



May 15, 2009

The Honorable Max Baucus
Chairman
Senate Finance Committee
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles E. Grassley
Ranking Member
Senate Finance Committee
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Baucus and Senator Grassley:

On behalf of the Direct Care Alliance, the national advocacy voice for direct care workers, I am writing to share our views as the Senate Finance Committee develops consensus legislation on health care reform. We applaud your leadership and commitment to reforming our nation's health care system and stand ready to work with you and your colleagues to accomplish this task.

The Direct Care Alliance envisions health reform that recognizes the critical role direct care workers play in providing care to the nation's elders and people with disabilities. Direct care workers—home health and home care aides, certified nursing assistants, personal care attendants, direct support professionals and other frontline workers—provide crucial health care and assistance with daily activities to more than 15 million Americans. They bring stability, peace of mind, freedom, and positive energy into the lives of the people they support, enabling them to live independently in their homes and communities.

Many workers talk about what they do as a calling, a spiritually rewarding way of giving and receiving love. But as a way to make a living, it leaves a lot to be desired. Low wages, high uninsurance rates, inadequate training, and few opportunities for career advancement all contribute to the profession's high turnover.

Efforts made to reform our health care system should enhance and fully utilize the professional skills and competencies of direct care workers – especially as an aging America increases demand for their services. In the words of *Retooling for an Aging America: Building the Health Care Workforce*, a report by the Institute of Medicine (IOM): "Because direct care workers provide the bulk of paid direct care services for older patients in nursing homes and other settings, it is vitally important that the capacity of this segment of the workforce be enhanced in both size and ability to meet the health care needs of older Americans. However, the recruitment and retention of sufficient numbers of these workers is challenging due to serious financial disincentives and job

dissatisfaction as well as high rates of turnover and severe shortages of available workers.”

The IOM report identifies a number of ways to improve recruitment and retention. It groups these strategies into three categories:

- Improving education and training;
- Increasing wages and benefits; and
- Improving the work environment (e.g. empowerment strategies and culture change).

These goals should be an integral part of any health care reform discussion.

With the number of Americans in need of direct care services projected to reach 27 million by 2050, now is the time for lawmakers to exert the leadership needed to build an effective long-term care system—one that assures all direct care workers a living wage, training opportunities to help them develop the necessary skills to provide the best possible care, and access to quality, affordable health care coverage.

We have attached our health care reform principles and highlighted major issues that should be addressed in each category. Also attached is “Marilyn Daniel’s Reward,” the cover story of the May 10 edition of the *Washington Post* magazine section, which reflects on the challenges faced by direct care workers and the countless ways in which they improve the health and quality of life of their clients. We hope you can find time to review these documents as further evidence of the need to reform our health care system.

In closing, we congratulate the Finance Committee on its continuing efforts and commit ourselves to providing any guidance or expertise that our members can provide on our industry’s role in the larger health care reform debate. Please do not hesitate to contact me directly at 212.730.0741 or lvega@directcarealliance.org.

Thank you for your dedication to this issue,

Sincerely,

A handwritten signature in black ink that reads "Leonila Vega". The signature is written in a cursive, flowing style.

Leonila Vega, Esq.
Executive Director



Direct Care Worker Principles for Health Care Reform

We Cannot Reform Health Care without Reforming Direct Care Jobs

Direct care workers are rarely mentioned in discussions about health care reform, but two facts place them at the heart of the issue. First, they are twice as likely as the average American worker to be uninsured. Second, they are the backbone of our nation's long-term care system, providing essential services and support to more than 15 million Americans.

We will not achieve health care reform until America's elders and people with disabilities are sure of receiving the direct care services they need when they need them, delivered by a qualified worker. And that will happen only when direct care workers receive family-sustaining wages, adequate training, health insurance, and other elements of a good job, making direct care a viable career option.

Direct care workers—home health and home care aides, certified nursing assistants, personal care attendants, direct support professionals and other frontline workers—provide crucial health care and assistance with daily activities. In addition, they bring stability, peace of mind, freedom, and positive energy into the lives of the people they support. Many workers talk about what they do as a calling, a spiritually rewarding way of giving and receiving love. But as a way to make a living, it leaves a lot to be desired.

According to PHI's Health Care for Health Care Workers campaign, approximately a quarter of all nursing assistants in nursing homes and a third of all personal and home care aides lack health insurance.

Even those whose employers offer insurance often cannot afford the premiums and copays. The median hourly wage for direct care workers in 2007 was \$10.48,

and 40 percent lived in households that received public benefits such as food stamps, Medicaid, or housing subsidies. Furthermore, some home care workers are excluded from federal Fair Labor Standards Act minimum wage and overtime protection.

Training is generally inadequate as well, leaving many new workers unprepared for the demands of the job. The only direct care workers required by federal law to have any training at all are those who work in Medicaid- or Medicare-certified nursing facilities and home health agencies. Even that training is a mere 75 hours—far less than is required of dog groomers or hairdressers. There are no federal requirements for other direct care jobs, although states often require some minimal training.

Studies show that all these factors contribute to the profession's high turnover rates—which are typically highest during the first six months on the job. Also contributing to high turnover is the lack of career advancement opportunities in direct care, where workers with years of experience or specialized skills are rarely rewarded with higher pay or more responsibility.

We can and must do better.

In the words of *Retooling for an Aging America: Building the Health Care Workforce*, a report by the Institute of Medicine (IOM), "Because direct care workers provide the bulk of paid direct care services for older patients in nursing homes and other settings, it is vitally important that the capacity of this . . . workforce be enhanced in both size and ability to meet the health care needs of older

Americans.” And elders are not the only people who need chronic care services.

According to PHI, there were about three million direct care workers in 2006, and we will need about a million more by 2016. Yet the number of women aged 25-54 entering the labor force—the core of the traditional direct care workforce—is expected to increase very little during that decade.

Clearly, we need to make direct care a career that

appeals to a broader section of the workforce, and that people can afford to commit to long-term.

The IOM report identifies a number of ways to improve recruitment and retention. It groups these strategies into three categories: improving education and training, increasing wages and benefits, and improving the work environment (e.g. empowerment strategies and culture change). These goals should be an integral part of any health care reform discussion.

Health Care Reform Principle I: Assure Living Wage and Overtime Protections

Policymakers should find ways to increase wages for direct care workers. These include

- Establishing payment mechanisms under Medicaid, such as setting wage floors, to ensure a living wage for direct care workers
- Extending federal Fair Labors Standards Act minimum wage and overtime protections to home care workers

Health Care Reform Principle II: Enhance Education and Training

Policymakers should support the expansion of career advancement and educational opportunities for direct care workers. These include

- Increasing federal training requirements for nursing assistants and home health aides to at least 120 hours
- Establishing reasonable state-based standards for personal and home care aides
- Supporting the creation of advanced and specialty certification programs for direct care workers

Health Care Reform Principle III: Expand Access to Quality, Affordable Health Insurance

Policymakers should support efforts to guarantee timely and meaningful access to quality health care for everyone, including direct care workers. This means ensuring that

- No one receives fewer or poorer services, or more limited health care coverage, on the basis of income, race, ethnicity, language, immigration status, health status, gender or gender identity, sexual orientation, age, disability, location, or any other factor
- Health care benefits are comprehensive, with people able to receive the health care they need when they need it
- Coverage is affordable to low wage workers and their families
- Coverage is available to individuals and to employees of small businesses
- Coverage is available to part-time workers and those who do not work regular schedules
- Coverage is portable
- Health reform addresses health disparities based on race, income, and ethnicity

The Direct Care Alliance is the national advocacy voice of direct care workers: the home care and home health aides, personal care attendants, nursing assistants, direct support professionals, and other frontline workers who provide essential care, services, and support to elders

and people with disabilities and chronic conditions. We empower workers to speak out for better wages, benefits, working conditions, and respect, in order to improve their quality of life and to promote direct care as a viable career opportunity.

The Washington Post

Marilyn Daniel's Reward

She works long hours for low wages as a home health aide -- a job so demanding and underappreciated that others leave in droves. So why hasn't she?

By Paula Span
Sunday, May 10, 2009

Rozzie Laney, the 91-year-old woman propped up in her hospital-style bed on this Monday afternoon, didn't respond. She'd had Alzheimer's disease for many years and no longer spoke; glaucoma and cataracts had taken her sight; she couldn't sit up without assistance. She hadn't left this little brick rowhouse in Northwest Washington, shared with her older sister, for years.

But Daniel, her longtime home-care aide, was convinced that Laney could hear her. "She knows my voice," Daniel said. So as she arranged a piece of terry cloth under Laney's chin, she kept up her quiet monologue. "Roz? Roz, let's eat."

Lunch came from a blender: Daniel had rummaged through the refrigerator and collected some cooked beans, a boiled potato and a little roast chicken, then pureed everything with a bit of water. Laney "doesn't like lumps in her mouth," Daniel explained. "You have to blend everything, or she'll spit it out."

Laney took the spoonful of mush Daniel pressed to her lips, swallowed, then opened her mouth for more. She had an appetite, but eating was a slow process; she fell asleep mid-meal. "Roz, come on," the aide coaxed, "almost done."

There was barely space, in this converted sunroom at the rear of the house, for a portable heater, for a few shelves that held linens, nightgowns and incontinence briefs, for two beds. Clarice Morant, who'd moved in more than 20 years ago to care for her baby sister, was dozing on the opposite one. A faded "Happy Birthday" bouquet still sat in the adjacent dining room, left from a family celebration a few weeks ago when Morant had turned 104.

Morant is a tiny woman, weighing less than 80 pounds, with an outsize will. She still paid the household bills, cooked up grits and sausage daily for her breakfast, baked a sweet potato pie each week. Their niece in rural Virginia and nephew in Atlanta fretted constantly about these two very elderly women living alone. Each had lost her husband decades ago, and each was childless, so even with Daniel's help, they were largely on their own. But Morant wouldn't hear of what her relatives delicately termed "other options." She wanted to stay in her home on Fourth Street NW; she wanted to keep her sister there, too.

"Move?" she said when the question arose. "No! For what?"

Staying at home, even as they grow frail or disabled, is what the great majority of seniors say they want. But "aging in place" depends on certain conditions. For the sisters, it took luck: If Clarice Morant broke a hip and became immobile, she and Laney couldn't stay here. It also took family: Their niece called daily; a goddaughter in Baltimore took Morant to doctors' appointments; their nephew flew in regularly for visits. Money definitely helped. And it took someone like Marilyn Daniel -- a major factor in keeping the sisters out of a nursing home.

After lunch, Daniel stripped the bed and changed the sheets, no simple task when the bed was occupied. She had to clamber up onto the mattress, carefully roll Laney onto her side, hold her in place with one hand while slipping the fitted sheet off with the other, then roll her onto her other side to pull off the rest of the sheet. She had to repeat the process to put on clean linens. The room was stuffy from the heater and the closed windows; a sweaty sheen formed on Daniel's face as she worked. If she botched this maneuver, or even something that looked as simple as raising her client to a seated position, she could injure her patient or herself.

Daniel is a small, sunny woman in blue scrubs, sneakers and bifocals, her hair parted in the middle and pulled into two little knots atop her head. She has a dimpled smile and a voice musical with the cadences of Trinidad, where she grew up. Energetic on the job, she's almost a senior citizen herself at age 63.

Mondays were among her longer stints. The sisters' house was her second stop; she'd already spent four hours at Mrs. H.'s house a few blocks away. A comparative youngster at 66, Mrs. H. had diabetes and hypertension; she had lost much of her vision, and she moved very slowly with a walker or cane. Daniel often accompanied her to the bank and the supermarket, via Metro's vehicles for the disabled. But Mrs. H. had fallen in the bathtub last week. "Her knees got bruised up, and she was kind of weak," Daniel reported. "She wasn't going anywhere today." Daniel had cleaned the house and done laundry instead.

A third client was waiting after Daniel left Fourth Street. She trotted to the bus stop -- Daniel spends a big chunk of each workday on city buses -- but the 62 wasn't in sight, so Daniel hoofed it. Willie Alston lived about a 15-minute walk away.

"Hello, hello," Daniel called out, descending into a basement rec room that had become a bedroom when Alston, entering the middle stages of dementia at age 84, moved in with his son.

"What's it like out?" Alston asked. He didn't leave the house very often.

Warm and sunny, Daniel reported.

"I got a trim," Alston announced, running a hand over his freshly cropped hair.

"It looks good," Daniel said. "You look like a young guy!"

By the time she helped him bathe and change, fixed his dinner, washed his clothes and sheets and cleaned his room, it was 7 o'clock, an 11-hour day. She took two buses back home, warily avoiding walking past the convenience store on Kennedy Street NW, where too many young men hung out. That made it a 12-hour day.

She looked tired. She hadn't stopped to eat all day. Next morning, she would leave her house before dawn, catch the E2 and spend another day with those who needed her.

The country will need hundreds of thousands more workers like Marilyn Daniel if it's going to keep today's elderly, followed by their far more numerous baby boomer children, out of institutions. Already, the occupational category called "personal and home-care aides" is the nation's second-fastest-growing, the Bureau of Labor Statistics reports. It projects a more than 50 percent increase in such jobs by 2016, second only to the demand for "network systems and data communications analysts."

It's not hard to see what's fueling the need. Americans survive far longer than they used to: A man who reaches age 65 can now expect to reach 82, and a woman 85, the National Center for Health Statistics reports. But most spend those extended lives contending with chronic illnesses and disabilities, including climbing rates of Alzheimer's, that can make it risky and difficult to maintain an independent household, or even to take an unassisted shower.

When that happens, when elders need long-term care -- and health policy analysts say more than two-thirds of them will -- they can be highly vocal about where they want to get it. A typically horrified reaction, from Marilyn Daniel's client Willie Alston: "Oh, no, I don't want no nursing home -- that's the last place I want to be." Fairly or not, nursing homes are seen as grim thresholds to the grave, and years of hearings and headlines about deplorable conditions in some facilities have made seniors and their families willing to go to extraordinary lengths to avoid them.

"You have to look at the quality of life," says Marla Lahat, executive director of Home Care Partners, Daniel's employer. She mentions a 95-year-old client, fiercely lucid but very frail, requiring a squadron of daily and overnight helpers, both agency workers and privately hired aides. "If she knew she could stay one more month in her home or live three more years in a nursing home, I think I know what she'd say."

Home care is generally less expensive, too, though hardly cheap. Through an agency, a home health aide who provides assistance with activities such as bathing, dressing or using the toilet costs an average of \$19 an hour in Maryland and the District, \$17 in Virginia, according to last year's annual survey by the MetLife Mature Market Institute. That means that a modest level of help -- hiring someone each weekday morning for four hours, say, while family members pitch in at other times -- adds up to roughly \$1,500 a month. A stiff tab, but other options are far stiffer: Assisted living in this area averages

\$3,700 to \$4,400 a month, MetLife found, and a shared room in a local nursing home will top \$7,000.

So perhaps it's not surprising that the nursing home population has been shrinking in recent years and the once-dramatic growth in assisted living has leveled off. Most older Americans who need help aren't in any facility; they're at home.

But finding reliable, compassionate caregivers to help keep seniors in their homes isn't easy, even in these miserable economic times. That's in large part because these demanding jobs are so poorly compensated. Benefits, particularly health insurance, are rare, and wages can be so low that many aides are eligible for food stamps.

Home-care aides make an annual appearance on Forbes magazine's list of the 25 worst-paying jobs in America. (The aides' mean annual wages put them ahead of shampooers and waiters, but behind parking lot attendants.) Once hired, they leave in droves; turnover rates run 40 to 60 percent a year, says labor economist Dorie Seavey of PHI, a nonprofit that aims to improve direct-care work.

"Who's going to want this job, even if you enjoy caring for people, when you know you'll barely make minimum wage, you're not going to have health insurance, you're doing a job that's backbreaking?" asks Leonila Vega of the nonprofit Direct Care Alliance, recently formed to push for better pay and conditions for caregivers. "You can be a home-care worker for 20 or 30 years and never receive a meaningful wage increase, never get a promotion. You could become an expert in working with people with physical disabilities or Alzheimer's; yet you never receive any recognition for your increased learning and experience."

Aides who do hands-on work with the elderly also suffer some of the highest workplace injury rates of any occupational group. When clients can't walk or shift from a wheelchair to a toilet seat, their aides do a lot of lifting and maneuvering that can cause orthopedic damage. In nursing homes, aides have access to mechanical lifts or can work in pairs to move people. In most private homes, they're on their own. And patients sometimes hurt aides; those suffering from dementia, in particular, can lash out, hit or spit. Daniel has been bitten several times when a woman with Alzheimer's clamped down during toothbrushing.

When it comes to wages and benefits, Daniel does better than many of her colleagues. Because it's a nonprofit funded primarily by the D.C. Office on Aging and because the District has a living wage law, Home Care Partners pays more than most agencies -- an average \$12.40 an hour. It also offers subsidized health plans and retirement accounts, though most of its 200 aides can't afford to take advantage of them, including Daniel. She has high blood pressure -- a condition that helped kill her mother -- yet feels she can't afford insurance. The cheapest individual plan Home Care Partners provides will cost an aide about \$180 a month and more than \$500 a month for the aide and a child.

"Still not fabulous," acknowledges Lahat, the agency's director. "But it's the best we've been able to do." Home Care Partners' benefits and wages have helped it win the loyalty of its workers nonetheless. "We probably have less turnover" -- about 18 percent a year -- "than almost any agency you will find," Lahat says.

For the industry as a whole, however, the turnover rate remains alarming. It worries health-care researchers, labor economists and, most of all, the people trying to hire reliable aides for their aging relatives.

"It's expensive. It's scary," says Sandy Rubin, who went through three agencies before finding Capital City Nurses in Chevy Chase to send three aides each week to her 96-year-old aunt in a Connecticut Avenue high-rise. "How horrible would it be if she were alone, if she had no help, and she didn't have the means? And there are hundreds of people like that, thousands . . .

"My friends and I say, 'My God, what's going to happen to us?'"

On Tuesday, Daniel left her small house in Woodridge on time, walked briskly past the empty storefronts along Rhode Island Avenue and got to the bus stop at 6:35 a.m. Where was the E2?

"Missed it," she said, frustrated. Mornings are when home aides are in greatest demand; some patients won't be able to get out of bed or dress until a helper arrives.

Daniel's two grown daughters had offered to help her buy a used car. They didn't like her walking to and from bus stops in sometimes dicey neighborhoods, where she'd witnessed drug deals on the streets, had her pocket picked and once heard gunfire. It would be safer, they thought, if she drove. But Daniel said that she couldn't afford gas, repairs and insurance; she was nervous about city drivers, anyway. The bus was better.

At least her roster of clients was a good one. She saw six seniors each week -- three of them just once, the others on multiple days -- and they were all "very nice, very mannerly. They thank me for everything, and I appreciate it," she said. Not like that woman who deliberately dropped her clothes on the floor, then demanded that Daniel pick them up. Not like the one to whom Daniel gave her home phone number -- a mistake she won't make again -- and who started calling late at night to ease her loneliness. Not like certain families who tried to take advantage, who asked Daniel to weed the garden or blamed her for every dish that someone else broke.

And not like the elderly woman whose visiting male friend drank heavily -- leaving empty bottles stashed around the apartment -- and who attacked Daniel one day. He tried to choke her, she said, and broke her nose. She fled and called the police, and the man was arrested. She disliked talking about this assault. It was "horrible," she said. "I cried

for days." At Home Care Partners, Lahat confirmed the attack, but said that while the agency checks clients' households for safety, it can't screen every individual who enters.

Nearly a decade after the attack, Daniel's bifocals still don't sit properly on her face, she said. "Now, every house I go in, I look, I watch . . . You can get hurt on the job." But when she thought about alternatives -- nursing home aides need additional certification, and she wasn't sure their patients were well cared for -- she stayed put. "When you reach a certain age, you need people around you to help you, to make you happy," was her philosophy. "I try to make them happy."

The house she was heading for, in North Michigan Park in Northeast Washington, presented no looming dangers. "Hi, Bernice. Good morning," she crooned as she arrived, touching her patient's cheek. "How're you doing?"

The Browns, married for nearly 62 years, had lived in this brick multilevel for 43 of them. Daniel admired George Brown's unstinting love for his wife and the way he'd taken care of her since Alzheimer's had struck a decade ago. But Brown, now 83, was weakened by prostate cancer; despite help from their daughter, he struggled with his multiplying responsibilities. Still, he declared, "I'm going to keep Bernice here as long as I can, long as I can hold up."

It can sound like a simple task, to give someone a bed bath. But it took nearly an hour for Daniel to painstakingly wash between each finger and along each neck crease, then rinse and pat with a towel. She had to turn Bernice Brown, now 84, to one side to wash her back; she checked for dangerous pressure sores that can develop when elders with fragile skin spend day after day in bed. "Okay, Bernice, lie back now," Daniel said softly, though there was no evidence her client, gaunt and silent, was listening.

It took another 40 minutes to feed Brown the breakfast her husband had prepared. But afterward, Daniel got her reward: Her client seemed to look at her for the first time this morning and smiled broadly, with a throaty chuckle. "What are you laughing at?" Daniel asked in mock outrage. She was delighted.

In a way, she'd always been a caregiver. The eldest of seven, she was cooking and cleaning, diapering and bathing from the time she was a kid. She had visions of becoming a nurse, but her family could never have afforded nursing school. In Trinidad, she explained, even high school cost money. So she left school after seventh grade to help raise her siblings, then married and followed her husband to Washington in 1974.

He abandoned her and their two daughters a few years later, but Daniel doesn't dwell on it. "Things happen like that," she said matter-of-factly. She took a job in a store downtown, then worked as a bank clerk. The family was barely getting by, living in subsidized housing and receiving food stamps, when an elderly amputee in the building needed a helper. Daniel took care of her for five years and, after the neighbor died, decided she wanted to continue working with older people.

She enrolled in a two-week course at the University of the District of Columbia, took the home-care aide certifying exam and passed on the second try. ("I got kind of nervous," she said.) After a few frustrating weeks with an agency whose paychecks bounced, she found Home Care Partners in 1996 and has worked for that agency ever since.

Many of the women who do this kind of work -- almost 92 percent of home-care aides are female -- share elements of Daniel's history. Almost one in four is foreign-born, says Robyn Stone, a veteran researcher and director of the foundation-funded initiative Better Jobs, Better Care, aimed at improving the direct-care workforce. Twenty percent of home-care aides lack a high school diploma, Stone says, but more than 30 percent have some college. A little more than half are white, about a quarter black, 16 percent Hispanic.

Though they make less than nursing home aides, they seem to like their jobs better. "They like being in people's homes, having that one-on-one relationship," Stone says. A perennial complaint from aides in facilities is that they're responsible for too many residents and can barely manage to complete their assigned tasks, let alone have meaningful conversations.

But Daniel could. She learned her clients' routines and histories; she'd met their relatives and seen their photo albums. "They tell you their stories, way back when they were young," she said. "I could write a book."

After more than 11 years taking care of Rozzie Laney -- officially her client, though much of what Daniel did benefited both sisters -- she knew that Laney was once a fine Southern-style cook, a regular churchgoer, an inveterate card player. Before she retired, Laney had earned her living as a cafeteria worker for Pepco, and she still relied on a small Pepco pension along with Social Security to help pay the household bills.

She was the youngest of four siblings; Morant, who moved to Baltimore after her marriage and worked off and on in factories, was the oldest.

As a young woman, Morant had ridden horses and tended a garden each summer; even last year, she grew a few tomato plants in the back yard. Until she was 102, Morant marked every August birthday with a fishing trip aboard a Chesapeake Bay charter boat with her niece's husband, returning to fill the freezer with spots and croakers.

Both sisters were already widowed 25 years ago when Laney began to falter. She was "not quite diagnosed, but you could see that something was coming on," her niece Gloria Henderson said. "A difference in her behavior. Moods. Disorientation." Laney began to lose track of what day it was, started to wander the neighborhood.

So Morant moved in to care for her younger sister, though she regularly took buses back to Baltimore, well into her 90s, to see doctors and -- possibly as important -- to bring home a decent corned beef sandwich. For several years, their brother, Ira Barber,

incapacitated by strokes, also lived with them on Fourth Street; Morant, with the help of another aide, took care of him, too, until his death a couple of years ago.

In 2004, the D.C. Caregivers' Institute presented Morant with an award citing her "extraordinary commitment and creativity while giving the gift of caregiving," a chunk of engraved acrylic that still sat in the sisters' living room. Morant's nephew and Marilyn Daniel accompanied Morant to the awards dinner, for which she donned a snazzy white suit.

You can't put anything past Classie, Daniel said, using the family nickname, a tribute to Morant's sense of style. "She checks on everything. If you move something to clean, you better put it back in the same place, because she'll say, 'Marilyn, I'm missing my so-and-so.' " When a helper picked up an item at the drugstore, "she checks her receipts. Don't try to cheat her!"

And, of course, Morant kept constant tabs on her sister. "Is her head down too low?" she would ask Daniel. "Is she dry?" Some aides might grow resentful at the constant questioning; Daniel responded with admiration. Morant, she said, "is a very determined woman."

Yet she recognized that Morant was struggling more. "I think she's going down, slowly," Daniel said. "She's getting weak." Visiting day after day, she saw changes in all her patients. Laney could still walk and say a few words (particularly, "Classie"), when Daniel first came in 1997.

Until a few months before, Bernice Brown was able to take a Stair-Glide from her upstairs bedroom to the first floor, walk slowly into the kitchen and have breakfast with her husband. But after a few days in a hospital last spring for treatment of a urinary tract infection, she lost her mobility and much of her ability to communicate.

Willie Alston, on the other hand, was quiet and withdrawn when Daniel began working with him the previous year. Now, between meals and baths, they bantered like old chums.

A continuing theme was his affection for televangelists. Alston, a broad-shouldered retired cabbie and city worker who now used a wheelchair, wanted to order the minister-hawked merchandise he saw on the Word Network and the other religious channels he watched all day. Daniel thought he was likely to be exploited. It was largely a moot point, since Alston's son held onto Alston's credit cards, but the debate continued.

She arrived one afternoon in time to hear an announcer urging, "Call now for your FREE Miracle Olive Oil soap."

"I'm gonna wash with that soap, and next time you see me, I'll be running up and down the steps," Alston, now 84, declared.

"Then you won't need me no more," Daniel teased. "I'll tell them, he bought soap from a preacher on TV, and now he's gone to North Carolina!" -- where he grew up.

"I'll be driving a car again!"

"Running! Driving!"

After they finished laughing, they went into the bathroom, and she helped him wash and dress.

The people who do this work go by many names and hold a variety of credentials -- or no credentials. They can be called "personal care attendants" or "nursing assistants" or "my neighbor's cousin who comes in to help my dad twice a week." They may, if their clients are poor, be paid by Medicaid; otherwise, except in the rare cases of seniors with long-term care insurance policies, they're paid by clients and families. (Home Care Partners, which aims to fill the gap between Medicaid and private-pay agencies, accepts payments on a sliding scale.)

Aides can work through a registry, a kind of hiring hall that matches employers with applicants but usually doesn't take responsibility for screening, training or supervising the people it places. They can work for an agency, which does screen and supervise employees -- though not always well. Or they can work strictly for themselves, in what's called "the gray market," which usually means getting paid under the table.

Researchers don't know much about the gray market, except that it's huge (representing a quarter of home-care aides, the Bureau of Labor Statistics has estimated, but other researchers think that's too low) and entirely unregulated.

Its appeal is easy to understand. Say an agency charges \$20 an hour to send an aide. The aide is probably getting paid less than half that; in the District, labor economist Seavey has calculated, home-care aides earned an average \$9.89 an hour in 2007. If you hire someone privately -- through a supermarket bulletin board, a classified ad or a personal connection -- and pay her \$15 an hour, she's getting a 50 percent raise (and probably isn't reporting her income or paying taxes on it). You're getting a 25 percent discount. She's not getting benefits, but then, she probably wouldn't have them through an agency, either.

One longtime home-care aide who wants to be identified only by her first name, Barbara, worked for an agency in Virginia years ago. "The first and last time," she says. "I do all the work; they sit in the office, collect all the money and give me pennies." They also impose all kinds of restrictions (some state-mandated) on what aides can and can't do for their clients.

"I want to do something to help the person, the agency says I can't," Barbara says. "I can't give medication, I can't cut fingernails or toenails, I can't do this or that -- it's ridiculous."

Barbara now works privately, caring for a man with dementia in Northwest; she earns \$700 for a five-day week.

The gray market represents a trade-off. Barbara owes back rent because she was unemployed for five months between clients, a lull that an agency would likely have filled. She relies on Medicaid for health insurance. If she gets hurt on the job, she won't be covered by workers' compensation as agency employees generally are. She's 61 but has no retirement savings, and, since she hasn't paid Social Security taxes on her income, her eventual monthly payments will be paltry.

Yet she's happier this way. "I love my work," she says.

Marilyn Daniel arrived at the sisters' rowhouse at 6:55 a.m. on Wednesday to find the household already astir. The sisters' niece Gloria Henderson and her husband, Lee, were visiting from Sutherland, Va. Yesterday they'd taken Morant shopping at the Sav-A-Lot. The narrow kitchen had been restocked with hanging baskets of fruit, bins of onions and potatoes. While Daniel pureed cornflakes, milk and a banana for Laney's breakfast, Morant stood at the stove making pancakes for their guests.

"She is the maitre d'," Henderson said of her 104-year-old aunt, with mingled admiration and exasperation.

For years, Henderson and her cousin in Atlanta had been pondering how long their aunts could safely remain at home. Morant had taken care of Laney herself at first and still watchfully supervised both Daniel and a neighbor she'd hired privately for times Daniel couldn't be there. "When she got to 90," Henderson said of her aunt, "we said, 'How long can she hold up?' Then she got to 100."

A couple of times, the family tried having an aide stay in the house overnight, just to have someone there. No go: Morant insisted on privacy. They've discussed, well, Henderson couldn't even bring herself to utter euphemisms like "facility" or "institution"; she talked about a different "remedy." But she also feared that her aunts, wrenched from their familiar surroundings, would falter. "We keep trying to figure it out."

However intense seniors' desire to age in place, their families sometimes wonder: Is it really the smartest choice? As the nursing home population shrinks, a raft of businesses has arisen to provide the services -- from bill-paying to retrofitting houses with grab bars -- that can keep people, old or young, at home with disabilities, at least for a while. But even when families can care for their eldest members themselves, or can find and afford paid helpers, staying at home can become increasingly worrisome.

One summer day, for instance, as Daniel arrived at the rowhouse, Morant told her, "There's something wrong with the phone." It was lifeless, no dial tone. How could Morant get her niece's daily phone call? Or reach the fire department if she needed to?

That morning, Daniel spent 40 minutes making calls to try to get the phone repaired. After a couple of phone-less days, she had to buy the sisters a new phone jack, which a neighbor installed. None of this was her job.

Another time, she walked into a client's house and found the place reeking of gas. "It hit you as soon as you came to the door," she recalled. "And she was just sitting and watching TV. I said, 'You don't smell the gas?' " But the sense of smell can deteriorate with age, and her client was in her 90s. Daniel threw open the windows; her client had to stay with her son for a few weeks while workmen replaced the furnace.

"Sometimes things happen, you know?" Daniel said. "Things happen."

Home care works well for someone like Ida Wyche, whose small apartment in a seniors' high-rise at 15th and U streets NW was Daniel's next stop on this day.

Wyche, a regal District native whose response to a question about her age was, "I'm thankful that the Lord has allowed me to be 82 years of age," could handle personal care herself. She had a social life, too -- chatted with friends in the building, sang in the choir at Metropolitan Baptist Church on Sundays. But painful arthritis made it hard to keep up with housekeeping. So Daniel -- "one of the sweethearts," in Wyche's assessment -- came for two hours each Wednesday. "She does the laundry. Bathroom, kitchen. Washes the floors, vacuums the carpets." If Daniel had a few spare moments at the end of her stint, Wyche would sit down at her beloved piano, and they'd sing "What a Friend We Have in Jesus."

But what about Willie Alston, so adamant about remaining in his son's house, yet so isolated? "He needs more human contact," his son Lorenzo recognized. Yet Lorenzo worked long hours at his insurance agency and might not get home until 9 at night. Other family members dropped by or called when they could, but on most days Willie Alston sat alone in his basement apartment with the Word Network -- except when Daniel came.

He was a gregarious guy; maybe he would flourish in assisted living or a well-run nursing home that offered recreational activities and communal meals. His son thought that might be the best option, "but he's said for years that he doesn't want it," Lorenzo said, frustrated. "So we're just doing the best we can."

The Alston home was Daniel's final stop today. When she was ready to leave, after a good-natured argument about whether Alston should order Miracle Manna ("the exact same ingredients mentioned in the Book of Ezekiel"), she told Alston that she'd see him tomorrow at 3.

"I don't guess I'll be running off nowhere," he said.

Partway through breakfast at the Browns' on Thursday morning, Daniel realized that something was amiss. Bernice Brown accepted a couple of spoonfuls of cereal, then appeared to doze off. "Mrs. Brown, Mrs. Brown, wake up," Daniel crooned. She wondered if George Brown, trying to prevent his wife's coughing, had been administering too much Robitussin at night. "Bernice?"

She gently stroked her forehead. "Mrs. Brown, how're you doing? You all right?" But Daniel couldn't rouse her. This wasn't normal.

Suddenly: "Mr. Brown, look! Something is wrong. Her eyes are turning up. We can see just the whites of her eyes. Bernice!"

Her husband hurried into the room. "She might be really sick, and we don't know it," he said, sounding frightened, "She's breathing, ain't she?"

"Yes, she's breathing." The woman's chest rose and fell. But she was otherwise inert, unresponsive.

George Brown took his wife's temperature and checked her blood pressure, skills a caregiver support program had taught him. Normal. "She's just sleeping," he said uncertainly; Daniel kept calling her name.

Probably only seconds passed -- but long seconds -- before Bernice Brown stirred slightly. "Her eyes are moving! Bernice?" Daniel cried. Brown's eyes refocused, and the muscles of her mouth began to move; wherever she had briefly gone, she had returned. Her husband exhaled.

"You all right?" Daniel asked her client. "You got me scared!" For the rest of the morning, she felt alternately relieved and rattled.

Only once in all her home-care experience had a client died in her presence -- a man who lived on Wisconsin Avenue -- years ago. But of course, her elderly patients died all the time. (In fact, her youngest client, 66-year-old Mrs. H, would die suddenly a few months later, leaving Daniel shocked and stricken. And Ida Wyche, now 83, would take a fall and need several months in a rehab facility.)

"I can see a toll, a mental toll," said Daniel's daughter Avril Daniel. "I remember the time she described losing a patient . . . the first time she had one die. That took something out of her."

Daniel had a longstanding uneasiness with death and its rituals, with viewings and cemeteries. "I don't want to witness that," she said. "I like to picture people alive." She rarely attended clients' funerals. She refused to watch her own mother's coffin get lowered into the ground.

Her schedule didn't leave much time for mourning, anyway. Home Care Partners expected, and her finances demanded, that when a client died, she move on to another within a few days. "I cry," she said, "but I cry to myself."

Perhaps those losses, her daughter speculated, explained Daniel's obsession with renovating her house. Avril and Marilyn Daniel own it together, a small peaked-roof farmhouse colonial with a nice-size garden out back. It was a bit of a shambles because it was full of not-quite-finished projects. In the past few years, guided by library books and how-to TV shows, Daniel had spent her rare days off from work sanding and painting, polyurethaning and tiling; she bought window shades and vanities on sale at home supply stores. Rehabbing is relaxing, "my recreation," she said.

"She's so into the house," Avril mused. "After working with patients, painting is an accomplishment." She had a point: A house, when you spent long hours working on it, slowly became an improved house. Old people, however compassionately you cared for them, declined.

By Friday, things were back to normal at the Laney-Morant household. The sisters' niece Gloria Henderson and her husband had left early for home, and Morant had gotten up to fix breakfast and see them off. It had been an effort, so now she was napping as Daniel began her changing/feeding/bathing routine with Laney.

Friday was another long day for Daniel; after her four hours here, she would walk a mile -- because the three-bus trip would take an hour -- to clean house and fix lunch for a client in her 90s. Then, she would spend three hours with Alston before taking a bus home. On Saturday morning -- and every other Sunday -- she would be with the Browns.

She was offering Laney a pinkish vitamin drink from a nipples bottle -- "she don't like plain water" -- when the phone rang. Henderson was calling to tell her Aunt Classie that they'd gotten home safely, and to be sure that everyone was okay there on Fourth Street.

Several times, social workers and case managers had suggested ways the sisters could receive more assistance. Laney, now low-income enough to qualify, could be enrolled in a Medicaid home-care agency that would provide an aide for more hours. Or, Morant herself could become a client of Home Care Partners and acquire an additional aide of her own. More help might be welcomed: Morant, slowing down now, sometimes wished that she had someone to make her breakfast. And changing or feeding her sister when no one else was there was increasingly difficult.

But switching to a different agency would mean losing Daniel. And if Morant became a client, some newcomer would have to join the rotation, because Daniel didn't have any more hours available. Morant nixed both alternatives.

So they continued with their patched-together arrangement: some help from family, some from neighbors, from Daniel, from a gray market aide. It was a decidedly imperfect situation. But it beat the alternatives.

"Gloria? Hi, hon," Morant said, taking the phone. "Yes, everything's all right. Marilyn's here."

The week before Thanksgiving, Laney began to have trouble breathing and spent a few days in the hospital; she came home with an oxygen tank. The family called a hospice organization.

In the early hours of Dec. 31, after Morant had held her for a long while and kissed her and whispered her goodbyes, Laney died in her own bed. She had recently turned 92. Daniel arrived the next morning to learn that her client was gone.

Despite her aversion to funerals, Daniel went to this one, concerned about Morant and knowing that she'd need help. Arriving at the house early, she brushed and braided Morant's silvery hair, helped her put on an elegant black suit and hat -- "she looked so nice," Daniel said -- and made her breakfast. Usually, Morant insisted on cooking her own; she didn't like the way Daniel fixed the grits. That morning, she didn't complain.

Morant walked into the service, held in a funeral chapel around the corner, with her nephew supporting her on one arm and Daniel holding the other. They sat in the front pew, Daniel clasping Morant's thin hand, as a pianist played and sang "Blessed Assurance" and "I Won't Complain." In his eulogy, Morant's pastor from Baltimore praised her for the tender care she'd taken of Laney year after year; the tribute made Morant wail, briefly. "That was an amazing love she had for her sister," her niece said afterward. "No greater love."

A small cluster of mourners came back to the house after the burial. The goddaughter from Baltimore had prepared lunch, but Morant had been up the night before making dessert: a peach cobbler and two of her famous sweet potato pies.

Daniel slipped away after the service, not wanting to face the cemetery, and headed back to the house to help set up the lunch. Then she caught a bus; she had other elders waiting for her.

But two days later, she arrived at the rowhouse at 7 a.m. for her usual shift. After some discussion with Home Care Partners, Classie Morant had become her client now.

Paula Span's book, "When the Time Comes: Families With Aging Parents Share Their Struggles and Solutions," will be published in June by Grand Central Publishing. She can be reached through www.paulaspan.com.