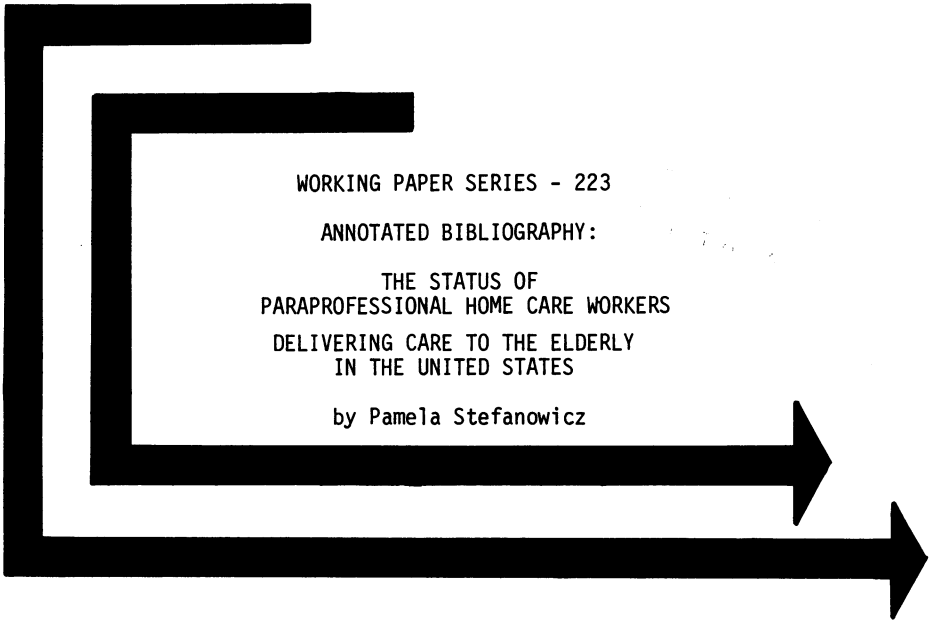

WORKING PAPER SERIES - 223

ANNOTATED BIBLIOGRAPHY:

THE STATUS OF PARAPROFESSIONAL HOME CARE WORKERS DELIVERING CARE TO THE ELDERLY IN THE UNITED STATES

by Pamela Stefanowicz

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DRAFT: 1992

INSTITUTE OF INDUSTRIAL RELATIONS

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INTRODUCTION

Home care for the frail elderly is increasing dramatically. Fueled by public policy and many private initiatives and widely supported by popular opinion, home care is often advocated as an ideal alternative to institutionalization. Nevertheless, little is known about the paraprofessional home care workers who deliver a large proportion of home care services. These workers provide the bulk of paid care in the form of help with housecleaning, shopping, meal preparation, transportation, companionship, and, in some cases, even medical care.

This annotated bibliography focuses on the working conditions of home care workers. The literature on home care workers can be difficult to locate for several reasons. First, home care services have historically developed under the auspices of separate social welfare and medical programs and workers provide both social and medical services. Relevant material can be found in both the social welfare and health care fields. Second, home care is delivered by a variety of personnel, including registered nurses, specialists, and paraprofessional workers. Computer searches are generally inadequate in distinguishing articles based on the kind of personnel or services involved in home care. Third, home care workers themselves go by a variety of terms -- homemaker-home health aide, chore worker, homemaker, aide, companion, etc. Although the terms "home care worker" and "paraprofessional" are becoming more widespread, the lack of a single occupational title makes it difficult to locate appropriate literature. Finally, some of most recent and valuable information available is not yet published or easily accessible.

While this bibliography focuses on the working conditions of home care, many references are also included because they discuss the public and private policy changes which impact these working conditions. The literature also includes articles based mainly on anecdotal evidence and personal experience. These are included for two major reasons. First, because there has been only limited research to date, articles containing personal observations may be the only information published concerning a particular aspect of home care work. For example, a few articles contain anecdotal evidence that agencies have problems placing male home care workers, an issue not yet addressed in home care studies. Second, the articles themselves often provide primary material in documenting the concerns of home care agencies and workers. For instance, only a few studies have documented home care agencies' efforts to reduce worker turnover. Some of the articles written by home care agency representatives provide additional documentation of the attempts to improve worker retention.

Hopefully, this annotated bibliography will prove helpful in identifying some of the gaps in the literature on home care

workers. There is virtually no research on the occupational hazards faced by home care workers in dealing with bodily fluids or potentially dangerous household cleaning products. An unknown, but probably very large proportion of home care is delivered by workers who are hired and paid directly by their elderly clients. Unfortunately, this market segment is rarely even acknowledged in the home care literature and very little is known about the working conditions of home care workers in these situations.

Aalberts, Nola.
(1988).

"The Outlook for Home Health Paraprofessionals," Caring, May, 7(5):20-23.

In this article, Aalberts reviews the status of the home care worker, focusing on the current worker shortage. The author suggests that administrators contributed to the shortage using hiring practices premised on the belief that it was less expensive to recruit new workers than to retain workers through increased salaries. Various steps being taken to improve the retention of home care workers are described. Some states are developing standardized training programs, titles, and definitions. In Southern California, some agencies have formed a coalition to provide special inservice training for aides. A few states are considering allowing Aid for Families with Dependent Children (AFDC) recipients to retain their Medicaid benefits while working as homemaker-home health aides. Massachusetts has established a wage-benefit package for aides working in state-funded programs at a rate of slightly over $7.41 per hour. Worker-owned agencies give homemaker-home health aides the opportunity to buy into their agency and participate in all levels of decision making. Union activity has resulted in wage increases, especially in New York. Aalberts suggests other possible actions, such as implementing standardized working hours, providing specialized training for certain target groups, assigning trouble shooters to help workers with problems, changing the image of the paraprofessional, developing shared aide programs, and interagency collaboration in the utilization of personnel for training or enrichment programs.

Aalberts, Nola.
(1989).

"Training Home Care Paraprofessionals," Caring, February, 8(2):26-27.

Aalberts argues that while training and education are crucial to the provision of quality home care service, they are often overlooked with respect to paraprofessionals and supervisors. The article discusses the benefits of training, such as increased self-confidence and skill improvement. The training process can also serve as a screening tool for home care agencies. The author provides a summary of the National HomeCaring Council's recommendations for

training and places emphasis on the need for in-service training.

Applebaum, Robert; Phillips, Paul. (1990).

"Assuring the Quality of In-Home Care: The "Other" Challenge for Long-Term Care," The Gerontologist, 30(4):444-450.

Applebaum and Phillips note that although the growth of in-home care has been praised for expanding long-term care options for people with chronic disabilities, concerns regarding the quality of in-home care are emerging. The authors discuss six critical factors that complicate efforts to assure quality, including client and provider characteristics, fiscal constraints, inadequate regulation, the lack of quality assurance methods, and the absence of a coherent social policy for long-term care. The authors then identify three areas of policy that need to be addressed: (1) changes in allocation priorities, including higher wages for workers; (2) new approaches to quality assurance, such as incorporating quality assurance mechanisms into agency operating procedures; and (3) expanded research on quality of care.

Arnold, Diane. (1987).

"The Brokerage Model of Long-Term Care: A Rose by Any Other Name," Home Health Care Services Quarterly, Summer, 8(2):23-43.

Arnold reports that the evolution of the organization of long-term care services in the United States has resulted in a fragmented non-system of long-term care for the elderly. One solution which has been proposed is to coordinate services through a pure brokerage model of service organization. Arnold argues, however, that such a model cannot meet the criteria for a fully coordinated system because it does not restructure the current organization of services. Arnold analyzes the limited impact of the brokerage model on service availability, concluding that brokers can do little to increase the supply of labor or other needed services because they do not control financing. Instead, Arnold advocates a consolidated model that will restructure and reform the system.

Atkins, Bobbie J.; Meyer, Ann B.; Smith, Nancy K. (1982).

"Personal Care Attendants: Attitudes and Factors Contributing to Job Satisfaction," Journal of Rehabilitation, 3:20-24.

This is a report on a job satisfaction study of 56 personal care attendants who had been referred by a center for Independent Living in Wisconsin between 1978 and 1980. Of those attendants surveyed, 54 percent were still working as attendants, 86 percent were female, 43 percent were under 27 years of age, 98 were Caucasian, and 88 percent worked for employers of same ethnic heritage. The results indicated that the job aspects the attendants liked best were: being able to help others (38 percent), doing something worthwhile (36 percent), working with people who made the attendants' own problems seem smaller (11 percent), and the salary (nine percent). The job aspects liked least included: the low salary (27 percent), lack of fringe benefits (18 percent), odd hours (14 percent), boring routine (nine percent), and too much responsibility (seven percent). Contrary to the authors' expectations, none of the following characteristics correlated with employment tenure: ascendancy, responsibility, emotional stability, personal relations, vigor, attitudes toward the disabled, pay compared to previous jobs, or percentage of time employers engaged in independent social or work activities without their attendants. The article concludes with suggestions to improve the working conditions of attendants.

Auditor General of California. (1987).

The Department of Social Services Could Reduce Costs and Improve Compliance with Regulations of the In-Home Supportive Services Program (Sacramento, California: Office of the Auditor General).

This report contains the findings of the Office of the Auditor General concerning the Department of Social Services' In-Home Supportive Services program (IHSS). A number of abuses of the program are reported, including the overpayment by some counties to providers and the failure of some counties to reassess clients at least every 12 months. Noting that state law does not authorize the county welfare departments to screen providers, the Auditor General reports on its investigation of the criminal records of both individual and contract providers. Based on this

review, the Auditor General estimated that 709 of the 11,083 providers (6.4 percent) in three counties had been convicted of crimes such as murder, assault with a deadly weapon, using and selling dangerous drugs, and petty theft. Various recommendations are made to the Department of Social Services with respect to reducing the cost of the program, complying with the program's regulations, and screening providers. Finally, the report contains the Department of Social Services' response to the Auditor General's recommendations.

Auman, Jane; Conry, Robert.
(1984/1985).

"An Evaluation of the Role, Theory, and Practice of the Occupation of Homemaker," Home Health Care Services Quarterly, Fall/Winter, 5(3/4):135-158.

This 1981 study conducted in British Columbia focused on the congruency between what the homemaker is trained to do and what he or she actually does are reported in this article. Research included the content analysis of client files from 1976 through 1980. Homemaker supervisors were interviewed about the discrepancies appearing in the files. Congruence was found in the areas of ambulate client, help dress, help bathe, care for children, clean, do laundry, prepare meals, and shop for groceries. Discrepancies between training and practice appeared in the area of: monitor client's state of health, assist with medication, and replace home care nurse on a temporary basis. Moreover, the authors found that the role of the homemaker had changed significantly between 1976 and 1980 and that increasing demands were being placed on the homemaker, especially because clients were becoming older. The homemaker has taken on the role of a "Good Samaritan," increasingly performing tasks aside the scope of her job.

Austin, Carol D.
(1990).

"Yes, But Who Will Deliver the Care?," The Gerontologist, 30(1):134-135.

Austin reviews The Management of Home Care Services, by Stephen Crystal, Camilla Flemming, Pearl Beck, Geraldine Smolka, and the Home Care Fiscal Management Consortium, Springer Publishing Company, New York, New York, 1987. She criticizes the focus of this book on innovative fiscal and program management practices because it overlooks a more fundamental concern, the inadequate supply of workers. She compares this to the

recent focus on developing assessment instruments for use in home care programs, resulting in sophisticated assessment methodologies while services remain generally unavailable. Continued reliance on the entry-level pool of workers, as well as increasingly restrictive immigration policies, will have limited impact on the labor shortage and a more fruitful approach would be one which recognizes the growing numbers of older workers, aged 62-70.

Barker, Judith C.; Mitteness, Linda S. (1990).

"Invisible Caregivers in the Spotlight: Non-Kin Caregivers of Frail Older Adults," in The Home Care Experience: Ethnography and Policy, Gubrium, Jaber F.; Sankar, Andrea (eds), pp. 101-127 (Newbury Park, California: Sage Publications).

Barker and Mitteness present the findings of a qualitative study of non-kin caregivers, comparing the results with those expected by family theory. The sample of 212 clients was drawn from large, Medicare-certified, urban, home health agency. Semistructured interviews revealed that 14% of the sample had non-kin caregivers, similar to the proportions found in other studies. Family theory suggests that non-kin caregiving is likely to be instrumental rather than personal in nature and that it will not be sustained on a long-term basis. In this study, however, one-third of the relationships lasted five years or more. Most of these started as light-care cases that gradually required more care. Non-kin caregivers were found to be undertaking many personal care tasks. As in the case of family caregivers, male non-kin caregivers tended to provide aid in transportation, financial, and other more instrumental areas, although some provided personal care. The caregivers described the rewards as intangible. The authors suggest that these non-kin caregivers differ from paid workers in that paid helpers are trained and perform limited and clearly specified duties. For non-kin caregivers, there are few limits on the kinds of tasks undertaken or the time involved. Non-kin caregivers attempt to construct and present their relationship with the dependent as one of kin, which may, in part, explain how they are able to maintain long-term relationships.

Bartoldus, Ellen; Gillery, Beth; Sturges, Phyllis J. (1989).

"Job-related Stress and Coping Among Home-Care Workers with Elderly People," Health and Social Work, August, 14(3):204-210.

The authors note that little is known about the job-related stress of home-care workers from the point of view of the workers themselves. Thirty-two home-care workers from six community-based, home-care programs sponsored by New York area Catholic Charities agencies were studied. The subjects were predominantly female, white, observant Christians, with a median age of 49 years. Workers were paid between $4.00 and $4.48 per hour. The scores from the Tedium Scale revealed little self-reported stress. Nevertheless, workers in six discussion groups mentioned many stressful aspects of their jobs. Shopping was considered the most conflict-ridden activity because of "the interactions between clients and workers over issues of what to buy, how much to pay, and money given and change returned" (p. 206). Traveling between clients and time constraints were also considered stressful. The subjects considered the clients, especially demanding clients, as more stressful than the tasks involved. Coping strategies appeared to include denial, identification with clients, and altruism. Limit setting was infrequently mentioned as a coping strategy. Low pay was the workers' primary dissatisfaction. The workers felt that the general public viewed them as "unskilled maids." The authors conclude by suggesting ways that social workers, administrators, and supervisors can improve their work with home-care workers and by encouraging advocacy and social action on behalf of the workers.

Bell, Grace W. (1962).

"Homemaker Service -- National Developments," in The Homemaker in Public Welfare, Public Welfare Project on Aging (ed), pp. 1-10 (Chicago, Illinois: American Public Welfare Association).

Bell discusses changes occurring in homemaker services by providing a history of the services and policies up to the early 1960s. Prior to 1955, comparatively few homemaker services served the elderly; however, over the years, services for the elderly have been expanding more rapidly than services for other groups. Homemaker services have been encouraged by several federal programs. Public law 87-395 provided almost $3 million

for Public Health Services studies, experiments, and demonstrations of out-of-hospital health services, with particular emphasis on the needs of the aging and chronically ill. Nevertheless, homemaker services often have been limited in scope. The legislative history of the development of medical assistance for the aged program reveals that the House Ways and Means Committee specifically excluded homemaker services from the definition of home health care services. The Bureau of Family Services policy attempted to define the extent to which medical care in public assistance could include personal care by home health aides, adopting a restrictive view in order to get federal financial support. The policy excluded homemaker services and concentrated on personal care services given under the supervision of a nurse or physician. Bell concludes with a statement expressing the need for expansion of homemaker services, along with adequate safeguards and standards.

Bell, Stephen H.; Burstein, Nancy R.; Orr, Larry L. (1987).

"Overview of Evaluation Results: Evaluation of the AFDC Homemaker-Home Health Aide Demonstrations," (Cambridge, Massachusetts: Abt Associates, Inc.).

This is one of Abt Associates' evaluation reports of the AFDC Homemaker-Home Health Aide Demonstrations. The demonstrations were designed to test the feasibility of training Aid to Families with Dependent Children (AFDC) recipients to provide homemaker-home health aide services to functionally impaired persons in their own homes. The seven demonstrations projects (conducted in Arkansas, Kentucky, New Jersey, New York, Ohio, South Carolina, and Texas) ran between January, 1983 and June, 1986. Results indicated that the projects significantly increased the amount of formal care received in every state, without affecting the proportion of clients who received care from members of their own households. While there were no demonstratable effects on survival or utilization of hospitals, nursing homes, or medical care, the evaluators did find significant beneficial effects on several measures of client health and functioning and on met client needs. The demonstrations also increased trainee employment and earnings, both through participation in the demonstration employment as well as from increased success in regular, nondemonstration employment.

Benjamin, A. E.
(1986).

"Trends and Issues in the Provision of Home Health Care: Local Governments in a Competitive Environment," Journal of Public Health Policy, Winter, 480-494.

Benjamin describes changes in the environment of home health care in the 1980s and considers how these changes have affected the ways in which local governmental agencies deliver home care. The author begins by providing a comprehensive overview of major changes in the home care market and policy, citing the predominance of Medicare as a payer for licensed home health agencies, the increasing demand for home health services, the reluctance of third party payers to cover home health, and the growth in proprietary agencies. The author compares the behavior public and private agencies, noting that all agencies must now compete for both individual clients and for formal referral agreements with hospitals and physician groups. Public home health agencies, on the average, provide fewer agency visits per user than private agencies and are less expensive, both in terms of visit charges and reimbursements. Public agencies tend to offer fewer specialized services and employ fewer special therapists and home health aides than private agencies. Nevertheless, public agencies also tend to offer a broader range of related services such as case finding, case management, and coordination of care than private agencies. The data for California indicate that public agencies have a lower percentage of their visits reimbursed by Medicare than private agencies, although even public agencies are highly reliant on Medicare payments. Public agencies are more dependent on reimbursement from the Medicaid program. Benjamin suggests that there are two types of public agencies. One is the "last resort" agency, responsive to state Medicaid clients, while the other type relies on Medicare and private pay. In regard to a general understanding of home care services, the author notes that is difficult to generalize across states because of differences in state licensure requirements and certificate-of-need (CON) legislation with respect to home care, as well as the variability in the fiscal health of state and local treasuries. In many areas, public home health agencies currently contract for services; however, as these contract agencies face increased competition, it may become problematic for them to accept referrals from public agencies when reimbursement is inadequate.

Berger, Raymond M.; Anderson, Steve.
(1984).

"The In-Home Worker: Serving the Frail Elderly," Social Work, 29:456-461.

Berger and Anderson discuss a study which addressed many of the problems of home care, focusing on the inadequate training of home care workers. In 1980, the Illinois Department on Aging contracted with the School of Social Work at the University of Illinois to provide training to all in-home workers employed through the Community Care Program. As part of the development of the training program, a study was conducted to develop a typology of problematic interpersonal situations, defined as any life task that demands some motoric, verbal, or cognitive response on the part of the person and whose solution is not readily apparent. In-person and telephone interviews were conducted with agency directors and some supervisors, followed by more in-depth interviews with supervisors of stratified, randomly selected agencies. The supervisors came up with a total of 98 problematic situations. The researchers developed a typology consisting of five groups: four major interpersonal problems and one type of intrapersonal problem. The four types are: (1) how to respond to requests and complaints; (2) how to initiate requests and influence the other; (3) how to respond to interpersonal behaviors that impede completion of assigned tasks; (4) how to respond to situations that threaten the immediate well-being of the client; and (5) how to cope with feelings of not being able to do enough. The researchers suggest that was has been labeled as "burnout" results from the failure of the worker to successfully resolve these kinds of problematic interpersonal situations. The author concludes with suggestions for training, assessment, and supervision of clients and workers.

Bergthold, Linda A.; Estes, Carroll L.; Spohn, Pamela Hanes; Swan, James H.
(1988).

"Running as Fast as They Can: Organizational Changes in Home Health Care," in Organizational and Community Responses to Medicare Policy: Consequences for Health and Social Services for the Elderly, Final Report, Estes, Carroll L.; Wood, Juanita B.; Associates (eds), pp. 60-90 (San Francisco, California: Institute for Health & Aging, University of California, San Francisco).

This paper reports on a study regarding the organizational changes occurring in home care agencies.

The authors begin by arguing that the changes in Medicare policy, tax reform laws, and certain regulatory modifications in the Medicare program have significantly affected the growth rate and restructuring activities of home health organizations. The study sample included a total of 166 randomly selected home health agencies in nine metropolitan areas of five states (California, Florida, Washington, Texas, and Pennsylvania). The major findings were that: (1) there are more for-profit agencies entering and leaving the market than nonprofit or voluntary agencies; (2) an overwhelming majority of the changes in organizational structure are in the direction of greater complexity and affiliation with larger systems; (3) most of the tax status changes are from nonprofit to for-profit, although by 1987 tax status changes appeared to have levelled off; and (4) the majority of agencies are looking for ways to reduce their reliance on Medicare as a reimbursement source.

Bergthold, Linda A.; Estes, Carroll L; Villanueva, Augusta. (1988).

"Public Light and Private Dark: The Privatisation of Home Health Services for the Elderly in the U.S.," in Organizational and Community Responses to Medicare Policy: Consequences for Health and Social Services for the Elderly, Final Report, Estes, Carroll L.; Wood, Juanita B.; Associates (eds), pp. 1-29 (San Francisco, California: Institute for Health & Aging, University of California, San Francisco).

Bergthold, Estes, and Villanueva review several definitions of privatization, outline selected strategies of privatization, suggest the consequences of such changes, and make recommendations on how to assess the trends, utilizing empirical data from research on the impact of medical cost containment and privatization on home health care in the United States. In home health, there has been a strong trend of replacement of public and nonprofit entities by for-profits. There has also been a trend toward informalization of care for the elderly. In particular, Medicare's prospective payment system program reduced hospital stays, transferring much of the care from the hospital to the home. Privatization of home care has also occurred through "reduction," including: (1) state defunding or the reduction in the amount of public funds directed toward certain services, and (2) policies that effectively shift the reliance of organizations away from state and toward private funding sources. Home care has been further privatized through "attrition," which involves a

gradual disappearance or loss of legitimacy. In addition, home health services are becoming increasingly privatized in that: (1) for-profit agencies are expanding at a rate greater than that of nonprofit or public agencies, (2) for-profit agencies are successfully targeting private funding sources, and (3) the market is becoming increasingly segmented, with the for-profits being more likely to refuse services to certain types of clients, especially on the basis on the client's ability to pay, than the other types of agencies.

Berkowitz, Lois.
(1986).

"Homemaker-Home Health Aide," Caring, August, 5(8):62-65, 68.

In this article, Berkowitz describes the homemaker-home health aide services offered by Homemaker Health Aide Service (HHAS), a United Way agency, in Washington, D.C. The author, who is the director of the program, notes that community home care needs have changed dramatically since the program was established in 1958. At that time, the urgent need was care for children during a family crisis. Now, the greatest need is at-home care for the frail elderly. In a recent year, 90% of HHAS's clients were over age 60. The article contains many examples of the types clients receiving care, illustrating the range of services that homemaker-home health aides provide.

Bittel, Eileen McCarroll.
(1989).

"A Century of Caring: The Visiting Nurse Association of Brooklyn," Home Healthcare Nurse, November/December, 7(6):31-36.

This is an historical overview of the Visiting Nurse Association of Brooklyn, Inc., New York. In the United States, the practice of visiting nursing began in 1877, when the women's branch of the New York City Mission sent its first trained nurses into the homes of the indigent. The VNA of Brooklyn started in 1888 as a self-supporting, self-governing organization whose purpose was to care for the sick in their homes and to teach hygiene. In 1890, the agency had sufficient funds to hire its first nurse. By that time, 21 organizations in the United States were engaged in visiting nursing, most employing no more than one nurse.

Boies, Annette H.
(1987).

"Role of the Home Health Aide in the Rehabilitation Process," Home Healthcare Nurse, November/December, 5(6):44-45.

In this article, Boies calls for greater recognition of the role of the home health aide. Boies notes that a home health aide who is appropriately trained and professionally supervised can enhance the efforts of the various services prescribed in the plan of treatment without undermining the patient's/family's independence. Boies suggests that an ongoing dialogue between the aide and the professional will permit recognition of the aide's contribution while also providing the aide with an opportunity for continued learning.

Bowers, Barbara; Musser, Karen.
(1987/1988).

"Changing Home Health Care Marketplace in Wisconsin," Home Health Care Services Quarterly, Winter, 8(4):5-24.

The authors surveyed the 148 certified home health agencies in Wisconsin, focusing on changes in the type of services provided and access. Forty-five percent of the agencies that were mailed surveys responded: 32 agencies were public; 20, nonprofit; and 15, proprietary. The study also included 35 open-ended interviews with providers from the three types of agencies and other knowledgeable persons. Providers cited as the major reasons for limiting access to home health care: (1) the changing interpretations of Medicare regulations, resulting in increased reimbursement denials; (2) the growth of hospital-based home health agencies which keep for themselves the discharged patients who are able to pay for services; and (3) the growth of Health Maintenance Organizations, which tend to have limited home health benefits. The type of care varies by agency. Forty seven percent of public agency visits, 53 percent of nonprofit agency visits, and 76 percent of proprietary agency visits are for nonskilled care. Most self-pay is for nonskilled care. Proprietary agencies report being the most adversely affected by the competition between agencies. Traditionally, the agencies saw the nonprofit/proprietary relationship as complementary, with the public and nonprofit agencies providing intermittent service for 1 to 1-1/2 hours, while proprietary agencies have tended to provide continuous service for a minimum of four hours. County or public

providers also cited problems unique to them: high percentages of Medicaid patients with inadequate reimbursement, large numbers of rural, indigent and hard-to-care for patients, high labor costs, poor public image, inflexible and unresponsive government bureaucracy, and their commitment to provide high quality care regardless of ability to pay.

Canalis, Donna M.; Coe, Ann E. (1986).

"Tri-Care and Home Helps: New Approaches to Home Care," Caring, August, 5(8):66-67.

This article describes the services of Visiting Nurse And Home Care, Inc., the largest private visiting nurse agency in Connecticut. It is comprised of four previously independent institutions which merged and now provide a full range of patient-oriented services. There are three major home care worker programs. Homemaker-Home Health Aide (HMHHA) services were established during the 1960s. Certification as a HMHHA by the State of Connecticut requires a completion of a 60-hour state-approved or sponsored training program, 160 hours of on-the-job training and at least four hours of in-service training, as well as 10-15 hours of orientation by the agency. As a result of Medicare cutbacks, the agency developed a new program, "Tri-Care," which provides home health aide care, skilled nursing, and homemaking. This service is offered for a minimum of three hours and at a rate lower than health aide service. The worker provides both personal care and homemaking services. The agency has also established a Home Help program. Home help employees are provided with 10 hours of training and the cost is lower than that of a home health aide or Tri-Care.

Canalis, Donna M. (1987).

"Homemaker-Home Health Aide Attrition: Methods of Prevention," Caring, April, 6(4):85-89.

This article discusses many of the policies and programs in place for Homemaker/Home Health Aides (HMHHAs) working for Visiting Nurse and Home Care in Hartford, Connecticut. Canalis writes based on her discussions over a six-year period with HMHHAs from that agency and conversations with employees from other agencies. The agency employs 150 HMHHAs. The predominant reasons for HMHHA attrition include: inadequate pay, lack of benefits, no opportunities for professional advancement, no recognition, isolation,

burnout due to job stress, and personal problems. The agency has responded with programs such as a career ladder and benefit eligibility after one year. Because the agency found that caring for the same client over an extended period of time was especially stressful, particularly if the care is complex and the patient care needs are demanding, the agency assigns aides to those clients on a rotating basis.

Canalis, Donna M.
(1989).

"Homemaker-Home Health Aide: Interruption of Services -- Methods of Prevention and Control," Caring, September, 8(9):52-55.

Canalis summarizes the preliminary findings of the National Association for Home Care's survey of home care agencies on recruitment and retention. She offers various suggestions to improve retention by changes in the following areas: benefits, salary, dealing with personal/family problems, transportation, commitment and responsibility, burnout, and child care. The article also discusses policies and programs that agencies can implement to reduce interruption of service, such as establishing back-up plans and using teams.

Caring.
(1988).

"An Overview: Home Care Services -- Part, Present & Future," December, 7(12):4-7.

This is a brief overview of the history, services, and financing of home care. The roots of home care services go back to visits made to the sick poor by religious orders. The article identifies and describes the development of home care in three settings: hospital-based home care services, community-based home care services, and homemaker services under the auspices of family agencies. The article also describes the various sources of funding: private contributions, United Way, local health and welfare departments, and fees.

Caring.
(1988).

"Homemaker-Home Health Aide Services," December, 7(12):10-11.

This article describes the range of activities performed by home care workers, as well as the variety of clients served by such workers. The author expected national certification standards to be implemented shortly because the Foundation for Hospice and Homecare's National HomeCaring Council had received a $118,000 grant from the Federal Administration on Aging to develop a national certification program for homemaker-home health aides.

Cashman, John W.
(1969).

"Special Implications of Public Law 89-97, Title XVIII," in Readings in Homemaker Service: Selected Papers Presenting the Background, Uses and Practices of Homemaker-Home Health Aide Programs, National Council for Homemaker Services (ed), pp. 104-108 (New York).

This article, written a few years after the enactment of Medicare, discusses the problems faced by agencies in attempting to meet Medicare requirements for certification. Problems include the lack of experience and know-how concerning the effective use of medical advisory boards, a shortage of many of the kinds of personnel needed to staff a certified agency, outmoded personnel policies, including state and local civil service requirements for full-time staff, difficulties in working with other agencies, long-standing inattention to record-keeping, financial problems, and failing to understand the 24 conditions of participation.

Cherry, Nancy M.
(1988).

"The Role of Official Tax-Supported Agencies in Home Care," The Nursing Clinics of North America, June, 23(2):431-434.

Cherry discusses how the role of the tax-supported, official public health agency has changed with respect to home care, comparing voluntary, nonprofit agencies with public agencies. Nonprofit agencies are operated by a Board of Directors and an executive director, with a specific, narrow focus. In contrast, public agencies are controlled by a political structure, with elected community leaders, and have multiple responsibilities,

making it difficult to focus solely on home care. The author suggests that while public health agencies will remain a stable source of care for the low-income, these agencies will need to collaborate with private agencies in the future.

Chichin, Eileen.
(1989).

"Community Care for the Frail Elderly: The Case of Non-Professional Home Care Workers," Women's Health, 14(3-4):93-104.

This article reviews the current research on home care workers, summarizing many of the issues that have been raised in the literature, and then suggests lines for further research and policy. In the United States, it is estimated that there is one homemaker-home health aide to every 1,000 citizens, while Sweden, Norway and the Netherlands have one home care worker for every 100 citizens. The one study to date which focused on the work situation of the home care worker (Donovan, 1986) suggests that almost half of all home care workers are foreign-born and almost all are female. The actual role and definition of home care workers is confusing and ambiguous. This lack of a clear definition causes role conflict for the worker when clients and staff have differing expectations. Although home care workers are faced with enormous responsibilities, much of home care work is seen as unpleasant, demanding or menial. Home care workers suffer a variety of problems in the work place. Besides caring for clients who may suffer from a range of physical conditions or functional limitations, they must also deal with different and sometimes difficult personalities. They may be subject to verbal abuse or be asked to do things that are not part of the job. Opportunities for job advancement are minimal or non-existent. In addition to inadequate supervision and training, low wages are a major problem. The currently fragmented system needs to be replaced by a vertical career ladder. Research is needed to understand what contributes to a successful match between workers and clients. On-site supervision is needed to prevent problems from developing into crises. At the national level, there is a need for comprehensive long-term care policies which would incorporate home care for frail elderly into a system of other necessary services.

Chichin, Eileen R.
(1991).

"The Treatment of Paraprofessional Workers in the Home," Pride Institute Journal of Long Term Home Health Care, 10(1):26-35.

Chichin reports the results of a study on the working conditions of home care workers, focusing specifically on abuse of workers. The study was undertaken by Marjorie Cantor and her colleagues at the Brookdale Research Institute on Aging of the Third Age Center at Fordham University. The final sample consisted of 306 home attendants and 181 home health aides selected randomly from biweekly payroll sheets provided by the seven agencies providing these services in New York City. The interview schedule consisted of both single items developed just for this study and a variety of standardized job satisfaction and psychological scales. The surveys were administered during two-hour face-to-face interviews and were supplemented by a smaller qualitative study in which several small groups were interviewed. With respect to treatment of the workers by clients and their families, the researchers found that two forms of harassment or negative experiences were reported with relative frequency. Forty percent of the respondents stated that they had been in situations where they were expected to do things that were not part of the job. Twenty percent reported being faced with client drunkenness or drug abuse on the job. Other types of harassment were reported less frequently. The study also asked about client behavior. Only three forms of client behavior which may be considered problematic were reported by the workers. About one-third of the workers reported their clients had sleep problems, 30 percent had depressed clients, and about 25 percent cared for clients who were confused. In general, workers characterized these situations as mild problems to presenting no difficulty at all. The single behavior found to be the most offensive was bossiness on the part of the client, with 15 percent of the workers complaining that their clients were bossy. In general, the study found that workers reported that positive things happened frequently, and the overwhelming positive responses to the survey suggest that positive relationships are based on mutual trust, caring, and concern. Nevertheless, the author notes that the survey may underreport abuse or other negative aspects of home care work.

Curtiss, Frederic R.
(1988).

"Recent Developments in Federal Reimbursement for Home Health-Care Services and Products," American Journal of Hospital Pharmacy, August, 45:1682-1690.

Curtiss describes changes in reimbursement policies for home health care products and services, as well as the influence of competition and consolidation on the home health care industry. Despite inadequate financing and reimbursement pressures, the demand for home health continues to grow. The degree of competition in the home health care industry is reflected in the bundling of services (gathering payments for services into a single per-capita rate), prospective price negotiations, and competitive bidding. This competition within the home-care industry and pressure on operating margins have spawned a flurry of recent mergers, acquisitions, and corporate restructuring. Home health care agencies and suppliers, particularly durable medical equipment suppliers, have been squeezed by inadequate Medicare cost-finding methods, low reimbursement rates, and a high number of denials of Medicare coverage. Recent federal measures revised definitions of Medicare coverage, established minimum and maximum payment periods for Medicare reimbursement, reduced payments for services and products covered under Medicare, resurrected prospective-pricing demonstration projects, reduced payments for durable medical equipment and home oxygen supplies, and expanded coverage of services for AIDS patients. State Medicaid program budgets are threatened by recurring administration proposals to cap federal matching payments and by the adoption of a competitive-bid approach to health-care contracting. To survive over the next few years, home health agencies and home-care suppliers will need to closely monitor operating costs and pay greater attention to the patient mix.

Donovan, Rebecca.
(1987).

"Home Care Work: A Legacy of Slavery in U.S. Health Care," Affilia, 13(3):33-45.

Donovan describes the working conditions of home care workers. The current conditions have historical roots in slavery and the persistent segregation of Black women in work roles as domestic servants in private households. Persistent wage discrimination is related, in part, to the segregation of women in typically female jobs that historically have been undervalued and

underpaid. Approximately 350,000 home care workers are employed nationwide by some 8,000 visiting nurse associations, hospitals, government agencies, and private agencies. The article reports on a survey conducted in 1985 with 404 home care workers in New York. Fully 99 percent of the respondents were women, and the median age was 47 years. Seventy percent of the women were Black and 26 percent were Hispanic. Two-thirds did not have a high school diploma and one-third had less than an eighth-grade education. The median earnings ranged from $5,000 to $6,999.

Donovan, Rebecca.
(1989).

""We Care for the Most Important People in Your Life": Home Care Workers in New York City," Women's Studies Quarterly, 1/2:56-65.

This article describes the status of home care workers and reports on a survey of New York City workers undertaken in 1985. There are 60,000 home care workers employed in New York City's personal care program. Home care work illustrates some of the worst features of jobs in the secondary labor market. Home attendants are employed on a temporary basis with an hourly wage of between $4.15 and $4.50. Workers must provide their own transportation. If they work a 24-hour shift, they are paid for only 12 hours. Periods of unemployment and underemployment are common. There is no advancement. Other problems include isolation, lack of supervision, minimal training, and work in dangerous neighborhoods and buildings. The survey, conducted jointly by Local 1199 of the Drug Hospital and Health Care Employees Union and Hunter College School of Social Work, involved face-to-face interviews with 404 home care workers. Ninety-eight percent of the workers are women, and 96 percent are either Black or Hispanic. Almost half are immigrants; most came from the Caribbean islands, especially Jamaica, the Dominican Republic, and Haiti. The median age is 47. Two-thirds of the women lack high school diplomas and nearly one-third have less than an eighth grade education. Thirty-six percent are married, 31 percent are separated or divorced, 22 percent are single, and 11 percent are widowed. Eighty-six percent have children and the average number of children is 3.5. The median annual income ranges from $5,000 to $7,000; as many as 34 percent of the workers have annual salaries under $5,000. Just nine percent hold other jobs, primarily in factory or domestic work; in no instance is the income from such secondary employment over $1,000 a year. As many as 80 percent are unable

to afford adequate housing; 35 percent often do not have enough money for food, and an additional 50 percent sometimes lack money to feed their families.

Doscher, Virgnia R. (1964).

Report of the 1964 National Conference on Homemaker Services (New York, New York: National Council for Homemaker Services).

This report on the first National Conference on Homemaker Services held by the National Council for Homemaker Services (incorporated in 1962) summarizes the issues addressed at the conference and contains the author's opinions with respect to home care. There were an estimated 303 homemaker service programs 1963. The majority of homemakers are mature women and often women needing or wanting some additional income. Doscher believes there exists a large pool of potential employees. It is essential that the homemaker be selected "not because of her need for employment but rather from the viewpoint of the service to be given" (p. 13). She also expresses concern with the "overprofessionalization" of workers. With municipal or state employment, a system may be set up with written examinations. Society would lose many homemakers skilled in preparing a grocery or laundry list but not proficient in written tests. The conference attendees also discussed the amount of personal care which homemakers should be permitted to give.

Dunn, Louise. (1986).

"Senior Respite Care Program," Pride Institute Journal of Long Term Home Health Care, Summer, 5(3):7-12.

Dunn describes a respite program established in Oregon in 1984. Respite care provides supervised companionship. The providers assist with feeding, walking and toileting, but do not give homemaking, transportation, or personal care services. The male providers are more difficult to place because impaired male patients are often suspicious or resentful of a healthy male providing respite care. One drawback of the program is that providers may become overly involved with the family. Providers may find it difficult not to interfere with family matters or routines. The author also identified several barriers to service, such as the lack of familiarity with the

concept of respite care by the public and caregivers' concerns about having a stranger in the house.

Estes, Carroll L.; Swan, James H. (1988).

"Privatization and Access to Home Health Care for the Elderly," in Organizational and Community Responses to Medicare Policy: Consequences for Health and Social Services for the Elderly, Final Report, Estes, Carroll L.; Wood, Juanita B.; Associates (eds), pp. 30-59 (San Francisco, California: Institute for Health & Aging, University of California, San Francisco).

This study examined the effects of three major organizational changes on access to home care: (1) the privatization of home health care; (2) the rationalization of home health care (increasing organizational complexity); and (3) the increased competition among home health providers. The study sample included 163 randomly selected home health agencies in nine metropolitan areas of five states (California, Florida, Washington, Texas, and Pennsylvania). Telephone interviews were conducted in 1986 and 1987. The authors found that for-profit agencies are more likely to refuse services to certain types of clients. This behavior is especially likely when the for-profit agency is independent and not part of a chain. Nonprofit agencies, when they become part of complex bureaucratic systems, are likely to take on the characteristics and behaviors of for-profit systems. In areas where agencies face greater competitive pressures, they tend to be less selective in allowing access.

Eustis, Nancy; Fischer, Lucy Rose. (1991).

"Relationships Between Home Care Clients and Their Workers: Implications for Quality of Care," The Gerontologist, 31(4):447-456.

Eustis and Rose studied the relationships between workers and their clients. A stratified, nonrandom sample of home care workers and clients was obtained, allowing three kinds of comparisons: care in urban versus rural settings, elderly versus working-age clients, and agency versus direct-hire workers. In-depth interviews were conducted with 54 clients, 39 workers, and 15 family members. The authors found that home care relationships cross boundaries between formal and informal ties in several ways: job responsibilities are diffusely defined, the job

includes the provision of companionship, and workers become involved in the "backstage" world of their clients. A personal, rather than professional, relationship develops which can create problems, such as the possibility of exploitation of the workers. The authors developed four configurations of the worker-client relationship, which vary with respect to: (1) the symbolic relationship (familiar or contractual) and (2) the behavioral dimension (based on indicators of friendlike versus nonfriendlike interactions). Some patterns emerged when relationships were compared between urban versus rural settings, between elderly and working-age clients, and between agency and direct-hire workers. Rural clients appeared to be more likely than urban clients to think of their worker as a friend or family member. Urban home care relationships were more likely to reflect contradictory pressures toward formality and informality. Younger clients were particularly more likely to talk about the importance of maintaining a job-oriented relationship; however, they were also more likely than older clients to say they discuss personal problems with the worker. Direct-hire arrangements can be more informal and flexible because there are no agency regulations to follow and it appeared that clients and direct-hire workers were somewhat more likely to be mutually confiding than in agency-hire relationships.

Fashimpar, Gary A.; Grinnell, Richard M., Jr. (1978).

"The Effectiveness of Homemaker-Home Health Aides," Health and Social Work, February, 3(1):147-165.

This article reports the results of a 1977 study of the role of the homemaker/home health aide (H/HHA) based on two questionnaires mailed to a total of 143 clients (response rate: 90.2 percent). Clients were those served by H/HHAs working for the second largest Visiting Nurse Association in the country, located in a large southwestern metropolitan area. Generally, clients received what they expected from services: reduced feelings of isolation and loneliness, maintaining the ability to stay at home, relief for caretakers, and the prevention of neglect. Eighty-one percent of the clients indicated that they thought the H/HHAs spent the necessary amount of time in the house each week. The study found a significant decrease in self-reported time left alone and in number of meals missed. Clients perceived H/HHAs as possessing several roles at the same time: H/HHA, friend, professional person, nurse, counselor, personal employee, maid. However, their professional roles were

more highly correlated with the perceived adequacy of service than their servant roles.

Fashimpar, Gary Allen. (1985).

"A Manual for the Administration, Scoring, and Interpretation of the Homemaker-Home Health Aide Program Evaluation Questionnaire," Home Health Care Services Quarterly, Spring, 6(1):65-84.

Fashimpar explains how to use, administer, score, and interpret the results of the Homemaker-Home Health Aide Questionnaire (H/HHA-PEQ). The instrument may be used to evaluate the quality and adequacy of H/HHA services provided and the extent to which the objectives of the client, the agency, and society have been met. Managers can also use the H/HHA-PEQ to evaluate employee performance, homemaker/client relationships, and changes in patterns of service utilization. The questionnaire is attached in an appendix.

Feldman, Penny Hollander. (1989).

"The Ford Home Care Project: Reducing Turnover Among Paraprofessionals," Caring, February, 8(2):28-29.

This article makes recommendations to reduce turnover based on the results of the Ford Home Care Project. The Project involved three demonstration work life programs. In San Diego, workers received extended training and a guaranteed 35-hour week. In New York City, workers received specialized training in serving specifically defined difficult cases and a $.30-per hour wage increment, along with ongoing professional support and status enhancement. In Syracuse and Milwaukee, experienced workers were promoted to full-time positions with a $.50-per hour wage increment, enriched fringe benefits, and staff status. The author recommends that agencies increase training to reinforce and supplement basic training and develop special skills and career tracks. The model of job satisfaction and intent to leave developed for the project suggested that training would reduce turnover by increasing supervisor support, mitigating feelings of isolation, and fostering relationships among peers, in addition to providing home care skills. Agencies should also provide specialized training programs to deal with categories of clients or cases particularly problematic, reversing the incentive operating in home care whereby new workers are given the harder cases while experienced workers are rewarded with easier

clients. Another recommendation is that employers ensure that there is an organizational support system available to aides to assist with problems as well as isolation. The project's experience suggests that new workers are the most vulnerable and early training can build commitment to the job. Racial and linguistic minorities also deserve special attention because of the resulting difficult situations that may arise when home care workers are seen as domestic service workers.

Feldman, Penny Hollander; Sapienza, Alice M.; Kane, Nancy M. (1990).

Who Cares for Them? Workers in the Home Care Industry (New York: Greenwood Press).

This book contains extensive background research on home care workers and reports the results of a demonstration project funded by the Ford Foundation in order to evaluate the various work life programs, suggesting that similar improvements in working conditions may ultimately enhance the quality of home care services. The first section of the book provides a general discussion of the labor market, the work force, and the industry conditions that affect home care employment. A conservative estimate places the number of home health aides at about 350,000 in 1986. Managers, workers, and union representatives have identified five major work life issues for home aides. First, wages are low, even below the rate paid to workers in similar positions in institutions. The median wage is $4.30 per hour. Second, the work is part-time and episodic. Third, as part-time workers, home care workers are generally ineligible for benefits. Fourth, the lack of uniform standards and sophisticated training are compounded by the problem of inadequate organizational support once workers begin employment. Fifth, there are no opportunities for advancement. Management is concerned with five issues that motivated them to participate in the work life demonstrations: (1) worker recruitment, (2) worker turnover; (3) productivity; (4) quality of service, and, in some cases, (5) union pressures. A questionnaire was completed by 1,284 home aides employed by seventeen agencies in five cities (Boston, New York City, Milwaukee, San Diego, and Syracuse). The median age was 45. Thirty nine percent had not completed high school and the median years of education was 12. Ninety eight percent were female; 49 percent were Black and seven percent Hispanic. The median personal income was $7,000. Sixty-five percent were the primary wage earner in their household. The median household income was $13,000. Eighteen percent of the

workers held more than one job. The main problems encountered by home aides are also discussed. The researchers tested several models of job satisfaction and intent to leave based on the questionnaire results. In all of the models used, age and/or race emerged as important personal characteristics contributing to job satisfaction and/or intent to leave the job. Training adequacy, task variety, and supervisor supportiveness were also important determinants of worker attitudes, affecting perceptions of loneliness on the job, satisfaction with the work itself, and satisfaction with pay and benefits. Loneliness and satisfaction with pay and benefits were, in turn, the significant attitudinal determinants of intent to turnover.

The second section of the book contains detailed case studies of the work life programs carried out in four cities. As part of the work life demonstrations, workers in San Diego received extended training and a guaranteed thirty-five hour week. Workers also participated in a project-sponsored employee support and development group and received uniforms and badges as a sign of their special status. In New York City, experienced workers received specialized training in serving specifically defined difficult cases and a $.30 per hour wage increment. They also received ongoing professional support and status enhancements, including a special title, badges, and program publicity. In Syracuse and Milwaukee, workers were promoted to full-time "staff aide" positions with a $.50 per hour wage increment, enriched fringe benefits, and staff status. The researchers found that each of the work life programs significantly reduced worker turnover. The most comprehensive program had the highest acceptance rate among workers selected for participation and the greatest impact on turnover.

The third section of the book draws on the case studies to present an overview of the work life programs and the study's implications for reducing turnover. The final section summarizes the book's major findings and discusses management strategies and policy options. In addition to the impact on turnover, the book discusses at length the problems faced by agencies in implementing and continuing work life programs.

Fine, Doris R.
(1988).

"Women Caregivers and Home Health Workers: Prejudice and Inequity in Home Health Care," Research in the Sociology of Health Care, 7:105-117.

Fine suggests that the lack of support for home care lies, in part, in the persistence of certain assumptions regarding the responsibility and capacity of family caregivers, who are predominantly women. Society assumes that families have sufficient personal and financial resources to provide adequate home care and that the family should be the provider of first choice. The home setting and domestic nature of the tasks, which wives and daughters ordinarily perform, privatizes the work and serves as a deterrent of public scrutiny and as an obstacle to change in public policy. Because home care workers are women and lower-class, it is assumed that they are suited to do whatever medial, tedious, or emotionally demanding tasks are required. Home care suffers from a bias of the health delivery system that favors medical over social services, and regards hospital care as superior to home care. The author suggests that the isolation of the home health worker and the stigma attached to women's work create the conditions for exploitation of the worker and abuse of the patient. The article discusses several cases of fraud and abuse that have taken place, especially in California. The article concludes with several policy recommendations regarding recruitment, training, assignment, and supervision.

Fisher, Dierdre D.; Greene, Rickey.
(1988).

"Training Seniors as Homemaker-Home Health Aides," Caring, March, 7 (3):11-15.

A previous study in New Jersey had shown that the single most significant factor in predicting the outcome of training and continued employment as a home care worker was age. This articles describes a training program for older homemakers in New Jersey. In 1983, the New Jersey State Department of Health was awarded a grant from the United States Public Health Service to train persons age 50 and over as homemaker-home health aides. By the third year, the grant had been expanded to 14 of New Jersey's 21 counties. The first year, 174 people were trained; 194, the second; and 240, the third year. Follow-up surveys were mailed three and six months after training. After three months, 91 percent of the first group of trainees and

87 percent of the second group remained actively employed as homemaker-home health aides. After six months, 88 percent and 77.7 percent remained employed. Almost one-third of the aides mentioned that they needed additional training. The lead agencies have responded favorably to the training. The advantages of hiring older workers are discussed at length.

Gilbert, Nancy.
(1989).

"Professionalism in the Homemaker-Home Health Aide Position," Caring, September, 8(9):48-50.

This article contains testimony presented to Massachusetts' Special Commission on Worker Availability in Long-Term Care by Gilbert, a graduate student nurse who worked briefly in home care as a homemaker-home health aide. The author discusses many problems faced by workers, such as dealing with a very frail population, inadequate pay, and lack of child care.

Gilbert, Nancy J.
(1991).

"Home Care Worker Resignations: A Study of the Major Contributing Factors," Home Health Care Services Quarterly, 12(1):69-84.

Gilbert mailed surveys to home care workers who had left one of 15 agencies in Massachusetts asking them about job satisfaction. Of the 342 questionnaires mailed, 66 (19.3 percent) were completed and returned to the researcher. After resigning, 46 (70 percent) of the respondents reported taking another job. Of these, 28 remained in the health care field, seven sought other human services jobs (child care, teacher's aide, school lunch programs), and 11 sought employment in other areas (office work, retail, factory work). Of those staying in health care, 11 went to another home care agency, seven were employed in institutions, and four took private duty cases. The mean salary for the new job was slightly higher; however, the median salary was the same. Gilbert found that the factors contributing to job resignation did not differ from the variables reported in other studies. Working conditions emerged as the major contributing variable, followed by salary, benefits, recognition and burnout. Isolation, school attendance, and image were next. A closer examination of working conditions revealed that the lack of professional advancement, the instability of work hours, the emotionally draining aspects of

caring for a client, and the lack of participation in developing care plans were the leading factors contributing to home care worker resignations.

Glass, Leah; Eisner, Laurel.
(1981).

"CETA As a Vehicle to Recruit Welfare Recipients and the Unemployed Into the Home Care Field," Home Health Care Services Quarterly, Fall, 2(3):5-21.

During 1978 and 1979, a CETA project, administered by State Communities Aid Association, provided jobs in the home care field for 320 unemployed persons, half of them prior welfare recipients. Six voluntary agencies employed the workers. The project provided a test of the feasibility of recruiting workers for the home care field from the ranks of the unemployed and those on welfare. At the same time, the project sought to prepare the workers for the unsubsidized job market. Of the 320 hired, two-thirds worked as home care workers and a small number obtained employment as housekeepers. The workers' performances compared favorably with those of similarly employed non-CETA workers. They generally reported positive work experiences and preferred full-time work to part-time. Some workers experienced difficulties working with clients who had interpersonal problems. When they were interviewed after leaving CETA, three-quarters of the workers had been employed at some time since CETA and half of the former CETA home care workers had most recently worked in home care. Reasons for accepting a home care job included the opportunity to help people, steady employment, a chance to learn new skills, full-time work, good pay, and work in the health field.

Gotay, Carolyn Cook.
(1983).

"Home Care for the Dying: Homemakers' Perspectives," Home Health Care Services Quarterly, 4(1):55-66.

Gotay summarizes the findings of a survey of homemakers working with a newly-developed Canadian program for providing home care for dying patients and their families. The results indicate that homemakers perform multiple roles, which they report tend to be more demanding physically and psychosocially than other kinds of homemaking. Being able to provide comfort in a time of extreme need is satisfying to homemakers, although frustrations exist as well. Gotay discusses the study's implications for program planning and future research.

Grant, Leslie A.; Harrington, Charlene. (1989).

"Quality of Care in Licensed and Unlicensed Home Care Agencies: A California Case Study," Home Health Care Services Quarterly, 10(1/2):115-138.

Grant and Harrington examined quality of care issues with respect to licensed and unlicensed home care agencies in California. Data were collected from interviews with 56 key informants in state and federal agencies, representatives of provider associations, consumer groups, professional associations, licensed and unlicensed home care providers, referral agencies, and legislators. Primary and secondary data from state and federal sources were also collected and analyzed. Many problems were found in the quality of services delivered by both licensed and unlicensed agencies. Most respondents expressed concern about potentially serious quality of care problems for consumers who received care from unlicensed agencies. However, the large number and diversity of providers make it difficult to monitor the quality of care. The findings indicate that there are similar problems in the quality of services provided by both licensed and unlicensed agencies. The development of stronger, more uniform standards for both types of agencies may provide greater safeguards against the potential for abuse.

Haemmerlie, Frances M.; Montgomery, Robert L. (1982).

"Role Conflict for Aides in a Homemaker Aide Program for Frail Elderly Persons," Psychological Reports, 51:63-69.

To determine whether aides in a homemaker program for the frail rural elderly experienced role conflict, the views of clients, aides, and staff were examined by means of an 18-item Likert-type test which assessed the degree of difficulty faced by aides in various problematic situations. While consensus existed among the three groups on a few items, for the most part, whether or not a situation was perceived as a difficult depended upon who did the rating. Clients were fairly insensitive to many of the problem situations, while staff appeared to be more sensitive than aides. This lack of consensus suggests that direct service workers might often not only find themselves in an uncomfortable position, but even worse, such a situation will not necessarily be recognized by either the program's clients or staff.

Haemmerlie, Frances M.; Montgomery, Robert L. (1984).

"The Homemaker Needs of the Rural Frail Elderly from a Client vs. Agency Perspective," Home Health Care Services Quarterly, Spring, 5(1):61-73.

Haemmerlie and Montgomery report on a study comparing and assessing the perspectives of clients, home care workers, and supervisors with respect to the homemaker needs of the rural frail elderly. Semi-structured interviews were conducted with the staff of a homemaker aide program located in south central Missouri, a random sample of 19 aides and 27 clients served by the program during 1980. Although generally the greatest level of agreement among clients, aides, and staff occurred with regard to general cleaning and straightening as needs met by the program, clients overwhelmingly emphasized the importance of light household services while the staff showed the most concern for such non-household categories as human service and personal maintenance needs. The staff and aides emphasized the role of the aide as a source of dependable psychological support, while this was infrequently mentioned by the elderly themselves. Nevertheless, the overall response from all three groups suggested a highly effective program.

Hall, Hadley Dale. (1983).

"The National HomeCaring Council's Standards for Paraprofessional Services: A Critical Guide," Pride Institute Journal of Long Term Home Health Care, Summer, 2(3):24-25.

This is a brief overview of the many different kinds of work done by employed caregivers. Hall suggests that the job descriptions and tasks of different workers (chore person, homemaker, home health aide, and home attendant) are basically the same. Any attempts to differentiate the functions are tied to funding sources. The author argues that all these functions should be performed by one person with adequate training. Meeting the standards of the National HomeCaring Council will protect clients and patients.

Harrington, Charlene; Grant, Leslie A.; Ingman, Stanley R.; Mildner, Sherry A.
(1988).

"The Study of Regulation of Home Health Care Agencies in Two States: California and Missouri," December (San Francisco: Institute for Aging & Health, University of California at San Francisco).

Home health agencies in California and Missouri were studied during 1983-1988, focusing on their organizational patterns, changes, and regulatory efforts. Data include information from federal and state sources and interviews with state and federal regulatory officials, selected home health care providers, and experts on home care. The organization and ownership of home health agencies in the two states differ substantially. The state government survey activities varied between the two states. California was unable to meet its annual survey requirements, while Missouri had generally met its obligations. Overall, very few enforcement actions were taken in either state over the period 1983-1988. Limited state survey activity makes it hard to judge quality. There are many barriers to regulation, especially in California because nursing homes are afforded greater priority. Limited financial support precludes surveyors from actually visiting home care agencies.

Harrington, Charlene; Grant, Leslie A.
(1990).

"The Delivery, Regulation, and Politics of Home Care: A California Case Study," The Gerontologist, 30(4):451-461.

This study describes seven basic types of home care service providers in California. The providers vary with respect to sources of payment, duration of care, supervision of personnel, and state regulation, as opposed to any statutory definitions of services offered and clients served. Many key officials and providers advocate regulatory reform by extending licensure to unlicensed agencies and providers. Competing special interest groups have not developed a consensus about regulation, leading to a political stalemate. Research has not determined differences in quality, access, and costs of licensed and unlicensed home care providers.

Heyrman, Helen.
(1987).

"National Accreditation: Will the Home Care Industry Be Permitted to Regulate Itself?," Home Healthcare Nurse, May/June, 5(3):5-6.

Heyrman provides a comprehensive description of home care regulation and suggests some possible future directions. The Joint Commission on Accreditation of Hospitals (JCAH), established in 1965, currently accredits about 1,000 hospital-based home care programs and is developing an accreditation program for free-standing home health agencies which it expects to implement in 1988. The National League for Nursing, established in 1967, currently accredits about 100 agencies, mostly Visiting Nurse Associations. Both have applied for deemed status to conduct accreditation for Medicare. Possible differences from Certification if accreditation is enacted are described. First, agencies would have to pay the costs. Second, JCAH and NLN would accredit for three-year periods instead of Medicare's annual re-certification. Currently, the only uniform national standards are Medicare's Conditions of Participation; neither the Older Americans Act nor Title XX of Social Security Act impose any national standards. Thirty-three states and District of Columbia have licensure laws for home care. OBRA of 1986 mandated development and implementation of Peer Review Organization oversight of home care. Congressman Edward Roybal of California has reintroduced his Homecare Quality Assurance measure, which calls for national quality assurance standards.

Hodges, Jan.
(1989).

"A National Certification System for Paraprofessionals: A Report of a Grant-Funded Training Project," Caring, February, 8(2):32-33.

In October, 1988, the Administration on Aging of the Department of Health and Human Services awarded a grant to Foundation for Hospice and Homecare to develop a national certification program for paraprofessionals. The states of Alabama, Iowa, and South Carolina will participate in the project by conducting pilot tests of the new materials. Project completion is scheduled for February 1990. Five states already have certification programs for paraprofessionals and six other states are considering certification. Training requirements vary from 40 to 120 hours.

Houchen, Betsy J.; Jones, Karen L.; Barbour, Elizabeth J.; Lunceford, Brenda L.
(1988).

"Diversified Funding and Programming for Homemaker and Home Health Aide Services," Caring, July, 7(7):36-43.

The Columbus Health Department, Ohio, has various home care programs using homemaker-home health aides. As the demographics of the community have changed, the need for diversified services, especially for homemaker-home health aide services, has increased. In 1980, the city agency expanded the number of full-time health aide positions from six to 30. Thirteen part-time positions were added over the last two years and health aides were added as part of the hospice team. The agency also created the position of "Field Counselor." The Field Counselors are experienced home health aides who assist with scheduling, orientation, joint visits, and daily monitoring of the aide program. The article also describes the agency's participation during two years in a federally-funded demonstration project that trained and provided one year of employment for recipients of Aid for Dependent Children (ADC). The authors suggest that several factors were responsible for the success of the diversified program, including the use of various funding sources, developing positive relationships with other organizations, the implementation of quality assurance measures, such as initial and ongoing training of aides, and the homemaker-home health aides themselves. Salaries for all positions were higher than competitors and benefits were provided for full-time workers. Combined with the possibility of upward mobility to the Field Counselor position, turnover was minimized, providing better continuity of care and patient satisfaction.

Jette, Alan M.; Branch, Laurence G.; Wentzel, Richard A.; Carney, William F.; Dennis, Deborah L; Heist, Marcia Madden.
(1981).

"Home Care Service Diversification: A Pilot Investigation," The Gerontologist, 21(6):572-579.

This articles describes home care services in Massachusetts, focusing on a demonstration program designed to evaluate a diversified approach to delivering home care. One Homecare Corporation (HCC) developed a program which separated the instrumental services from the affective functions of traditional homemaker services. The primary instrumental services of housecleaning, laundry, and meal preparation were

subcontracted to existing professional housecleaning and laundry service vendors. The HCC developed a new companion service to replace the traditional homemaker. Companions worked from 9-18 hours per week for a monthly stipend of between $50 and $100, plus mileage. In addition to providing affective support, the companions' duties included some grocery shopping, preparing light lunches or snacks, recreational activities, and limited escort services. Consumers who received diversified homecare services were just as satisfied with the amount and quality of care as clients who received traditional homemaker services. Service diversification did appear to demand more case manager time.

Jones, Patricia A.
(1988).

"The Home Care Personnel Shortage Crisis: Preliminary Results of a NAHC Survey," Caring, May, 7(5):6-9.

Jones presents the preliminary results of a survey by the National Association for Home Care regarding personal shortages. The Association surveyed 2,197 member agencies during March 1988 and received over 1,000 responses, of which 841 responses were suitable for data analysis. Fifty-six percent of the agencies said they were having difficulty recruiting and/or retaining Registered Nurses. Forty-eight percent reported having problems recruiting and retaining homemaker-home health aides. The factors contributing to the homemaker-home health aide shortage cited by the agencies included: low wages, transportation problems, poor benefits, lack of advancement opportunities, poor role image, inadequate training, and others. Agencies on the east and west coasts, especially in New York State, as well as the deep south, were more likely to report shortages.

Kane, Rosalie A.; Kane, Robert L.
(1987).

Long-Term Care: Principles, Programs, and Policies (New York: Springer Publishing Company).

This book is a broad overview of long-term care, aiming to present and evaluate the evidence on the effectiveness of long-term care programs by reviewing most of the major studies concerning long-term care. The first half of the book discusses definitions of long-term care, the need for such care, the current status of long-term care, and issues such as quality, access, and cost. The authors note the growth in home

care, especially in proprietary and skilled nursing facility-based home care agencies. Much of this growth is attributable to Medicare's prospective reimbursement policy, which encourages hospitals to discharge patients earlier. This section includes a detailed description of home care financing and expenditures. In discussing quality, the authors note that quality assurance has barely been explored for home care and other community long-term care programs. It appears problematic to improve the quality of care without upgrading the skills and the salary of nursing assistants and homemaker/home health aides. The authors note, however, that some argue the cost of any real change would be prohibitive. The authors caution that any savings achieved by home care requires precise targeting of those likely to enter nursing homes in the near future, a very difficult task.

In the chapter on home care, the authors discuss both descriptive and evaluation studies of home care programs. Most of the studies focus on the outcomes and utilization patterns of home care. An additional nine studies are reviewed that focus on more narrower questions about the details of home care delivery, such as one study that examined the effects of combining the categories of homemaker and home health aide into one job category.

Kane, Rosalie A.
(1989).

"Toward Competent, Caring Paid Caregivers (Editorial)," The Gerontologist, 29(3):291-292.

Kane, in light of articles appearing in the same issue of The Gerontologist addressing abuse by nursing home personnel, suggests that the development of a paraprofessional labor force for long-term care deserves a high place on the national agenda. She notes that debate regarding the cost-effectiveness of home care has ignored the fact that both home care and nursing home care are based on a poorly-trained, poorly-paid, poorly-benefitted labor force. The author raises several areas that need to be addressed by research, such as what makes it satisfying to serve as a paraprofessional worker and what kinds of supervision, support, and surveillance are necessary to assist the caregivers and to protect clients.

Kane, Nancy M.
(1989).

"The Home Care Crisis of the Nineties," The Gerontologist, 29(1):24-31.

Kane examined how publicly-owned, for-profit providers of unskilled home care performed financially in the early to mid-1980s. The payers for custodial care are largely Medicaid and self-paying patients. During the early 1980s, Medicare became a major payer for unskilled services associated with acute care. For-profit agencies became the fastest-growing group of providers after legislation in 1980 eliminated the requirement of state licensure for Medicare certification and the majority of agencies providing unskilled care are now proprietary agencies. To assess the profitability of unskilled services, and hence, the future availability and quality of these services, Kane reviewed the annual reports, audited financial statements, and prospectuses of ten of the 12 largest publicly-held home care service companies. Only three indicated consistently positive profitability over a multi-year period and these were withdrawing from the unskilled service market for various reasons. The lack of profits is understandable when one considers the financing of unskilled services. Most self-payors, especially those over age 75, are women with limited economic resources and public financing is inadequate. As a result, the poorly paid home care worker is subsidizing the cost of home care and the elderly patient is receiving a lower quality of care because of financial limits placed on providers.

Katcher, Bruce L.; Buhler-Wilkerson, Karen.
(1989).

"Applying the Principles of Organizational Psychology to Improve the Selection of Home Health Aides and Homemakers: Part I," Home Healthcare Nurse, Jan./Feb., 7(1):37-41.

The authors conducted a job analysis in developing a screening tool for homemakers employed by Bayada Nurses, a national health care agency. The data were gathered through a literature review, individual interviews with an unspecified number of administrators, supervisors, coordinators and aides, and field observations of homemakers. The sample included private pay, private insurance, Medicare, Title XX, and Medicaid patients. A list of 69 major tasks was compiled and supervisors were asked to rate the difficulty and degree of previous training required for each task. The frequency of tasks was estimated

from a sample of 87 client visitation records. The article contains two detailed charts illustrating the job analyses of personal care activities and homemaker activities, showing the proportions of patients requiring each activity. The researchers identified six major dimensions of homemakers/home health aides performance: the match between the homemaker and the client and the homemaker's experience, maturity, attitude, presence, and personal care skills. The study found that certain personality characteristics and attitudinal orientations are as important, if not more important, than personal care skills.

Katcher, Bruce L.; Buhler-Wilkerson, Karen. (1989).

"Applying the Principles of Organizational Psychology to Improve the Selection of Home Health Aides and Homemakers: Part II," Home Healthcare Nurse, March/April, 7(2):41-43.

In this article, Katcher continues his discussion of the recruitment procedures being developed for homemakers employed by Bayada Nurses, a national health care agency. There are four components to the selection system: the employment application, a reference check, a structured interview guide with a scoring system (where aides are asked role playing questions), and a written examination with multiple-choice questions. The agency plans to train supervisors in the selection process using video tapes and will eventually evaluate the selection system. There are three sources of information for evaluation of the homemaker: RN supervisors will rate performance; several clients of each aide will be asked to complete evaluations; and personnel data. The authors suggest that dimensions such as maturity, attitudes toward the elderly, and other personality characteristics may be more important than mastery of personal care skills, questioning the current movement of regulatory agencies and those interested in quality assurance to concentrate on training.

Kaye, Lenard W. (1985).

"Home Care for the Aged: A Fragile Partnership," Social Work, 30:312-317.

This study examined the impact the friends and family of the elderly on job satisfaction in home care based on in-person interviews with 24 indirect service staff and 67 direct service workers of three agencies providing care to elderly under Older Americans Act,

Title III-B. The majority of the direct service providers were nonwhite, with an average age of 41.4 years. Less than 14 percent had college degrees and 98.5 percent were women. The average age of the indirect service staff was 36.2. Eighty-three percent were female and 90 percent had college degrees. Although the informal support network was perceived to be the preferable source of most home care help, formal intervention was seen as best for housekeeping functions, specialized duties, and repetitive tasks for the homebound aged. Workers expressed the belief that relatives living outside the household and friends and neighbors were significantly more likely to make their job easier, whereas relatives residing in the client's home were a less positive influence on the home care workers' job performance.

Kaye, Lenard W.
(1985).

"Setting Educational Standards for Gerontological Home Care Personnel," Home Health Care Services Quarterly, Spring, 6(1):85-99.

The home care literature is filled with calls for professionally-based supervision and training of workers. Others, however, argue that the thrust for professionalization has contributed to the scarcity of in-home support services. Some researchers suggest that advanced educational requirements may inflate the cost estimates of home care and that training nonprofessionals and supervision by the elderly and their families may be sufficient. Kaye interviewed both direct service providers and indirect service staff employed by three urban-based, Older Americans Act funded home care programs in order to elicit their opinions regarding educational requirements. Both types of workers assigned the greatest importance to on-the-job experience. Personal experiences also ranked high in importance. The home-based worker indicated a strong tendency toward higher valuation of classes at school, as well as community training programs. With respect to prescribing educational achievement levels, scores indicate that a high school education will satisfy the requirements of in-home service functions and a college level education will usually satisfy the demands of the other positions.

Kaye, Lenard W.
(1986).

"Worker Views of the Intensity of Affective Expression During the Delivery of Home Care Services for the Elderly," Home Health Care Services Quarterly, Summer, 7(2):41-54.

Kaye's study of the extent of noninstrumental care is based on in-person interviews with 24 indirect service staff and 67 direct service staff of three agencies providing care to elderly under the Older Americans Act, Title III-B. The majority of the direct service providers were nonwhite, with an average age of 41.4 years. Less than 14 percent had college degrees and 98.5 percent were women. The average age of the indirect service staff was 36.2. Eighty-three percent were female and 90 percent had college degrees. The findings suggest that home care services were significantly shaped by client expectations for non-instrumental (affective/emotional) forms of aid.

Keenan, Joseph M.; Fanale, James E.; Ripsin, Cynthia; Billows, Linda.
(1990).

"A Review of Federal Home-Care Legislation," Journal of the American Geriatrics Society, 38:1041-1048.

This is a thorough overview of the impact of federal legislation on home care. Medicare, Title XVIII of the Social Security Act of 1965 restricted care to 100 home visits and required at least three days prior hospitalization. These restrictions were lifted by the Omnibus Budget Reconciliation Act of 1980; however, the language in the Act failed to define "home-bound" and "intermittent," leading to increased denials as each of the fiscal intermediaries interpreted the terms differently. In 1988, the United States District Court, District of Columbia, in Duggan v. Bowen, upheld the allegation that HCFA was inconsistently processing claims, and all claims since February, 1987 were to be reviewed. HCFA subsequently published the Medicare Home Health Agency Manual. In 1982, TEFRA expanded benefits to include hospice services. OBRA of 1987 provided guidelines for protection of patients' rights in the home, established a training and licensure requirement for home health aides, and required periodic surveys of home-care agencies to assess compliance with Medicare standards and guidelines. The legislation clarified and broadened the definition of home-bound to include those who can leave home only with considerable or taxing effort or with assistance of another person or some mechanical device. Medicaid,

Title XIX of the Social Security Act of 1965, restricted services to the traditional short-term model of Medicare until 1981. In 1980, section 2176 of OBRA allowed states to apply for waivers that would permit coverage of a much broader range of services, but the program failed to extend benefits to a significant numbers of recipients. Title XX of the SSA of 1975 was consolidated with other social services programs by OBRA of 1981 into Social Services Block Grant. The average proportion of funds allocated by states to the elderly under the SSBG is 18 percent (ranging from zero to 50 percent). The Older Americans Act of 1965, under Title III, awards funds to support 674 Regional Area Agencies on Aging, but the funding is limited. The Department of Veterans Affairs is beginning to explore care in noninstitutional settings. The article also discusses current proposed legislation: Lifecare Long-Term Protection Act (Kennedy), Long-Term Home Care Act of 1989 (Roybal, Pepper), Elder-Care Long-Term Care Assistance Act of 1989 (Waxman), and Basic Health benefits for All Americans Act (Waxman, Kennedy).

Kethley, Alice J.
(1987).

"The Benjamin Rose Institute: A Case Study in the Development of Services to the Elderly," Pride Institute Journal of Long Term Home Health Care, Summer, 6(3):18-24.

Kethley, the executive director of the Benjamin Rose Institute in Cleveland, Ohio, discusses the history and current programs of the Institute, one of the oldest social and health service agencies in the United States, established in 1908. Today, the agency has three divisions: Community services, Residential and Rehabilitative Services, and the Margaret Blenkner Research Center. The Community Services division "Home Health Care department" is certified by Ohio for Medicaid and Medicare and accredited by the National Home Care Association. The increase in early discharges from the hospital is forcing the program to decide whether to continue to provide full rehabilitation and personal care for those discharged. Kethley notes that nonprofit agencies have become very competitive with each other in grant-writing and fund-raising efforts. Also, competition from new proprietary sectors has impeded the willingness of nonprofits to pool staff and financial resources. Many nonprofit organizations are trying to attract private pay clients, yet the nonprofits are unable to compete with the proprietary agencies for private dollars. The Institute is considering methods of joint venturing with both nonprofit and proprietary agencies.

Kilbane, Kathleen; Blacksin, Beth.
(1988).

"The Demise of Free Care: The Visiting Nurse Association of Chicago," The Nursing Clinics of North America, June, 23(2):435-442.

The Visiting Nurse Association of Chicago has undergone many changes since founded in 1889. In 1986, the VNA decided to severely limit the free care it provided. The agency had been delivering 47 percent of the uncompensated home care in Chicago. The Chicago Department of Health provided the majority of the remaining uncompensated care visits. Two factors in particular led to this decision. One was the tremendous increase in the volume of free care visits because of the increasing needs of the population. The second factor was the increased competition from the private home health industry. The VNA has subsequently responding by establishing a for-profit subsidiary and emphasizing profitable and specialized services at the expense of preventive services.

Levit, Katharine R.; Lazenby, Helen C.; Cowan, Cathy A.; Letsch, Suzanne W.
(1991).

"National Health Expenditures, 1990," Health Care Financing Review, Fall, 13(1):29-54.

Health care expenditures during 1990 are presented in this article. The National Health Expenditure (NHE) category of home health care includes expenditures for services and supplies furnished by non-facility-based home health agencies (HHAs). Spending reached $6.9 billion in 1990. An additional $1.6 billion, not included in the NHE home health care category, was spent for care furnished by facility-based (primarily hospital-based HHAs) agencies. Spending for home health care services grew faster than spending for any other category of personal health care in 1989 and 1990, increasing 22.5 percent in 1990, close to the 24.9 percent increase in 1989. After four years of slower growth, spending for home health care accelerated again in 1989, primarily because of increased funding by the Medicare and Medicaid programs. Public sources financed three-fourths of the services. More than one-half of public spending was paid by Medicare and almost all of the residual by Medicaid. Out-of-pocket payments accounts for 12.1 percent of agency spending and the residual private share, 14.4 percent, was split between private health insurance and non-patient revenue.

Liszweski, Diane M.
(1988).

"Diversification and Corporate Restructuring Revised: Back to Square One?," The Nursing Clinics of North America, June, 23(2):399-413.

Liszweski discusses the diversification and corporate restructuring of hospitals and home care agencies, suggesting that agencies and hospitals may now start divesting themselves of corporations peripheral to their central purpose. The article discusses the burst of restructuring activity in the hospital sector in the late 1970s. Home care agencies began to form multicorporate structures in the early 1980s. The author notes that in 1986 the word "retrenchment" began appearing in the health care literature. Among the reasons noted for an apparent move to more limited diversification actions are the failure of previous efforts to bring anticipated returns and the recognition that health care is a local market. With continued pressure to contain costs, agencies with multicorporate structures will need to concentrate on their core business.

Loeb, Laura E.
(1990).

"Caring for Caregivers: Addressing the Employment Needs of Long Term Care Workers," September (Washington, D.C.: Older Women's League).

Loeb pulls together much of the information available about the working conditions of home care workers and nursing home aides, examining the implications of such conditions for the future of long-term care. Long-term care workers (a term used to refer to both home care workers and nursing home aides) are employed by more than 25,000 nursing homes and about 12,000 home health agencies. Wages for home care workers average $4.25 an hour; nursing aides do slightly better, averaging $4.50 an hour. Most lack health insurance and very few have pension coverage. Nursing aide turnover rates range from 70 to 100 percent per year, while the turnover rate for home care workers is 60 percent. There is already a shortage of long-term care workers in some areas, most notably in the northeastern states, and in the future there will be an even greater shortage. Cost containment measures have led to increased workloads, low wage increases, pressure for greater productivity, and in the case of home care workers, the fallout from uncertainty over Medicare reimbursement. Included in the report are areas identified for further

research, as well as descriptions of research currently being undertaken on long-term care workers. Attached to the report as appendices are: (1) Preliminary Recommendations to Congress by the Pepper Commission on Long Term Care, (2) the Statement of the President of OWL Before the Pepper Commission, A Hearing on Options in Long-Term Care, and (3) various press releases and articles on long-term care workers.

Lombardi, Tarky, Jr. (1988).

"Recruitment, Training and Retention of Home Care Paraprofessionals," Caring, May, 7(5):54-58.

This article summarizes the findings from New York Senator Lombardi's Task Force on Recruitment, Training, and Retention of Home Care Workers. Senator Lombardi suggests that the shortage of workers not only adversely affects home care, but the entire health care delivery system which has come to depend so heavily on community care. The article reviews many of the contributing factors leading to the shortage of home care workers, including the increased need for home care resulting from changes in the health care system and demographic changes; the low wages, limited benefits, and lack of guaranteed income; the poor working conditions, including isolation and irregular hours; the lack of job mobility/career opportunities; improved market conditions which make other job opportunities more promising; and state and federal regulations and requirements which limit flexibility in worker employment and assignment. Many potential actions that could be taken to help alleviate the shortage are reviewed. These include a statewide local assistance program to allow local groups to develop plans to address the shortage, training grants, funding demonstrations and innovative programs, creating job promotion activities, revision and coordination of state regulations, improved working conditions and management practices, assessing the impact of the Immigration Reform and Control Act of 1986, and more studies to obtain quantitative and detailed information about the home care market.

Lutz, Sandy. (1990).

"Home-Care Agencies Offer Bonuses for Business," Modern Healthcare, August 20, 73-74.

Lutz briefly describes the practices of two for-profit home care agencies to win allegiance from hospital

discharge planners. The agencies, Olsten Health Care Services in New York, and CareTeam Management Services in Texas, allow hospitals to accumulate "free hours" which they can then pass along to patients. The hours are awarded for home health aide or homemaker services which typically are not reimbursed by Medicare or private insurers.

MacAdam, Margaret A.; Yee, Donna. (1990).

"Providing High Quality Services to the Frail Elderly: A Study of Homemaker Services in Greater Boston,"April, (Waltham, Massachusetts: Bigel Institute for Health Policy, Heller School, Brandeis University).

MacAdam and Yee report the results of an extensive study of homemaker services undertaken by researchers at the Bigel Institute for Health Policy, Florence Heller School, Brandeis University. The study employed qualitative and quantitative methods to examine the process of authorizing service, to describe the characteristics of homemakers and the needs of clients, and to explore issues affecting the delivery of care, drawing on Litwak's shared function theory. In particular, the study sought to understand the degree of match between the home care worker's role and the client's needs for assistance in living at home. Quantitative data were collected from homemaker and client records; qualitative information came from interviews with agency management at two agencies and from observation and interviews with homemakers and elderly recipients of homemaker services as care was being delivered. The typical worker is a woman, with an average age of 45; 60 percent are single. The average homemaker has been on the job three to four years, her pay ranging from $5.75 to $7.10 per hour, averaging $6.42. Most homemakers work less than 24 hours per week. The homemaker and the client informally negotiate the tasks to be performed as well as the work schedule. Homemakers prefer to work with clients who are able to describe their service needs and preferences. Homemakers are able to respond to client emergencies which they feel are within their capacity. Homemakers are not treated as part of a professional caregiving team and when cuts in hours are made, they are not told which tasks that they no longer have to perform. Clients prefer workers who are responsive to client preferences. They are reluctant to criticize current workers but they will describe poor service by past homemakers. The clients seemed to accept the limited range of tasks performed by homemakers. The report includes copies of the

interview guides, as well as the homemaker and client data collection forms.

Melden, Michele.
(1991).

"Follow-Up Report to Little Hoover Commission, Hearings on 'Elder Care at Home,' March 20, 1991," June 21 (Los Angeles: National Health Law Program).

Meldon's report for the Little Hoover Commission describes community-based programs in the states of New York, Colorado, New Jersey, Ohio, and Oregon. Based on these programs, she makes various recommendations for California. These include supporting non-medical care as a cost-effective alternative to nursing homes; continuing reimbursement of family members; providing case management to coordinate services and to monitor the quality of care; and tapping into a variety of funding sources, making wider use of Medicaid personal care and home- and community-based waiver programs.

Miller, Judith Ann.
(1991).

Community-Based Long-Term Care: Innovative Models (Newbury Park, California: Sage Publications).

This book contains an overview of community-based long-term care and then presents detailed descriptions of 12 programs considered successful in providing quality and cost-effective care. The first section of the book includes detailed descriptions of the various kinds of community-based long-term care services and programs, as well as comprehensive overviews of the funding, certification, and licensure of services, including home care. Each chapter is coauthored by the director/developer of the particular program being described.

Montgomery, Douglas G.
(1981).

"Working in Aging Services: Job Satisfaction, Regulation and Turnover," Journal of Health and Human Resources Administration, 4:477-493.

This is a study of turnover in 42 agencies serving elderly clients in 1978. The author interviewed 428 workers in those agencies to identify the climate of work environment, including achievement, concern for excellence, problem-solving emphasis, reputation, training opportunities, atmosphere, and initial job

orientation. The average turnover rate in a one-year period was 24 percent. The major concerns of in-home nursing workers included disagreement with funding sources about service provision, disagreement with governmental regulatory agencies about services for clients, excessive paperwork, and interference by their agency's rules with service provision. The study found that in agencies with lower turnover rates the following organizational policies were important: participatory decision-making, worker perceptions that their services are effectively delivered and worthwhile, and teamwork.

Moore, Florence M.; Layzer, Emily.
(1983).

"Supporting the Homemaker-Home Health Aide as a Valuable Player on the Home Care Team," Pride Institute Journal of Long Term Home Health Care, Summer, 2(3):19-23.

Moore and Layzer present an overview of the homemaker-home health aide position. The demand for homemaker-home health aide service has skyrocketed. In 1963, there were an established 3,900 aides; as of 1982, there were 240,000 full-time equivalents. The job, depending on the individual's skills and training, falls somewhere in between domestic housekeeping and adjunct nursing care. Without adequate training, home care workers may cause harm to themselves and their clients. Certain personal characteristics appear essential to the worker's performance, including emotional maturity (independence, self-direction, self-discipline), a genuine concern for many different kinds of people, sensitivity, an ability to acquire the knowledge and skills needed for the job, and basic communications skills. Studies indicate that the low pay and lack of fringe benefits lead to high turnover rates. Agencies are implementing a variety of policies to improve retention: increasing financial remuneration, promoting a sense of affiliation with the agency, concrete recognition of the value of the homemaker-home health aide's contribution, and incorporating a system of experience levels to allow for lateral and vertical mobility.

Moore, Florence.
(1988).

Homemaker-Home Health Aide Services: Policies and Practices (Ownings Mills, Maryland: National Health Publishing).

Moore's book is a basic, comprehensive overview of homemaker-home health aide services. The first chapter

includes an introduction to the kinds of services provided during home care, including several vignettes and a thorough historical overview. The second chapter describes the wide range of situations in which people may need home care. The third chapter addressees the need to further the development of assessment tools for determining who requires home care services. The next chapter discusses the providers of home care. In addition to the informal system, there is wide variety in the types and organization of agency providers. The four main types are voluntary nonprofit, public tax-supported, for-profit, and hospital-supported agencies. Some of the major issues discussed in this chapter are: (1) the growth in competition among agencies; (2) program behavior which follows funding; and (3) the scarcity of data about provider agencies. The fourth chapter also includes profiles of six agencies in the United States and one in Canada. Additionally, there is an extensive description of the characteristics of home care workers. Traditionally, homemaker-home health aides have been women starting a second career; however, they are increasingly women from single-parent families. Agencies are increasingly hiring aides on a temporary, part-time basis. Problems faced by homemaker-home health aides, leading to high turnover, include: inadequate salaries, lack of benefits, lack of professional advancement, lack of recognition, isolation, burnout due to job stress, and personal problems. Moore briefly addresses the concerns raised by some programs that continue to use the individual provider method for home care services. The fifth chapter covers the costs and financing of home care and discusses the fragmentation of home care. Chapter six focuses on the various ways in which home care services are coordinated. Chapter Seven is an extensive, thorough discussion of quality of care in homemaker-home health aide services. The chapter also addresses the need for training and supervision of home care and describes the various voluntary accreditation efforts. Chapter Eight discusses home care programs in various other countries. The last chapter outlines possible directions for home care in the future, advocating universal national health care.

Mulkey, Oren A., Jr.; Allen, Ruth M. (1988).

"A Private/State/Federal Cooperative Venture for Training Home Care Workers," Pride Institute Journal of Long Term Home Health Care, Fall, 7 (4):36-38.

In 1984, a training program was set up by the University of Texas School of Allied Health Sciences

(Galveston) at 15 not-for-profit and 36 for-profit agencies in Texas, Arkansas, New Mexico, Oklahoma, and Louisiana. A total of 1,427 home care workers were trained at a cost of less than $300 per person. The only outcome noted is that the program increased the labor pool.

Munro, Peggy.
(1988).

"Setting Standards: Massachusetts Council for Homemaker-Home Health Aide Services," Caring, April, 7(4):22-25.

Munro describes the state-funded homemaker program in Massachusetts. In 1988, the state spent $83 million on the program. The Executive Office of Elder Affairs contracts with 27 home care corporations, which are nonprofit, community-based agencies, many of which are also Area Agencies on Aging. These corporations provide case management and some services, but usually deliver homemaker services through subcontracts with 147 homemaker provider agencies. The state sets wages, resulting in the highest wages in the country for homemakers ($7.01 an hour in 1988). The state also determines training requirements. In 1987, the state allowed an optional add-on of $.84 to encourage recruitment and retention of workers. The agencies used the extra funds for travel reimbursement and other benefits and incentive programs.

National Council for Homemaker Services.
(1969).

"Guidelines Regarding Personal Care in Homemaker Services," in Readings in Homemaker Service: Selected Papers Presenting the Background, Uses and Practices of Homemaker-Home Health Aide Programs, National Council for Homemaker Services (ed), pp. 80-85 (New York).

This paper discusses guidelines for homemaker-home health aide jobs with respect to personal care. Standards for personal care developed after a conference in 1960 with representatives of homemaker service agencies, nursing organizations, the American Medical Association, the American Heart Association, the American Cancer Society, the National Foundation, and the American Public Health Association. The conference reflected the increasing concern over the nature and extent of personal care given by home health aides. The conference members suggested that homemakers be allowed to perform those procedures that are normally done by family members, as long as the

homemakers were under the supervision of a nurse or physician.

National Council for Homemaker Services, Inc.; Council on Social Work Education.
(Undated).

A Unit of Learning about Homemaker-Home Health Aide Service: Teacher's Source Book (New York, New York).

This book contains an overview of what was known about homemakers in the mid-1960s. It was estimated that 200,000 homemaker-home health aides were needed in 1964 while there were only 10,000 aides employed full- or part-time. In the United Kingdom, with a population of 55 million, there are an estimate 70,000 home helps employed. The Council considered "homemaker-home health aide" to be a generic term which had evolved in the 1960s. Some of the different names employed in the past included substitute mothers, visiting homemakers, housekeeping aides, and health aides. Although workers were formerly limited to providing short-term, emergency household help, they now often provide help for longer periods of time.

National Council for Homemaker Services.
(1969).

Readings in Homemaker Service: Selected Papers Presenting the Background, Uses and Practices of Homemaker-Home Health Aide Programs (New York).

This collection of readings discusses several issues with respect to homemaker services in the late 1960s, including: (1) the philosophy and goals of homemaker-home health aide services; (2) the variation in homemaker service (the different groups served and service models); (3) standards; (4) administration and financing of programs; (5) staff development; and (6) home help services in other countries.

New York City Home Care Work Group.
(1990).

"Building the Home Care Triangle: Clients and Families, Paraprofessionals and Agencies in Partnership with Government," January (New York).

The Home Care Work Group consists of a broad range of representatives from service agencies, labor, client advocacy groups, and universities. This report is the result of quantitative research, focus groups, and extensive discussions among members of the Work Group.

The report describes the home care system in New York and presents the view of three groups with respect to their expectations for home care: clients, workers, and agencies. The Work Group paper discusses the common grounds among the different groups and recommends several broad changes.

New York State Department of Health. (1988).

"New York State Home Care Workers Study, Phase 1," (New York).

This paper reports the results of the Long Term Care Policy Coordinating Committee's extensive survey of home care agencies in New York. It is the first of three studies; the others included an analysis of the low income labor market and a survey of home care workers. Of the questionnaires mailed, 417 were returned, representing 523 of the 880 agencies/programs in New York. The survey revealed that forty percent of the responding agencies are proprietary, 17 percent are public, and 44 percent are voluntary. Agencies rely heavily on Medicaid. Statewide, an average 41 percent of revenues are received from Medicaid. The survey also included questions on both client and worker characteristics. Agencies average 124.8 workers per agency, ranging from 1 to 1,6000. Agencies rely heavily on part-time workers and the average agency employs 43 percent of their workers on a part-time basis. Agencies differ considerably in the frequency of each type of contact between supervisors and workers. On the average, workers are evaluated 2.8 times per year. Three methods are commonly used to evaluate workers: home visits, interviews with clients/patients, and clinical record audits. Starting wages range from $3.35 to $8.20 per hour, averaging $4.75. The average annual wage is $8,888.46 per year. Forty-three percent of new hires are already trained and certified; 39 percent of the new hires are trained by the agency which hires them. With respect to worker recruitment, 65 percent of the agencies report that their recruitment efforts are continuous. In addition to the descriptive summary, the survey results are presented in 63 tables. A copy of the Agency Survey is attached as an appendix.

New York State Department of Social Services. (1990).

"Strengthening the Home Care Work Force in New York State," January (New York).

This paper reports the results of the third survey by the Long Term Care Policy Coordinating Council (LTCPCC). The survey was designed to identify problems with the content, organization, compensation, or other characteristics of home care which might have a negative effect on worker retention and the report contains extensive survey results and analyses of each of these areas. The Council surveyed a sample of 1,425 home care workers in New York. In presenting the findings of the extensive survey, the report also compares workers in New York City with workers in upstate New York and Suburban New York City. The mean age is 42. Forty-two percent had less than a high school education and 41 percent graduated from high school but had no further education; 17 percent had some education beyond high school. Workers in New York City were less likely to have completed high school, probably because only 38 percent of New York City workers were born in the continental United States. Thirty-seven percent are married; 29 percent are single; 25 percent are divorced or separated; and 9 percent are widowed. About 21 percent of the workers have a pre-school-age child and 36 percent have a school-age child. Before coming to home care, 61 percent of the workers had held another job. The survey results include the types of jobs workers held prior to working in home care, as well as the reasons for seeking employment in home care. Most home care workers heard about their home care job by word-of-mouth. Seventy-eight percent of the current workers had received training when they first took a home care job. About two-thirds of the workers work full-time (more than 30 hours per week) and one-third work part-time. Over a third of workers work more than 40 hours a week. Of the twenty-two tasks listed in the survey, only five are performed by more than ten percent of the workers. The most commonly performed tasks are those related to homemaking. On average, home care workers are paid $5.02 an hour, resulting in an estimated annual take-home pay of $8,734. The survey results suggest that improved fringe benefits and, to a lesser extent improved wages, have a demonstrated effect on job acceptability which, presumably, is related to worker retention. The simulations conducted by the researchers indicate that guaranteeing hours may be the most effective way to retain home care workers.

Older Women's League; American Federation of State, County and Municipal Employees, AFL-CIO.
(Undated).

"Chronic Care Worker Bill of Rights," (Washington, D.C.: Older Women's League).

Ten rights for long-term care workers are proposed. These include: (1) a fair hourly wage, overtime pay, shift differentials, differentials for complex cases, paid travel, and a guaranteed number of hours per week; (2) benefits; (3) freedom to decline overtime; (4) adequate staffing, equipment, supplies, and time; (5) appropriate paid training; (6) in-service training and continuing education; (7) adequate on-the-job supervision; (8) information about responsibilities, role, and tasks; (9) support that gives workers the opportunity to meet with others; and (10) the right to be counted as a valued member of the health care team.

Older Women's League.
(Undated).

"Basic Facts about Chronic Care Workers," (Washington, D.C.).

This two-page fact sheet describes the working conditions of home care workers and nursing home aides. There were about 1.3 million nursing aides in 1986, with nearly half working in nursing homes. Ninety percent are women and 38 percent are Black or Hispanic. The average hourly wage is $4.50. There are at least 300,000 home health aides, but little reliable national data exists. They are also nearly all women and disproportionately Black and Hispanic. Most are middle-aged or older. The average hourly wage is $4.25. Home health aides earn less than their counterparts in nursing homes, are more likely to work part-time, and are less likely to have any benefits. The sidebars include comments from political leaders regarding the importance of long-term care workers and from long-term care workers discussing their working conditions.

Older Women's League; American Federation of State, County and Municipal Employees, AFL-CIO.
(1988).

"Chronic Care Workers: Crisis Among Paid Caregivers of the Elderly," (Washington, D.C.: Older Women's League).

Current national data about nursing home aides and home health aides are summarized in this report. The

information is basically the same as that contained in OWL's "Gray Paper: The Womanly World of Long Term Care: The Plight of the Long Term Care Worker" (Washington, D.C.: undated). The discussion includes information about the number of these workers, who they are, where they work, and their hours, wages, benefits, and training. In 1988, there were between 11,00 and 12,000 home health agencies in the United States; about half were certified for reimbursement under Medicare. In 1986, aides constituted an estimated 26 percent of full-time staff equivalents in certified home health agencies. The average starting wage in the home care industry now ranges between $4.00 and $4.25 per hour. The second part of the paper reviews key elements contributing to a growing crisis among paid caregivers of the elderly: current shortages of workers, aggravated by high turnover, the projected demand for workers. and the impact of recent public policy changes, including legislation setting minimum standards for training. Appended is a chronic care workers' bill of rights and a call to action.

Older Women's League.
(Undated).

"The Womanly World of Long Term Care: The Plight of the Long Term Care Worker (Gray Paper)," (Washington, D.C.).

This is an overview of the working conditions of home health workers and nursing home aides. Nursing home aides provide up to 90 percent of patient care. Nursing aides are overwhelmingly women (90 percent) and very disproportionately African American (31 percent). The Census Bureau found that nursing aides averaged, in 1979 dollars, $3.98 per hour in 1979 and $3.91 in 1986. One researcher estimates that there are at least 300,000 home health aides in the United States. Data available show that long-term care workers are midlife women, disproportionately minorities, working for low wages and few benefits. Turnover ranges from 70 to 100 percent a year for nursing aides. On average, the turnover rate is 60 percent for home care workers; 80-90 percent leave within two years. Many problems lead to high turnover, including low wages, few benefits, unpredictable income due to sporadic hours for home aides, inadequate training, no upward mobility, and stressful working conditions. Training is inadequate. As of 1986, only 13 of 34 states with home health licensure had any stated requirements for the duration and content of home health aide training. In some areas, especially in the northeastern and western states, there is a shortage of long-term care workers. The report also discusses the policy changes

that have exacerbated the problems faced by long-term care workers. The paper suggests that the aging community may benefit by adopting some of the policy directions taken by the Independent Living movement, such as allowing the receiver of care more control by hiring workers directly instead of through a home care agency.

Pemberton, Annie May.
(1962).

"Homemaker Services to Older People," in The Homemaker in Public Welfare, Public Welfare Project on Aging (ed), pp. 20-23 (Chicago, Illinois: American Public Welfare Association).

The North Carolina State Board of Public Welfare ran a two-year demonstration of homemaker services for the aged receiving public welfare. The program was underwritten by a $20,000 grant from the Doris Duke Foundation. Both white and Black homemakers, serving their own race, were employed in each county. The program was subsequently expanded to other counties. Pemberton discusses the qualifications of a good homemaker and notes that aside from the social value of the services for the aged, the program has provided new employment opportunities for many middle-aged women without previous work experience or training.

Pesznecker, Betty; Horn, Barbara; Werner, Joanne; Kenyon, Virginia.
(1987).

"Home Health Services in a Climate of Cost Containment," Home Health Care Services Quarterly, Spring, 8(1):5-21.

The concerns of Medicare certified home care agencies in the Northwest region (Washington, Idaho, Montana, Alaska and Oregon) were studied beginning in 1986 using the Delphi method survey technique. The first round of questions was answered by 106 of the 179 Medicare-certified agencies in the region. Of the responding agencies, 18.8 percent were for-profit and 74.2 percent were not-for-profit. Almost 60 percent were community-based and 41 percent were hospital-based. The agencies were almost equally split between rural and urban communities. The major concerns of the agencies included: the increased time needed by greater numbers of highly acute patients, growing demands for 24-hour coverage and on-call services, increased demand for personal care services including home health aides, chore-workers and housekeepers, and the lack or limited availability of needed community resources.

Reimbursement concerns included the lack of reimbursement for chronic, custodial, maintenance, and respite care.

Pomeranz, William; Rosenberg, Steven. (1985).

"How Nonprofit Organizations Can Develop Comprehensive In-Home Support Services by Utilizing Various Funding Streams," Home Health Care Services Quarterly, Summer, 6(2):33-55.

Pomeranz and Rosenberg wrote this article for home care organizations, suggesting that home-chore services can provide nonprofit organizations with opportunities for service, employment, training, and economic development. The authors describe the ways that such organizations can fund and develop home-chore programs, examining five major funding sources and the opportunities for combining program funds. The authors then discuss various issues to consider in competing for contract bids with proprietary providers. Marketing strategies are outlined for each funding source, including which services to offer and how to project a favorable agency image. Special emphasis is placed on ways to tap the often overlooked, but largest, client population, the private pay sector. Finally, the authors present guidelines for preparing budgets.

Reif, Laura. (1980).

"Expansion and Merger of Home Care Agencies: Optimizing Existing Resources Through Organizational Redesign," Home Health Care Services Quarterly, Fall, 1(3):3-36.

Reif analyzes the extent to which expansion and mergers by home care agencies are proving effective strategies for improving in-home services for persons who require long-term care. The reorganization strategies of nine comprehensive home care providers are described and the barriers to restructuring examined. After reorganization, agencies appear to be more successful in reaching greater numbers of potential clients, in providing more appropriate, well-coordinated services, and in making more effective use of existing resources. Nevertheless, inadequate funding impedes the development of home care services and expansions and mergers are only a partial solution.

Ricker-Smith, Katherine; Trager, Brahna. (1978).

"In-Home Health Services in California: Some Lessons for National Health Insurance," Medical Care, March, 16(3):173-190.

The authors examined California home health data for 1966 through 1973, documenting the effect of major policies on the development and subsequent decline of in-home health services under Medicare and Medicaid. A review of those policies, supported by the California data, indicate that in-home health services have been greatly restricted by historical underdevelopment and legislative and regulatory actions. During the period of study, home care agencies did not hire additional staff, except for homemakers. Both the number of visits provided by homemakers and their share of clients increased.

Roberts, Deborah N.; Sarvela, Paul D. (1990).

"Community Care Workers in Rural Southern Illinois: Job Satisfaction and Implications for Employee Retention," Home Health Care Services Quarterly, 10(3/4):93-115.

This cross-sectional study examined factors related to community care worker job satisfaction in order to assess problems related to employee turnover. Data were collected from 393 community care workers who worked with elderly clients in the 13 southernmost rural counties in Illinois in 1987. The questionnaire contained two open-ended questions aimed at determining what respondents thought was the best thing about the job and why they thought newly hired employees quit soon after being hired and a shortened version of the Job Descriptive Index Scales (JDI) developed by Smith, Kendall and Hulin (1969) to measure job satisfaction in relation to the work itself, supervision, and pay. All the workers but one were female. The majority were white, married, between the ages of 31 and 44, and had either graduated from high school or had a GED certificate. The only category with a higher proportion of low scores than high scores was pay. The work itself, training and supervision were described more positively. The job and supervision were more related to overall job satisfaction than training and pay. The results suggest that the majority of workers were satisfied with their job; however, workers employed for more than one year had lower satisfaction scores than those employed for less time. The authors note that agencies may be protecting themselves

somewhat because they tend to hire older workers and older workers have lower turnover rates in general.

Rosenfeld, Alan S.
(1981).

"Factors Affecting Home Health Agency Behavior: An Interactionist View," Home Health Care Services Quarterly, Summer, 2(2):59-100.

Rosenfeld notes that most policy analyses imply that reimbursement policies are the most significant factor in understanding home health agency behavior. In contrast, he argues that home health agencies establish their role in the long-term care delivery system through a process of internal and external interactions and that subsequent referral patterns reflect those roles. The case records of 18,406 patients discharged from 45 Massachusetts home health agencies in 1976 were examined. The agencies all faced the same potential reimbursement policies. The study found that the agencies provided very different service patterns in terms of skilled and personal care, as well as the types of disabilities served and reimbursement received. Rosenfeld suggests that each agency adapts to and serves its own clients best, which may not correspond to the needs of the community.

Royse, David; Dhooper, Surjit; Howard, Kim.
(1988).

"Job Satisfaction Among Home Health Aides," Home Health Care Services Quarterly, 9(1):77-84.

The authors surveyed 132 home health aides in Ohio about job satisfaction using Locke's Action Tendency Interview Schedule. Questionnaires were distributed during agency staff meetings. The age of the aides ranged from 18 to 70, with median age of 50. The median length of time employed as an aide was six years, ranging from less than one year to 20 years. The authors found that respondents who had been employed in home health care for five years or less were more satisfied than those who had been working for a longer period of time. There were no differences in job satisfaction by age. The authors suggest that the more experienced home health aides may be given larger caseloads or more debilitated clients or senior aides have different expectations which result in decreased job satisfaction. The authors also speculate that the work may become less challenging or that burnout occurs because so few clients recover.

Sabatino, Charles.
(1989).

"Homecare Quality," Generations, Winter, 12-16.

Sabatino suggests that understanding home care and ensuring quality care are exacerbated by the artificial compartmentalization of home care. He compares home care with a "tri-animal," a creature made by mixing and matching the head, body, and feet of various animals. The head of the animal can be compared to the provider or its organizational form (who the provider is), the body of the animal to the various services available from the provider (what the provider does), and the legs of the animal to the various funding sources (how the animal runs). Sabatino also discusses several major issues -- the scope of regulation, capacity versus actual care, client empowerment, and the monitoring and enforcement, as well as worker employment and training.

Salvatore, Tony.
(1985).

"Organizational Adaptation in the VNA: Paradigm Change in the Voluntary Sector," Home Health Care Services Quarterly, Summer, 6(2):19-31.

Salvatore describes the organizational history of Visiting Nurse Associations (VNA). There have been four distinct, but overlapping stages of the development of the VNAs. Each stage is presented as a paradigm, "a specific pattern of values, behaviors, and structures held in common in varying degree by agencies that also differ as to scale, location, sophistication, and other factors" (pp. 20-21). These paradigms are "public health nursing," "community nursing service," "the home health agency," and the "home care enterprise." Salvatore suggests that the VNA's are entering a new stage, with the emergence of a supraparadigm, the "Home Care Enterprise."

Schirm, Victoria.
(1989).

"Shared Care by Formal and Informal Caregivers for Community Residing Elderly," Journal of the New York State Nurses Association, March, 20(1):8-14.

Using a convenience sample of clients of the Benjamin Rose Institute, Schirm surveyed 53 functionally impaired elderly who were receiving care from an informal caregiver as well as from professional nurses

or home health aides under nursing supervision during 1986, 1987, and 1988. The findings suggest that home care was possible because of the combined efforts of formal and informal caregivers. Formal caregivers were more likely to assist elderly with bathing and to manage the supervision and teaching aspects of nursing care. Informal caregivers assumed more responsibility in helping with the instrumental activities of daily living and administering oral medications.

SEIU, Homecare Workers Union/Local 434. (1988).

"We Who Care: The Story of Los Angeles County's Homecare Workers ," January (Los Angeles).

This is a detailed overview of the In-Home Supportive Services (IHSS) Program in Los Angeles County, as well as home care in general. There are some 40,000 IHSS workers in Los Angeles County, providing care to over 52,000 elderly and disabled county residents. The pay for homecare workers is low: $3.72 per hour. The statewide IHSS budget for the 1987-88 fiscal year totalled $496 million, with federal funds covering 61 percent of program costs, the state, 34.5 percent, and counties, the remaining 4.6 percent. Los Angeles County's budget for fiscal year 1987-88 was $176 million, with $8.2 million in county funds. The program is administered by the Adult Protective Services division of the Department of Public Social Services. At the state level, county IHSS programs are monitored by the Department of Social Services. Statewide, IHSS services are provided through one of three delivery modes. Private contract agencies serve 18.6 percent of all recipients and county welfare staff serve an additional 1.1 percent of the recipients. The third and largest type of service, the Independent Provider (IP) system, covers the remaining 80.3 percent of clients. Los Angeles County uses the IP system exclusively. The report continues with an overview of the types of services offered, as well as client and worker characteristics. Sixty-eight percent of the 130,000 California recipients of IHSS services were 65 or older in 1986. The workers are mostly women. In Los Angeles County, they are predominantly Black and Latina women. Most are middle-aged or older. Most providers are not family members of the clients. The Homecare Workers Union is asking support for a Homecare Workers' Bill of Rights including fair pay, the right to basic health insurance, and improvements in the homecare program.

SEIU, Homecare Workers Union/Local 434. (1988).

"A Need for Care: Homecare Workers without Health Insurance," March (Los Angeles).

The SEIU surveyed 1,000 Los Angeles County homecare workers with respect to their health insurance coverage. Sixty percent of the home care workers have no health insurance; for workers under the age of 65, the proportion without insurance rises to 65.1 percent. Workers are employed an average of 27.6 hours per week, corresponding to an annual income of $5,339, which is below the poverty level. The current pay is $3.72 per hour. Only 17.1 percent of workers have a second job to supplement their homecare wages. Homecare workers are significantly older than the population at large, with an average age of 48. As an older population, they are more likely to be in need of health care services. Almost 89 percent of those surveyed are women and women are more likely to have health insurance coverage than men (40.8 percent versus 32.2 percent). Of those with insurance coverage, 13.5 percent receive Medicare, 14.8 percent are covered by Medi-Cal, 33 percent are covered under a spouse's plan; and 8.8 percent are covered through a second job. Approximately half of those surveyed have children. Only 12.6 percent of the uninsured workers have coverage for dependent children and 14.8 percent of those with insurance lack coverage for dependents. Workers without insurance experience substantial difficulty in attaining care.

SEIU, Homecare Workers Union/Local 434. (1988).

"Homecare: Invisible & Inadequate. Quality of Care in the Los Angeles County IHSS Program," May (Los Angeles).

This report summarizes California's In-Home Supportive Services program, focusing on the problems encountered with service by the 52,000 IHSS clients in Los Angeles County. The lack of outreach leaves many without any services. There is no referral system to link clients with providers and there is no provision for back-up or relief care when the regular home care worker is unavailable. The county does not screen workers and workers do not receive any training. Low wages have resulted in a scarcity of workers. Clients supplement provider wages out-of-pocket or inflate the number of hours worked. Immigration law changes are further limiting the availability of workers.

SEIU, Homecare Workers Union/Local 434B. (1989).

"Clients Speak Out on their Lifeline: Testimony submitted April 28, 1989 by The Homecare Workers Union Local 434B Service Employees International Union," April (Los Angeles).

These are testimonies gathered by the SEIU and presented to Assemblyman Terry Friedman in opposition to proposed cuts in California's In-Home Support Services (IHSS) program budget. The report contains 103 testimonies from clients receiving IHSS services, briefly stating the client's first name, age, illness, services needed, and what would happen if the program were to be cut.

SEIU, Homecare Workers Union/Local 434B. (1990).

"Homecare Workers Deserve a Living Wage: The Inadequacy of California's Minimum Wage," May 18 (Los Angeles).

This is the testimony presented to the California Industrial Welfare Commission by the SEIU concerning the inadequacy of California's minimum wage, $4.25 per hour, effective July, 1988. Homecare workers in the In-Home Supportive Services program constitute the largest group of minimum wage workers. In Los Angeles County, there are approximately 55,000 homecare workers; statewide, there are nearly 130,000 homecare workers employed through IHSS earning minimum wage, usually without health insurance or other benefits. The union's survey of 1,027 workers found the average age to be 49. Nearly 89 percent of the workers are female. The average number of hours worked per week is 27.6 and the average weekly wage is $117.30. Seventeen percent have a second job and the average hourly wage of that second job is $6.07.

SEIU, Homecare Workers Union/Local 434B. (1990).

"Homecare Workers at Risk: Inadequate Training and Protection Against Blood-borne Infectious Disease," January (Los Angeles).

This paper reports the findings of a survey of 610 home care workers employed in Los Angeles County's In-Home Supportive Services (IHSS) program with respect to the handling of bodily fluids. IHSS is California's largest publicly-funded homecare program, serving approximately 140,000 persons statewide and over 54,000 persons in Los Angeles County. While the job duties of

an overwhelming majority of homecare workers bring them into contact with potentially infectious bodily fluids at least weekly, there is little training on how to avoid infection from blood-borne disease. Fewer than one out of four workers surveyed received any training or information. Where training is reported, it is self-motivated and is frequently outdated and/or inadequate.

Short, Pamela Farley; Leon, Joel.
(1990).

"Use of Home and Community Services by Persons Ages 65 and Older With Functional Difficulties," National Medical Expenditure Survey Research Findings 5, September (DHHS Publication No. (PHS) 90-3466) (Rockville, MD.: Agency for Health Care Policy and Research, Public Health Service).

Short and Leon present the findings of the 1987 National Medical Expenditure Survey Research with respect to home- and community-based service utilization. Federal expenditures account for about one-third of all expenditures for home and community services. Two million of the 5.6 million age 65 and older with functional disabilities used formal services. Home care was the most commonly used service, broadly defined to include any professional or homemaking services provided in the home except home-delivered meals; it was utilized by 19.7 percent of those age 65 or older with functional difficulties. Home care was usually provided by a homemaker, a category which includes both paid domestic helpers as well as staff from a home health agency or similar organization. Homemakers served almost half of the elderly with functional difficulties who received home care (8.1 percent); 4.9 percent were seen by home health aides; 4.5 percent by nurses, 1.6 percent by physicians; and 5 percent by other nonphysician medical providers. The findings support those of the 1982 Long-Term Care Survey, which found that one in four of the 4.4 million noninstitutionalized elderly persons receiving help with physical or instrumental activities of daily living received such assistance from paid helpers, although almost all had nonpaid help.

Showers, Denise M.
(1989).

"Paraprofessional Training: In a Time of Changing Federal Regulations," Caring, February, 8(2):45-48.

In this article, Showers speculates on the content of the final draft of federal standards for the home care

health industry. The regulations may cover such areas as: interpersonal communication, basic nursing skills, personal care skills, mental health and social service needs, clients' rights, and special needs population. The author expected the regulations to be issued shortly.

Somers, Anne R.; Moore, Florence M. (1976).

"Homemaker Services -- Essential Option for the Elderly," Public Health Reports, July-August, 91(4):354-59.

Somers and Moore present an overview of homemaker services. In 1975, approximately 1,800 administrative units were providing homemaker services and less than half were among the 2,300 certified home health agencies. The number of homemakers was estimated at 44,000. As of 1975, there was one homemaker for every 5,000 persons. This compares poorly with other countries, such as Sweden, where the is one aide for every 121 persons. The article also briefly discusses financing and costs, standards, and accreditation.

Spiegel, Allen D.; Domanowski, Gerard F. (1983).

"Beginnings of Home Health Care: A Brief History," The Pride Institute Journal of Long Term Home Health Care, Summer, 2(3):28-33.

This is a fairly comprehensive history of home care services, discussing their development in both the health and the social/welfare fields. The authors trace the development of home health services from the first organized services, offered by early dispensaries which sent physicians to people's homes, to the emergence of home care programs through hospital, governmental agencies, voluntary health associations, and private insurance companies by the time of World War II. The article also addresses the more recent changes in home health delivery effected by Medicaid, Medicare, Title XX of the Social Security Act, Older Americans Act, and Public Health Service and Health Care Financing Administration activities. The authors also describe how home care services developed in social services programs starting in 1903 when the Family Services Bureau of the Association for the Improvement of the Condition of the Poor in New York City employed women to help sick women by caring for children and helping with housework. Other organizations soon followed, concentrating on child care. Growth was slow until the beginning of

Depression. The Works Progress Administration (WPA) employed women as "housekeeping aides," usually on a contract basis with organized services. By the early 1940s, when the WPA was discontinued, there were 38,000 homemakers in the nation. The article also reviews some of the national conferences and early research efforts on home care.

Spohn, Pamela Hanes; Bergthold, Linda; Estes, Carroll L. (1987/1988).

"From Cottages to Condos: The Expansion of the Home Health Care Industry Under Medicare," Home Health Care Services Quarterly, Winter, 8(4):25-55.

This paper explores in detail the influence of Medicare changes and other federal, state, and private policies on the expansion of the home care market. The home health care industry has undergone a dramatic period of growth since the passage of Medicare in 1965. There has been a dramatic increase in the total number of Medicare-certified agencies providing care, as well as the number of clients served and hours of care provided. The authors suggest that overall growth does not equate with improved access or availability of needed services in the home for the frail and functionally-impaired elderly. Research findings from the first year of a three-year study designed to document the impact of cost containment policies on community-based care for the elderly are reported in summary form to illustrate the authors' position. The home health agency survey, using random sampling techniques, selected 25 home health agencies in each of the nine SMSAs in the study (San Francisco/Oakland, San Diego, Seattle, Dallas/Ft. Worth, Houston, Miami, Tampa/St. Petersburg, Philadelphia, and Pittsburgh). Interviews were conducted with the agency directors. The researchers found that forty-seven percent of the agencies surveyed reported adding services since 1984. The most frequently mentioned new services were IV therapy and rehabilitation therapies. Homemaker or companion services were mentioned to a lesser, but still significant extent. Of those agencies providing home health aide services, 63 percent had increased the number of aides employed and 63 percent had increased homemaker services. The most common requests for services that could not be provided were for private duty nursing, free care, physical therapy, and home health aides. The reasons for not offering these services include inadequate staffing, lack of funding, Medicare restrictions, and the inability of clients to afford such services.

Steeno, Terrence J.; Moorehead, Betty B.; Smits, James R. (1977).

"Homemakers as Change Agents," Social Casework, May, 58:286-293.

The authors suggest that the homemaker needs to be elevated to the status of a change agent whose purpose is to create or facilitate planned change. The United Way defines homemakers as trained personnel who go into homes as substitute homemakers (or housekeepers) when there is a temporary absence or incapacity of the regular homemaker. Although the National Council for Homemaker Services introduces a broader concept, these definitions are still too narrow. Many people view the homemaker as an aide or a person providing a subsidiary service. This perspective limits the homemaker's potential value as part of the treatment team. Society currently reinforces this attitude by placing little value, both economically and socially, on the role of the homemaker in the family.

Sterling, Mildred. (1978).

"Visiting Aides Training Program," Health and Social Work, August, 3(3):155-164.

Sterling describes the visiting aides program of a nonprofit hospital in Florida. Project Renew was a government-funded program that sought to develop ways to provide the elderly with companionship, as well as opportunities to supplement their incomes. In 1974, Project Renew offered the services of two Companion Aides to the Elderly to the hospital's social work department. The aides had to be at least 55 years old and complete a Red Cross course in the basics of home care and were subsidized through Project Renew at the rate of $2.10 an hour. During the first three years of operation, the program graduated 24 visiting aide trainees. Four of the graduates are now employed in agencies serving the elderly and the others provide home care for patients and usually work on temporary or short-term assignments, forming a registry of trained people. In addition to the benefits for the patients, public funds have been saved.

Stillman, Joseph; Gould-Stuart, Joanna. (1988).

"Quality of Work and Quality of Care in Home Care," September (New York: The Conservation Company, formerly Pickman Consulting Group, Inc.).

This study involved extensive observations of home care workers from three provider agencies in New York City. In addition to observation, interviews were conducted with those workers, their clients, clients' family members, and the workers' supervisors and other agency staff. The study was funded by the Ford Foundation as an auxiliary to the national demonstrations reported in Feldman et al. (1990) that tested various work life programs. The main job difficulties described by home care workers were problems with clients' behavior, problems with the behavior of the clients' family members', working conditions, job tasks for bedridden clients, boredom, weekend or replacement workers, sleep-in conditions, and sexual harassment. Problems with the behavior of the clients and their family members were cited more often than any other problem area. The study found that good relationships between workers and clients took many forms and the study authors noted that a good relationship can make extraordinarily difficult and painful situations endurable. Building trust and communication is a principal challenge for workers.

Surpin, Rick.
(1987).

"Cooperative Home Care Associates: A Status Report," (New York: Community Service Society of New York Working Papers).

Cooperative Home Care Associates (CHCA), established in 1985, is the largest known low-income worker cooperative enterprise in the United States. Located in the South Bronx, New York, the agency provides skilled and reliable home health aide services in Bronx and Upper Manhattan, generally under contract to agencies which provide comprehensive home care services. The agency has the dual purpose of improving wages, fringe benefits, working conditions, job stability, and upward mobility for the low-income, primarily Black and Latina female work force and to ensure high quality home care. In 1987, the agency employed 130 home health aides and expected to employ 200 by the end of 1987. The agency pays higher than average wages. Surpin discusses many of the problems faced in starting the agency, including the lack of management experience and the market structure of home care which makes it difficult to provide full-time work.

Surpin, Rick.
(1988).

"Improved Working Conditions Lead to Improved Quality," Caring, May, 7(5):26-29.

Surpin discusses the working conditions of home care workers which need improvement, calling for improvements in wages, benefits, working conditions, and opportunities for advancement. Home care worker turnover averages 60 percent a year. Eighty to ninety percent leave a particular agency within two years. Most home care paraprofessionals work for several agencies before leaving the field. The job requires someone comfortable with the high level of isolation, autonomy, and responsibility. Workers thrive on the one-to-one relationships they develop with their clients. Nevertheless, even with "good" clients, there is a constant struggle to define their job as distinct from domestic work. Two major obstacles to improving working conditions are general cost containment policies and societal views which devalue this kind of work.

Surpin, Rick.
(1988).

"Cooperative Home Care Associates: A Worker-owned Home Care Agency," Pride Institute Journal of Long Term Home Health Care, Fall, 7(4):31-35.

Cooperative Home Care Associates (CHCA), New York, was established in January 1985 as a worker-owned home care agency. At first the agency had only one contract, making it difficult to provide full-time employment because the hospital made referrals for morning-only care. The agency increased the number of its contracts and, by the end of 1986, it provided full-time employment for 70 percent of the workforce. Annual turnover from the beginning has been half the industry average of 60 percent and, as of the end of the third quarter of 1988, turnover was down to 20 percent. Surpin attributes the high retention rate to the relatively high wages and benefits combined with job stability. Since 1986, recruitment efforts have focused almost entirely on training new aides. Instead of the traditional lecture method, small group training is used. Selection is based principally on personality characteristics such as maturity and attitude towards work and patient care. Reducing turnover is important for continuity and quality care.

Surpin, Rick.
(1988).

"The Current Status of the Paraprofessional in Home Care," Caring, April, 7(4):4-9.

This is a discussion of the working conditions of home care workers, comparing these workers with the more favorable conditions faced by hospital and nursing home workers. The status of home care workers resembles that of the nurse aide in institutions prior to unionization in the 1960s and 1970s in terms of their pay and benefits and that of private-duty nurses prior to World War II because of their low professional standing and isolated working conditions. The typical wage is between $4.00 and $4.50 an hour, with somewhat higher rates in rural and some suburban areas. Home care workers are rarely rewarded for good performance, experience, or increased skills or given differential pay for night or weekend work. They are also exempt from standard labor practices such as paying time-and-a-half for overtime. The home care worker rarely has job stability. While the one-on-one relationship with their clients makes home care workers feel helpful, appreciated, and trusted, they face considerable job-related stress, including daily travel to unfamiliar and often unsafe neighborhoods and being treated like a maid. Another problem with home care work is the lack of a career ladder. In order to advance, the worker must leave the job and return to school.

Szasz, Andrew.
(1990).

"The Labor Impacts of Policy Change in Health Care: How Federal Policy Transformed Home Health Organizations and Their Labor Practices," Journal of Health Politics, Policy and Law, Spring, 15(1):191-210.

In this article, Szasz examines the impact of health care policy change on labor policies, using survey data from the 1986 study "Organizational and Community Responses to Medicare Policy: Consequences for Health and Social Services for the Elderly," by the Institute for Health and Aging and Institute for Health Policy Studies at the University of California, San Francisco. That study surveyed 148 Medicare-certified, non-publicly owned agencies, representing a random sample of agencies from nine urban SMSAs in five states. The Omnibus Budget Reconciliation Act of 1980 brought qualitative changes, including new opportunities for organizational growth and competition. Subsequent attempts to control growth of home health care (cost

containment, increased denial rates, lowered reimbursement) brought further organizational change. In home health care, labor costs account for 70-90 percent of an agency's budget. It is difficult to lower wages because there are shortages of some home health workers, such as nurses, while other workers, such as the homemaker/chore workers are already paid near minimum wages. Instead, agencies have increased their use of part-time employment, a strategy that works better with low-skilled workers. By 1986, the survey showed that productivity gains become the top agency priority. Various measures were taken by agencies to increase productivity, especially the implementation of policies designed to increase the amount of work done by home care workers and nurses.

Tiagha, Hannah.
(1981).

"Role Analysis of the Position of the Homemaker-Home Health Aide," Home Health Care Services Quarterly, Winter, 2(4):39-56.

This article reports on a study analyzing the role of the homemaker-home health aide. The article begins with an overview of the current status of homemaker-home health aide services, focusing on the National HomeCaring Council's prescriptions for quality service. In 1958, there were 138 agencies providing in-home care in the United States and Canada; in 1978, there were 5,000 agencies in both countries and an estimated 82,000 aides employed in the United States. For the study, data were collected from two "best practice" agencies (agencies adhering to the National Council's standards) in one of the suburban counties of New York using a multiple-choice, 60-item questionnaire on expectations for the aide's role. The study sample included consumers, aides, and supervisors. Eighty-eight percent of the aides were black; 84 percent of the consumers were white; and 100 percent of the supervisors were white. The study found that while there was relatively high intragroup consensus on items of personal attributes, there was a relatively low level of intragroup consensus with respect to personal care skills and interacting and socializing skills. Supervisors had the highest level of consensus, while consumers had the lowest level, perhaps because the latter rarely meet to discuss their common problems and may view the service in the context of concrete, individual needs. With respect to intergroup consensus, the study found that conflicts more likely existed between consumers and aides than between supervisors and aides or between supervisors and

consumers. The role segment concerned with household management and nutrition showed significant intergroup conflict. Role ambiguity was also found for behaviors that involve tasks that are "too specialized" (taking temperature, pulse and respiration measurements) and discretionary tasks that some felt bordered on cosmetic activities. The study also asked about satisfaction. The majority of the aides were satisfied and most of the aides were evaluated by their supervisors as doing a very good job. An overwhelming 97 percent of the users said they were "very satisfied" with the service.

Trager, Brahna.
(Undated).

"Recruitment and Training of Homemaker-Home Health Aides," in A Unit of Learning about Homemaker-Home Health Aide Service: Teacher's Source Book, National Council for Homemaker Services, Inc. and Council on Social Work Education (eds), pp. 37-41 (New York, New York).

This is a general overview of homemaker services. Trager was the Executive Director of the San Francisco Homemaker Service when she wrote this article. Perceptions of homemakers range from that of a "kind of fairy godmother who, with miraculous skill, fortitude and understanding manages to keep the family intact no matter what the circumstances may be" to a "fancy, over-priced, over-trained, over-supervised character who is unnecessary since 'anybody can do simple housework, give a bath or even do a few nursing procedures.'" At the time, homemaker and home health aide service was being advocated as a fruitful solution in the poverty program that could take women off of relief rolls. The author states that she finds it hard to explain to the uninitiated the precise differences between the various workers with similar titles and duties. Training is important. Although during interviews, agencies look for a special kind of attitude, workers still need to be trained to be mature, flexible, and adaptable. The author also discusses the dangers of overspecialization when the needs of the clients can change from day to day.

Trager, Brahna.
(1986).

"Home Care and Public Policy," Caring, August, 5(8):4-10.

This is an historical overview of the development of home care services. Most of these services developed in the 1950s, in three basic forms: hospital-based

home care, community-based home health services, and homemaker services, usually under the auspices of family agencies. Homemaker services originally were intended primarily for families with children. Later, the emphasis shifted to services for older people with health problems. The agencies were sparsely distributed, concentrated in urban centers and on the two coasts, and suffered from chronic financial problems. They depended on contributions from United Way and local health and welfare departments, and on fees. Later, Medicare, Medicaid, and other programs such as Title XX and the Older Americans' Act, offered home care services, but these programs were extremely rigid. Care was limited to a narrow range of reimbursable services. Other programs, such as chore services for the poor, meals programs, day health services, and friendly visitors are all provided in a fragmented manner and suffer acute funding problems. The Omnibus Budget Reconciliation Act of 1980 did not change the core problems, but rather left intact certain limitations. The fundamental problem with the project approach used to evaluate home care is that it focused on the avoidance of nursing home admissions as the primary test of home care's usefulness. The implementation of prospective payment under Medicare has exacerbated the situation by discharging to the community sicker patients which agencies are unable to serve. Home care services should not be considered an "alternative" to institutional care, but rather evaluated as a distinct method of care, directed to people with different needs.

Turner, Peggy A.
(1983).

"Homemaker-Home Health Aides as Members of the Home Care Team," Pride Institute Journal of Long Term Home Health Care, Summer, 2(3):26-27.

Turner proposes three major types of support for the homemaker-home health aide. The first is conceptual, which includes support for the homemaker-home health aide as a full-fledged, valuable member of the home health care team. This includes clarifying the role, responsibilities, and cost-effectiveness of the homemaker. The second level of support is organizational. Homemaker-home health aide services must have the full support of their sponsoring organization, including policies and plans to follow-up and evaluate the organization's structure, staffing, quality assurance mechanisms, and supervision. This also includes agency policies that support and recognize the value of individual workers. The final

level is individualized support for the homemaker, including the opportunity and climate for participation in client care plans and agency recognition of exceptional service and length of service.

Tuttle, Donna.
(1989).

"The Impact on Quality: Homemaker-Home Health Aide Training," Caring, February, 8(2):41-44.

As a result of recent legislation in Iowa, home care agencies receiving state funding must assure that each homemaker-home health aide has received adequate training. The workers are required to complete a program equivalent in content and depth to "A Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health Aide." At least 60 classroom hours, 15 hours of practicum, and 12 hours of yearly inservice training are required. Tuttle discusses some of the current approaches to providing training, including adult education classes at community colleges and programs offered by single agencies or agency coalitions.

U.S. House of Representatives, Select Committee on Aging; Prepared by The American Bar Association.
(1986).

"The "Black Box" of Home Care Quality," (Washington, D.C.: U.S. Government Printing Office).

The report is a comprehensive description of the major quality control mechanisms now in place: federal and state regulations, industry accreditation, long-term care ombudsman programs, certificate-of-need legislation, and other legal controls such as tort law, potential oversight by insurance companies, employment and labor law, and federal tax laws. Nevertheless, regulation is inadequate and the quality of home health care unknown because of: (1) the lack of data, (2) standards which focus on capacity instead of measuring actual care given, (3) the lack of direct accountability to the consumer, (4) weak monitoring and evaluation, and (5) few sanctions. Recommended changes include: wider applicability of standards, strengthening the content of standards, bonding and insurance, consumer empowerment (grievance procedures, consumer input), monitoring, including client-centered review, sanctions, education and training, and research and data collection.

Vahey, JoAnn T.; Eno, Fran; Hill, Glenda. (1989).

"Creating a Statewide Network for Training Homemaker-Home Health Aides," Caring, February, 8(2):34-40.

Idaho has taken statewide steps to improve the standardization and coordination of the training of certified homemaker-home health aides. The state has transferred responsibility for training from the individual service agency to educational institutions. The first grant in fiscal year 1986 from the Department of Health and Human Services was used to train 65 homemaker-home health aides. Monies were used for curriculum development, the production of videotapes, and the distribution of videotapes and other materials throughout the state. Additionally, a standard curriculum for training aides was developed and approved by the Idaho State Board of Nursing and the Idaho State Board for Vocational Education. A second grant in fiscal year 1987 allowed the state to extend the training program statewide through a center located on the Boise State University. Starting in 1988, the curriculum will become accessible through each vocational education regional school. During the development year for a statewide training network, fiscal year 1987, a total of 11 classes were implemented throughout Idaho. A total of 93 trainees completed the program. Four other positive results of the project were: (1) liaisons were established with each vocational education area; (2) Job Training Partnership Act (JTPA) funds were accessed and used to pay for training some students and no student was denied access to training because of lack of funds; (3) a number of employers paid the tuition for students; and (4) employment for students became possible in many types of agencies.

Wallace, Steven P. (1990).

"The No-Care Zone: Availability, Accessibility, and Acceptability in Community-Based Long-Term Care," The Gerontologist, 30(2):254-261.

In this article, the availability, accessibility, and acceptability of community-based long-term care in Missouri are examined, focusing on those eligible for services from Medicaid and the Social Service Block Grant. For the study, open-ended interviews of one to two hours were conducted with all the state program case managers and their supervisors in the service area, as well as a convenience sample of personal care

agencies, hospital discharge planners, and community advocates. Respite, transportation, live-in care, and counseling were among the various needs which respondents felt were difficult to meet. Three principal types of access barriers were identified. The first involved the agencies that provide in-home services. For example, some agencies would promise to have a worker available, when in fact they did not have adequate staffing. A second barrier is the limited funding for community care programs. The third barrier is the limited knowledge and authority of those involved in linking the disabled elderly with services, such as discharge planners, case managers, physicians, and others. Factors found to limit acceptability of home care included fear of theft by in-home workers, worker turnover, fear of dependence, and racial prejudice.

Watkins, Elizabeth.
(Undated).

"Homemaker Service in the United States," in A Unit of Learning about Homemaker-Home Health Aide Service: Teacher's Source Book, National Council for Homemaker Services, Inc. and Council on Social Work Education (eds), pp. 19-23 (New York, New York).

This chapter is a brief history of homemaker services. Prior to World War I, two voluntary family agencies provided homemaker services to families: the Family Service Bureau of the Association for the Improvement of the Conditions of the Poor in New York City and the Associated Charities of Detroit, Michigan. In 1923, the first organized homemaker program in the United States was initiated by the Jewish Welfare Society of Philadelphia, Pennsylvania, to place women in homes where the mother temporarily incapacitated. During the 1920s and early 1930s, there was a gradual increase in programs sponsored by voluntary family and children's agencies. The depression years of the 1930s saw the development of programs of housekeeping aides under a federal program of the Works Progress Administration to train and provide employment for needy women and provide services through health and welfare agencies to families, the disabled, and the aged. During the 1940s and 1950s, there was a slow but steady increase as federal funds became available through several federal programs. The Office of Education and the Manpower Development and the Training Programs of the Department of Labor, as well as some state and local governments, provided funds for training. Currently, agencies are expanding under various auspices and the services are becoming more widespread. Agencies are more flexible,

with fewer rigid time limitations for service. Homemaker services are being expanded to new groups, such as migrant farm laborers.

Wood, Juanita B.; Estes, Carroll L. (1985).

"Private Nonprofit Organizations and Community-Based Long Term Care," in Long Term Care of the Elderly, Harrington, Charlene; Newcomer, Robert J.; Estes, Carroll L. (eds), pp. 213-231 (Beverly Hills, California: Sage Publications).

Wood and Estes report the results of a study of private, nonprofit organizations delivering long-term care services. During 1982 and 1983, the researchers conducted 846 telephone interviews with various types of provides and other knowledgeable persons from a wide range of service agencies and other organizations in eight states and 32 urban communities. The study found that a subtle but profound reshaping is occurring in the community-based human service delivery system. Initially, following the budget cuts, both government units and service agencies attempted to maintain systems in place but in attenuated form. With the exception of home health, agencies have increased their clientele without increasing their budgets. Only home health agencies report increased personnel and budget capacity. Home health agencies are increasingly reluctant to treat Medicaid patients. Sixty percent of the agencies increased services by increasing the number of visits without adding new services. Only a small proportion of the agencies reported the elimination (12 percent) or reduction (21 percent) of any services, but the services that were eliminated were generally homemaker/chore, occupational therapy, or mental health services. Agencies were concerned with the greater demand for their services since the implementation of Diagnostic-Related Groups and increased competition. The authors suggest that the delivery system is becoming increasingly fragmented.

Wood, Juanita B. (1985/1986).

"The Effects of Cost-Containment on Home Health Agencies," Home Health Care Services Quarterly, Winter, 6(4):59-78.

Federal health care cost-containment policies have induced changes in the organization of home health care agencies. Wood examined data collected from a sample of home health agencies in 1983 and 1984. In 1983, 100 home health agencies (HHAs) were surveyed and in 1984,

82 of those same agencies participated. The survey included 20 visiting nurse associations, 11 hospital-based agencies, two hospital organizations, and 49 free-standing agencies. Exactly one-half of the HHAs were multi-service agencies. The extent of changes to for-profit tax status and merging with other organizations are examined, as well as reasons for such changes. Agencies reported the largest personnel increase in part-time employees. This is due, in part, to the practice of contracting out for some special therapies. Another factor responsible for the increase in part-time employment is that agencies have, with the assistance of Jobs Bill money, undertaken the training of welfare recipients to become home health aides, especially in Pennsylvania and Texas.

Wood, Juanita B.; Estes, Carroll L. (1988).

"'Medicalization'" of Community Services for the Elderly," Health and Social Work, Winter, 13:35-42.

In this article, the authors examine how private nonprofit providers have responded to increasingly austere conditions, including a reduction in federal spending on human services, the imposition of cost containment, and beneficiary cost sharing. Data were collected by telephone surveys in which respondents were interviewed in both 1983 and 1984 as part of the three-year study entitled "Public Policy, the Private Nonprofit Sector and the Delivery of Community-Based Long Term Care Services for the Elderly." The authors describe the three phases of agency change: "(1) 'cutback management' following taxpayer revolts and federal budget cuts (1978-81); (2) reorganization for the competitive medical market (1982-83); and (3) full-fledged participation in the competitive service delivery system (1984)." The private nonprofit sector has changed its emphasis from providing a combination of social and health services to focusing on medical services.