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The National Declaration for Strengthening Direct Care Services and Benefits for People with Disabilities and Older Adults

by

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Preamble – Principles of Democracy, Human Dignity & Inalienable Rights

As we go forth through the 2020s in the 246th year of this American experiment, and as the oldest democracy in the world, it is in times as today, that our generation of Americans have experienced the duration of continued presence of the COVID-19 pandemic in society and its devastating impact upon society. For people with disabilities and older adults who rely upon direct care services and benefits, this is a time of severe crisis. Through this crisis, we are discovering a renewed awareness of a fundamental principle of democracy, namely, that it is self-evident that human dignity is equally endowed amongst all humanity, in every person throughout the world and throughout all time.

It was only a few short years ago, with the signing of the Americans with Disabilities Act on July 26, 1990 by Honorable President George Bush, that American Society reached a new level of awareness about this principle of democracy, human dignity in which he stated: "*Our success with this act proves that we are keeping faith with the spirit of our courageous forefathers who wrote in the Declaration of Independence: 'We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain inalienable rights.' These words have been our guide for more than two centuries as we've labored to form our more perfect union. But tragically, for too many Americans, the blessings of liberty have been limited or even denied. The Civil Rights Act of '64 took a bold step toward righting that wrong. But the stark fact remained that people with disabilities were still victims of segregation and discrimination, and this was intolerable. Today's legislation brings us closer to that day when no Americans will ever again be deprived of their basic guarantee of life, liberty, and the pursuit of happiness*."

Thusly, in the light of these defining moments of the rule of law that sets forth a threshold on human dignity, we are today compelled, just as previous generations of Americans, to work to bend the arc of history at a time when we are evidencing a crisis for people with apparent and non-apparent disabilities and older adults. The standards that have served us in the past fall to the crisis of direct care worker shortages, of new technologies that challenge civil rights, fundamental rights, and human dignity itself, and of laws frozen in time that result in people living in the shadows of human despair with 40-year asset limitations and no cost-of-living increase, that have robbed people of their basic guarantee of life, liberty, and the pursuit of happiness.

In as much this is a healthcare problem, it is also an American civic problem of indifference. Therefore, we must renew our commitment to these two principles of democracy, namely, **human dignity and certain inalienable rights**. We must solve this crisis with a commitment to do so by The White House, Congress, and the people of the United States of America. The other side of this crisis is to deepen our ability as a democracy and as a civil society to care for one another.

I. Solve the Direct Care Workforce Shortage Crisis Whereby the Solutions Create an Arc That Meets the Needs of All Who Rely Upon the Direct Care Workforce Well into the Future.

Throughout the United States of America, the COVID-19 pandemic has had a devastating impact upon the lives of people with disabilities and older adults. For millions of people in the United States who rely upon Personal Care Assistants (PCAs) as part of our overall nation's healthcare platform, evidence suggests the highest level of unfilled PCA jobs since the beginning of PCA programs 40 years ago.

While the need for tens of thousands upon tens of thousands of PCAs across the United States goes unfilled, this need will dramatically increase within ten years. By 2030 in the United States, the number of older adults over age 62 will accelerate. How will we prepare for such a future if we do not solve the direct care workforce crisis today? Metropolitan Center for Independent Living is working on major initiatives that create the possibilities of going to scale *nationally*. Thusly, strengthening the nation's Direct Care Workforce requires solving the crisis today whereby the solutions create progress, momentum, and an arc that meets the needs of all who rely upon the direct care workforce well into the future. The five areas are:

College Credit Certificate Curriculum Leading to the Certificate of a "Certified PCA": Metropolitan Center for Independent Living (MCIL) received a Bush Foundation Community Innovation grant in support of a two-year effort to contribute to solving the Personal Care Assistant (PCA) worker shortage crisis through a committee of key stakeholders. Jesse Bethke Gomez, Executive Director of MCIL, served as one of three technical writers who wrote what became the approved Direct Care Workforce Report of Recommendations by Minnesota Olmstead Subcabinet in March of 2018. Among the recommendations is: "Provide tiered credential options and career ladders for direct care and support professionals." The work of MCIL answered the call to realize this important recommendation. MCIL hired a faculty team from Minnesota State who developed a college credit certificate program as a basis the credential of a Certified PCA. This curriculum has twelve competencies that comport with the 12 PCA competencies of essential skills by CMS of the federal government.

Kate Caldwell, Ph.D. authored a report for MCIL, "**A More Certain Future: Certification for Personal Care Assistants/Aids**," which identifies how to bring this curriculum to the U.S.

A. The Certified PCA linked to statutory median wage of a Certified Nursing Assistant, is an opportunity for The White House, Federal and State governments to support a proof of concept toward scalability for the 4 million Direct Care Workforces across the United States.

B. **Solving the PCA Worker Shortage Crisis with a Certified PCA at competitive wages also requires that Direct Care Benefits (budget model) are adjusted to last throughout the duration of a Service Plan.**

C. **The creation of a formal education and credential of a voluntary additional career lattice of a Certified PCA most likely leads to potentially higher compensation for PCAs, as a result of a competitive PCA rate structure with sustainable PCA reimbursement rates. Therefore, it is essential to assess the need to study:**

   1. **How best to consider increases in direct care benefits (client budget model), so that;**
   2. **Direct care service hours remain the same, and;**
   3. **Are filled by Certified PCAs paid at competitive wages, and**
   4. **That benefits are upwardly adjusted for the duration of a service plan for the individual.**

PCA Rate Framework: Having a college program leading to the credential of a Certified PCA in and of itself does not create a compensation differential. This is why perhaps for the past 40 years, no one across the United States has already developed such college credit curriculum. There is a way to substantially develop a certificate program for a "Certified PCA" that then has similar job classifications to other certificate programs, such as a Certified Nursing Assistant. Benchmarking competitive compensation for a "Certified PCA" requires the passage of a PCA Rate Framework. Explanation is required. At the state level, a PCA Rate Framework, such as the PCA Rate Framework MN Statute 256b.851 passed into law in 2021 in Minnesota, has component values that take into account competitive workforce factors that would then establish comparative compensation at the median wage of a Certified PCA. Therefore, the linkage of a certificate program with a statutory rate framework and competitive workforce factors as component values can create a market rate and, most likely, a compensation differential for the Certified PCA versus the generic PCA, which does not require a formal education.

A. **The PCA Rate Framework is an opportunity for Federal and State to assess a proof of concept of the Certified PCA role with a view toward scalability for the 4 million Direct Care Workforces across the United States and to link that with statutory wages at the median wage of a Certified Nursing Assistant.**

PCA/Direct Support Professional College Service Corps Pilot: Metropolitan Center for Independent Living was funded by the Margaret A. Cargill Foundation Fund of the Saint Paul and Minnesota Foundation to establish a Personal Care Assistant (PCA) College Service Corps Pilot Project. The agency is working with an Advisory Committee on the development of one of the first-ever PCA College Service Corps in Minnesota and, in the United States. MCIL is deeply grateful to the Minnesota legislature for passage of a bill in the 2023 session that provides for MCIL to enact a PCA College Service Core Pilot and to report on this project to the legislature.

The aims of this pilot initiative harken to the formation of AmeriCorps. The Honorable President Bill Clinton, in his "call to serve" as a renewal of American values, brought forth AmeriCorps. His acceptance speech, as noted by the Clinton Foundation in 1992, included the following quote: "*Think of it. Millions of energetic young men and women serving their country by policing the streets or teaching the children or caring for the sick. Or working with the elderly and people with disabilities. Or helping young people to stay off drugs and out of gangs, giving us all a sense of new hope and limitless possibilities*." Thusly, this effort starts in Minnesota, and as this effort is one of the major initiatives to address the PCA worker shortage crisis.

This is as much a vision for America to bring forward this opportunity so that eventually, throughout the United States, by working with "*the elderly and people with disabilities*" in this new era and bringing forth the call to serve to college students to play a dedicated role in the PCA Workforce. It is about a renewed affirmation of the importance of service, dedication, and the hallmark of who we are as a civil society, namely, advancing the ability of people to care for one another.

A. **MCIL is committed to work on the success of this pilot in Minnesota and to assess scalability throughout Minnesota for the Direct Care Service sector.**

B. **The PCA College Service Corps Pilot is an opportunity for The White House, Federal and State government to follow Minnesota's lead (***Minnesota passed legislation 2023 session for this pilot***) with a proof of concept toward scalability for the 4 million Direct Care Workforce across the United States.**

PCA Apprenticeship Program: The U.S Department of Labor requires a "formal education" in order to establish an apprenticeship program. Sequentially with the formation and implementation of a Certified PCA curriculum as a formal educational requirement, there is much work needed beyond proof of concept toward the establishment of an apprenticeship program within Minnesota in working with MN DEED, MN DHS, and Minnesota Department of Labor and Industry.

A. **The PCA Apprenticeship Program is an opportunity for The White House, Federal and State government to support a proof of concept toward scalability for the 4 million Direct Care Workforce across the United States.**

PCA Scholarship Program: How do we invest in the PCA workforce sector in which many PCAs struggle with reaching livable wages? We need to contemplate the role of the Federal government, state government, and the private sector, including the philanthropic sector, toward a scholarship program that accelerates PCA certification completions for PCAs and people seeking to become PCAs through a Certified PCA curriculum and related educational opportunities identified above.

A. **Creation of a Scholarship Program is an opportunity for The White House, Federal and State government to support a proof of concept toward scalability for the 4 million Direct Care Workforce across the United States. Certainly, AmeriCorps should be proactively seeking to be part of this effort.**

II. Assure Federally Mandated Direct Care Technologies Do Not Infringe upon the Civil Rights and Fundamental Rights of Individuals Who Rely upon Direct Care Services and upon Worker Rights of Personal Care Assistants.

With the realization that the healthcare platform for the United States includes hospitals and clinics on one end of the continuum and home and community- based services, also known as long-term services and supports, on the other end, notably for people with disabilities and older adults, the foundation for all health and human services, including Personal Care Assistant Programs are based upon Federal law, civil rights, legal protections, and the U.S Constitution.

Direct Care Services such as Personal Care Assistant Programs and related elements of this growing home care and workforce sector, including but not limited to Electronic Visit Verification, far-reaching changes at the state level to PCA Programs, and strengthening the PCA workforce sector are all subject to assuring fairness, civil rights, fundamental rights, worker rights, and all the legal protections for people who rely upon PCAs and for the PCA workforce.

Strengthening Direct Care Services requires the continued focus on the rights of people who rely upon PCAs and for people who serve as PCAs as well. Federal laws that assure civil rights, fundamental rights, legal protections, and proper safeguards serve as the basis for people with disabilities and older adults in receiving home and community-based services, such as PCA services, include but are not limited to the following:

- **The Americans with Disabilities Act**, notably Title II of the Americans with Disabilities Act (ADA) of 1990, covers all healthcare and social services programs and activities of public entities

- **Section 504, Rehabilitation Act of 1973**, including programs and activities that are conducted by HHS or receiving Federal financial assistance from HHS

- **Both ADA and Section 504** – require that covered entities make reasonable modifications in their policies, practices, and procedures to *avoid discrimination on the basis of disability* unless it would result in a fundamental alteration of the program

- **Section 508 of the Rehabilitation Act of 1973**, covering access to electronic and information technology provided by HHS

- **Presidential Executive Order 1250**, it is up to our generations of Americans to bring forward the best of who we are as an American civil society in bending the arc of history for the better for all who today rely upon our current nation's home and community-based long-term services and supports and for tomorrow's many generations to come.

- **Section 1557 of the Patient Protection and Affordable Care Act (ACA)** ensures that an individual is not excluded from participating in, denied benefits because of, or subjected to discrimination as prohibited under Section 504 of the Rehabilitation Act of 1973 (disability), under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act or its amendments.[1]

- **The United States Constitution, Ninth Amendment:** "**The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.**"

  Cornell Law School* presents an overview of the current doctrine of the Ninth Amendment of the U.S. Constitution with the following recap by Justice Goldberg, whom they quote:*

  "*The language and history of the Ninth Amendment reveal that the Framers of the Constitution believed that there are additional fundamental rights, protected from governmental infringement, which exist alongside those fundamental rights specifically mentioned in the first eight constitutional amendments. To hold that a right so basic and fundamental and so deep-rooted in our society as the right of privacy in marriage may be infringed because that right is not guaranteed in so many words by the first eight amendments to the Constitution is to ignore the Ninth Amendment and to give it no effect whatsoever. Moreover, a judicial construction that this fundamental right is not protected by the Constitution because it is not mentioned in explicit terms by one of the first eight amendments or elsewhere in the Constitution would violate the Ninth Amendment. Nor do I mean to state that the Ninth Amendment constitutes an independent source of right protected from infringement by either the States or the Federal Government. Rather, the Ninth Amendment shows a belief of the Constitution's authors that fundamental rights exist that are not expressly enumerated in the first eight amendments and an intent that the list of rights included there not be deemed exhaustive.*" *4** [2]

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[1] https://www.hhs.gov/civil-rights/for-individuals/disability/index.html
[2] https://www.law.cornell.edu/constitution-conan/amendment-9/ninth-amendment-current-doctrine

Revisit the development of Electronic Visit Verification (EVV) in a manner that is consistent with all other development protocols for electronic health records and related health technologies defined in the 21st Century Cures Act.

H.R. 34 – The 21st Century Cures Act, passed into law by the 114th Congress in 2016, includes "*Section. 12006. Electronic visit verification system required for personal care services and home health care services under Medicaid*.[3]" Section 12006 is one sentence and does not include any other language or requirement, such as for a government-controlled Global Positioning System (GPS). Section 12006 did not provide for an explicit methodology by which EVV was to be developed, standardized, or to work in accordance with other parts of the Cures Act. This Law called for the development of our Nation's electronic health records and health-related electronic technologies, notably with highly specific protocols for their development. Elaboration is required.

The Cures Act, for what appears to be most if not all other areas that call for the development of electronic health records and health-related technologies, have clear and specific sequential protocols for their development. Throughout the Cures Act, there are protocols on specific areas in healthcare that require the designated Health and Human Service Officials and Committees to work with key constituents on the development of new health-related technologies. The 21st Century Cures Act sought to attain greater clarity, functionality, regulatory standardization, and interoperability on Electronic Health Records and other health-related technologies.

For instance, in **Section 11002. Confidentiality of Records**, there is a robust set of protocols to ensure assessing the effect of the development of this new technology on the patient; "*Not later than 1 year after the date on which the Secretary of Health and Human Services (in this title referred to as the Secretary) first finalizes regulations updating part 2 of title 42, Code of Federal Regulations, relating to confidentiality of alcohol and drug abuse patient records, after the date of enactment of this Act, the Secretary shall convene relevant stakeholders to determine the effect of such regulations on patient care, health outcomes, and patient privacy*."

Contrast language of Section 11002 with Section 12006 on EVV, which is one sentence, and there is no similar language, like Section 11002, that would have required "***the Secretary to convene relevant stakeholders [people with disabilities and older adults] to determine the effect of such [EVV] regulations on patient care, health outcomes, and patient privacy***."

[3] https://www.congress.gov/bill/114th-congress/house-bill/34/text

The language of Section 12006, by its lack of any protocols, is not consistent with the specific accountabilities, sequence, and oversite found in the development of other health-related technologies throughout the 21st Century Cures Act, such as for Section 11002, and creates a grave concern for people with disabilities and older adults, who are mandated by law to utilize EVV. If it is not consistent, then how can it therefore be fair?

Based upon the evidence, the very language of Section 12006, with no protocols in the law for the development of EVV, which has resulted now in a government-controlled GPS, did not take into account the spirit, context, and protocols by which all other health-related technologies were to be developed in H.R. 34 – The 21st Century Cures Act.

Furthermore, it is also important to note that the Cures Act, in its work on the development protocols, standardization, and interoperability of Electronic Health Records, there does not appear to be stated a requirement for a government-controlled GPS for any other group of protected classes of people, let along for non-protected classes of people. CMS has provided the option on whether or not states include the government-controlled GPS capability. According to CMS: " *CMS also notes that there is no requirement to use global positioning services (GPS), but it is one approach for implementation of the EVV requirements. A common alternative to GPS is Interactive Voice Response, which requires the caregiver to check-in and out using a landline or cellular device located at the individual's home*." (Source: CMS: FAQ Section 12006 of the 21st Century Cures Act CMS). However, the concern remains on how was the option for a GPS EVV brought forward when H.R. 34 made no mention for this provision.

Further research is needed to assess if, for any other class, notably protected classes of Americans if H.R. 34 – The 21st Century Cures Act has resulted in mandated government-controlled GPS for any of the technologies covered in the scope of this enactment. Thus far, it appears that EVV is the sole technology called forth by the Cures Act that has resulted in a government-controlled GPS mandated for protected classes namely, people with disabilities and older adults.

The President of the United States and Congress should work together to remedy Electronic Visit Verification for people with disabilities, older adults, and PCAs as well, in order to assure conformance of EVV with the rights of all protected classes and worker rights.

Out of an abundance of concern for the civil rights and fundamental rights of people required to use EVV, there should be an immediate pause to the GPS component while remedies are studied in fairness with protocols consistent with the protocols for other new technologies in the 21st Century Cures Act.

A. Whereas the Secretary shall convene relevant stakeholders, including People with Disabilities, Older Adults, and Personal Care Assistants, to determine the effect of Electronic Visit Verification, whether its development called for it to be accessible, and notably whether the government-controlled GPS adversely impacts patient care, health outcomes, and patient privacy and employment law and

B. Whereas EVV regulations, whether its development called for it to be accessible, and notably whether the government-controlled GPS adversely impacts the spirit and letter of Title II of the Americans with Disabilities Act, Section 504, Rehabilitation Act of 1973, Section 508, Rehabilitation Act of 1973, Presidential Executive Order 1250, Section 1557 of the Patient Protection and Affordable Care Act (ACA), Health Insurance Portability and Accountability Act, employment law and

C. Whereas that all EVV regulations, specifically whether the government-controlled GPS adversely impacts the civil rights and the fundamental rights of people with disabilities and older adults and Personal Care Assistants under the Ninth Amendment of the U.S. Constitution that established that all individuals are protected from governmental infringement, which exist alongside those fundamental rights specifically mentioned in the first eight constitutional amendments.

III. The Agency for Healthcare Research and Quality lead the formation of Quality Improvement Policy on Direct Care Services for Centers for Medicare and Medicaid Services (CMS), and Quality Improvement Requirements for State and Agency Providers of Direct Care Services.

Dr. W. Edwards Deming wrote a book in 1982 entitled "Out of the Crisis" (Massachusetts Institute of Technology Publisher). By the 1980's Dr. Deming had helped rebuild Japan after World War II, assisted with saving the American Auto Industry in the 19070's and was among the global thought leaders in advancing a new theory of knowledge called quality improvement. Jesse Bethke Gomez, the Executive Director of Metropolitan Center for Independent Living personally met and trained with Dr. Deming on his Theory of Profound Knowledge. There is a need nationally for the federal government to adopt quality improvement direct care policies that are linked to state funding, and services as part of the healthcare platform of the United States of America. It is 50 years from when the U.S. Auto industry adopted quality improvement as a strategic commitment to the entirety of the industry. It is timely that the United States adopt a similar commitment to quality improvement for direct care services by the federal government.

Agency for Healthcare Research and Quality (AHRQ) is a major division of the federal government's Health and Human Services (HHS) Department. AHRQ is central to advancing a quality improvement policy and culture in contributing to a way for the direct care sector to employ a way *out of the crisis*. The mission of AHRQ is the following: The Agency for Healthcare Research and Quality's (AHRQ) mission is to produce evidence to make healthcare safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.[4]

Dr. Deming in his book "Out of the Crisis" he wrote: *Government service is to be judged on equity as well as on efficiency*.[5] The idea leads to the question; Why employ a Quality Improvement (QI) policy and culture for our Nation's direct care/homecare sector? While it seems self-evident that our country would naturally adopt such a framework, throughout the past 40 years of direct care PCA/DSP services, very little QI research has been prioritized for this sector. Without a quality improvement framework such a sector is only left with a focus on waste, fraud and abuse, while important, is less likely to lead to innovation and breakthroughs leading to greater equity, efficiency, accountability and added value in the service of people with disabilities and older adults.

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[4] https://www.ahrq.gov/cpi/about/mission/index.html
[5] W. Edwards Deming, "Out of the Crisis," (Massachusetts Institute of Technology, 1981) 198.

A. AHRQ should be required to develop quality improvement policies, standards, for CMS and commit in its strategic plan to advance research and quality in the home care sector and direct care services.

B. CMS should require all 50 states to employ quality improvement protocols in administering statewide direct care funding and related services and supports, and institute training and protocols on quality improvement for providers of direct care services.

IV. Remove the Unfair 40-Year Frozen Asset Limitation for People with Disabilities and Older Adults with a Cost-of-Living Framework That provides Continual Fairness in Asset Adjustment Thresholds.

Certain Federal benefits for people with disabilities and older adults require asset limitations, along with other requirements, in order to qualify for Federal and often State-related life-sustaining health and human services. The Federal asset limitations enacted in 1983 did not have a cost-of-living adjustment as part of the law. This has meant for the past 40 years that people with disabilities and older adults have had to meet the same asset limitation of $2,000 for an individual and $3,000 for a couple. Do we, as a nation bound by our Declaration of Independence, the United States Constitution, and, as a civil society, believe that we have maintained human dignity for people with disabilities and older adults bound by these asset limitations for the past 40 years?

There are countless numbers of elected officials, whether in the Executive branch or the Legislative branch; over the past 40 years all the while, these fixed dollar amount asset limitations have been in place for people with disabilities and older adults in order to receive related health and human services. The freeze at the current levels of $2,000 per individual and $3,000 for couples has been in place since 1989 and has never been upwardly adjusted *since* 1983. To change the laws that have frozen asset limitations at the same fixed dollar amount – that results in year after year of people living with disabilities and older adults living in the shadows of human despair – will end 40 years of denying people of their basic guarantee of life, liberty, and the pursuit of happiness, their civil rights, and fundamental rights. It is a principle of democracy that it is self-evident that human dignity is equally endowed amongst all humanity in every person throughout the world and throughout all time.

Therefore, be it resolved that:

A. **Congress should seek to adjust the asset limitations to no less than $10,000 per individual and no less than $20,000 for couples, along with cost-of-living increases henceforth each year thereafter.**

B. **2. Congress should seek Federal-related health and human services that work in concert with state programs, the necessity by the states on conformance with the asset limitations no less than $10,000 per individual and no less than $20,000 for couples along with cost-of-living increases henceforth each year thusly thereafter.**

V. About MCIL

Metropolitan Center for Independent Living with the mission statement, **Removing Barriers, Promoting Choices**, assists people with apparent and non-apparent disabilities in advancing independent living within the seven-county metropolitan area of St. Paul and Minneapolis. MCIL's Governing Board of Directors are committed to independent living for people with disabilities and more than 50% of Board Members are individuals with disabilities.

Founded 41 years ago as one of 405 Centers for Independent Living nationwide and guided by the Centers for Independent Living Rules and Regulations of the Workforce Innovation and Opportunity Act (*Act 45 CFR Part 1329 November 28, 2016*) and Minnesota State Statute (*268A.11 Centers for Independent Living*), MCIL retains a workforce of nearly 230 employees and personal care assistants. By statute, at least 50 percent of MCIL employees and board members are people with disabilities. Each year, MCIL reaches more than 5,500 people with direct services and an additional 29,000 people who receive information and referrals along with system navigation advice as an operations site for call center serving people with disabilities throughout Minnesota.

VI. Jesse Bethke Gomez, MMA, Executive Director of MCIL

Jesse Bethke Gomez, MMA is Executive Director for Metropolitan Center for Independent Living. Jesse is a transformative Chief Executive Officer and thought leader on complex healthcare, human service and public health policy issues driving societal progress. He is among "**The Top 100 Most Influential Health Care Leaders in Minnesota**" *(Minnesota Physician Nov. 2020).* Jesse was among the 100 Leaders invited to The White House Hispanic Summit in 2011 host by The Honorable Barack Obama, President of the United States of America. Jesse's expertise is in serving as a Chief Executive Officer for a number of nonprofit corporations throughout his career on advancing the health, well-being, prosperity and human dignity of marginalized populations.

He has the distinction and honor of being twice appointed by the Minnesota Supreme Court, 2011 and 2015 to the **Minnesota Judicial Selection Commission**. Jesse has served on 38 Boards and Commissions. He holds a Master's degree in Management and Administration with a concentration on strategic leadership. Jesse is also a **National Kellogg Fellow** in Public Health Leadership from the University of North Carolina Chapel Hill. He is a Graduate of the Minnesota Executive Program for Advanced Strategic Leadership from the Curtis L. Carlson School of Management, University of Minnesota. Jesse also personally trained with **Dr. Edwards Deming**, who helped to rebuild Japan after WWII, and who led the world-wide quality improvement movement. Jesse collaborated with **Tor Dahl**, of Tor Dahl & Associates, Chairman of the World Confederation of the Productivity Sciences. Jesse is a national speaker and published author.

VII. MCIL's Call to Action: Out of the Direct Care Crisis!

For over twenty years, the United States has faced a direct care workforce crisis that has only been exacerbated by the COVID-19 pandemic. We are at a threshold whereby the direct care crisis is becoming a major civil rights issue of our generation for people with disabilities and older adults. The Metropolitan Center for Independent Living (MCIL) is resolute in solving this direct care worker shortage crisis and is leading efforts to focus on scalability across the United States. We welcome you to be part of this call to action: Out of the Direct Care Crisis!

Scan to support the National Declaration for Strengthening Direct Care Services and Benefits for People with Disabilities and Older Adults!