

**CLOSURE:**  

---

**COOPERATIVE HOME CARE**  
**OF**  
**BOSTON**

~ ACCOMPLISHMENTS & ANALYSIS ~

APRIL, 1994 — APRIL, 2000

*Submitted to the:*

*Submitted by the:*

**PHI**  
349 East 149th Street  
10th Floor  
Bronx, New York 10451

Telephone: (718) 402-7766

Fax: (718) 585-6852

Steven L. Dawson  
President

Peggy Powell  
Executive Administrator

Rick Surpin  
Chairperson

*"Cooperative Home Care of Boston has meant a lot to me. It has made me more confident and competent. Sharing time with elders, I heard many stories and learned many things. My job was not a burden, it was an honor."*

~ Linda Sullivan, CHCB Home Health Aide

*"CHCB has a stellar reputation among providers, both for the quality of its services and its concern for the welfare of its employees. It is deplorable that such an agency has been forced to close its doors because of inadequate funding, particularly when Massachusetts is committed to finding appropriate jobs for former welfare recipients. It is time for the Commonwealth to address the true costs of service delivery, to stop exploiting one population, low-income workers, to serve another, the frail and sick who want to stay at home."*

~ Peggy Munro, Executive Director of the  
Massachusetts Council for Home Care  
Aide Services {The Commonwealth's  
trade association of home care providers}

## EXECUTIVE SUMMARY

~ Closure: Cooperative Home Care of Boston ~

Six years ago, the Paraprofessional Healthcare Institute (PHI) asked the foundation community to take a great risk: to help PHI start a totally new, worker-owned home health agency. In response, a broad range of Boston-area funders provided more than \$500,000 over six years, matched by national foundations, to initiate and support Cooperative Home Care of Boston (CHCB).

### Background

Soon after its inception in 1994, CHCB became a highly successful trainer of women transitioning from welfare to work, as well as a highly regarded provider of home care services. Throughout its six-year span, this worker-owned agency trained and employed more than 200 women—the vast majority of whom had been dependent upon public assistance and were single mothers of young children. In turn, CHCB's aides provided excellent care to literally thousands of home-bound clients who were ill, elderly or disabled, residing within Boston's poorest communities.

At its height in 1996 and 1997, CHCB grew to more than 70 workers, was profitable, and provided more than \$100,000 in healthcare services each month. However, in December of 1999, CHCB was forced to close its doors—the 26<sup>th</sup> home care agency lost in Massachusetts during the past two years, reflecting a national trend in home care agency closures.

Fortunately, CHCB was able to ensure a full and honorable closure of operations: providing all staff and clients more than 30 days notice; securing new jobs for all aides who wished to remain employed; transferring all clients safely and seamlessly to other care providers; and paying in full all employees, lenders and vendors.

### Analysis of Closure

Six years ago, an expanding, stable marketplace allowed PHI to establish CHCB with relatively few resources and only limited Boston-area experience. When, three years later, Federal welfare and home care public policy turned suddenly negative, the marketplace proved far less forgiving. Weaknesses that could be ignored four or five years earlier could no longer be tolerated as CHCB attempted to navigate a shrinking, essentially politically-driven, marketplace.

The primary causes of CHCB's closure were external, and all but one related to significant reversals in public policy. These external factors included:

- **Federal Medicare reimbursement cuts;**
- **State Medicaid reimbursement constraints;**

- **Federal and state welfare-to-work restrictions; and**
- **The full employment economy / negative population trends.**

However, not all factors were external. Internal factors that contributed to CHCB's closure also included:

- **Internal dynamics of the administrative staff;**
- **Rough hand-off during new CEO transition;**
- **Inability to re-build a strong management team; and**
- **The challenge of market diversification.**

### **Lessons Learned**

PHI has drawn important lessons from these experiences at CHCB, lessons we are applying at the five other existing enterprise and training sites PHI now serves within its "Cooperative Healthcare Network," as well as at potential new sites that we are now researching in other parts of the United States. The most important lessons learned at CHCB include:

- 1} **A market-based business partner is essential;**
- 2} **Diversification is complex and expensive;**
- 3} **The emerging healthcare marketplace requires agencies of scale;**
- 4} **A single entrepreneurial leader is insufficient;**
- 5} **Recruitment of participants is fast becoming a limiting factor for community-based employment organizations;**
- 6} ***Programmatically*, PHI's enterprise model requires a full training/development capacity; and**
- 7} ***Financially*, PHI's strategy requires the presence of both an enterprise and a training/development capacity.**

### **Conclusion**

We are proud of CHCB's accomplishments: the 200 inner-city women whom we trained and employed, and the thousands of low-income, home-bound clients they in turn served. We are also proud that—with strong training, counseling, supervision and full-time employment—we proved our two initial premises: that we can create decent healthcare jobs for low-income women transitioning from welfare, and that they, in turn, can provide excellent care.

We wish to thank the Boston-area and national funding communities for your willingness to support the Paraprofessional Healthcare Institute in our effort to forge the link between the quality of healthcare jobs and the quality of the resulting care. Unfortunately, public policy undermined CHCB just as it was beginning to flourish. Clearly, unless these policies change, the quality of

paraprofessional jobs and the resulting quality of care will continue to deteriorate across the Commonwealth—and throughout the nation.

Finally, your consistent support has helped PHI face the necessity of closing CHCB's doors with both dignity and an opportunity for reflection. The lessons learned here will be deeply valued by others.

APRIL, 1994 — APRIL, 2000

Six years ago, the **Paraprofessional Healthcare Institute (PHI)** asked the foundation community to take a great risk: to help PHI start a totally new, worker-owned home health agency—**Cooperative Home Care of Boston (CHCB)**. In response, a broad range of Boston funders, including the Boston, Riley, Hyams, and Stearns foundations, the Farnsworth and Cox trusts, the Peabody Charitable Fund and Sailors Snug Harbor provided more than \$500,000 in grants over a six-year period.

In addition, these grants were matched by national foundations—particularly the Mott, Ford and Heron foundations—and public funders, including the Federal Department of Health and Human Services and the Massachusetts Department of Transitional Assistance.

PHI founded CHCB in 1994 as a for-profit, worker-owned “direct care” trainer and service provider primarily within Boston's home health industry. PHI created CHCB as a replication of the highly successful Cooperative Home Care Associates, now 15 years old and employing 550 inner-city women in the South Bronx, New York.

Our purpose in initiating Cooperative Home Care of Boston was to create a model enterprise and training program that would:

- A] Recruit and train low-income women to become “direct-care,” paraprofessional health workers; and
- B] Provide quality direct-care health services to ill, elderly and disabled clients in the Boston area.

During CHCB's six-year span, the worker-owned agency trained and employed almost exclusively inner-city women of color—the vast majority of whom had been dependent upon public assistance and were single mothers of young children. CHCB also developed a reputation within the Boston healthcare community as an exceptionally high-quality provider of paraprofessional home care services.

Unfortunately, in December of 1999, CHCB was forced to cease all operations—the 26<sup>th</sup> home care agency in Massachusetts to close in the last two years. This report provides a brief history of Cooperative Home Care of Boston, as well as an analysis of why CHCB was forced to close its doors after having successfully trained and employed more than 200 low-income women and served thousands of clients within Boston’s lowest-income communities.

## **BACKGROUND**

### **Paraprofessional Healthcare Institute**

The nonprofit PHI, headquartered in the South Bronx, is an eight-year-old, national “healthcare employment development” organization focused particularly within long-term healthcare services. The mission of PHI is twofold:

- To create decent jobs for low-income individuals, especially women who are unemployed or transitioning from welfare to work; and
- To provide high-quality healthcare to clients who are elderly, chronically ill or disabled.

PHI has linked this twofold mission through a “Quality Jobs / Quality Care” school of thought: We believe that creating quality jobs for paraprofessional workers—who provide the majority of direct-care health services—is an essential element in the provision of high-quality, cost-effective services throughout the healthcare industry.

## **HISTORY OF CHCB**

### **Start-Up and Early Profitability**

On April 22, 1994—with sponsorship from the Fenway Community Development Corporation and the United South End Settlements—CHCB began operations on Huntington Avenue, bordering Fenway and the South End. By the end of 1995, CHCB had created a highly successful training program and had become a modestly profitable provider of paraprofessional home care services.

CHCB remained profitable through 1997, growing to 72 workers with a volume of just over \$100,000 per month in revenues. During that time, CHCB worked primarily as a “subcontractor” to Federally-funded, Medicare-certified home care agencies—the certified agency provided *professional* nursing services to the client, while CHCB was contracted to provide the *paraprofessional*, or “aide-level” services. CHCB also provided some services paid for by Medicaid funds.

At its peak, CHCB's largest contractor was the Visiting Nurse Association (VNA) of Greater Boston, which used primarily Federal Medicare funding to pay for CHCB's paraprofessional home care services. In 1997, the VNA of Boston accounted for more than 80 percent of CHCB's revenues. CHCB's rapid growth with the VNA and other Boston-area contractors was attributed to the exceptionally high quality of services provided by the cooperative.

Finally, not only was CHCB successful in training low-income women for positions as home health aides, it was also successful in improving the quality of the paraprofessional's job. Home care jobs typically pay poorly, and are usually part time (averaging between 20 and 25 hours per week). In contrast, during 1997, CHCB aides averaged more than 33 hours per week, and received wages and health benefits of \$9.50 per hour—among the highest in the local market. Annual turnover of aides at CHCB was less than 30 percent annually, in comparison to between 40 and 60 percent in the rest of the home care industry.

### **Policy and Market Shifts**

Unfortunately, in 1998, CHCB began to experience the simultaneous impact of two major shifts in Federal public policy: 1] "welfare reform," which significantly harmed CHCB's training program by disrupting its recruitment systems and substantially reducing its funding; and 2] the Balanced Budget Act of 1997, which eventually resulted in the slashing of Medicare funding nationwide by 45 percent. CHCB's training program soon began to falter, and more importantly, the VNA and other customers began to limit the number of cases and lengths of visits requested of all their contractors, including CHCB.

While not the only cause attributable to CHCB's demise (see "Analysis," below), these two fundamental reversals in welfare and healthcare public policy combined to threaten the stability of the cooperative. In early 1998, CHCB began to lose money each month.

The cooperative's founding President resigned in April of 1998, replaced by Maryann Colaizzi, a registered nurse with extensive home care clinical and administrative experience in the Boston area. Unfortunately, losses continued to mount through the summer and, by the fall, CHCB was forced to suspend its entry-level training program.

### **Efforts to Diversify Market**

Throughout the remainder of 1998 and then into 1999, Ms. Colaizzi succeeded in diversifying CHCB's range of services away from its sole reliance on Medicare services. Reimbursements from the Boston VNA dropped to less than 50 percent of CHCB's revenues, in large part due to an innovative

relationship with a small network of long-term care facilities in Jamaica Plain—called the Alliance for Home Care—in which CHCB provided “temporary staff relief” to the Alliance’s nursing and retirement homes.

With additional support from national and local philanthropic sources, in particular the Amelia Peabody Charitable Fund, a limited version of the Medicare-certified entry-level training program was re-instituted. In addition, two-dozen experienced aides (who had received their certification elsewhere and thus required only “re-orientation” training) were hired.

Unfortunately throughout 1999, despite aggressive attempts to diversify contractors and recruit more staff, service volume remained low—approximately 60 to 70 percent of its high point. Of equal importance, the length of cases and visits continued to drop: The typical home care visit—which had been 2.5 hours in 1997—shrank to 1.5 hours due primarily to the changes in Medicare funding. This forced average hours to drop to approximately 27 hours per aide per week, far too little income on which to raise a family.

Therefore, turnover of staff climbed to above 40 percent annually.<sup>Ω</sup> At the same time, Boston’s full employment economy, the shrinkage of the “post baby-boom” workforce, and changes in welfare policies combined to make recruitment of new aides exceptionally difficult. As a result of these multiple forces, CHCB was unable to grow larger than 52 paraprofessional staff during its final year.

### **Decision to Close**

With volume remaining low, the cooperative’s losses mounted into the fall of 1999, threatening to erase CHCB’s initial equity investment and the earnings it had retained during the profitable years. If CHCB were to continue to stay in business for much longer, a delayed closing would likely result in an inability to pay vendors, creditors, and perhaps even employees.

Before deciding to close, one final alternative was investigated: a merger with another community-based home care program managed by the Women’s Educational and Industrial Union (WEIU). The WEIU’s home care agency was approximately the same size as CHCB, and worked with similar clients. The hope was to form a single, larger agency by combining the two workforces. Unfortunately, the leadership of the two agencies could not identify a profitable strategy to intertwine the two staffs.

---

<sup>Ω</sup> Those who left were primarily new staff—a large core of aides with greater seniority, some of whom had worked for CHCB since its inception, remained with the cooperative until its final days.



Therefore, in November of 1999, the worker owners and Board of Directors of Cooperative Home Care of Boston voted to close permanently the agency by December 31<sup>st</sup>, 1999.

### **An Honorable Conclusion**

Maryann Colaizzi, President of CHCB, generously agreed to stay with the cooperative throughout its final days and skillfully ensured a full and complete closure of the enterprise. The most important elements of the wrap-up included:

- **All CHCB employees were given at least 30 days notice of the decision to close.**<sup>9</sup> Remarkably, more than 90 percent of the staff stayed with the cooperative through the final month.
- **All CHCB home health aides who wished to remain employed secured jobs at other agencies.** CHCB arranged jobs for 33 aides: 17 with WEIU, eight with the VNA of Boston, four with long-term care facilities associated with the Alliance, and four with other home care agencies. Sixteen aides chose not to seek employment immediately.
- **Twelve CHCB aides received specialized “cross-training” in November, allowing them to take the Commonwealth’s test to become a Certified Nurse Aide (CNA).** Five of those 12 decided not to sit for the State’s test immediately, but seven took the test and passed, securing a “portable” credential allowing them to seek employment not only with home health agencies, but also in nursing homes and hospitals.
- **All CHCB clients were transferred safely and seamlessly to other home care providers—often remaining with the same aide that had served them at CHCB .** The majority of clients were assumed by either WEIU or the VNA of Boston.
- **All CHCB employees received all pay owed.** All employees also received a “severance” check of between \$50 and \$150 in recognition of their loyalty to their clients and the cooperative.
- **All CHCB worker owners, throughout the history of the cooperative, received every dollar they had invested as membership fees.**

---

<sup>9</sup> CHCB’s closure contrasts with Optimum Home Care, which shut down its operations in the Boston area in the early fall of 1999: Optimum gave its clients and 700 workers one day’s notice before closing (see *The Boston Globe*, attached).

- **All lenders to CHCB—which included a range of community- and faith-based investors—were repaid *in full*.**
- **All vendors owed money by CHCB, from the landlord to the local office-supply store, were repaid *in full*.**

We particularly wish to thank the **ICA Group of Boston**, PHI's technical assistance partner, which not only provided financial and business advice throughout the life of CHCB, but was also instrumental in ensuring the smooth closure of the enterprise.

We also thank the **Women's Educational and Industrial Union**, which worked closely with the leadership of CHCB to ensure a smooth transition of many of CHCB's clients and aides.

### **ANALYSIS OF THE CHCB CLOSURE**

Although the shutdown of CHCB can be traced most simply to fundamental changes in both healthcare and welfare public policy, the full story is more complex. Below we assess the array of factors for CHCB's closure; in the section that then follows, we also review key lessons learned from CHCB's six-year history.

#### **External Factors of Closure**

▣ **Federal Medicare Reimbursement Cuts.** In 1997, Congress passed the *Balanced Budget Act (BBA)*. Among many provisions, the BBA required significant cuts in Medicare-funded home care reimbursements. Federal policy makers feared that utilization of homecare was spinning out of control; in reaction, they demanded an immediate retrenchment.

The BBA instituted an "Interim Payment System" which capped home care agency reimbursements at, essentially, 1994 levels. While the intent of Congress was to reduce Medicare home care spending by 15 to 20 percent from 1997 through 1999, the unintended consequence over the past three years has been a devastating 45 percent cut nationwide. Agencies such as the Visiting Nurse Association of Boston thus experienced a dramatic drop in funding, which in turn eventually decreased CHCB's revenue from the VNA by about 50 percent.

Not only were the number of cases reduced, the typical length of a visit by a CHCB aide to her client dropped from 2.5 hours to about 1.5 hours. This not only decreased revenues, it made it far more difficult

for CHCB to construct full-time jobs for its aides, which in turn contributed to higher staff turnover.

▣ **State Medicaid Reimbursement Constraints.** Although CHCB primarily worked in the Federally-funded Medicare system, it also provided some in-home services that were funded by Medicaid (which is jointly funded by the Commonwealth and the Federal government).

Unfortunately, during CHCB's six years of activity, the rates for Medicaid in-home services were increased by the Massachusetts legislature only once, and only by 2.5 percent. In comparison, nursing home reimbursement rates in Massachusetts increased by more than 18 percent during the same six-year period.

▣ **Federal and State Welfare-to-Work Restrictions.** In 1996, Congress passed the *Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)*. While the intent of PRWORA was to increase "work opportunities" for welfare recipients, one result was that many established, successful training-based programs lost both public funding and a reliable source of potential recruits.

This consequence was due primarily to an ideological bias, embedded within the PRWORA, *against* entry-level, skilled-based training, preferring instead "immediate attachment" of welfare recipients to a job. Even though CHCB's program was highly effective—particularly as measured in terms of women transitioning off of public assistance who remained employed for one year or more—CHCB lost access to public training dollars. In addition, public assistance recipients were directed *away* from CHCB by their welfare case workers because any form of skilled-based training—even CHCB's, which was only four weeks long and guaranteed a job upon graduation—was not considered an approved "work activity."

In response, CHCB was forced in 1998 to suspend temporarily its entry-level training program. It could no longer afford critical elements of its model—such as a full-time counselor to help new employees adjust to employment—and it had to construct totally new recruitment strategies to find potential workers. Even when CHCB re-started its entry-level training program in 1999, that program was wholly dependent on philanthropic funds, and due to limited funding, was forced to restrict both the length and depth of the program.

▣ **Full Employment Economy and Negative Population Trends.** CHCB reacted to Medicare cuts primarily by diversifying and increasing its number and types of contracts. As a result, CHCB still experienced a demand for its services. However, this demand tended to be in the form of short-hour visits, primarily for morning care, at geographically dispersed cases—making for relatively unattractive, essentially part-time jobs.

At the same time, the full-employment economy in Massachusetts began to offer low-income women other job alternatives, typically at pay comparable to what CHCB offered, often with more secure hours and less demanding responsibilities. Simultaneously, the “post-baby-boom” workforce began to shrink—offering fewer and fewer new potential entrants into the paraprofessional home health field.

This combination of a full employment economy and a shrinking workforce dramatically increased competition for labor throughout Boston. Given that CHCB was offering relatively unattractive jobs, it experienced increasing difficulty in attracting new workers into the cooperative. Indeed, this same dynamic has created a severe labor “shortage” of direct-care health workers throughout the Northeast.

In response, CHCB hired not only entry-level workers, but also already-certified aides in an attempt to build its workforce. However, those experienced aides often kept their prior employment relationships with other agencies in order to patch together more hours of work. This weakened their ties of loyalty to the cooperative, and frequently made them unavailable for assignments from CHCB.

This “certified aide” phenomenon, along with a weakened training and support program, combined to increase staff turnover to industry norms. The result was that CHCB was unable to grow quickly enough to re-claim profitability.

### **Internal Factors of Closure**

▣ **Dynamics of the Administrative Staff.** Three years after the successful start-up of the enterprise, external pressures began to increase, and in turn the cohesion of the administrative staff began to falter. Trust among senior management was at times quite low, resulting in an excess of energy spent ineffectively addressing internal dynamics, rather than resolving mounting business concerns.

After the new CEO entered the agency near the beginning of its fifth year, the administrative staff turned over almost entirely during the following six months. This turnover caused significant operational disruption, and left the agency with relatively little historical knowledge.

▣ **Rough Management Transition.** The change of CEO, from the founding President to Maryann Colaizzi, was the first leadership succession PHI had experienced among its cooperative agencies. Although we did many things well, including keeping the home health aides involved and informed, PHI failed to provide sufficient orientation and support to Ms. Colaizzi as she worked to secure her position both within CHCB and throughout CHCB's external environment.

PHI failed to realize how different was the CHCB model for Ms. Colaizzi compared to her experience within the rest of the industry—not only in ownership structure, but in substantive areas such as training and coordination. We have now successfully applied our lessons learned in Boston to several other sites, where we have since experienced relatively smooth leadership transitions.

▣ **Inability to Re-Build a Strong Management Team.** The turnover in administrative staff noted above—at the point when the CEO position changed hands—was an opportunity to build a new senior team under new leadership. However, although the number of senior team members was quite small (only four key positions), neither the new CEO nor PHI could successfully identify strong candidates for these positions.

This inability to re-build effectively a senior management team was a critical weakness in the recovery plan. We wish to note, however, that while we list this as an “internal factor,” our inability to attract strong staff was due at least in part to the broader phenomenon of a massive exodus of administrative talent out of the home care industry—resulting primarily from the turmoil caused by the historic reversal in Medicare policies.<sup>φ</sup>

---

<sup>φ</sup> When PHI sought new leadership during its exploration of a merger between CHCB and WEIU, the top four potential candidates told us they were not only uninterested in leading a new venture, they each were trying to leave the home care industry entirely.

▣ **The Challenge of Market Diversification.** Although successful at diversifying CHCB's market beyond its early reliance on the VNA of Boston, we underestimated the new pressures that rapid diversification would place upon the internal operations of the cooperative. With systems designed initially around the needs of one primary contractor, CHCB's billing, accounting and clinical procedures soon faltered under the weight of servicing 20 different contracts.

Furthermore, PHI's central staff had not previously developed deep expertise in these "back office" and clinical matters, since all of its sites had been initially designed to function solely within a relatively simple, Medicare-funded marketplace. When diversification called for more sophisticated business and clinical support, PHI was unable to respond quickly—forcing us to seek outside, untested consulting sources as an admittedly poor alternative.

As a result, in order to maintain internal stability, Ms. Colaizzi was forced to allocate far too much of her time managing day-to-day matters, rather than focusing on CHCB's more strategic needs of market and workforce development.

In summary, six years ago an expanding, stable marketplace allowed PHI to establish CHCB with relatively few resources and only limited Boston-area experience. When Federal policy turned suddenly negative—both in welfare and home health care—the marketplace proved far less forgiving. Weaknesses that could be ignored four or five years ago could no longer be tolerated as CHCB attempted to navigate a shrinking, essentially politically-driven, marketplace.

### **LESSONS LEARNED**

PHI has drawn important lessons from both our positive and negative experiences at CHCB, lessons we are now applying at the five other existing enterprise and training sites we serve within the "Cooperative Healthcare Network."<sup>Ⓛ</sup> We are also applying these lessons to our explorations with the national Catholic Welfare-to-Work Initiative<sup>Ⓜ</sup>, which at this time is PHI's

---

<sup>Ⓛ</sup> The five sites include: *Cooperative Home Care Associates* (South Bronx, New York); *Home Care Associates* (Philadelphia, Pennsylvania); *Quality Care Partners* (Manchester, New Hampshire.); *VNA Training Institute* (Metropolitan Detroit, Michigan); and *Careers in Health Care* (Pine Bluff, Arkansas).

<sup>Ⓜ</sup> The Welfare-to-Work Initiative, a program to create new worker-owned healthcare and childcare cooperatives, is jointly sponsored by the national Catholic Campaign for Human Development, Catholic Health Association and Catholic Charities USA.

primary mechanism for exploring new site development in other parts of the country.

The most important lessons learned at CHCB include:

- 1) **A market-based business partner is essential.** Given the continuing turbulence within paraprofessional healthcare, a new, stand-alone agency has little chance of survival. Therefore, a strategic partnership with an existing, stable healthcare provider is essential, *one that will guarantee a sizeable portion of the new cooperative enterprise's service market.*

A strategic partnership is distinct from simply developing a dependence on a large, single provider, as CHCB did with the VNA of Boston. In a strategic partnership, the market-based partner engages the cooperative enterprise directly into its strategic planning for paraprofessional services. CHCB was never able to achieve that level of relationship with the VNA of Boston, and indeed, such a relationship is difficult to forge unless conceived right at the beginning as part of the start-up of the new enterprise.

- 2) **Market diversification is complex and expensive.** While CHCB was wise to diversify its base of services—among different providers within home care services, as well as toward other paraprofessional services such as staff relief in nursing homes—such diversification requires a high level of sophisticated “back office” and clinical capacities. These capacities require not only expertise, but also sufficient revenues to cover the resulting overhead.

Providing staff relief to facilities creates an additional challenge: It increases the risk that the cooperative's highest-quality aides will be lured away to employment within those facilities. While this may be best for the individual employee, the cooperative must be confident it has a sufficient inflow of new participants to replace exiting workers.

- 3) **Scale matters.** The primary result of the reversal in Federal policy toward home care services is an increasing consolidation of the industry—reimbursements are now so low that more than 30 percent of all Medicare home care agencies nationwide have been forced to close or merge. A secondary result for paraprofessional providers such as CHCB was, as we have seen, the necessity to diversify away from a sole reliance on publicly-funded home care services.

Both factors lead inevitably to the conclusion that a small agency, unless heavily subsidized, is unlikely to survive within the emerging paraprofessional marketplace: Where CHCB could be profitable at 65 aides three

years ago, a new agency today must likely grow to at least 100 aides—and preferably twice that size—to be profitable and truly stable.

- 4) **A single entrepreneurial leader is insufficient.** The multiple business and social goals of an agency such as CHCB, particularly when implemented within a hostile marketplace, will wear down the best of leaders if forced to work essentially alone. No matter how strong the support from PHI's central staff, we have now concluded that leadership within these enterprises must be shared by at least two strong, entrepreneurial individuals employed *inside* the agency—"partners" who can strategize together. They, in turn, must then build a strong management team.

As noted earlier, however, this challenge of building breadth within management staff is particularly difficult within an industry experiencing an exodus of leadership due to the chaos of public health and welfare policy.

- 5) **Recruitment of participants is fast becoming a limiting factor for community-based organizations.** Dramatic changes in demographics in the United States—particularly here in the Northeast<sup>β</sup>—coupled with disruptions in welfare-to-work and workforce recruitment systems—have made the recruitment of low-income participants one of the greatest challenges facing community-based training and employment programs nationwide.

Increased competition for labor throughout the economy offers new opportunities for those hoping to improve employment prospects for low-income workers. However, the bollixing of recruitment systems by public welfare and workforce agencies—due to a horrific mix of ill-conceived policy and bureaucratic implementation—has crippled the capacity of community-based training agencies to recruit and support effectively low-income individuals seeking decent, long-term employment.

- 6) **Programmatically, PHI's enterprise model requires a full training/development capacity.** Facing a retrenchment in home care funding and reversals in welfare policies, CHCB cut back its overhead and restricted its training program in order to survive. Lost, therefore, were many essential elements of our training/development model: We were forced to rely too heavily on already-certified aides who proved less reliable than aides we trained ourselves; our entry-level training program was shortened from four

---

<sup>β</sup> Demographic pressures are particularly acute in the long-term healthcare field. Over the next 25 years, the elderly in Massachusetts will increase by nearly 50 percent, while "traditional" caregivers—women between the ages of 25 and 54—will literally decrease by seven percent.



weeks to three; and we could no longer afford employment of a counselor to help new employees transition from welfare to work.

The inevitable result was that aide turnover at CHCB—which had been exceptionally low during the more stable years—climbed back toward the industry average. High staff turnover is devastating, not only to the enterprise, but also to the cooperative’s goal of strengthening the link between the quality of the job and the quality of the resulting care. Our conclusion, therefore, is that a full complement of training and development capacities is necessary if we hope to meet both the business and social missions of PHI’s enterprise strategy.

7) ***Financially, PHI’s model requires the dual presence of an enterprise and a training/development capacity.*** From a financial perspective, CHCB can be thought of as two businesses: a healthcare service provider and a workforce training provider. Combining these two “businesses” within a single agency lies at the heart of PHI’s strategy, for it allows both a sharing of overhead and the recruitment of a larger, and deeper, management team. Without revenues from both “businesses,” the cooperative as a whole will falter.

Total reliance on philanthropic funding for the training portion of the agency is a temporary tactic at best. Consistent, rational support from public welfare-to-work and workforce development agencies is essential for the PHI model to thrive—a likelihood dependent, however, upon a significant change in workforce public policy.

## CONCLUSION

We are proud of CHCB’s accomplishments—the 200 inner-city women whom we trained and employed, the thousands of low-income, home-bound clients they in turn served, and the reputation we forged within Boston’s healthcare community. We are also proud that—with strong training, counseling, supervision and full-time employment—we proved our two initial premises: that we can create decent healthcare jobs for low-income women transitioning from public assistance, and that they, in turn, can provide excellent care.

Unfortunately, abrupt changes in public policy undermined CHCB just as it was beginning to flourish. Welfare policy and healthcare policy, at both the state and Federal levels, constricted rather than encouraged the link between creating quality jobs and quality care.

Fortunately, what remains for PHI in Massachusetts is our effort to challenge these policy reversals: PHI now employs a full-time policy advocate in Massachusetts, Ms. Barbara Frank. In one short year, Ms. Frank has succeeded in

creating strong links among the three key stakeholders—consumers, providers and labor—who are impacted by paraprofessional healthcare and welfare policies. For example, PHI has been commissioned by the Institute of Health Policy at Brandeis' Heller School to provide an analysis of the healthcare workforce crisis for the Institute's Health Policy Forum to be held this June.

In fact, the current shortage of healthcare workers has created a rare opportunity: to forge common ground among key stakeholders and to gain the attention of public policy makers. For unless welfare and healthcare policies change and become more fully integrated, the quality of paraprofessional jobs and the resulting quality of care will continue to deteriorate across the Commonwealth—and throughout the nation.

We wish to thank the Boston-area and national funding communities for your willingness to support the Paraprofessional Healthcare Institute in our effort to forge the link between the quality of healthcare jobs and the quality of the resulting care. Most importantly, your consistent support has helped PHI to face the necessity of closing CHCB's doors with both dignity and the opportunity for reflection. The lessons learned here will be deeply valued by others.

