elements of quality care, services, and support" (see page 10). Every program and initiative that PHI undertakes is intended to improve one or more element within those two essential constructs.

Essential Elements of a Quality Job for Caregivers

To ensure that all direct-care workers are able to provide the highest-quality care to all long-term care consumers, PHI advocates for 9 essential elements of a quality job:

Compensation

- Family-sustaining wages*
- Affordable health insurance and other family-supportive benefits
- Full-time hours if desired, stable work schedules, balanced workloads, and no mandatory overtime

Opportunity

- Excellent training that helps each worker develop and hone all skills—both technical and relational—necessary to support long-term care consumers
- Participation in decision making, acknowledging the expertise that direct-care workers contribute, not only to workplace organization and care planning, but also to public policy discussions that impact their work
- Career advancement opportunities

Support

- Linkages to both organizational and community services, as well as to public benefits, in order to resolve barriers to work
- Supervisors who set clear expectations and require accountability, and at the same time encourage, support, and guide each direct-care worker
- Owners and managers, willing to lead a participative, on-going "quality improvement" management system—strengthening the core caregiving relationship between the long-term care consumer and the direct-care worker.

* See The Basic Economic Security Tables for the United States, Wider Opportunities for Women, 2010. **http://www.wowonline.org/documents/BESTIndexforTheUnitedStates2010.pdf**

PHI within the Eldercare/Disability Services Universe

Systemic change need not be system-wide. More often, systemic change impacts only one portion of the larger universe. Therefore, PHI can effect change in an endless variety of ways, large and small. For example:

- Pennsylvania re-designs its direct-care training standards, encouraging a system of portable credentials for direct-care workers that is recognized across the long-term care service spectrum.

- Nurses who practice the PHI Coaching Approach fundamentally re-frame how they understand their supervisory role and, thus, change their behavior—from a sole emphasis on clinical tasks based on a punitive style, toward a relational perspective that helps their staff solve problems collaboratively and communicate well with residents and their family members.
- The 1,700-worker Cooperative Home Care Associates and its labor union, SEIU 1199, develop a model Labor Management Committee dedicated to fostering a relationship-based resident and worker environment.
- Several PHI "Partnership Site" providers—high-quality employers within their respective industries of home and residential care—re-structure their management systems, based on cross-functional "leadership teams" that include and thus empower direct-care staff.
- The Federal Centers for Medicare and Medicaid Services (CMS) gives guidance to state Medicaid offices on how to define, monitor, and collect data on the millions of direct-care workers funded by the states.

Essential Elements of Quality Care

For consumers of paid long-term care services, eight out of every ten hours of service are provided not by a nurse or a doctor, but by a direct-care worker—a home health aide, certified nurse aide, or personal care worker.

Therefore, for consumers who rely upon services and support from direct-care staff, PHI has identified the following nine essential elements of high-quality care, services, and support—whether those services are received in the consumer's home or in a residential setting.

Quality long-term care is *care*, *services,* and *support* that are…

Individualized

- Directed by *informed choices* made by the consumer (or, where appropriate, by family members or other designated representatives);
- Offered at the *time and place most preferable* to the consumer, in a manner that is safe and unhurried; and
- Provided in a way that honors the *consumer's individuality and preferences*.

Respectful

- Acknowledging the consumer's right to *dignity and privacy*, both physical and emotional;
- Supporting all those involved in the caregiving relationship—the consumer, family members, and the direct-care worker—to *relate as individuals* in an environment of trust and mutual respect; and
- Sustaining the consumer's full range of *relationships* with friends and family members, and promoting opportunities for broader community engagement.

Professional

- *Holistic*—supporting well-being, health, independence, and quality of life;
- For consumers with medical needs, consistent with *progressive standards of clinical practice*—those that are individualized, respectful, and coordinated across settings; and
- Provided by direct-care workers who have *quality jobs* that allow them to provide the highest quality services and support.

Still, the eldercare/disability services universe is large, varied, and complex. In response, PHI must be both *opportunistic*, creating change whenever and wherever we might find an available point of leverage, and *strategic*, constantly seeking those points of leverage, such as altering payment policies or partnering with large stakeholders that offer the greatest power to create fundamental change.

PHI's Theory of Change

To achieve our vision of a relationship-based services system, we have developed a theory of change that requires expertise in all five of PHI's program disciplines. Our theory—based on 20 years of field experience—is intended to position PHI uniquely within the intersection of the two fields of eldercare/disability services and low-income workforce development:

1) **School of Thought:** PHI has helped to craft a *Quality Care through Quality Jobs* disruptive school of thought, advocating for a "high investment–low turnover–high return" business model that values relationship-centered care and is a direct challenge to the current eldercare/disability services system.

2) **Key Stakeholders:** The long-term care universe is shaped by the four key stakeholders—consumers, labor, employer/providers, and public policymakers. Each of these has an essential and legitimate role within the system, yet all have developed protective mechanisms to guard their self-interests, creating a classic "locked-down" social service system in which change is fiercely resisted.

   Into this locked-down system, facilitated by our *advocacy* and *communications* expertise, PHI has positioned itself to become a resource to all four of these key actors—valued by each, yet perceived as independent and credible by all.

3) **Systems Analysis:** Using our *policy/advocacy* and *research* tools (which are deeply informed by our own practice experiences), along with our *evaluation* expertise, PHI works with the key stakeholders to analyze the current system and recommend detailed, effective alternatives such as training re-design, new competency and certification models, reformed payment and reimbursement systems, and innovative service delivery models.

4) **Demonstration:** Using our employer-based *training and organizational development* skills, our *curriculum and workforce development* tools, and our *evaluation* expertise (all of which are deeply informed by our policy experience), PHI partners with stakeholders to demonstrate that well-designed and -implemented *skill-based* interventions result in *effective and efficient* improvements in both job quality and care quality outcomes—for both individual employers and for entire delivery systems.

5) **Relationships Based on Expertise:** Finally, by offering expertise of real value to each key stakeholder's self-interest, PHI is developing trusted *relationships* with leaders among these stakeholders—working always to turn key actors among these stakeholders into allies. Building upon these relationships, we then undertake coalitional and other *multi-stakeholder* initiatives, providing PHI the opportunity to disseminate our disruptive

We are constantly asking ourselves how much to challenge—while still remaining "in relationship" with—our key stakeholders.

school of thought throughout the system—urging each of the key stakeholders toward a *shared* relationship-centered, *Quality Care through Quality Jobs* perspective.

Admittedly, this strategy presents PHI with a constant challenge: to "sell" our services into a marketplace that we are simultaneously advocating to change. The result is often a degree of dissonance: contracting with—and thus being accountable to—large organizations/institutions (providers, unions, governments, advocacy groups), while at the same time attempting to alter fundamentally their perspectives. We therefore are constantly asking ourselves how much to challenge—while still remaining "in relationship" with—our key stakeholders. This tension has been named by John Morris of the Annapolis Coalition on the Behavioral Health Workforce as "making just the right amount of trouble."

Yet at the same time, our strategy also helps provide an answer: **The *greater the value* that we offer key stakeholders, the more we can simultaneously advocate change *and* strengthen our relationships.** Therefore, although PHI still has much work ahead to become of ever greater value to the four key stakeholders, our success to date is based upon consistent implementation of our systems-based strategy.

Sectoral Employment Initiatives

We have forged PHI's field-building strategy within a workforce development framework that is now known widely as "sectoral employment development." A sectoral workforce strategy is a systems approach that:

- **Targets a specific industry or cluster of occupations**, developing a deep understanding of the interrelationships between business competitiveness and the workforce needs of the targeted industry.
- **Intervenes through a credible organization**, or set of organizations, crafting workforce solutions tailored to that industry and its region.

PHI soon grew to become one of the first national low-income sectoral workforce initiatives in the United States.

- **Supports workers** in improving their range of employment-related skills, improving their ability to compete for work opportunities of higher quality.
- **Meets the needs of employers**, improving their ability to compete in the marketplace.
- **Creates lasting change in the labor market system** to the benefit of both workers and employers.[7]

This school of thought, specifically designed to achieve advancements for *low-wage workers*, is one that PHI has helped to define over the past two decades: PHI co-authored, with leadership from the Aspen Institute, two seminal documents written on sectoral strategies: *Jobs and the Urban Poor*, published by Aspen in 1995, and later, *Sectoral Strategies for Low-Income Workers: Lessons from the Field*, published in 2007.

PHI soon grew to become one of the first *national* low-income sectoral workforce initiatives in the United States.[8,9] Since that time, other national nonprofit sectoral organizations have emerged, most notably, the Restaurant Opportunities Centers United (ROC-U), which works to

Half the states in the nation are now employing, or actively investigating, sector strategies.

improve low-wage restaurant workers' wages and working conditions.[10]

A recent white paper published by the National Network of Sector Partners, *Sector Snapshot: A profile of sector initiatives* (2010), has documented the strength and resilience of the sectoral approach to workforce development: Half the states in the nation are now employing, or actively investigating, sector strategies, with 11 of those states having appointed leadership teams to explore more active support for these strategies. Of the several hundred survey respondents in 2009—programs actively engaged in sectoral initiatives hailing from all regions of the country—73 percent reported that, despite the recession, "their most successful initiative expanded in the last two years, in terms of jobseekers or workers served."[11]

The Power of a Sectoral Strategy

A sectoral strategy acknowledges that low-wage workers are employed within a *labor market system*—including not simply the supply of labor (workers) but also demand (employers)—and that these labor-market dynamics are further influenced by a complex matrix of educational institutions, labor organizations, employment laws, and welfare policies, to name only a few.[12]

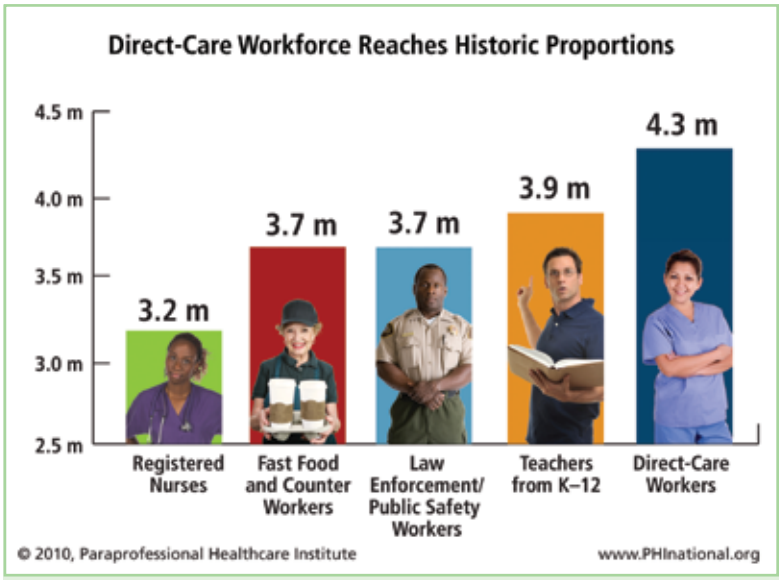
Therefore, to improve job quality in any permanent way, focusing solely on the "supply side" of the equation (primarily by improved training of low-income individuals) is necessary, yet in itself, wholly insufficient. Instead, simultaneously focusing on the "demand side" by changing employer practices—as well as by working with a broad array of other key actors within the targeted labor market environment—is essential to secure sustainable improvements for low-income employees.

Not only engaging employers, but engaging employers in issues beyond training and education, is required for a full-bore sectoral strategy.

In contrast, much of the workforce development world engages employers primarily within the limited sphere of training-related issues—and at most, career ladder designs. While necessary, such training-only interventions tend to limit the value that the practitioner can offer the employer and, therefore, limit the influence the practitioner can have on overall job quality.

Therefore, practitioner engagement cannot stop at "supply-side" training-related issues, but must address other essential "demand-side" elements that determine the quality of jobs for low-wage workers—ranging from wages and benefits, to supervision, to the overall management culture. Not only engaging employers, but *engaging employers in issues beyond training and education*, is required for a full-bore sectoral strategy.

The Eldercare/Disability Services Workforce



The eldercare/disability services sector[13] employs more people than nearly any other industry in the country—4.6 million jobs for all occupations within the sector. Furthermore, this employment sector is increasing at three times the rate of other jobs within the U.S. economy.[14]

By 2018, the eldercare/disability services sector will employ more people than any other industry in the country.

Among these eldercare/disability service occupations, direct-care jobs form the employment core. These direct-care positions, more formally called "paraprofessionals" within the industry, include three main categories: Home Health Aides; Personal Care Aides; and Nursing Aides, Orderlies and Attendants. These workers typically are employed by home care agencies, personal care programs, nursing homes, assisted living facilities, adult day care settings, group homes, and private households.

Direct-care workers provide a range of personal services (transferring from bed to chair, eating, bathing, companionship). In some cases, Certified Nurse Aides (CNAs) and Home Health Aides (HHAs) perform limited clinical duties (*e.g.*, taking blood pressure, assisting with range-of-motion exercises), typically under the direction of a licensed or registered nurse.

However, formal training is quite limited: federal law requires only 75 hours for CNAs and HHAs; several states have established higher training requirements, but none more than 175 hours. There are no federal requirements for personal care aides (PCAs)—although many states have instituted limited training standards for their PCAs (typically no more than 40 hours). While these distinctions exist in regulation, it is also true that the clinical tasks that home care workers perform in the privacy of their clients' rooms do not always comport with formal regulations.

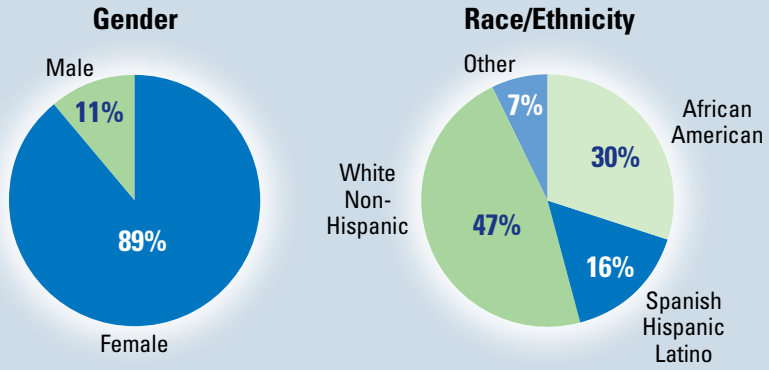
Direct-care services are paid for primarily by public funders.

Direct-care services are paid for primarily by public funders—approximately 70 percent are funded by Medicare, Medicaid, and the Older Americans Act, with Medicaid being the largest among these. As such a disproportionate funder of these services, government tends to dictate the policy framework within which direct care is delivered. And since Medicaid is funded in large part by states, each of the 50 states—and even some regions within states—has its own set of regulations and guidelines for direct-care training requirements, job responsibilities, and service protocols.

Demographics of the Direct-Care Workforce[15]

Given the sheer scale of direct-care employment within low-income communities, and the centrality of their role in offering essential services to millions of elders and people with disabilities, direct-care workers stand at the intersection of two critical social needs—employment and health care—both of which will grow in importance in the coming two decades.

A mostly female workforce…that is also diverse



Source: PHI analysis of the U.S. Census Bureau, Current Population Survey (CPS), 2010 Annual Social and Economic (ASEC) Supplement.

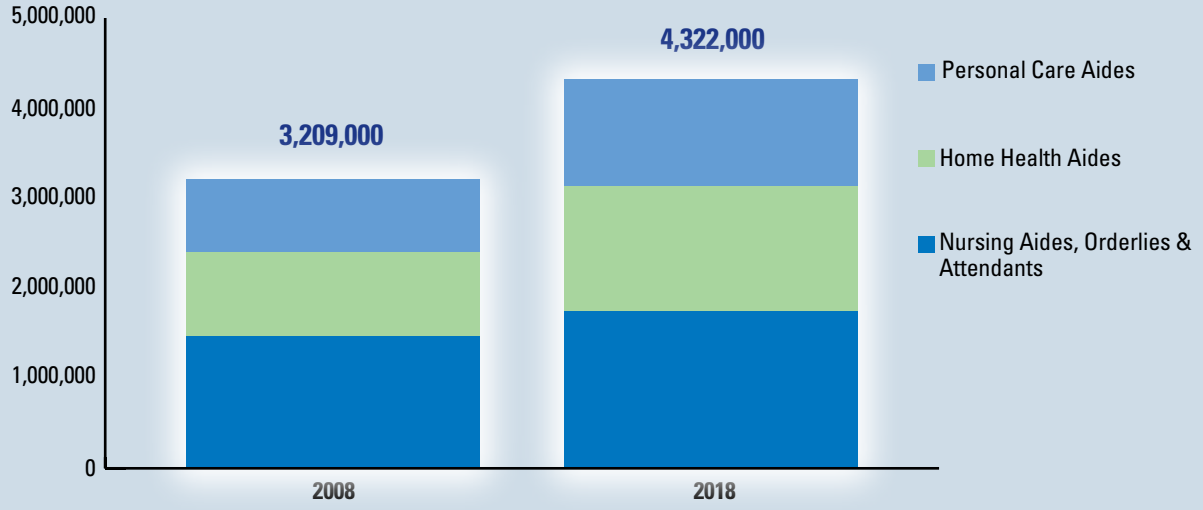
The vast majority of direct-care workers are female (89 percent). They are disproportionately minority: 47 percent are white; 30 percent African American; 16 percent Hispanic and 7 percent are other races/ethnicities. The average age of a direct-care worker is 42, with home-based workers tending to be older than facility-based workers. Of all direct-care workers, 23 percent are born outside the U.S. and 55 percent have a high school education or less.

Of course, the demographics of different states, and even different regions within states, vary widely.

Demand Projections

Including those also employed in acute-care settings (hospitals and doctors' offices, etc.), direct-care workers are among the nation's fastest-growing occupations: The latest 2008 employment estimate for the direct-care workforce surpassed the 3.2 million mark, and projected demand calls for an *additional 1.1 million new positions* by 2018. Over the same period, when combined with turnover and replacement needs, anticipated job openings for direct-care workers *approach 1.5 million*.

Direct-Care Workforce to Surpass 4.3 Million by 2018



Source: DOL/BLS, Employment Projections Program, 2008-18 National Employment Matrix, available at: http://www.bls.gov/emp/empiols.htm

By 2018, the resulting 4.3 million direct-care workers are expected to exceed the number of K-12 teachers (3.9 million), all law enforcement and public safety workers (3.7 million), and registered nurses (3.2 million). And since most of these direct-care jobs pay within the bottom quartile of all U.S. occupations, the importance of this workforce to employment within low-income communities cannot be overstated: *One out of every 12* low-wage workers in the U.S. is a direct-care worker; in New York City, *one out of every seven* low-wage workers is a direct-care worker.

Job Quality[16]

Unfortunately, the quality of direct-care jobs nationwide is relatively poor: In 2009, the median hourly wage for all direct-care workers was just $10.58—significantly less than the median wage for all U.S. workers at $15.95/hour. Nursing Aides earned $11.56, while Personal Care Aides and Home Health Aides earned under $10 per hour ($9.46 and $9.85, respectively).

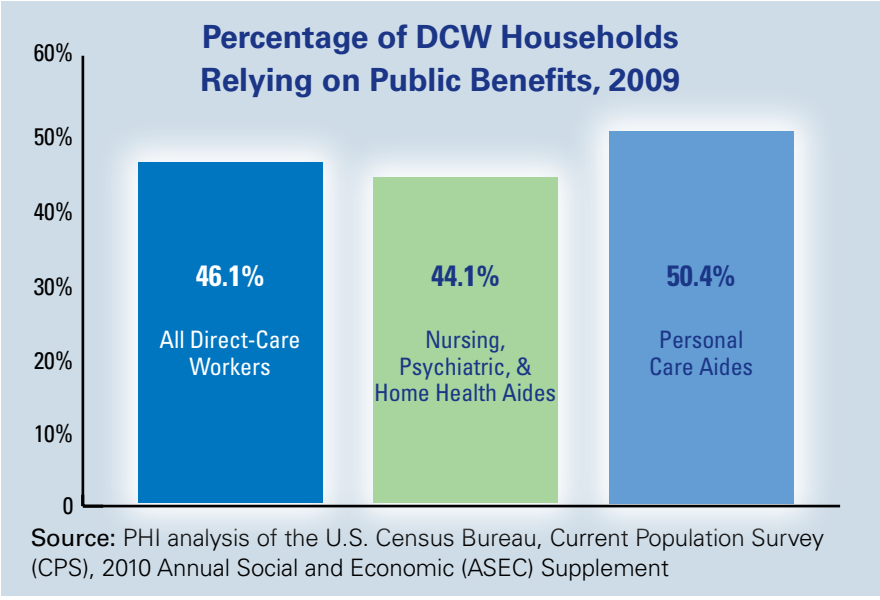
Over the past decade, despite increasing demand, Nursing Aides, Orderlies and Attendants have seen only a modest increase in their real, inflation-adjusted wages to $9.22/hour (measured in 1999 dollars). Even more remarkably, Home Health Aides and Personal Care Aides have seen their real, inflation-adjusted wages *decline to under $8.00 an hour*.

In a bitter irony, an estimated 900,000 direct-care workers in 2009 did not have health coverage.

A significant proportion of the direct-care workforce is employed part time. In 2009, 48 percent of direct-care workers worked less than full time year-round. Over half (58 percent) of Personal Care Aides worked part time or full time for only part of the year. Part-time hours reduce overall earnings and thus, in 2009, median annual earnings for direct-care workers averaged just $16,800. This means that about 45 percent of direct-care workers live in households earning income *below 200 percent of the federal poverty level*.

In a bitter irony: despite serving the health care system, an estimated 900,000 direct-care workers in 2009 *did not have health coverage*. One in every four nursing home workers and more than one-third of aides working in agency-based home care lacked health coverage. While two-thirds of adult civilian workers in America receive health coverage through an employer, less than half of direct-care workers (47 percent) have such employer-based coverage.

Finally, and just as troubling, 46 percent of direct-care workers live in households that receive one or more public benefits such as food stamps, Medicaid, housing, child care, or energy assistance.



Source: PHI analysis of the U.S. Census Bureau, Current Population Survey (CPS), 2010 Annual Social and Economic (ASEC) Supplement

Importance to Elders and People with Disabilities

The direct-care workforce provides a life-line of support to consumers requiring assistance with daily living. In a 1985 landmark report, the National Citizens Coalition for Nursing Home Reform, now re-named the Consumer Voice, issued a national study that asked residents of nursing homes to identify what was the most important determinant of their day-to-day quality of care. The primary factor identified was the "accessibility and attitude" of the direct-care workforce.[17]

Indeed, *eight out of every ten* hours of service delivered by paid staff to elders and people with disabilities are provided, not by a doctor or nurse, but by a direct-care paraprofessional. *Seven out of ten* employees within eldercare/disability service programs are direct-care workers.

> "As it exists today, the education and training of direct-care workers is inadequate to impart the necessary knowledge, skills, and abilities to these workers, especially as the complexity and severity of older adults' needs increase and as more adults are cared for in home- and community-based settings. The government should raise the federal minimum training requirement for nurse aides and home health aides to 120 hours and states should establish minimum standards for personal care aides if they have not already done so."
>
> –IOM Report, *Retooling for an Aging America*, 2009

In a milestone report issued by the Institute of Medicine in 2009, *Retooling for an Aging America*, the IOM raised the importance of the direct-care workforce to national attention, dedicating one of six chapters exclusively to the role of the paraprofessional within eldercare services. The report called for increasing minimum training standards for direct-care workers and for the inclusion of direct-care workers within new models of care delivery and coordination.

The Essential Context of the Whole Organization

PHI's experience with direct-care workers has only further underscored the power of the "sectoral employment" school of thought described earlier: That while high-quality selection, recruitment, and training are essential for a quality job, equally important is the entire context of employment—the working conditions—established by the employer/provider. Among those working conditions, not only are decent wages and benefits necessary, but so too are skilled supervision, peer mentor support, and the overall culture of the organization.

CMS has officially acknowledged the importance of relationship-based organizational cultures.

In April 2009, the Centers for Medicare and Medicaid Services (CMS)—the federal agency charged with managing the multi-billion dollar Medicare and Medicaid programs—officially acknowledged the importance of relationship-based organizational cultures by issuing new "interpretive guidelines" for nursing homes. Notably, these new CMS guidelines encouraged long-term care facilities to create a "homelike environment" through resident-centered practices, requiring an expanded role for direct-care workers in order to ensure that everyday decisions are made "closest to the resident."

In parallel, PHI now focuses its work not only on the training of direct-care workers, but also on strengthening overall organizational capacity. This requires PHI to assist all levels of staff leadership within eldercare/disability organizations—from direct-care workers to nurses to CEOs—providing them the essential skills to create a culture of quality jobs and quality care.

Nurse Competencies

The Hartford Institute for Geriatric Nursing, in collaboration with the Coalition of Geriatric Nursing Organizations and Pioneer Network, in June 2010 issued a set of 10 competencies for licensed nurses in nursing homes to promote and facilitate person-directed care and culture change in their organizations.* Among the 10 priority competencies, the very first states that a competent nurse:

> *…models, teaches and utilizes effective communication skills such as active listening, giving meaningful feedback, communicating ideas clearly, addressing emotional behaviors, resolving conflict and understanding the role of diversity in communication.*

These skill-based competencies are the core of PHI's organizational development assistance. And though these competencies are written for nurses within nursing home settings, PHI's assistance with major home- and community-based systems underscores that the same skills are required throughout the eldercare/disability services sector.

* See **http://pioneernetwork.org/Data/Documents/TenCompetenciesReport0510.pdf**

The Industry

Definition of the Industry

Services provided through what PHI identifies as the "eldercare/disability services industry" span both the conventional *health care sector* and *health assistance services*. Traditionally, eldercare/disability services employers include Nursing Care Facilities, Residential Care Facilities, and Home Health Care Agencies.

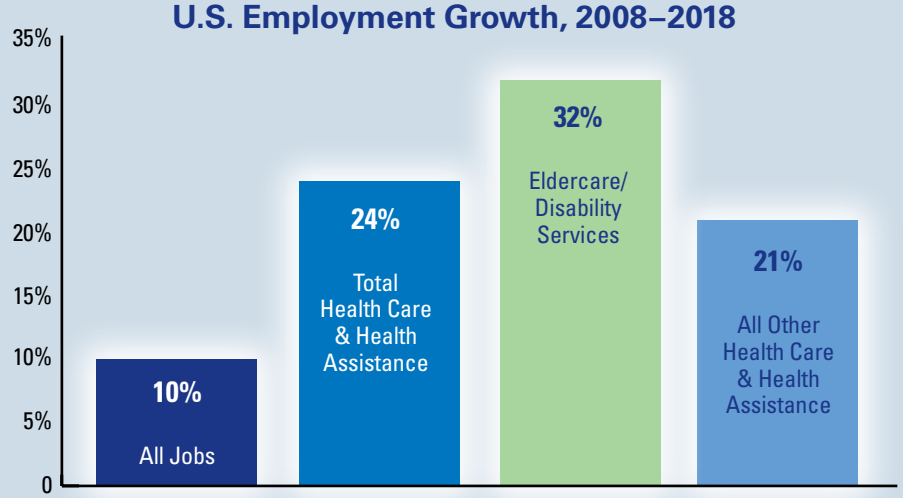
Yet other settings and service providers have been gaining in importance, and are included in PHI's definition. These non-traditional settings include: private households that directly employ direct-care workers, self-employed direct-care workers, employment services that hire out direct-care workers to nursing and residential care facilities, and community-based establishments (such as day programs) that provide non-residential, non-medical, and/or rehabilitative personal and social assistance services and supports to persons with disabilities.

Importance to the Economy

Well-known is that the health care sector has been a major engine of economic growth in the U.S. over the last five years. In fact, in some states, health care has been the only employment sector that has grown, while all other sectors have declined or remained flat.

The health care sector has been a major engine of economic growth.

Less well-known, however, is that the eldercare/disability services industry is *the* key driver of job growth within the health care and health assistance sector. Employment within eldercare/disability services is expected to increase 32 percent during the ten-year period 2008 to 2018, compared to 21



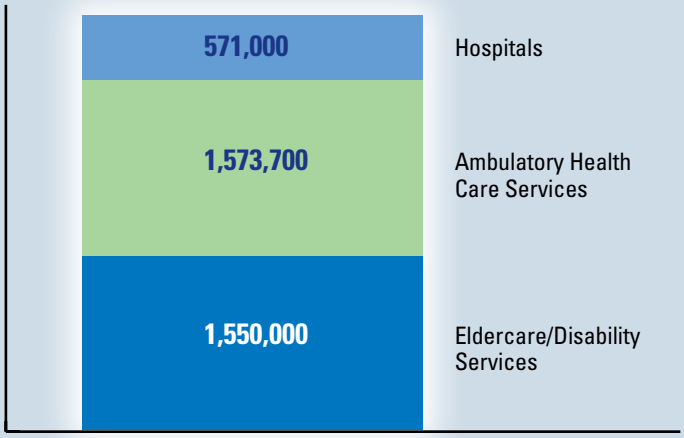
Source: DOL/BLS, Employment Projections Program, 2008-18 National Employment Matrix, available at: **http://www.bls.gov/emp/empiols.htm**

percent for all other jobs in the health care and health assistance sector.

Finally, the broader eldercare/disability services labor market—including not only paraprofessionals, but all staff—is expected to generate over 40 percent of new jobs within the health care and health assistance sector from 2008 to 2018, or nearly 1.6 million out of the 3.7 million new jobs projected.

Structure of the Industry

The eldercare/disability services industry is generally divided into two categories: 1) home- and community-based care, providing in-home services and supports and day and respite programs, and 2) residential care facilities, ranging from skilled nursing homes and intermediate care facilities for persons with developmental disabilities to small group homes. The distinction is generally intended to differentiate between services provided in one's own home versus in a congregate facility where room and board are part of the services provided.



Source: DOL/BLS, Employment Projections Program, 2008-18 National Employment Matrix, available at: **http://www.bls.gov/emp/empiols.htm**

Estimates of the number of nursing home residents vary from 1.5 million to 1.8 million.[18] About 366,000 people are estimated to live in non-institutional group quarters, and approximately 8 million people needing long-term care live in households.[19] Federal surveys indicate that family members, relatives, friends, and volunteers are by far the principal providers of in-home services and supports to people living in households.

Family members, relatives, friends, and volunteers are the principal providers of in-home services and supports to people living in households.

Home- and Community-Based Industry[20] For the home- and community-based portion of the sector, PHI tracks two official industries: *Home Health Care Services* and *Services for the Elderly and Persons with Disabilities*.

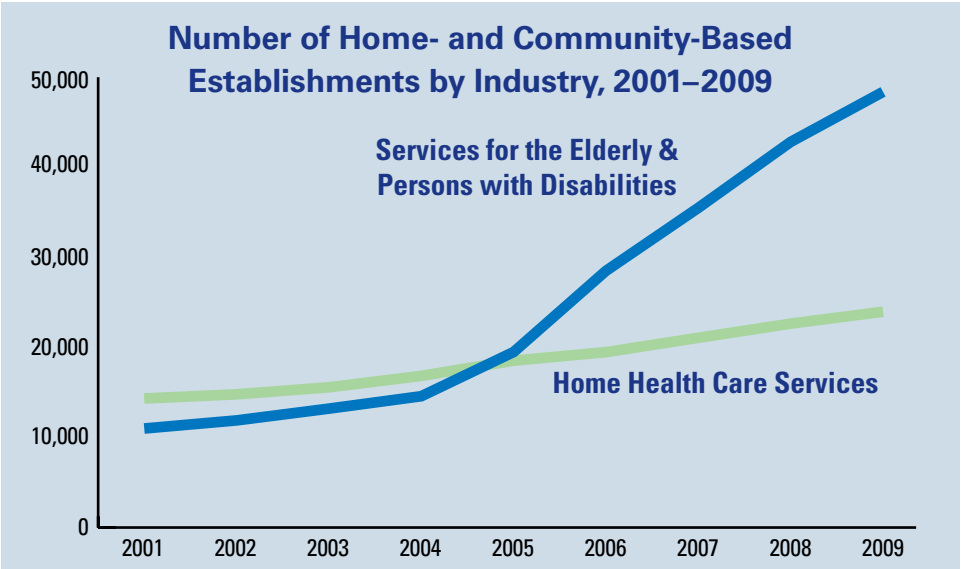
The employers that make up the home- and community-based agencies are highly varied in terms of size, ownership structure, and the diversity of services and goods that they provide. Some of the main employer types include the following:

1) **Home health care companies** provide medically oriented home health care services and often non-medical home care or personal assistance services as well.
2) **For-profit franchise chains** provide non-medical personal assistance services. Various media report that the largest and fastest-growing non-medical home care companies are franchises.
3) There are also numerous non-franchise **private-duty home care companies** that specialize in the provision of non-medical home care. The customers of these companies tend to be private-pay clients or clients relying on non-Medicaid funded state programs.

The number of agency providers in both home-based industries has skyrocketed in recent years.

4) Finally, there are hundreds of thousands of **home care workers employed directly by private households**. This category includes public programs that fund consumers to hire their own independent provider, as well as an uncounted number of individuals who hire their own workers within a vast "grey market" of employment arrangements.

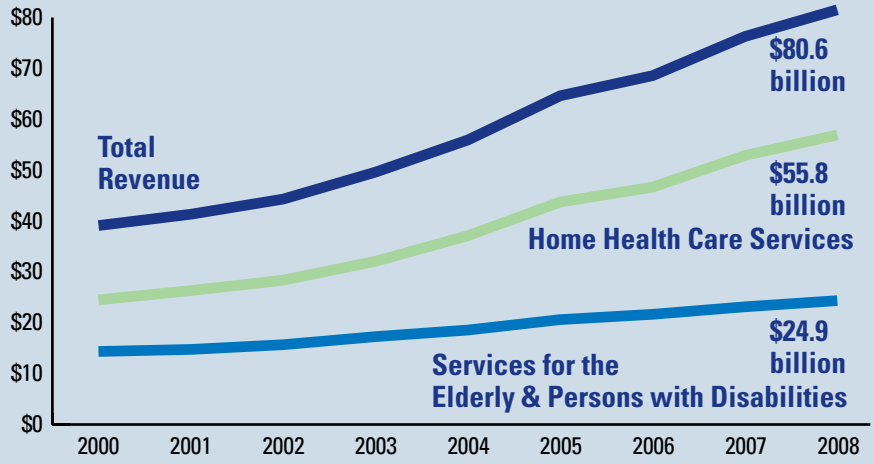
The number of agency providers in both home-based industries has skyrocketed in recent years. As shown below, the number of *Home Health Care Services* "establishments" has grown from 14,000 in 2001 to nearly 24,000 in 2009. Yet establishments captured in *Services for the Elderly and Persons with Disabilities* have increased from 11,000 to 48,000.



Source: U.S. Bureau of Labor Statistics, Quarterly Census of Employment and Wages

According to the Service Annual Survey Data of the US Census Bureau, in 2008 the combined revenues of the two key industries providing home care and personal assistance totaled over $80 billion (see chart on page 21). Nonprofits dominate the less regulated *Services for the Elderly and Persons with Disabilities*, while for-profits now dominate *Home Health*

Care Services. However, the for-profit segment of the former more than doubled from 2000 to 2008, a trend that reflects rapidly growing business activity in the provision of non-medical care, attributable in part to minimal state licensing requirements in many states.



Source: U.S. Census Bureau, Health Care and Social Assistance, 2008 Service Annual Survey Data for Health Care and Social Assistance. Available at: http://www.census.gov/services/sas_data.html

Nursing and Residential Care Facilities Sector

Industries in the Nursing and Residential Care Facilities sector provide residential care combined with either nursing, supervisory, or other types of care as required by the residents. In this sector, the care provided is a mix of health and social services, with the health services being largely some level of nursing services.

The industries that make up the nursing and residential care sector include:

1) **Nursing Care Facilities:** This industry comprises establishments primarily engaged in providing inpatient nursing and rehabilitative services. The care is generally provided for an extended period of time to individuals requiring nursing care. These establishments have a permanent core staff of registered or licensed practical nurses who, along with other staff, provide nursing and continuous personal care services. Included in this industry are: nursing homes, skilled nursing facilities, group or rest homes with nursing care, and inpatient hospices.
2) **Residential Mental Retardation, Mental Health, and Substance Abuse Facilities:** This industry group comprises establishments primarily engaged in providing residential care (but not licensed hospital care) to people with mental retardation, mental illness, or substance abuse problems. These facilities may provide some health care, though the focus is room, board, protective supervision, and counseling. This industry includes group homes, intermediate care facilities, and hospitals—all for persons with mental retardation, or mental health and substance abuse issues.
3) **Community Care Facilities for the Elderly:** This industry comprises establishments primarily engaged in providing residential and personal care services for:

- The elderly and other persons who are unable to fully care for themselves, and/or
- The elderly and other persons who do not desire to live independently.

The care typically includes room, board, supervision, and assistance in daily living, such as housekeeping services. In some instances these establishments provide skilled nursing care for residents in separate on-site facilities.

The number of nursing facilities has stagnated over the past nine years; however, the numbers of community care facilities for the elderly and of residential facilities for mental retardation, mental health, and substance abuse have both grown by about 20 percent over the same time period.

Private, for-profit nursing homes account for nearly two-thirds of all nursing facilities, while non-profits represent about 30 percent. Slightly less than half of all nursing facilities operate independently, while the majority are part of large nursing home chains.[21]

According to the Service Annual Survey Data of the U.S. Census Bureau, in 2008 the estimated revenue of the nursing and residential care facilities sector totaled over $168 billion. More than half of that revenue was accounted for by nursing facilities.

Number of Nursing and Residential Care Establishments by Industry, 2001–2009

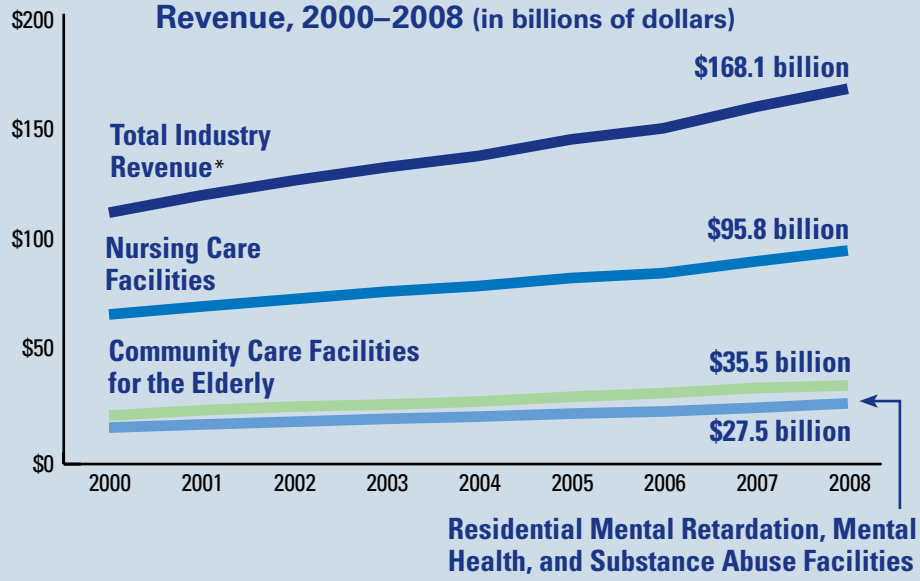
Source: U.S Bureau of Labor Statistics, Quarterly Census of Employment and Wages

In order, the major payers for nursing home stays are:

1) Medicaid
2) Private pay
3) Medicare, and
4) Long-term care insurance

One-fifth of nursing home bills are paid for out of pocket—entirely or primarily. Medicare is a major payer during the first three months of a nursing home stay, but this shifts to out-of-pocket pay being primary, and then to Medicaid as a person spends down their assets over time. Medicaid pays for only one-fifth of residents during the first month; that proportion grows to reach more than four-fifths for stays that are more than three years in length.[22]

Estimated Nursing Care and Residential Facility-Based Revenue, 2000–2008 (in billions of dollars)



* Total Industry Revenue also includes revenue for "other residential care facilities"

Source: U.S. Census Bureau, Health Care and Social Assistance, 2008 Service Annual Survey Data for Health Care and Social Assistance. Available at: http://www.census.gov/services/sas_data.html

Five Environmental Trends

Although PHI has enjoyed considerable success, what has worked well up until now—helping PHI create a nationally recognized position within both the eldercare/disability services and workforce development fields—may or may not work well in the future.

Several factors of profound import will influence PHI's emerging strategy over the coming decade:

1) **Demographics:** The Baby Boom generation is aging—out of the workforce and into eldercare and disability service settings. This is a tectonic demographic shift that simultaneously increases demand for eldercare/disability services while limiting the traditional supply of eldercare/disability services workers. Demography is indeed destiny, and this intersection of workforce and eldercare/disability services will create social and economic tensions in the United States that will dramatically increase for at least the next 20 years. Demand for the type of expertise that PHI offers—both in policy and practice—will expand accordingly.

The next decade and beyond portends a fundamentally different, and far more challenging, battle over competing social investments.

2) **Public budgetary exhaustion:** Advocates within the social service worlds are accustomed to fighting against "budget cuts" and arguing hard for even small expansions of social services. Yet the next decade and beyond, with a current federal deficit of $14 trillion and endless rivers of additional red ink, portend a fundamentally different, and far more challenging, battle over competing social investments. Therefore, advocates cannot continue simply to demand social justice for workers and consumers and expect thereby to win additional resources—they now must simultaneously develop models of service delivery that generate true *efficiencies* and increased *effectiveness* within the care delivery system.

3) **Health care reform:** The historic passage of the *Patient Protection and Affordable Care Act* provides a range of opportunities to test new, efficient service delivery models. Though by no means a foregone conclusion, support within the Act for emerging "care coordination teams," "transitions in care," "accountable care organizations," and "comparative effectiveness research" offers fresh territory within which advocates can design new models of relationship-centered organizations—models built around a better-trained and -supported and, thus, a more valuable and valued front-line workforce.

In addition, health care reform will increase health insurance access dramatically for the direct-care workforce—25 percent of which, ironically, currently has no health coverage—which will in turn improve the quality of these jobs significantly.

The historic passage of health care reform provides opportunities to test new, efficient service delivery models.

4) **Person-directed values:** The concept of consumers directing their own care—and even hiring their own caregivers—originated within the disability community and is now emerging within the eldercare services sector. This trend will be further fueled by Baby Boomers who are far more self-assured and demanding

in terms of health care services than previous generations.

Creating person-directed caregiving services—what PHI calls "relationship-centered" care—requires a set of skills quite distinct from traditional medically oriented caregiving practices. Currently, PHI is one of the few organizations in the country that offers this skill-based approach to re-casting organizational cultures.

5) **Philanthropic re-structuring:** The philanthropic universe has been fundamentally altered in the past three years, due most obviously to dramatic capital losses within foundation portfolios. The inevitable result is a reduced capacity to make significant, long-term grant investments.

Creating person-directed caregiving services requires a set of skills quite distinct from traditional, medically oriented caregiving practices.

Less obvious is the trend within foundations to act, either formally or informally, increasingly as "operating foundations"—playing a more explicit role in defining the field's strategies, and seeking explicit outcomes. The combination of the two trends—fewer resources targeted toward narrower goals—will make it increasingly difficult for field-building organizations such as PHI to pursue their own mission and strategies. The future requires that we learn to engage with foundations more as clients, and less as benefactors.

These five trends, no doubt along with many others, will reshape both the eldercare/disability services and workforce development fields; they have already begun to re-shape fundamentally PHI's work. Yet while we can articulate in response an overall strategy, it cannot be too narrow a path. Rather, it must be a "strategic corridor" that points PHI in the right direction, but provides a fair degree of latitude—allowing us to adapt constantly to a range of changing, unpredictable circumstances.

The future requires that we learn to engage with foundations more as clients, and less as benefactors.

Five Lessons Learned

Finally, PHI's two decades of experience have offered many lessons—out of both successes and challenges. We highlight below five lessons that have shaped fundamentally PHI's core organizational strategies and tactics.

1. Positioning

Within the retail business world, there is a famous question, "What are the three most important elements of success for a retail business?" The answer: "Location. Location. Location."

The same question for the sectoral employment world, "What are the three most important elements of success for a sectoral strategy?" would find a precisely parallel answer: "Position. Position. Position." For in order to influence an entire sector, the workforce practitioner must establish and maintain a careful organizational balance of being in relationship with each of the key stakeholders—offering *real* value to each, yet being perceived as "in the pocket" of none.

Establishing position can be achieved neither easily nor quickly. It requires crafting over time valuable assets (knowledge, expertise, tools, relationships), and learning how to make those assets available to the maximum number of key stakeholders. It further requires evidence, tested over time through multiple experiences, that the practitioner's organization is committed to the entire sector, not any one particular stakeholder.

The workforce practitioner must be in relationship with each of the key stakeholders.

2. Asset-Based Fundraising

Many are the workforce demonstration programs and development organizations that receive start-up funding—only to falter when that initial support ends. This typically occurs when program leaders think of fundraising, at best, as paying for current programs and, at worst, as filling gaps in their budgets.

Workforce leaders should design their initiatives from the outset with the intention of converting grant funds into assets.

Instead, workforce leaders should design their initiatives from the outset with the intention of *converting grant funds into assets*: At the end of the initial funding, what assets will have been created that will in turn attract additional grants and/or fee income? Such organizational assets can be quite tangible, such as new tools or systems; or less tangible but nonetheless powerful, such as staff knowledge and expertise, or even relationships with key actors within the sector.

Therefore, the most effective fundraising does not simply focus on the present—in the sense of fulfilling a grant commitment to achieve a particular program outcome—but in addition should also look forward. That is, current funding must simultaneously achieve the promised program impact and create something of future value.

In looking forward, leadership should ask two questions:

- What assets will we create with this funding, and
- Who will value those assets?

The "who" might be other funders, or key stakeholders, or potential clients—but a clear answer to each of these questions is essential in order to build a powerful, sustainable organization.

Finally, the term "value" is essential here—for there exists a crucial distinction between a funder or client *valuing* an asset, and simply *appreciating* it. A potential funder/client might appreciate an organization's assets, but it only truly values an asset when it is willing to pay for it—in the form of new funding or fee income.

3. Building Ladders *and* Raising the Floor

Two distinct paths are available to the workforce practitioner to improve jobs for low-income workers:

- Removing barriers in order to gain access to good jobs; and
- Fundamentally re-structuring the quality of poor jobs.

Both paths may be available within the same sector: In the health care field, creating a career path to become a nurse is an example of the first path; improving wages and benefits for certified nurse aides is an example of the second.

Yet while both paths are honorable and worthy of investment, in the current workforce development world, there exists a heavy emphasis on the first: creating ladders to "escape" poor quality jobs. This bias appears to derive at least in part from the increasing influence of the community college system, which has a clear economic self-interest in promoting formal education as the primary cure for low-wage jobs.

Public policies and nonprofit strategies must focus equally on both "building ladders and raising the floor."

However—particularly in an economy in which "good jobs" are scarce—this overemphasis on removing barriers to access is self-limiting, for it can never access enough existing "good jobs" for the millions of low-income individuals in need of decent employment. The workforce development community must confront this bias in a much more direct way, insisting on public policies and nonprofit strategies that focus equally on both "building ladders *and* raising the floor" for the millions of low-wage jobs that now flood the U.S. economy.

4. Expertise, with an Attitude

One tension that PHI has experienced over the years is the expectation that an organization must be either a research shop, or an advocate, but not both. We have at times been informed that since we are "biased" on behalf of workers and consumers, we cannot participate in analyses to determine, say, the best methods for creating new training standards. The occasional result has been that a more research-oriented organization has been hired instead to perform the analysis—even though that organization might have far less expertise in the field than PHI—because it can better claim to be "unbiased."

Our best response to this presumption is two-fold:

- To continue to undertake our own rigorous evaluation of work in the field, so that our word can be trusted when we state that an intervention does or does not work—even if it is our own intervention, and
- To continue to become the most informed organization in the country, so that our expertise simply cannot be ignored.

"Expertise, with a point of view" is not only possible, but essential.

We continue to believe that "expertise, with a point of view" is not only possible, but essential, in creating fundamental change in such a complex system as the eldercare/disability services sector. One need only measure the progress and innovation of the disability community, relative to that of the eldercare community, to note how the advocacy base of the former has achieved far more profound change than the research base of the latter.

5. "Going to Scale" Reconsidered

PHI itself has achieved a degree of scale: Certainly its New York City-based home care system, managing $150 million annually, and employing more than 1,800 people, is not trivial, and PHI itself continues to achieve considerable policy and practice impacts in over a dozen states and nationally. Furthermore, as described earlier, we intend to continue to grow and leverage maximum strategic impact.

Around us we see troubling signs of instability in the nonprofit sector.

And yet, around us we see troubling signs of instability in the nonprofit sector—the recent microcredit hyper expansion and collapse in India being the most egregious.[23] Just a few years ago, when the economy was growing—and the stock market was indeed surging too far ahead of it—the philanthropic community was aggressively urging nonprofit grantees to "go to scale." Understandably frustrated by the limited impact that workforce development strategies were having on low-income communities, funders sought higher leverage, and—relative to today—had greater resources available to help spur their grantees toward more ambitious plans.

Now, within our current Great Job Recession, the resources of the philanthropic community are relatively constrained, and calls for "going to scale" can no longer be backed quite so boldly with commensurate amounts of funding. This humbling reality should give the workforce development world an opportunity to pause, and question whether "going to scale" is always an appropriate strategy. Simply urging organizations to grow—defined by size of budget, or number of programs, or geographic reach—does not always translate to greater impact.

Simply urging organizations to grow does not always translate to greater impact.

Clearly, managing large-scale growth is a skill-set unrelated to effective program creation. Few nonprofit leaders have experience in managing growth, and even the best "strategic business plans" produced by third-party consultants cannot compensate for that lack of direct experience. In addition, such scale strategies often include "sustainability" plans that require the selling of services in the marketplace—in a bid to diversify away from philanthropic support—which requires yet another completely different skill-set from nonprofit program development.

In this current weak economy, attracting and maintaining the resources to build a larger operation is certainly more difficult—and even if achieved, a larger operation may be slower to adapt to rapid change than a smaller, more agile one. Therefore, even when "going to scale" is a shared aspiration between funder and grantee, an appropriate question to ask is *when* is it appropriate to pursue? Perhaps, in these very troubled times, an "enclave" strategy is more appropriate, in which philanthropy deepens and protects high-quality programs, rather than exhorting them toward expansion as the sole definition of success.

Endnotes

1 See *Sectoral Strategies for Low-Income Workers: Lessons from the Field*, Aspen Institute, Washington, 2007, at **http://www.aspeninstitute.org/publications/sectoral-strategies-low-income-workers-lessons-field**

2 For a full description of the start-up of CHCA, see *A History of Cooperative Home Care Associates*, by Dawson, S. L. & Kreiner, S. L. (1993). Unpublished paper prepared for the Home Care Associates Training Institute.

3 According to Phillibber Associates, which is employed by the Robin Hood Foundation to assess all of Robin Hood's training grantees, CHCA ranks above average among its peer training programs in six out of seven categories.

4 PHI was originally incorporated as the Home Care Associates Training Institute; later its name was changed to the *Paraprofessional Healthcare Institute*. In 2009, we re-branded ourselves simply as *PHI*.

5 See: Dawson, S.L., Powell, P., and Surpin, R. (2000). *Closure: Cooperative Home Care of Boston: Accomplishments and Analysis*. PHI. Retrieved on April 10, 2011 from: **www.directcareclearinghouse.org/download/Closure_CHCB_Accomplishments_and_Analysis.pdf**.

6 PHI is currently testing the feasibility of offering online training services, which would generate income.

7 See *Sectoral Strategies for Low-Income Workers: Lessons from the Field*, Aspen Institute, Washington, 2007, at **http://www.aspeninstitute.org/publications/sectoral-strategies-low-income-workers-lessons-field**

8 Organized labor, long before PHI, undertook what should also be considered a "sectoral" strategy, through unionization of workers. Therefore, PHI was the first *independent nonprofit* to undertake a national sectoral workforce strategy.

9 In 2007, PHI was recognized for its contribution to the field by the National Network of Sector Partners, winning the NNSP's *Cindy Marano Trailblazer's Award for Innovative Leadership*.

10 ROC-U was initially founded to support restaurant workers displaced by the World Trade Center destruction in New York City, and has since grown into a national organization employing a three-part sectoral strategy: 1) industry research; 2) partnering with employers to help low-wage workers obtain living-wage jobs; and 3) supporting restaurant workers in confronting exploitation in the workplace. Also, ROC-U has supported the creation of worker-owned restaurants as an enterprise-based strategy, parallel to PHI's.

11 See *Sector Snapshot: A Profile of Sector Initiatives,* 2010, National Network of Sector Partners, Oakland, California, 2010, at **http://www.insightcced.org/publications/wdpubs.html**.

12 For employment within the healthcare sector, the public policy context is particularly influential, since government both funds and regulates the industry to such an extent that little systemic change can occur without addressing public policy in some form.

13 See The Industry, following on page 18.

14 For far greater detail, and data source citations, see PHI's Fact Sheets and Chart Gallery, at **http://phinational.org/policy/**.

15 Statistics in this section are from PHI analysis of the 2010 Annual Social and Economic Supplement to the 2010 Current Population Survey.

16 Wage estimates presented in this section are from the Occupational and Employment Statistics Program of the Bureau of Labor Statistics. The non-wage statistics are from PHI analysis of the 2010 Annual Social and Economic Supplement to the 2010 Current Population Survey.

17 NCCNHR. *A Consumer Perspective on Quality Care: The Resident Point of View*. 1985.

18 Kaye, H. Stephen, Harrington, Charlene, and LaPlante, Mitchell P. (2010), "Long-Term Care: Who Gets It, Who Provides It, Who Pays, And How Much?" *Health Affairs* 29(1), 1-11.

19 Ibid.

20 Seavey, D. (Forthcoming 2011) *Background Report on the U.S. Home Care and Personal Assistance Workforce and Industry.* Bronx, NY: PHI.

21 National Nursing Home Survey: **http://www.cdc.gov/nchs/nnhs/facility_tables.htm**

22 Kaye, H. S., Harrington, C., LaPlante, M.P. (2010). "Long-Term Care: Who Gets it, Who Provides it, Who Pays, and How Much?" *Health Affairs*, 29(1), 1-11.

23 For more information see *Deutsche Welle*, "Indian Microfinance Industry Mired in Scandal" at **http://www.dw-world.de/dw/article/0,,6405968,00.html**.

Visit our PHI Policy*Works* website at **www.PHInational.org/policy**.

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