We Are The Roots

Ruth Glasser
and
Jeremy Brecher

Part I: History

Roots of CHCA

Although hundreds of people have contributed to making CHCA what it is, the visions and preoccupations of a handful of founders and senior staff can still be seen in every aspect of its operations today. Although they come from a wide variety of ethnic, religious, racial, and vocational experiences, the founders and senior staff interviewed for this project had many elements of background and values in common. All describe themselves as people who felt out of place in their communities of birth. From young ages, they felt that they did not fit in with their peers, and often they came from unique backgrounds that made it difficult for them to identify communities that they could properly call their own. In one way or another, they have been searching for community all their lives, and their searches have led to multicultural experiences and philosophies of life. In their searches, these future company leaders became very articulate about what community meant to them, and how it fit in with larger political visions.

Rick Surpin, the moving force behind the creation of CHCA and its president for more than a decade, grew up in Staten Island as a member of a Russian-Jewish family whose father owned a struggling wholesale produce company. "I grew up living in border territory, and that's what I was comfortable with. I grew up in a family that had middle-class values but basically had working-class income."[6] "In reality," Rick says, "it was a life of living on the border of a middle-class Jewish community, and ostensibly we were Jewish but that community had far more material things than we did, and so we felt very different from the people there."[7] Rick's early social life was spent sharing workdays with the mostly Italian-American and Irish-American truck drivers who worked for his father's company.

Peggy Powell, who came on board six months after CHCA got started and is now the director of workforce strategies for the Paraprofessional Healthcare Institute, was brought up by an Afro-Caribbean father and an Italian-American mother. The family initially lived in Harlem, where Peggy and her siblings were very sheltered from street life. Later, when they moved to St. Albans, Queens, "It was the first time I truly experienced what I considered to be real racial prejudice. Even though we were light-skinned blacks, I never felt the sense of isolation and racial prejudice until I moved to Queens and was in an all-white community."[8]

Kathleen Pérez, who joined CHCA shortly after Peggy and had worked with both Peggy and Rick in an earlier venture, describes growing up in Brownsville, Brooklyn, within a large Puerto Rican migrant family during the turmoil of the 1960s. After living in a mixed community where most were poor, the family moved to Staten Island. There, Kathleen felt for the first time what it meant to be a person of color:

> We moved from Brownsville into the shock of Staten Island, which was still very white then. We were actually one of the few Latino families in Brownsville, which was mostly African American. But it was still a mixed neighborhood, we still had Jewish neighbors, and Jewish stores, so I think there was a connection there, and a mixture that shaped who all of us are in terms of how we identified. Staten Island was horrible to me; the schools were horrible compared to the schools that we had gone to in Brooklyn.[9]

Christine Archambault, director of nursing from 1994 to 1996, says, "I think that my whole being was shaped by the fact of being French in Brooklyn

---

[6] Surpin, interview by Ruth Glasser, tape recording, Bronx, NY, 26 August 1997.
[7] ibid., Brooklyn, NY, 21 August 1996.
[8] Peggy Powell, interview by Ruth Glasser, tape recording, Bronx, NY, 9 February 1996.
[9] Kathleen Pérez, interview by Ruth Glasser, tape recording, Manhattan, NY, 9 January 1996.

where there were no other French people. And there certainly weren't French people from this island where we came from." Christine and her family also felt like outsiders in the Catholic Church, which was dominated by Irish personnel and their interpretations of the religion. Christine says, "I felt like I never fit, and I adopted other people's groups. So my friends growing up were mostly Jewish; that seemed the closest that I could come to being French."[10]

All of these company leaders had heavy responsibilities from childhood. Peggy's mother contracted tuberculosis when Peggy was thirteen, and she and her sister and a cousin who lived with them became responsible for cooking and cleaning for her brothers and father. Rick grew up almost literally within his father's company, napping "on bags of potatoes and onions," working in the warehouse, and helping on the delivery trucks. From an early age, Christine felt that she was the designated caretaker of her family.

Their backgrounds and subsequent life experiences made Peggy, Rick, Kathleen, and Christine understand both the tensions and richness of cross-cultural life, which, surprisingly, many people even in New York City never experience. They also understood what it meant to be poor, or at least on the margins economically. At the same time, they felt the importance of finding and forming community. Peggy couldn't wait to leave St. Albans: "I wanted to be back in the city. Harlem represented for me the one place that I felt connected and felt a real sense of community." Contrary to her mother, who had wanted to escape Harlem, "I just always felt like I wanted to contribute, I wanted to be able to give back, that I didn't want to run away from this community."[11]

Rick also grappled with the issue of community and his place in it. Fresh out of college, he went to work for a Staten Island community corporation serving a black neighborhood. "On an intellectual level, I would say I could never be the director of a community development corporation in a black neighborhood, but in fact that was my fantasy, that I could be the one person that was allowed in."[12]

Christine's experiences gave her insights into different alternative communities:

> While I went to school and maintained a kind of academic life of some sort, [I] ended up with the street, with mostly Latin and Black gay men. Later in my life I became part of the disabled community, and that's

[10] Christine Archambault, interview by Ruth Glasser, tape recording, Brooklyn, NY, 16 February 1996.
[11] Powell, interview, 9 February, 1996.
[12] Surpin, interview, 26 August 1997.

> another whole story of a group of people that I became part of and looked at the world through that pair of eyes. When I came out as a lesbian I was like, "Ah, my own group!" I always I think knew that I didn't belong in the mainstream – but how to find something that was mine?[13]

Both Rick and Peggy were peripherally active in the civil rights and anti-war movements of the 1960s but were left unsatisfied by them. For Peggy:

> When I listened to people, people were talking about jobs, improving education, wanting to have safety in their communities. I decided that I really wanted to apply my learnings to trying to do something that I felt was more tangible and more meaningful, and job creation and training to me was the way that you helped people become more empowered, you helped them get things that gave them control over their lives, and I didn't think words did that, and I didn't think songs did that, and I didn't think slogans did that.[14]

After college experiences in the anti-war movement, Rick "felt like we were all actors on a much larger stage that I really didn't feel very good about. I felt like there was no control over it and that so many people were involved who really didn't care."[15] When he joined the community development corporation in Staten Island, eventually becoming its director, he developed a vision of a more manageable locally based politics:

> The vision was all about democracy and community, that what you could do at the community level was create a democratic institution that was participatory, but that participatory didn't mean collectivist so much as it meant that everybody could have a voice and come to decisions and that you could have control over your resources and you wanted to get more resources into poor communities. Build on a sense of community that was multiethnic and create institutions that would support that, and programs that would support that, and use resources in a much more creative way.[16]

Childhood and young adult experiences gave these leaders insights into how to constitute and organize their ideas of community. Rick had fantasies from early

---

[13] Archambault, interview, 16 February 1996.
[14] Powell, interview, 9 February 1996.
[15] Surpin, interview, 21 August 1996.
[16] ibid.

childhood of being a guerrilla fighter. "To me, what a guerilla fighter does is create space for having an alternative life. Some space where you can live who you are. Eventually, you want to go into the city and take over the city, but you don't really know if you can do that some day."[17] He identified with the pirate leader Jean Lafitte, who built a community he called Shangri-la in the swamps of Louisiana. Rick's other fantasy was to have a produce company larger than any of his father's competitors. "I used to get all these manuals about how plants should be built; it was nothing like what we had as a warehouse. And I had a restaurant and sleeping facilities for all the drivers and the people who worked there."[18]

Peggy, who often compares CHCA to a family, describes her insights as family-based:

> I just think that from a sense of how to organize or how to get things done, I brought that from just upbringing, and living in a household where you were constantly negotiating everything, or trying to figure out how do you listen to people, how do you move people, how do you try to figure out what you need to get something. I never formally had any training to know how to organize and how to work.[19]

Kathleen drew some of her ideas of what she wanted a community to be like from early work in Native American communities:

> I was working with Native American people, which also was a big piece of learning for me. A lot of the participatory stuff, the long house, being involved in what's going on in the long house and meetings with people from Six Nations upstate, in Akwesasne, there was a whole thing going on there about sovereignty rights that I got involved in while I was in college upstate. And then ended up going to South Dakota for two summers to work on the Black Hills Gathering to stop uranium mining in the Black Hills.[20]

Many of these strands would eventually be woven into the fabric of CHCA.

The Mutual Aid Project

Rick's first self-initiated agency, the Mutual Aid Project (MAP), came out of years of community work and study.

---

[17] ibid.

[18] ibid.

[19] Powell, interview, 9 February 1996.

[20] Pérez, interview, 9 January 1996.

> I knew that I wanted to start a nonprofit that combined community organizing and adult education in a Freirian way.[21] You needed to figure out how to do as much things on a self-reliant basis and a community basis as you could, but you also needed resources to do that and make that good, and to a large extent that meant a balance between professionals and the community doing things. Adult education to me was all about how to transfer skills and get people thinking about those issues and working on them collectively.[22]

Rick got started with funding from the Administration on Aging, gradually adding on money from various progressive foundations. The project eventually focused on putting people into the food industry. The goal was to create community restaurant/cultural centers. "But in order to fund that, we did a food-service training program for cooks and assistant cooks in the mainstream industry, and for the cafés. We also did a food-buying service for food co-ops, day care centers, and senior centers."[23] MAP echoed both Rick's family background in the food distribution business and his aspiration to build, if not a Shangri-la in the urban wilderness, then at least an island of decency and cooperation.

Throughout the years of the Mutual Aid Project, both the personnel and many of the concepts that would be used for CHCA were brought together. Peggy, restless as a recently divorced mother and graduate student, met Rick through her contacts with a national church headquarters where she worked as an administrative assistant. Rick hired her in 1979 to direct MAP's food-service training program. Kathleen, who had a degree in nutrition education and was, like Rick and Peggy, interested in Freirian approaches to learning, was hired to train people to work in commercial kitchens. Seeking to figure out how to create community restaurants as worker-owned businesses and have a federation of businesses that would be linked at the core, MAP contracted with the Industrial Cooperative Association (ICA). The project thereby developed a relationship with Steve Dawson, who would later become an important part of the Paraprofessional Healthcare Institute's senior management team.

In the concrete articulation of visions of community creation, MAP set up some models for the future. Rick says:

---

[21] Paulo Freire is a Brazilian educator who pioneered adult literacy and popular education programs for poor people, geared towards developing critical thinking and political empowerment.

[22] Surpin, interview, 21 August 1996.

[23] ibid.

> In many ways, Mutual Aid Project is the real antecedent for Cooperative Home Care – the thoughts about structure, the thoughts about a specific vehicle that had a very practical purpose that also could be a home for developing community and thinking about how to do that. Peggy ran the food training program and Kathy [Pérez] was hired as an instructor in that program. That's how their collaboration formed and the techniques were developed a lot, and the three of our relations really formed as people who really cared about the same thing. And it was the first time I had ever gone out on my own and, instead of trying to take an institution and transform it into something, by that time I was convinced that the way to do something was to build it.[24]

Forming CHCA

Problems with funding hampered and eventually closed down MAP. In 1983, Rick went to work for the Community Service Society (CSS), a long-standing social service agency working on direct service, research, and advocacy around poverty issues. While at CSS, Rick directed its Center for Community Economic Development, where he concentrated on creating decent jobs in low-income New York communities. After an 18-month experiment with a worker-owned carpentry company, he began to work with fellow CSS staffers Fred Grumm and Tom Bettridge on the possibility of forming a home health care company. From prior organizing and academic work, Rick knew something about the industry, "and then there was the market opportunity where we got to meet somebody from Montefiore [Hospital] and talk with them and they were intrigued, and from there it took off."[25]

This early relationship with Montefiore, along with the needs of the local population, made a South Bronx location logical. Rick, Fred, Tom, and other members of the CSS team worked with ICA to create a home health aide agency that would provide jobs for low-income local people that were a cut above other jobs in the industry. Higher wages, benefits, and respectful treatment would produce workers who would in turn provide better services to needy clients.

From the beginning, CHCA was planned as a worker-owned company. Rick had some specific ideas about what that meant:

> What I saw was that all of worker ownership activity had focused on plant closings, and that there was something really off about that, that

[24] ibid.
[25] ibid

> that didn't jibe with what I thought was really necessary, to build something from scratch.[26]

Nor was it enough to just build a worker-ownership structure into the new company. Rick agreed with Staughton Lynd's argument that

> what happens on the shop floor is determinant, that you can do lots of things, but if you don't change shop floor working conditions and what life is like on the shop floor then you'll never make anybody happy, and that politics that takes place above that level is interesting and important but not nearly as important as what happens there.[27]

How to actually make this community happen was a challenge the founders grappled with and that senior staff have continued to deal with throughout the years. First, there was the tension between setting up and running a viable business and having a caring community respectful of its workers. As Rick said:

> What I learned at the Mutual Aid Project was that you really have to do all the things of doing a business, and what I learned from the carpentry company is that politics of community, including respect as the foundation for community, was only possible if there was a business first.[28]

From the very beginning, this tension was reflected in the difficulties of finding senior staff with both technical knowledge and a sense of caring and community. At first the founders hired an experienced health industry manager whose good technical knowledge of the industry pleased their funders. Nevertheless, after one year he was fired. Staffers describe him as a person who sat at a computer all day and never mingled with the rest of the personnel, as someone not sensitive to the class, gender, and racial dynamics of the agency's members. Senior staff then tried to groom an African American female employee for the position, but it soon became clear that the company's needs were too urgent and that she was not going to be able to acquire the necessary skills. With some reluctance, Rick became the president of the company.

In the tension between political visions and practical knowledge, vision appeared to win out. Although, as Rick said, it was critical for the leaders to know the industry and be able to organize a company, they had to approach the work with common goals and understandings. To a certain extent, technical skills learning could take place along the way. With this in mind, a few months after the inception of the new

---

[26] Surpin, interview, 21 August 1996.

[27] ibid. Staughton Lynd is a historian, labor lawyer, and social activist who has written about and participated in many worker-based struggles.

[28] ibid.

project Rick brought his old Mutual Aid partners, Peggy Powell and Kathleen Pérez, into the business. After several years directing a food pantry and soup kitchen, Kathleen was happy to come on board in 1987. She soon began to establish CHCA's training program.

With this emphasis on shared vision and community mindedness, with skills coming along the way, an organizational approach to employees was developed. Job descriptions were often somewhat fluid, with tasks changing according to the developing skills of the employee and the evolving needs of the organization. Employees were encouraged and supported in their personal growth in ways that would benefit both themselves and the company.

Christine feels that this job fluidity and personal development emphases have helped to create a sort of trickle-down effect whereby trainees and home health aides (HHAs) feel like they can fit in and develop their potential. Self-development and mutual respect have always been the emphasis for everybody in the organization:

> There is no "other" here. If we say we're looking for women who are on public assistance and then they become owners of a company, that's an incredible distance to travel. Well, there's an understanding, not articulated really I don't think, that if we want growth for people it's because we want to grow.[29]

As senior staff was added, they articulated their visions of community emerging from their own experiences. As a woman of color from a working-class background, Peggy felt that she brought to the table a unique understanding of the culture of the applicants and what should be expected from them. Bringing recruits into CHCA was not just about training and filling home care slots, it was also about creating a community:

> It's about feeling like an outsider, and this place helps you feel like an insider. That's what I'd like to believe we provide in terms of the company, and why people feel this sense of connection.[30]

Although the home health aide work in the field was by nature relatively solitary, the CHCA office would provide a gathering place. The company would offer opportunities both for personal growth and to participate and become part of a group. Peggy remembers that in the beginning she had no grand visions of what the program would look like, but rather:

---

[29] Archambault, interview, 16 February 1996.

[30] Powell, interview, 9 February 1996.

> It just meant to me being able to work with the women to further their development and do it in a way that we'd always done it when we were at Mutual Aid Project; it was a way to help develop their self-esteem, their sense of self about their role, to be able to really participate and ultimately to govern a company, and to be able to validate in some ways, based on what I designed and what I did, reinforcement of this culture that really valued them as people.[31]

As she developed programs and worked with the women, Peggy refined and articulated her visions of what was being created:

> We see ourselves as not just creating jobs for people, but also creating an alternative community that people can feel really connected to, particularly people who don't feel connected other than to an immediate family member. For some of the workers in our company who are feeling pretty isolated, both isolated in jobs and isolated from the broader community of people, it's like, this is a place that wants to organize you in, that wants you to be there as something more than a person to bring money in. I think I would define it as a community of support, a community that challenges you to grow, a community that sort of takes you where you come in and says that there is a common purpose here, meaning, among other things, to provide quality care for folks. And our other common purpose is to support each other and to really learn from each other and to be connected to each other. So that each of us who get attracted to this place for different reasons about not feeling connected can have a different place where we do feel connected.[32]

The Economic Context

CHCA's culture had to develop within a rapidly changing industry environment. At first it appeared to be an opportune time to start a home health aide company.

> When we started out it was a boom time in home care. Federal policy had changed the prospective payment/reimbursement system in Medicare, creating incentives for hospitals to release people early, late in '84 and '85. There were tons of articles and op-ed pages about what this would mean for home care. Home care grew exponentially, at pretty much 20 percent growth rates in those early years. In New York that was even more true because New York used [home care under] Medicaid.[33]

---

[31] Powell, interview, 9 February 1996.

[32] ibid.

[33] Surpin, interview, 26 August 1997.

Nonetheless, CHCA's first year was one of turmoil, with the company about 50 percent below its financial projections. For its first several years, the company was "very focused on basic issues" – notably recovery. By 1989 the company had stabilized financially and was employing about 160 total staff.[34] But longer-range problems gradually became apparent. "We'd become really clear that we were milking every possible dime we could for workers out of our own revenues and that that wasn't going to be enough. Our initial hope of making it a better job out of a viable business was not possible without higher reimbursement rates."[35] CHCA helped form the New York City Home Care Work Group to promote a restructuring of the industry that would provide higher reimbursement for workers:

> So '88–89 actually was this kind of great moment where … the rise of Dennis Rivera and [Service Employees International] 1199, and his leadership combined with Mario Cuomo thinking about running for the presidency, and Jesse Jackson running for the presidency … and Cardinal O'Connor who … wanted to prove that he had working class roots. … He'd proven how conservative he was on abortion issues, so now he was trying to prove that he was a real New Yorker … and that all came together. … There's this picture of Jackson and Rivera and the Cardinal. So Cuomo ended up actively working on this … increase in wages and benefits. And we all worked in a very complementary way in organizing consumers and agencies to support them.[36]

While the effort was briefly successful, a counter-movement set in by 1990, leading to pressures for consolidation in the industry.

> From '90 to '95 … the industry experienced a lot of growth and a lot of turbulence in regulation. The administration began to define home care regulations differently. There were public interest lawsuits about the definition of "homebound." There were denials on 40 percent of Medicare claims for home care.[37]

Public policy began to aim to freeze utilization.

> That really creates a climate of, "We don't know what we're going to get paid for, and we are going to get paid late no matter what." Most non-profits don't have the money to do that; it's only the very big ones that can deal with that. And so that just fostered consolidation.[38]

---

[34] Dawson and Kreiner, CHCA: History and Lessons, 1993, 17.
[35] Surpin, interview, 26 August 1997.
[36] ibid.
[37] ibid.
[38] ibid.

In 1990, in response to changing market conditions and to its internal dynamics, the company began to develop a long-range strategic plan. The plan focused on the need for growth, realignment, and formalization of management responsibilities, and a management salary structure that could attract high-quality staff.

By the end of 1990, the company had grown to 200 employees and planned to grow to about 500.[39] In 1990, it created an associated nonprofit corporation. Now called the Paraprofessional Healthcare Institute (PHI), the nonprofit initially handled company training functions, but soon became the vehicle for foundation-funded efforts to replicate the CHCA model at other sites, including Philadelphia and Boston. Kathleen Pérez left CHCA and Rick and Peggy devoted increasing proportions of their time to activities beyond the day-to-day management of the company.

Meanwhile, the home care market continued to change rapidly. All businesses were affected by growing federal, state, and city pressures for cost saving. In the early 1990s, the Visiting Nurse Service (VNS), a dominant player in the New York City home care industry, became CHCA's largest contractor. Hospitals became more profit-oriented in the era of managed care, and they increasingly saw home care as a potential source of profit – but only if they used their own certified HHA agencies and subcontracted with licensed agencies where they didn't have to pay as much. VNS, for example, gave CHCA $12.42 per hour for acute care, compared to the $10.00 or $10.50 hospitals paid their own paraprofessional contractors.[40] To counter these pressures, CHCA sought to move toward a de facto preferred provider relationship with the VNS.

Future of CHCA

At the beginning of 1997, CHCA employed more than 320 workers. But it remained a relatively small agency vulnerable to a consolidating market, cost-cutting pressures from regulators, and low-cost competitors. In response it was developing a bold strategy to transform its own economic environment by developing a managed long-term care organization designed to become the principal contractor for CHCA's own services.

Independence Care System, Inc. (ICS) is a nonprofit related corporation of the PHI, developed in cooperation with other health care organizations and groups representing health care consumers. Its plan is to become the managed-care organization for people with disabilities who receive Medicaid and live in the Bronx,

---

[39] Dawson and Kreiner, CHCA: History and Lessons, 1993, 19.

[40] Archambault, interview by Ruth Glasser, tape recording, Bronx, NY, 4 September 1997.

Manhattan, Brooklyn, and Queens. ICS has developed a new model of home and community-based care that utilizes CHCA home health aides as well as professionals from other health care organizations. The model emphasizes participation by "consumers" – members of the managed-care organization – both in governance of the company and in planning and managing their own treatment. A "care team" is assembled for each client, including medical professionals, paraprofessionals, members of the client's family and social network, and the client himself or herself. Although a full range of medical and social services is available, the model emphasizes home care and community-based care, putting the client and the home health aide at the center of the care network.

ICS has required, and is still requiring, more rapid change at CHCA. Still relatively small, ICS is expected to require at least 1,000 home health aides when fully staffed. These aides will be given additional training and will fill higher-level specialized positions, allowing them to earn higher wages and providing them with greater employment stability.

ICS has increasingly absorbed the attention of CHCA's original senior managers. Rick says:

> That's where most of my energy has gone, where most of my heart is. I believe the future of Cooperative Home Care probably is coming up under that umbrella of a much broader and diversified organization. In the same way that hospitals talk about themselves as systems, what we're really talking about is a system of care that will be multi-institutional, so it won't be just one hospital, but it will have members and consumers that will probably be 1,000 five years from now and 2,000 ten years from now, and it will probably have about 1,000 to 2,000 workers in it as well. Probably not all from Cooperative Home Care, but probably all working with the same standards determined by the managed care organization, and probably 1,000 people from Cooperative Home Care.[41]

In 1997, CHCA successfully lobbied for state legislation to establish ICS. It soon recruited a senior management team and start-up was projected for 2000. CHCA was already beginning to change in anticipation of the new opportunities and demands these changes would entail.

---

[41] Surpin, interview, 26 August 1997.

Part II: Functions

Running a company like CHCA is a complex business involving the integration of many different functions. In the early days of CHCA, organizational roles tended to be quite fluid with staff members performing multiple functions.

Whatever may be written in company policy statements, a company's culture is both shaped and revealed by the ways these functions are actually performed. At CHCA there is an effort to make every function and every department expressive of the company's broader values and philosophy. Even as technical a department as Administration illustrates some of the specific characteristics of CHCA's culture. Betsy Smulyan, vice president for administration until she left the company in 2000, observes:

> We're not a bank with tellers behind the windows. . . . We listen to people's individual issues. We can help them with what their particular problem is; we're not just going to give them a stock answer.[42]

Some problems might include garnishment for hospital bills during a period when a worker was uninsured or disability forms that doctors had filled out incorrectly. "We're trying to help people, not just process paper. Sometimes people have to push us a little bit because we're too busy now to sit down and listen to every single person every single minute." But "we really see you as part of our company; you're not just relating to somebody in an office, like you normally are."[43]

In Part II of this study we focus on five of CHCA's crucial functions:

- recruitment;
- training;
- case management;
- home care;
- governance.

Recruitment

The Labor Pool

The founders of CHCA may have had their own vision of the ideal worker and what they wanted their health care community to look like. In recruiting, training, and forming a community made up of HHAs, however, they had to contend with the lives, aspirations, and personal histories of these women.

CHCA recruits from a labor pool of women who have arrived or come of age in New York City during a time of enormous decline in the manufacturing jobs that had provided the first rungs of social mobility for prior generations of immigrant workers. As economist Andrés Torres points out:

> Well before the much-publicized dual crisis of manufacturing flight and fiscal collapse that befell the New York area in the mid 1970s, manufacturers had been steadily leaving the city. Between the early 1950s and the early 1960s, some 200,000 manufacturing jobs were lost, about a 20 percent decline.[44]

The changes of the local and national economy to a more service-oriented one, along with the constraints of racism and intractable ethnic niches, severely limited the work choices of these women. They could, and did, work in food service,

---

[42] Betsy Smulyan, interview by Ruth Glasser, tape recording, Bronx, NY, 27 August 1997.
[43] ibid.
[44] Andres Torres, Between Melting Pot and Mosaic, 1995, 39–40.

hotel, retail, and menial hospital jobs. Those with enough education and English language skills worked in secretarial or clerical positions, while some recent immigrants worked in small factories or sweatshops run by immigrant entrepreneurs, often commuting great distances to do so. Some had been forced out of jobs by factory or retail closings, and many had relied on public assistance at least once in their adult lives.

Florinda Pimentel, a Dominican immigrant, spent five years working in a jewelry store where she felt appreciated but received low pay and worked long hours.

> We were working from 8:00 [a.m.] until 11:00 at night. I worked polishing sometimes, sometimes making diamond cuts, in shipping – wherever they needed you, they sent you, and it was too much. For two years I didn't see my children except Sundays, since it was the only day I didn't work.[45]

During a few months on public assistance, Florinda worked as a church volunteer helping elderly in her neighborhood. A woman who was also involved noticed her affinity for this work. She told Florinda that she could get paid for caretaking where she herself was working – CHCA.

Ramona Pichardo, also Dominican, was tired of a dead-end combination of factory work and public assistance.

> I worked raising my children, two jobs on the sewing machine. I had a machine in the house and when I left my job I went back to sew at home. Working in a factory isn't easy. Working inside with 20, 30, 40 people and the boss rushing you or scolding you and all that.[46]

An African American aide who worked at a restaurant for many years had long-standing, affectionate relationships with her customers. When she got pregnant, her manager pressured her to quit. She stayed home for ten years to raise her baby properly. Sick of welfare, she applied to CHCA when she saw an ad in the paper.

These profiles are but shorthand for a variety of backgrounds that have both commonalties and differences. CHCA's home health aides are African Americans from the United States South and New York City; West Indians from Jamaica, Trinidad, and St. Croix; Indo-Caribbeans from Guyana. They are Latinas who are Puerto Rican migrants or the children of migrants raised in New York; Dominicans from the island; and immigrants from Guatemala, Honduras, and Ecuador. CHCA's location and the wage levels for home health aides largely define the labor pool.

---

[45] Florinda Pimental, interview by Ruth Glasser, tape recording, Bronx, NY, 21 June 1996.
[46] Ramona Pichardo, interview by Ruth Glasser, tape recording, Manhattan, NY, 21 June 1996.

> The labor pool is African American, Latin, newer Latin immigrants who have fifth- to eighth-grade reading and math levels; roughly 50 percent of them have gone to high school and finished, the other 50 percent have not. They work in fast-food restaurants, they get on civil service lists, they once could have worked in factories but no more. Now you get a somewhat younger person that has years at home with their baby and now they're ready to go to work. I think welfare rules are basically forcing everybody to look for a job, and most of the people who work in the company are either on welfare or on the edge of welfare, and getting food stamps and on Medicaid.[47]

Despite these differences, many share certain qualities that include growing up within tightly knit family or community settings in urban neighborhoods or small towns, strong backgrounds in family nurturing and community work, and strong problem-solving abilities. Even those who grew up in New York generally have close ties to another place – a town in the American South where they spent summers with grandparents and other relatives, a parent's town in Puerto Rico. For the most part, the HHAs are women who come from migrant backgrounds or have close personal ties to a migrant past. As will be discussed below, these are the women likely to place a value on caretaking and to accept a low-paying job.

This cross-section of the population of HHAs must be seen over time, however. The years have witnessed fluctuations in the ethnic and racial composition of this work force, as well as the ages, levels of education, and motivations of the applicants. These demographic fluctuations reflect both larger societal changes and CHCA's constant adjustments in recruitment and training tactics.

At the organization's inception, for example, the majority of the aides were African American women. Within a few years, however, more Latinas came into the company, particularly after the funding and creation of the organization's ESL program in 1990–91. Since the program's end in 1995, fewer of these women entered the training program, since it requires basic competency in English. Recently, the narrowing of other job options, the curtailment of welfare benefits, and changes in sources of training money have brought a younger group of African American and Latina women and more second-generation New York City dwellers to CHCA's doors. A new bilingual (English–Spanish) training program was begun to bring in more immigrant Hispanics.[48]

---

[47] Surpin, interview, 21 August 1996.

[48] This new program has been quite successful. Since 1998, the numbers of Latina participants have increased substantially.

Selection

From the inception of CHCA, its organizers struggled over what type of people would be appropriate home health aides. Possessing relatively similar organizational visions, their varied points of view on how to implement their visions within the company reflected in large part their class, race, gender, and working background differences. Peggy has clear memories of arguments with Rick Surpin and Fred Grumm over criteria for accepting HHA trainees:

> I walked into the very first team meeting, and there were a couple of women that were in that team meeting that I instantly said, based on what they said to me or the way they behaved, "No way would I want this woman taking care of me." When Rick talks about how we developed this nice balance of hard and soft, what he doesn't talk about is the fights we had, because I'd say to Fred, "What's with this person?", and what they valued in her was that she was assertive, which to me was aggressive. I think when you're an organizer, particularly when you're mass organizing or you're out there in the street, you value the boisterous person, the one who's the fighter, and from a training or from a recruitment perspective, that's the last kind of woman that I really want. That person is not the right person, in my mind, for doing this work and creating community.[49]

Peggy remembers innumerable discussions over concepts of caring, and how to translate these concepts into an interview guide and other mechanisms used to screen applicants:

> There had not been much thought given to what terms meant, so everyone could sit in a room and agree that they wanted somebody who was caring, but there had never been a sit-down meeting in which people talked about how caring for them was reflected in what the responses were like. We very much may have looked at the same person and come up with very different conclusions about whether that person should be in the program or not.[50]

Interviewers learned to ask themselves if they would want the applicant to take care of their own parents or grandparents. They asked detailed questions about applicants' backgrounds and carefully observed nonverbal as well as verbal cues.

> One way caring was reflected is when we gave the person the care plan to look at, did the person start the activities that were focused on the

---

[49] Powell, interview, 9 February 1996.

[50] ibid.

> client first or that were focused on the home first? This was a very discreet way that we said, this person is much more likely to be connected to the [client], that they see value in the personal care side as opposed to the housekeeping and the laundry and the shopping.
>
> We saw it in people who had an informal caretaker background. We saw it in people who were basically other-oriented. It was like, are you a person who is going to give outside of yourself, that you get some intrinsic reward from helping others? Because this work doesn't pay enough for someone to just take this work as a job.[51]

Staff has experimented with a variety of ways to bring in and select appropriate applicants. As a recent piece written on recruitment explains:

> Individuals are recruited from community-based organizations, the New York City Housing Authority, adult continuing education programs, pre-employment/job readiness training providers, CHCA flyer distribution, and word of mouth.[52]

A great deal of time goes into the selection of candidates, from the detailed intake application form through drug screening and processing of child care and employment forms. Over the years, staff has had to struggle between the competing needs for a careful versus an efficient process that will bring in large numbers and thus help the organization grow. At first, for example, the procedure was to perform a small group interview and, then, individual interviews on the same day. Since 1994, however, staff has conducted open houses, two-hour orientation sessions where as many as 50 people can come at a time and learn about the company.

The open-house system developed in response to changing Department of Employment regulations, which began to require job applicants to stop at newly established neighborhood career centers. The open house was also a way for CHCA to maintain some control over the process of selection of candidates. At the open houses, staff looks at the behavioral dynamics of members of the group. As intake secretary Daisy Mauras explains, "In the open houses, we have an observer all the time, so they observe the way the person acts, the way they answer, plus they have a questionnaire."[53] After the open house, staff decides who will be invited back for an interview. At the same time, the open houses have given potential applicants an opportunity to decide whether this demanding job is really for them.

---

[51] Powell, interview, 9 February 1996.

[52] Cooperative Home Care Associates, "CHCA Intake and Application Process, 1997, 5.

[53] Daisy Mauras, interview by Ruth Glasser, tape recording, Bronx, NY, 6 January 1997.

In many ways, the process has been developed to require that the potential aides demonstrate responsibility. Applicants must come in during certain hours to complete their initial intake form. After the open houses, it is the applicant who needs to call back to find out if she has been accepted for an interview. She is responsible for showing up for her appointment, and then calling to see if she has passed the interview. Finally, she must demonstrate readiness with child care and medical tests, and show up on time for the pre-class orientation. With this series of hurdles, staff has developed a system to test the commitment and behavior of would-be HHAs.

Although the selection process has been subject to continuing evaluation and adjustment, the basic emphasis on the human characteristics of the recruits has remained throughout. According to Florence DeVore, director of training in the mid 1990's: "People who were caregivers in the home for someone before seem to be better candidates, and people who are mature, which is not necessarily mature chronologically – we've had some really young women who were really just perfect."[54]

> The interviews are used to evaluate potential employees' attitudes and likely behavior on the job. One of the interview questions is about an elderly woman who is your client. She's married to a gentleman who's also as old as she is, but she's your client and she asks you when you cook for her would you mind putting in a little extra food for him, and when you do her laundry would you mind throwing in some of his clothes, too. The company doesn't have a policy on that; how would you handle that? Now if the person says to me, "Well, that's not my job!" she's not coming in, I'm not going to take her. If the person says, "Well, it's not going to hurt for me to put in a little extra food, I'm already cooking. I think I would just go ahead and do it" – fine, because it tells me that she's got a human-to-human connection. And that's what I'm looking for. I'm looking for the heart.
>
> I tell them in the beginning that you'll see that we're always smiling; we enjoy our job. Anybody who brings any negativity into this room, I'm going to let you go. It doesn't mean you can't voice your opinion, I want you to do that, but there's a way for you to do it. So in the interview that's what I'm looking for, how is this person sounding. If she says, "Well, my job is just to take care of the old lady" – even the words that they use, for me, makes a difference in terms of their level of sensitivity.

---

[54] Florence DeVore, interview by Ruth Glasser, tape recording, Bronx, NY, 4 September 1997.

> Sometimes the more education a person has the less well they'll do in this job. Because their expectations for themselves are much higher, and they've got options. As bad as it is to say it, the people who seem to do better here are the people with less options. Because then you're willing to accept a job making only $6.25 an hour. A job where you may not always be treated respectfully, depending upon where you're working.
>
> The training staff and the coordinators do most of the interviewing. So we've got to deal with folks in the classroom and the coordinators are going to have to deal with them once they start working. So we're thinking about that. We're not thinking about the numbers. We're thinking about, "Is this person going to be appropriate for us to deal with in the classroom?" and I think that the coordinators think about, "Is this person going to make a good employee?" [55]

Impact of Recruitment Process on CHCA Aides

CHCA's recruitment practices obviously affect the kinds of people who become part of the organization. But it has a subtler effect as well, shaping workers' initial expectations of what life in the company will be like.

Workers' expectations are deeply affected by past personal experience and the experiences of family and friends. Experiences with CHCA are often very different from other jobs, from the outset. And that can begin to modify expectations regarding human relations at work.

Work relations in the home health care business are notoriously poor. Trinidadian Annette Dance received training in another program before she came to CHCA: "I decided I was going to go to school for this thing I saw, home health aide. I figured well, I was always in the Red Cross, I had had different types of jobs, I would do it." She described the training she received as "fantastic."

> But after that, forget it, they don't do anything else after that fantastic. They tell you you have to work six months to get your certificate. One year, I still can't get my certificate. They find excuses why they can't give it. You work, you go in to pick up your paycheck, there's no paycheck for you. They have a little cubicle window and the lady says, "You don't have money here." You walk out and they close the door on you.[56]

She went to the office to see what was wrong and was told they had no record of her working there.

---

[55] Florence DeVore, interview, 4 September 1997.

[56] Annette Dance, interview by Ruth Glasser, tape recording, Bronx, NY, 17 May 1996.

> The company violated the labor law providing that after 72 hours of work, you're supposed to be paid. They weren't paying. And people would come over there with their last token to get money. Some people would be crying there. These women had a household and they wouldn't get a check and they would be crying and sometimes I had to give somebody else a token. I couldn't understand why these people were doing this; they were making the money but they didn't want to pay the workers. Then I realized maybe if they keep the money in the bank overnight, then they could get profit on it. So then I started looking to different angles of what they were doing. So I decided okay, I'm bringing the union in here, and then I started working with 1199.[57]

Her experience with CHCA was radically different. A classmate suggested that she go to a place that was opening in the Bronx. Reluctantly, she went. She talked to Peggy and other staff people, and they decided to hire her. "The way they talked to me alone, I was very impressed, and I hadn't done a day's work for them. The way they speak to you as an adult, as a person, I was very impressed with that considering where I came from."[58]

Vivian Carrión, born in New York of Puerto Rican parents, recalls:

> I was a little nervous in the sense of, "Oh, this is just another dead end job." I didn't think there was a place like this. Everybody was so nice. I was kind of curious – why are they so nice? It's like, "There can't be so many nice people in this world." I stayed quiet – I'm the type that likes to stay quiet at first and just look and observe. I liked [CHCA] from the beginning – but I held back.[59]

CHCA staff not only treated applicants with dignity, they also validated their personal life experiences. Bibi Yusuf, a recent immigrant from Guyana, went to an agency to inquire about HHA work and was referred to CHCA. She was told that they were interviewing 75 but only taking 25. Bibi was scared that she was not going to get the job.

> She was asking about experience and stuff. I had no experience besides looking after my son. I did things for my father but I didn't count that as experience. My father was sick. Now I can see how that would be experience but I didn't really count that at the time. I'm thinking job experience.[60]

---

[57] ibid.

[58] ibid.

[59] Vivian Carrión, interview, 13 March 1996.

[60] Bibi Ameena Yusuf Ishmael, interview by Ruth Glasser, tape recording, Bronx, NY, 7 March 1996.

She was surprised and happy when she was accepted.

Some applicants overcame serious obstacles in search of the higher-quality job that CHCA represented. Dominican Ramona Pichardo said, "I was tired of working in a factory. I worked and raised my children with two jobs, sewing on a machine. I didn't want to live from the government any more, I only did it because I needed to." But when she asked about CHCA, "The public assistance social worker told me that my English wasn't good enough to take the training. When I went back, she told me, 'I can't give you the address of Cooperative Home Care, because you don't know much English.' I said to her 'Yes, I want you to give me the address, because I'm going to go and I'm going to struggle to be able to do the training.'"[61]

No doubt the way in which Ramona was treated during the recruitment process had an impact on her attitudes toward training and work.

Training

CHCA's Training Program

CHCA started its life as a service provider in 1985 by hiring and using already-trained HHAs. Subsequently, the company subcontracted the training to outsiders. Trainees went for two weeks to a site to listen to lectures. They had little hands-on experience or direct contact with instructors.

Since the original training was out of the hands of CHCA, it did not reflect the ethics of respect and support with which the company wished to deal with its workers. As Peggy said:

> The problem was that we had tightened up on the front end of who we brought in through interviewing, but we had no control over how we oriented people to the industry and the training. We took this group and we sent them to a community college, Bronx Community, Queensborough Community, whatever, and then someone else trained them. And the "someone elses" that were training them were nurses from the industry who didn't have a lot of respect for the paraprofessionals, saw them as limited people. We had little control over how this person who had never been in the industry was being enculturated in their thinking of what this industry was.[62]

Early HHA experiences confirm this. When Florinda Pimentel trained in 1987 at Bronx Community College, she says:

---

[61] Pichardo, interview, 29 March 1996.
[62] Powell, interview, 9 February 1996.

> Everything was taught on the basis of lectures. And the lectures were in a different place each day. I would arrive in the morning and go to the room where I had been yesterday, and they would say to me, "This is not where the teaching is today. You have to go to another building."
>
> One of the experiences that I still remember, every time I think about it I laugh because when one needs a job one doesn't think too much about what's happening. . . . One day we arrived and they put us in a room that they were repairing and it didn't have a window [pane]. And this was November, the temperature was like 12 degrees. And everyone had their coats and gloves on, their hats, and the teacher trembling in a corner. And we were there the whole day listening to him speak nonsense. And later when we got together, we were 14 people, it occurred to us to think that this was a way to test and see if we would be able to take care of people in whatever type of place.[63]

Ironically, there were also problems with mastery of technical skills. Florinda remembers that

> when I finished the course, I said, "God help me, because I don't know how I'm going to take care of anybody." Everything I've learned has been through the therapists, the nurses, when they would go to see the patients I would ask a lot of questions. I learned on the job.[64]

CHCA decided to establish its own training program in 1987. It was a difficult process, requiring compliance with a state-approved curriculum. At the same time, the curriculum needed to be adapted to make sure that effective teaching and learning were actually taking place. At first the program was not only totally experimental but also virtually unfinanced, as Kathleen recalls, "From the very beginning I was the one that took on the training program. We had to actually do it with whatever we could scrape together before we could go after funds."[65]

Kathleen remembers that

> from the beginning we saw education as, "We're doing this because we want to create democracy, and we want a workforce that is always learning, and participates in its own learning and its own development." [But] the priority was always to create a company that was going to be able to survive its first three years before we were profit-making, and to

---

[63] Pimentel, interview, 21 June 1996.
[64] ibid.
[65] Pérez, interview, 9 January 1996.

> create a successful company we had to focus all of our attention on doing that.
>
> What happened is that timing was faster paced than we had expected it to be, because we couldn't find many people that understood what we were trying to do.[66]

As they worked to develop the training program (an ongoing process that continues to this day), senior staff had even more opportunities to solidify their visions of a cooperative workplace. They also had to work harder to understand the particular lives and needs of the workers and to explore their own limits in being able to attend to those needs. Establishing the training program also meant more difficulties in deciding where to draw the boundaries around the company's intentional community. Given that the training program was constrained by funding, staff, and industry limits, who would be accepted and who rejected? How much time and energy could staff put into dealing with the outside problems of potential workers? What did school and work readiness mean, in relation to both the company and the larger population in need of jobs?

In the beginning, cultural differences and power issues made it difficult even to get feedback from the workers on what they liked and didn't like in their training experiences. Kathleen remembers well the heatless incident described by Florinda, commenting ruefully that "It's so funny that she thought that this was how they were going to prove that they could handle this work, because they were being tortured. What an image they would have of an employer!"[67]

In general, Kathleen found that the Latina migrant and immigrant trainees saw teachers as "on the right hand of God." Afro-Caribbean women tended to be less reverent, but also had a profound respect for professionals, whereas African Americans had "the opposite ... this cynicism and this distrust that goes really deep." No matter what the background and attitude, getting feedback and participation was a challenge because all of the trainees had "been around enough to know that you don't say what you really think in a workplace, no matter how different this workplace is claiming to be, or how nice the people appear to be."[68]

One way the staff tackled this problem was by using HHAs as assistant teachers from the very beginning. The training program was both an opportunity to upgrade a few bright and ambitious HHAs and to provide trainees with instructors who were their cultural and vocational peers. This arrangement allowed trainees to

---

[66] Pérez, interview, 9 January 1996.
[67] ibid.
[68] ibid.

communicate more honestly to the staff through the assistant instructors, and for these former HHAs to communicate their ideas to senior staff within a less threatening, more equal context.

Kathleen's own negative experiences with school also encouraged her to be imaginative in constructing the training program. She sympathized with the trainees, many of whom had negative or fearful attitudes towards anything that smacked of school, because she herself was someone who "didn't fit into formal education and [was] always very critical of it."[69] She organized the program within a framework of adult education methods. She remembered:

> We would just experiment. I would read a book or go to a workshop. We found out what the gaps were in terms of their literacy and their fear of learning, and tried to address those things.[70]

From the beginning, the program emphasized process as well as content, social skills as well as technical mastery. Since the HHAs' work had everything to do with getting along with other people, the classroom became a laboratory for social interaction:

> So when, for example, in a session of the training it became clear that people were having a lot of trouble working together in groups, and that there was a real need for some activities that could get at group building because of the tensions between Latinas and African Americans, and the younger women and the older, and the women from the Dominican Republic and the women from Puerto Rico, and "I can write better than you can write," and all of that stuff that happens when more than one person is in a room, we were able to say, "Okay, well, what can we do about that?"[71]

The trainers would confront those tensions head-on, addressing them through activities aimed at building cooperation. These included ice-breaking games and a supportive atmosphere that de-emphasized formal schooling and academic skills. As trainers still emphasize, "Speling duz nat kownt." HHA Juana Gómez remembered still another strategy:

> I have learned more English here than during the time I was in the university. Because I became more confident. We were a small group, nobody laughed at anybody, the teacher helped a lot and gave one advice. Every day they changed our table. During a week, it was rare

[69] ibid.
[70] ibid.
[71] ibid.

> that you would sit twice with the same person. At lunch hour everyone shared her lunch. They tried to make one learn to deal with the different types of personalities that there are. Because one goes to work not just with one person, but with different people.[72]

Shy or less educated HHAs like Ramona Pichardo also benefited enormously from a training that, emphasizing participation, prepared her for the job, an active role in the company, and life in New York in general:

> I was a person who didn't speak too much, I wasn't very developed. But now I think I have a little more [ability] to ask you or another person a question. After I came in and did the training, it helped me to develop more. And I'm grateful to the company. There were many people who gave me a hand and cooperated with us.[73]

Florinda, now an associate instructor, says that the difference between the training she received and the CHCA program is between "day and night." The in-house training is a month long and gives ample opportunity for participation.

> The demonstrations are very important because it's more visual, and besides, many times the brain tells one one thing and the hand does another. If one has the opportunity to do something and one does it well, it makes it easier with the client. There's more demonstration of how to help the patient, to show the forms of communication between the patient and the home health aide, with role play.
>
> There are fewer complicated speeches. The form is much simpler. There's no talking about cells or the pancreas in great detail; what is taught is [in relation to] the diabetic, because you'll have to know if the patient has diabetes.
>
> There's also more opportunity because there are more exams, more quizzes; you have time to pick your brain, to really see what you're learning. As you're learning, they give you the opportunity to demonstrate it.[74]

Trainers have constantly experimented with new ways of teaching over the years. Kathleen describes it as a constant struggle, because

> the baggage that we all have about school, and about a workplace, and about relationships between professionals, is so huge, and our own stuff

---

[72] Juana Gómez, interview by Ruth Glasser, tape recording, Bronx, NY, 14 March 1996.
[73] Pichardo, interview, 29 March 1996.
[74] Pimentel, interview, 21 June 1996.

> that we need to unlearn, because one of the things I think that we were very good at, and that CHCA is still very good at, is that we don't pretend to know what we're doing. So it was this struggle to learn when we were being patronizing, treating people in a way that didn't respect who they were and what they were bringing, and there's no way anybody is going to learn to have self-esteem or feel empowered if you're not respecting what they bring.[75]

One of the ongoing challenges for the training program has been the increase of regulations, requirements, and responsibilities in the field of home health care. CHCA's training program has had to struggle to balance content with process. It has also had to struggle to find – and keep – appropriate personnel who understand and work to achieve that balance.

By federal and state law, training programs for HHAs have to be run under the supervision of a nurse. But since the inception of its training program, CHCA spent years trying to find a director of nursing who fit in with the organization's philosophy of participatory training and respect towards the trainees. As Christine, Peggy, and Rick explained it, nurses are typically trained to think hierarchically. Looked down upon by doctors within the medical pecking order, they in turn tend to see aides as their professional inferiors. CHCA tried to head off this problem by carefully interviewing nurses about their attitudes and abilities to work within CHCA's framework. Each of nine nurses, culled from a variety of ethnic and racial backgrounds, professed to embrace CHCA's educational philosophy. But when it came down to practice, each found it difficult to work on an equal basis with instructors and coordinators or to show the required respect for the HHA trainees.

All this changed with the hiring, in 1994, of Christine Archambault. Two years later, she explained:

> Most nurses don't fit at Cooperative Home Care. In fact at the interview they said, "Well, are you worried that we had nine directors of nursing before you?" I said, "No, that's actually encouraging because I never identified myself as a nurse. It's not how I think of myself, and I never fit as a nurse."[76]

Christine valued being a nurse with nontraditional thinking. She saw her outlook as an asset to an organization that she viewed as nontraditional in itself:

> It's important that people value that people have particular skills. But they're not better people or worth more as human beings. Nurses think

[75] Pérez, interview, 9 January 1996.

[76] Archambault, interview, 16 February 1996.

> that they're there to tell someone else what to do, and therefore the implication is that that person is not worth as much, and they communicate that and I think that that's what's created the problems.[77]

At the same time, Christine recognized the ongoing tension within the training between process and content. Feeling that content was being somewhat neglected for innovative teaching, she tried to bring the program more into balance:

> They didn't have someone who said, "But you're leaving out something in what we're teaching and what we're doing that matters." This is not an abstract learning experience only, it is not just to grow as a human being. It's to have the competencies that are required to do this job.[78]

To teach the content effectively, however, instructors have had to be aware of what is going on in the nonwork lives of the trainees and HHAs. As poor women who have had to learn survival skills the hard way, those who come into training and work as HHAs have special strengths and abilities. They also have many obstacles to overcome. Lack of confidence in themselves because of poor educational experiences, poverty, and difficult family situations are among the biggest problems.

Those who were HHAs themselves have a particularly good understanding of these circumstances, and how they affect the processes of learning and performance in the field. Associate instructor Florinda Pimentel says, for example:

> Although one recommends that they read the book that they're given, not everyone reads it. They always need verbal reinforcement. Many times, they don't have the habit of reading. Most of us are mothers. And they go to work, and when they come back from work they come back to cook, to work, to iron, to help the child with homework. And so it's normal that although they say, "I'd like to read this when I'm finished," probably when they finish [the chores] they're so tired that they fall asleep. I find that that's more the problem than a lack of understanding – the lack of time and help in the home.
>
> So because of this if someone in the rap session says to me, "Why shouldn't I do this," or "What should I do in this case," instead of saying, "Read the book," I tell her exactly what they have to do. But I do recommend that when she has a little bit of time, she leaf through the book.[79]

---

[77] Archambault, interview, 16 February 1996.
[78] ibid.
[79] Pimentel, interview, 21 June 1996.

Clearly, company leaders and instructors must negotiate between a sensitivity to pressures affecting the HHAs and the concrete needs and limits of the company. CHCA puts a great deal of time and money up front into the training and, thus, must maximize its rate of success by choosing candidates who will be work ready within four weeks.

Peggy feels that CHCA's limited time for training calls for a very down-to-earth attitude regarding who is chosen and how much personal transformation they can go through. When asked about the fact that HHA candidates tend to be women who already have highly developed organizational and coping skills, Peggy comments that CHCA's ability to train a broader population depends very much upon sources of funding and the company's need for growth. For several years, for example, the company received funds to conduct an English as a Second Language (ESL) program. This enabled the organization to bring in Latina workers with limited English and spend six weeks giving them the basic language skills necessary to be eligible for the entry-level training.

Peggy's strong sense of pragmatism, however, allows her to make difficult decisions and not to agonize over such limitations:

> I know I can't rescue the world, so I have to take a very small sliver of it and say, "This is what I can reasonably do." And I'm not going to lose any sleep over it, because I know that I've still created this drop in the bucket, 300 jobs, that's provided this opportunity for those 300 women, and it may not have been there [without us], despite the fact that they may be the cream of this group that we're looking at. They still may not have gotten the access anywhere else, because when they come to us, it's not that they haven't taken stabs at other places. I want our company to be here for those numbers of women, however small it may be. But I'm real clear that we can't service the broader need.[80]

Within the training program itself, however, the blurriness of such boundaries gets to the heart of the company's ongoing debate over who is to become and stay a member of the CHCA community, and what level of involvement in trainee lives is appropriate or possible. Kathleen describes several situations that illuminate these tensions. One was the use of talking circles during the training:

> Talking circles was based on a Native American thing that women did, passing a talking stick to talk about feelings. The talking circles worked for letting them air their fury at us, and their fear, but…we started using them for other things to get at – women's issues, relationships,

[80] Powell, interview, 9 February 1996.

> their children, coping with daily life – which was great if we had a way of addressing them, or of giving them real support as workers or in their lives, but we didn't.[81]

Because of their own limited time and resources, staff usually referred trainees with life problems to outside agencies. All too often, the women were treated disrespectfully in such organizations and came back to CHCA frustrated. "And so," Kathleen reflected, "it would create resentment and more work for us in the long run."[82]

Part of Kathleen's agenda also had to do with her concern regarding the more negative consequences of adult education:

> . . . because a lot of them were going to lose a lot of friends. That was something that I learned about adult education. One of the things that [Stephen Brookfield] wrote that I really loved was that it's absurd to think that learning is just this wonderful process that makes you gloriously happy at the end, which is kind of the mainstream way of thinking about education and what it does for your life.[83] Well the reality is, especially if you're a woman, that it makes your husband beat on you, and it makes your friends resent you, and it changes you in such a way that there's no going back. Once you learn how to think critically, there's nothing to do but to see the world in a very different and more painful way. And that was very real for our women. So that we wanted, and it was by design, for them to form friendships, which is why we had them in groups.[84]

In an attempt to help the women form a meaningful new community, trainers encouraged the multicultural class groups to get to know each other and to work out their own problems.

> We devised all these really fun ways of switching partners and making them sit next to each other and work with people that they didn't want to work with. If we saw that there was tension between two women, we'd sit them together and not intervene, but say, "This is what life and work is about. Figure it out." [85]

---

[81] Pérez, interview, 9 January 1996.

[82] ibid.

[83] Brookfield is a professor of education at Teacher's College, Columbia University, and the author of numerous books on adult education and critical thinking.

[84] Pérez, interview, 9 January 1996.

[85] ibid.

But within a company struggling for survival, only limited energy could be focused upon anything not directly related to the work. As time went on, Kathleen found these competing agendas harder and harder to reconcile. There were always agonizing decisions to be made about the needs of the individual versus the needs of the group. In one training session, for example, the instructors discharged an African American trainee with a continuously sullen attitude. As the trainee walked to the elevator, Kathleen and co-worker Melissa Trotman felt a strong sense that they'd made a wrong decision. They retrieved the woman, "and we told her what she needed to do to get through the training, and that we would support her rather than challenge her in getting through the process." When they sat down and talked with her later, they found out that her mother had died of AIDS six months before the training began. Looking back on the incident, Kathleen feels that

> [we] went overboard in terms of having an expectation that they shouldn't be able to express anger and disappointment and who they are in the classroom, because we were kind of contextualizing it to the point where I think we expected them to behave like they were with patients in the classroom.[86]

Indeed, personality and social skills count a great deal in the classroom, as in the office and out in the field. Christine's concern is that sometimes even technical skills get sacrificed on the altar of personality:

> There's still a feeling that if it's a nice person and they work hard and they're pleasant and they don't argue with you when you teach them, [they will pass the course]. I'd rather have someone express their frustration. Be not always so nice in terms of the learning, but more direct about things. I still think people get through who are very nice and the people who are not as pleasant or have a little more edge are not as successful when I think they might be absolutely fine.
>
> We do give a lot of thought to how someone is in a group, but this is not group work. Yes, they need to be part of Cooperative Home Care and we're a group, but on a day-to-day basis, a person is alone out there and someone who does well in a group, maybe they'll be terrible individually.[87]

Such comments point to the perennial issues that an organization like CHCA has to wrestle with: What kind of a person should be accepted at the company? What

---

[86] ibid.

[87] Archambault, interview, 16 February 1996.

kind of person is the company trying to mold? What influence does the lowest-level worker have in forming the culture of the company? To what kind of organizational culture would that person ultimately belong?

For Kathleen, these are issues of such magnitude that they ultimately strongly influenced her decision to leave the company in 1995. She felt that CHCA chose to ignore the implications of its screening mechanisms. In her view, the company chose to accept those who were easiest to work with and would not engage with the anger and higher expectations of the long-term minority poor. She and Melissa Trotman constantly grappled with the issue of longer-term needs versus a short, intensive training.

As Kathleen remembered it, the two women

> both felt that this situation with the African American women required a dedication of time that was different than that we were giving it. Because we see the same thing in second-generation Puerto Rican women. And my take on it is that it has to do with what happens in this urban setting, and what happens to communication and the fury that people feel in a workplace after being here and having expectations that are not being met by a workplace. And new immigrants have lower expectations and are thrilled by a lot less than those of us that have been here and have gotten shit.
>
> To me, if we're talking about being a cooperative and allowing expression and people to challenge power, that's the way it is. It's offensive and it's aggressive. Other ways don't work.[88]

Evolution of the Training Program

In 1995 Kathleen left the company and Peggy became increasingly busy with the replication project. CHCA brought in an experienced trainer, Florence DeVore, to become director of training and to work with Christine and the assistant instructors to revamp the training program. The program was under great pressure both from rising technical standards required by regulators and from the need of the company to grow.

Florence had to start by reconstructing the curriculum itself. "I used some of the materials that I had found that were here but it was scattered and it wasn't a curriculum."[89] She set to work "documenting stuff so that others could use it."

---

[88] Pérez, interview, 9 January 1996.

[89] DeVore, interview, 4 September 1997.

> Really making a facilitator's guide. So if you're not here today, and somebody needs to train that course, who can do it? And almost immediately we found out that it worked. We had started putting them together one by one, and I remember I was off on a Friday and we got the call that Ruth [Wyatt, formerly a staff person in the training program] had to go to England and she wasn't going to be able to come in on Monday to train body systems [basic physiology]. Well I didn't train body systems, but what I had Christine do was fax me the body systems piece from the manual we were putting together. So I was able to review it over the weekend, get in here early on Monday morning, and teach the course. And it really made a difference last cycle that they had the manual, since everybody was training new courses that they hadn't trained before.[90]

In upgrading the curriculum, Florence greatly expanded the role of the assistant trainers, promoting them to associate status. By doing so, she gave them a chance to advance individually and to model CHCA's ethics of self-development, teamwork, and participatory behavior for the trainees.

> We out of necessity moved from one key trainer to a large team of people. The underlying message is that everyone can learn, that everyone can teach, and we're all doing this together. Even if you use our kind of techniques of teaching, if you have one person up there who seems to know everything, that's part of the message. So if you have a whole team of people and there is no lead instructor, I think the message to the trainees was, "And you have to participate, too." And they did.
>
> The skills training comes best from the associate instructors, or from folks who've been out there doing the work. Sure I can go and I can show somebody how to make a bed, I can show people how to do all these skills, but I can't say, "When I was a home health aide." . . . They can say that, and so people are able to make that connection, and I think that really makes a difference. We're continuing to upgrade them, we've moved them from senior home health aides to assistant instructors and now they're associate instructors and later on they can be full instructors.[91]

Florence also included other office staff in her teacher training sessions, expanding their skills and giving them a new appreciation of what being an instructor entailed:

---

[90] ibid.

[91] ibid.

> Platform skills are basically, how to stand up in front of the classroom and train actual topic content. How to use newsprint to enhance your presentation, how to hide your notes so that the group doesn't know that you're really using notes but that they think that you've got all this content in your head. How to work the room, how to field questions. Some stuff on group dynamics. How to use the tools of the trade such as the overhead projector. I did a three-night session for the training staff. The first portion was primarily giving them the content material, and then they had an opportunity to practice and be videotaped and then get feedback on their presentation. And they said that it helped them so much that they would never believe that they'd be able to stand up and do courses. And they've done it. Some of the nontraining staff also participated. [One] has been doing our time sheet presentation, and she did an absolutely outstanding job with it. The staff themselves, they're training these courses now, and they feel so good about themselves.[92]

Florence brought much to CHCA from her long experience as a nurse and as a trainer. She set concrete rules and standards for trainees, making it clear that would-be home health aides had to demonstrate certain attitudes in the classroom for very pragmatic reasons. In this way, she reduced the sense of a cult of personality, as well as agonies of letting trainees go late in the training cycle, or leaving the coordinators to grapple with serious problems.

> I had to let people know [that] when the instructors give you feedback. . . I want to see that you know how to accept feedback appropriately, and utilize it. Not because "I just want you to be sweet to me." We're preparing you for going out in the field, and [the] Visiting Nurse Service is our biggest contractor. They think very, very highly of our trainees, and we want them to continue to think that way. . . . So if you roll your eyes at me when I give you some information, then as far as I know is if your client says something to you, their family member, or the visiting nurse, you're going to roll your eyes at them. So you get one chance to roll your eyes at me, and then I'll tell you about it, and if you do it again to any one of the staff here, then you're out.[93]

For Florence, the issues of acculturation are closely tied to those of work.

> I think a lot of it really is like a play on the name, the cooperative nature of the work out there. That the person has the ability to be cooperative in the way that they relate to the visiting nurse and the

[92] DeVore, interview, 4 September 1997.
[93] ibid.

> nurse who'll be coming in to do their annual performance review visits. Cooperativeness in the way that they talk to their coordinator on the phone. A lot of it is around attitude, I guess, the attitude that we expect. We clearly will be impressing upon them in the same way that we impress upon the entry-level people that we get positive reports from VNS all the time about our home health aides and that we expect that to continue. And the way that continues is for people to operate appropriately and to interact appropriately with people out in the field, and that's part of our expectation. So it's kind of like talking to them about those kinds of things. Hopefully they'll also get a feel for the family, or for lack of a better word, the friendship that the staff here has for one another, that cooperative feel. Hopefully they'll have a chance to see it and feel it and take some of that away with them when they go out there and start working.[94]

Although Florence has changed the structure of the training staff to reflect and model company values of development of individual potential, cooperation, and teamwork, she has reduced the use of games. Although she believes in participatory and fun learning, she says, "We're not here just to entertain people. We're here for people to go away with a certain amount of information in a very short period of time." Games are played with a concrete purpose, to help ground the information while allowing trainees "to use as many senses as possible." For a unit on nutrition, for example:

> The last portion of this session is for them to make a diet for their client. We get questions back and forth about what the various nutrients are, we talk about what some of the special diets are. Then we have them reach into a paper bag and pull out a diet slip. It identifies that your client is on a low-sodium diet, for instance. He hates bland food. Prepare dinner for him and a snack for later. Once they find out who it is they're supposed to be preparing a meal for, they prepare a meal for their client. We set the food up all around the room, and cover it over and it'll say "dairy products," "meat," "poultry," and they're told that they're going to go food shopping now. And they take a shopping bag, and they go around.[95]

Upgrading HHA's skills to meet new regulatory requirements has also involved significant changes in attitudes and approaches to the trainees as well as the veteran aides. Christine gives the example that

---

[94] ibid.

[95] ibid.

we have to teach blood pressure. And I was told by some people in senior management that people couldn't learn blood pressure. Okay, but we have to try, we have to come as close as we can, because we have to teach it. I taught the training staff to do blood pressure, and then they taught me what was good about my teaching and what wasn't good, and what didn't work, and then they added stuff, and then there was this very creative process of making up how we were going to teach blood pressure.

Then you have to decide how to pass and fail somebody. According to the regulations, a registered nurse has to pass you on every one of your skills demos, including blood pressure. And we had to figure out how to do that. And how much did a nurse make somebody nervous, or how much did I make somebody nervous, and what was passing, anyway? How many times would you have to do it correctly to say, "Yes, you passed"? What was the amount that you could have it off by? We were actually going to have the associate instructors sign off as passing and I would countersign. And which were the ones that it worked better for them to be able to say, "Well I can't pass you on this, the nurse has to pass you"? So that was all negotiated in terms of what was going to work.

When I first started they didn't expect everyone to actually get all the skills, that they would learn them in the field. But I said, "No, the day they walked into the client's home, they must have the skills." That was to me non-negotiable. You cannot say that the person is going to really learn it later on. Because when they needed it, they needed it.

The nurses could never fail anyone because there was no place for them to go. So we developed this workshop so that the nurses could feel comfortable failing somebody in a skill. People came back in and we retaught temperature, pulse, respiration to the whole workforce. We lost three people as a result of that. I was scared, but I also felt like that was a standard.[96]

CHCA has also added two new kinds of training programs in response to the company's need for appropriate aides and rapid growth. One is bilingual training.

We found over time that a lot of our really good home health aides happen to be women who are Latina, and since the population that we

[96] Archambault, interview, 4 September 1997.

> serve is often a Latino population, that we want to be able to have enough people to service them. And our numbers were dropping, and we thought that one of the reasons why that was happening was because in the past CHCA had an ESL class, and people went through the ESL class and then came into the training program. But there are a lot of people now who might have been eligible for the ESL class, but since we don't have it they've been rejected because they were not able to make it in the training program itself. So what we thought we might do then is for some of those people who were somewhat limited but still had some English skills, was that if we had a class that was bilingual, then when we see them squinting and we know that they're not getting it, it could be said in Spanish.
>
> The bilingual training also allows the associate instructors to participate in collective curriculum building in a new way. Instead of sending out for an expensive professional translator, the staff decided that they wanted to do it themselves, and . . . each person takes responsibility for several of the courses, and as they began to translate their materials they pass them around to all the other Spanish-speaking staff, and each person reviews it and makes their own adjustments. It works really well for us because we have a really multicultural Latina staff, [from] Guatemala, Panama, Dominican Republic, and Puerto Rico.[97]

Another new course is a five-day training program for people who are already certified but want to come and work for the company.

> So that rather than have people just come work for the company without having an opportunity to learn a little bit about the way we do things, to have a refresher in the content that they need as well as the skills that they need to go out there and work for us, to be comfortable that they can do the job. And we'll also give them an opportunity to feel a little bit of the Cooperative Home Care culture. I think that that will produce less problems that we sometimes have with people who come from other companies and then work for us. Many of them don't have the same way of dealing with clients and the nurses in the field in the way that we expect them to do it. So we'll have that opportunity to let them know what our expectations are. It's called the CAT program, Competency Assessment and Training Program for certifieds.[98]

---

[97] DeVore, interview, 4 September 1997.

[98] ibid.

In Peggy's view, some of the original emphasis of training was inevitably lost with the new staff and requirements. Originally, the training program was the "socializing element of the company":

> We trained people for the skills they needed to do the job. At the same time it was a design that really socialized people for Cooperative Home Care and what that culture meant, in terms of participation, in terms of the centrality of the paraprofessional. We had decided that the key elements were worker-owned and participative management, focus on quality training, those kinds of things. When the training program was headed up by Kathy, by myself, in the early days, the program [was focused on] group learning, group process, teamwork, minimizing of hierarchical kinds of interactions, things around authority relationships, and cooperation as its core. That was a very discrete aspect in the training. The dilemma that came up used to be, "What is the purpose of the training program?" Is it to empower and develop the women, or is it to train people for jobs? And there were those of us who said, "It's primarily to train people to be workers in the job, and to do that in a way that really empowers them."
>
> There is much more of a mixture today of people who have come from a professionalized training background, whose focus has often been in the design and delivery of programs, whether they're health education programs or they're training programs, with some core in there who are primarily the assistant instructors, who basically grew up in the company, who in their guts know and live the culture of what the development of this company has been over the last 12 years or so. So within the existing training staff now you have this small core of people who are the veterans, for lack of a better word, and who live and breathe the originating kind of dogma and culture of the company.[99]

But in Florence's view, team building is still an important aspect of CHCA's training, even if it is sometimes pursued by different means.

> As soon as they walk in the classroom they're given their team identity, which is their team name. So this group coming in, they'll know that you're class '97-6. And the objective here is for you all to help each other through this program, that it's not going to be easy, and the only way you can make it through is by looking at the name of this company, which is Cooperative, and we expect you to cooperate with each other

[99] Powell, interview by Ruth Glasser, tape recording, Bronx, NY, 26 August 1997.

> and help one another through this. We start talking about the cooperativeness of the group and how any sense that you're not cooperating with your classmates, the instructors, or any staff members is immediate reason for me to just let you go. We're not saying you're not a good person, we're just saying that you're not a match for this company. And that we look at it like a relationship. Some people stay in relationships that don't work because they're afraid to change them, but here, if this relationship isn't working, I'm going to call you in my office and I'm going to let you know this relationship isn't working and I'm going to let you go.[100]

How Aides See Training

Many candidate aides come to training with fears and expectations of failure. Vivian Carrión recalls, "It was scary at first, because you say to yourself, 'Are you going to make it?' I said 'Wait a minute, I raised three kids, I'll make it.'" [101]

The training itself can help to counter bad past experiences and self-doubts. It is designed to provide social support, opportunities to learn from mistakes without feeling failure, and plenty of "second chances." Vivian says,

> The classes give you a lift. Everybody makes you feel good. It's like, you make mistakes and it's okay to make mistakes; if you did something wrong, you just do it all over. When we were in class, I was so afraid when they used to give us the demonstrations – how to handle a person, how to transfer them from the bed to the wheelchair. I kept saying to myself, "I'm not strong enough to handle somebody, take somebody that can't walk and put them in the wheelchair."
>
> There's little techniques that they show you. But even though they show you, at first you say, "Oh my God, I'm either going to kill a person, I'm going to drop a person, I'm going to wind up hurting somebody!" But the way they teach you and the confidence they give you, it doesn't matter if they have to teach you things over. They give you the opportunity to do things over and over that you feel – even though you're doing it right deep down inside you say, "No I'm not doing it right. It might take somebody one day, it might take another person one week." [102]

The training gives students an opportunity to work around their weak points.

---

[100] DeVore, interview, 4 September 1997.
[101] Carrión, interview, 13 March 1996.
[102] ibid.

> Everybody's different. The written test is in English, and we have a lot of workers that are capable of understanding it but – it's just like me with Spanish, I can't read it too well. [The trainers] come around, and if you're having trouble reading it, they'll translate it into Spanish, and if you can't write your answer in English, you can write it down in Spanish. As long as they know that you know what you're doing and you understand the questions. I have a weak spot, and I told them from the beginning. You can set a book in front of me and I can read it with no problem, but when it comes to spelling, I'm very, very bad. Sometimes I go blank.[103]

On written tests like the GED, students are often given a certain time for completion. "That's what I was afraid of. When [CHCA] gave us the written tests, they didn't give a certain time. So you could take time without worrying about it."

> They teach you how to do stuff, and then the return demos, when you have to do it yourself with another person. If you did it wrong the next time, they give you another chance to do it again. And they actually show you what you did wrong, and they'll teach you again, and then you do the return demo again. And it didn't matter to them if you did it wrong two or three times. They would actually show you again. And if they had to give you maybe extra teaching on the side, they would, with no problem.[104]

For Bibi Yusuf, training helped her overcome her sense of isolation as an immigrant. She met a few women who were very helpful to her, made her at ease, and are still her closest friends because they were so kind to her. She didn't know anything about America. Everything was new to her, the people, the way of living. She didn't even know there was a different language, such as Spanish, spoken in the United States; she thought everybody spoke English. In training, people were very supportive and kind, friends explained things to her, people tried to make things easy, made her very comfortable and relaxed, traveled together and had their lunch together. She didn't feel left out or like the only one who didn't understand what was going on. She was the only trainee from Guyana, but they made her feel part of everybody who was there:

> I didn't feel like I was the only Guyanese. Now when I look back I say, "Yeah, I was," but at that time I didn't feel like it because even though they were Spanish together and they spoke Spanish to communicate, they didn't leave me out. So I felt like I was part. They were translating

[103] Carrión, interview, 13 March 1996.

[104] ibid.

> if I didn't understand something. So I didn't realize at the time it was a different culture.[105]

Now an associate instructor herself, Bibi explains:

> If the instructor was a home health aide before, it made it easier; she knows what I'm going through. A nurse [might think], "Oh, what a stupid question." Because right away you think of a nurse, it doesn't matter how nice the person is, right away you say, "That's a nurse, it's different." This is a home health aide, she's an assistant instructor, but you feel more comfortable.[106]

For those with little education, the CHCA training can be especially difficult – and especially rewarding. Ramona Pichardo, who did not have the opportunity to complete grade school, said:

> I've learned a lot. When I entered the company I knew how to write a little and a little about numbers. But there I had three weeks to ground myself in a little more education. I didn't know how to use a thermometer. I didn't know what temperature was. When one is not educated, one doesn't understand what the human body is about, and there I learned a little about the human body, what a disease was.[107]

CHCA has continuing in-service training programs and provides additional opportunities for advance training. Bibi joined the company at a time when there was only a brief initial training. After she had been on the job she went back for more training to become an assistant instructor.

> Everything was new; it was like learning all over again, at a much higher level. Like you took time to make a bed, you observed it and you did it and you had to do it the right way. I would look, I would observe, I would have to assist in correcting. The nurse would be with me for the first couple of days. She would sit with me a few times and I observed how she was correcting the person, and then she would let me take the lead. Now I'm learning all these things which make sense. But at the same time, I still have to go back to my own personal experience. At the time I thought I was a good home health aide, but I could have been a better home health aide with this knowledge.[108]

---

[105] Yusuf Ishmael, interview, 7 March 1996.
[106] ibid.
[107] Pichardo, interview, 29 March 1996.
[108] Yusuf Ishmael, interview, 7 March 1996.

Continuing Learning

Once the women have successfully completed the one-month training period, they plunge immediately into work. As company personnel tell the women, the interviewing and training processes are stringent precisely because there is a guaranteed job at the other end. The HHAs, applicants and trainees are told from the beginning, represent the company and the quality of its services.

During the three months after training, the new HHAs are essentially in a probationary period where they are carefully monitored by coordinators and visiting nurses. Not all come out the other end.[109] As Faith Wiggins, at the time director of CHCA's newly created Department of Workforce Development, explains:

> In the training we're trying to really test out people's problem-solving skills, and we do that in the interview, but a lot of that really doesn't happen until they're actually out there and working. So often that's where people fall short and then that's where any problems with child care usually are revealed. Usually people can pull it together for the four weeks of training, but on the job if that child care really isn't firm or secure, then usually people are absent. And not following policy is another reason why people in the initial stage don't make it through the on-the-job training. [And] a lot of people once they are actually out there doing it realize, "Hey, I don't want to do this." So there's a choice that gets made on the person's part – is this worth it for them? [110]

During the first three months, the new HHAs attend two rap/OJT sessions, conducted by instructors, coordinators, and company leaders. At these meetings, they compare their experiences in the field and brainstorm problem solving for each other's cases. At the end of the three-month period, successful trainees are given a graduation ceremony and two certificates, one for home health care and the other for personal care.

But even after the three months are over, HHAs are not finished with their training. In accordance with state regulations, constant changes in the medical field and in the scope of their jobs, and CHCA's goal of providing opportunities for further education, HHAs attend 14 hours per year of mandatory in-service training sessions.

---

[109] Rick Surpin, "The Realities of Welfare Reform and Work," 1997, 6. Recent company literature shows the stringency of the recruitment, training, and retention process. In a typical cycle, out of 250 scheduled for an open house, only 17 complete the course and are subsequently employed. Of these, 10 are still with the company one year later.

[110] Faith Wiggins, interview by Ruth Glasser, tape recording, Bronx, NY, 1 February 1996.

These cover different topics that relate to problem solving, case issues, and new regulations. They also learn constantly in the field from the nurses who supervise them and visit the patients, from the coordinators, and by comparing experiences with each other.

In a sense, there has been a gradual switching of content and function of the entry-level and in-service training programs. While Christine, for example, has insisted that mastery of technical skills must take place within the entry-level training, she tries to remold the in-service training to foster the critical thinking, ideas exchange, validation of personal experiences, and mutual support that are intrinsic to CHCA's values:

> I'd like to move all of our in-services into this model of teaching. Everyone gets a chance to talk about what they're doing, and they get to hear not, the nurse, "Oh, you did it wrong," but "Here's another way to do it, and this worked for me, and it turned out to be more effective." Some people give examples of their problem solving that they're proud of and you're like, "Oh, this is scary, this is not good problem solving." But to have another home health aide say, "Well, I don't know about that, but this is what I do" – they hear it, it's a totally different feeling.[111]

HHAs also continue learning on the job and from other aides. Bibi Yusuf, for example, had a dying cancer patient who was often very angry and difficult to deal with. She knew little about cancer and didn't realize how much pain it caused – to her it was just another disease. But the death from cancer of a friend, 28 years old and a member of CHCA's office staff, changed her attitude. "I remember when my co-worker passed away, I went home that night. I was so upset and angry and I was telling my mother, what kind of thing is this? She'd never seen me like this before. I didn't have any answers." After that, Bibi went back to the cancer patients she worked with and put things together. "I surprised myself, too. I didn't even realize I was that angry about it, and both clients passed away shortly, too. It did mean a lot to me."[112] She talked about it with another aide whose mother had died of cancer. She didn't realize at the time how much pain they go through. She came to understand that how the patient responds has nothing to do with the HHA, but that the aide has to work extra hard to make them comfortable.

This learning she passes on:

> Now if a home health aide tells me, my client has cancer, I ask a lot of questions, "How is she doing; how is she coping with the pain; what are

[111] Archambault, interview, 4 September 1997.
[112] Yusuf Ishmael, interview, 7 March 1996.

> some of the things you are doing to make her comfortable; does she get upset a lot?" [113]

When another HHA had a client with cancer who was being nasty to her, she helped her to understand that it was not something she was doing wrong, but something that happens when people are sick and in a lot of pain.

> If I know that there's a HHA that has a cancer client, I tell them "Please, be very understanding, don't take anything they say personally, because it has nothing to do with you. It's just the pain they're going through."
>
> I learned a lot more being here, listening to others. Not only the instructors, but the trainees. They come in with a lot of information, they have family members, and sometimes when you're talking and they express, they go deep, they bring a lot themselves. So with what they bring in, what I read about, and talking to the other instructors, it's a big thing for me.[114]

For some the job is a place for social and emotional development. Sarah Lee says what she learned on the job was

> how to control my tongue. Controlling my tongue and taking a little more than what I thought I could take. I know now what my father was talking about. When you are a child, and you see things like that, even a real young adult, you don't understand. But then when you get out here and you have to do the same thing that you saw your father do, you say, "Oh man, that's what Daddy was talking about." Learning how to control. He didn't use those words, but that's what it is. You know control will take you a long way. It will take you more ways than what I was in my younger days.[115]

A bilingual aide comments that the job has

> changed my personality in the sense that I'm more open. Even my own sons noticed that. They tell me, "Oh my God, Mom, she's a big shot in her company." Because they see me talking when my co-workers are calling the house and they see me explaining to them in Spanish.[116]

Working with patients from different ethnic groups brings rewards to the aides as well. As Ana Cuevas puts it:

---

[113] Yusuf Ishmael, interview, 7 March 1996.
[114] ibid.
[115] Sarah Lee, interview by Ruth Glasser, tape recording, Bronx, NY, 21 March 1996.
[116] Carrión, interview, 13 March 1996.

> Every patient you go to from a different country, you learn something from. They learn something from you, and you learn something from them. The first time that I worked with a Nicaraguan, she said to me, "I want you to make me some tortillas." And I said to her, "I don't know how to make them, I can buy them for you in the supermarket." She said, "No, no, I want you to make them, I'll show you how." Then she showed me. Since I knew this was my case, my patient, I had to make her feel good. So I learned, and she was pleased.[117]

In a sense, training at CHCA never ends.

Case Management

Although in many home health care companies aides work largely on their own, CHCA's coordinators keep a close eye upon and maintain constant contact with the HHAs in the field. At the time of this study, four coordinators and a supervisor worked within CHCA's Patient Services Department.

The coordinators work long, intense hours to fulfill their duties. They match HHAs to cases, monitor HHA performance on the job, and troubleshoot when necessary with aides, patients, and visiting nurses. Coordinators also participate in interviews of applicants, training, case management, and Worker Council sessions. The supervisor, longtime CHCA employee Jeanie Taylor, does some of all of the above, monitors agency compliance to state regulations, and supervises the coordinators' work.

Since an ethos of cooperation, communication, and personal initiative is inculcated in the HHAs from the time they are applicants and trainees, they are expected to let their coordinators know when they or their clients have problems. As Alice Bates, CHCA's longest employed coordinator explains, "They're our eyes, hands, everything. They let us know all about the patients."[118] It is the HHAs who flesh out the scanty case descriptions, telling the coordinators about the particular living situations, needs, and desires of the patients. In turn, coordinators can monitor HHA performance and provide them with support as needed. When successful, the job can be extremely rewarding.

> You're sending somebody out that wants to work in this type of work, and they're helping somebody get up on their feet. Sometimes the patients are just lonely and they need somebody to be in there talking with them

---

[117] Ana Cuevas, interview by Ruth Glasser, tape recording, Bronx, NY, 11 July 1996.
[118] Alice Bates, interview by Ruth Glasser, tape recording, Bronx, NY, 4 January 1997.

> for three hours. So you know you're doing your part in that, helping that person out.[119]

In managing cases, each coordinator works with a particular geographic district and matches HHAs to clients living within that district. For the duration of the case, she is the supervising coordinator for that aide. Although Jeanie does not have her own cases, she will step in and coordinate as needed. She also is aware of what all four coordinators are doing, even as she does her own work: "That's one of the better qualities that I have. I can write something or I can be on the phone with someone and I can still hear what's going on at the coordinators' desks."[120]

Jeanie knows all the 300-plus HHAs and is on top of their current cases, their personalities, and their family situations. She says:

> How do you remember that stuff? But you do. You know which aides will give you a problem traveling to another borough; you know off the top of your head which aides are allergic to pets, which aides may have worked with a particular patient before and it's not good to send that aide back again; you know which aides are timid and if the patient has a strong personality, a little bit too aggressive, and that it wouldn't work out; you know which aides have a strong personality and are aggressive and wouldn't work with the particular patient.[121]

The enormous amount of data to assimilate and the day-to-day stresses make case coordination a very difficult job. Phones ring constantly, crises and complaints are common. It is also a difficult job to leave behind, as Alice observes:

> You always take it home. Even sometimes when you're on vacation, you're trying to remember, is that patient covered? You know that person is ill and she can't get up, or she can't make food for herself, and it stays with you because you're thinking, "Oh my goodness, did I send somebody to this patient, she's home, she probably can't get to the kitchen, or she can't get up to go to the bathroom."[122]

One of the most challenging aspects of the job is matching HHAs with patients, as Alice points out:

> Like if we get a Muslim patient, we try to match them up with a Muslim aide, because we know that that aide knows exactly what to do. One of

---

[119] Alice Bates, interview, 4 January 1997.

[120] Jeanie Taylor, interview by Ruth Glasser, tape recording, Bronx, NY, 3 April 1996.

[121] ibid.

[122] Bates, interview, 4 January 1997.

> my patients was a Muslim, and you had to take your shoes off at the door. The first aide went in and she didn't take her shoes off. I looked around and it so happened that one of the other workers, she was a Muslim.
>
> You have the West Indian people that they'll say, "Oh, send me somebody that can cook." You look through the list, someone that can cook, okay, maybe from the islands, and the patients, they feel so much better.
>
> You have to take into account, how long will it take this aide to get up there. You don't want to send somebody from Manhattan all the way up to Coop City. You know it's going to take two hours to get there and so you try to match people in your area, or at least where they can take one or two buses.[123]

The coordinators try to be sensitive to the needs of both patients and HHAs. They take personality and culture into account when possible. Alice, for example, has had aides who were too shy to communicate by phone or in person and has accepted notes and letters describing their relationships with patients. She and the other coordinators try to forge relationships between people of common languages and cooking styles. Clearly, the coordinators recognize that both culture and personality play a profound role in providing the best service to the clients. As the case of the Muslim patient shows, they must learn enough about the various cultures of aides and clients to make compatible matches, troubleshoot, and handle difficult situations.

But this flexibility has some limits that reflect the bottom-line needs, possibilities, and values within the company. Coordinators do not tolerate, for example, bigotry on the part of patients or HHAs. Patients who object to aides who speak their language but come from other countries, on the grounds that they don't know how to cook their food (a common code for more deep-rooted prejudices) are told politely but firmly that they will need to adapt to the aide, teaching her how they want the food prepared. An African American aide who objected to being placed on a case in Washington Heights "with all those Spanish people" was quickly fired.

HHAs who are habitually late, absent, incompetent, or uncommunicative regarding important aspects of patient care also do not last long in the company. Those who let their personal needs interfere with their job, who don't plan ahead and let their coordinators know when they need time off, find themselves in precarious

[123] ibid.

positions as well. Thus, reprimanding and firing aides are other difficult aspects of the coordinator's job.

To provide the best-quality service to the patients, the coordinators need to be tough and demanding. The day-to-day requirements of the job performed by Patient Services demand a certain type of personality and have fostered a very particular culture within this department. The department is the liveliest within CHCA, a unit of African American and Latina women with a New York brashness that is refreshing to some employees and difficult for others. Christine says, "Jeanie is in your face, and I love it. When Jeanie doesn't agree with me, she tells me." [124] Christine, who works between the CHCA's Patient Services and Training Departments, sees Patient Services as unique within the organization:

> Jeanie runs an incredible unit and I know that she's appreciated but there's ways in which I think she's not been appreciated because there's a practical element to that unit that is not as present in the rest of the organization. You have to get that case assignment, you cannot sit and discuss it. There's an immediacy to the client assignment, to the problem solving.
>
> [No one] grasps deeply what that means to your life, when you live your job in those ways, where you're on call in the evenings, where you're on on the weekends, that you don't take off the day after Thanksgiving.[125]

The culture of Patient Services is very different from that of other units within CHCA that perform other functions. Kathleen Pérez believes that differences between Patient Services and the Training Department are a result of the nature of their different jobs. "We were always warmer and fuzzier than Patient Services. One of the difficulties is, how do you create more of a common culture in those two worlds, given that you're doing something day to day that's quite different?" [126]

Changes in training personnel and focus have helped to bring these departments more into alignment. More explicit requirements for trainees, explained by Florence and other staff members from the beginning of the training cycle, have helped to weed out potential problems. Structural changes in CHCA have helped as well. A new generation of nurses, for example, has caught up on supervisory visits to HHAs in the field. They are more available to troubleshoot and problem solve for HHAs, taking some of the pressure off the coordinators. And whereas case

---

[124] Archambault, interview, 16 February 1996.

[125] ibid.

[126] Pérez, interview, 9 January 1996.

management meetings used to involve long and inefficient discussions regarding problem aides, Christine says that the new worker review meetings

> actually happen every two weeks and we talk about everybody. . . . What we used to do in those meetings is exchange data. . . . Now that exchange of data happens in other ways and what happens in those meetings is that . . . there's a real exchange, and it's not just the storytelling that has a kind of "gotcha" feel to it.[127]

Peggy sees Patient Services as increasingly the repository of values that previously were focused primarily in the training program:

> In Patient Services you have people who have grown up with this company, who have internalized values, consciously and unconsciously, about the original informal culture that we tried to put in place in the way that we interact and behave and deal with each other. The individuals in Patient Services at this point have a history and a broader grasp about the unarticulated day-to-day goals and philosophy of the company.[128]

Patient Services is the site of a great deal of informal community-building activity. Coordinators know a great deal about the families and personal lives of the HHAs. Coordinators administer or are involved in susus, revolving loan funds, in which many HHAs of West Indian origin participate. The Patient Services unit heavily patronizes those aides who supplement their income by selling candy, jewelry, clothing, and cosmetics.

In fact, the Patient Services unit is a source of both fierce loyalty and some controversy among the HHAs and other office staff, pointing to the ways in which ethnicity, function, and personality contribute to subcultures viewed very differently by the various office staff and home health aides. In contrast to New-York-born-and-bred Christine, for example, others express the view that Patient Services is too loud, dominant, and intimidating, clashing with the modes of expression of immigrants and recent arrivals to New York.

Patient Services has been a source of friction to those in the office who prefer a quieter and gentler working environment, as well as to those who deal with HHAs too timid or afraid to approach the coordinators. Practical problems have arisen because some HHAs prefer to speak about their problems and complaints to the instructors or to members of other departments, rather than the coordinators.

---

[127] Archambault, interview, 16 February 1996.

[128] Powell, interview, 26 August 1997.

These office staff members then must intercede as tactfully as possible with the coordinators.

Some aides express fear about going to the coordinators to complain, apprehensive that they will be considered troublemakers or people with bad attitudes and thus will not be selected as jobs come up. This is a critical issue, since one of the biggest complaints among HHAs is that they don't always get enough hours of work per week to make a living. Some HHAs even feel that the coordinators play favorites, that they prefer particular people or members of their own ethnic/racial groups and give them first choice of available work. Other aides complain that there are more jobs for Latina HHAs because of their language skills. On an anonymous survey, some workers expressed the feeling that they were not listened to in cases of conflict between aide and client (see Appendix 2).

Jeanie maintains firmly that there are no favorites, and is constantly explaining the jobs situation to the workers. In doing so, she helps fulfill company goals of making HHAs informed participants who understand the inner workings of the company.

> You actually have to bring that worker in, and sit her down, and make sure that she understands exactly what's going on. And you take her from point A to Z, explaining about the things that are happening at the state level, how we get cases, how we make the decision who gets the case, and really attempt to make that worker understand why she has the hours that she does.[129]

Other HHAs believe that it is the aide's own attitude and availability for work that makes the difference in how Jeanie and the coordinators treat her. Some recent immigrants are the coordinators' strongest advocates, perhaps reflecting their own positioning within the United States economy. Often, they frame their perceptions by separating themselves from those they feel have been spoiled by entitlements, who from their point of view are not willing to make sacrifices to earn money. Juana Gómez says:

> What happens is that many women who have Section 8, who have food stamps, who live in [public] housing, and they can't work a lot, so they give them four hours or six hours. There are many who they call, "Come to work, can you work the weekend?" "Ay, I can't." "Do you want twelve hours at night?" "Ay, I can't because my husband doesn't want me to." But since I always tell them "yes," they call me directly.[130]

---

[129] Taylor, interview, 3 April 1996.

[130] Gómez, interview, 14 March 1996.

Ramona Pichardo feels the same way. She believes that some disgruntled aides

> blame the coordinators, that they give a better case to one or the other; that's not true. They have to be available, they have to be calling the coordinator.
>
> I don't believe either that the Hispanas have better work than the American, or the American better work than we Hispanas. To me, all of us work equally, and depending upon the cases that come up and depending upon whether a person wants to work. Because there are people who they call, "Ay, I'm not going to work weekends for anybody." Or if they live in the Bronx and the case is here in Manhattan, they don't want to take the bus or come from the Bronx to here.
>
> There are certain workers who are preferred by the coordinators, because they've earned it, because [they] have worked and [are] always available.[131]

Indeed, many have no hesitation about expressing themselves, feeling that the atmosphere of CHCA in general is one of free expression. Juana says,

> If I don't like something, I don't disrespect anyone. But I call Adria, who right now is my coordinator, and I go to see her and talk to her. If she doesn't resolve the issue, well I go to Jeanie until she resolves it. What I can't do is go to the president or to Jeanie without seeing Adria. If I have a problem, I speak, and if I didn't want to be on a case I would say it as well. I don't have a martyr complex.
>
> If I want work, I go and I plant myself in the middle of the coordinators, "Give me work, give me work, give me work." If they have it, they give it to me, and if they don't, they tell me, "I don't have any."[132]

If what matters most in workplace culture is what happens day to day on the job, Patient Services provides the critical link between CHCA as a whole, the agency's clients, and workers' individual experience at the worksite. And the job of the coordinators becomes ever more complex as CHCA's strategies for survival change. With new and increasingly formal preferred-provider arrangements with the Visiting Nurse Service, the advent of private pay clients, and the coming of Independence Care System, the future for CHCA's coordinating staff promises to be challenging indeed.

---

[131] Pichardo, interview, 29 March 1996.

[132] Juana Gómez, interview by Ruth Glasser, tape recording, Bronx, NY, 17 May 1996.

Home Care

All of CHCA's other functions revolve around its central one: providing care for clients in the home. The way CHCA selects home health aides, trains them, and supports them on the job has been crucial in shaping both the company's culture and in making it a success. But similarly crucial for CHCA's culture and success has been the background, life experience, motivation, capacity, and continuing development contributed by the home health aides themselves – what they bring and what they develop on the job.

"This is No Easy Work"

It is impossible to grasp either the culture of CHCA or its contribution to the company's success without a sense of the character of the home health aide's work. HHAs perform a range of medically important procedures, including taking blood pressure, making sure patients take their medicine, moving patients, bathing patients, exercising patients, observing changes in the patient's condition, and calling in further medical intervention when appropriate. The specific tasks are laid out in a treatment plan provided by a visiting nurse. In contrast to aides in a hospital, HHAs operate largely under their own supervision, with only occasional oversight from visiting nurses. They have to manage not only themselves but also the patient and the household setting. They have to exercise judgment in situations that are often unique. Their competence can mean the difference between life and death. HHAs who have done nonmedical personal care or housekeeping make clear that home health care requires far more responsibility. Veteran HHA Sarah Lee, for example, went to a training program for six months and got a personal care certificate from the Department of Aging. "Taking care of elder people wasn't like this type of work. You went in their home and went shopping and did their laundry for them. Two hours with one, then another."[133] Another HHA observed that for housecleaning, "You are just there to do the house job, no client. But in this field, you've got to deal with the client." As HHA Alma Velázquez puts it, "We get more training in things that will help to save the life of the patient. Not only medicines but also diet, many different moral and physical things that help them a lot."[134]

The HHA's role in patient care goes far beyond the specific tasks laid out in a treatment plan. Recent research has stressed the crucial role of human interaction and caring in the healing process; for example, longevity is greater for people with strong families and social networks and cancer patients enrolled in support groups

---

[133] Lee, interview, 21 March 1996.

[134] Alma Velázquez, interview by Ruth Glasser, tape recording, Bronx, NY, 23 May 1996.

live substantially longer than similar patients who are not. Failure to follow medical instructions – for example, failing to take prescribed medication or to adhere to prescribed diets – is a major source of medical failure. Lifestyle changes – for example, regarding smoking, drugs, alcohol, exercise, rest, and diet – are crucial aspects of recovery and health. Yet these are all areas the present medical system finds difficult to address. HHAs who are able to contribute to these needs can make a big difference in patient comfort and recovery.

Thus the human dimension of an HHA's work is crucial. As HHA Vivian Carrión put it, "A good aide is somebody that will care about their client, not just come in and do a job and leave."[135] Sarah notes that you sometimes hear a client talking about how good an aide is. "She's rubbing her hands or doing her like this, touching her. You can tell by that." To be a good aide she says,

> they need feelings. Feelings. Compassion. If you see a person that has a client and you never see her touch that client whatsoever, then you know she's not going to make a good aide, that she's in it because she has to be, that's work for her, but if you see a patient with a client, and she's forever touching that client, and she's forever talking to that client, then you know she's a good aide, and you know she has compassion. But if you've got one that doesn't show compassion, they're not going to make a good aide.[136]

In Sarah's view, many of the things that make a good aide are learned in childhood:

> First, there's compassion. The ability to accept things that you can't do anything about. Comfort, try to comfort people, and most of all, be a friend to them. Be a real good friend to them, because most of them need it. If you get a elder person, not even a elder person, anybody, and you touch that person, especially an AIDS patient, or you even give them a hug, or squeeze the hands or something like that, and show them that you are not scornful of them, that makes their day. You got some aides [who] think, if you talk to [AIDS patients], or you touch them, then [you're] going to get AIDS.[137]

Communication is crucial to an HHA's work, as one aide explained:

> You have to have some communication with them. They're going to tell you about their family, they're going to tell you about their medication. You got all day to listen to them. You can't just go there and do what

---

[135] Carrión, interview, 13 March 1996.

[136] Lee, interview, 21 March 1996.

[137] ibid.

> they [the visiting nurses] tell you to do – bed, bath, sit in the tub or take a shower, fix their food, and go to the laundry. It's always something else in between that they are going to talk about. Even though you give them breakfast, they going to set down and start talking, they going to be telling you about their family so you got to listen to it and learn how to keep it confidential.[138]

Many HHAs who have held other jobs comment on the difficulty of the work. The authors have come to agree heartily with Sarah, "This is not no easy work. This is no easy work whatsoever."[139] Beyond the demands of the work itself is the problem of dealing with extremely difficult patients and families. "They think you're their maid. They want to control you; they want you to jump when they snap their fingers, give you an order; they want you to do it right then. They act more like they doing you a favor than you are helping them."[140] Vivian gave an example of a patient so difficult that few HHAs were willing to work for him:

> We had this patient – as a matter of fact the company doesn't have him any more, because no aides wanted to go to his house. The aides kept leaving him and leaving him and leaving him. Then when it was my turn, my coordinator told me, "Vivian, he's like this and like this and like this." And, oh my God, he made everybody's life miserable. He cursed all those aides out; I heard him curse at those aides. And the company got rid of him, because they didn't have no one to go there when the last aide quit. The company talked to him and his relatives, who were really nice, but they couldn't get through to him. You try your best; he always used to find something wrong.[141]

Additional examples of difficult patients and other difficulties of the job – and of how CHCA's HHAs deal with them – are presented below.

Traditions and Experiences of Caring

CHCA recruitment and hiring place strong emphasis on people with experience caring for others. Although in some cases this includes work experience, it more often means caring for ill, elderly, or disabled family and community members. Interviews with HHAs indicate that they are often people who have dedicated substantial portions of their life to such caring. What also emerges in the interviews

---

[138] All quotations without attributions are from anonymous interviews, at the request of the interviewees.

[139] Lee, interview, 21 March 1996.

[140] ibid.

[141] Carrión, interview, 13 March 1996.

is how often this represents the continuation of a tradition of caring handed down, usually from older female relatives, and how deeply the caring role is embedded in most HHA's role and identity.

Vivian's parents were born and married in Patillas, Puerto Rico, and then came to Manhattan and the Bronx.

> I have gone with my mother when my mother used to take care of people in the neighborhood. My mother was always a community volunteer. She helped, especially the ones that didn't have anybody to help them. I think that's why I got interested in this job. She used to help a lot of people that were homebound. And when I was growing up, as far as I know, there was nothing like home attendant or stuff like that. A lot of people who were homebound relied on church people to come and help them. She did it on her own but she also did it through the church.[142]

Her mother took her on some of her home visits.

> The first time I got real scared. I think I was about ten or eleven. And she was cleaning this lady with the ostomy bag, and I thought it was so gross. I got nauseous. But then my mother tried to explain to me, "You know this lady has this disease and she couldn't pass her stools the normal way, and the only way the doctor could save her life or she will die was to do the operation." She didn't go into big words or anything, she just told me, "Don't worry, as you get older, you'll understand." And she said, "People are still the same, even though they look different." And she was some special lady. And she used to tell us, "Even though something might look a little strange to you, people deep down inside, they're the same." That's why when I'm having a problem I think about her or my granddaughter and it seems to give me a lift.[143]

When she was about sixteen, Vivian also went with her mother to take care of Vivian's grandmother who had cancer, and who also used an ostomy bag.

> The feeling came back. I said, "Oh my God, this looks nasty." But this is my grandmother, and I loved her. So when my mother used to go over and take care of her, I used to go and help her. And one time my mother couldn't go, so she sent me. And I did it by myself. I changed her, I washed her. I didn't feel like the first time, like "ugh." I didn't have any problem after that.[144]

---

[142] ibid.

[143] ibid.

[144] ibid.

Vivian believes her mother had a deep impact on her ability to do HHA work. "I like people in general. Like my mother said, everybody deep down inside, we're all the same, even though we might look different, so the way she brought us up, I guess that helps a lot."[145]

Florinda Pimentel, who grew up in Santo Domingo, Dominican Republic, also had an ethic of caring ingrained in her from an early age:

> There was an elderly couple that since I was nine years old I had to care for them, because my mother made me. I had to go for two hours each afternoon to prepare their lunch, to clean the house a bit, wash and organize their clothes.[146]

Betty Cooper was raised in New York by a foster mother who took in many children on both a short- and a long-term basis. When there were bake sales, Girl Scout events, and other community activities, her foster mother was always involved. "She was always a part of something in the community, she loved it because it involved children." Her mother encouraged her to participate; when she resisted, her mother said, "Go and see what you can learn, even if you don't like the leader."

Betty wanted to be a nurse, an aspiration she traces to her mother's concerns. "I remember Mom saying that there are so many sick people that nobody cares anything about, and when you go to the hospitals and things it looks like sometimes they don't have the time to help you. Sometimes just to have somebody to talk to is good."

And she traces her ability to be a good HHA to her mother's attitudes. She

> always had an answer for something. And it was never harsh or embarrassment or anything like that. It was always, "You can be as good as you want to be, and you can treat the next person the same way." A lot of times I have taken that attitude into some of these homes. Because you find some of the clients, they're angry because they're sick, they're angry because they're shut in, and they can't do the things they used to do. They can't walk, or they can't take care of themselves, and I don't know, somehow I just got that extra something. I say, "Mom would have done so-and-so." And most of the time I come out on top. Everybody that I've really really worked with, most asked for me to come back.[147]

---

[145] Carrión, interview, 13 March 1996.

[146] Pimentel, interview, 21 June 1996.

[147] Betty Cooper, interview by Ruth Glasser, tape recording, Bronx, NY, 23 May 1996.

On many occasions, others recognized these women as natural caregivers. Sarah Lee, who came from a North Carolina family, recalls,

> When my father got sick, my sisters and I and my brother, my aunts and others tipped in to help him out. He stayed sick for about a year and a half, and I took a leave of absence and we had to take turns in the hospital because they didn't have that many nurses helping him out, helping my mother out so it wouldn't be too much on her. And when the doctor got ready to tell us what was wrong with him, out of all my brothers and sisters he picked me to tell what was wrong and left it up to me to tell my mother and the rest of the family what was wrong with my father. And then I saw other people in the hospital that weren't getting as much care as my father because he had his family around and they didn't have anyone except the nurses. [The hospital] was doing the best they could but they was short. So that's how I became a home health aide in the first place, because of what I was doing for my father, and what I saw in the hospital: that there were people there who wasn't getting the care they was supposed to be getting because of the shortage of nurses. So I said, "There's other people in this world that's not getting the care they need." [148]

Since many of the HHAs grew up in tight-knit neighborhoods or rural towns, many modeled their idea of caregiving after their own childhood experiences of family and community.

> You see some of the elder people out here just can't make it, and they don't have anybody helping them. Sometimes the family's not that close, so they don't see them. And we, the home health aide, are the only people they come in contact with that they call their friend, that they talk to, telling you their personal problems. Sometimes it gets too much for you, it weighs heavy. Because they tell you, don't get involved, but how can you not get involved with a client? You see they don't have anyone but you. They talk to you, they tell you everything.[149]

HHAs also bring a more mundane form of training in skills and self-discipline to the job. As one aide put it, "If mama didn't make me stay in the house to cook, to iron, or to wash, and do things to clean the house or whatever, I don't think that I would be able to do this." Another described her difficulty getting to her first case by public transportation and how nervous she was when she arrived: "And

---

[148] Lee, interview, 21 March 1996.

[149] ibid.

then I started doing the work, fixing [the client's] breakfast, helping her with this, making the bed, tidying here. Those are things I'm accustomed to doing every day, so I didn't see it like something huge." [150]

Ability to Deal with Difficult People and Family Situations

When asked to identify the most difficult aspect of the job, many HHAs reply that it is dealing with difficult patients and family members. But as observers we have been struck by the frequency with which both HHAs and other staff members at CHCA address these difficulties as problems to be solved rather than as simply something to complain about. One HHA describes how she calms both herself and a visually impaired hypertensive diabetic patient by drawing on religious faith, counting to reduce anger, calming talk, helpful activity, sharing her own experience, and empathic listening.

> In this field, sometimes you have to swallow a lot. And sometimes you have to say, "Lord, give me strength" and count one to ten. Some of your clients is not all Ps and Qs; some of them'll get on your nerves. I'll give you an example. This morning I got to work at a quarter to nine. When I rang the doorbell, the first thing she met me, "I can't find my syringe!" She was all up in a rage. I said, "Lord, give me strength." I tried to talk to her. I said, "Calm down." Because she's the type – she's diabetic, and she's hypertension, and she gets upset just like that. The least little anything.
>
> We are supposed to go to the laundry today. "Oh I ain't going nowhere, I can't find my syringe." I don't know what she want to find the syringe for, because she wasn't using those syringes, but in the back of her mind, somebody done moved her syringe. So I told her, "Calm down, I'll go and look for your syringe." So I went in there and they were up in the closet. She can't see, her vision is bad, so she didn't see the syringes. When I came back she said, "Oh, where did you find them?" I said, "Up in the closet." "Well I looked up in the closet, I didn't see them." What can you do? You have those people like that. Sometimes they get on your nerves really bad, but you just have to cope with it. You want to work, you have to do it.
>
> With this lady being hypertension, I know I have a certain way I've got to handle her. I have to talk to her; I have to tell her in my terms that's how I am, because I am also hypertension. Sometimes people come by, knock on the door. Right away she goes off, "Why they knocking on my

[150] Yusuf Ishmael, interview, 7 March 1996.

> door?!" I say, "Don't be like that." And in a few minutes, if you talk to her, she calms down nicely. She has a lot of problems, so I guess I'm the only one that she could really give off on. Because I'm there eight hours, automatic she going to talk to me about this and she going to talk to me about that.

Bibi Yusuf says that with clients who are not feeling well and who are occasionally nasty,

> I never thought of saying anything. I would just keep quiet and try to do something else, and I would come back to them and think, "Okay, she's not feeling well, let me go and make her a cup of tea or find something to do not to make her more upset."
>
> One client I remember specifically. Even though she was very ill and I was trying my utmost best to help her with her food and personal care, she was more concerned with whether the floor was mopped every day or the bathroom was cleaned every day. So that's like taking away from herself, and I know the nurse specifically said to focus more on the client because she was very ill.[151]

At the nurse's suggestion, she tried to read to the client, but she got angry, saying she could read herself.

> I was trying to figure out "How do I try to please my client?" This is what I was told to do but she was more interested in the other thing [the cleaning]. I was doing it, but she wanted it done more often even though it didn't need to be done. That was just something I had to battle for myself and think, "Okay, well, I just have to try to make her comfortable, make her happy." If that's what she wants, like if she wants the fridge defrosted every week, I just have to do it. Because I don't want to aggravate her. This is what made her happy.[152]

At times the behavior of patients can be truly extreme. Trinidad-born Annette Dance says,

> "In this job you meet some weird people, some weird things, some weird habits, some sexual things that people put on you. Guys come after you, they'll offer you money to go to bed with them. Because he's a diabetic and he can't get this up – crazy stuff." [153]

---

[151] ibid.

[152] ibid.

[153] Dance, interview, 17 May 1996.

She arrived to take on one new patient only to have him ask the nurse if her crotch was wet. "When I see how he reacts I say, 'Oh, I must be in for it.'" For the first couple of days he was all right. "Next thing I know I go there one morning – you're riding on the bus for an hour and a half to get to work – and I get there and he has no clothes on."[154] She coped.

> I told him, "You know what I'm going to do. I'm going to take a walk, you get your head together, when I come back, another ten minutes, you could put your clothes on." Then next time I go back he's hanging out. I saw it was going to be a constant problem. So what I tell him, I point and say, "That little piece of thing you have hanging out, you should be ashamed; you should really close that stuff up." Embarrass him into putting on clothes.[155]

One of the most difficult conditions to deal with is bigotry. Sarah Lee recounted how she has "come in contact with prejudice" on the job: "I had one case, the lady had gone to the bank, and the lady she was dealing with was black." When she returned home, the patient didn't know that Sarah was in the kitchen.

> She was in the bedroom and she was telling one of her neighbors, "I was dealing with this niggerish woman and I didn't even know it." So when I came out of the kitchen, she got this strange look on her face. She asked me, "Did you hear what I said?" I said, "No, why, what you say?"[156]

Sarah says she learned to control herself in this way in other jobs before working at CHCA.

> I didn't do it in just one day, or not even two months. It took a couple of years or more for me to learn how to control. But when you're in someone's house and you're doing a job you have to learn how to control. And I used to call my coordinator a lot, and I would yell at her to get it off my system. But she understood. I would tell her what had happened and why I did what I did.[157]

She says it was hard for her to learn, because she is outspoken by nature.

> On the job, you're there to do that job, so you do that job, and you have to learn how to bite your tongue, count to ten, which I have done a whole lot, because like I said, I'm outspoken, but when you're working,

---

[154] Dance, interview, 17 May 1996.
[155] ibid.
[156] Lee, interview, 21 March 1996.
[157] ibid.

> you have to bite your tongue a lot and you have to count, and you have to say the Lord's Prayer a whole lot, because some are very prejudiced.[158]

Florinda Pimentel had a case of prejudice that turned into abuse. She was sent to the house of a Puerto Rican woman who declared that she didn't like Dominicans. The woman told her, "If you're going to work here, you're going to do what I tell you." Florinda replied, "Fine, as long as it's within my job description." But the woman continued to insult her, gave her unreasonably heavy housework, threw her breakfast against the wall, and refused to let Florinda sit down to eat her lunch. With great effort, Florinda controlled herself, but told her coordinator that she had to leave the case.[159]

Family members can be as difficult as patients and handling them skillfully can be important for good patient care. Vivian Carrión says:

> You have families that will try to help, to share the responsibility that we have. But there are some of them that just want to come in and take over. [That] is fine: as long as they're doing something right for the patient, I really don't care. But sometimes they want to come in and take over and really hurt the client instead of helping them. For example, if I have a diabetic and they bring them a piece of pie, a piece of cake, I say, "Maybe you could just have a thin slice." Because you don't want to say, "No, you can't eat that." And they usually go along with that. It depends upon how you say it. If you're going to be aggressive, they're just going to push you out of the way. "No, this is my mother." And they'll just give it to her.[160]

Annette Dance remembers a long-term case with a very obese patient who needed to use a walker. She had a pacemaker, had had a stroke, and didn't talk for the last three years of her life. It was a "crazy family to work for. Too much people and noise." She had to fight to save food for her patient from rest of the family. "I could watch her and figure out what was going on. I would go away on vacation and come back and immediately see if something was wrong and call the doctor." Some family members would smoke and curse in the house, and sometimes the HHA threw them out of house, because only the patient was supposed to be living there. (The patient's daughter and son would back her up, although other family members didn't care, according to Annette.) Annette observes that she had to control the family to get the patient what she needed.[161]

---

[158] ibid.

[159] Pimentel, interview, 21 June 1996.

[160] Carrión, interview, 13 March 1996.

[161] Dance, interview, 17 May 1996.

Sometimes the HHA's interventions help other family members as well as the patient. Betty Cooper had a client with a son who had mental problems. Betty could anticipate when the mental problems were coming. He was in and out of the hospital. "Mom means well, but he's old enough to make his own decisions and she doesn't let him do that." The aide called him and talked to him. He was very happy to hear from her and grateful that she helped his mom. "He said he tried to keep the stove and bathroom the way she did, and the windows open for fresh air." Betty told him to please take his medication and continue in the outpatient clinic.[162]

After initial conflict can come great closeness between aide and patient, and the patient's death can then be a blow for the aide. Dominican-born Miguelina Sosa remembers that she eventually became good friends with a difficult patient:

> There was a 92-year-old patient, a Puerto Rican woman. She lived alone; she had two sons and a granddaughter. One of the sons came almost daily to the house and they had a lot of arguments, they parted with arguments. I would say to her, "Do you want a cup of tea or a glass of water?" And she answered me, "I haven't asked you for water," very rudely. So I would disappear, I'd go into the kitchen or the bathroom, leave her alone so that she would calm down.[163]

Eventually, Miguelina's patience won the client over, and they spent many interesting hours talking about the woman's memories of growing up. When the patient died, Miguelina felt a great loss. At the same time, the woman's friends acknowledged the aide's special role in her life: "When I arrived at the funeral home, there were the people from the church, the neighbors and all that. The people came to me and said, 'What a shame, your little old lady died.'" [164]

Problem Solving and Judgment

Good home care is not something that can be provided by rote. Every patient and every situation is different, requiring problem solving and judgment. Vivian Carrión says,

> It's like dealing with a book of regulations; sometimes when you're dealing with people you just can't go by the book. You're not going to do something that's going to get you in trouble, but sometimes the rules have to be bent a little bit. We're allowed to do certain household tasks,

---

[162] Cooper, interview, 23 May 1996.
[163] Miguelina Sosa, interview by Ruth Glasser, tape recording, Bronx, NY, 23 February 1996.
[164] ibid.

> but we're not allowed to do certain things. Like for example we're not allowed to get up on ladders and change curtains. But sometimes you have clients who don't have a relative or somebody to come over and do it, and if you think you're capable of doing it, you do it. I also have a client who sometimes can't get her own insulin. Now [if I do that for her] I will lose my job. I wouldn't do it. But I will call the nurse and tell her, "Listen, she's having problems with her other arm and she's having difficulty giving her insulin, she keeps squirting it out." And the nurse will come.
>
> You have to use your judgment, what you think you could do without getting yourself in trouble, and without hurting anybody else, and without hurting the client, of course. You have to have a good sense of judgment because that's the only way that you could really help people that really need help. You just can't go in and say "Well, I'm going to do what's on my regulations." You've got to go into people's homes and first you've got to observe, of course, and then you have to decide how you're going to handle this person. You just don't go and handle everything the same. Some people might be more sensitive than others. Some people might be more aggressive than others. You have to go with an open mind when you go into people's homes. You have to remember you're a stranger going into their house and they don't trust you just as much as you don't know about them.[165]

Annette similarly emphasizes the need for flexibility in dealing both with patients and with institutions: "A lot of times I make a lot of noise but then there are times you have to be soft, you have to know when to get that point across, maybe in a softer tone, but direct. You have to know [how] to manipulate your patients or the institution you're into."[166]

Because much of the work is performed in dangerous areas, good judgment – "street smarts" – is often required to do it safely. Vivian says, "I was born and raised here so I try to be as careful as possible and look around. I went into this building one time and I'm telling you, all I could see is the dirty condoms in the hallway." There were men who appeared to be drunk or on drugs. "I was afraid, because they used to hang out in the hallway during the day. I told my coordinator and she just told me to be careful." The men said "hello"; she said "hello," walked right by, and went upstairs.

---

[165] Carrión, interview, 13 March 1996.

[166] Dance, interview, 17 May 1996.

> One thing about this company, if you go into somebody's house or building and you don't feel safe going in, all you have to do is call. You're not forced to go in. But it has never come to that point where I'm afraid to go in. I am afraid, but I'll go in. But if I ever see that I'm in danger, I will run out. And the company doesn't hold that against you. I would call from the nearest phone in the street. I've got to think about my safety too.[167]

Creative problem solving is often essential to administering effective treatment. One HHA describes how she deals with a hypertensive patient's demands for more salt in her food.

> She's on me about salt. Now I'm not a big salt user, I don't use salt. But she want to use salt and she don't need salt because she hypertension. I say, "You don't need this and that." But you know what I found out I can do? She says, "Oh, you fixed me some grits, put me some salt in it." I get the salt shaker and shake it like I'm shaking salt in it. I ain't shaking nothing in it. And I say, "Oh, I don't think I put enough of salt." You put a little bit in there. So there's always a way to get around them, even though they get on your nerve sometimes.

Her skills for coping with this situation come from her own experience both in her own life and on the job.

> I learned that because I'm hypertension myself. All the things that I went through, the doctor told me you don't need to go through. You've got to learn how to control yourself. I have to be in control to help control her. Because if I'm all whacked out, she's going to be all whacked out too. Sometimes to get her mind off things I go out and buy her a little box of Equal. You learn things just as you go.

Many of the HHAs appreciate the fact that, in contrast to other jobs, here they are able to utilize their intelligence. Florinda Pimentel comments, "I like the complicated cases, because with them one doesn't get bored. You have a lot of hours and you're always busy."

She enjoyed working with a patient who had had a stroke and couldn't speak, and learned to read her nonverbal signals. "When I brought her what she had asked for, it was a joy, because I saw in her face that she knew I understood her." [168]

---

[167] Carrión, interview, 13 March 1996.

[168] Pimentel, interview, 21 June 1996.

Stress Management Skills

Dealing effectively with the HHA job requires dealing effectively with the aide's own stress. Annette describes some of the techniques she has used.

> A lot of times count to ten, walk away, drink water, a lot of praying. Or put things back in their perspective. I'm in this person's home, and she does not feel well, she doesn't want to be bothered. Would you like to be bothered if you don't feel well, if you had this disease? For me trading places with the person has helped me a lot. Sometimes I would go totally berserk on the patient and make something funny. Then I'll have them laughing because I'll try to say something funny or do something funny. Right now I have a patient with those big old walking shoes, orthopedic shoes. I say "Let's get your blue suede shoes," to get her to put her shoes on, because she doesn't want to wear them.[169]

Religion and spirituality play a significant role in dealing with stress.

> The stress of going to work in different neighborhoods, going in people's houses – you go in people houses, different atmosphere, people have black candles, green candles. For me, I open doors, I walk spiritually. I may laugh and make a lot of jokes and fun around, but I have to be very spiritual to like this kind of job. To go into people homes, people who are so sick and who envy you because they're sick, [or] they're in a state of denial. It's a lot, a lot of stress. [Spirituality] helps me to walk without fear. Helps me [if] I see you have things that to me don't look kosher in your house. Helps me [to believe] whatever you do is not going to harm me. That's strong spirituality.
>
> I've gotten jammed up a couple of times in elevators. . . . Just walking the streets alone in different neighborhoods . . . You have to ask God to take you there, bring you back home. I don't bring it out much in my meetings, I bend my head. People might think I'm bending my head just thinking; most of the time I'm praying, asking God for us to open our minds and heart in what we're doing here – Is this the right thing?[170]

Sarah Lee describes how she deals with stress and some of the toll it takes.

> Take it out on my family, my husband especially! I come in sometimes and he would say something to me and I would blow up at him and then later on I explain to him that I had something on my mind. I

---

[169] Dance, interview, 17 May 1996.
[170] ibid.

> wouldn't go in detail because [the patient] told me in confidence. I just tell him that I had a bad day. Or, I explode at Alice [her coordinator]. Sometimes I come in, I play gospel music. I used to take a drink but I don't drink any more because I'm a hypertension. Sometimes I come, get by myself, and I just cry. And that's it. Or take me a nice hot bubble bath; that'll relieve some of the stress. I pray and listen to gospel music. And cry a lot.[171]

Vivian had one quadriplegic patient who was so difficult that few aides were willing to work for him.

> I used to turn off my husband a lot, completely shut him out mentally, so I started to do that with [this patient]. I did what I had to do. If he needed to be changed, if he needed to be suctioned, whatever, I did it. If anything had to be cleaned, I cleaned it. Then I would go into the living room. He was always in his bed, and that was his choice. I used to go to the living room, either read a book, read my newspaper, or watch TV. And I used to just block him out. I guess he wanted me to fight back, like the other aides, and I didn't fight back. So as the time went by, it was more easy. The difficult days were less.[172]

Values

Because the HHA work is low paid and highly demanding, most successful aides have to find intrinsic motivations to do the work. Vivian says, "If you don't care about people you can't do this job."[173]

Sarah would tell new HHAs,

> You can expect rewards, personal rewards. No one is going to walk up to you and say, "I reward you," but with your own feelings you know you helped the old lady today or old man, [help] that they would not have got if you weren't there. That you went in and you did the best job you could for them, and they say "thank you"; that's rewarding in itself. You not going to get it from everybody, so don't look for it from everybody. And it's a very difficult job, you have to want to do this. And don't think you're going to come in and make a whole lot of money because you not. Yes, you going to get paid, but you not going to get rich off it, except by knowing the fact that you helped somebody, somebody who couldn't

---

[171] Lee, interview, 21 March 1996.

[172] Carrión, interview, 13 March 1996.

[173] ibid.

> help themselves. And one day, if we all live to see it and get old, somebody going to turn around and do the same for us. That's what I'd tell them.[174]

She sees this attitude as rooted in her family's values.

> The home training, the talks and things my father and mother used to tell us. "What goes around comes around." You mistreat someone, someone going to mistreat you. You be compassionate to someone, someone going to be compassionate to you.[175]

For Bibi Yusuf, who comes from a conservative Muslim family:

> When I started doing this job, my family didn't understand why I wanted to do it or how I managed to do it, where I had to, like, feed someone, clean someone, because I never had this experience before in my life. But I said that when I went home at the end of the day I feel like I did a good job, I earned my money, I made a difference in the world, and somebody depended on me. And the way I would talk with pride about my job, and about my clients, it put a whole different feeling, like they have a new respect for this job, they saw it differently: "Wow, you do all of that?" And to someone else it's like a little, "But hey, not everybody could do that," because you've got to go in there and take care of someone and it's not an easy job. My sister said to me flat, "I can't do that, I don't have the patience for that."
>
> When I first did it, I said to myself, "If I don't like it and I think I'm not doing a good job, I'm going to switch." Many people said to me, "Why don't you go to school, why don't you become a bank teller?" I said "No, my job may not be a lot but I love my job, I enjoy my job." When I didn't have a job, I would be calling [my coordinator] every day. I didn't care if it's a replacement, I had to take two buses – I wanted to go, because I enjoy it, and it made me feel good.
>
> I was right in the job, especially religiously, in my religion. They don't even think women should go out and work out there, but with this kind of work . . . I always wanted to be a teacher or a nurse. And I find that I'm getting satisfaction from my job. The paycheck was important, I had to pay my bills, but at the same time I enjoyed what I was doing; I felt like I made a difference.[176]

---

[174] Lee, interview, 21 March 1996.

[175] ibid.

[176] Yusuf Ishmael, interview, 7 March 1996.

Commitment to the job can lead workers to do a better job. Annette Dance had a patient with fluid in the lungs and broken ribs. She asked the doctor if she should make baby food. The doctor said it would be a lot of work, but would be better, so she did. "The better care I take of my patient, the longer she's going to live, I'm going to have a job, she's going to be home. Because of your misfortune in life, I have a job. I put food on my table because of your misfortune, so I should be able to give a little care and a little more, a little extra."

Commitment to the success of the company provides a related motivation. For example, with a difficult patient, Annette says,

> When you listen to the neighbor when you're doing the laundry, "Oh, you're another one already, again?" You'll hear stuff like that and you'll find out later on, [the patient] probably had three different agencies there with different aides changing like every two days or every week. You want to work, and you want to make this company work, [so] you find a way to cope.[177]

Special Individual Skills and Talents

Many HHAs bring particular skills, talents, and experiences to the work. Vivian Carrión grew up bilingual in a multicultural neighborhood. "I grew up in a mixed area. You grew up with blacks, you grew up with whites, and you grew up with your own nationality. Speaking both languages, I help a lot of the girls that don't understand English."

She goes to the doctor with non-English-speaking patients to interpret for them.

> A lot of these patients keep their illness a secret from their families. They don't want their families to worry too much about them. The family might know what's going on but they don't want to go into details. A lot of them do have some family member or friend that could go with them on their appointment, but they choose to have the aide who speaks both languages.[178]

Out of her own personal tragedy, Betty Cooper gained special knowledge and compassion regarding AIDS, and she shares what she has learned with other HHAs. Her son was diagnosed HIV positive in 1987. When he came to her and told her, she didn't know very much about the disease or how serious it was.

> So I said to him, "What we're going to do, we're going to deal with this as a family. So you're HIV positive, so you go to the clinic and put yourself

---

[177] Dance, interview, 17 May 1996.

[178] Carrión, interview, 13 March 1996.

> there so you can get medications and then start treatment, all right?" And he said, "Mommy, I'm not going to lose my family?" And I said, "No, that would never happen, we will always be here." For several months, I shut it out, because if you really think about it, it's devastating.[179]

Her son had to have home attendants.

> Those people coming in and out of my house, it was like some of them was just there to make the hours, they didn't really care about his feelings or how he was. I remember one lady came and she sit there with gloves on the whole time she was there. And he wanted me to tell them when they came in that he was HIV positive. He said, "Mommy, you tell them, let them know because you know how people are." And I would, I would ask them, "Did the agency tell you that he was HIV positive?" And they would say, "No, he is?" And I would say, "Sweetheart, you can't get it like that." I would sit down and try to explain. You still have people that don't believe what you're saying, that you can't get it by just touching somebody or giving him his lunch or breakfast. And I had all the necessary tools as far as Clorox and the water and washed things down very well.
>
> I guess that's how I really came to get into home service because I just saw so many people, and I said, "If this happened to my son, this happened to a lot of people out there." And then when I would go to the hospital – I had become the mother of the eighth floor over there in North Central Bronx, because I was coming with shopping bags and I was bringing them up beef patties and French fries and cigarettes and all these things. And they used to come and tell Eric, "You got the greatest mom in the world," and "don't ever lose your family love." There was one guy there I felt so sorry for. His mother, his sisters, everybody, dissociated themselves from him and he was in the hospital with nobody, he had nobody to talk to. And he was in the final stages; he was going through a lot.[180]

At his request she went and talked to him. He talked about his growing up, how he thought he and his sister were very close, but that his mother and aunt were keeping her away from the hospital. "But when you're sick [is] when you need people most," Betty says.

> Out of my son's death, I think there came a lesson: that you always can help somebody else, regardless. When I came [to CHCA], I'll never forget the interview. Katherine says to me, "Why do you want to do this? You

---

[179] Cooper, interview, 23 May 1996.

[180] ibid.

> have all these certificates, that you can work in a hospital, that you can do all these things. Why do you want to go into the home?" And I said, "You know what I think? There's a lot of people out there that need me. And I think I can do the most by doing this instead of going to the hospital and working eight hours and just going home, because you see so many people there and you do your floor or whatever you have to do, and that's it." [181]

Her first client for CHCA was an AIDS patient. It was "a lot of stress." She was "not ready because of memories." But her own experience helped her deal both with the patient and with the dynamics of his family. "It got a little bit stressful with his mother. I tried to understand her part of it, because I knew how I was. But everybody's not alike, and regardless to how stress hits you, it doesn't hit [another] person the same way." The client's mother would inspect what Betty cooked and would tell her to motivate her son to go outside. But

> you can only push them so far. He's supposed to tell me what he wants to do. He's not six years old. I can't walk in here and say "Listen, we're going out today, and we're going to go to this place and we're going to do this." This is a man that's thirty years old already. I mean we'll sit down and we'll compromise and we'll do things together. But their attitude changes. I could see my son, his attitude changed from day to day.[182]

Sometimes the patient was in a good mood, sometimes bad. She got used to it and tried to explain it to the patient's mother. Sometimes the patient didn't want to take his medication. But she always found the medication that he hid. Sometimes she could tell whether or not he had taken medication. Sometimes he didn't want to eat a basic meal, he wanted a slice of pizza. She would try to please him, feeling that next year he might not be here to enjoy that pizza.

Governance and Participation

CHCA's founders started off with strong democratic impulses and a desire to form a company that would truly belong to its workers not only on paper but as a living, breathing reality. From the start they envisioned CHCA as an employee-owned company in whose governance workers would play a critical role. At the same time, they did not envision it as a collective with no formal hierarchy. Managers would run the company day to day; indeed, part of their responsibility would be to foster a participatory culture, which would make employee ownership real. As Rick put it:

---

[181] Cooper, interview, 23 May 1996.
[182] ibid.

> One of CHCA's central tenets from the outset was that organizational culture has a greater influence over how employees understand and act on the concept of "owning the firm" than legal structure. In the early 1980s worker ownership practitioners typically emphasized the reverse – structure over culture.[183]

In its early years, CHCA maintained an informal organizational culture that provided employees with direct access to top managers. Rick recalls that workers expected to feel invisible to and distrustful of their employers, but that his accessibility made a difference:

> I was so approachable that people really felt like they could come up to me and say anything they wanted. They would tell other people [and] it just got around that you could come into my office. And to the extent that you were able to take care of the problem or at least try to do something about it, there was a process of believing that I worked for them. I do think it's the thousand little acts and the consistency between them that make all the difference in the world.[184]

Employee Ownership

CHCA opened in January 1985, with a board consisting of three members from the Community Service Society (CSS), which initiated the company, and two managers. The CSS members were to serve in effect as "trustees" who would gradually be replaced by board members elected by employee owners.[185] Once the HHAs had passed their three probationary months in the field and received their certificates, they became eligible to buy shares of company stock. For $50 down and $3.65 per week, over a period of five years they could buy a $1,000 share in the company. As soon as they began this process, they became voting members of CHCA, eligible to elect board members or run for the board themselves and to receive annual dividends from the company's profits. The process of recruiting HHAs to become owners and electing board members was delayed by the business turmoil of the company's first two years and the difficulty of creating a company that employees would consider "worth owning." By March 1987, however, more than 40 workers had applied for ownership. In the first board election, five worker-members were elected, establishing a majority-worker board.[186]

---

[183] Surpin, to Bob Giel and Sue Ellen Hershman, personal communication, 11 April 1995.
[184] Surpin, interview, 21 August 1996.
[185] Dawson and Kreiner, CHCA: History and Lessons, 1993, 9–10.
[186] ibid., 15.

Workers have had varied understandings and opinions regarding this program. Over the years some, like Alma Velázquez, have joined enthusiastically right away:

> From the beginning, when they said, "Let's become worker-owners," I was there. It caught my attention. Up till today I try to tell everyone to do it, it has a good benefit. When I got my first dividend check, ave María, that was the greatest.[187]

Others have been skeptical or more cautious. One worker said:

> At the time that I was asked I wasn't interested because I didn't know anything about being a worker-owner. After I learned what it meant to be a worker-owner, meaning that you would have not only one share in the company, but that you would also have the opportunity to vote, an opportunity to learn more about the company that you're working for, that I would be more a part of this company, which I wanted, then and only then, did I consider becoming one, and I did.

Workers' experiences with ownership before CHCA were varied. Vivian Carrión, for example, had owned virtually nothing in her life:

> At first I was a little confused. But once I became a worker-owner and I saw the extra benefit that comes along with it, I enjoyed it. Then I said to myself, "If you can really own a part of this company, wow, that's great," because the only thing I had owned was the furniture in my house and of course the clothes on my back and that's about it. I'd never owned any property, anything like that.[188]

Sarah Lee, in contrast, had experience not only with property, but also with collectively owned property:

> We owned our own land and lived in the neighborhood with most of the family. From one end of the street to the other end was nothing but family. And the land goes back to my three times great grandfather. They left it not to one person but to the whole clan. As long as the tax is paid, we own it. And he left it like that so it won't ever be sold.[189]

Sarah believes that employee ownership provides workers with motivation to help the company:

> You own a share of something. It's not a big share, but then you're going to work even harder to try to keep it going. And on the Christmastime,

---

[187] Velázquez, interview, 23 May 1996.
[188] Carrión, interview, 13 March 1996.
[189] Lee, interview, 21 March 1996.

> you look forward to a little extra money that you know there's something you want to do with it. And twice a year, you get a extra hundred in your paycheck, probably coming the time you especially need it. I think we all think a lot about that, because we own one share, we are going to try to make it the best company out here. When you go into a person's home, you try to do the best work you can. If you see somebody out there you figure would make a good home health aide, you try to get them into this company. Because you want them to – I used to tell them – get a share of the profit. And when you know you got something good, you're going to try to keep it that way. And by we doing good jobs, the client that we working for, would like pass the word on by mouth, "Oh I got this aide from Cooperative Home Care; she's good." And then the one she talking to might belong to another home health care [company], but it might not be doing as good as we are doing. So then they're going to get their nurse or whoever: "Can I get into Cooperative Home Care?" As many jobs as we can get, that'll bring in money, and then maybe our salary go up.[190]

Another aide feels employee ownership gives workers a right to speak up.

> This is my second time being on the board, and you know I'm always outspoken when I think I'm right. When I think I'm right, I'm going to speak. When I'm not, I'm going to be quiet, going to say nothing, listen. I think I have a right to say it because when you pay your thousand dollars for this worker-owner, it gives you a share, it gives you a voice to voice your opinion. So I think I have a right to voice my opinion when I think it's right.

Ramona Pichardo says:

> It's the only company that has offered me an association of which I can become a member. I don't regret it because one receives dividends and feels like part of a family.[191]

CHCA's workers feel especially privileged when they compare themselves to workers in other home health companies. As Ana Cuevas says:

> After you have your certificate for three months, you can become a worker-owner. I think it's a good idea that the company is worker-owner, because we are the proprietors of the business, and we have many benefits that other companies don't have. At least when I meet a person

[190] ibid.

[191] Pichardo, interview, 29 March 1996.

> in the street from another agency, I tell her about the benefits. We compare opinions of her [workplace], of mine, and they're very different. They don't have voice through a vote, they don't have a uniform allowance, dividends. As worker-owners, we have the right to vote. We vote to put in or take away a person from the board.[192]

Teams

When CHCA had just a few workers, Rick remembers, there were

> lots of hallway discussions. Very little life in the individual offices, the life always happened in the hall. Decisions were made relatively quickly, but there was still lots of discussion and there was a sense of involvement, even though it was clear that Peggy and I made final decisions.[193]

As the HHA staff quickly grew to more than 25 workers, it became clear to company managers that other modes of communication and feedback had to be established. They labored to develop a company consciousness and participation among workers not used to being consulted for their opinions. Within these structures, all workers could participate, not just those who were officially worker-owners.

When CHCA took control of the training at the beginning of 1988, they began constructing teams that reflected the bonding HHAs had done in the classroom. Betsy Smulyan reflects:

> The concept came from the fact that we liked the idea of keeping the groups who trained together, together, for a lot of very good reasons. Because people felt tied to each other, they knew each other, they liked a chance to get together again, because they had formed a bond during the training, and so we thought we would continue doing the in-service meetings in teams, which gave the people a chance four or five times a year to get back together with their group and schmooze, in addition to having the in-service. And so the idea was, well, let's devote a portion of each of those meetings to governance stuff.[194]

Through the teams, information was passed on to the workers and opinions solicited from them. In the growing company, it gave workers a chance to feel a sense of community within a small group. As time went on, senior managers developed a team-leader system based on electing representatives from each of the groups.

---

[192] Cuevas, interview, 11 July 1996.
[193] Surpin, interview, 21 August 1996.
[194] Smulyan, interview, 8 January 1997.

Unfortunately, a number of problems plagued the functioning of the teams. First, attrition of class members meant that groupings originally based on classroom training were depleted and recombined with other groups. Second, it was difficult to discuss governance or operational issues during the in-service sessions, a time when several intensive hours needed to be devoted to upgrading the skills or information of the HHAs. Third, it became increasingly impractical to organize in-service meetings by teams, given different HHA schedules. Moreover, with the changes in the industry, in-services became less based on levels of experience within the field and more on universal upgrading of the entire HHA workforce. Fourth, as the system spawned some 15 teams, they became increasingly challenging to manage. It was impossible for senior staff members to attend constant cycles of 15 meetings to make sure that information was being correctly imparted and election procedures followed. Yet managers did not feel that the teams were capable of functioning independently of senior staff supervision.

The Worker Council

Since early 1996, the team system has been reconfigured into the Worker Council. The council is divided into five geographically based regions. HHAs who live in each region come to meetings together and elect representatives from their region. All employees, whether owners or not, are eligible to participate. The Worker Council representatives relay worker concerns to the Board of Directors and the company's top management. In turn, they relay information back to their constituents. Although this system is no longer based on groups of aides who have bonded through training, it gives HHAs a chance to get to know each other for the first time. Senior staff hopes that eventually these subcouncils will foster a mentoring relationship between aides of long duration and those who have more recently come to the company. As Faith Wiggins puts it:

> I think that we have to get smarter about how we as a community help each other, meaning how home health aides who are here can be a real resource to the new people coming in, in a way that has not been structured into Cooperative Home Care yet. I think we're moving towards creating a structure for that kind of support.[195]

Education for Governance and Participation

Company leaders also work hard to make sure that the HHAs understand the company's finances, and the often-difficult decisions that the managers have to make. Betsy Smulyan, CHCA's longtime director of finance and vice president for

[195] Wiggins, interview, 1 February 1996.

administration, shares the training program's concern with adult-education friendly methods of communicating with the workers:

> To me one of the important parts of the company's finances is making sure people understand [them], which is a very difficult goal, and we've only touched the surface of achieving it. I've always spent time on worker-education stuff in various forms. I've been interested in how you break down topics to be able to get people engaged in them, and particularly people who may have blockages to getting engaged, either at the level of interest or at the level of hard skills. And usually at the worker-owner assembly I try and do some kind of game based on whatever the theme seems to be for the company at the moment, so a couple of years ago we did "The Price is Right" and guessed the company's revenue. We've also done games where you give people play money and you have to go around the room and spend the money at different stations to show how the company spends its money.[196]

Through opportunities to participate in the company, HHAs have been able to gain a greater understanding of the rationales behind company structures and decisions. Those who have been elected by their peers to serve on the Board of Directors have had a particularly good opportunity to grapple with the hard choices involved in running a company. Comparisons with peers working both within and outside the health field often serve to put CHCA in a favorable light. As Alma Velázquez comments:

> I talk with people from other agencies or whatever type of job [and] they don't have health insurance, they don't have benefits. And [at CHCA] as a worker I have a vote, I can speak up if I feel like it and whether it hurts them or not they have to listen, and they have to answer me. Sometimes in the bus they ask me [about CHCA]. We are the best-known home health aides; they say to me, "Ah, that's the agency that came out in the newspaper." I myself say, "God willing, [President] Clinton should recognize [CHCA] like you do so that we will always have work." [197]

Rick believes that the HHAs are more aware now than they were in the early years of the company:

> People understand today what's going on in the industry. They hear about agencies closing down, they know their friends are out of work [or] working less hours, they know their friends are not getting wage

---

[196] Smulyan, interview, 8 January 1997.

[197] Velázquez, interview, 23 March 1996.

> increases. And they read the paper about budget cuts in Medicaid and the State Legislature.[198]

The same process of participatory education described above has also been used to acquaint HHAs with changes in the industry and the issues involved in managed care, the new direction in which the company is moving.

> Six months ago there was a worker-owner assembly where management staff wrote a skit to be played out in front of all the worker-owners about what the difference in care would be between the traditional service arrangement and service by our managed long-term care organization. And that was our first kind of very public discussion beyond the board and Worker Council discussion about the managed-care organization. A good discussion followed in each worker-owner assembly meeting. Reinforcement is probably the biggest form of learning in the company; being able to get the same message across in various ways is the most effective way for people to get it.[199]

The education process is a critical part of community building at CHCA, but it is not infallible. Senior staff recognizes that with company growth it becomes more and more difficult to control the flow of rumors and misinformation within the company:

> There are just some long-standing myths about individual people, about relationships among people, about where power is, about how people get cases, who benefits, who doesn't, and there's probably an equally long-standing history of trying to deal with those myths and mostly the end result is that the myth has more power than anything. It creates a real problem for an organization like ours. At least historically, one of the things that my organizing background brought to bear was a real wanting to live in the informal life. I didn't want the formal life and the informal life of the company to be so disparate. So there was an attempt to try to have them as integrated as possible, knowing that there would always be kind of a secret whispering life.[200]

Staff hopes that with systematic education, repetition of information, better control of company attrition, and improvement in the company's governance mechanisms, this problem will diminish. Betsy believes that only through long-term investment of time and willingness to experiment can communication be improved: "There's

---

[198] Surpin, interview, 21 August 1996.

[199] ibid.

[200] ibid.

a trial and error process in terms of, you've got some information to put out, do you put it out in writing first, do you have meetings first? We go around in circles a little bit, but I also feel like we've moved forward, slowly."[201]

The HHAs' Contribution to Company Leadership

Even a conventional company needs commitment, participation, and leadership from its employees. In a democratic, employee-owned company these needs are far more important. Yet the CHCA workforce is recruited from sectors of the population – women, people of color, immigrants, the poor – who have been largely excluded from such roles in business, government, and other major social institutions. As a result, those organization-strengthening capacities that workers bring with them are even more precious, and the development of further capacities within the organization even more important.

Despite their exclusion from leadership roles in business and government, many CHCA workers bring important leadership experience in families, churches, and community organizations. Sarah Lee, a veteran HHA who has played many leadership roles within CHCA, was the superintendent of her Sunday school class when she was a child.

> That means that I open up the Sunday school, I was responsible for getting Sunday school teachers, I was responsible for the lesson that they was teaching the smaller kids. There were three groups. The young kids that couldn't read, the grades from one to five, and from six to eight. And it was just young adults and young kids. Grownups would be there but they wouldn't participate. We had to learn how to conduct and control the lessons that we had to learn about Jesus Christ.[202]

Sarah's organizational experience in church helped her play a leadership role on the CHCA board. But she has also played an important role in the organization as someone who raises and discusses issues that are not being openly articulated, particularly issues concerning possible discrimination. This too grows out of her earlier experiences. "I was always outspoken. I was 'sassy.' I was referred to as 'that sassy gal of Romer's,' because all my other brothers and sisters are easy. I never have been; I don't expect I will be, not at this age."[203]

She had a reputation as a fighter when she was growing up. Something happened a couple of years ago that brought her childhood back to her. A girl she had grown

---

[201] Smulyan, interview, 8 January 1997

[202] Lee, interview, 21 March 1996.

[203] ibid.

up with, and used to fight, called her by a racist epithet. They were in a department store, tempers flared, and they both got in trouble. "You treat me like a person, I'm going to treat you like one. You mistreat me, I'm gonna mistreat you," Sarah says. On another occasion,

> My son came home one day from school saying that his teacher had called him this "N" word. And somehow I saw spots. The next morning I went out there. They knew me because I volunteered for school a lot. The teacher said she called him that name because he was acting like one. I said, "In that case, so are you." She got very insulted. So I said, "Well how do you think my son feel? If you get insulted, he get insulted." And the school guard was with me because she knew I had fast hands, because I was getting ready to smack her face. I was called that too and I always fought. I would fight you at a heartbeat until I learned that anyone can be that "N" word, anyone, as long as you act ignorant and stupid.[204]

Sarah makes a sharp distinction between what is appropriate on the job and what is appropriate in the company headquarters:

> You can't be outspoken on the job. You can be outspoken in here. Say with your coordinators, your president, Peggy, anybody else. When I was on the board, I had a lot of complaints, and they wanted to call a meeting so that they could get it out. Other people complained. So what I did, I went to Rick and I asked him to call a meeting because I had a lot of people complaining about certain things, and they wanted to talk about it in the meeting. He called the meeting, we had the meeting. So I said, "Well, now the people that was complaining to me, now's the time to complain." [205]

Betty Cooper brings experience in the PTA. She started as recording secretary but hated recording notes because she couldn't read her writing. Then she became treasurer. After that she was elected president and served for three years. She got involved with the parents, school programs, candy sales, bake sales. They had educational programs also. The PTA brought in movies, put books in classrooms, and organized trips.

At one point she came into conflict with a school cook who tried to make kids eat food they didn't want. Betty managed to work it out. The cook suggested that the

---

[204] ibid.

[205] ibid.

PTA make up some menus. Betty decided that would do and pulled in the parents. She held a meeting where people packed in and everyone gave their ideas. She took the ideas back to the cook and she used them.[206]

Some workers have wanted to nominate Betty for the CHCA board, but she feels she isn't ready yet. But she uses her leadership experience in another way in the company – by encouraging others. "I said, there's one person up there that I'm going to push this time, Denise Clark. I see in Denise what I saw in myself when I was involved with the schools and all these things."[207]

Drawing on a multicultural workforce and client base, CHCA has a pressing need for people who can bridge the gaps between languages and cultures. Some HHAs bring strong skills in intergroup relations. Annette Dance says,

> Everybody's not like me; they tend to think I'm a little crazy, so since you think I'm crazy, I'm going to act crazy. I go to the Hispanic workers. "Hey, mira, how you doing?" I try and see if I can communicate with them. You have to kind of like break in because I think a lot of it is that sometimes they don't really understand, and because they don't understand they tends to be clannish and stick together. I was talking to them and [one of them] said, "We learned English when we came here, but it wasn't enough." How are we going to bridge this gap once and for all? Because I would like to bridge it. That's why I keep telling everyone in my class, "If I tell you something in English, you've got to tell me about something in Spanish." We've got to have a trade-off.[208]

Sarah is also concerned with bridging cultural gaps. She observes that "some but not all black stay with black, some Puerto Rican stay with Puerto Rican." To get along you have to learn about each other's ways:

> If you respect my ways and I respect your ways, we can get along. But if you don't respect my ways and I don't respect your ways, we're never going to get along. Say I'm quiet, and the other person is very outspoken. So you know I'm quiet, so you try to bring me out. So I can be – not as outspoken as you are, but to say what's on my mind. By me being quiet, I would tend to keep it in. But if you bring me just steady, talking to me, then you going to bring me to a place where I haven't been, which is kind of outspoken. And then you learn about how I grew up, and I

[206] Cooper, interview, 23 May 1996.
[207] ibid.
[208] Dance, interview, 17 May 1996.

> learn about how you grew up. And you learn about my kids, and I learn about your kids. And you learn my ways, and I learn your ways.[209]

Many HHAs bring a strong commitment to the success and well-being of the company, which both results from and motivates their involvement with its governance. Annette says,

> Being on the board long ago gave me an idea of what's happened or what's happening, and I still feel very proud of my company. I'm in no rush to change. I remember the times when we had small board meetings; I would always bend my head; it took them a while to realize what I was doing; I basically was praying that this company would work.
>
> When I felt angry that problems weren't being attended to, I used to tell my president, "This company's our baby, and it's growing." Then I told him "Such and such has happened, and it stinks, so the baby's pooping all over us. What are you going to do? Are you going to put a diaper on it? Are you going to potty train it?" And this is how I try to make things drastic.[210]

Employee Governance in a Growing Company

CHCA managers remain concerned that the worker role in company governance be a living reality, not just something on paper. As Betsy observed,

> If you have a governance structure but you don't feel like there's true participation and true information, then do you really have a good governance structure? You can have a good legal governance structure and you can follow it up with rules, but if you don't feel like there's real participation, it's not a good governance structure.[211]

Although managers sometimes get discouraged about the difficulties of promoting democratic governance, they recognize that within the context of the larger society in which they are working their achievements are remarkable. Regarding HHA participation on the board, for example, Betsy comments:

> Rick and I have talked about [it] a lot, and we always come back in the end [to] the estimation that probably we've got a board that understands as much about our company and is as involved in decisions as most boards. Boards are not supposed to run a company day to day, and

---

[209] Lee, interview, 21 March 1996.
[210] Dance, interview, 17 May 1996.
[211] Smulyan, interview, 27 August 1997.

> they're not supposed to know everything. They're supposed to have a general underlying understanding and faith in management of the company, and basically I think our board has that.[212]

Taken in the context of the disenfranchised communities from which many of the workers have come, this is no mean feat.

CHCA's achievements in terms of creating and maintaining informal involvement with the life of the company are equally impressive, especially given the dispersed workforce and the impact of continuing growth. As Betsy says:

> A sense of ownership seems to come very naturally; home health aides have a very strong sense of ownership. I don't think it comes mainly from participation in governance decisions or attending worker-owner assemblies, although that may be a small portion of it. I think it's much more informal stuff about coming to the office and knowing your coordinator and chatting with people and knowing people from your class and keeping in touch with the people who taught you in class and just starting to feel comfortable when you come in the office; that engenders that feeling of belonging that then starts to slowly translate into a sense of ownership.[213]

As CHCA continues to grow and develop, many of its workers and managers are striving to maintain and deepen that sense of ownership and belonging. As in many other cases, staff share values but are interested in different approaches. Christine, for example, hopes that the use of a work-based, supportive, problem-solving approach in the in-services will help build community among the aides:

> The deep thing we have in common is our values about the work . . . . So I think if we focus on that work it . . . creates a community of people in a way that's different than a social group. . . . There's other ways to do that, and the council is one way to do that, but I'm very focused myself on what it is that we actually do, and I think we lose track of that if we don't listen to the stories that home health aides tell, and I think this is a way of focusing on those individual experiences and bringing them back, so that training doesn't lose track of what it is they're training for, and that senior management keeps in touch with why we're here. . . . And I think that you can have a council that advises on management issues, and I think that's wonderful; you can have a board that advises

---

[212] Smulyan, interview, 27 August 1997.
[213] ibid.

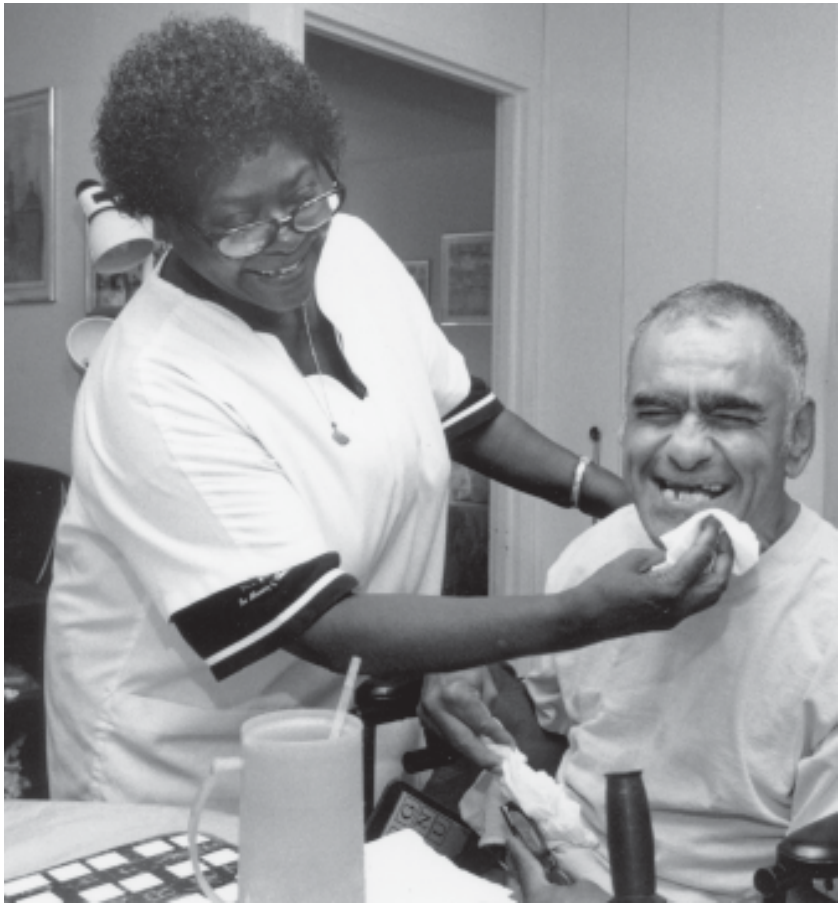
> on governing issues, but you also have to have that in terms of the work itself.[214]

Rick reflects:

> What I would say to traditional worker-ownership people is, [the board of directors] has absolute legal control, but I believe that the politics and legality are based in a social community, that it's totally different when people know one another and have expectations of one another and talk in the hallways as well as vote in a booth. As we expand, can we create a cellular-like structure where that feels the same, which is what the regional meetings or Worker Council are supposed to be about – can we pull that off? [215]

[214] Archambault, interview, 16 February 1996.
[215] Surpin, interview, 21 August 1996.

Part III: Themes in CHCA Culture



Certain themes occur over and over in different aspects of life at CHCA. In this section we will look at those themes in terms of four overlapping sets of relationships: the organization, external relations, human relations, and the community. We will conclude with a brief look at the contribution of CHCA culture to its success as a human and as a business enterprise.

The Organization

Handling Conflict

Any organization involves conflicts and contradictions, among different groups and among the goals and practices of the organization itself. The character of recurring conflicts and the ways they are handled form a crucial part of any organization's culture.

A striking aspect of CHCA's culture is the assumption that, under the conditions that prevail, the various goals of the organization and the interests of various groups are likely to be in partial conflict. This acceptance of partial conflict is quite unusual in organizations, but it is articulated repeatedly in many different aspects of life at CHCA.

This acceptance of the inevitability of conflict can be seen in one of the longest-running conflicts at CHCA, that between the personal development needs of those in the available labor pool and the business needs of the company. In discussing this, Peggy asked:

> Where do you put your emphasis? And the limited amount of time resources you have? Are you a company that's providing a business and a service, or are you an organization that's designed to grow people, build people, empower people to do whatever? I say the tension won't go away.[216]

Such tensions mean that sometimes decisions have to be made that lead to a loss. CHCA culture legitimates the discussion, and, in effect, the mourning of such losses. For example, in the mid 1990s the company tightened some of its hiring policies.

> It was really a survival question, like could the company survive at the next phase, and it meant letting some things go that were very pure to some of us. It meant you had to let in people who were more job ready. The other side of that argument was that we were abandoning people that in the prior [time] we could work with, we were committed to, and we were saying, "We can't develop that person, we don't have the capacity; we have to bring in people who are more job ready; we have to bring in people who have some degree of higher skill."[217]

Along with its acceptance of tension and conflict, CHCA culture encourages efforts to formulate a creative response that can achieve conflicting goals more fully even

---

[216] Powell, interview, 26 August 1997.

[217] ibid.

if it can't make the conflict go away. In the case of the conflict between personal development needs and business needs, Peggy provides an example of such a response:

> There is more screening out the person who has multiple barriers to immediate employment. I'm not in disagreement with that, except I feel and felt like, if our goal is to empower, and is to really provide jobs for this population, then we have to figure out another strategy to continue to serve that group, to not just completely slam the door. Which is what it felt like for a period of time, that we were saying, "Well we're sorry but you can't come in." And now there is much more investigation and figuring out how to work with other community-based groups much more closely, to have them do the job readiness, the recruitment, to do an employer-based kind of training development with groups who are geared up to do that, but to do it in a collaborative, partnership fashion, so that the programs end up becoming feeder programs.[218]

The pushing of limits while recognizing that some limits are inevitable is not just part of management culture:

> My experiences growing up poor and with limited resources [have taught me] that ... we dig in and do what we've got to do. And I know that we are very pragmatic people. It's just part of living a particular kind of life that you live, knowing that you have to behave as if you have more power than you have, but you have to recognize at the same time that there are limits to that power. That's the duality that I live and that I believe our women live too. They speak like they expect the world, but they're very pragmatic people.[219]

One HHA expressed it thus:

> Right now, things are real bad. Every day you pick up the paper, every day you listen to the news, it's all, "This is cut out, that is cut out." So I know we need a raise but if you can't get it, you can't get it, that's all. Because Medicaid is cutting out and this is cutting out and that is cutting out. So what can you do?

The practice of both acknowledging and limiting conflict applies likewise to conflicts among individuals and groups in the company. Peggy, who like many others compares CHCA to a family, observes:

---

[218] ibid.

[219] ibid., 9 February 1996.

> Conflicts are a way of life, because that's what I grew up with, and that's part of family. You don't just break apart because you had a fight, or because you share a common reason for being together [it doesn't mean] that you don't fight. Or you don't have differences, or that everyone gets along, or that all needs are met. That is the TV image of family, and I have a much more sobered image of family. There are different understandings, I believe, that I bring to this work that come from my class roots, that come from my race roots, that come from my gender roots.[220]

Conflicts are also mediated by the multiplicity of interests and relationships that tie people together. As Rick says of long-standing ethnic issues in the company:

> It's not like the conflicts have gone away, but there's a lot of practice and belief of both sides living with each other. People being in the same room with each other, so there have been some cross friendships, and certainly a sense of familiarity. I think that there are very few adult institutions that are communities that you can see people over time, where people come together regularly. Whether it's because of ethnicity and/or training [cycle]. There's probably five or six major ways to get to know each other. People who were in the same training and in-service class over three years, [whether] they're black or Latin, some of their class is gone, so there may be ten people left from their class, and there's a certain camaraderie that comes from making it over time.[221]

Intentional Change

Related to CHCA's attitudes about conflict is its approach to change. From the beginning the company has repeatedly and deliberately tried to transform itself. Yet this effort at change rarely takes the form of a set of commands. While eschewing unguided drift, CHCA culture recognizes that you can't just order change, but that it requires a process that takes into account limits, obstacles, and resistances.

Consider, for example, the approach of a manager who became head of a department in which some members were in conflict:

> There were some interpersonal things that people were having amongst themselves. That preceded me so I didn't know what it was. I only knew that it was getting in the way of doing the work. Because you can't have people working in the same department who aren't speaking to each

---

[220] Powell, interview, 9 February 1996.

[221] Surpin, interview, 21 August 1996.

other. Because then you're not communicating information that this person needs to know because you're pissed at them.

I let them know I wasn't anybody's mother, and so I wasn't going to go in between trying to get people to make friends, but if it impacted on the work of the unit then I was going to have to step in. But I don't want to have to do that. So let's just have a regular staff development session on what makes a good team and where were we falling back. I did a training session. I had them identify what makes an effective team and then take another look and see where were we falling short. That was so perfect, because the team decided for themselves how we needed to be to work effectively. And we identified goals for ourselves as a team in terms of communication and all of that, and it made a difference. So I think we're a well-functioning team, and over time the team has become more and more cohesive. There aren't things that people say, "Oh, that's her job." Everybody helps one another to get things done.[222]

CHCA's approach often involves an iterative process in which the same issues are addressed repeatedly, but with an effort to find new and better solutions at each stage. An example is the evolution of policy regarding the right of HHAs to refuse cases due to personal preferences and problems.

Over the years there was a growing tendency toward supporting the home health aide's right to refuse a case. And there was a lot of debate. A number of staff meetings took place about refusing cases, about why HHAs would refuse, what the impact of refusing cases is for the company, what it is for the client, so there was a lot of input on the part of the Patient Services staff around coming up with a policy. Everybody wasn't happy, but they reached consensus on what the policy should be. But problems about variations and the degree to which this or that coordinator would enforce the policy remained. Monitoring revealed that some coordinators were still enforcing the policy loosely. They met again – and came up with – new guidelines specifying under what conditions the HHA can clearly refuse, and when an HHA will receive a warning.

This was tied to guaranteed hours. Everyone reached pretty much general agreement that refusing these cases was creating havoc with guaranteed hours. They decided to have a meeting with people who were in the guaranteed hours program, to put out one clear line and message about

[222] DeVore, interview, 4 September 1997.

> under what circumstances would you be guaranteed hours or not guaranteed hours. The coordinators conducted that meeting. The problem around guaranteed hours and refusing cases has gone away. There was a clear shift to really implementing the policy in a way over time that, there was enough ownership in it that real change occurred as opposed to just simply dumping a policy out or having a few meetings or whatever, and it still being a very loosely interpreted policy.[223]

This doesn't mean there is no resistance to change. Christine cites as one example the company's attachment to organizing its case geography by zip codes rather than by the health zones used by some important customers. Another concerned changes in the training curriculum.

> When I wanted to change the training to meet New York State Health Department standards, the senior home health aides were very upset. So we compromised, and we still compromise over what's included in the curriculum. And there are still things that I would like to change, and they will change over time, but there was a process.[224]

Iterated change can result in reinventing the company. Such reinvention has happened twice, first with the replication project, and now with ICS. Today, according to Rick:

> I think we're at a point of starting over from a very different platform. It's kind of like being a teenager – that you feel different, you feel much bigger, you are at a different platform, but you are starting life all over, it's a new world that you've ventured into. The actual years are not the same, but in this business given what's happening, what we're about to try, we're about to try an early version of adolescence and still act like we're grownups in the outside world.[225]

Institutionalizing Values

In a sense, CHCA as a whole is an effort to institutionalize the values that guided its formation, inscribing principles of democracy, respect, caring, and service within a business organization. Both the ownership structure and the principles of management reflect that goal. However, it has also been an ongoing theme in the organization's development.

---

[223] Powell, interview, 26 August 1997.
[224] Archambault, interview, 4 September 1997.
[225] Surpin, interview, 26 August 1997.

An example (one that also illustrates the process of iterative change) is the development of structures for worker participation in the life of the company. Initially this was a largely informal process. Then the system of teams grew out of the training classes. These then developed elected team leaders. The team system was then transformed into the Worker Council.

A more recent example is the creation of the Workforce Development Unit. According to Peggy:

> There was no real participation structure over the early years. There were participation activities, certainly, but there was no dedicated function to developing the workforce. The Workforce Development Unit was created because of a recognition that there needs to be more tending to and figuring out ways of doing activities and different strategies for building participation in the company – the Worker Council activities, the activities of once again struggling with what kind of social events does the company attempt to do – really treating that as community building.
>
> I think the company has made a major step forward in creating this Workforce Development Unit. Because somebody has to see protecting this culture as their job, and if they don't see that, then I fear we could lose it. Because everybody is working so hard to make the business survive.[226]

External Relations

In Tension with the Market

Like any business, CHCA sells a commodity in a market. But CHCA's culture manifests its own characteristic ways of dealing with this reality.

First of all, CHCA sees the market as very much a means rather than an end. Its original purpose was to create jobs for a particular segment of the community, and it has steadfastly closed its ears to "market signals" telling it to do otherwise. For example, a company seeking to maximize its profit would have probably sought a very different niche within the home care market, emphasizing much more the higher-skilled, nursing- and specialist-based end of the market. CHCA instead has kept its emphasis on creating employment for home health aides. A similar philosophy is guiding the creation of ICS. As Rick put it:

---

[226] Powell, interview, 26 August 1997.

> No one else wants to serve the same population we're doing [people with physical disabilities]. Everybody looks at this as a population that's incredibly difficult, and why bother? It's not worth the money, and you won't make a lot of money on them. And that's true and we don't care. We will do a lot of home care with it.[227]

CHCA's difference from a conventional company in this regard is illustrated by its attitudes about wages. It is not surprising to hear workers say that they would like to earn more money. What is more striking is to hear the frustration with which top managers talk about the inadequate pay the company is able to provide for its workers. Raising workers' income is seen as a fundamental goal. Florence DeVore describes her own efforts to do so:

> What I want to do is have a real staff of trainers. They're well on their way to all being trainers. That was the reason why we decided to change their title from "assistant instructors" to "associate instructors." And then my hope is that later on they'll become "instructors"; the "associate" will be dropped. And hopefully we can give them some more money for that as well.[228]

CHCA characteristically sees the market not as a given, but rather as something to be reshaped. For example, its initial goal of decasualizing HHA work to provide steady employment was precisely an effort to restructure the labor market. The formation of the Home Care Work Group and the campaign to reform the regulatory structure for home care in New York aimed to restructure the entire market in which the company operated. Today PHI is similarly involved in an effort to change the payment structure for home care nationwide.

This assumption that the market should be transformed rather than simply taken for granted also underlies the recent development of ICS. As Rick put it:

> I really became convinced that the way to get our corner of the world where we could show what we wanted to do and have something of real substance and have something that we could grow much bigger upon was getting a portion of the market that we could control, was to do what is in effect managed long-term care that we now call "Independence Care."
>
> We've created our own market, so we now have control over market opportunities that we didn't have before.

---

[227] Surpin, interview, 26 August 1997.

[228] DeVore, interview, 4 September 1997.

> If ICS is a reality we'll have lots of people to provide jobs for and longer hour jobs and there'll be possibilities for upgrading that just weren't there before.[229]

One key element of CHCA's efforts to restructure its market has been the linking of producer and consumer needs. Its founding premise was that upgrading HHA jobs was intimately linked to upgrading the quality of service. The Home Care Work Group similarly linked providers and consumers in the policy arena. ICS, with its involvement of consumer advocacy organizations and its consumer council, continues this approach.

> What Christine and I both want to do very much is figure out how to structure this so that it feels like a consumer/worker co-op. To retain the worker co-op for providing the service, but to have consumers drive what they want, and to have an organizational format for reconciling where those things don't meet exactly. That in many ways is the task of this new organization.[230]

None of this removes the market as a reality within which CHCA recognizes that it has to function. As the VNS has increasingly become the dominant high-quality/high-paying player in the New York home health care market, for example, the company has had to orient more and more strongly toward its requirements. And the overall development of the company has been driven by the need for growth that results from rates that don't even keep up with inflation. "Volume is the only way to deal with staying financially viable. So that's what drives us."[231] An awareness of this market reality increasingly pervades all levels of the company.

> People do realize now that turning down cases means we don't get the hours, means we don't do as well. If the market forces have made it somewhat more difficult for agencies to get work and agencies have to be more aggressive, I think we've to some extent been successful in doing that. We're more focused on volume of work as being an issue, whereas before you just sort of took what came in; it wasn't really a problem.[232]

Alliances

CHCA tends to think about its environment not only in terms of a market but also in terms of a wide range of relationships with other groups. Its very origin involved

---

[229] Surpin, interview, 26 August 1997.
[230] ibid.
[231] ibid.
[232] ibid., 27 August 1997.

cooperation with such organizations as the Community Service Society, Montefiore Hospital, and ICA. As Rick put it, "We had a special angle and we used a network of people that we had developed."[233] The creation of the Home Care Work Group represented a similar approach:

> I was looking for a way that would put us in direct relationship with the consumer groups who have a lot of political power … like the Alzheimer's Association, Eastern Paralyzed Veterans' Association, Independent Living Centers for … people with disabilities. They became over time the major actors in the Home Care Work Group. The unions were the major actor in the beginning, but over time the consumer groups really cared about these issues, and cared about a relationship with us. I think our value to those groups [is that] we've been able to translate what's going on in the policy world and in the provider world in ways that they can begin to have some action on. Usually what just happens is that they decry what's happening and it's not in readily translatable terms for policy purposes. They kind of become voices in the wilderness. People will listen to them and spend time with them but things don't go their way … and we've been a translator, a bridge for them.[234]

Of course, such relationships are not always entirely benign. CHCA frequently relates to outside organizations in a way that recognizes CHCA's dependence on them while also trying to change it. A prime example is the relationship with the Visiting Nurse Service:

> We have been in a traditional contractor–supplier relationship with VNS, but with a twist. They value us as a high-quality provider but we have often been reduced to the lowest common denominator because they work hard at treating and paying everybody the same. They have had no idea what makes us different or high performing – it's as if there is an iron curtain and communication is mostly one way. At the same time, we have always looked for openings to get them to value what we do more, to work with us on a more equal footing.[235]

However, by 1997, the relationship had changed dramatically and Rick expressed hope that it would become a real partnership:

> During the last two years, the relationship with VNS has moved way beyond the traditional boundaries. First, they saw that we had an

---

[233] Surpin, interview, 26 August 1997.

[234] ibid.

[235] ibid.

> unusually high number of nurse requests for our services so they worked with us to foster those requests from one nursing team and one section of the Bronx. It is something that we have wanted for a long time and everybody involved seems to be very happy with the results. We believe nurse–aide teams on a geographic basis are an important building block for quality care and quality jobs but could never do it before.
>
> Second, we need VNS as a partner in Independence Care. But they saw us, for quite a while, as a competitor with their own managed long-term care program. The more "competitive" they talked, the more concerned we became about being taken over. After all, how many examples are there of a $600 million organization and a $6 million organization being equal partners? We came out of this spiral, though, and I think are in a good place mostly because neither of us really wanted to walk away from the other, and we figured out what was most important to each other.
>
> Today, it seems very likely that we will be entwined with VNS as a key supplier of paraprofessional services and as a customer/contractor for skilled nursing and rehabilitation services in ICS. I think we both have a lot to learn from each other and we are moving toward a level and an informal structure that will enable us to do that. I never expected to be in this place but it is what we wanted.[236]

Insularity and Outreach

Social change has always been a goal for CHCA, but, like the broader social movements from which it emerged, it has always been ambivalent about how much to do this by creating an island of decency in the midst of an oppressive environment, how much by challenging the institutions that shaped that environment.

> I think in that first period we had a very narrow view of what we were doing and it clearly was kind of like, create a Shangri-la in the swamps. And we also wanted to keep it small. In our model, social community was the basis for participation. We thought of it as having control over your own community. It was more like town meeting politics writ larger.
>
> There are lots of examples that I now know of, companies that start things totally differently from what the rest of the industry is doing. Most of those companies try to get industry dominance and get everybody

[236] Surpin, to Ruth Glasser, personal communication, 29 December 1997.

> to come over to them. We never tried to do that. Apple Computer was different dramatically than anything that ever appeared before as a computer, and failed in beating IBM but it did try to beat IBM. We didn't give a shit about beating anybody.
>
> Over time, the company's emphasis has shifted somewhat. For example, it has become increasingly concerned about the standards of the industry as a whole.
>
> I care about that today, and I've cared about that in the last several years, but in the first five years, this was a vision that was much preferable, to be Shangri-la in the swamps.[237]

Human Relations

Inscribed in CHCA, both as an organization and as a community, are norms and practices regarding how people should behave toward each other as individuals. These revolve in one way or another around the idea of respect – a concept of particular importance with a population that is used to being denied respect not only in the workplace but also in many other aspects of life.

A Culture of Respect

Asked about the origins of his approach to incorporating respect in CHCA's culture, Rick noted that they were "mostly very personal."

> I grew up heavy and was made fun of, and I couldn't do a lot when I was younger. The normal things of growing up were a little bit later. I became very sensitive. I felt that people as a rule are incredibly mean, and I also came to believe that the more money they had, the more material things they had, they were that much meaner. Or unconscious and looser and therefore meaner: they just didn't pay any attention to what the effect was on the other person. And I felt like people didn't listen, that they were too involved in what they wanted to say. That respect was really basic, things like that. Trying to figure out what you could do with what they said rather than simply rejecting it out of hand or acting like they didn't say anything at all. Remembering what they said. Saying "hello" and "goodbye" to people.
>
> I've often felt invisible and I feel that most people who are born working class feel invisible and I think that that is just the striking thing about life in this country, that so many people feel invisible. In your own home,

---

[237] Surpin, interview, 26 August 1997.

> or in your own community, you don't feel invisible. Creating a good place is about creating a place where invisible people can feel visible and valued and want to be visible. I didn't know any place like that.[238]

From the beginning, CHCA was intended to be a "place like that." This involved both formal organizational design and the expectations of behavior. Peggy recalls:

> In designing the programs in the company – the training programs, or the governance – it was building a reinforcement of what the values were of the company itself. The philosophy of the company as a company that really is centered on the needs of the paraprofessional. So there was a consciousness given to designing programs that was meant to both highlight and reinforce the notion that the paraprofessional needed to be respected, that cooperation and working with each other was something that was central to the company's philosophy, and that the work that they did was really valued and respected. And we needed to do that both in the way we designed training programs, and to make sure our behavior closely modeled what our philosophies were.[239]

Basic norms of respect are expected from employees at all levels, and are inculcated into new recruits. In the training program, for example, trainees are firmly told that uncooperative behavior will not be accepted:

> For instance, laughing at your classmates when they're struggling with getting a demo. What we expect you to do is to go over there and help them with it, not stand back and laugh at them. Because laughing at them is uncooperative. This is difficult enough. They don't need you standing around laughing at them.[240]

The sense of respect crosses many ethnic, occupational, and other barriers. Sarah Lee recalls:

> We had a team leader who couldn't speak too good English. But we all got along, we all understood what she was talking about, because we all were striving for the same goal, which was trying to get everybody involved into the company. The most important thing is to get people to open up and talk, to learn each other's ways, and be respectful to each other.[241]

---

[238] ibid., 21 August 1996.
[239] Powell, interview, 26 August 1997.
[240] DeVore, interview, 4 September 1997.
[241] Lee, interview, 21 March 1996.

One way respect is shown at CHCA is the combination of high expectations with acceptance of imperfection. A common comment by aides about CHCA training programs, for example, is that it's okay to make mistakes and that you are given a chance to correct them. In observing in-service training, it is common to hear a worker make a comment which seems to be vague or not to the point, and then to hear the instructor, instead of scorning or ignoring it, asking questions designed to give the worker additional opportunities to articulate what they had in mind.

Florence DeVore explains some of the thinking that underlies this approach:

> My view as a trainer and educator is, you can't bully anybody into learning. If we want people to learn, then we need to be as supportive of them as possible, and if they're doing something that's inappropriate, then we need to find out, do they know what's appropriate? Because if we're saying that the population that we're recruiting from, many of them are people who haven't been in school in a long time or have dropped out of school, whose lives in some ways may have been chaotic, may be trying to make the transition from welfare to work or may have been on welfare for 15, 20 years, well then, okay; they're coming to us limited. Let's not punish them for their limitations. Let's first try to teach them how they should be.[242]

Another way that respect for individuals is ingrained in CHCA culture is the idea that different people learn in different ways. As Peggy put it, "If a teacher doesn't get one to see something, they have failed as teacher. It's not because one is stupid."[243] This is observable in CHCA educational programs, which generally use a wide range of different techniques, including demonstrations, visuals, practices, games, written materials, as well as spoken instruction, to get the same information and points across.

While CHCA culture recognizes and accepts the limitations on what individuals bring with them, it also puts a strong emphasis on individual development. Many aides feel that their experience at CHCA has had a major impact on their lives. For Florinda Pimentel:

> It's given me another way of thinking. It's helped me in educating my children as well. I've put a lot of emphasis on them staying in school and going to university, and I have more patience to listen to them.[244]

Ana Cuevas says:

---

[242] DeVore, interview, 4 September 1997.
[243] Powell, interview, 26 August 1997.
[244] Pimentel, interview, 21 June 1996.

> I compare before and after, how my life was. It has changed in the sense that before I had patience and dedication and all that, but now I feel more responsible. I feel like I have to get things done, like I owe it to other people to help them. I feel a more profound sense of collaboration and dedication to my job. If I don't like my job, I can't do it well. [Now I'm] more responsible, more sure of myself, I feel more womanly.
>
> Cooperative is an open door for a woman to become independent, to get out of the cycle of public assistance. Cooperative gives a woman an opportunity to feel important, to feel different, to feel that she is somebody. I think that when a woman enters Cooperative, it automatically changes her life.[245]

Talking the Talk and Walking the Walk

CHCA culture puts a strong emphasis on consistency between expressed values and what happens in everyday life. As Rick wrote retrospectively, CHCA recognized that a positive work environment "had to be both consistent and genuine to counteract the deep-rooted suspicion toward managers that employees typically bring to a work place."[246]

Peggy indicates what that means for training programs:

> This culture that I'm talking about is the culture of this company that makes the paraprofessional's needs, and the client's needs, central to the way that we go about doing business. The training programs have to figure out ways of building that in as part of what we do, of making it visible in the training that we do. So you don't design teacher-centered training programs. You build in small-group work, you do programs that really value the trainee as a person who brings experience and skills. So that in its implementation there is little inconsistency between the rhetoric and the ideology and the practice. There's a structural way of building that into the training programs.
>
> We have a responsibility in designing our programs and conducting them to narrow the inconsistency gaps. I don't think they're ever perfect, but I think that in designing these programs it's something that we have to pay attention to, that there is a culture of work here that's based on a certain philosophy about the paraprofessional and who that person is, and that has to be tended to, in the way that we treat people, that we

---

[245] Cuevas, interview, 11 July 1996.

[246] Surpin, to Bob Giel and Sue Ellen Hershman, personal communication, 11 April 1995.

> train people, and that we work with people. The less dissonance in that, the more trust that the workers feel about the company and the company's management. I don't think people look for 100 percent, but I do think that they are very sensitive to great dissonance between word and deed. I remember someone once saying, "I look at your mouth but I watch your feet." [247]

At times such consistency requires acknowledging inequalities of power. In the early days of CHCA, Peggy recalls,

> [The managers] weren't going to allow a decision to be made that was going to be detrimental to the company, so we clearly had more power and more control. Yet we painted this picture like everybody was equal. And the result was when we began to exercise what we felt was our legitimate power and control in stewardship of this company, then of course we began to be distrusted as being hypocritical and as speaking double-speak.[248]

Consistency with core values also requires that people in positions of authority have the strength and humility to admit when they are wrong, and be willing to accept the power of people hierarchically below them to challenge their decisions. Christine recalls that when she began to revise the training curriculum:

> I couldn't just say "No, you must teach this." Some things I said that, but not everything because there was a process that people had to go through and sometimes I was wrong. I knew some things, I knew what was required, but I didn't know the best way to teach it, or the best way to make that transition. In some cases I was wrong about how to teach something, or what should be included, or how fast someone could learn. These were some of the least powerful people in the administration, who wouldn't let me do something, and that was the way it was.[249]

Community

In addition to being a formal organization, CHCA is also an informal community with norms, a folklore, and a sense of membership, that differ from either the formal organizational structure or the relations among individuals. Many of the themes discussed in other sections are also reflected in the practices and values of CHCA as a community, but issues around boundaries and growth are crucial for understanding CHCA as a community.

---

[247] Powell, interview, 26 August 1997.

[248] ibid., 9 February 1996.

[249] Archambault, interview, 4 September 1997.

Contours of Community

As a formal organization, CHCA has rather clear boundaries regarding who is a member of the organization and who is not. It expends a great deal of time, thought, and emotion on those whom it hires and perhaps even more on those whom it fires. Although the founders initially responded to pressure to hire on the basis of technical competence, one of the lessons they drew from early experience was to put heavy emphasis on the personal traits of candidates to be sure that their values and commitments matched those of the culture the company was trying to construct.[250] Rick recalls that in the early years of the company top managers were focused, among other things, on

> trying to figure out who the right people were to be here. I think that in many ways, in retrospect, certainly one of the most important parts of my job was to make sure that the right people in staff positions were here and those that were not were gone, and over time I came to take that as like I was the guardian of who's here and who's not, at management and administrative staff levels.[251]

Rick describes the management team for ICS as "people who really like us and share our values," as well as being very high-level people in the home care industry. About a potential trainer he says, "We haven't seen her training but we really like her and we think that she's the most likely person to bring in for additional capacity."[252]

The community membership is not just a question of who is employed. Considering oneself, and being considered by others, as part of the community is something that develops over time. According to Betsy, when people first come to work at CHCA, they don't know if it will work out or if they will come to feel tied to the place. "If people stay long enough to start to feel a commitment and to start to feel a sense of success in their work, that they're doing well, then they start to infuse that kind of sense of what it's about." But that sense of identification is something that "grows gradually at very different rates."[253]

The dispersal of workers to individual work sites in people's homes also shapes the character of CHCA as a community. The construction and maintenance of

---

[250] Jeremy Brecher remembers that when Rick and Peggy first approached him about this study he indicated various reasons he might not be the appropriate person to do it; they replied that they believed in finding people who shared their values and regarded most other considerations as secondary.

[251] Surpin, interview, 26 August 1997.

[252] ibid.

[253] Smulyan, interview, 27 August 1997.

community is particularly dependent on a few individuals who interact with a large number of others. Some of these, like the coordinators, are in work roles that connect them with many other workers; others take on roles of leadership and communication either formally through the board and Worker Council or informally through personal networks, informal business activities in the workplace, or other means. One Latina trainer, for example, became a key contact point for many of the Latina aides. According to Betsy, "People find their acculturation into the company in different places, and a good relationship and a sense of understanding with one staff person can play a big part in making them feel part of the company."[254] Rick observes:

> The company is a funny place, because you can say that you have 325 people, but there are only 25 who work there as a core shop-floor kind of thing. Then there are 300 people who in another place would be looked at as temporary workers, and you wouldn't care if they were the same people year after year. We absolutely do, but only a core group of them really determine what life is like.[255]

Ambivalence about Growth

Anyone who spends much time talking with members of the CHCA community will observe how often concerns about growth are expressed. Although most people expect that growth will help the company financially and will probably not adversely affect the quality of its jobs, they are very concerned about its impact on CHCA as a community.

Everyone from senior managers to HHAs has felt this growth acutely. Rick remembers, for example, that in the early years, it was much easier to establish an informal atmosphere of trust and communication:

> I think what's hard for me is, I don't really know what's going on. And I used to manage largely through informal sources. I used to get a lot of knowledge from different layers of the organization, and that took a great deal of time, and I don't have that time any more. I'm not spending informal time in the office; I'm not even spending a lot of time in the office.[256]

Florinda, like many other workers of long duration, mourned the passing of an age when the company was smaller and people knew each other and socialized more. She said:

---

[254] Smulyan, interview, 27 August 1997.
[255] Surpin, interview, 26 August 1997.
[256] ibid., 21 August 1996.

> We've grown a lot. And this has created a lot of change, because before we were little and we were comfortable that way. Rick and Peggy were more available. But now there are other people [to consult with] so that you can bother [Rick and Peggy] as little as possible.
>
> There needs to be more time to get together more. Not in in-services or groups, but in cultural get-togethers. One time they did that and it was really good, each person bringing a dish and music from their country. Or create things so that people can be together for an hour or two, sharing, communicating, not work-related – a picnic.[257]

Yet workers of all levels generally understand that growth is essential for the company's success. Senior staff tries to communicate their own mixed feelings and the trade-offs involved in such growth, which affects them personally as well. As Rick puts it:

> We've moved from a family atmosphere to a community atmosphere, and we're always in danger of losing that sense of community, and there are good things and bad things about both the family and the community.
>
> Size is a really funny thing. I remember going to a Christmas party in 1990 and I no longer knew everybody. And I remember being terribly depressed.[258]

At the same time, he recognizes growth as critical to the company's success:

> Growth was certainly a problem, of growing and maintaining quality, and we were scared of it. At the same time we knew we had to. We actually didn't grow as big as we should have and didn't grow as fast as we should have relative to what the market wanted us to do, and that in retrospect is a huge business mistake. Growth itself created huge tension between Kathy and me; she wanted us to stay small. And we always had trouble expanding outward in terms of hiring new people outside the core. It was very familial.
>
> My own choice would be to have a 200-person company, to have a really very intimate set of relationships across layers, and have it be more of a cultural and social community with a governing board that controlled the social community and a financially viable place. That was what I wanted to do; that's what we did. That can't survive.[259]

---

[257] Pimentel, interview, 21 June 1996.

[258] Surpin, interview, 21 August 1996.

[259] ibid.

As is characteristic of CHCA's culture generally, there is a recognition of trade-offs, of losses connected with gains, combined with a search for constructive responses, in the way growth is considered. Christine notes some of the issues:

> At what point do you start to split off functions, or do you split off into two similar groups with similar functions? There will be a point when you can't have entry-level training people doing the in-services because the practicalities of scheduling people's lives . . . become too difficult. How many coordinators do you have before you start another office? How many can you have that overhear each other? At some point we're going to have to be centralized. But it already starts to happen in terms of people's functions, and I worry about that. There's something that's going to happen that we're going to probably be pretty uncomfortable with.

At the same time she hopes that new training approaches emphasizing critical thinking "can help answer some of the problems of how to become a large organization and stay a place that we all want to come to work in" and that it can "keep at least the important parts of the smaller CHCA."[260]

Rick proposes to retain a sense of community in a growing company by encouraging the development of smaller units at lower levels:

> In some ways, go back to our roots of thinking smaller and more locally. But not everybody will know each other. The harder part of that: how do you get people to feel part of a larger whole? I think there will be some loss in that. We won't pull that off as well; that will be much harder to do. You can do uniform policies and stuff like that, but that's not the feeling of it. And I don't have a clue about how to do that yet, and there's no agreement. I've felt for a long time that we should get to the place where board members should be elected regionally. No one agrees about that today. But I think there's a logic to this: as you get bigger you have to figure out what in effect is the cellular structure, and how do you get to that?
>
> I actually think that everybody in management at Cooperative Home Care is really clear there are going to be losses, and we don't know what they are. And I think what we've come to is that we're on a journey that we can't afford to look back on. We need to let it happen and take as much from what we've already done and learn from that and make

[260] Archambault, interview, 4 September 1997.

> sure that we capture what we think is really valuable in what we have, and make sure that we don't lose any of those things that are most valuable.[261]

Impact of Culture on Outcomes

Many of the benefits of CHCA's culture are intrinsic. To work in a place where people treat each other with respect provides in many ways its own reward. To feel that you are performing a valuable service to other human beings is also, for many people, itself a benefit. In these and many other ways, CHCA's culture lies at the heart of its success as a human enterprise. Do these aspects of CHCA's culture also help the company's bottom line? The methodological obstacles to providing a verifiable answer are probably insurmountable. However, there are some ways in which CHCA's culture has clearly contributed to its business success.

From its beginning, CHCA has won support from a wide range of outside institutions based on its values and its ability to carry them out in practice. These range from the foundations that helped fund it, to the consumer groups that have given it support, to the political support that has allowed it to win special legislation for ICS.

CHCA's ability to increase its business at the highest-level reimbursement rates has resulted primarily from its high-quality ratings with the Visiting Nurse Service. These in turn are primarily the result of its ability to recruit, train, and support HHAs who are ready, able, and willing to provide the highest quality care. Virtually every aspect of CHCA culture described in this study contributes in one way or another to that outcome.

CHCA has survived and grown during a period of industry consolidation. As Christine points out, "It's very hard for everyone to know that we're doing well as a company and nobody else is. We'd almost be wiped off just for our size, even though we're really good."[262] This obstacle has been overcome largely because CHCA's high quality has allowed it to develop a de facto preferred-provider status with the VNS.

Christine explains that the VNS gave CHCA permission to meet with local Bronx office nurses. "At some point Rick said, 'A low rate of incidents.' And I saw one of the nurse managers go, 'Incidents? I spend my whole day responding to incidents.'"[263] Christine interrupted everybody and followed up the point.

---

[261] Surpin, interview, 26 September 1997.
[262] Archambault, interview, 4 September 1997.
[263] ibid.

> Our kinds of thefts, for instance, are in general because someone ordered something on somebody's credit card with their knowledge. They went over the boundary into friendship from work. They borrowed some money. Yeah, the client said she could. But it's still inappropriate and it's still wrong. And we take that very seriously. But nobody stole your jewelry, lied about something significant. Thefts other companies have are substantial. There's one theft now in another company for $60,000. We don't have those kind of things.[264]

Christine recalls:

> The nurse manager practically stood up at the table and said, "I want your aides. Start with me." And she has since then been referring any case that that she has control over. She's been saying, "I want Cooperative Home Care." And we've made sure we never turn down a case from her no matter what. She's told all the nurses about CHCA and so they ask for us.[265]

Surely this success can be interpreted as a result of CHCA's culture.

---

[264] Archambault, interview, 4 September 1997.

[265] ibid.

Afterword

Changes in the Industry

Since We Are the Roots was completed, there have been dramatic changes in the context in which CHCA and other home health care providers operate. Public policy designed to reduce costs by reducing utilization of services has resulted in reduced number and length of visits permitted in the Medicare, Medicaid, and managed-care sectors. The federal Medicare home care benefit has been slashed, reducing funding for home care nationwide by 40 percent between 1997 and 1999. The Balanced Budget Act of 1997 set a cap on agency reimbursements – based on per-person, per-year limits on home health visits – at 1994 levels. These cuts have been aggravated by regulatory changes that have made home health care agencies more costly to operate.

The result has been continuing turmoil in the industry. Three thousand agencies, more than 20 percent of home care providers, have been closed, while many others have experienced mergers.

In the late 1990s, booming employment in the low-wage sector of the economy created labor shortages in health care throughout the country, even in high-immigration regions like New York City. Modest wage increases occurred in the home health care industry just to retain the labor force. Unless immigration is further increased, however, labor shortages are likely to grow. Demographic trends indicate that women aged 25 to 44 will decrease over the next decade, decreasing the supply of workers among the group that has traditionally filled these direct-care jobs.

Meanwhile, several trends are likely to increase the demand for home health care workers. The U.S. population aged eighty and over will increase more than 14 percent between 2000 and 2005. Health industry employers are increasingly substituting paraprofessionals for nurses and other medical professionals. Political pressures are rising to expand long-term care for people with disabilities and chronic illnesses.

CHCA and ICS

Within this difficult context, CHCA has continued to grow. In one year it increased from 360 to 500 paraprofessional aides, and it is under continuing pressure to grow, perhaps to as much as twice its present size over the next five years. In 2002, the company employed 690 home health aides, 450 of whom were worker-owners. Since 1998, it has continued to turn a modest profit.

In 1998–99, CHCA graduated 475 new trainees; another 416 trainees successfully completed the program in 2000 and 2001. In spite of competition for workers provided by a booming labor market, CHCA has experienced a remarkable retention rate for trainees, two-thirds of whom were receiving public assistance prior to beginning training. (Previously 85 percent of new CHCA trainees came directly from the welfare rolls, but the "work first" policy resulting from welfare reform has made it impossible for many of those leaving the rolls to enter programs that require substantial training.) The company reports that among recent graduates, 87 percent remained employed at the end of 90 days, and 72 percent were still employed at the end of a year. More than 150 of CHCA's aides have worked for the company for five years or more. This in an industry characterized by annual turnover rates of 40 to 60 percent!

In 1997, CHCA and its affiliates lobbied a measure through the New York State Legislature that authorized the establishment of Independence Care System, Inc., a nonprofit chronic care demonstration program, using Medicaid funds to provide services to physically disabled clients. ICS is the first Medicaid-funded, managed long-term care program in New York State designed expressly to meet the needs of people with disabilities. By 2002, enrollment had reached 400 client members.

ICS's clinical goal is to enable adults with disabilities or chronic illnesses to remain at home, or in the least restrictive setting possible, by integrating the full range of primary care, acute care, and home- and community-based services in a comprehensive, flexible manner. Its program has been developed in cooperation with consumer groups like the local Independent Living Centers. ICS provides formal consumer involvement in governance of the organization by including consumers on its staff, board of directors, and advisory council. ICS and CHCA are linked both in daily operations and by overlapping members on their boards of directors.

ICS's employment goal is to provide high-quality paraprofessional jobs to low-income women by contracting with CHCA and other agencies that maintain high standards for home care services. Paraprofessionals will serve as the immediate link between client–family caregivers and professional service providers. This should allow a deeper, longer aide–client relationship that provides clients and their families greater continuity of care, while providing more stable, meaningful work for aides.

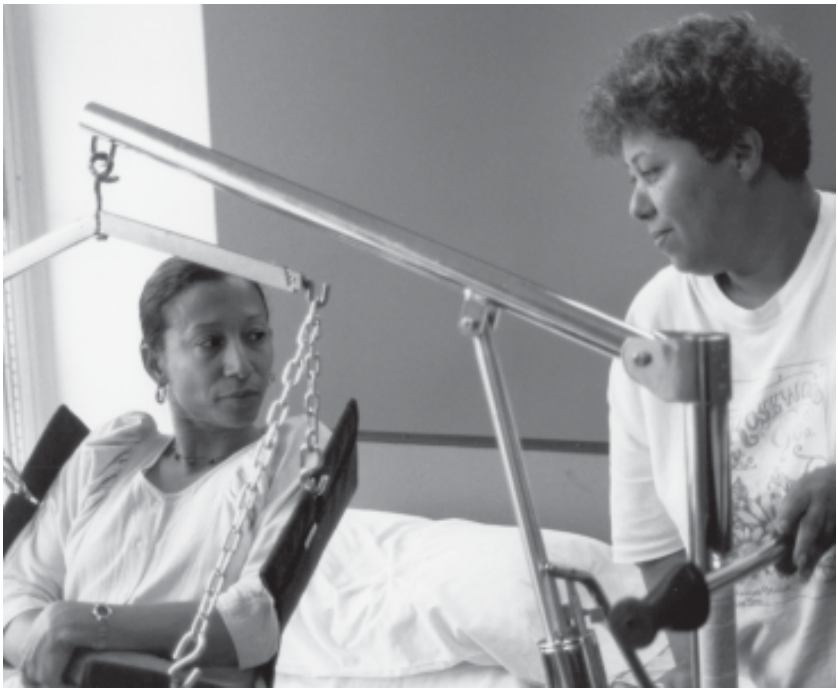
Spreading the Word

The CHCA-initiated Paraprofessional Healthcare Institute (PHI) continues to play a significant role in amplifying CHCA's "school of thought" and as the vehicle for moving that school's agenda in the policy arena. A key PHI goal is to convince political stakeholders nationally and in several key localities to view health care policy through a "labor-impact lens." PHI is currently developing a national sector-wide agenda on behalf of low-income women seeking decent employment within the health care industry. To that end, PHI has initiated two advocacy organizations. The Direct Care Alliance, which PHI staffs, brings together providers, organized labor, and consumer organizations to address paraprofessional labor and care issues. The Workforce Alliance, initially staffed by PHI, represents community-based trainers, employers, organized labor, and others who are promoting reform of workforce development systems. PHI also has served as a consultant for partners such as the Catholic Health Association and the Service Employees International Union in Los Angeles.

PHI also links together a group of affiliated worker-owned enterprises and employee-centered training programs devoted to paraprofessional health care services called the Cooperative Healthcare Network. In addition to CHCA, the network includes Home Care Associates of Philadelphia and Quality Care Partners of Manchester, New Hampshire, two cooperatives modeled after CHCA; the VNA Training Institute of Southeast Michigan, a metropolitan Detroit paraprofessional recruitment and training initiative; and the Good Faith Fund's Careers in Health

Care, a nursing assistant training program in Pine Bluff, Arkansas. Together, these sites employ or have successfully placed close to 900 paraprofessional health care workers. In 2001, PHI hosted its third annual Paraprofessional Assembly, bringing together paraprofessionals from all five sites to exchange and amplify their experiences as home health care workers.

Appendix 1: Interviewees



Ameer, Zianna: February 23, 1996
Archambault, Christine: February 16, 1996; September 4, 1997
Bates, Alice: January 4, 1997
Carrero, Sonia: April 3, 1996
Carrión, Vivian: March 13, 1996
Cooper, Betty: May 23, 1996
Cuevas, Ana: July 11, 1996
Dance, Annette: May 17, 1996
DeVore, Florence: September 4, 1997
Eisenberg, Elissa: January 6, 1997
Esquea, Evelyn: May 17, 1996
Gómez, Juana: March 14, 1996; May 17, 1996
Hinds, Lorna: January 13, 1997

Lee, Sarah: March 21, 1996
Mauras, Daisy: January 6, 1997
Mitchell, Jeanette: June 13, 1996
Pérez, Kathleen: January 9, 1996
Pichardo, Ramona: March 29, 1996
Pimentel, Florinda: June 21, 1996
Poue, JoAnn: July 7, 1996
Powell, Peggy: February 9, 1996; March 22, 1996; August 26, 1997
Rodriguez, Migdalia: January 13, 1997
Santiago, Olga: June 13, 1997
Sharper, Andrea: March 13, 1996
Sosa, Miguelina: February 23, 1996
Smulyan, Betsy: January 8, 1997; August 27, 1997
Surpin, Rick: August 21, 1996; August 26, 1997
Taylor, Jeanie: April 3, 1996
Velázquez, Alma: May 23, 1996
Wiggins, Faith: February 1, 1996
Williams, Clara: May 8, 1996
Yusuf Ishmael, Bibi Ameena: January 28, 1994 (by Ana Juarbe); March 7, 1996

Appendix 2:
Research Methods Supplement

In preparing We Are the Roots, we used a wide range of methods. These included oral history interviews, group interviews, information-gathering events, participant observation, a survey, and review of the research design by those studied. The purpose of this brief supplement is to describe the methods used, to assess their strengths and weaknesses, and to discuss how they were combined. We hope this information will be useful for future studies of employee-owned workplaces.

A number of difficulties are inherent to this kind of research. People's willingness to share their knowledge and experience depends upon the trust they have in the researchers and the research process. There is little information about an institution's culture that is "objective." Different individuals inevitably have different viewpoints and understandings. This is true of managers, workers, and even the researchers. What people remember or think they know may or may not be accurate. This appendix tries to show how we dealt with these difficulties.

Establishing the Project

The specific research methodologies used here can only be understood and evaluated in the context of the overall process through which the project functioned. CHCA senior management initiated the CHCA research project. Throughout the research process, they made it clear to the rest of CHCA's staff that they supported the project. They provided space, staff support, and problem solving, and encouraged participation by all company workers. They wanted diverse opinions to be frankly expressed, and accepted the necessity that some participants would require confidentiality as a condition for cooperation.

From the very beginning, the project was conceived of as a long-term effort, to take place over a year and a half to two years. It involved an investment of time and informal social interaction, as well as the creation of appropriate mechanisms for advice and feedback from the very populations that were going to be studied. Researchers who breeze in and out of a workplace or a community are generally not trusted by their subjects. Nor should they be, since they can all too easily be seen as management tools and are all too likely to make superficial assessments of what is going on.

The CHCA research project involved a collaboration between two historians with many years of work in community contexts, but with different roles and sets of skills. Jeremy Brecher had a broad overview of issues of workplace democracy and public policy and a strong sense of how they related to the company. His tasks involved occasional visits to the company, meetings, and interviews, helping to design the research mechanisms, and doing a great deal of the writing and interpretation of the research results. Ruth Glasser had the bilingual and bicultural skills necessary to interview a largely Latina and overwhelmingly female population. She spent more day-to-day time at the company, conducting interviews, sitting in on meetings, and having informal discussions with company personnel. She also participated in the design of research mechanisms and writing and interpretation of the research. Brecher and Glasser's decade of previous collaboration helped to forestall tensions that could easily arise in such a division of labor.

Design Committee

One unusual feature of this project was the decision to involve the employees being studied in designing and supervising the research. This was done in part to gain the benefit of their knowledge and insight. It also accorded with the values of both the researchers and the employee-owned and participatory company.

A Design Committee made up primarily of home health aides from different ethnic and racial backgrounds and lengths of time with the company, along with at least one office staff member, helped guide the project almost from its beginning. Through the Design Committee, the researchers learned what the hopes, fears, and expectations of the home health aides might be and how to address them. Design Committee members, for example, expressed fears that the researchers would be like some of the journalists they had experienced, careless in obtaining and using information from interviews. When these fears were identified, the researchers were able to assure the committee members that their methods and intentions were different from those of journalists. In addition, they were able to address such fears by creating an agreement with committee members that any interview material would be shown to and approved by each informant before being passed on to senior management or used in any other way. When these words were actually carried into action, the researchers were perceived as people who could be trusted. It became fairly easy to obtain interviews with home health aides and to use them under different arrangements – with attributions, anonymously, or with other conditions as directed by interview subjects.

The Design Committee made it possible for the researchers to seek guidance on how to handle delicate subjects, thus making interviewees or their peers part of the problem-solving/research process. The Committee made suggestions as to how to tackle sensitive issues in interviews, as well as what questions and phrasing were appropriate for the survey. It is the belief of the researchers that both the formal mechanism of the Design Committee and the informal goodwill it created helped make the project as successful as it was. Peer participation, consistency of word and action on the part of researchers, and word-of-mouth dissemination of information by subjects all created an atmosphere of trust and cooperation.

Oral History

The researchers conducted approximately 40 in-depth individual oral history interviews. Our basic interview methodology is explained in History from Below: How to Uncover and Tell the Story of Your Community, Association, or Union.[266]

---

[266] Brecher, History from Below, 1995.

The interviews explored the personal backgrounds of the informants and many dimensions of their experience at CHCA.

For a project involving the study of the culture of a workplace, oral history is an invaluable tool. The aim of the CHCA project was to get beyond a dry chronology of what had happened in the organization, to how it happened and why. The researchers also explored the issue of whether CHCA had a distinctive culture and what its culture consisted of. Interviews with people helped uncover the processes by which decisions were made, programs and projects started, and how people evaluated what was going on in the workplace. Oral history helped to put these processes into the larger contexts of individual lives and collectivities, including class, racial, and ethnic cultures, showing the multiple frames of reference from which people acted and interpreted their workplace experiences. Through careful probing, the oral history interviews also helped to elicit information on what people viewed as the culture of CHCA and their own role within that culture.

Before conducting the interviews, the researchers took care to find out what different types of people made up the collective that was CHCA. Multiple points of view were critical (as in any oral history project) to provide "checks and balances" of interpretation of different events, processes, and programs. This meant including all levels of the workplace hierarchy, making sure that people of different ethnic and racial backgrounds, educational levels, and lengths of time in New York City and the United States were represented. In addition to multiple discussions with CHCA office staff and home health aides about what the appropriate representative categories were, the researchers used a survey (discussed in more detail below) to confirm what might otherwise be considered impressionistic findings.

To provide a basis for trust, informants were assured that they would have the opportunity to review and revise transcripts of their interviews. No one except the researchers would have access to their interviews without their approval. The individual interviews allowed informants to provide their own knowledge and understanding of CHCA's history as well as their information about personal background and contributions to CHCA. At the same time, separate interviews allowed each interview to serve as a control for the information provided by other subjects. The researchers systematically asked open-ended questions, which invited information and opinions that might contradict those being provided by other informants – including management.

Other Types of Interviews

The researchers also conducted two other kinds of interviews as part of their ongoing attempt to generate information in a variety of ways. While individual

life-history interviews are the staple of most oral history projects, there are times when group or topic-focused interviews can be useful as well.

We were concerned that the basic chronology of the company that we had been provided represented primarily the experience of management. To try to get a better sense of how workers understood the company's history, we organized a History Evening. At this event, ethnically diverse workers who had spent different lengths of time in the company discussed the evolution of CHCA. With the aid of a roll of large paper, workers constructed a year-by-year time line of major company events and turning points. This time line construction led to an informal discussion of the evolution of the company, which was tape recorded.

This was the first time that the researchers had experimented with this particular technique. The workers' history of CHCA didn't contradict the management view with which we were familiar, but did provide differences of emphasis. We failed to anticipate that the discussion would be dominated by workers who had been there since the early days of the company. They expressed a strong sense of nostalgia for the early years of a smaller and more intimate company.

We were concerned that the material we were getting through conventional oral history interviews always placed informants' experience at CHCA in the context of an in-depth exploration of their entire life experience. During one Friday, nicknamed "Story Day," we invited workers to drop in and tell us about their best and worst experiences on the job or with the company. About a dozen workers took us up on this invitation, explaining the funniest and saddest things that had happened to them as CHCA workers.

The Story Day approach turned out to be a successful experiment, one that both researchers and CHCA staff felt was worth repeating. Story Day was a vehicle for getting a different and perhaps more casual take on what working at CHCA meant to its employees. Typically, compared to the oral history interviews, anecdotes were more focused on the work and the institution rather than on the worker herself. Story Day performed a second function as well: at our request, workers gave us advice on what it took to be a good home health aide. Thus, Story Day was also part of a developing idea that one of our roles as researchers was to generate materials that could be recycled back to new or veteran workers in useful educational formats.

Participant Observation

Glasser's actual physical positioning in the company was strategically beneficial. Her base was a desk in the Patient Services Department, literally the heart of the whole operation. As someone who spent hours just "hanging out" at the company,

Glasser became a familiar figure rather than an outside researcher dropping in and out. Swapping personal opinions and stories with office personnel and home health aides on subjects having nothing to do with the research project, she became a human being. With lots of time to schedule interviews, Glasser could develop relationships with informants over time. They were able to get to know her and understand the project before being interviewed.

Many hours of researcher time were also spent attending various types of company meetings and trainee classes. Sometimes the participation was passive, consisting of note-taking and observation. At other times, the researchers used the meetings to explain the project or provide updates on its progress, or as a vehicle for implementing parts of the research (see "The Survey," below). In this way, the researchers got exposure to CHCA in a wide variety of ways. At the same time, they were both observed and observing.

Long-term informal participant observation was beneficial in a variety of ways. First, it allowed the researchers to observe the organization in all of its fluidity, rather than merely taking a "snapshot" of one phase of its evolution. Second, it permitted observation of the interaction of CHCA's personnel in various combinations. Third, it allowed the researchers to see the consonance (or lack thereof) between people's words in the interviews and their actions within the company.

The Survey

A survey of approximately two-thirds of the home health aides was conducted during the second year of the project. It was administered in both English and Spanish at a series of Worker Council meetings, a governance mechanism in which all workers are invited to participate. Those who did not attend the meetings were able to pick up copies of the survey and fill them out at home.

This survey was largely based on a survey conducted at CHCA six years earlier. Now-irrelevant questions were eliminated; other questions of pressing current interest were added. A draft of the survey was filled out by members of the Design Committee, who then provided a critique and numerous valuable suggestions for improvement. These were incorporated into the final instrument. This process provides a good example of how the work of the project was improved by the participation of home health aides in research design.

The survey fulfilled multiple goals. First, it was a way to test opinions given in the interviews and the investigators' own impressions. For example, many opinions were given on the proportions of different ethnic groups within the company and the percentage of new immigrants versus second-generation New Yorkers; the survey provided factual information against which these opinions could be checked.

Second, since it was closely modeled on the prior survey, it produced a collection of data useful for comparative purposes. For example, how the ethnic composition of the workforce had changed over the six years since the previous survey could be clearly established.

Third, the survey broadened and deepened worker participation within the project. All those who had not been interviewed now had an opportunity to be heard. Everyone surveyed, including those interviewed, could express their opinions anonymously. Thus, the survey became a way to counterbalance the possibility that oral history informants gave the researchers "party line" information. This is always a danger in oral history interviews (even when done most sensitively and with most awareness of leading questions), particularly when the informants are being asked to express their opinions about their current workplace.

Synergism

The variety of approaches used in this study added up to more than the sum of its parts. Each method provided a valuable crosscheck to the others. The freedom to diverge from a predefined research methodology meant that new techniques could be added to confirm or disconfirm tentative conclusions. This fluidity was also consonant with the CHCA culture that was the object of this study.

In general, it is our belief that participatory workplaces lend themselves to participatory and innovative approaches to research. For these approaches to be successful, however, it is vital to work with a management that is not invested in preconceived conclusions about its company. Within a general atmosphere of respect for workers, it is much easier for researchers to secure the cooperation of the workforce and to expect that workers will express their true points of view about company culture.

The Survey: Sample Results

This survey was conducted in April and May of 1997. Of 320 home health aides, 214, or nearly 67 percent of the workforce, filled it out. The survey was presented and filled out at five Worker Council regional meetings and, in 48 cases, as individual or take-home forms.

The survey's 50 questions overlap to some extent those of a survey conducted for CHCA in 1991. This was done to compare the results. In 1991, 145 of 170 home health aides, or 85 percent, were given the survey orally at in-service meetings.

The following section gives a sense of the survey results, which both confirmed and fleshed out the qualitative information gathered through the oral histories.

Survey Answers

Question 5: Where were you born? [267]
This question was asked in the 1991 survey. In 1991, the choices were:

- United States 45%
- Puerto Rico 21%
- Dominican Republic 6%
- Jamaica 3%
- Haiti 1%
- Other 23%

In the 1997 survey, the choices included all of the above, as well as New York; United States – not New York, and specification of ethnic background, in order to take into account New York-born Latinas and non-New York-born African Americans. In this way, we were able to quantitatively address the issue of migrant and immigrant backgrounds and how important they are within the culture of the company. Additionally, asking those surveyed to specify "other" meant that we were able to find out more about the diversity of Latinas and West Indians within the company.

Using the criteria of the first survey, our results were:

- United States 29.0%
- Puerto Rico 24.0%
- Dominican Republic 27.0%
- Jamaica 4.0%
- Haiti 5%
- Other or unspecified 15.5%

With this comparison, we can see that the United States-born proportion has actually diminished, the Puerto Rican population increased slightly, and the Dominican population more than quadrupled.

Using our more specific criteria, the results were:

- New York-born African Americans 14%
- Non-New York-born African Americans 8%
- New York-born Latinas 6%
- Puerto Rican-born 24%

[267] Because of rounding off, the percentages in the first and third sections of Question #5 don't total 100%.

- Dominican-born 27%
- Other Latin American-born 8%*
- West Indian-born 10%**
- Unspecified 2%

* In this category, in descending order, were Ecuadorians, Hondurans, Guatemalans, Nicaraguans, Cubans, Mexicans, Peruvians.

** In this category, in descending order, were Jamaicans, Guyanese, Antiguans, Crucians, Haitians, Nevisians.

The following three questions were not asked in the 1991 survey. They provided for multiple choices and more extensive answers.

Question 43: What gets in the way of coming to company meetings and events?
- "Child care": 60 (28%)
- "Work schedule": 51 (24%)
- "Other family responsibilities": 37 (17%)
- "Transportation": 28 (13%)
- "Health": 7 (3%)
- 23 (11%) left the question blank
- Under "other": "Nothing": 32 (15%) answered: "Nothing," "N.A.," or "No problem." Others said, "Nothing at the moment, however situations do change," "nothing, only go to meetings, not social events," "Nothing yet."

Other responses included:
"Getting a babysitter."
"Changing hours and changing cases."
"Most times it is okay."
"Transportation sometimes."
"Child with health problems."
"Sometimes I just want to stay with my children since I never get to be with them."
"Work schedule sometimes." (2)
"Communication."
"Dangerous neighborhood at night."
"Other family responsibilities sometimes."
"Other responsibilities in general."
"Only if the children have health problems."
"Time getting from eight hour job, if meeting starts at five."

Question 47: How do you think the company can be improved?
- 96 (45%) left question blank.
- 9 (4%) misunderstood question.

- 7 (3%) said "Don't know."
- 13 (6%) said that the company was doing a good job, or "Nothing," or "N.A."

Other responses included:
- "Have more meetings." (1)
- "Give more training." (1)
- "More hours/work." (16)
- "Better pay." (9)
- "Better health insurance/benefits." (2)
- "Get more cases/contracts." (16)
- "More afternoon cases." (3)
- "Day care for meetings." (1)
- "Hire more workers." (5)

Other answers:

"Don't pay for insurance for people that bring children, just give tokens for transportation."

"Figure it out."

"More training in different types of needs in the company."

"Give more hours in the area they live or somewhat uptown in the vicinity."

"Children covered under health insurance."

"By giving more training to the HHA in a bigger aspect."

"Provide more preparation to HHA specialty."

"More contracts with other HMOs."

"No idea as of yet."

"Everything seems to be working out slowly but surely."

"If they have feelings or treat us like people."

"Working together at all times."

"By saying the truth from the beginning."

"By bringing more opportunities into the company."

"Same way and pace it is going."

"By sharing information with other workers."

"They are pretty well organized."

"By listening to all the different opinions."

"When people come out of training they should have more jobs waiting."

"By us HHAs working hard and being responsible."

"Do training in Spanish."

"Continue the way they are training and supervising the HHAs."

"Keep giving good service."

"Keep cases, keep good workers."

"More communication with HHA."

"Don't give more training to the new person, but rather try to give more training to those of us who are already here."

"Getting better educated each day."

"More hours – at least eight per day."

"Health insurance for families."

"Trust between HHAs and staff, continue to give top quality training/follow-ups/ continue to support each others' goals."

"That the coordinators be more friendly, although there are some who are very nice."

"Offer more work to employees and see the difficulties that employees have with their salary."

"Things can be improved if everyone cooperates with everyone else."

"I'll tell you later."

"There should be more communication, but the company should also take an interest in the problems of the workers."

"Getting private cases, HMO."

"When the HHAs tell you something, investigate it, and send someone out."

"When the HHA says something, investigate it, help her, and make the client see that we aren't servants, we've taken classes."

"Don't give more training, more hours to those who are already in the company, start the HMO."

"Stop training HHAs because there are enough and not enough work."

"Give the HHA a bigger year-end bonus because sometimes the person doesn't have the money to buy a gift."

"By getting more communication and stop talking behind people's back."

"Doing the same as we are doing and stay with contact and communication to help complaints, problems, etc., in the workplace."

"By keeping always on top of their workers with meetings, in-service, retraining."

"Make it easier for the trainees on probation – some of the policies are too strict for a person who is making the transition from not working to working."

"Getting the company more clients so the aide can get a raise, by becoming HMO and still having aides in the field, you get money two ways instead of one way."

"We should socialize with each other more, not too much, but a little more."

"By putting the workers to work close to home as possible (it always takes me so much time to commute back and forth to work)."

"If there were a way to get public and private donations, so Cooperative can expand into other cities and states around the U.S."

"I feel that workers that want to work weekends or that can should work them in place of people for whom working weekends are not convenient. It would be a good idea if HHAs could work six days a week, Mon.–Sat., with a day off (variable) during the week, and Sundays could be optional or overtime and it would work as a better incentive especially when HHAs are inconvenienced by working full weekends, i.e.: Sunday church, weekend shopping, summertime weekend activities with family. Especially church and church activities when a person is very accustomed to attending religiously. I feel we are not given a choice and are limited to opinion on mandatory weekends."

Question 49: What could the company do to provide more support for workers?
- Blank 84 (39%)
- "Don't know": 7 (3%)
- "Good job," "Nothing," or "N.A.," 8 (4%)

Other answers
- "Have more meetings." (2)
- "More training." (3)
- "Better health insurance/benefits." (8)
- "Union." (5)
- "More hours." (10)
- "More pay." (10)
- "More jobs/cases." (2)
- "Convenient hours." (2)

Other answers:

"Organize like other companies – child care, even if you have to take something out of our pay, invest in a playroom on the sixth floor for in-service for children two to fourteen years old; ask around, people might agree to help with toys and other stuff, I know I would."

"Group sessions – meetings explaining the things that upset you the most in dealing with people."

"Give more credits to HHA."

"One-on-one meetings with the workers."

"Fundraising for the workers in need."

"Pay more if the company can."

"Support workers before terminating them or changing their work site because VNS disagrees or has a complaint against them."

"They are doing it now."

"They should listen to workers when they talk to the coordinators: they need more hours."

"Has done enough."

"Give job hours according to needs and responsibilities of workers."

"Job security for a stable foundation."

"Give out cases according to availability."

"Pay more attention."

"More communication." (2)

"Work hard together."

"Listen to us and give more support."

"Listen to workers more." (2)

"Try to give them the hours they need to work and Saturday and Sunday should only be up to HHA."

"Have support group sessions."

"Be more sensitive."

"Stop hiring more workers."

"Continue to do what we are doing."

"Be there to listen and try to assist in any problems that we may have."

"Give HHAs clients closer to where they live." (2)

"Keep communication lines open."

"Give us at least a $2.00 raise and stop working us to death."

"Be there for them whenever the aides need them."

"To hear the HHA."

"Have a support group and listen to people's problems."

"Have coordinators visit clients first."

"Offer more jobs – the cost of living is high and the salaries low."

"Listen to our complaints about the patients because many are good people and others you have to be patient with."

"Look for help from the city."

"Maybe the coordinator would come to the home sometimes and see for themselves what is going on; that way they can provide more support for the worker."

"Communication, trust, and fair distribution of cases."

"Have social workers who also speak Spanish."

"Don't only listen to the clients but also believe in the HHA and appreciate her." (2)

"Job security."

"Inspect all the households to see if they are clean or not."

"More hours and pay according to how much time the worker has with the company."

"Meeting between coordinators and HHAs where the HHAs can speak and explain their problems."

"More communication between HHA and coordinator."

"Talk more with the worker."

"Listen to the HHA when she has problems."

"Take the worker more into account when client makes complaint against her."

"More hours because the price of hours is frozen, a lot of time earning the same."

"Understand our personal opinions."

"Listen to workers when there is a patient complaint."

"Medical benefits for children."

"Guaranteed hours and better benefits."

"Work for all HHAs."

"Understand them more in their labor."

"Supervise the site where we work."

"Defend the interests of the workers."

"Worker content when salary adequate."

"Health insurance for family."

"Take more of an interest in how the relationship is between the HHA and the patient and support the employee more if there's a problem in the house."

"Better assure the security of the work site outside and inside the house."

"Listen when they have a complaint."

"Support meeting."

"The company can set up a free GED class for those who want to progress into more education and better paying jobs."

"Also to make room for new trainees who succeed at getting a job at Cooperative. If Medicaid and Medicare cut finances for home care, where will they be in the future?"

"Having more in-service training talking about their work status. When CHCA gets a phone call concerning the HHA's children I think we should be notified immediately."

"Provide space for the workers to encourage each other. Maybe once a month have someone come back with good reports and words of wisdom."

"Have in-service meetings with the ladies once a month like we used to have."

"Make it easier for the trainees to become workers, lighten up on some policies such as absences, latenesses, disciplinary policies because trainees should have rights also."

"I believe the company is already very supportive of workers, just keep doing a good job."

"Listen to us. Help us to better work our cases, support us on any kind of problems."

"Get more psychology to deal with people and learn ways to talk without offending anybody."

"Give us more work because with four hours it doesn't help us at all."

"Always look for a solution in the work situations that come up."

"Give full-time work to the employees."

"Believe in the HHA and trust her when she speaks, not the client, and understand that we are all human; value our work more."

"Have a company employee supervise once in a while when the case is difficult."

"Send someone from the company to evaluate the HHA because many are responsible but many are not."

"Know how to listen better to each one of the HHAs and know their problems and feelings and support them in the areas that they need it because sometimes all of us have problems and we don't know how to express them and that affects us in our daily cases."

"Really take an interest in each one of the workers since often we have big problems and we try to continue with and carry out the work without support."

"Believe us a little bit when a client complains to the coordinators because they say that the client is always right even if he lies and the HHA is the one who has been treated unfairly."

"The workers should trust and explain whatever problem they have to their coordinators or someone in the agency."

"Offer more work and a reasonable salary."

"Understand (at least try) what HHAs sometimes go through in the field, e.g., difficult clients, rough neighborhoods, rude family members, etc. Give support when needed."

References

Brecher, Jeremy. 1995. History from Below: How to Uncover and Tell the Story of Your Community, Association, or Union. West Cornwall, Conn.: Commonwork/Advocate Press.

Cooperative Home Care Associates. 1997. "CHCA Intake and Application Process," CHCA, New York, August, photocopied.

Dawson, Steven L., and Sherman L. Kreiner. 1993. Cooperative Home Care Associates: History and Lessons. New York: Paraprofessional Healthcare Institute.

Glasser, Ruth. 1995. My Music Is My Flag: Puerto Rican Musicians and Their New York Communities. Berkeley: University of California Press.

Surpin, Rick. 1997. "The Realities of Welfare Reform and Work," paper presented to Annual Meeting of the National Association of State Budget Officers, July 2.

Torres, Andrés. 1995. Between Melting Pot and Mosaic: African Americans and Puerto Ricans in the New York Political Economy. Philadelphia: Temple University Press.