Jobenomics Washington DC Direct-Care Initiative

5 November 2018

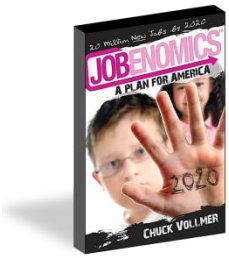
Executive Summary, The **Jobenomics Direct-Care Initiative** involves direct-care services by mainly home-based small and self-employed businesses via a community-based direct-care center. Direct-care occupations are projected to increase by many millions of new jobs, due to the need for cost-effective healthcare, social assistance, behavioral-care, elder-care, and child-care services, and the inability of traditional institutions (like hospitals and community care facilities) to service ever-growing medical, health and societal needs of American's urban and rural poor. Due to rapid advances in online technologies and the high cost of institutionalized care, medical, health and social assistance industries are evolving from centralized inpatient care, to outpatient (ambulatory) care, to delivering on-demand care services directly to the point-of-need.

Proposed Jobenomics Washington DC Direct-Care Program

- **Direct-Care Services** include:
  - **Healthcare** and **social assistance**, the fastest growing occupations in the USA.
  - **Behavioral-care** includes drug addition, PTSD, obesity, spousal abuse, chronic illness, etc.
  - **Elder-care** forecasts 17 million assisted-living bed shortfall by 2020.
  - **Child-care** is the single biggest cost keeping women homebound.

- **Direct-Care Center** would connect service providers and clients via a **call and information center**. The center would start **home-based firms** certified to provide **in-home services** while connected to tele-health and other providers.

Enabled by technology and driven by economics, on-demand direct-care to local denizens (inhabitants, residents) is rapidly augmenting outpatient and inpatient services. The **Jobenomics Washington DC Direct-Care Initiative** provides direct-care to Washingtonians starting with financially-distressed neighborhoods in Wards 5, 7 and 8. A Direct-Care Center will train, certify, manage, provide, monitor and mass-produce direct-care startup businesses that are linked via modern telehealth networks to more experienced practitioners in outpatient and inpatient centers. In addition to mass-producing direct-care startup businesses and jobs, a Direct-Care Center would also provide education, training, certification, quality control, ICT (information and communication technologies) and EMT (emergency medical technician) related services for the community.



Jobenomics deals with the process of creating and mass-producing startup companies and jobs. Jobenomics' principal focus is on citizens at the base of America's socioeconomic pyramid with special emphasis on minorities, women, youth, veterans and other hopefuls who want to develop a skill, career or start a business. The Jobenomics National Grassroots Movement has an estimated following of over 30 million people via media, website, blog, and lectures. Jobenomics' website receives tens of thousands of monthly page views with the majority the viewers spending a half hour or more online, not counting time spent reviewing downloads of Jobenomics' eleven books and research on economic, community, business and workforce development. Today, Jobenomics has garnished wide-spread support for its economic, urban renewal, small business, and workforce development efforts. Two dozen U.S. communities have started Jobenomics initiatives led by local community leaders. In 2018, Jobenomics America TV, a weekly show, was launched associated with various online content providers and a national TV network.

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Direct-Care Services Overview.

Jobenomics Direct-Care initiative includes healthcare, social assistance, behavioral-care, elder-care, and child-care. It also can be expanded to include addressing social issues such as caring for the homeless.

Healthcare and Social Assistance.

Healthcare and Social Assistance Employment This Decade

Source: BLS CES5000000001, Seasonally Adjusted

	1-Jan-10	1-Aug-18	New Jobs (000s)	% Growth	% Growth Per Year
	Jobs (000s)				
Healthcare and Social Assistance	**16,696**	**19,932**	**3,236**	**19%**	**2.3%**
Healthcare	**13,658**	**16,038**	**2,380**	**17%**	**2.0%**
Ambulatory Healthcare Services	5,885	7,503	1,618	27%	**3.2%**
Offices of Physicians	*2,254*	*2,641*	*387*	*17%*	2.0%
Offices of Dentists	*815*	*947*	*132*	*16%*	1.9%
Offices of Other Health Practitioners	*656*	*928*	*271*	*41%*	***4.8%***
Outpatient Care Centers	*629*	*936*	*306*	*49%*	***5.7%***
Medical and Diagnostic Laboratories	*224*	*282*	*58*	*26%*	***3.0%***
Home Healthcare Services	*1,060*	*1,462*	*402*	*38%*	***4.4%***
Other Ambulatory Healthcare Services	*247*	*308*	*61*	*25%*	***2.9%***
Hospitals	4,671	5,182	511	11%	1.3%
Nursing and Residential Care Facilities	3,102	3,353	251	8%	0.9%
Nursing Care Facilities	*1,651*	*1,607*	*-44*	*-3%*	***-0.3%***
Residential Mental Health Facilities	*564*	*634*	*70*	*12%*	*1.4%*
Community Care Facilities For the Elderly	*728*	*942*	*214*	*29%*	***3.4%***
Other Residential Care Facilities	*161*	*171*	*11*	*7%*	*0.8%*
Social Assistance	**3,038**	**3,894**	**856**	**28%**	**3.3%**
Individual and Family Services	1,640	2,437	797	49%	**5.7%**
Emergency and Other Relief Services	139	172	33	24%	2.7%
Vocational Rehabilitation Services	348	338	-10	-3%	**-0.3%**
Child Day Care Services	849	937	89	10%	1.2%
	Lost Jobs	*Below GDP Annual 2.4% Growth Rate*			*Above GDP*

According to the U.S. Bureau of Labor Statistics (BLS), the Healthcare and Social Assistance sector comprises establishments providing health care and social assistance for individuals. The sector includes both health care and social assistance because it is sometimes difficult to distinguish between the boundaries of these two activities. The industries in this sector are arranged on a continuum starting with those establishments providing medical care exclusively, continuing with those providing health care and social assistance, and finally finishing with those providing only social assistance.[1]

So far this decade (the 2010s), the U.S. Health Care and Social Assistance sector added 3,858,000 jobs—the largest of any single private U.S. industry sector. As shown, of the 21 listed subcategories, nine categories have grown faster than the average 2.4% rate of yearly GDP growth (Gross Domestic Product is the best measure of the health of the U.S. economy), ten are growing at a rate below GDP and two lost jobs. Consequently, the U.S. Health Care and Social Assistance sector is not producing jobs at a rate commensurate with the health of the overall economy or meeting the demands of our population that is experiencing a rapid rise in physical health, mental health, and behavioral health issues.[2]

[1] U.S. Bureau of Labor Statistics, Health Care and Social Assistance: NAICS 62, https://www.bls.gov/iag/tgs/iag62.htm
[2] U.S. Bureau of Labor Statistics, Table B-1, https://www.bls.gov/webapps/legacy/cesbtab1.htm

Healthcare.

Due to rapid advances in technologies and the high cost of institutionalized care, the Healthcare industry is evolving from centralized inpatient care, to outpatient (ambulatory) care, to delivering on-demand healthcare services at the point-of-need.

The Healthcare sector is the second largest producer of jobs of all subsectors this decade generating 2,280,000 new jobs. However, compared to 2.4% per annum GDP growth, this sector is growing at a subpar 2.0% per annum. Of the three subsectors, Ambulatory Healthcare Services employment was the star performer with an overall growth rate of 3.2% per annum. The other two subsectors, Hospitals, and Nursing and Residential Care Facilities, barely grew over this decade with per annum growth rates of 1.3% and 0.9% respectively.

- *Ambulatory Healthcare Services (NAICS 621).* Ambulatory care or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals. Outpatient Care Centers grew the fastest at 5.7% per annum growth producing 306,000 new jobs. Offices of Other Health Practitioners came in second best with 4.8% annual growth and 271,000 jobs. The Offices of Other Health Practitioners subsector includes Chiropractors, Optometrists, Mental Health Practitioners (except Physicians); Physical/ Occupational/Speech Therapists, and Audiologists who usually practice in small offices, walk-in centers or clinics. The Home Healthcare Services subsector was third, growing at 4.4% and producing 402,000 new jobs.

  Home Healthcare Services is one of the primary areas of the Jobenomics Washington DC Direct-Care Initiative. It comprises establishments primarily engaged in providing skilled nursing services in the home, personal care services, 24-hour home care, homemaker and companion services, physical therapy, medical social services, medications, medical equipment and supplies, counseling, occupation and vocational therapy, dietary and nutritional services, and high-tech care, such as intravenous therapy.

- *Nursing and Residential Care Facilities (NAICS 622)*. In the Nursing and Residential Care Facilities subsector, the worst performers were Nursing Care Facilities (a negative 0.3% rate of growth with a loss of 44,000 jobs) and Residential Mental Health Facilities (1.4% growth and only 70,000 new jobs). They were the worst performers largely due to the high cost of managed care facilities and government inaction on the growing mental health crisis. However, Community Care Facilities For the Elderly (assisted living, managed care, skilled care, and hospice care) grew at 3.4% per annum adding 214,000 jobs.

  Elder-Care is another major focus area for Jobenomics Washington DC Direct-Care Initiative. The difference between Community Care Facilities For the Elderly and Jobenomics Elder-Care is that the former requires public or private facilities and the latter provides in-home services. In-home residential care is projected to grow exponentially over the next decade due to retiring baby boomers, the wealthiest American living generation, who can afford in-home services.

- *Hospitals (NAICS 623)*. While hospitals added 511,000 jobs this decade, hospital employment grew at an insufficient rate of 1.3% per annum during a decade of positive economic growth and growing healthcare demand. Due to the rising costs of healthcare, hospitals are facing an array of financial challenges including recruiting and retaining physicians and skilled medical professionals, the challenges of maintaining profitability and caring for patients with inadequate medical insurance—the central focus of the belabored Affordable Healthcare Act. Emergency Rooms and Psychiatric Hospitals are severely overextended. Moreover, Hospital prosperity and growth could experience a major downturn if the United States experiences a medical or financial crisis in the future.

  According to the Association of American Medical Colleges, the United States could see a shortage of up to 120,000 physicians by 2030, which poses a "serious threat" to patient care in a nation that will not only continue to grow but also age considerably over the next 12 years.[3] To mitigate this shortage, the Jobenomics Washington DC Direct-Care Initiative plans to implement proven telehealth and AI assistant apps to reduce the number of doctor visits.

Social Assistance.

Social Assistance (NAICS 624) includes Individual and family services, community food and housing, and emergency and other relief services, vocational rehabilitation services and child day-care services. Social Assistance (also called safety net and need-tested programs) include the Earned Income Tax Credit and Child Tax Credit for low- and moderate-income working families, and other programs that provide cash payments to eligible individuals or households. These other programs include Supplemental Security Income for the elderly or disabled poor and unemployment insurance; various forms of in-kind assistance for low-income people (food stamps, school meals, low-income housing assistance, child care assistance); programs that help people pay home energy bills; and various other programs such as those that aid abused and neglected children.

Most Expensive Need-Tested Programs

Source: U.S. Congressional Research Service, Need-Tested Benefits: Estimated Eligibility and Benefit Receipt by Families and Individuals

FY2012 ($ Billions)	Selected Need-Tested Programs *Source: Congressional Research Service, December 2015 Report*	Recipients (Millions)
$77.8	Supplemental Nutrition Assistance Program (SNAP)	58.0
$54.9	Earned IncomeTax Credit (EITC)	62.9
$50.7	Federal Supplemental Security Income (SSI)	8.4
$33.4	Housing Assistance	10.8
$22.1	Additional Child Tax Credit (ACTC)	51.9
$7.2	Women, Infants and Children (WIC) Nutrition Program	8.1
$6.7	Temporary Assistance for Needy Families (TANF)	5.8
$5.2	Child Care and Development Fund (CCDF)	1.9
$3.5	Low-Income Home Energy Assistance Program (LIHEAP)	18.3
$261.5		**226.1**

[3] Association of American Medical Colleges, New Research Shows Increasing Physician Shortages in Both Primary and Specialty Care, 11 April 2018, https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/

U.S. Congressional Research Service's 30 December 2015 report examined estimated benefit receipt by families from nine major need-tested benefit programs listed above. According to the CRS, an estimated 135 million persons were eligible for benefits, and an estimated 106 million persons (1 in 3 persons in the population) received benefits from one of these programs in 2012. The estimated median annual benefit amount from the nine programs in 2012 was $3,300. An estimated 25% of families that received benefits from one or more of the selected programs received a total of $9,027 or more. "Families with children who received $9,027 or more had characteristics indicative of a more disadvantaged population: working less than full-time all year, lacking a high school diploma, being in a family headed by a single woman, being of a racial/ethnic minority (other than Asian-American), and being in a large family." [4]

The Social Assistance sector created 856,000 jobs with Individual and Family Services subsector providing almost all the jobs (49% growth rate and 797,000 new jobs) of the Social Assistance total. Individual and Family Services include child and youth services, and services for the elderly and persons with disabilities. Vocational Rehabilitation Services was the worst performer with a loss of 10,000 jobs and a negative 3% growth rate. Vocational Rehabilitation Services includes federal-state programs that help people who have physical or mental disabilities get or keep a job, or helping people with disabilities find meaningful careers. Child Day Care Services also was a weak performer growing at a sclerotic 1.2% per year over the last 8.5 years adding only 89,000 jobs. Because approximately 70% of all households in Washington DC Wards 5, 7 and 8 are headed by single moms, with children under 18 years old, the lack of child-care services is one of the greatest inhibitors of upward social mobility in the District of Columbia.

Healthcare and Social Assistance

College Degree	Occupation	Number of U.S. Jobs in 2014	Number of New Jobs	Growth Rate
No	Personal care aides	1,768,400	**458,100**	26%
Yes	Registered nurses	2,751,000	**439,300**	16%
No	Home health aides	913,500	**348,400**	38%
No	Nursing assistants	1,545,200	**267,800**	17%
No	Medical assistants	591,300	**138,900**	23%
No	Medical secretaries	3,976,800	**118,800**	3%
No	Licensed practical and licensed vocational nurses	719,900	**117,300**	16%
Yes	Physicians and surgeons	708,300	**99,300**	14%
Yes	Physical therapists	210,900	**71,800**	34%
No	Childcare workers	1,260,600	**69,300**	5%
No	Dental assistants	318,800	**58,600**	18%
No	Emergency medical technicians and paramedics	241,200	**58,500**	24%
No	Medical and health services managers	333,000	**56,300**	17%

According to the BLS Employment Projections 2016-26 Summary, Healthcare and Social Assistance are the fastest growing U.S. occupations. 4 million new jobs, or 40% of all new jobs, are projected next decade. Most do not require a college degree. A Jobenomics Washington DC skills-based training and certification programs can mass-produce home-based self-employed Direct-Care businesses.[5]

[4] U.S. Congressional Research Service, Need-Tested Benefits: Estimated Eligibility and Benefit Receipt by Families and Individuals, 30 December 2015, https://fas.org/sgp/crs/misc/R44327.pdf

[5] BLS, Employment Projections 2016-26 Summary, https://www.bls.gov/news.release/ecopro.nr0.htm

Behavioral-Care.

Behavioral-care includes promotes well-being by preventing or intervening in mental illness such as depression or anxiety, but also prevents or intervenes in substance abuse or other addictions. Behavioral care puts emphasis on the individual to change or adapt to environmental factors (poverty, discrimination or abuse) that enhance the individual's ill-being.

According to the U.S. Drug Enforcement Administration, drug overdose deaths hit the highest level ever recorded in the United States last year. Preliminary figures indicate that more than 72,000 Americas died in 2017 from drug overdoses from heroin, fentanyl, and other opioids. The District of Columbia was rated the worst State/District for drug use based on an arrest, overdose rates to opioid prescriptions, and meth-lab incidents, according to a May 2018 WalletHub report. The report rated the District of Columbia #1 (out of 51) in "Drug Abuse & Addiction" and #1 in "Drug Health Issues & Rehab."[6] The Jobenomics Washington DC Direct-Care Initiative is designed to provide early intervention and prevention services to prevent drug addiction from claiming more deaths and provide face-to-face counseling at the point-of-need.

According to the American Hospital Association, one-quarter of all Americans experience a mental illness or substance use disorder each year, and the majority also has a comorbid physical health condition (anxiety disorders, phobias, hypertension, obesity, insomnia, etc.). Hospitals and major health institutions provide essential behavioral and healthcare services to millions of Americans every day. However, hospitals prone to treat the most severe cases and are greatly understaffed.

The most common disruptive behavior disorders in young children include oppositional defiant disorder (ODD), conduct disorder (CD) and attention deficit hyperactivity disorder (ADHD). Typical behaviors of a child with ODD include frequent temper tantrums, abnormal angriness and argumentativeness, and low self-esteem. Children with CD often exhibit delinquent behavior, such as fighting and lying, and refusal to accept rules. Characteristics of ADHD include inattention, difficulty concentrating, impulsivity and constant restlessness and fidgeting.

In 2018, the District of Columbia's Department of Behavioral Health allocated $233,330,000 for behavioral health, a large but insufficient sum of money considering the drug epidemic, mental health, and other associated behavioral issues. The Department provides prevention, intervention and treatment services and supports for children, youth and adults with mental and substance use disorders including emergency psychiatric care and community-based outpatient and residential services via a network of community-based providers and unique government delivered services.[7]

[6] Wallet Hub, Drug Use by State: 2018's Problem Areas, 14 May 2018, https://wallethub.com/edu/drug-use-by-state/35150/
[7] DC.gov, Office of the Chief Financial Officer, https://cfo.dc.gov/page/annual-operating-budget-and-capital-plan

Elder-Care.

By 2020 older Americans are projected to need 20 million assisted- or managed-care beds. Today, only 3 million beds are available nationwide.

As mentioned earlier, nationwide, Nursing and Residential Care Facilities barely grew over this decade with 0.9% per annum—a growth rate grossly insufficient to care for aging baby boomers. Building new assisted-care facilities is not the answer with financially strapped senior citizens who cannot afford the typical $10,000/per month fees. In-home services will be needed and are projected to grow at a rate of 15% per year.

According to a report by the U.S. Government Accountability Office (GAO), 52% of baby boomers aged 55 and older have no retirement savings, and the remainder has meager nest eggs to support their retirement. Amongst those with some retirement savings, the median savings is about $104,000 for households aged 55 to 64, which is equivalent to an inflation-protected annuity of only $310. Consequently, most baby boomers will have to rely on social security that only provides necessities.[8] Furthermore, according to the Economic Policy Institute data, pension pots for future retirees are even bleaker with median pension pots of only $8,000 for Americans aged 50 to 55 and $6,200 for Americans aged 44 to 49.[9]

The District of Columbia Office on Aging (DCOA) advocates, plans, implements and monitors programs in health, education and social services that promote longevity, independence, dignity, and choice for older District residents (age 60 and older), people with disabilities (ages 18 and older) and their caregivers. DCOA also administers the Older Americans Act core services from Title II ($6.8 million in FY 2017) that administers supportive, nutrition, health, caregiver and elder rights services through the Senior Services Network comprised of 22 community-based organizations and 40 programs.

According to DCOA' 2019-2022 Plan for Aging, there are 113,644 Washingtonians older than 60 years of age. This cadre currently represents 16.5% of the District's population, a 12.7% increase since 2010. Individuals between the age of 65 to 74 years have the highest growth share in the District this decade and are expected to grow in number. More than half of the District's seniors live alone, which makes elder-care even more important to combat the social isolation that makes these senior Washingtonians vulnerable. [10]

The Office on Aging is the District of Columbia's Agency on Aging that oversees direct services to persons 60 and older through a Senior Service Network. Within the Senior Service Network are eight community-based agencies, funded by the Office on Aging, to provide health, education and social services.

[8] U.S. Government Accountability Office, Retirement Security, Most Households Approaching Retirement Have Low Savings, May 2015, https://www.gao.gov/assets/680/670153.pdf

[9] American Equity Investment Life Insurance Company, analysis of 2016 Economic Policy Institute data (https://www.epi.org/publication/retirement-in-america/#chart1), Tipping the Scales on Retirement Savings, https://www.american-equity.com/resources/blog/a-closer-look-at-the-average-retirement-savings-by-age

[10] District of Columbia, State Plan on Aging, 2019-2022, https://dcoa.dc.gov/sites/default/files/dc/sites/dcoa/publication/attachments/DCOA%20State%20Plan%20on%20Aging%20FY2019-FY2022_FINAL_7.18.18%20Reduced.pdf

Washingtonians are required to become registered DCOA participants through the Senior Service Network Lead Agency in their Ward. The Office on Aging operates the ADRC Information and Assistance Unit and the DC Aging and Disability Resource Center, a one-stop resource for long-term care information, benefits and assistance for residents age 60 and older and people with disabilities age 18 and older. Additional services provided through the community agencies include Adult Day Care, Adult Education, Emergency Shelter, Health Insurance Counseling, In-Home Relief, Legal Services, and Transportation.[11]

The DC Office on Aging offers DC residents (ages 60 and older) homemaker services, including personal care, light housekeeping, laundry, meal preparation, shopping, and other in-home services for frail seniors. Social workers or nurses conduct assessments and provide case management services to the senior, and the certified home health aides provide the service.[12]

[11] DC.gov, Office on Aging, Our Senior Service Network, https://dcoa.dc.gov/service/our-senior-service-network

[12] DC.gov, Office on Aging, Personal Care and Home Health Services, https://dcoa.dc.gov/book/how-should-you-or-your-loved-one-be-cared/personal-care-and-home-health-services

Child-Care.

Today, only 8% of childcare arrangements are in a caregiver's own home. This percentage could be expanded significantly and safely if managed by a Direct-Care Center.

Single Mom Households, Race & Income By Ward

Source: Census Bureau, Statistical Atlas

	District of Columbia Wards							
	1	2	3	4	5	6	7	8
Single Mom Households (with children under 18)	33.3%	12.0%	12.9%	24.5%	**68.6%**	29.8%	**68.6%**	**70.2%**
African American Population (% of total)	30.1%	8.8%	7.0%	55.3%	**68.0%**	34.1%	**93.8%**	**90.9%**
Median Household Income (000s)	$87.6	$101.3	$116.3	$76.4	**$60.8**	$97.8	**$38.6**	**$31.1**

Affordable childcare is a significant issue for predominantly African American female-headed households in the District of Columbia, especially in Wards 5, 7 and 8 that have a vast majority (70%) of single mother headed households with children under the age of 18. Despite working multiple jobs, most African American female-headed households are living in or near poverty levels.

The District of Columbia Department of Human Services (DHS) operates a federally-funded child care assistance program that helps eligible families pay for child care. It assists with payment for child care on a sliding fee basis. Child-care options include Center-Based Providers, Family Home Providers, Relative Care Providers (selected by the parent or guardian to provide care in the child's home), In-Home Providers (care provider selected by the parent or guardian to provide care in the child's home), Head Start Programs (care for children 3-5) and Pre-Kindergarten Programs.[13]

For most single mom households in Wards 5, 7 and 8, Center-Based Providers are not an affordable option. According to Child Care Aware of America, center-based care for a single child in the District can cost upwards of $23,000 a year, which is one of the most exorbitant amounts in the United States. In neighboring Virginia and Maryland, center-based childcare costs average $13,000 to $15,000 a year.[14] In Wards 8, 7 and 5, $23,000 equates to 74%, 60% and 38% of median household incomes. Consequently, in-home childcare appears to be the only viable option for financially-distressed households.

[13] DC.gov, Department of Human Services, Child Care Options, https://dhs.dc.gov/node/127952

[14] Dcist, Child Care Costs In D.C. Are Sky High. Here's What D.C. Lawmakers Are Trying To Do About it, 8 August 2018, http://dcist.com/2018/08/post_111.php

Federal, State and Local Government Funding For Direct-Care Services.

Today, the government is responsible for funding most direct-care services.

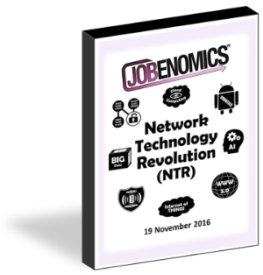
The U.S. federal government funds 126 separate programs targeted at low-income people. U.S. welfare and social program expenditures consume about 63% of mandatory spending of the U.S. federal budget. Four federal funded health insurance programs and safety net programs equate to approximately $2.2 trillion per year. These four federally funded health insurance programs include Medicare, Medicaid, Children's Health Insurance Program, and Affordable Care Act at the cost of $1 trillion or 26% of the federal budget. $400 billion worth of federal safety net programs consumes about 9% of the federal budget.[15]

According to the most recent survey by the National Association of State Budget Officers, the 50 states and the District of Columbia spent $1.2 trillion in state revenues in FY16. Of this amount, welfare and social assistance programs consume approximately $400 billion of state, county and municipal government revenues. $200 billion of state funding is for health insurance for low-income families through Medicaid and the Children's Health Insurance Program. These programs provide health coverage or long-term care to roughly 74 million low-income children, parents, the elderly and people with disabilities. In FY18, the District of Columbia's budget allocated $2 billion through the Departments of Human Support Services, which equates to 23% of the District's $8.8 billion General Operating Funds.

[15] Center on Budget and Policy Priorities, Policy Basics: Where Do Our State Tax Dollars Go?, 25 July 2018, https://www.cbpp.org/research/state-budget-and-tax/policy-basics-where-do-our-state-tax-dollars-go

Network Technology Revolution, Digital Economy, and On-Demand Direct-Care Services.

Network Technology Revolution.



Jobenomics defines the Network Technology Revolution (NTR) as the "perfect storm" of next-generation network and digital technologies that will (1) transform economies, (2) revamp existing institutions, businesses, labor forces, and governments, (3) institute new and different ideas, beliefs, behaviors and cultures, and (4) change the very nature of human endeavor and work.

The nascent NTR already has been brilliantly innovative and creatively disruptive to healthcare, social assistance, behavioral-care, elder-care, and child-care practitioners. The NTR will continue to revolutionize these fields of endeavor. The following list of over three dozen revolutionary network and digital technologies enable direct-care operations.

The NTR is characterized by a "perfect storm" of highly advanced technologies, systems, processes and services including **big data** (datasets that are too large to efficiently handle), **cloud computing** (practice of using a network of remote servers hosted in data centers to store, manage, and process big data), **semantic webs** (thinking websites), **synthetic reality** (blending of the virtual and natural worlds), **mobile computing** (proliferation of smart mobile devices and micro-devices), **ubiquitous computing** (embedding microprocessors in everyday objects to communicate without human interaction), **quantum computing** (harnessing the power of atoms and molecules to perform memory and processing tasks), **5G broadband networks** (50-fold speed increases and 1000-fold data volume improvements), **geo-location** (the process of determining the location of an entity by means of digital information processed via the Internet), **near-field communications** and **beacons** (short-range wireless technology that connects devices), **inductive charging** (electromagnetic wireless charging of devices, micro-devices and nano-devices), **spatial sensing** (real-time detection, measuring, mapping and analysis of objects in relationship to the environment), **computer vision** and **pattern recognition** (training computers to gain high levels of understanding from digital images and videos and recognizing patterns and regularities in the data), **natural language processing** and **speech recognition** (the ability of a computer program, machine or intelligent agent to understand and respond to human speech), **data mining** and **predictive analysis** (using advanced algorithms to analyze large databases to make predictions about unknown future events), **machine learning** (systems that can learn and teach each other), **transfer learning** (machine "reasoning" that takes lessons learned from past human experiences and applies it digital domains), **deep learning** (an artificial intelligence technique allowing machines to extract patterns from big data in the same manner that the human brain does), **robotics** (automated machines capable of movement), **telepresence** and **telechirs** (operating machines remotely to sense and create an effect or control), **cobotics** (collaborative robots working in direct interaction with humans, a "centaur"), **nanobotics** (also called nanomachines, nanoids, nanites and nanomites are microscopic self-propelled machines with a degree of autonomy and reproductive capability at the molecular level), **chatbots** (web robots that run automated tasks or simulate conversations with users), **mechatronics** (technology combining electronics and mechanical engineering), **memetics** (machines that can create memes to mimic cultural traits and ideas), **biometrics** (agents that can identify and track biological traits), **smart cards** (credit card-like devices that can send and store personal and identifying material), **blockchains** (distributed digital

economy public ledgers), **fintech** (financial technology oriented to transforming incumbent financial institutions and corporations), **multifactor credentialing** (automated authentication and identification of crowds, individuals and intelligent agents), **emotive surveillance** and **management** (systems that analyze and manage emotions), **identity management** (controlling user access and restoring damaged online identities), **anonymity networks** (networks that enable users to block or trace data and identities), **ambient intelligence** (when formerly dumb or mute objects are given the ability to communicate), **artificial intelligence** (or AI, intelligent algorithms and agents that will augment human interactions), and **intelligence agents** (AI agents that replace or supersede the need for human intervention and actions).

Digital Economy.

The digital economy (also known as the web economy, internet economy, network-centric economy, or the new economy) is an economy that based on digital and networked technologies, which is increasingly intertwining and preempting today's traditional economy. In addition to NTR technologies, processes, and systems, the digital economy consists of various components including government (policy and regulation), infrastructure (internet, networks, telecom, and electricity), and providers (digital service, content, information and knowledge workers).

The Digital Economy is an economy based on digital and networked technologies, which is increasingly intertwining and preempting today's traditional economy. The **E/M Economy** consists of electronic and mobile commerce that is transforming economies, government, business and cultures via emerging network and digital technologies, systems, processes and services. The **Sharing Economy** is a new wave of peer-to-peer access-driven businesses that are characterized by the ability of individuals to rent or borrow goods rather than buy and own them or to quickly fulfill consumer demand via the immediate provisioning of goods and services. The **On-Demand Economy** is a business model where consumer demand is satisfied by near real-time provisioning of goods and services. The **App/Bot/AI Economy** refers to the range of economic activity surrounding intelligent web-based applications. Apps (applications) are the digital interface through which we live, work and play and the primary way we engage with media, brands and ultimately with each other. A bot, also known as a web robot, an internet chatbot or simply bot, is an interactive, artificial intelligence-driven software application that runs automated tasks or simulates a conversation to deliver text-, voice- or video-based information to a user via a networked device. Artificial intelligence (AI) is the intelligence exhibited by machines or software that can do things normally done by people. The **Platform Economy** encompasses NTR-enabled social, business and government activities. A platform (network) business model creates value by facilitating exchanges between two or more interdependent groups, usually consumers and producers. Retail (pipe model) stores are giving way to e-retailing (platform model). For example, Healthcare is now emphasizing outpatient and telemedicine (platform) services in addition to inpatient (pipe) care. A **Gig/Contingent Workforce Economy** is an environment in which temporary positions are common and organizations contract with independent workers for short-term engagements. A **Data-Driven Economy** involves accessing and exploiting information and knowledge contained in big-data pools to maximize operational efficiencies and reduce costs. The **Internet of Everything Economy** brings together people, process, data, and things to make networked connections more relevant and valuable than ever before—turning information into actions that create new capabilities, richer experiences, and unprecedented economic opportunity for nations, businesses and individuals.

The On-Demand Economy is a business model where consumer demand is satisfied by near real-time provisioning of goods and services built on top of a technology infrastructure that brings the online and offline world together either instantaneously or scheduled. The rise of the on-demand economy is changing consumer habits, supply chains, regulations, competition, and investment. The most popular forms of on-demand are ground transportation, **healthcare**, retail/shopping, business-to-business (B2B), and food/grocery delivery service. Home, lodging, parking, health and beauty, logistics and financial services are also on the rise.

On-Demand Direct-Care Services.

Traditional healthcare businesses are grappling with how to respond to shifting consumer expectations and searching for ways to improve their supply chains to deliver goods and services more quickly. Consumer demand for personalized time-saving service and innovations in digital app-based matching technologies enable the rise in direct-care services and are shifting power away from centralized inpatient and outpatient providers to consumers.

The on-demand economy's growth is nothing short of phenomenal. Quoting SAGE (a business research firm) statistics,

- More than 280 companies now provide on-demand goods and services across 16 industries, up from 76 companies in six industries offering such services in 2014.
- More than 22 million Americans are spending nearly $58 billion per year in the on-demand economy. 46% of on-demand consumers have an annual household income below $50,000.
- An estimated one-third of the American workforce is engaged in contract or on-demand work.
- Fueling the growth of the on-demand market is e-commerce, which also is expanding. By 2020, global e-commerce spending will total $4 trillion, or 14.6 percent of all consumer spending, up from an estimated $2 trillion in 2016.
- By the end of 2017, more than 2 billion people worldwide were using their mobile devices to make a purchase.
- In the United States, approximately 27 percent of all dollars spent in retail e-commerce transactions will be via mobile devices by the end of 2018.

The healthcare services industry is a multi-trillion dollar industry. Sadly, this industry is replete with inefficiencies (poor referrals, referral leakage, medical errors, missed appointments, no-shows, long waiting times, antiquated processing systems, etc.). Accordingly, the healthcare organizations are turning to telemedicine and telehealth technology to improve delivery of services and access to specialized care in-home or remotely. On-demand healthcare apps are reinventing the way patients interact with doctors as well as delivering medicines to a patient's doorstep.

According to the American Telemedicine Association, there are currently about 200 telemedicine and telehealth networks in the United States, with 3,500 service sites. Over half of all U.S. hospitals now use some form of telemedicine. Medicare, Medicaid, and most private sector insurance plans cover approved services, and medical conditions. Common examples of telemedicine services include primary care and specialist referral services, remote patient monitoring, consumer medical and health information and medical education.[16]

[16] American Telemedicine Association, About Telemedicine, http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-faqs

Here are a few of the on-demand business leaders involved with direct-care services:

- **Teladoc** is the nation's largest telehealth platform with 20 million members and over 3,000 licensed healthcare professionals, resolves medical issues between patients and physicians via phone or video consults. Teladoc specializes in general health, specialist services, therapy, dermatology, sexual health, and behavioral health.[17]

- **DoctorOnDemand** connects patients in minutes to board-certified doctors and therapists over live video, and have prescriptions sent directly to pharmacies. Via a smartphone, tablet or computer, a healthcare practitioner can access a patient's medical history, diagnose symptoms, perform a virtual exam and recommend treatment including prescriptions and lab work. According to DoctorOnDemand, 90% of common medical and mental health treatments can be accomplished remotely at a price less than urgent care and in-pharmacy clinics.[18]

- **Go2Nurse** is an on-demand nurse/caretaker application service that includes traditional nursing and caretaker services, at-home pregnancy care, help with newborns, eldercare and specialized care for dementia, Alzheimer's and Parkinson's patients.

- **referralMD**'s cloud-based web app aims to standardize referral network communication between primary care physicians and specialists. Capable of integrating across EMR platforms, the app provides real-time status updates, business intelligence, and performance measurements to complete referral exchanges quickly and efficiently.

- **American Well** offers software, services, and access to clinical services – a complete telehealth service for healthcare companies, employers, or a delivery network. American Well's mobile and web service connects doctors with patients for live, on-demand video visits over the internet and handles all the administration, security, and record keeping that modern healthcare requires.[19]

- **MDLive**'s has more than two million people in all 50 states who take advantage of virtual care anywhere. MDLive's telemedicine system offers a patient experience, a provider experience, and a call center. A patient can come in through the mobile app, through a website or the call center. MDLive's provider network is the nation's largest and is comprised of physicians who are Board Certified in Internal Medicine, Family Practice, Emergency Medicine and Pediatrics; as well as trained, licensed mental health professionals providing counseling and behavioral health services.[20]

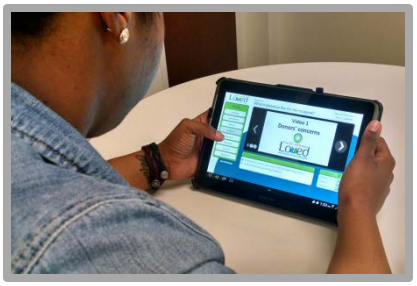
- **SnapMD** positions its virtual care management system as a complete true point-of-care solution with a patient interface, a provider interface and an administrative back-end that enables the healthcare staff to operate the platform and their telehealth program.[21]

While these mobile apps are technologically revolutionary, they lack the critical human element—the "foot soldier." Regardless of how brilliantly led or technologically equipped, most Army's need foot

[17] Teladoc, https://www.teladoc.com/
[18] DoctorOnDemand, https://www.doctorondemand.com/
[19] American Well, https://www.americanwell.com/avizia-acquisition/
[20] MDLive, https://www.mdlive.com/
[21] SnapMD, https://snap.md/technology/

soldiers to ultimately win battles and secure victories. Medical, healthcare and social assistance industries are no different.

Because of this limitation, the Jobenomics Washington DC Direct-Care Initiative will mass-produce direct-care foot soldiers "enlisted" mainly from the ranks of "empty nester" female head of households who have proven maternal caregiving aptitudes and skills. Equipped with mHealth (mobile health) and eHealth (electronic health practices supported by electronic practices and communications) and other task-related technology (shown), these foot soldiers can be at the "front line" delivering on-demand triage and services while tethered to more experienced practitioners located at inpatient centers.



mHealth and eHealth technology effectively streamlines communication between patients, direct-caregivers and their direct care center to medical/health/wellness/assistance professionals. One of the most important direct-caregiver roles is to educate, equip, coach and monitor home-bound patients with personalized 24/7 mHealth management systems and preventative healthcare services.

Coaching and monitoring are paramount to successful caregiving. Given the plethora of health and wellness apps (40,000+) on the market, direct-care patients need supervision and advice. Since many of these apps could have serious consequences on patient health, Jobenomics direct-caregivers will be instructed and issued by the Jobenomics Direct-Care Center FDA-approved applications that interface with medical/health/wellness/assistance professionals and institutions.

Automation is slowly supplanting cognitive work giving rise to "centaurs" (a combination of human operators, and intelligent agents and smart machines). Healthcare and social assistance industries are integrating smart machines (that communicate with humans) and intelligence agents (that learn human behavior) at greater and greater rates. Today, these automated machines/agents need human support to perform most tasks. However, they can perform enough complex tasks to support direct-care givers and patients alike.

New AI (artificial intelligence) powered chatbot apps are making huge inroads in remote patient preliminary diagnosis and care, thereby reducing unnecessary doctor visits. A chatbot (also known as a chat robot, smart bots, talkbot, chatterbot, interactive agent, conversational interface or artificial conversational entity) is a computer program or an artificial intelligence which conducts a conversation via auditory or textual methods. Siri, Alexa, and Google Assistant are examples of primitive chatbots.

According to the Massachusetts Institute of Technology, Babylon Health, a London-based digital-first healthcare provider, is shifting the front line of healthcare from inpatient centers to the point-of-need. By using accessible and affordable chatbots, unnecessary patient visits to doctors and hospitals have been cut in half. While other organizations (Ada, Your.ME and Dr. AI) have similar technology, Babylon Health is the forerunner because it is the only system integrated into a national healthcare system (the U.K's National Health Service). Around 40,000 Britons downloaded and are using Babylon's healthcare app. In 2017, 40% of the Britons who used the app elected self-treatment rather than seeking an

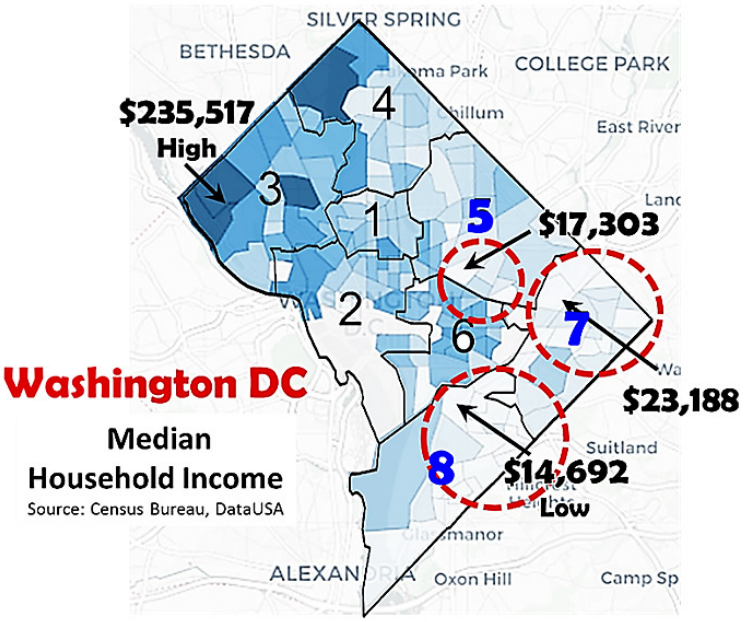
appointment with a doctor. Babylon has also co-launched the U.K.'s first digital doctor's practice called GP at Hand that allows patients to chat with the chatbot or talk with a real doctor via a video link.[22]

While it is too early to assess what types of mHealth and eHealth technologies that will be used by the Jobenomics Washington DC Direct-Care Initiative, it is safe to assume that District of Columbia could be America's direct-care leader. Since digital technology is not constrained geographically, Wards 8, 7 and 5 would not only benefit from better healthcare but also by having thousands of self-new employed direct-care givers that could apply their newfound skills across the Washington DC metropolitan area.

[22] Massachusetts Institute of Technology, MIT Technology Review, The precision medical issue (November/December 2018),Dr. Bot will see you now.

Jobenomics Washington DC Initiative.

Jobenomics Washington DC Focus Areas



Goal is to reduce income inequality increase income opportunity.

The Jobenomics Washington DC Initiative focuses on the creation of largely home-based, startup businesses, located in the most impoverished neighborhoods in Washington DC in Wards 8, 7 and 5.

Wide Disparity Between WDC Wards

Source: Census Bureau, ACS 2016 5-Year Data

	Richest ← WARDS → Poorest							
	3	2	6	1	4	5	7	8
Per Capita Income (000s)	$85	$70	$60	$52	$46	$34	$23	$19
Minority Race & Ethnicity	27%	33%	47%	56%	78%	81%	98%	95%
Owner-Occupied Housing Units	53%	35%	40%	35%	59%	47%	36%	20%
Median Home Value (000s)	$835	$635	$607	$584	$531	$414	$247	$239
Female Householder	5%	4%	16%	16%	23%	30%	48%	55%
Bachelor's Degree Or Higher	86%	84%	71%	67%	48%	42%	17%	15%
Married	43%	26%	32%	27%	40%	28%	23%	22%
Children Under Povery Line	3%	5%	18%	25%	13%	18%	41%	49%

Jobenomics' economic, community, business and workforce development programs emphasize marginalized neighborhoods.

There are wide economic and social disparities between the District's Wards. In Ward 3, the median per capita income is $83,300 with the most influential neighborhoods median household income reaching as high as $235,517 as shown on the earlier chart. In Ward 8, median per capita income is $18,787 with

the least influential neighborhoods median household income is as low as $14,692. As shown, statistics for race, housing, households, education, marital status and child poverty are equally disparate.

Jobenomics Washington DC Initiative is more about future income opportunity than past income inequality. Income inequality represents a rearward view on how much money a person possesses at a given time. Income opportunity represents a forward view of wealth potential and upward social mobility. Jobenomics recognizes income inequality as a starting point, but focuses on income opportunity, via business and job creation, especially at the base of America's economic pyramid. The term *opportunity* implies favorable conditions or prospects to attain advancement or success. Today, many financially-distressed and marginalized communities no longer believe in the American dream of upward mobility, fairness, and optimism. Sadly, in the third wealthiest American metropolitan area, the American dream is languishing east of the Anacostia River.

Income opportunity and socio-economic mobility are closely associated. Socio-economic mobility is the movement of an individual or group from one income level to another and can be upward or downward. With a few exceptions, mass upward socio-economic mobility has been the general trend since the creation of the United States. Most people who enter the US workforce from high school or college move from initial lower paying jobs to higher paying careers. Those who drop out of school or society are likely to entrench themselves in the lowest income quintile with much lower mobility. While welfare and unemployment payments provide a safety net for those in the lowest quintile, these payments tend to trap these same individuals in low quintiles by eroding their socio-economic mobility. The longer a person is out of the workforce, the harder it is for that person to get a meaningful job.

Jobenomics WDC Initiative Job Creation Goal

JWDC Business Initiative	Jobs	2-years	5-years
Community-Based Business Generator,	Direct	100	300
Digital Academies & Entrepreneur Clubs	Indirect	100	300
Urban Agriculture	Direct	50	250
(Indoor Hydroponics Aquaponics)	Indirect	150	750
Urban Mining	Direct	25	200
(eCycling)	Indirect	75	600
Renewable Energy	Direct	100	300
(Solar Installation/Maintenance)	Indirect	100	300
Direct Care	Direct	300	750
(Health, Elder, Child, Behavioral)	Indirect	300	750
Digital Economy	Direct	300	750
(eCommerce, eSports, Apps)	Indirect	300	750
	Direct	875	2,550
	Indirect	1,025	3,450
	Total	**1,900**	**6,000**

Goal: 6,000 new jobs within 5-years by mass-producing local startup businesses that are anchored in Wards 8, 7 and 5.

Jobenomics Washington DC Initiative's goal is to produce 6,000 new jobs within 5-years by mass-producing local startup businesses anchored in Wards 8, 7 and 5. This goal is very achievable.

Is 6,000 New Jobs Achievable?

Source: Census Bureau, Statistical Altas	Working Employed	Non-Working Capable	
		Unemployed	Not-in-Labor-Force
Ward 8	26,300	7,385	25,500
Ward 7	28,200	6,337	25,100
Ward 5	40,500	5,279	25,600
	95,000 Total Employed	**95,201** Total Available Labor Pool	

Jobenomics WDC Goal: 6,000 New Jobs Within 5-Years

101,000	**89,201**
Increase 6% ←	**Decrease 6%**

Jobenomics WDC would have to decrease unemployed and sidelined workers by only 6% which is very achievable.

Wards 8, 7 and 5 employ 95,000 Washingtonians. Conversely, 95,200 denizens (inhabitants or residents) are either unemployed or sidelined citizens who are capable of working. Moreover, the District of Columbia employs 794,900 people, but only 386,100 (49%) live in the District.

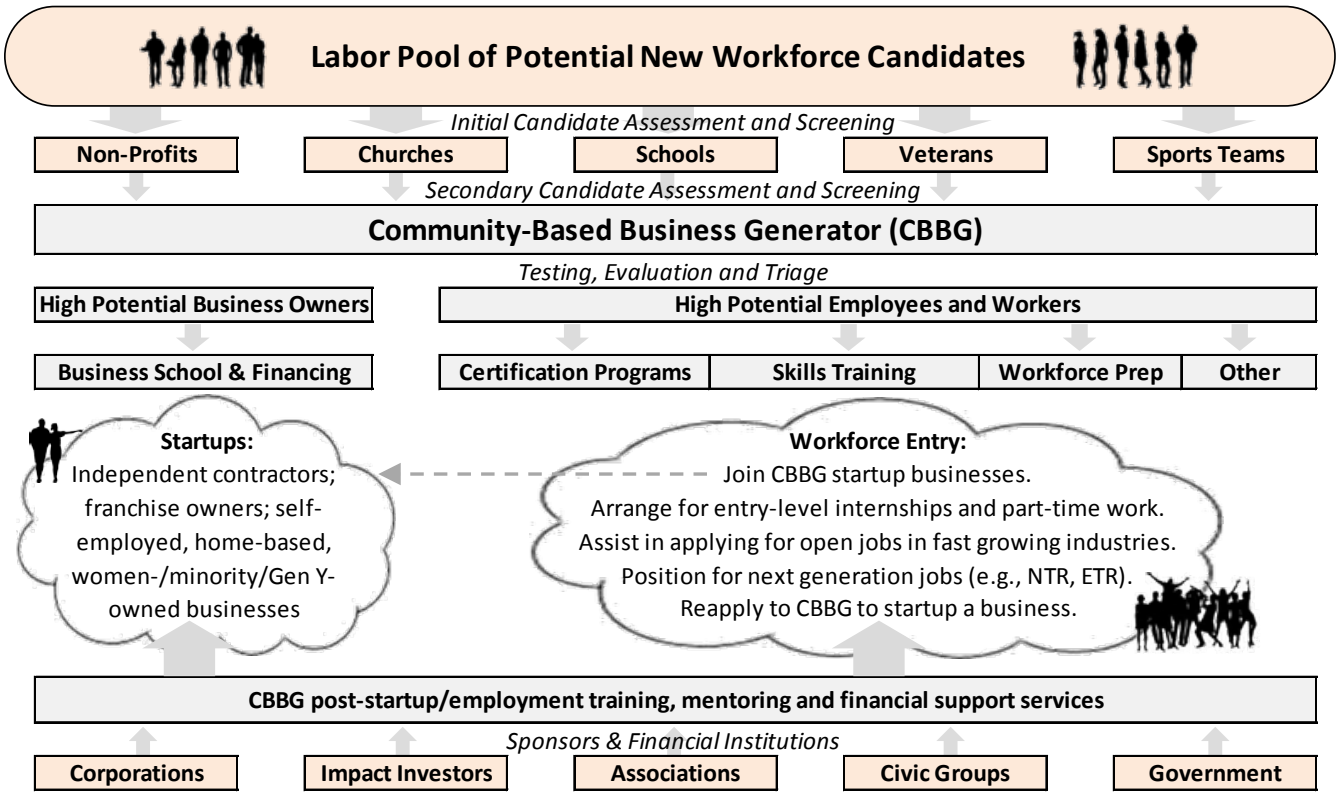
To create 6,000 new jobs, the Jobenomics Washington DC Direct-Care Initiative only needs to move 6% of the capable non-working Ward 8, 7 and 5 denizens into the labor force, or entice 1.5% of the 408,800 people, who work in the District but live elsewhere, to relocate to Wards 8, 7 and 5.

Jobenomics Community-Based Business Generator Concept.

The way that the District of Columbia can plan, manage and support small business and job creation is via community-based business incubators, business accelerators, and business generators.

Business incubators tend to focus on high-tech, silver bullet innovations that have extraordinary growth and employment potential. Business accelerators focus on expanding existing businesses to make them larger and more profitable. The Jobenomics business generator concept involves mass-producing small and self-employed business with an emphasis on lower-tech but plentiful service-providing businesses at the base of America's economic pyramid.

Jobenomics Community-Based Business Generator Concept



Jobenomics Community-Based Business Generators mass-produce startup businesses by:

(1) Working with community leaders to identify high-potential business owners and employees,

(2) Executing a due diligence process to identify potential high-quality business leaders and employees

(3) Training and certifying these leaders and employees in targeted occupations

(4) Creating highly repeatable and highly scalable "turn-key" small and self-employed businesses,

(5) Establishing sources of startup funding, recurring funding and contracts to provide a consistent source of revenue for new businesses after incorporation, and

(6) Providing mentoring and back-office support services to extend the lifespan and profitability of businesses created by the Jobenomics community-based business generators.

The process starts by using community leaders to identify high potential job seekers. Churches, non-profit institutions, schools, sports teams, and veterans groups are a great source for identifying talent, desire, and fortitude. These organizations provide the first phase of the triage process by screening and assessing high-performance people who are known to them. The second stage occurs during onboarding that involves Jobenomics screening and assessing. The third stage uses aptitude and personality tests to determine potential career paths.

Once completed, Jobenomics separates candidates into a business leader group and a high potential employee group for training. The leader group will undergo management and startup business training. The employee group will undergo skills training based on the role that they will assume in the startup business (operational, technical, mechanical, financial, marketing, administrative, etc.). After the training is completed and certifications awarded, the team will commence startup operations under the guidance and assistance of the Jobenomics Community-Based Business Generator team. Jobenomics contends that Community-Based Business Generators could vastly improve the rate of startups and expanding businesses, and reduce the rate of contracting and closing businesses.

Jobenomics Community-Based Business Generator Process

Starting with a pool of tens of thousands of candidates, Jobenomics will work with local civic organizations (churches, non-profits, sports teams, etc.) to identify and nominate the top 30% to 50%, who they know, for the Business Generator program. This stage of the due diligence process provides an initial assessment of individuals.

These nominees undergo standard aptitude and personality tests to identify:

- Those that prefer other educational (GED and postsecondary) or training (vocational) centers for career development,
- Those that are qualified and suitable for immediate employment with existing companies, and
- Those that desire and have an aptitude for starting a small or self-employed business. Jobenomics Community-Based Business Generator will help all people who enter the program to find meaningful employment and career paths.

Jobenomics envisions that 25% of the nominees would seek a traditional education and training path, 25% would be hired directly by existing business who are looking for quality workers, and 50% would seek a more independent and self-sufficient route offered by a small business startup or self-employment.

Of the 50% that choose Business Generator training and certification process, Jobenomics anticipates that approximately 25% will eventually implement a small business startup or incorporate as a self-employed business. The 75% that undergoes but does complete Jobenomics Community-Based Business Generator process will be certified (with empirical data by professional testing and evaluation) as high-quality candidates for immediate employment or traditional education/vocational training.

Many of the initial candidates are likely to prefer working for existing companies rather than going through the Jobenomics process. Anticipating this, Jobenomics will implement a "pipeline" to connect these individuals who have undergone some level of due diligence to companies that are hiring. Consequently, the Jobenomics management team includes a nationally recognized leader who developed such a pipeline system that has matched 250,000 veterans with companies. This system is ideally suited for matching Jobenomics candidates to local employment vacancies.

The overall objective is to mass-produce small and self-employed businesses, which makes the Jobenomics Community-Based Business Generator process unique as a traditional business and workforce development center. Traditional workforce development processes focus on preparing potential workers for employment by existing businesses—usually large corporations. For individuals at the base of the American economic pyramid (especially those in depressed urban and rural areas), the odds of employment at existing businesses are slim as evidenced by the long lines at traditional job fairs versus the low percentage of people hired.

The Jobenomics process focuses on preparing workers for starting a business, whether they start one or use the experience to be more competitive to get a job. In today's world, gainful employment is difficult and oriented to those that are currently employed, credentialed or high-skilled. Conversely, a common complaint that Jobenomics often hears from companies is that they have a very hard time (1) finding good people who want to work, (2) who have the right attitudes and aptitude for work, and (3) who have workforce credentials, experience or related skills.

Every nominee that enters the Jobenomics process will establish a self-employed business, which can be incorporated in a matter of days, and undergo elementary business training. The reason for setting up a small business is to make them more competitive in today's job market. Many employers prefer to "try

before they buy." An incorporated self-employed individual can position themselves for contract work (1099) as a prelude to standard full-time work (W2).

Even if a self-employed individual never receives an income as a self-employed business, that individual can present themselves with credentials (Employer ID Number, website, business card, and skills resume) that align with the business community. Also, Jobenomics will provide additional credentials regarding the individual's workforce aptitude, skills, and suitability tailored to the specific hiring opportunity. Jobenomics credentialing, along with letters of recommendation from the nominees' sponsoring organization, will greatly distinguish the individual from the masses of unemployed or new or returning workforce entrants.

Jobenomics Washington DC Direct-Care Initiative.

Proposed Jobenomics Washington DC Direct-Care Program

- **Direct-Care Services** include:
  - **Healthcare** and **social assistance**, the fastest growing occupations in the USA.
  - **Behavioral-care** includes drug addition, PTSD, obesity, spousal abuse, chronic illness, etc.
  - **Elder-care** forecasts 17 million assisted-living bed shortfall by 2020.
  - **Child-care** is the single biggest cost keeping women homebound.

- **Direct-Care Center** would connect service providers and clients via a **call and information center**. The center would start **home-based firms** certified to provide **in-home services** while connected to tele-health and other providers.

The **Jobenomics Direct-Care Initiative** involves direct-care services by mainly home-based small and self-employed businesses via a community-based direct-care center. Direct-care occupations are projected to increase by many millions of new jobs, due to the need for cost-effective healthcare, social assistance, behavioral-care, elder-care, and child-care services, and the inability of traditional institutions (like hospitals and community care facilities) to service ever-growing medical, health and societal needs of American's urban and rural poor. Due to rapid advances in online technologies and the high cost of institutionalized care, medical, health and social assistance industries are evolving from centralized inpatient care, to outpatient (ambulatory) care, to delivering on-demand care services directly to the point-of-need (the central focus of the Jobenomics Direct-Care Initiative).

Enabled by technology and driven by economics, on-demand direct-care to local denizens (inhabitants, residents) is rapidly augmenting outpatient and inpatient services. The **Jobenomics Washington DC Direct-Care Initiative** will provide direct-care to Washingtonians starting with financially-distressed neighborhoods in Wards 5, 7 and 8. A Direct-Care Center will train, certify, manage, provide, monitor and mass-produce direct-care startup businesses that are linked via modern telehealth networks to more experienced practitioners in outpatient and inpatient centers. In addition to mass-producing direct-care startup businesses and jobs, a Direct-Care Center would also provide education, training, certification, quality control, ICT (information and communication technologies) and EMT (emergency medical technician) related services for the community.

The Jobenomics Washington DC Direct-Care Initiative is part of a larger Jobenomics Washington DC Initiative that features five additional business and job creation initiatives for Wards 8, 7 and 5.

JWDV Business Initiative

Direct Care
(Health, Elder, Child, Behavioral)

Jobs	2-years	5-years
Direct	300	750
Indirect	300	750
Total	**600**	**1,500**

Over the next 5-year period, Jobenomics Washington DC Direct-Care Initiative's 1,500 (750 direct jobs and 750 indirect jobs) job creation goal equates to 25% of the total job creation goal as envisioned by the overall Jobenomics Washington DC Initiative. As a point of comparison, according to a spokesman for the Washington Redskins, 10-years after approval of the new Redskins stadium in Landover, only 100 full-time direct and 3,500 indirect game day only jobs were created.[23]

A number of factors are expected to lead to job growth in direct-care technology development as well as direct-care business and job creation: (1) growing population, (2) longer life expectancy, (3) chronic and age-related disease growth, (4) improved service-providing technology and (5) increasingly generous healthcare, social assistance and welfare programs.

Examples of the types of direct-care service businesses that would be created include (from lower skilled jobs to higher skilled occupations): visiting, cleaning/janitorial, maintenance, food services (delivery, cooking), shopping, transportation, counseling, paralegal, med-techs, physical therapy, social and wellness assistance, nursing, and au pairs services and other various in-home and remote services.

The Jobenomics Washington DC Direct-Care Initiative includes the creation of one or more Ward-based Direct-Care Centers. These centers would provide in-home services from local small, micro and self-employed businesses managed by community-based direct-care centers equipped with the latest information systems connected to a network replete with remote sensing, telehealth, real-time teleconferencing, and mobile phone direct-care apps.

In addition to training and certifying basic caregiving skills, a Direct-Care Center would provide proper regulatory oversight and quality control. The Direct-Care Center would also work with larger established businesses that provide services higher up the skills chain. Small and self-employed businesses can provide basic services at a lower cost than larger businesses, which is extremely important to denizens who cannot afford the price of current caregiving services. The principal role for government agencies in the District of Columbia would be to provide proper oversight of the Direct Care Centers; quality control of the center's practitioners; fast-track policies, regulations and licensing arrangements conducive to direct-home care; and help the Center's management team pursue funding from various federal, state, local and private sector partnerships.

Mass-producing self-employed, home-based childcare businesses that are safely managed could have a significant impact on homebound mothers. More mothers could have home-based childcare businesses to supplement their income. More mothers could be emancipated from the home to pursue other occupational pursuits. The requisite childcare skills are natural for mothers who are or have raised families. Jobenomics believes that mothers should be afforded the opportunity to monetize these skills.

[23] Washington Post, 10 Years Later, FedEx Field Is Still Receiving Mixed Reviews, 25 December 2006, http://www.washingtonpost.com/wp-dyn/content/article/2006/12/24/AR2006122400749.html

There is no shortage of female talent in Wards 8, 7 and 5 that would be interested in starting a self-employed home-based business to provide in-home or remote direct-care services to those in need. As stated earlier, approximately 70% of households with children under 18 in Wards 8, 7 and 5 are headed by single mothers or grandmothers. Most of these women have demonstrated that they possess the household management and care-giving skills appropriate to this Direct-Care Initiative.

Female Workforce in Wards 8, 7 & 5

Source: Census Bureau, Statistical Altas

	Working Employed	Non-Working Capable	
		Unemployed	Not-in-Labor-Force
Ward 8 Female	15,400	3,926	15,300
Ward 7 Female	16,200	3,682	12,700
Ward 5 Female	21,300	2,376	14,500
Female	**52,900** Employed	**52,484** Available Labor Pool	

Also, the Washingtonian female labor pool is quite large with approximately half of the female labor already working. As of July 2018, the Ward 8, 7 and 5 female workforce consists of 52,290 employed women and 52,484 women who are currently looking for work (unemployed) or capable of working (sidelined in the Not-in-Labor-Force category). Many of these employed and unemployed women are serving in lower-level or menial jobs and would relish the opportunity to change their career paths or to start their own business. The prospect of direct-care jobs or business ownership also would be a powerful inducement for women who are currently unemployed, underemployed or sidelined.

Micro and self-employed businesses are ideally suited to provide direct-care, either on a full-time or part-time basis. These businesses are relatively easy to start. James McQuivey, a leading analyst tracking the development of the digital disruption, states that digital startups are at least 100-times easier to create and have 10-times the number of innovators that can innovate at one-tenth the cost than traditional startups. Micro and self-employed businesses are ideally suited for direct-care occupations, either on full-time or part-time basis. These businesses are easy to start and are the types of business that will provide opportunities for job seekers with personal care skills, especially those with maternal skills.

In the absence of workfare, discouraged workers will seek welfare, especially if it provides generous benefits with few strings attached. However, work of any kind makes a huge difference alleviating poverty and promoting self-sufficiency. According to the Census Bureau, in 2016, only 2.2% of U.S. full-time workers are below the poverty level. Even part-time work makes a significant difference. Only 13.0% of part-time workers are below the poverty level, compared with 21.6% of work capable adults who did not work during the year.[24]

[24] U.S. Census Bureau, Historical Poverty Tables—People, Table 25, Work Experience and Poverty Status for People 16 Years Old and Over: 1987 to 2016, http://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html

While there is no evidence that people on welfare are immune to work, there is evidence that many recipients often lack the skills necessary to obtain the types of jobs that pay above-average wages, which, in turn, makes welfare and means-adjusted social benefits attractive. To address the skills deficit conundrum, Direct-Care Centers provide federally approved skills-based training and certification programs oriented to Lifelong Applied Learning with certifications in weeks, jobs in months and careers within a year. Direct-care centers would also use principles associated with time-banking as a way to transition individuals from welfare to workfare or a system to allow welfare recipients keep benefits and use their time and talents to build caring community economies through inclusive exchanges.

Time-banking is not a new concept. TimeBanks USA is a 38-year old registered 501C3 non-profit organization headquartered in Washington DC with a network in 9 countries 34 states with over 200 active independent TimeBanks across the United States.[25]

Time banking is an opt-in system with members earning time credits by providing services such as elder care, child care, home care, and various other forms of community outreach and mentoring. Typically, time credits are created by exchanging skills for services that are recorded using time banking software. The IRS has ruled on two occasions that Time Banks are not commercial barter exchanges and create no contractual rights. The IRS has ruled that there will be no taxable consequences to volunteers who earn credits as reimbursement for services rendered.

[25] TimeBanks USA, http://timebanks.org/about/

Next Step for the Jobenomics Washington DC Direct-Care Initiative.

Local community-leaders helped Jobenomics develop the Jobenomics Washington DC Direct-Care Initiative. For this initiative to come to fruition, other leading community-leaders, non-profit and for-profit institutions, business executives, and government officials must become stakeholders that will help develop the final program document. Once a final document is completed, the stakeholder team will conduct a roadshow and town hall meetings to introduce the Jobenomics Washington DC Direct-Care Program to the general public.

This Coalition-Building, Program Development, and Business Plan Creation Phase should take three months. A detailed proposal is under development for funding of Phase I's coalition-building, program development, and business plan creation activities. This proposal will include actionable milestones and funding requirements.

The Jobenomics Washington DC Direct-Care Initiative is part of a larger Jobenomics Washington DC Initiative that features five additional business and job creation initiatives for Wards 8, 7 and 5. Consequently, community-leaders might choose to integrate the Direct-Care coalition-building effort into a wider outreach and coalition-building undertaking. Should this be the case, a Direct-Care program could be implemented separately as a forerunner effort or integrated into a more comprehensive effort with some of all proposed business and job creation programs.

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