Matthew J. O'Nesti
Finance Subcommittee on Health and Human Services Hearing
March 14, 2023

Chair Carruthers, Ranking Member Liston, and members of the Finance Subcommittee on Health and Human Services, my name is Matt O'Nesti. I have been an Ohioan living with a disability for 24 years, and have been relying on caregivers and direct support staff for about the last 15 years.

I am here today to advocate for an increase in wages for direct support staff. This increase needs to be to the livable wage of $20 an hour. This is a fair wage because these caregivers are the people who are entirely responsible for allowing us, members of the disabled community, the ability to live autonomously. To have the care which can then potentially give us the independence we need to live a life with some sense of normalcy. In order for us to even have the chance of achieving this "normalcy" we need to take action on a level that is concerned with retaining these caregivers. Because as it stands, myself, and countless others are living in a state of chaos and flux. This is not a hyperbolic statement, this is a fact. I know no other way to describe the true disarray of constant turnover in a home. To be constantly training new staff, to lose good caregivers to better paying jobs with benefits, to never be able to make plans more than a month in advance out of fear of not having the manpower to help. It's an unfair way to live in an already unfair circumstance.

I've been able to make a lot out of this unfair circumstance. I've been a comedian since I was 15 years old, I've earned a bachelor's degree from Kent State University, and I'm now fighting for my communities' ability to chase after whichever dreams they see fit to pursue. None of this is even remotely possible without having the direct support staff that I had. I would've never been able to move from Youngstown to Kent to pursue the degree of my choice without a team of direct support staff. Quite frankly, when my team of caregivers started to decrease while in college, my goal of actually graduating was put in jeopardy. I was incredibly fortunate to have online classes, and professors who understood why I sometimes would be absent from lectures. This instability was directly related to the temporary nature of being a caregiver. After graduating I moved back home to Boardman where I still live. I had aspirations to continue on my journey to further my pursuits to be a free individual. To find employment, to follow my passions as an artist and entertainer, to join my friends on those goofy little trips I'm sure all of you have had the luxury to experience where you get to see these fleeting beauties the world has to offer. Sadly, that hasn't been my reality. I don't have the support staff to pursue a 9 to 5 as video editor at a news station. I only have direct support for 2 days yet my waiver says I require 24 hour care. And although I'm incredibly fortunate to have natural supports in my life in a way others may not, my father, mother, brother…have jobs of their own. Responsibilities they need to keep up on. This leaves me stuck in limbo. To have to constantly wait as the world passes me by.

It DOES NOT have to be this way. We can make immediate change by advocating for direct care workers to be treated with the respect they deserve by giving them the compensation they are rightfully due.

This point can be understood by realizing who's wages direct support staff are competing with. Caregiver compensation needs to be increased because it is an absurd idea that direct care supports' wages are competitive with fast food. This comparison is to not denigrate the fast food or service industry worker, I would never do that to a fellow also just trying to survive…quite frankly we all learned through the pandemic that these service workers are what holds us together in our day-to-day lives. And caregivers are a part of that community but they are outliers for one simple reason…their responsibility is the care and support of another human being. Whether it be tending to bathroom and hygiene needs or heating up supper in the air fryer, there is an undeniable human element at play. Their responsibility is much more significant. I wish it were different. Because if it was then I would not need to rely on others to function in daily life.

These contradictions that have forced workers out of the direct support market have also illuminated the absurdity of the argument of forcing us to rely on natural supports for our main means of care. This incongruity now creates a loss of opportunity for all involved. Having to rely on my parents or my brother to be the ones to ensure I can get to Columbus to testify in front of congress, or to Pittsburgh for a show, or to the college of my choice 45 minutes away, means I wouldn't have been able to do all those things and now I'm living a life where all of my aspirations are constantly disrupted. That's a loss of opportunity for me and my natural supports because they also have work responsibilities, relationships they want to keep up, and other opportunities they may see fit to pursue that they have to now choose between. Or be forced to do all and burn out, also leaving everyone involved worse for wear. What am I supposed to do when my parents are gone? What about if something happens to my brother or he wants to live a life I know a lot of you have promoted where he gets married and has kids of his own to care for? Where do I go? How will I survive in my day-to-day life in a way that allows me to be a productive member of society?

In closing, and to reiterate once more the most important detail of this whole debate. Direct care workers need to have their wages increased to a livable wage. In order for members of the disabled community to live without a sword constantly hanging above their heads this needs to be done and treated as the urgent matter it truly is. If you believe we as a community also have a claim to lead a life that allows us to flourish, then you will also advocate for us to receive and retain the care we desperately need.

Chair Carruthers, Ranking Member Liston, and members of the Finance Subcommittee on Health and Human Services, I would like to thank you again for the opportunity to share my story which has hopefully clarified why direct support care workers are so important and need to be compensated as such. I would be happy to take any questions the Subcommittee may have.

ECONOMY

Restaurants can’t find workers because they’ve found better jobs

Nearly 2 million hospitality and leisure jobs remain unfilled in what economists call a ‘deep, profound’ shift in the labor market

By Abha Bhattarai
and
Maggie Penman
Updated February 3, 2023 at 9:10 a.m. EST | Published February 3, 2023 at 6:00 a.m. EST

General Manager Alex Sirigu works on payroll at Atwood's Tavern in Cambridge, Mass. (Carlin Stiehl for The Washington Post)

After losing her longtime restaurant job at the beginning of the pandemic, Emilia McGrath scrambled to find a backup plan.

She traded in her apartment in Boston for her childhood bedroom in Bowdoin, Maine, moving in with parents to briefly work at a private school. Eventually, the 28-year-old found a job working on exhibits at a children's museum a couple of hours away.

That short-term plan has become a permanent one. McGrath makes less than she did in restaurants but has far better benefits, including paid time off, health insurance and a predictable schedule. For now, at least, she's done with restaurants.

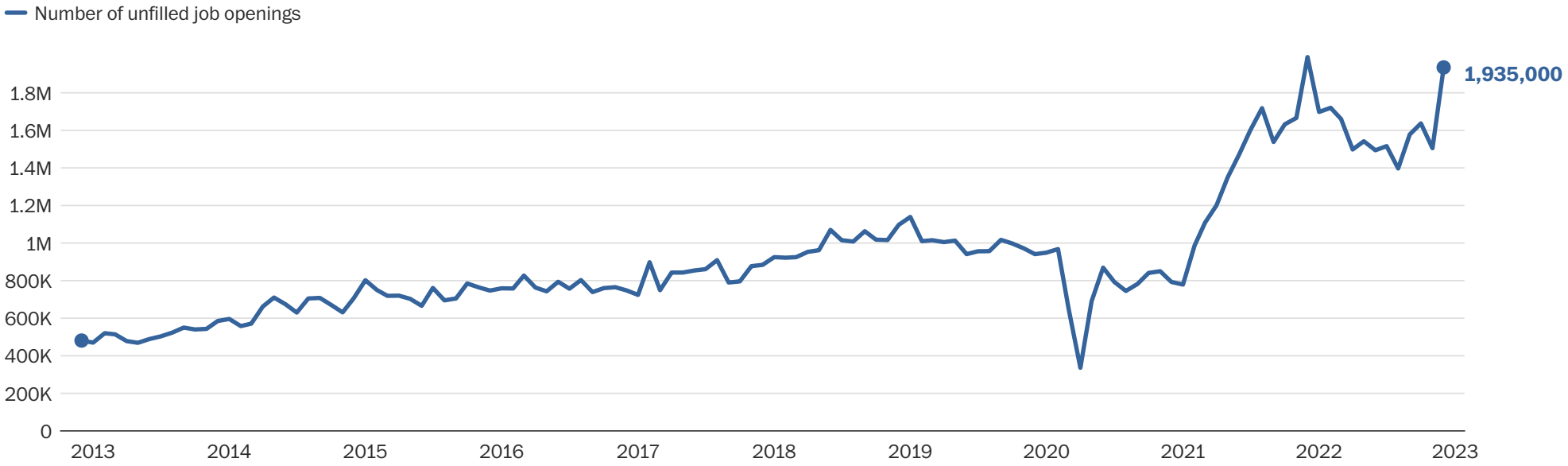
“It feels like a healthy change,” she said.

Nearly three years since the coronavirus pandemic upended the labor market, restaurants, bars, hotels and casinos remain short-staffed, with nearly 2 million unfilled openings. The leisure and hospitality industry, which before the pandemic accounted for much of the country’s job growth, is still short roughly 500,000 employees from 2020 levels, even as many other sectors have recovered.

But these workers didn’t disappear. A lot of them, like McGrath, who were laid off early in the pandemic, moved to behind-the-scenes office work where they are more likely to have increased flexibility, stability and often better pay.

Leisure and hospitality job openings are near record highs

The service sector, which has yet to make up for pandemic losses, is struggling to find enough workers.



Source: U.S. Bureau of Labor Statistics via FRED

Employment in professional and business services — a catchall category that includes office jobs in accounting, engineering, law and other white-collar firms — has soared by 1.4 million during the pandemic. And tens of thousands of additional people are working in finance, construction, and transportation and warehousing.

“There’s this reshuffling going on that is explaining why lots of industries can’t find workers,” said Betsey Stevenson, an economics professor at the University of Michigan and former Labor Department chief economist. “Their workers have left to go somewhere else.”

These migrations have been possible in part because so many workers have left the labor force entirely. An estimated 2.5 million people have died, retired or otherwise dropped out since 2020. Americans older than 55, in particular, stopped working at heightened rates during the pandemic because of covid-related health risks. Plus, rapid run-ups in home values and stock prices made it financially viable for scores of older Americans to retire. Those extra vacancies in the job market, researchers have found, created room for people in the service industry to move into new lines of work.

As a result, workers are “missing” from certain service jobs — often the ones most visible to the public — slinging drinks, steaming lattes, waiting tables, cleaning hotel rooms or caring for babies.

“There’s been a shift away from the sectors where we have the most person-to-person contact,” said Nick Bunker, economic research director at the jobs site Indeed. “It feels like no one’s working, even though we can tell from government statistics that they are.”

It isn’t clear, exactly, how many workers made the switch from service work to other industries. The Bureau of Labor Statistics tracks employment by sector but offers little visibility into workers’ movements or motivations. But labor economists say there has been a discernible shift away from service-sector work, which has altered the U.S. job market and possibly reshaped it for the long term.

In interviews, many workers said they made the switch thinking it would be temporary, but found the new stability tough to give up.

Ashton Rodriquez, who lives in Cleveland, switched careers in March 2020 after nearly 15 years working in restaurants and bars. She had been considering starting her own jewelry business for years but said the jolt of the pandemic sped things up.

“Like a lot of people, I had time to sit with myself and figure out what I really wanted,” the 34-year-old said. “It was a forced decision in a way, but not an unhappy one.”

She makes twice the money she made as a bartender at LongHorn Steakhouse and says she likes having control over her own hours. Instead of working well into the morning, she's often in bed by 8:30 p.m. "Working for yourself is super scary," she said. "But I would never go back."

The movement of workers away from hospitality jobs is playing a role in the economy's broader inflationary problems. Pressure to attract workers has driven up wages in the industry — by 23 percent in the past three years, more than in any other sector — complicating the Federal Reserve's task of containing inflation. Fed Chair Jerome H. Powell this week flagged service-sector inflation, as a result of higher wages, which are compounded by costlier food and gas, as a particular concern for the central bank.

"Clearly labor is important for restaurants, but so are food prices," Powell said in a Wednesday news conference following the Fed's latest interest rate increase. "There are lots of things in that mix that will drive inflation. I would say overall, though … you're not going to have a sustainable return to 2 percent inflation in [the service] sector without a better balance in the labor market."

The job sector shift has been most pronounced in the United States, where 20 million Americans suddenly lost their jobs in early 2020. Unlike many European countries, which helped workers stay on the job by subsidizing their wages, the United States took a different approach, offering additional

unemployment benefits once people were out of work. Employers cut 14 percent of the U.S. workforce in the first month of the pandemic, with many of those losses concentrated in restaurants, hotels, child-care centers and other service employers.

[*Finding child care is still impossible for many parents*]

William Spriggs, a labor economist who was originally critical of the mass layoffs in the United States, now says the shake-up may have ultimately encouraged service workers to look beyond low-wage jobs.

“This has been a good evolution — it has raised wages and changed the structure of the labor market in a deep, profound way,” said Spriggs, chief economist for the AFL-CIO. “Workers who were trapped in low-wage jobs were able to escape by switching to higher-paying industries.”

Indeed, federal data shows that any worker who switches jobs generally gets higher pay increases — an annual increase of about 7.7 percent, as of December — compared to 5.5 percent for employees who stay put.

At the same time, a burst of retirements during the pandemic helped set the stage for low-wage workers to move into “professional occupations” that often came with better pay, more flexibility and lower exposure to health risks, according to a recent paper published by the National Bureau of Economic Research.

“When older workers — who were in relatively high-paying jobs at the top of the ladder — retired, everyone else was able to climb up a step, from a worse job to a better one,” said David Wiczer, an economics professor at Stony Brook University and one of the paper’s co-authors.

The jobs that remained empty, the researchers found, were the less desirable ones: low-skilled, low-wage, customer-facing jobs.

[*The red-hot labor market has helped boost unions*]

Business is booming at the Westgate Las Vegas Resort & Casino. Barry Manilow is back onstage, and the hotel — where Elvis Presley famously performed hundreds of shows — is fully booked for weeks at a time.

But workers are tough to come by. The property is operating with just 1,400 full-time employees, down from more than 2,000 before the pandemic.

“Las Vegas is back but the workers are not,” said Gordon Prouty, the hotel’s vice president of public relations. “Many people moved on. We had a very tenured staff here. Some people decided to retire rather than the come back. Others moved. And others were slow to come back because they had health concerns or wanted to work remotely — it’s a very front-facing industry.”

The positions that have been hardest to fill, he said, are the workers who interact most frequently with guests, such as casino dealers, security guards, waitstaff and bartenders, and housekeepers. The resort has raised pay and is hosting additional job fairs.

“Staffing has been a constant challenge after covid,” Prouty said. “We’ve had to get creative.”

Economists say the dynamic could soon change, as a cooling economy prompts tech giants, insurance firms, banks and real estate companies to lay off more office workers. It's possible some of those employees, particularly those in administrative and secretarial jobs, could go back to service work. In January, the hospitality and leisure industry added 128,000 new jobs — the most of any sector.

For now, demand continues to outpace supply. Fresh data this week showed that hospitality and leisure openings account for nearly 2 million of the country's 11 million job openings.

[*Job openings spiked in December to high not seen since summer*]

In Cambridge, Mass., Atwood's Tavern has struggled to refill its ranks after laying off its entire workforce early in the pandemic.

Many long-timers — including McGrath, who works at the children's museum — left for new pursuits. One employee now works at a science lab; a few others took remote customer service positions.

“The people who used to work in restaurants have gotten new jobs,” said General Manager Alex Sirigu. “They’ve all moved on.”

The restaurant, which used to recruit exclusively by networking and word of mouth, has begun posting openings at “every single online platform,” from local classifieds to national job boards, he said. Sirigu has also taken steps to make the jobs more attractive: Raising wages by as much as 20 percent and closing earlier, at 11 p.m. instead of 1 a.m. on weeknights.

“The pool of workers has gotten much smaller,” Sirigu said, adding that almost all candidates are new to the industry. “It’s mostly younger people, entry-level applicants who are fresh graduates or high school students. We are having to start from scratch.”

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Living Wages and the Retention of Homecare Workers in San Francisco

Candace Howes
Connecticut College, chow@conncoll.edu

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Comments
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Living Wages and Retention of

Homecare Workers in San Francisco

Candace Howes
Department of Economics
Connecticut College
chow@conncoll.edu
(860) 439-5447

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Living Wages and Retention of Homecare Workers in San Francisco

Abstract

This study records the impact on workforce retention of the nearly doubling of wages for homecare workers in San Francisco County over a 52-month period. Using descriptive statistics and logistic regression analysis I find that the annual retention rate of new providers rose from 39 percent to 74 percent following significant wage and benefit increases and that a $1 increase in the wage rate from $8 an hour – the national average wage for homecare – would increase retention by 17 percentage points. I also show that adding health insurance increases the retention rate by 21 percentage points.

Introduction

Between 1996 and 2002, due to a confluence of political forces, including unionization of the workforce, the establishment of a consumer-labor coalition and a campaign for a living wage ordinance, wages for In-Home Supportive Services (IHSS) workers in San Francisco County more than doubled. In March 2000, healthcare benefits were added to the compensation package and in October of the same year, the Living Wage Ordinance took effect and dental benefits were added.[i] IHSS jobs now pay $10 an hour in San Francisco and even part-time workers receive medical, dental and vision care benefits making them among the best jobs available to low skilled female workers, and especially for new immigrants.[ii] But IHSS jobs have not always been good jobs. As recently as 1995, all IHSS independent providers in California earned the state minimum wage, which was $4.25 at the time, and none received benefits of any kind.

The primary concern of this study is to examine the impact of the nearly doubling of wages and the addition of healthcare benefits on the stability of the IHSS workforce in San Francisco County.[iii] Using descriptive statistics and logistic regression analysis, the study examines the impact of the wage and benefit increases on workforce retention. This study is one of the very few large-scale empirical investigations of the effect of wages on labor market outcomes in any direct care industry, and possibly the only such study specifically addressing conditions in the homecare industry. The project is based on a unique database, which matches approximately 18,000 San Francisco County homecare workers to the 15,500 service recipients they cared for between November 1997 and February 2002.

The principal conclusion[iv] reported in this article is that:

- The annual retention rate of new workers rose by 89 percent, or alternatively, the turnover rate fell by 57 percent;

Logistic regression analyses also show that:

- Wage increases and health and dental insurance all contributed to increasing the retention rate of new workers;

- Were it not for the wage increases, a large proportion of the workforce would have left for other jobs in the tight labor market that prevailed until 2001 in San Francisco;

- A $1 an hour increase from an hourly wage of $8.00 – the average wage paid to homecare workers in the U.S. - increases the probability of a new worker remaining for a year by 17 percentage points;

- Adding health insurance increases the probability of a new worker remaining for a year by 21 percentage points;

- At a wage equal to the California state minimum wage of $6.75, even if health insurance was offered, the turnover rate of new workers would be 56 percent a year; without health insurance the turnover rate would approach 75 percent a year;

- While the turnover rate is slightly lower for people caring for family members, wage and benefit increases have roughly the same marginal effect on retention of both family and non-family providers.

The paper will first provide some background on IHSS, the homecare workforce and its working conditions. Section 2 explains the scope and method of the study. Section 3 presents the results of substantial wage and benefit increases. In section 4, I discuss the labor market outcomes. Section 5 concludes the paper.

1 Background

What is homecare?

Homecare is the first stage in the continuum of long-term care that is provided to a large population of frail elderly, working-age disabled, and disabled children in the United States. It is estimated that 13 million people needed long-term care in 2000, of which 11.6 million received community-based care, mainly homecare. Informal, that is unpaid, caregivers provide most of the home-based long-term care, but in 2000 there were approximately 1.5 to 2 million people providing formal long-term care in home and community-based settings and an additional 1 million providing formal care in institutional settings.[v]

The number of people in need of long-term care, especially in the community setting, is expected to double in the next 50 years to 27 million. Since women between the ages of 25 and 54 provide most long-term care, and since this population is expected to increase by only 9 percent by 2050, the current widespread shortage is expected to worsen as the growth in the number of people over 65 greatly outpaces younger cohorts of the population (Stone & Wiener 2001). Without a reliable workforce to deliver quality care, homecare services fail and the burden falls on expensive residential care facilities and on families.

Many consumers of formal homecare services are low-income elderly individuals or disabled people of working age whose services are paid for through Medicaid. In California, where it was estimated that approximately 1.6 million people needed some level of informal or formal home aide in 2000 (MPI 2001), there are now over 265,000 low-income people receiving formal home care services through the Medicaid-supported In-Home Supportive Services (IHSS) program (CDSS 2002b).[vi]

In contrast to the usual practice in other states of providing publicly funded homecare services through agencies that contract directly with the state, 85 percent of California IHSS service hours are provided through the independent provider mode and 95 percent of IHSS providers are independent providers.

Under the independent provider mode, the consumer has the option to directly hire, to train and to supervise the caregiver while state and county agencies set the wage and benefit rate and pay the provider. So although consumers have little control over the monetary conditions of work, the consumer is responsible for replacing a provider who quits. Every time a consumer hires a new provider, she has to explain the organization of her household and her specific care needs and work out a new and often complicated set of understandings about how to accomplish the necessary tasks within the intimate setting of her home. Thus, consumers and providers alike have an interest in establishing matches that are mutually respectful, trusting and of long duration.

Working conditions and retention

Typically, a homecare assistant will arrive in the morning to help a consumer out of bed, to bathe and dress them and assist them with their morning meal. In the case of an elderly person, they may transport them to a day health facility or, for the more independent of working age, help them get to work. The homecare worker may shop for food, clean the house, do laundry, and in some cases help manage the household finances. The severely impaired clients of working age may require assistance for much of the day to travel to and from and function effectively at work. Such an intimate relationship between provider and client works for the consumer only if the two can develop a high degree of trust. That trust will depend, among other factors, on the continuity of the relationship between the consumer and provider. [vii]

The conditions of IHSS employment are often difficult and hazardous. While many homecare workers prefer the flexibility and opportunity to work in the client's own home to nursing home work, it does mean that the job may require weekly or even daily travel to multiple sites, and that the worker has limited control over the conditions of her worksite. Homecare workers at times face real physical hazards such as frequent heavy lifting, contact with bio-medical hazardous materials, travel in unsafe neighborhoods and even physical abuse from clients or their family members.

Despite its significance, homecare work has been so undervalued that there is already a severe shortage of workers and turnover is estimated to be 40 percent a year nation-wide (Stone & Wiener 2001). Most homecare workers, who on average earned $8.00 an hour nation-wide in 2001 (BLS 2003), find it difficult to achieve the financial stability necessary to stay with the job. The average duration of matches between a consumer and provider is thus an important measure of stability and quality of care, and yet, as of the end of 1997, only 68 percent of all San Francisco IHSS providers and only 28 percent of all new providers would still be there a year later.[viii] A 68 percent retention rate, here measured as the percent of workers who are still providing homecare after a year, is equivalent to a 32 percent turnover rate.

If the turnover rate of homecare providers is contrasted to the annual turnover rates of nurses aides (100%) and home health care givers (50%) (Dawson 2000; Massachusetts Health

Policy Forum 1999; North Carolina Division of Facility Services 1999, 2000), homecare retention seems quite high. However, if one considers that the homecare giver, unlike a nurse's aid or home health care worker, is often the only person the client can depend on, having to replace 32 percent of providers seems like an intolerably large number of new providers that must be found every year just to serve the existing client base.[ix]

Homecare is one of the most important jobs available to low-skilled working women, and especially recent immigrants and so the economic rewards of this employment significantly affect the economic well being of many poor families in San Francisco and nation-wide. Thus, any improvement in compensation for homecare workers may potentially mitigate the problem of worker supply and reliability in the industry, while at the same time significantly and materially affecting the quality of life for a large share of poor working women at the very bottom of the wage distribution. San Francisco County, where wages for homecare workers doubled in a five-year period, provides concrete evidence of this.

Who are homecare workers?[x]

Who providers are explains a lot about why retention is low or turnover is so high. On the whole they are very poor women of color and/or recent immigrants with low levels of education, who have access to a very limited range of low wage jobs. Most are doing the job only part-time while simultaneously working other jobs. The wages and benefits they receive for homecare relative to other jobs available to them should significantly impact their attachment to the job, though the compensation effect may be mitigated by the non-market nature of family care giving. In over half of all cases, providers are caring for a member of their family. The jobs available to native-born African Americans and whites are significantly better than those available to non-native born workers and even many native-born Latinos, given the segmented nature of the labor market and the prevalence of ethnic job niches.

Table 1 shows that in November 1997, nearly half of the 5,700 providers in San Francisco were Russian or Chinese, most of whom were probably immigrants.[xi] Ten percent of providers were Latinos, many of whom were probably immigrants from Mexico or Central America. Thirty percent were native-born English-speaking African-Americans or whites. The

remaining 13 percent were immigrants from other South and Southeast Asian countries. The proportion caring for family members varies somewhat by ethnicity, with Whites and Russians least likely, and Blacks and Latinos most likely to be caring for a family member. The labor force was so segmented by ethnicity that 86 percent of the 7,000 matches in November 1997 were between providers and recipients of the same ethnic group. Only white providers, who were also likely to be caring for Latino, Russian or Black recipients, had crossed ethnic boundaries in any significant numbers. Given the variation across ethnic groups in access to jobs and cultural norms about family care-giving, this study will examine whether the impact of the wage and benefit increases varies significantly by ethnicity and the family relationship between caregiver and recipient.

Most of the providers worked part time at IHSS work. For example, on average the workforce worked 89 hours per month, or just over 20 hours per week, while the median was 75 hours. Only 25 percent of the workforce worked more than 110 hours per month. Latinos averaged 103 hours, with only 25 percent working more than 142 hours, or nearly full time.[xii]

The data used in this study do not provide any direct measure of the income or economic status of providers. However, a 1999 survey of San Francisco IHSS providers, taken when the wage had already reached $7 an hour, found that the annual income from all jobs of 46 percent of providers was less than $10,000 and 64 percent earned less than $20,000 a year. Sixty-nine percent of the Chinese providers, 46 percent of Spanish-speaking and 42 percent of English-speaking providers earned less than $10,000 a year at any job (San Francisco Health Plan 1999). In a more recent survey of Alameda County IHSS workers, we found that the mean individual income for providers was $13,361 and the mean family income was $22,512 (Howes, et al. 2002). Thirty-five percent of Alameda County IHSS workers had family incomes that put them below the poverty line at a time when the wage rate was already $8.50. It is quite possible that most IHSS workers in 1997 earning $5.69 an hour lived below the poverty line. Since a consumer's income cannot exceed more than about $966 a month to qualify for the service, most consumers must have individual incomes in the range of $10,000 to $12,000 a year, suggesting consumers and providers share similar economic status.

In sum, the homecare workforce is composed of very poor native-born and immigrant women who work part-time, often at multiple jobs. Despite the low pay, IHSS jobs are probably very important in the poor communities of San Francisco. For the very poor family providers of the Chinese, Latino and Black communities, the IHSS wages, when combined with the SSI payments to the recipient, may constitute the entire household income. For others, like the Russian immigrants, IHSS jobs may be the only job they can do while learning English and retraining for a new career in the United States. For many older Russian and Chinese immigrants, who will never learn English, it is one of the few, and one of the best jobs they will ever have in the U.S.

2 Scope and method of study

This study examines the effect on labor market outcomes of economic events over a 52-month period from November 1997 to February 2002.[xiii] The period of analysis is punctuated by a number of events that may have impacted a provider's decision to enter or exit the workforce. During the first 8 months, there was little economic incentive for providers to change their behavior. The first substantial wage increase above the minimum wage occurred in June 1998. During this period, the San Francisco economy was expanding rapidly and unemployment rates were less than 3 percent so it is unlikely that IHSS jobs would have been economically attractive relative to other available jobs. Other factors, such as family commitment or a preference for part-time work might have attracted providers to the job. In July 1998 the wage rose for the first time to a level more than $1 above the minimum wage.[xiv] In March 1999, the HEALTHYWORKERS plan made individual health insurance available to any IHSS employee who had worked a minimum of two months and who worked at least 25 hours in one of those months. In September 1999, as the San Francisco Living Wage Campaign neared completion, the county raised the wage to $9 per hour, $3.25 above the state minimum wage. In January 2000, individual dental insurance was added and all workers were automatically signed up for the program. When combined with the health insurance benefit, IHSS became one of the very best jobs available to low skilled workers, especially those who did not have English-language skills. The wage rose to $9.70 in July 2000 and again to $10.00 in January 2001.

At the same time wages and benefits were increasing in IHSS, however, a very tight labor market in San Francisco would have provided rapidly increasing wages and job opportunities in other occupations as well, presumably offsetting some of the effect of the IHSS wages on retention and making it necessary to control for labor market conditions in the empirical analysis of the effect of wages and benefits. The San Francisco labor market was expanding until late 2000, with the unemployment rate dropping from 3 percent in 1998 to 2.1 percent in 2000. By 2002, in the wake of the dot.com crisis, unemployment had risen to 5.9 percent. Employment in the leisure and hospitality industries grew through 2001, while employment in education and health services grew only through 2000. Despite the overall declines, among the occupations experiencing the fastest growth rates are janitors and cleaners, salespersons, cashiers and waiters and waitresses, all occupations in which IHSS workers routinely find jobs (California EDD 2004).

Although there are numerous anticipated labor market effects, including an increase in the length of matches between consumers and providers, an increase in the supply of workers and perhaps hours worked, the principal objective of this paper is to examine the effect of wage and benefit increases on retention of the workforce. I expect the significant improvement in compensation for homecare workers to raise the retention rate of workers in the labor market. As noted earlier, 20 percent of providers leave the job annually.

Since many IHSS consumers hire family members, however, market signals may be muted by commitment and obligation. For example, a provider who is working for a family member, not because it is the best job, but because they are the best person to do the job, may be more likely to stay in a bad job. So turnover is expected to be lower for family providers and the effect of wage and benefit increases is expected to be less than in the case of non-family providers.

The results presented here include descriptive statistics that compare retention of both new workers and all workers at the beginning and end of the study period to see if there has been an improvement. In order to gauge the relative effect of wage increases, health and dental benefits and whether or not the provider is a family or non-family, on retention, I have conducted

a logit regression analysis, regressing the probability of a new worker lasting a year or longer on wages and a set of indicator variables as specified in the equation below.

Model Specification and variables

The model being estimated in this study has the following specification and will be estimated using logit regression:

$$\ln\left(\frac{P_{it}}{1-P_{it}}\right) = \beta_0 + \beta_1 Wage_t + \beta_2 Wage_t * Family_{it} + \beta_3 Family_{it} + \beta_4 HealthIns_t + \beta_5 DentalIns_t + \beta_5 SFEmpl_t + \varepsilon_{it}$$

Where,

- $\ln\left(\frac{P_{it}}{1-P_{it}}\right)$, where P_{it} is the probability of the *i*th new provider lasting at least a year from date of entry, where entry date is given by month *t*;
- $Wage_t$ is the wage rate in San Francisco County at time *t*;
- $Wage_t$*$Family_{it}$ is an interactive variable that measures the effect of the wage in month *t* if the *i*th provider is a family provider;
- $Family_{it}$ is a dummy variable which indicates whether the ith provider is a family provider or not at time *t*;
- $HealthIns_t$ is a dummy variable which indicates whether health insurance is available to all eligible providers at time *t*;
- $DentalIns_t$ is a dummy variable which indicates whether dental insurance is available to all providers at time *t*;
- SF $Employment_t$ measures the employment level in San Francisco at time *t*.

Measuring retention

For the purposes of this study, retention will be measured as the probability of a new provider lasting more than one year in the workforce from the date of entry. Providers leave, or are not retained, for many reasons, some of which do not interrupt the care of their consumer. As

described in some detail below, the measure of retention used in this paper will focus only on the retention that is important for continuity of care.

Over the 52-month period between November 1997 and February 2002, a total of 18,000 unique providers worked for IHSS consumers in San Francisco. Many cycled in and out of the IHSS workforce, so that there were a total of 22,600 entries and 13,300 exits, with an average of about 7,000 providers working in any given month over the period of the study. No doubt, many of those providers entered the workforce because they agreed to care for a family member or friend or neighbor and many left permanently when their consumer lost eligibility. Evidence from statewide data tells us that about 20 percent of recipients are terminated every year for a variety of reasons including death, placement in an out-of-home facility, or because they move out of state or become ineligible or just disappear (CDSS 2002a). If a provider quits IHSS when and because her consumer is terminated, that quit does not disrupt the care of an IHSS consumer, although it could be argued that IHSS is losing a skilled provider from its labor force. But in other cases, when a provider leaves the workforce, she leaves behind an eligible consumer who may experience difficulties, including a lapse in service or the inconvenience of having to train a new provider.

For the purpose of analyzing retention in this paper, I focus on the failures to retain (turnover) that may cause difficulties for the consumer and exclude separations that occur "naturally" because the consumer has been terminated. A provider who leaves the workforce at the same time as her consumer is assumed to be leaving because the specific job she was doing ended and she had never intended to work for anyone other than that consumer, as would be the case for many family providers as well as people caring for a friend or neighbor. In contrast, "turnover" (failure to retain) is defined as a quit in which the provider leaves the service before her consumer is terminated. Of course, there will be cases in which the provider leaves because the consumer found someone else they prefer, but it is not possible to make the distinction between voluntary and involuntary match ends with the CMIPS data.

During the period of analysis, of the 13,800 providers who were terminated for any reason, only 5,700 left an eligible consumer behind. Because we are excluding the 8,100

providers who left at the same time as their consumers, the population of analysis for this paper includes the 8,700 providers who remained in the service over the period of analysis and the 5,700 who left a consumer behind when they separated.

Retention is measured, in this analysis, as the probability of a new entrant remaining in the workforce for a year or longer. Because there is so much turnover in the workforce, with 62 percent of all providers leaving in the 4 year period, new entrants always represent a large share of the provider population. However, since the data is truncated at both ends it is not possible to do an analysis of trends in retention for the entire workforce. If a wage or benefit improvement increases the probability of a provider staying with the job, then the percent of providers who remain in the job for at least a year after entry should increase.

Finally, a considerable number of consumers and providers exit and reenter the service, sometimes numerous times.[xv] Providers may exit and reenter because they are attached to consumers who are doing the same. On the other hand, for many providers, exit and entry patterns may reflect the nature of the low wage labor market in which many jobs are highly substitutable. Even though the consumer or provider may reenter the service, the exit represents disruption of the service for the consumer. Therefore, for the purposes of measuring provider retention, I have treated any provider who exits and reenters, and in which there is a two-month hiatus, as a new provider. If both provider and consumer exit together, the exit is not treated as turnover, and therefore not included in the population or measure of retention.

Independent Variables

Wages are set administratively by the county and all workers in San Francisco are paid the same hourly wage at any point in time.[xvi] The wage variable takes on the value of the wage rate for each month during the analysis. The wage rate changed five times during the period of study.

A Family dummy variable, and its interaction with the Wage variable, are included to capture the effect of being a family provider and to discern whether this effect is influenced by

the Wage.[xvii] As noted earlier, I expect that family providers' retention is less affected by a wage increase. I assume their commitment to the job has less to do with remuneration than with family obligation, but that the impact of Family varies across ethnic groups due to differences in cultural norms about care-giving.

The county offered an identical individual health insurance package to all eligible providers beginning in October 1999. Some, but not all workers, signed up for the HEALTHYWORKERS program. Unfortunately, I do not have data to show whether individuals signed up or not, so the health insurance variable is a dummy variable coded 1 in the months during which insurance was available. A similar dummy variable was constructed for dental insurance which became universally available in January 2000. In this case, all workers were immediately enrolled, so having individual level data on whether or not they were enrolled would not improve the analysis, though data on usage, also not available, would.

A variable measuring the employment level in San Francisco was included to capture the effect of employment trends in the local labor market which might affect provider retention. The San Francisco labor market was very tight and expanding through much of the period of analysis for this study, and the occupations that provide alternative employment to IHSS workers were among the fastest growing in the County. Thus I would expect a negative coefficient on SF Employment since as the employment level in San Francisco increased providers would be pulled out of homecare into alternative rapidly expanding occupations.

Finally, because of the significant labor market segmentation by ethnicity, and because alternative jobs as well as cultural factors which influence a provider's decision to provide homecare vary by ethnicity, I have estimated the equations separately for each ethnic group.

Data

The analysis was conducted using the Case Management, Information and Payroll Services (CMIPS) database for San Francisco County. Each county in California submits information to the state about the demographic characteristics and authorized hours for every

recipient and every provider of IHSS services. The state compiles the data, uses them for pay-roll purposes and returns the data to the counties for their own use. While the data are confidential, the San Francisco Public Authority and Department of Social Services have authorized the use of these data for the purpose of this analysis, subject to the constraints imposed by confidentiality.

The dataset indicates the beginning date on which the consumer is authorized to receive service and the date that the provider begins to provide service to each consumer. It also indicates the end date for service for each consumer. Using these data it is possible to determine when each match begins and ends and when each provider and each consumer enters (if after November 1997) and exits the service (if before February 2002), thus allowing analysis of trends in turnover of the workforce. Because I can match the provider to their consumer, I can also remove those providers who enter and exit with their consumer. Details of the demographic composition of both the workforce and the consumer population are also available, including details on race, ethnicity, and gender. [xviii]

3 Results

Trends in retention – descriptive statistics

To determine whether there was any change in the retention trend, I contrasted the percent of providers, excluding those who exited with their consumers, that had lasted a year or more for the four-month period including November 1997 to February 1998 to the percent lasting a year or more for the four months beginning in November 2000 (Table 2a). In 1997-98, only 78 percent of these providers were still in the workforce after a year, while by 2000-01, 85 percent of were still in the workforce a year later, which provides some support for the hypothesis that wage and benefit increases raised retention rates. Retention increased for all ethnic groups though the increase for Whites and Russians, which groups already had the highest retention rates, was fairly small. The table also shows similar increases in retention for family and non-family providers. The aggregate numbers mask some widely different trends among ethnic groups. In particular, there was an especially large increase in retention among African-American and Latino non-family providers and an actual decline in retention of white non-family providers.

Retention among new providers who did not exit with their consumers – adjusted retention – showed a huge increase (Table 2b). Thirty-nine percent of all new providers in the four months between November 1997 and February 1998, excluding those that left for natural reasons, remained for at least a year (a turnover rate of 61 percent). By 2001, retention had risen 89 percent to 74 percent. (This represents a 57 percent decline in the turnover rate which fell from 61 percent to 26 percent.) The smallest increase in retention, which was still 32 percent, was among Russians who already had much higher retention rates than other ethnic groups. Even Whites, for whom retention of all providers had only increased marginally, saw a very large increase in new provider retention. In the aggregate, the adjusted retention rate for non-family providers increased by 94 percent and for family providers by 81 percent. Several things stand out in the data disaggregated by ethnicity and family. The retention rate for new Black non-family providers increased by almost 300 percent and even for new family providers more than doubled. Among white providers, it was the family provider retention rate which showed the greatest gains, nearly tripling.

Regression results

Logistic regression analysis was conducted to parse out the causal determinants of the changing impact of the independent variables on the probability of a new worker remaining in the workforce for a year after entering. This paper presents the regression results only for the retention of new workers, adjusted to net out those workers who left with their consumer. The logit analysis for all new workers, including those who left with their consumers, was also performed with similar results.[xix]

Table 3 summarizes the variables used in the regression analysis, their meaning and basic descriptive statistics. For new workers that entered during the period between November 1997 and February 2001, [xx] adjusted for natural exits, the sample average probability of a provider lasting a year from entry was 68.3 percent. The average retention rate varied by ethnicity, ranging from 76 percent among Russians to 55 percent among African-Americans. The average entry wage for new providers through February 2001 was $8.85. Over the 41-month period, 81.8 percent of providers had access to health insurance and 71.3 percent had access to dental

insurance. In 51 percent of observations of new providers, the provider was matched to a family consumer.

Table 4 shows the results of a logit analysis regressing the probability that an individual provider lasts more than a year beyond their entry month on the independent variables. The estimated coefficients and their standard errors are presented. Based on z-statistics (not shown) all variables for total providers are significant at the 1 percent level. However, for large sample logit analysis, the Baysian information criterion (BIC) value provides a more reliable measure of significance (Pampel 2000; Raferty 1995). Specifically, the BIC value for each coefficient refers to the difference in model information with and without the independent variable. BIC values less than or equal to 0 indicate little support for including the variable. BIC values are also presented in Table 4. The table notes indicate the degree of significance measured by each range of BIC values.

Chi-squared statistics for all regressions are sufficiently high to reject, at a very high level of significance, the null hypothesis that the combined variables have no explanatory power. Pseudo R-squareds, which are a measure of the improvement in the log likelihood relative to the baseline, are recorded in the table, and range between .39 and .47. The coefficients in a logit analysis (which measure the increase in the logged odds of the dependent variable due to a one unit increase in the independent variable) have little intuitive meaning other than to indicate whether the direction of change is the predicted one. If the estimated coefficient on an independent variable is negative, then the probability of lasting a year due to a one unit increase in the independent variable declines.

From Table 4, we see that for the total population, an increase in the Wage rate has a positive effect on retention and that the coefficient is very strongly statistically significant. The Family variable is very strongly statistically significant in the aggregate but its inclusion is not justified for Latinos or Blacks and only positively or weakly positively justified for the other ethnic groups. Similarly the Wage*Family variable is also very strongly statistically significant in the aggregate, but its inclusion is not justified for Latinos, Chinese or Blacks and only slightly statistically significant for Russians and Whites. In other words, while in the aggregate there is

evidence that being a family provider reduces the retention rate relative to non-family providers, the disaggregated analysis does not strongly support differences in family and non-family providers. Health Insurance showed the predicted positive effect and the estimate is very strongly statistically significant at the aggregate level and strongly or very strongly statistically significant at the disaggregated level. Dental Insurance also has the predicted effect and is of very strong statistical significance at the aggregate level. At the disaggregated level, the inclusion of Dental Insurance is not justified for African-Americans. Finally the coefficient on the SF Employment is negative and very strongly statistically significant at both the aggregate and disaggregated level. This is consistent with the hypothesis that as employment in San Francisco increases, workers are drawn out of homecare.

The more intuitive method of presenting results of a logit analysis is to show the marginal probability associated with a 1 unit increase in each independent variable, measured either from the mean of the dependent variable or from the mean of all the other independent variables. Table 5 shows the marginal probability of a new worker lasting a year or more associated with a one unit increase in each independent variable, evaluated at the mean of all the other independent variables. Of course, since the underlying functional form in logit analysis is non-linear, the marginal probabilities depend on the levels of all the other independent variables, as well as the level of the dependent variable. So I have also provided, in Table 6, the marginal probabilities for each independent variable first holding the value of all independent variables at their mean, and second setting the wage at the California minimum wage rate of $6.75, holding the other independent variables at their means.

Table 5 shows that there is a 12 percentage point increase in the probability of staying in the workforce for more than a year if the wage increases by $1, where the mean value of the wage is $8.50. The results in Table 5 suggest that on average, new family providers are 23 percentage points less likely to last a year than new non-family providers, but that the effect of a wage increase on their propensity to remain is positive so that at the margin a $1 wage increase measured at the mean of all the independent variables, will increase family providers' probability of staying a year by 3 percentage points more that of non-family providers. As discussed above, the coefficients on the Family and Wage*Family variables are either not statistically significant

or only marginally statistically significant suggesting that on the whole, family and non-family providers are similarly likely to remain in the workforce for a year.

Both Health and Dental Insurance have a large effect on retention rates, increasing the probability of remaining a year or more by 17 and 19 percentage points in the aggregate results. Both coefficients are very strongly statistically significant in the aggregate regression and highly quantitatively significant with a large marginal effect for all ethnicities, but especially for Blacks and Whites. With the exception of Dental Insurance for African-Americans, which coefficient is not statistically significantly different from 0, all coefficients are very strongly statistically significant.

Finally, the SF Employment variable, which is strongly statistically significant in both the aggregate and disaggregated ethnicity level results, indicates that the probability a homecare worker will remain in the workforce for a year declines over time due to changes in local labor market conditions. At the mean of employment, the estimated marginal probability of remaining in the workforce for a year decreases by 1.6 percentage points when the San Francisco employment level rises by 1,000. Since the San Francisco employment level increased by 35,000 from 397,000 to 432,000 between November 1997 and December 2000, employment growth in the SF labor market would have had a numerically significant impact on the probability of workers remaining for a year. Table 5 indicates that the effect of changes in the employment level were much greater for African-Americans and Whites, than for the other ethnic groups. In fact, an increase in San Francisco employment from the mean of 404,000 to 432,000 would have reduced African-American retention by 140 percent and White retention by 244 percent.

Table 6 shows the marginal and total probabilities of remaining for a year at wage rates of $6.75, $8.00, $8.85, and $10.00, holding other independent variables at their means. In the aggregate, the marginal probability associated with a wage increase declines from 18 percent at $6.75 to 7 percent at $10.00. However, the disaggregated figures show that the diminishing marginal probability is driven entirely by Latino, Chinese and Russian providers, and that Black and White providers actually have increasing marginal probabilities with rising wage rates.

Finally, Table 7 shows the difference in the probabilities of remaining a year associated with having Health and Dental Insurance available to all, versus having no insurance. If there were no Health Insurance, the model predicts that, holding all other variables at their mean, the probability of new providers lasting a year would be only 61 percent. When Health Insurance is added the probability rises by 21 percentage points to 82 percent. The marginal effect of going from no Dental Insurance to Dental Insurance is 22 percentage points. Holding Wage and Health Insurance at their means, adding dental insurance increases the probability of lasting a year from 62 to 84 percent.

4 Discussion

The results of the regression analysis support the hypothesis that wage and benefit increases will increase the retention rate for new entrants, especially when netting out those new providers who entered and left with a distinct client. While new entrant retention remains low at 74 percent compared to retention of all providers (85 percent), the retention that most matters for the security of consumers – that which excludes natural exits - has risen significantly for both family and non-family providers. The results do not support the hypothesis that changes in wages and benefits will have a smaller impact on family providers relative to non-family providers, although here the results are more mixed. The results support the hypothesis that trends in the local labor market would have drawn people out of homecare over most of the period of analysis and confirm that retention would actually have fallen but for the wage and benefit improvements.

The effect of wage increases on the marginal probability of retention varies across both ethnic groups and at different levels of the wage rate. Of particular note is that the marginal effect of wages is at a maximum at fairly low wage rates for Latinos, Chinese and Russians, while it rises, approaching a maximum, at much higher wage rates for Whites and Blacks. Table 6 shows that at the aggregate, if the wage were $6.75, a $1 increase would increase retention by 18 percentage points, while at $8.85 a one dollar increase would improve retention by only 12 percentage points. But for Blacks and Whites a $1 increase in the wage at $8.85 increases retention by over 50 percentage points. In a previous paper (Howes 2003) I found that the alternative jobs which are available to homecare workers varied by ethnicity. When asked what

jobs they had left or currently held in addition to their IHSS jobs, Blacks and Whites consistently reported being in higher paying jobs than Latinos, Chinese or Russians. Thus, the results of the other study, when combined with the evidence from this study, suggest that for Blacks and Whites the wage in homecare must reach a much higher level before homecare becomes an acceptable alternative to their other jobs.

As noted above, the increase in the retention rate of Black non-family providers and White family providers is especially large (Table 2). The evidence from the regression analysis again supports the notion that the wage at the beginning of the period of analysis was far below the threshold that would make it attractive to either group, but that by the end of the period, as the wage approached $9 and $10 an hour, it was reasonably competitive, especially when combined with health insurance. The best explanation I can offer for why the retention rate for White non-family providers increased by only half the rate of family providers is that many had come into IHSS in the process of transitioning from welfare, but by 2000 were leaving IHSS to find the full time jobs which were required under the CALWORKS program. It is not possible to statistically test this hypothesis because of the problems of multicollinearity that are caused by the fact that the CALWORKS reforms occurred at the same time that health insurance and dental benefits were added. However, we know there was a sudden increase in the number of White providers immediately after the CALWORKS program started and an equally sudden decline in the number of white providers when the number of hours of work that was required to participate in CALWORKS was increased, which fact supports the hypothesis that welfare reform helps explain the trends in white non-family retention.

The fact that there is very little difference, at the disaggregated level, in the responsiveness of family and non-family providers to wage increases is surprising. A common belief in the field of long term care is that family providers are doing it for love rather than money. But these results suggest that even when love is a factor, providers still need to eat and feed their families, which means that they still have difficulty taking on the job of providing homecare for their family members if the pay is low.

The results reveal that health insurance had a much larger marginal impact on Blacks and Whites than on other ethnic groups. Health insurance was introduced in this market when the wage was $7.00 an hour, which is above the wage rate that has the greatest marginal effect for Latinos, Chinese and Russians, but well below the wage rate that has the maximum effect for Blacks and Whites. It is possible that wages had already drawn sufficient numbers from the first group to partially dampen the effect when health insurance was introduced. For Whites and African-Americans, perhaps what distinguished this job from their other low wage jobs initially was health insurance and so the marginal effect of health insurance on Blacks and Whites was greater.

Dental insurance is associated with marginal probabilities that are somewhat larger than those of health insurance, except for Whites and Blacks. In the case of Blacks, the coefficient on dental insurance is statistically insignificant. Dental insurance was introduced in this market at the same time that individuals involved in the welfare-to-work program in California were being asked to increase their hours of work to 40 per week. Since it is difficult to disentangle the effects of these two developments, I suspect the predicted positive effect of dental insurance is being offset by the negative effect of increased work requirements for welfare recipients, especially for Black and White providers.

Finally, the results for the San Francisco employment variable fully support the hypothesis that trends in the local labor market were drawing people out of homecare. Were it not for the wage and benefit increases, the model predicts that the retention rate would have been much lower. In fact the model suggests that in the case of Blacks and Whites, there would have been virtually no retention, but for the wage and benefit increases. Until late 2000 or even into 2001, the San Francisco labor market was very strong and there was significant growth in the kinds of jobs homecare workers take when they are not doing homecare.

5 Conclusion

This paper has reported the results of a study of the impact of a significant wage increase on an ethnically diverse, low wage, largely female and immigrant workforce in San Francisco.

Over the four-year period in which the wages and benefits increased, the retention rate for all providers rose by 9 percent and for new providers by 89 percent. Alternatively, the turnover rate fell by 31 percent for all providers and by 57 percent for new providers. The model estimates that a $1 wage increase from $8 – the average hourly wage paid to most homecare workers nation-wide – would increase the retention rate by 17 percentage points, holding other factors constant. The impact of going from no health insurance to health insurance for all is estimated to increase the probability of a provider lasting a year from 61 to 82 percent. Dental insurance appears to have a similar marginal impact on retention of 22 percentage points. By and large, family providers are found to be just as likely to work longer if they are paid a living wage as are non-family providers.

The increase in retention associated with wage and benefit increases affects all ethnic groups. What is particularly striking is that the wage and benefit increases have greatly reduced the differences in retention among ethnic groups, raising, for example, African-American non-family and White family provider retention rates up to levels which are comparable to the population. The results support the view that wages must rise above $9 an hour and health insurance must be included to get any substantial improvement in retention among white and African American providers. While these two groups represented only 20 percent of the San Francisco workforce as of February 2002, more than 50 percent of providers state-wide are White or African American. In other research, I have shown that there is a very high degree of same ethnicity matches among providers and consumers. Thus, if there is a shortage of African-American and White providers, the recipients in those communities may have a particularly difficult time finding providers.

The country is facing rising demand for and thus probable critical shortages of long term care workers over the next 40 years and homecare offers the most cost effective mode of providing long term care for many of the elderly and disabled. The results of this study suggest that an adequate and stable workforce depends critically on offering competitive wages and health insurance. What constitutes competitive compensation varies by ethnic group, but what is clear is that no matter what group providers belong too, all are more likely to stay in homecare as the wage rises and health insurance is added.

References

Bureau of Labor Statistics (BLS). 2003. "Occupational Employment (2001) & Wage (2002) Data: OES Survey Results."

California EDD. 2004. Employment Development Department, Labor Market Information Division, Information Services Group, Employment by Industry Data, www.calmis.ca.gov/file/indhist/sanfrhaw.xls

California Department of Social Services (CDSS). 2001. "In-Home Supportive Services: IHSS Providers – Characteristics of Caregivers in the In-Home Supportive Services Program," October.

California Department of Social Services (CDSS). 2002a. "In-Home Supportive Services: Recipient Report – IHSS: Keeping the quality of life at home," June.

California Department of Social Services (CDSS). 2002b. "In-Home Supportive Services: Paid Cases – July 1997 – September 2002," October.

Community Health Network of San Francisco. 2000. Health Insurance for California In-Home Supportive Services (IHSS) Workers, June 5. Office of Managed Care.

Dawson, Steven L. 2000. Testimony presented at the Congressional Briefing on the Direct-Care Workforce in Long-term care, Senate Committee on Health, Education, Labor and Pensions, June 16. In Direct Care Alliance, The Launch of the Direct Care Alliance: A report on the Conference Proceedings. http://www.directcarealliance.org/?

Howes, Candace. 2002. "The Impact of a large wage increase on the workforce stability of IHSS Home Care Workers in San Francisco County," Working Paper, Department of Economics, Connecticut College, November. http://laborcenter.berkeley.edu/homecare/howesabstract.shtml

Howes, Candace and Howard Greenwich with Lea Grundy and Laura Reif. 2002. "Struggling to Provide: a portrait of Alameda County Homecare Workers," East Bay Alliance for a Sustainable Economy and Center for Labor Education and Research, University of California, Berkeley. Berkeley and Oakland, CA. http://laborcenter.berkeley.edu/homecare/homecare.pdf

Howes, Candace. 2003. "What makes homecare a good enough job?" forthcoming, Feminist Economics.

Le Blanc, Allen J., Christine Toner and Charlene Harrington. 2001. "State Medicaid services offering personal care services," Health Care Financing Review 22(4):155-173.

Massachusetts Health Policy Forum. 2000. "Health Care Workforce Issues in Massachusetts," Massachusetts Health Policy Forum Issue Brief No. 9, June. http://ihp.brandeis.edu/mhpf/pages/publications.htm

Medi-Cal Policy Institute. 2001. Understanding Medi-Cal: Long Term Care. Oakland, CA: Medi-Cal Policy Institute, September.

North Carolina Division of Facility Services. 1999. "Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofesisonal Aide Workers," Septermber. http://facility_services.state.nc.us./provider.htm .

North Carolina Division of Facility Services. 2000. "Results of a Follow-Up Survey to States on Wage Supplements for Medicaid and Other Public Funding to Address Aide Recruitment and Retention in Long-Term Care Settings," November 4. http://facility_services.state.nc.us./provider.htm

Pampel, Fred C. 2000. Logistic Regression: a Primer. Sage University Papers, Series: Quantitative Applications in the Social Sciences.

Raftery, A.E. 1995. Bayesian model selection in social research. In P.V. Marsden, ed., Sociological Methodology 1995, 111-163. London: Tavistock. (cited in Pampel)

San Francisco Health Plan. 1999. Final Results, HEALTHYWORKERS Health Insurance Survey. June.

San Francisco Health Plan. 2000. San Francisco Health Plan: HEALTHYWORKERS summary of Benefits, July 2.

Sherr, Karen. 2002. Beatrice and Lucia: a Book of Drawings. San Francisco: Homecare Empowerment, Research and Organizing (HERO).

Stone, Robyn I. and Joshua M. Wiener. 2001. "Who will care for Us? Addressing the Long-Term Care Workforce Crisis." Washington, D.C: The Urban Institute.

Table 1 Providers by Ethnicity and Family Relationship to Recipient, Nov 1997

		Total workforce	Percent family providers
Latino	10%	588	67%
Chinese	21%	1,198	53%
Russian	25%	1,434	48%
Black	14%	820	68%
White	16%	925	43%
Filipino	5%	269	78%
OtherAsian	5%	280	75%
Other	3%	175	56%
Total	100%	5,689	56%

Table 2 Workforce Retention: [a]

a. Percent of All providers who remained in workforce for at least one year, adjusted to remove natural exits [b]

	Family			*Non - Family*			*Total*		
	1998	*2001*	*change*	*1998*	*2001*	*change*	*1998*	*2001*	*change*
Latino	0.80	0.89	12%	0.56	0.76	34%	0.72	0.84	17%
Chinese	0.83	0.90	8%	0.70	0.80	15%	0.77	0.86	12%
Russian	0.85	0.86	2%	0.77	0.80	4%	0.81	0.83	3%
Black	0.73	0.85	16%	0.47	0.78	64%	0.65	0.82	27%
White	0.79	0.88	12%	0.84	0.81	-3%	0.82	0.84	2%
Total	***0.82***	***0.88***	8%	***0.73***	***0.80***	9%	***0.78***	***0.85***	***9%***

b. Percent of New providers who remained in workforce for at least one year, adjusted to remove natural exits [b]

	Family			*Non - Family*			*Total*		
	1998	*2001*		*1998*	*2001*		*1998*	*2001*	*change*
Latino	0.52	0.78	50%	0.28	0.57	104%	0.41	0.68	65%
Chinese	0.39	0.79	103%	0.28	0.67	140%	0.34	0.75	122%
Russian	0.62	0.80	29%	0.56	0.74	34%	0.58	0.77	32%
Black	0.36	0.80	121%	0.16	0.63	287%	0.27	0.72	166%
White	0.27	0.73	170%	0.31	0.55	78%	0.29	0.65	120%
Total	***0.44***	***0.80***	81%	***0.34***	***0.67***	94%	***0.39***	***0.74***	***89%***

[a] Workforce retention measures the percent of the workforce that remains for a year after entry. [b] Adjusted retention measures worker retention as a proportion of all those providers who did not leave with their consumer (including those who remained and those who left although their consumer remained).

Table 3 Variables Included in Logit Regression Model of Workforce Retention

Variable	***Definition***	***Sample Average[a]***	***SD***
Dependent Variable			
Total Workforce Retention	Probability that a new worker will remain for a year after entry	0.68	0.46
Latino Retention	Probability that new Latino worker will remain for a year after entry	0.61	0.49
Chinese Retention	Probability that new Chinese worker will remain for a year after entry	0.69	0.46
Russian Retention	Probability that new Russian worker will remain for a year after entry	0.76	0.42
Black Retention	Probability that new Black worker will remain for a year after entry	0.55	0.50
White Retention	Probability that new English-speaking white remain	0.65	0.49
Independent Variables			
Wage Rate	Wage rate at time t	$8.85	1.573
Wage Rate*Family	wage rate at time t * family for individual i at time t 0 if otherwise	4.487	4.648
Family	1 if provider i is related to consumer 0 if otherwise	0.495	0.500
Health Insurance	1 if there is health insurance available to all providers at time t 0 of otherwise	0.818	0.386
Dental Insurance	1 if there is dental insurance available to all providers at time t 0 if otherwise	0.713	0.452
SF Employment	San Francisco employment at time t (000s)	406.9	11.991

[a]means are for total workforce to month 41

Table 4 Logit Results of Probability of a New Provider Remaining in Workforce for a Year of More after Entry

Coefficients	**Total**	**Latino**	**Chinese**	**Russian**	**Black**	**White**
Wage	0.737****	0.527****	0.804****	0.645****	1.019****	0.795****
(SE)[a]	(0.039)	(0.100)	(0.074)	(0.070)	(0.144)	(0.117)
BIC value	361.8	25.2	116.2	81.3	47.4	43.2
Wage*Family	0.205****	0.136	0.173**	0.218**	0.136	0.240*
	(0.035)	(0.099)	(0.062)	(0.074)	(0.100)	(0.123)
	31.4	-0.8	5.1	5.8	-0.9	1.2
Family	-1.403****	-0.664	-1.033	-1.424*	-0.779	-1.892*
	(0.302)	(0.854)	(0.537)	(0.627)	(0.894)	(1.089)
	18.4	-2.0	0.9	2.3	-1.9	0.4
Health Insurance	1.035****	0.922***	0.613****	1.404****	0.820***	1.596****
	(0.090)	(0.266)	(0.169)	(0.169)	(0.262)	(0.314)
	129.0	9.4	10.3	65.7	7.1	23.0
Dental	1.155****	1.461****	0.819****	1.457****	0.450	1.243****
	(0.116)	(0.326)	(0.223)	(0.225)	(0.372)	(0.349)
	95.6	17.4	10.6	38.8	-0.9	10.0
SF Employment	-0.097****	-0.093****	-0.086****	-0.105****	-0.085****	-0.117****
	(0.003)	(0.009)	(0.006)	(0.007)	(0.009)	(0.010)
	902.4	91.5	206.3	234.3	96.7	144.2

Table 4 continued

Coefficients	**Total**	**Latino**	**Chinese**	**Russian**	**Black**	**White**
Constant	32.539****	32.104****	27.919****	36.436****	25.070****	39.058****
	(1.252)	(3.719)	(2.307)	(2.630)	(3.289)	(3.747)
	672.4	71.8	143.6	189.0	55.4	105.9
N=	10,574	1,031	2,979	3,037	1,395	1,216
Pseudo R sqrd	0.374	0.319	0.319	0.394	0.376	0.467

[a]standard errors are in parentheses and BIC values are below.

[b]BIC value: *0-2 weak; **2 – 6 positive; ***6 – 10 strong; ****10 + very strong

Table 5 Marginal Probability of New Provider Remaining in Workforce for a Year or More after Entry at Mean of Independent Variables [a]

	Total	**Latino**	**Chinese**	**Russian**	**Black**	**White**
Wage	0.123	0.100	0.133	0.081	0.688	0.575
Wage*Family	0.034	0.026	0.029	0.027	0.092	0.174
Family	-0.235	-0.126	-0.170	-0.178	-0.526	-1.370
Health Insurance	0.173	0.175	0.101	0.176	0.533	1.155
Dental Insurance	0.193	0.276	0.135	0.182	0.337	0.900
SF Employment	-0.016	-0.018	-0.014	-0.013	-0.057	-0.084

[a] Measures the marginal probability of a worker remaining a year or more associated with an additional unit of the independent variable, measured at the mean of the independent variables.

Table 6 Marginal Probability and (total probability) of New Provider Remaining in Workforce for a Year of More after Entry at various wage levels [a]

	Total		Latino		Chinese		Russian		Black		White	
Marginal probabilities associated with $1 increase in wage and (total probabilities) at given wage levels												
$6.75	0.18	(0.44)	0.15	(0.57)	0.24	(0.52)	0.17	(0.70)	0.23	(0.11)	0.36	(0.19)
$8.00	0.17	(0.66)	0.12	(0.65)	0.18	(0.66)	0.11	(0.77)	0.47	(0.47)	0.46	(0.57)
$8.85	0.12	(0.79)	0.10	(0.75)	0.13	(0.79)	0.08	(0.85)	0.67	(0.68)	0.57	(0.72)
$10.00	0.07	(0.90)	0.07	(0.84)	0.07	(0.90)	0.04	(0.92)	0.89	(0.87)	0.69	(0.87)

[a] Measures the marginal probability of a worker remaining a year or more associated with an additional $1 of wage, measured at the mean of the other independent variables. Numbers in parentheses are total probability of provider remaining in workforce for a year at each wage rate.

Table 7 Probability of New Provider Remaining in Workforce for a Year of More after entry Associated with Health and Dental Insurance [a]

Probability of remaining 1 yr or more	Without	With	Marginal probability
Health Insurance	0.61	0.82	0.21
Dental Insurance	0.62	0.84	0.22

[a] Measures the probability of a worker remaining a year or more when there is no health insurance or no dental insurance and when all have access to insurance, holding other independent variables at their mean. Final column is the marginal probability associated with adding health insurance or dental insurance.

Endnotes

[i] Under the Living Wage Ordinance the city was required to pay at least $9 an hour to any employee who worked on a county service contract or who worked on city property. It is difficult to separate the effects of the Living Wage Ordinance, which was supported by the Union (SEIU), from the effects of union bargaining with the Public Authority in as much as wages for IHSS workers were increased to the level required by the Ordinance a full year before the Ordinance took effect. Since the political campaign for the Ordinance probably influenced the Board of Supervisors' decision to raise wages, this study, in effect, examines the impact of the wage increase – due to both bargaining and the Living Wage Ordinance.

[ii] IHSS jobs represent about 20 percent of all the low wage jobs done by women in San Francisco County where approximately 20 percent of workers work for less than $11 an hour. IHSS represents a very large share of the jobs available to low skilled immigrant women (Howes 2002).

[iii] This study focuses only on the "independent providers" which comprise over 95 percent of the IHSS workforce.

[iv] In a longer, largely descriptive paper (Howes 2002) I report several other conclusions, including that the match length between a provider and consumer increased, the supply of workers rose significantly and that the proportion of same ethnicity matches between providers and consumers increased, all apparently due to wage and benefit enhancements.

[v] The Bureau of Labor Statistics estimates that there were 1.8 million formal long-term care workers, including 414,000 homecare workers, nation-wide in 2002 (BLS 2003). However, BLS counts only those homecare providers who work at wage and salary employment in nursing and personal care facilities, residential care facilities and home health services, which excludes some of the principal modes in which homecare aides are employed, namely through temporary help agencies, public agencies or as self-employed independent providers. In California alone, there are currently 300,000 people working as independent providers of homecare through public agencies and there are an estimated 100,000 in six other states that have similar public programs (LeBlanc, et al. 2001). There is virtually no information about the number of people who work as independent contractors to those private employers.

[vi] If the consumer's services are covered under Medicaid, they cannot hire their spouse or in the case of a minor, their parent, but they can hire other family members, friends and neighbors. Consumers who do hire spouses or parents can be covered under what is called the Residual program, which is funded entirely by the state. Half the consumers in San Francisco currently choose a family member or relative and at the state level half of all consumers indicate that they have hired a family member, friend or neighbor (CDSS 2001).

[vii] In a book of drawings Karen Sherr (2002) has illustrated the relationship between an elderly Irish client and her Filipina homecare worker. The book describes the fear and anxiety and loss of privacy that may grip the client when a new person enters her house to provide these services. It also illustrates the vulnerability of the provider, who must balance the complicated needs of her own very low income household with those of her client.

[viii] Author's calculations from CMIPS data.

[ix] As is discussed later in this paper, some of the turnover should be considered a natural consequence of the death or reclassification of clients. An alternative measure, one that measures retention and therefore nets out those providers who leave service because they are attached to a client that leaves, turnover was closer to 27 percent.

[x] The descriptive statistics that follow are calculated using November 1997 data from the San Francisco Case Management, Information and Payroll System (CMIPS) database which is provided to the county by the state. This is the first month the data were available. Because the wage rate did not begin to rise significantly above the state minimum wage until July 1998, the workforce in 1997 represents the workforce before the impact of significant improvements in compensation.

[xi] Thirty-seven percent of all recipients are foreign-born (CDSS 2002a). Since many recipients are being cared for by friends or neighbors, in all likelihood, many of the providers are foreign-born as well.

[xii] Although most IHSS workers work part-time at their IHSS work, many of them probably have other jobs. Howes, et al. (2002), found that 40 percent of providers in Alameda County, California, which is across the Bay from San Francisco, had more than one job, and 45 percent of the workforce worked more than full time at all jobs.

[xiii] Data availability set the constraint on the period of analysis, as data were available beginning only in November 1997 and at the time of the analysis through February 2002.

[xiv] This wage increase coincides with the beginning of the CalWorks program. CalWorks was the California version of Welfare Reform and it is possible that some entry and exit into the workforce was linked to the effect of new work requirements. Approximately 12 percent of workers in Alameda County reported that they had been on welfare immediately before taking the job. However, the inclusion of a variable to capture the effects of CalWorks was not significant in the logit regression analysis, possibly due to multicollinearity problems, as will be discussed below.

[xv] Twenty-six percent of all recipients who left IHSS services in California between August 1998 and December 2001 returned during that period (CDSS 2002a).

[xvi] Some consumers may augment their providers IHSS wage. In a survey in Alameda County (Howes, et al. 2002), where the wage was only $8.50 at the time, we found that 7 percent said consumers sometimes paid extra and only 2 percent said they usually or always received extra money from their consumer. Such data are not available for San Francisco. But the small numbers who regularly supplement their providers wages in homecare suggest this is not an important consideration.

[xvii] In an earlier specification, I included two dummy variables to capture the effect of being a non-family same-ethnicity provider (NFSE) and a non-family different-ethnicity (NFDE) provider (with family provider as the base category). I expected both NFSE and NFDE providers to be of shorter duration than family providers and that the NFDE would have the shortest duration. However, there was no real distinction between NFSE and NFDE effects on retention.

[xviii] Seventy-two percent of the workforce is female. Gender did not prove to be a statistically significant explanatory variable and so was not included in final regressions.

[xix] Those results are not presented in part because, as suggested above, I am more interested in turnover of new workers whose departure disrupts their consumers lives and in part to limit the paper to a manageable length.

[xx] The averages are for the period up to February 2001, because I am measuring the probability of a provider lasting one year into the future. Since the data end in February 2002, the probability of lasting a year is measured for each month up to February 2001.

CARSEY INSTITUTE

POLICY BRIEF NO. 7

SUMMER 2007

Low Wages Prevalent In Direct Care and Child Care Workforce

KRISTIN SMITH AND REAGAN BAUGHMAN

The large scale movement of women into the paid labor market has brought sweeping change to the structure of family life, affecting who cares for the elderly and children. Today, our society depends, in part, on the caring work of many paid professionals and, as the number of elderly and children grow as is predicted by demographers, our society will increasingly depend on these workers. This policy brief examines the economic well-being of workers in two low-wage, predominantly female care giving occupations plagued with high turnover—direct care workers (personal care assistants, home care aides, home health aides, and certified nursing assistants) and child care workers (preschool and nursery school teachers, center-based child care providers, and home-based family child care providers). High turnover in both the direct care and child care workforce contributes to lower quality care leading to unfavorable outcomes for the elderly and children. Although these paid caregivers are employed, hourly wages are low and many live in low-income families and lack health insurance. Furthermore, research shows that those who work in occupations involving care work face a wage penalty, that is they earn less than expected based on their job characteristics and qualifications.[1]

Direct Care and Child Care: Fast Growing Occupations in the Nation

As the baby boom cohort nears retirement age, the question of how to provide necessary health care and personal services to a growing elderly population has become an immediate policy problem facing the United States. By 2030,

Direct care workers provide the majority of paid hands-on care, supervision, and emotional support to millions of people with chronic illnesses and disabilities. These paraprofessional workers hold a variety of job titles, such as personal care assistants, home care aides, home health aides, and certified nursing assistants (CNAs). They work in diverse settings, including private homes, adult day centers, assisted living residences, hospitals, and nursing homes. In their jobs they may:

- assist with personal care activities, such as bathing, dressing, toileting, and eating;
- provide comfort and companionship;
- shop, prepare meals, and clean the house;
- provide oversight, administer medications, and measure vital signs.[2]

Child care workers provide early care and education to millions of preschool-age children, and after-school care and enrichment to gradeschool-age children. They work in child care centers and in private homes, and include preschool teachers, nursery school teachers, family child care providers, early childhood teacher's assistants, nannies, and child care providers.

it is projected that there will be about 70 million Americans aged 65 and older, more than twice their number in 2000.[3] As individuals age, their need for assistance with activities of daily living (ADLs) and long-term care increases.[4] Currently, about 6 million people over the age of 65 require assistance to manage their everyday activities[5] and about 2.6 million Americans worked as direct care workers in 2005.[6] Between 2004 and 2014, direct care occupations are projected to be among the fastest-growing in the nation.[7] In fact, the Bureau of Labor Statistics reports that between 1992 and 2005, home health aide was the fastest growing occupation closely followed by home care aide, highlighting the demand and preference for home-based care.

The demand for child care providers has also grown substantially over the last few decades as more women with children have entered the labor force, and as the number of children in America has grown. By 2030, it is projected that there will be 24 million young children, those four years old or younger, an increase of 26 percent from the number in 2000.[8] The growing number of children in need of nonparental care has fueled the growing number of child care workers. Between 1992 and 2005 the child care occupations grew by 66 percent.[9] The child care workforce is projected to grow 38 percent between 2004 and 2014, a higher rate of growth than projected for the overall workforce (14 percent).

Profile of Direct Care and Child Care Workers

Direct Care and Child Care Workers Predominantly Female

In 2005, 2.7 million workers 19 or older were employed in direct care occupations, constituting 2 percent of the American workforce (see Table 1). Another 1.6 million were in child care occupations (roughly 1 percent of the total workforce).[10] Both of these occupations are predominantly female—89 percent of direct care workers and 97 percent of child care workers are women.[11]

Among female workers, 2.4 million (or 3 percent) are direct care workers and 1.5 million (or 2 percent) are child care workers. Direct care workers are increasingly working as home health aides, as more and more elderly Americans remain in their homes as they age, but still need assistance with activities of daily living. Forty-two percent of female direct care workers are home health aides and another 41 percent are nursing home aides (see Figure 1). The remaining 17 percent work in hospitals. According to the CPS, 12 percent of the child care workforce works in a home environment, and 88 percent work in a child care center.

Table 1. Direct Care and Child Care Workers, 2005

	All Workers		Direct Care Workers		Child Care Workers	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
All Workers	149,326	100	2,673	2	1,561	1
Female Workers	69,557	47	2,389	89	1,510	97

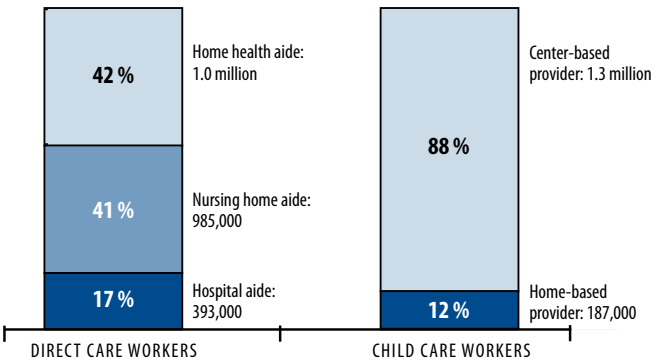
Source: 2006 March CPS
Numbers in thousands. Based on weighted data for workers 19 years and older.

Direct Care Workers Disproportionately Minorities and Foreign Born

Roughly half (49 percent) of female direct care workers are minorities, and black women disproportionately work as direct care workers (see Table 2). Just under one-third of female direct care workers are black, non-Hispanic—a proportion two times higher than that found in the child care workforce and the female workforce overall. Similarly, a higher proportion of direct care workers are foreign born (20 percent) compared with child care workers (16 percent) and all female workers (13 percent). One difference across industry and occupation within the direct care workforce is that home health aides are proportionately less likely to be black, non-Hispanic and proportionally more likely to be Hispanic than the direct care workers employed in hospital or nursing home settings. The child care workforce more closely mirrors the overall female workforce with regard to race and ethnicity, although child care workers are slightly more likely to be Hispanic than all female workers.

Child care workers are more likely to be married than direct care workers (49 percent and 38 percent, respectively), and are more likely to have children. About one quarter of

Figure 1. Distribution of Female Direct Care and Child Care Workers by Occupation Group, 2005



Source: 2006 March CPS

Table 2. Demographic Characteristics of Female Direct Care and Child Care Workforce, 2005

	All female workers	Direct care workers	Child care workers
Race and ethnicity			
White, non-Hispanic	70	51	63
Black, non-Hispanic	13	30	15
Other, non-Hispanic	6	5	6
Hispanic	11	15	16
Foreign born	13	20	16
Marital status			
Married	54	38	49
Previously married	21	31	18
Never married	25	31	33
Children under 18 years	41	43	47
Single mother	14	24	17
Average age	42	41	38
Rural residence	15	20	14
Sample size	48,708	1,696	1,115

Source: 2006 March CPS
Percentages based on weighted data for female workers 19 years and older.

direct care workers are single mothers, while only 17 percent of child care providers and 14 percent of all female workers are single mothers. Nursing home aides are more likely to have children than home health or hospital aides (50 percent, 40 percent, and 32 percent, respectively) and have a higher likelihood of being a single mother. Nearly half of center child care providers have children, and marriage rates are also high among this group of workers, while home child care providers are likely to have never married, nor to have children. These differences in marital status and parenthood status leave direct care workers more vulnerable to economic stress than child care workers as the direct care workers' paycheck is more often the sole support for a family with children.

Child Care Workers More Highly Educated than Direct Care Workers

Close to two-thirds of direct care workers have only attained a high school degree or less, while less than half of child care workers have these low levels of education (see Table 3). About one-quarter of direct care workers have continued their education past high school and acquired some college education.[12] Very few direct care workers have attained an associate's degree (9 percent) or a bachelor's degree or higher (6 percent). However, child care workers appear to be a diverse group in terms of skill, with 27 percent having some college education, 12 percent achieving an associate's degree, and 19 percent having a bachelor's degree or higher.

Direct care and child care workers have similar work hours, with 69 percent of both groups working full-time (35 hours per week or more), which is lower than all female workers (75 percent work full time). Hospital aides and nursing home aides are more likely to be employed full-time (73 percent and 77 percent, respectively) than home health aides (63 percent). Similarly, child care providers working in a home setting are less likely to work full-time than center-based child care providers (59 percent compared with 70 percent).

Direct Care Workers Have Higher Median Hourly Wages, Yet Are More Likely to be Living in Low-Income Families

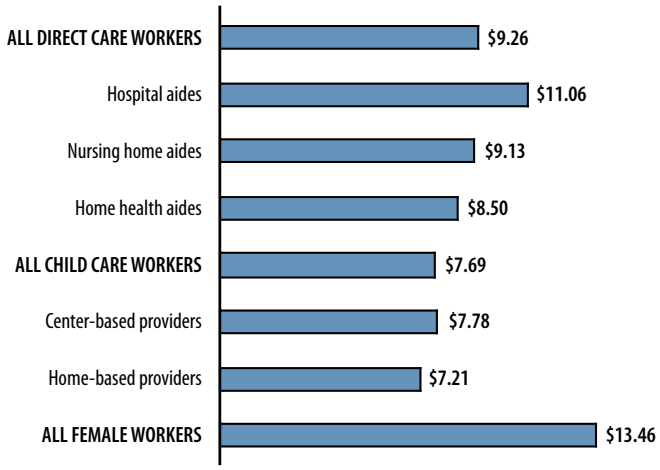
Despite larger investments in education on the part of child care providers, direct care workers median hourly wages are higher than child care workers ($9.26 and $7.69, respectively), although both care work occupations earn substantially less than all female workers ($13.46).[13] Variation exists between the direct care occupation groups—hospital aides

Table 3. Economic Characteristics of Female Direct Care and Child Care Workforce, 2005

	All female workers	Direct care workers	Child care workers
Education level			
High school or less	37	62	42
Some college, no degree	22	23	27
Associate's degree	11	9	12
Bachelor's degree or higher	31	6	19
Average hours per week	37	37	36
Percent full-time (35 or more hours)	75	69	69
Average number of weeks worked per year	46	44	44
Average annual earnings	$30,441	$17,228	$15,125
Average hourly earnings[1]	$18.58	$14.56	$9.89
Median hourly earnings[1]	$13.46	$9.26	$7.69
Average total family income	$74,385	$40,445	$56,203
Percent in poverty	8	19	15
Percent low-income family[2]	22	49	36

Source: 2006 March CPS
Percentages based on weighted data for female workers 19 years and older.
[1] Hourly wages are calculated using total annual earnings in 2005 divided by annual hours worked in 2005.
[2] Low-income families are those living below 200 percent of the federal poverty level.

Figure 2. Median Hourly Wages of Female Direct Care and Child Care Workers, 2005



Source: 2006 March CPS
Hourly wage calculated for workers age 19 and older with positive earnings.

have the highest median hourly wages ($11.06), followed by nursing home aides ($9.13) and home health aides ($8.50). Center child care providers and home child care providers have similar median hourly wages ($7.78 and $7.21, respectively) (see Figure 2).

Although direct care workers earn more per hour than child care workers, they have lower total family income. On average, direct care workers' total family income in 2005 was $40,445, while child care workers' total family income was $56,203. The lower total family income among direct care workers is due to their lower average other family income, comprised mostly of spouses earnings but also includes assets. Recall that direct care workers are less likely to be married than child care workers, thus they are more often the sole economic providers for their families. Despite their work effort, nearly one fifth of all female direct care workers live in poverty and nearly half live in low-income families (below 200 percent of federal poverty line). Although still a sizable proportion, fewer child care workers (36 percent) live in low-income families, and only 22 percent of all female workers live in low-income families.

Direct care workers are also more likely to be minorities. Black, Hispanic, and other minority men's wages are typically lower than white men's wages. Thus, even among married direct care workers, their average total family income is likely lower than child care workers because of the higher proportion of minorities working in the direct care workforce, given that these women are likely to be married to lower earning minority men.

One Quarter of Direct Care and Child Care Workers Uninsured

In 2005, 60 percent of direct care workers had health insurance through the private sector (that is, through their employer, their spouses' employer, or purchased though a private health insurance company), and 38 percent of all direct care workers received health insurance through their employer (see Table 4). Twenty-two percent of direct care workers relied on public health insurance (primarily through Medicaid or Medicare). Fully 25 percent of direct care workers had no health insurance coverage in 2005.

Wide variation in health insurance coverage exists depending on the direct care workers' work setting. Hospital aides have the highest rates of private health insurance coverage (84 percent) and nearly two-thirds receive health insurance through their employer (63 percent). A small proportion relies on public health insurance (10 percent) and only 13 percent are uninsured. Approximately two thirds of nursing home aides receive their health insurance through a private sector source (63 percent) and 44 percent receive health insurance through their employer. Nineteen percent of nursing home aides rely on public health insurance, and 24 percent are uninsured. Home health aides, on the other hand, have the lowest level of private health insurance coverage (49 percent) and only 23 percent receive coverage through their employer. Use of public sector health insur-

Table 4. Health Insurance Coverage for Direct Care and Child Care Workers, 2005

	Private sector insurance[1]			
	All private sector insurance	Employer health insurance	Public sector insurance[2]	No insurance
All female workers	78	51	12	16
All direct care workers	60	38	22	25
Hospital aides	84	63	10	13
Nursing home aides	63	44	19	24
Home health aides	49	23	29	30
All child care workers	61	20	18	27
Center-based providers	62	21	18	27
Home-based providers	53	12	20	33

Source: 2006 March CPS
May total to more than 100% because some workers are covered by more than one type of health insurance.
[1] Private sector insurance includes insurance through an employer or union, or purchased directly from an insurance company.
[2] Public sector insurance includes insurance through Medicare, Medicaid, including state plans, military health care, and Indian Health Services.

ance is relatively high among home health aides (29 percent), but even so, nearly one-third of home health aides have no health insurance.

The story is similar for child care workers, except child care workers have lower rates of employer health insurance than direct care workers, suggesting that child care workers rely to a greater extent on other private insurance, through their husband's employer for example, than direct care workers. Compared with all female workers, both direct care and child care workers are more likely to be uninsured or use public health insurance and less likely to have private sector health insurance. This disparity likely signals differences in employer provision of health insurance coverage and indicates that public insurance is not making up the gap for direct care and child care workers. Often, health insurance coverage is only offered to full-time employees and home health aides and home-based child care providers are less likely to work full-time hours. In addition, direct care and child care workers may not utilize employer health insurance when offered due to their inability to afford the premium.

Direct Care and Child Care Turnover

High Turnover in Caregiving Workforce Problematic in Delivery of Quality Care

Turnover impedes the provision of quality care in both the direct care and child care industries. Nursing homes, other long-term care providers, and state governments say that turnover and vacancies among the direct care workforce is a problem. In a recent national survey, 37 of 43 states reported serious shortages of direct care workers.[14] Additionally, state-level and employer-based studies of turnover among direct care workers report annual rates that range from 25 percent to well over 100 percent.[15] High rates of turnover have negative ramifications for the consumers, employers, and workers. High levels of direct care worker turnover have been shown to adversely affect patient outcomes in nursing home settings[16] and lead to inadequate and unsafe care, poorer quality of life, and reduced access to services.[17] Staff vacancies in the direct care field are associated with a higher risk of medical, physical, and social problems among clients and inconsistent care can negatively affect patients' quality of life and increase their likelihood of health problems.[18] Turnover is costly to employers as well, with the cost of separation, vacancy, replacement, training, and increased worker injuries estimated to be at least $2,500 per separated employee.[19] Workers are adversely affected by high turnover through increased workloads and increased risk of injury, and more stress and frustration.[20]

Similarly, high turnover among the child care workforce is problematic. Research shows that turnover rates among the child care workforce range between 27 and 39 percent annually.[21] Shortages in the elementary schools fuel turnover among the most highly qualified child care workers as teaching jobs offer better pay, benefits and job conditions. High turnover among child care providers contributes to lower-quality care, leading to unfavorable outcomes among children, such as lower language and social development.[22] Child care providers play an important role in promoting child development, especially for preschoolers, whose early life experiences play a critical role in their development. High quality child care enhances early brain development, cognitive and language development, school readiness, and sets the stage for successful early school achievement.[23] Therefore, understanding the factors that prevent turnover among direct care and child care workers can lead to improvements in the quality of care that the elderly and children receive.

Direct Care and Child Care Occupation Retention

Job turnover has been noted as a major and costly problem in the direct-care and child care industry.[24] Turnover is costly for the employer who must recruit and train a replacement worker, and in the case of paid caregivers, it causes discontinuity in care for the elderly or children receiving that workers' care. However, many times an employee leaves her employer, switching to another employer, but remains in the same occupation. Using an individual matched file from the 2005 and 2006 CPS, we present a measure of occupation retention, defined as direct care or child care workers who remain in the same occupation one year later (from the spring of 2005 to the spring of 2006).

Among women employed in the direct care workforce in 2005, 60 percent remained in the direct care occupation a year later in 2006, while 33 percent left the field to work in another occupation and 7 percent left the labor force altogether.[25] A similar proportion, 65 percent, of child care workers were still employed as child care workers one year later, in 2006.

Because characteristics predicting whether a woman will remain working in the care giving occupations are closely related to each other—for example, lower educated women also tend to have lower earnings—a multivariate regression analysis was used to ascertain the independent effects of each of the listed characteristics on the likelihood of remaining in the care giving profession one year later (from 2005 to 2006), statistically controlling for each of the other factors. The odds ratios are presented to indicate the relationship between the characteristic and the likelihood of remaining in the care giving profession (either direct care worker profession or child care worker profession separately) relative to a woman in the reference category. An odds ratio of 1.0

Direct Care and Child Care Workers in Rural America

Direct Care Workers Disproportionately Reside in Rural America

Direct care workers are more likely to live in a nonmetropolitan, or rural area (20 percent) than child care workers (14 percent) and all female workers (15 percent). Nursing home aides have the highest prevalence of rural residence at 22 percent, followed by 19 percent of home health aides, and 17 percent of hospital aides. Only 8 percent of home-based child care providers reside in rural areas, while 15 percent of center-based child care providers reside in rural areas. The lower fraction of hospital aides and home-based child care providers relative to the other types of direct care and child care workers in rural areas may reflect the constrained choice available to rural residents when choosing care for the elderly or children, since hospital and nursing homes are more likely to be located in metropolitan areas. It may also reflect increased demand for home-based care in rural settings, where nursing home placement would move the elderly farther away from their homes and families. In 2005, 478,000 direct care and 212,000 child care workers lived in nonmetropolitan, or rural areas, while 1.9 million direct care and 1.2 million child care workers lived in metropolitan, or urban, areas.[26]

The rural direct care and child care workforce are more likely to be white, non-Hispanic than the urban caregiving workforce (see Table 5). While 72 percent of rural direct care workers and 88 percent of rural child care workers are white, non-Hispanic, only 45 percent of urban direct care workers and 59 percent of urban child care workers are. One-third of urban direct care workers are black, non-Hispanic and 17 percent are Hispanic. Very few rural direct care or child care workers are foreign born. The high proportion of minority direct care workers, and specifically black direct care workers discussed above, appears to be driven by the high proportion of urban minorities who work in the direct care profession.

Rural direct care and child care workers are more likely to be married than their urban counterparts, but rural child care workers have by far the highest marriage rates (63 percent). About 45 percent of both rural and urban direct care and child care workers have children, but direct care workers (both rural and urban are equal at 24 percent) are more likely to be single mothers than urban child care workers (18 percent) or rural child care workers (10 percent).

Rural and urban direct care workers have similar education levels, however urban child care workers are more highly educated than rural child care workers. Even so, rural child care workers are more highly educated than either the rural or urban direct care workforce. The percent of direct care and child care workers working full-time is the same regardless of rural or urban residence. Health insurance coverage is similar regardless of rural or urban residence for direct care and child care workers, with one exception—rural child care workers rely on public sector health insurance to a greater extent than their urban counterparts.

Rural direct care and child care workers have lower hourly wages than their urban counterparts and child care workers earn less than direct care workers regardless of residence. The median hourly wages of rural child care workers is $6.59, while urban child care workers earn $8.17 per hour. Likewise, the median hourly wages of rural direct care workers is $8.65, and urban direct care workers earn $9.62 per hour. However, rural direct care workers have the lowest average total family income ($35,115), and urban and rural child care workers have the highest total family income ($56,664 and $54,122, respectively). Despite their very low median hourly wages, rural child care workers have higher total family income than either of the rural or urban direct care workers, and are the least likely group to live in poverty, reflecting their high marriage rates and low likelihood of being a single mother. Regardless of rural or urban residence, one-fifth of direct care workers lived in poverty in 2005 and one half lived in low-income families.

Table 5. Characteristics of Rural and Urban Direct Care and Child Care Workers, 2005

	Direct Care Workers		Child Care Workers	
	Rural	Urban	Rural	Urban
Race and ethnicity				
White, non-Hispanic	72	45	88	59
Black, non-Hispanic	18	32	6	17
Other, non-Hispanic	3	6	3	6
Hispanic	7	17	3	18
Foreign born	3	24	1	19
Marital status				
Married	43	37	63	46
Previously married	32	31	12	19
Never married	25	32	25	35
Children under 18 years	45	42	44	47
Single mother	24	24	10	18
Average age	41	41	41	38
Education level				
High school or less	65	61	48	41
Some college, no degree	23	23	30	27
Associate's degree	9	9	8	12
Bachelor's degree or higher	3	7	14	20
Average hours per week	37	36	36	37
Percent full-time (35 or more hours)	69	69	65	69
Health insurance coverage				
Private health insurance	60	60	62	61
Employer health insurance	39	38	15	21
Public health insurance	25	21	24	17
No insurance	24	25	23	28
Average annual earnings	$15,068	$17,775	$11,994	$15,683
Average hourly earnings[1]	$10.72	$15.59	$9.60	$9.98
Median hourly earnings[1]	$8.65	$9.62	$6.59	$8.17
Average total family income	$35,115	$41,839	$54,122	$56,664
Percent in poverty	18	20	8	16
Percent low-income family[2]	50	48	37	36

Source: 2006 March CPS

Percentages based on weighted data for female workers 19 years and older.

[1] Hourly wages are calculated using total annual earnings in 2005 divided by annual hours worked in 2005.

[2] Low-income families are those living below 200 percent of the federal poverty level.

indicates that a woman with this characteristic is as likely to remain in the occupation one year later as a woman with the specified reference or comparison characteristic. Ratios under 1.0 (over 1.0) indicate that a woman is less (more) likely to remain in the occupation.

Higher Wages Increase Retention of Direct Care Workers

Hospital and nursing home aides are more likely to remain in the direct care occupation than home health aides (see Table 6). The odds that hospital aides remain in the direct care occupation are 2.4 times greater than the odds that home health aides remain in the direct care occupation. Nursing home aides also have higher odds of remaining in the direct care occupation than home health aides (1.7 times more likely).

Higher annual earnings increase the likelihood of remaining in the direct care occupation. As annual earnings rise, the odds of remaining in the direct care occupation increase by 21 percent, after statistically controlling for the effects of other factors.

Likewise, direct care workers with children under 18 are more likely to remain in the direct care workforce. Hispanic women are 1.7 times as likely as white, non-Hispanic women to remain in the direct care workforce over the 1-year period. Older direct care workers are more likely to remain in the direct care workforce.

Longer Work Hours Increase Retention of Child Care Workers

The number of hours worked is significantly associated with whether a child care worker remains in the child care workforce one year later. After controlling for the other factors in the statistical model, the odds of remaining in the child care workforce increase by 2 percent with every additional hour worked per week.

Race and ethnicity are significantly associated with whether a child care worker remains in the child care workforce, with white, non-Hispanic women being more likely to remain than Hispanic and other, non-Hispanic women. Similar to direct care workers, having a child under 18 increases the odds of remaining in the child care workforce, as does age.

Table 6. Logistic Regression Predicting Odds of Remaining in Direct Care or Child Care Workforce

	Direct Care Workers Remain in Direct Care Occupation in 2006	Child Care Workers Remain in Child Care Occupation in 2006
	Odds Ratio	Odds Ratio
Direct care worker		
Hospital aide	2.39*	NA
Nursing home aide	1.65*	NA
Home health aide	1.00	NA
Child care worker		
Center-based provider	NA	1.20
Home-based provider	NA	1.00
Annual personal earnings (log)	1.21*	1.08
Hours worked per week	0.99	1.02*
Employer health insurance	0.88	0.74
Any college	0.74	1.37
Married	0.99	1.34
Children under 18 years	1.63*	1.68*
Race and ethnicity		
White, non-Hispanic	1.00	1.00
Black, non-Hispanic	1.19	0.56
Other, non-Hispanic	0.58	0.42*
Hispanic	1.71*	0.97*
Age	1.02*	1.02*
Sample size	482	356
chi-square	41.9	34.3
degrees of freedom	12	11

Source: Individual-Matched 2005–2006 March CPS
** Significant at the 90-percent confidence level.*
NA Not applicable.
Based on unweighted data for workers 19 years and older surveyed in both 2005 and 2006.

Discussion: Policies to Increase Wages

Research links high turnover in both the direct care and child care workforce to lower-quality services and care and to negative effects on children and the elderly. Improving the quality of these paid care giving positions, through increased wages, benefits and working conditions is key to recruiting and maintaining a quality direct care and child care workforce.[27] Our findings show that direct care workers with higher wages are more likely to remain in the direct care workforce one year later. The recently passed legislation to raise the federal minimum wage from $5.15 per hour to $7.25 per hour will effectively increase the wages of many paid caregivers—32 percent of direct care workers' and 46 percent of child care workers' wages will increase by a hike in the minimum wage (see Figure 3). In 2005, 12 percent of direct care workers and 28 percent of child care workers were paid an hourly rate of $5.15 or lower. Another 20 percent of direct care workers and 18 percent of child care workers earned between $5.16 and $7.25 per hour. Some states have legislation that sets their minimum wage higher than the federal minimum wage,[28] and it is also possible for states to establish a wage floor for a specific occupation through legislation.

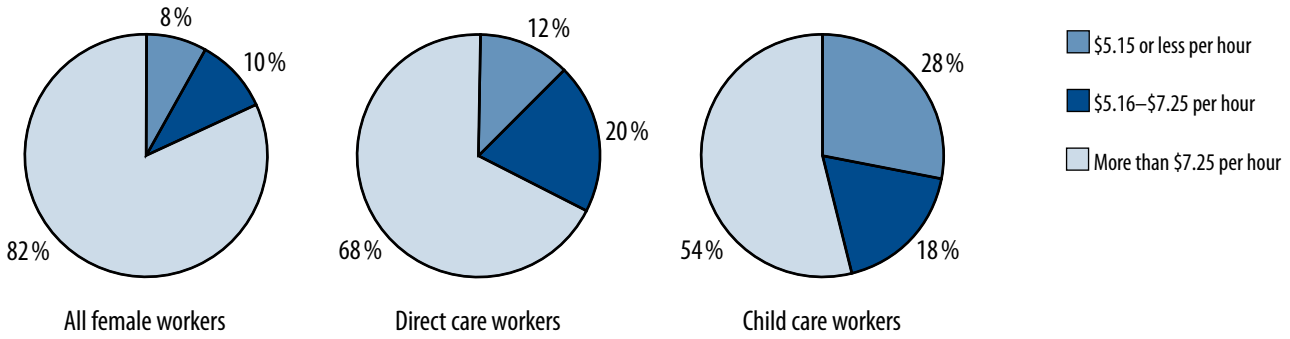
A second policy geared toward raising the wages of direct care workers is currently being implemented in many states. Medicaid is the primary payer for long term care in the United States and contributes more than half of the direct care worker reimbursement funds. Twenty-three states are experimenting with raising the reimbursement rates via "wage pass-through" provisions in their Medicaid programs targeted at direct care workers. States have structured their pass-through provisions in a variety of ways, but regardless of the structure, the intent is to increase the labor supply of direct care workers, with the particular aim of decreasing turnover.

As many of these policies have only recently been implemented, it is not clear whether or not they have achieved the intended effect.[29] However, there is some evidence that wage pass-through provisions are ineffective for a number of reasons, including: the amounts may be too small to make a difference; they are an unreliable source of funding as they are not automatic from year to year; they usually target one industry of the direct care workforce (nursing homes); and some states fail to monitor that the pass-through actually is distributed to the worker through increased wages or benefits.[30]

Other strategies advanced by states, localities and advocates to improve direct care wages and benefits include linking rate increases to provider performance goals and targets; collective bargaining by direct care workers; and pursuing living wage advances, minimum wage improvements, and health insurance initiatives targeted at direct care workers.[31]

Several states have initiatives to build a more skilled and stable child care workforce.[32] One strategy used to simultaneously increase wages for child care providers and improve quality of child care services is a tiered reimbursement rate system, with higher reimbursement rates for child care centers with higher credentials and more highly educated staff, and offering rewards to those centers with the greatest improvements in measures of quality. Another initiative uses professional development stipends for child care providers who meet certain educational and training qualifications.

Figure 3. Distribution of Direct Care and Child Care Workers by Minimum Wage Categories, 2005



Source: 2006 March CPS

Conclusions

One in every two direct care workers and one in every three child care workers live in a low-income family (below 200 percent of the poverty line), and many live in poverty. Hourly wages for the caregiving workforce are low and many lack health insurance. Despite work, these families struggle to make ends meet. Our society depends on the care work of many paid professionals—direct care and child care workers—to help meet the daily needs of our children and the elderly. To stem turnover and provide quality services to young children and the elderly, job conditions among the direct care and child care workforce must improve, and increasing wages is a promising place to start.

Data used in this policy brief

Analyses presented in this policy brief rely on data from the U.S. Census Bureau's 2006 Annual Social and Economic Surveys (ASEC) of the Current Population Survey (CPS). The CPS provides a nationally representative sample of households and the individuals in those households, and collects demographic, economic, and employment information. The CPS is a widely used source of data on labor force issues in the United States, and provides official government statistics on employment, poverty, and health insurance coverage. Demographic information refers to respondents' characteristics in the year of the survey (2006), while employment and income information refer to the preceding year (2005).

The direct care and child care workforce is identified based on both occupation and industry variables in the CPS for the longest job held in the previous year, or in 2005, following methodologies used in previous research.[33] By including both occupation and industry in the definition we can exclude occupations or industries that are not generally considered part of the direct care or child care workforce (such as health aides that work in manufacturing plants). Specifically, the direct care occupation codes included are personal and home care aides (3600) and nursing, psychiatric, and home health aides (4610). Direct care industries include private households (9290), hospitals (8190), nursing care facilities (8270), residential care facilities, without nursing (8290), outpatient care centers (8090), home health care services (8170), individual and family services (8370), and other health care services (8180). This yields a sample size of 1,696 female direct care workers 19 years old and over: 278 hospital aides, 703 nursing home aides, and 715 home health aides. With regard to the child care workforce, the child care occupation codes included are preschool teachers (2300) and child care workers (4600), and child care industries include private households (9290) and child day care services (8470), which yields a sample size of 1,115 female child care workers 19 years old and over: 989 center-base child care providers and 126 home-based child care providers.

The analysis of one-year workforce retention rates is based on an individual matched file created from the 2005 and 2006 CPS files. Households participate in the CPS on a rotating basis. Each household is interviewed for four consecutive months and then reinterviewed for four additional months one year later. Therefore, roughly 40 percent of the households interviewed in the spring of 2005 were also interviewed one year later, in the spring of 2006. Because of sample attrition due to geographic mobility, interviewer error, processing problems linking the same individuals across the two surveys, and response error, our individual linked file represents approximately 32 percent of the original 2005 sample (yields a sample size of 482 direct care and 356 child care workers). The linked file has several advantages that recommend its use, including its large sample size that allows for subgroup analysis like the present study, conventional information on employment status and earnings, occupation and industry, and demographics, and clearly defined beginning and end points for measuring transitions.

Comparisons presented in the text are statistically significant at the 0.10 level. See the shadow box at the front of this brief for definitions of the direct care and child care workforce. The term "rural" here refers to persons living outside the officially designated metropolitan areas. "Urban" refers to person living within metropolitan areas. For more information on official definitions, see Office of Management and Budget, OMB Bulletin No. 60-01 (December 5, 2005), available at http://www.whitehouse.gov/omb/bulletins/fy2006/b06-01_rev_2.pdf.

Endnotes

[1] England, P., M. Budig, and N. Folbre. 2002. "Wages of Virtue: The Relative Pay of Care Work." *Social Problems*. 49(4): 455–473.

[2] Wright, B. 2005. "Direct Care Workers in Long-Term Care." Washington, DC: AARP Public Policy Institute.

[3] U.S. Census Bureau projections. "Table 2a. Projected Population of the United States by Age and Sex: 2000 to 2050". Accessed online at http://www.census.gov/ipc/usinterimproj/natprojtab02a.pdf on January 3, 2007.

[4] U.S. Congress, Committee on Ways and Means. 2004. *The Green Book*. Government Printing Office: Washington, D.C.

[5] Paraprofessional Healthcare Institute (PHI) and North Carolina Department of Health and Human Services (NCDHHS). 2004. "Results of the 2003 National Survey of State Initiatives on the Long-term Care Direct-Care Workforce." New York: Paraprofessional Health Care Institute.

[6] U.S. Bureau of Labor Statistics (BLS). 2005. "Occupational Employment Statistics May 2005." Washington, DC: U.S. Bureau of Labor Statistics.

[7] Hecker, D. 2004. "Occupational Employment Projections to 2012." *Monthly Labor Review*. Washington, DC: U.S. Bureau of Labor Statistics.

[8] U.S. Census Bureau projections. "Table 2a. Projected Population of the United States by Age and Sex: 2000 to 2050". Accessed online at http://www.census.gov/ipc/usinterimproj/natprojtab02a.pdf on January 3, 2007.

[9] U.S. Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook,* 2006–07 Edition, *Child Care Workers,* Accessed online at http://www.bls.gov/oco/ocos170.htm on May 07, 2007.

[10] Researchers estimate the child care workforce to be approximately 2 million, when including child care teachers, teacher's assistants, and child care workers. It is suspected that home-based child care providers are undercounted by the CPS, due to the reluctance of some workers to declare their occupation if they are concerned about unreported income, or if they do not define their child care services as an occupation, as in the case of relatives caring for children. The figures presented in this policy brief likely underrepresent the number of paid relatives, nannies, and other paid non-relatives (such as friends, neighbors, and licensed and unlicensed family child care providers) caring for children. See Burton, A., M. Whitebook, M. Young, D. Bellm, C. Wayne, R. Brandon, and E. Maher. 2002. "Estimating the Size and Components of the U.S. Child Care Workforce and Caregiving Population." Washington, DC: Center for Child Care Workforce, and Seattle, WA: Human Services and Policy Center.

[11] The remainder of this brief describes the female direct care and child care workforce 19 years old or older.

[12] The federal government requires that Certified Nursing Assistants (CNAs) have a minimum of 75 hours of training, and this training is provided at community colleges and trade schools, as well as by certain employers and non-profit agencies. Less training or no training is required for Licensed Nursing Assistants (LNAs), home health aides, personal care assistants, etc.

[13] A median wage means that 50 percent of the workers in the occupation earn wages below this figure, and 50 percent earn wages above it. Hourly wages are calculated using the total annual earnings in 2005 divided by the annual hours worked in 2005.

[14] Of the 478,000 rural direct care workers, 67,000 (14%) are hospital aides, 218,000 (46%) are nursing home aides, and 193,000 (40%) are home health aides. Of the 212,000 rural child care workers, 198,000 (93%) are center-based child care providers and 14,000 (7%) are home-based child care providers. Of the 1.9 million urban direct care workers, 326,000 (17%) are hospital aides, 754,000 (40%) are nursing home aides, and 812,000 (43%) are home health aides. Of the 1.2 million urban child care workers, 1.1 million (87%) are center-based child care providers and 173,000 (13%) are home-based child care providers.

[15] Wright, 2005.

[16] PHI and NCDHHS. 2004.

[17] Barry, T., D. Brannon, and V. Mor. 2005. "Nurse Aide Empowerment Strategies and Staff Stability: Effects on Nursing Home Resident Outcomes." *The Gerontologist* 45: 309–317.

[18] Dawson, S. and R. Surpin. 2001. "Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care." New York: Paraprofessional Health Care Institute; and Super, N. 2002. "Who Will Be There To Care? The Growing Gap Between Caregiver Supply and Demand." Washington, DC: The George Washington University.

[19] Coleman, B. 2003. "Consumer Directed Personal Care Services for Older People in the U.S." Washington, DC.: AARP Public Policy Institute; and Fleming, K., J. Evans, and D. Chutka. 2003. "Caregiver and Clinician Shortages in an Aging Nation. *Mayo Clinic Proceedings* 78: 1026–1040.

[20] Seavey, D. 2004. "The High Cost of Frontline Turnover in Long-Term Care." Better Jobs, Better Care, Washington, DC: Institute for the Future of Aging Services.

[21] Dawson and Surpin, 2001.

[22] Whitebook, M. 1999. "Child Care Workers: High Demand, Low Wages." ANNALS, AAPSS, 563: 146-161; and Hayes, C., J. Palmer, and M. Zaslow (eds.) 1990. "Who Cares for America's Children? Child Care Policies for the 1990's". Washington, DC: National Research Council, National Academy Press.

[23] Whitebook, M., C. Howes, and D. Phillips. 1990. "Who Cares? Child Care Teachers and the Quality of Care in America: Final Report." Washington DC: Center for the Child Care Workforce.

[24] Shonkoff, J. and Phillips, D. 2000. (eds.) *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academy Press. Pp. 307–20.

[25] Seavey. 2004; and PHI and NCDHHS 2004.

[26] The small total sample size (482 direct care workers and 356 child care workers) who are present in both 2005 and 2006 prohibits examining those who change occupations and those who exit the labor force separately.

[27] Dawson and Surpin, 2001.

[28] The following six states have minimum wages higher than $7.25 per hour as of January 1, 2007: California ($7.50), Massachusetts ($7.50), Oregon ($7.80), Rhode Island ($7.40), Vermont ($7.53), and Washington ($7.93).

[29] The authors investigate whether Medicaid pass-through provisions actually decrease turnover in a separate paper, Baughman, R. and K. Smith. 2006. "Reducing Direct Care Work Turnover: Do Wage Pass-Throughs Matter?"

[30] Seavey, D. and V. Salter. 2006. *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants*. Washington, DC: AARP.

[31] Seavey, D. and V. Salter. 2006.

[32] For a more full discussion of the state initiatives underway, see Whitebook, M. and B. Eichberg. 2001. "Finding a Better Way: Refining and Assessing Public Policies to Improve Child Care Workforce Compensation." Washington, DC: Center for Child Care Workforce.

[33] Montgomery, R., L. Holley, J. Deichert, and K. Kosloski. 2005. "A Profile of Home Care Workers From the 2000 Census: How it Changes What We Know." *The Gerontologist*, 45(5):593-600.

AUTHORS

Kristin Smith is a family demographer at the Carsey Institute and Research Assistant Professor of Sociology at the University of New Hampshire. (kristin.smith@unh.edu)
Reagan Baughman is Assistant Professor of Economics at the University of New Hampshire. (reagan.baughman@unh.edu)

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Huddleston Hall
73 Main Street
Durham, NH 03824

(603) 862-2821

www.carseyinstitute.unh.edu

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THE DIRECT CARE WORKER: The Third Rail of Home Care Policy

Robyn I. Stone
Institute for the Future of Aging Services, American Association of Homes and Services for Aging, 2519 Connecticut Avenue, NW, Washington, DC 20008-1520; email: rstone@aahsa.org

Key Words home health aides, long-term care workforce, staff recruitment, staff retention

■ **Abstract** Home health aides, home care workers, and personal care attendants form the core of the paid home care system, providing assistance with activities of daily living and the personal interaction that is essential to quality of life and quality of care for their clients. High turnover and long vacancy periods are costly for providers, consumers, their families, and workers themselves. In 2002, 37 states identified worker recruitment and retention as major priority issues. Demographic and economic trends do not augur well for the future availability of quality home care workers. Policymakers in the areas of health, long-term care, labor, welfare, and immigration must partner with providers, worker organizations, and researchers to identify and implement the most successful interventions for developing and sustaining this workforce at both policy and practice levels. The future of home care will depend, in large part, on this "third rail" of long-term care policy.

INTRODUCTION

The home is the setting of choice for most Americans who need long-term care. National polls indicate that older adults and younger people with disabilities want to remain in their own homes in their own communities for as long as possible. Many hospitalized individuals with postacute-care needs also rely on home health care to make the transition back into the community, to provide rehabilitation, and to address restorative concerns.

Since the early 1980s, policymakers, providers, and consumers have focused primarily on how to finance home care and, in particular, how to level the playing field between Medicaid-funded nursing homes and community-based long-term care. Federal policymakers have focused most of their attention on how to control expenditures associated with the Medicare home health benefit. Until recently, very little attention has been paid to the availability and quality of the workforce that provides the services and support. During the economic prosperity of the 1990s,

however, providers and consumers began to experience a serious shortage of direct care workers in nursing homes, assisted living, adult day care, and home care. Even individuals able to purchase services in the private market expressed frustration at their inability to find qualified workers. Unlike in the late 1980s, when an economic downturn "solved" the worker shortage, the recent economic slowdown and rising rates of unemployment have not stemmed the tide of unprecedented vacancies and turnover among direct care workers. In a 2002 national survey, 37 states reported that nursing and home care aide recruitment and retention are priority concerns [Paraprofessional Healthcare Inst., submitted; (23)].

Many factors contribute to high vacancy and turnover rates among direct care workers. Wages tend to be quite low. In 2001, the median hourly wage was $8.46 for home health aides and $9.27 for nursing aides, orderlies, and attendants (28). Benefits are typically inadequate. Of particular concern to many workers is the lack of access to health insurance. Where coverage is provided, the premiums and copays are frequently not affordable for most of these low-wage workers living at or near the poverty level.

The negative public image of the home care worker (e.g., a poorly trained woman with few skills receiving low pay for unpleasant work and with little hope for advancement) discourages individuals from seeking or remaining in this occupation. Research supports anecdotal evidence that workers themselves do not feel valued by their employers and, particularly, their immediate supervisors (26). Findings from a number of studies underscore the prominent role supervisors play in determining the frontline workers' levels of job satisfaction and decisions to remain on the job (7). The work is physically and emotionally challenging, and these pressures are exacerbated by staff vacancies and the lack of a backup workforce. At the same time, the clients to be cared for are increasingly more sick and more disabled. Job preparation and continuing education and training frequently fail to prepare workers for these challenges.

CHARACTERISTICS OF THE HOME CARE WORKFORCE

Direct care workers form the core of the paid postacute and long-term care system. After informal caregivers, these frontline workers provide the majority of hands-on care, supervision, and emotional support to millions of people with chronic illnesses and disabilities living in their own homes or other community-based settings. The care they provide is intimate and personal. It is also increasingly complex and frequently both physically and emotionally challenging. Because of their ongoing daily contact with the care recipient and the relationships that develop between the worker and client, these frontline workers are the "eyes and ears" of the care system. In addition to helping with activities of daily living such as bathing, dressing, toileting, eating, and managing medications, these workers provide the personal interaction that is essential to quality of life and quality of care for chronically disabled individuals.

The term direct care worker subsumes several categories of individuals providing home and community-based services. Home health aides tend to be employed by certified home health agencies and work under the supervision of a registered nurse (RN). Those providing home health services reimbursed by Medicare or Medicaid are subject to federally or state-mandated training requirements. Home care or personal care workers hired by state, local, or nonprofit agencies to provide assistance with activities of daily living and other supports may or may not work under RN supervision and may or may not be subject to any training requirements. Independent providers are hired directly by individual consumers rather than through an agency. A growing number of public programs have adopted this consumer-directed model where beneficiaries have the option of hiring and firing their own workers, including family members.

According to U.S. Bureau of Labor Statistics (BLS) estimates (28), home health and personal care aides held about 746,000 jobs in 1998. This figure, however, underestimates the total number of home care workers because many aides are hired privately and may not be included in official federal statistics. One California study of independent home care workers, for example, reported that the state employs more than 200,000 independent personal care workers through its In-Home Supportive Services (IHSS) program, 72,000 in Los Angeles County alone (4). In their national study of home care workers providing assistance to the Medicare population, Leon & Franco (15) found that 29% of the workers were self-employed.

A comprehensive profile of nurses' aides (NAs) and home care workers using national data from the Current Population Survey from 1987 through 1989 compared demographic characteristics and work conditions for hospital aides, NAs, and home care aides (5). Yamada (34) updated the data on home care workers using the same data sources and methodology to assess trends in this workforce between the late 1980s and late 1990s. Not surprising, the vast majority of these workers in both periods were female. Compared to the late 1980s, home care aides in the late 1990s were younger, more educated, and more likely to have children. Although home care aides tended to be older than nursing home and hospital aides in both periods, the mean age of home care aides declined over the 10-year period. Home care aides still have less education than other aide categories, but almost 30% of these workers in the late 1990s had at least some college education.

With regard to working conditions, the proportion of home care aides working full time increased over the 10-year period from 29% to 46%. These workers were still less likely to work full time and full year than were NAs or hospital aides. Yamada found that 18% of those working part time preferred to be employed full time but had not been able to find such a position. Home care workers were somewhat more likely than NAs to have earnings from other work (23% compared with 20%), which suggests that many home care aides hold more than one job and work full time but without access to the benefits of full-time status.

Yamada's analysis indicates that these jobs continue to be characterized by low wages and poor benefits. Median hourly wages of home care aides increased

slightly over the 10 years from $5.81 to $6.00 (adjusted to 1998 dollars based on the Consumer Price Index); both mean and median family income increased as well. Hospital aides still had the highest wages of the three groups. In the late 1990s, 16% of NAs and 22% of home care aides were likely to be living at or below the poverty line.

Yamada found little change over the 10-year period in employer-provided health insurance coverage for NAs and hospital aides (42% and 62%, respectively), but the proportion of home care aides with some type of employer-sponsored coverage increased from 14% in the late 1980s to 26% in the late 1990s. Yamada also found a substantial increase in the percentage with Medicaid coverage, nearly tripling in all three groups—11% of NAs, 16% of home care aides, and 5% of hospital aides. These estimates, however, belie the fact that there have been significant increases in coinsurance rates for employees over the past 10 years. The employee portion of the insurance premium can be as high as 50% for long-term care employees (18). For home care aides, this makes health coverage unaffordable. For example, a survey of nearly 200 direct care workers in Massachusetts found that 1 in 4 were uninsured in 2002 (11). Cousineau (4) found that 45% of the 72,000 independent home care workers hired through the IHSS program in Los Angeles were uninsured.

DEFINING THE PROBLEM

The severe shortage of NAs, home health aides, and home care aides that began in the late 1990s has been the primary trend influencing the current wave of concern about the long-term care workforce. High turnovers rates, particularly in the three months posthire, and high vacancy rates have negative effects on providers, consumers, and workers. The cost of replacing workers is high. Zahrt (35) documented the costs of replacing home care workers, including the costs of recruiting, orienting, and training the new employee and the costs related to terminating the worker being replaced (e.g., exit interview, administrative functions, separation pay, unemployment taxes). The total cost associated with each turnover was $3362.

In addition to the financial costs of the initial hire and termination, there are costs associated with lost productivity during the time it takes for each new hire to complete the learning curve (1). Furthermore, this estimate does not include the cost of attrition that occurs between initial hires, training, and retention. White (30) found that out of 351 potential home care worker recruits who completed a scheduled interview, 216 were accepted into the training program, 133 actually started classes, 106 graduated, and only 46 were still with the agency 6 months after they were placed.

Leon and colleagues (16) found that across all Pennsylvania long-term care providers, the estimated annual (recurring) cost of training due to turnover was at least $35 million. Nursing home training costs accounted for $23.9 million and home health/home care agencies' costs accounted for $4.8 million. The regions

encompassing large metropolitan areas accounted for 75% of the costs. In addition to the recurring turnover costs, one-time state training costs for filling currently open jobs were estimated at $13.5 million in 2000.

High turnover and vacancy rates also have negative consequences for consumers. Although there is little empirical evidence to establish causal links, anecdotes and qualitative studies suggest that problems with attracting and retaining direct care workers may translate into poorer quality and/or unsafe care, major disruptions in the continuity of care, and reduced access to care (33). The reduced availability and frequent churning of home care workers may affect clients' physical and mental functioning. A reduced pool of workers also places more pressure on family caregivers, who are already providing the bulk of care to disabled individuals living in the community.

Direct care workers also suffer from the effects of labor shortages and high turnover. Short staffing places undue burdens on individuals who remain on the job. In home care, short staffing may limit aides' personal interaction with their clients. Short staffing may also result in increased rates of injury and accidents, although there have been no empirical studies documenting a direct relationship. These workers are already employed in one of the most hazardous jobs in the service industry (24, 32). Some researchers have speculated that overworked and frustrated workers may also be more likely to physically or emotionally abuse home care clients or become the victims of abuse from underserved clients (Paraprofessional Healthcare Inst., submitted) (22).

The future availability of direct care workers does not look promising. There will be an unprecedented increase in the size of the elderly population as the baby-boom generation ages. This phenomenon will likely translate into increased demand for home and community-based services, particularly in light of the fact that most people prefer to remain in their own homes. The BLS estimates that personal and home care assistance will be the fourth-fastest-growing occupation by 2006, with a dramatic 84.7% growth rate expected. The number of home health aide jobs is expected to increase by 74.6% and that of NAs by 25.4%, although these estimates may be tempered by the rate of economic growth and the extent to which purchasers are willing or able to pay. At the same time, as baby boomers approach old age, the pool of middle-aged women with relatively low levels of education, which has traditionally provided care, will also be substantially smaller. Finally, with very low population and labor force growth, even a "normal" business cycle recession would likely yield only a modest increase in the number of unemployed who could become part of a direct care worker pool.

The problem, however, goes beyond the supply of direct care workers. Simply filling positions with warm bodies is not an adequate solution. Although there is little empirical research documenting the causal link between the quality of home care workers and quality of care/life for consumers, anecdotal evidence suggests that the quality of the worker has a significant effect on clinical, functional and lifestyle outcomes. To develop and sustain a quality home care workforce, policymakers, providers, and consumers must have a better understanding of the mix

of appropriate screening, training, and ongoing clinical and management supports necessary to achieve these objectives.

FACTORS INFLUENCING SUPPLY AND TURNOVER

Most of the studies that have examined the factors affecting the supply of and turnover in the direct care workforce have been conducted in the nursing home setting. The most comprehensive study of home care worker satisfaction and turnover was conducted over a decade ago (8). The research team designed a case-control study with a sample of 1289 workers in 5 cities. They assessed the impact of salary increases, improved benefits, guaranteed number of service hours, and increased training and support on worker retention. In the aggregate, the interventions reduced turnover rates from 11% to 44%. The study found that financial rewards were important to worker satisfaction, motivation, and retention, but several job qualities proved to be even more important. Workers were more satisfied and more likely to remain in the job if they felt personally responsible for their work and received ongoing feedback from their supervisors. The researchers concluded that good personal relationships between management and workers and between the worker and the client are essential for successful retention.

A study of independent home care workers in California (2) found that those workers indicating more decision-making authority over how they do their work reported less stress and greater job satisfaction than those who had little or no control over their own schedules and how care was provided. Another qualitative study (17) of independently employed home care workers found that the relationship with the client was a primary influence on whether someone remained in the job.

A recent study (14) of wage increases for independent home care workers in San Francisco County, California found that a near doubling of the wage rate (not adjusted for inflation) between November 1997 and February 2002 was associated with a 54% increase in the number of workers and a 17% decline in the proportion of the workforce leaving the job within the first year of employment. These results should be interpreted with caution, as other external factors, including a Welfare-to-Work requirement that may have moved some welfare recipients into these jobs and the introduction of a low-cost health plan to home care workers, could have affected supply and turnover outcomes.

THE ROLE OF PUBLIC POLICY

Health and Long-Term Care Policies

Health and long-term care policies at the federal and state levels significantly affect the recruitment and retention of the direct care workforce through reimbursement, regulation, and program design. Medicare and Medicaid account for most long-term care expenditures (25). Their reimbursement policies play a substantial role

in determining workers' wages, benefits, and training opportunities. Although providers have some flexibility in setting wages and benefits, the flexibility is limited by this third-party payer constraint (1). If payment rates fail to keep up with the true cost of providing services, organizations have less flexibility to offer competitive wages and benefits.

For years, states have tried to control Medicaid home care expenditures by placing limits on reimbursement (13). Many home health providers relied on Medicare to make up for Medicaid shortfalls. The Balanced Budget Act of 1997, however, reduced payments to home health agencies and now reimburses through a prospective payment system. At the same time, states are currently experiencing serious budget deficits that threaten to reduce Medicaid rates even further.

Regulatory policy in the long-term care area has focused primarily on protecting the consumer and pays little attention to the needs or concerns of direct care workers. Although the regulations do address the need for training, they do not fully address the range of educational and ongoing support activities that home health aides, homecare workers, and personal care attendants may need in order to assume increasingly complex and complicated responsibilities. Federal law requires home health aides providing Medicare services to pass a competency test covering 12 areas and also requires 75 h of classroom and practical training supervised by an RN. Home care and personal care workers employed by agencies that are reimbursed by Medicaid or other state programs may also be subject to certain training requirements, but this practice varies by state and local community.

One major issue for the development of the home care workforce and those providing services in residential settings, such as assisted living and adult care homes, is the degree to which states are willing to modify their nurse practice acts to allow aides to perform certain tasks (e.g., administering medications, changing catheters). A number of states, including Oregon, Kansas, Texas, Minnesota, New Jersey, and New York have enacted nurse delegation provisions, but the latitude and interpretation of the provisions vary tremendously. The issue is important because nurse delegation provides more autonomy for the worker and also offers an opportunity to create career specialties (for example, medication aide) that may empower workers and perhaps lead to higher wages.

Workforce Development and Educational Policies

Federal and state labor policies also have an important role to play in the expansion of the labor pool and training of direct care workers. The federal Work Investment Act (WIA), administered by the U.S. Department of Labor (DoL), integrates employment, adult education, and vocational services at the state and local level. Local workforce investment boards (WIBs) oversee WIA service delivery and decide how funds will be used. One-stop centers, governed primarily by business leaders representing local industries with employment opportunities, are the hubs of WIA service access and delivery.

DoL's Employment and Training Administration has begun to explore partnerships with employers to create apprenticeship programs for high school students and others interested in becoming nursing assistants and home care workers. The Carl D. Perkins Vocational and Technical Education Act, administered by the U.S. Department of Education, awards grants through the states to state and local secondary and postsecondary educational institutions to prepare individuals for further education and careers in current or emerging fields. The Perkins Act explicitly encourages partnerships between educational entities and employers, presenting opportunities to home care agencies who want to improve direct care worker recruitment and retention.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the Temporary Assistance for Needy Families (TANF) block grant program, replacing Aid to Families with Dependent Children, the country's basic cash assistance program. TANF, administered by the U.S. Department of Health and Human Services (DHHS), espouses a "work first" philosophy and provides funds through a federal/state matching program for supportive services (e.g., transportation, child care), employment counseling and job placement, employability training, and occupational training. Although long-term care providers have been ambivalent about using TANF to expand their labor pool, there are multiple examples of organizations that have had success with training, placing, and retaining former welfare recipients as home care workers and personal care attendants (e.g., the Home Care Cooperative in New York and the IHSS program in San Francisco and Los Angeles).

The Nurse Reinvestment Act of 2002 was passed in response to growing concerns about the nursing shortage in the United States. Although the legislation focuses primarily on activities designed to increase the supply of nurses in hospitals and out-patient acute and primary care settings, the provisions extend to the long-term care sector. The Health Resources and Services Administration, the DHHS agency responsible for implementing the law, has developed a series of grant programs designed to evaluate various career ladder models and to disseminate findings across the health and long-term care fields.

Immigration Policy

Given the current labor shortage and gloomy projections about the future pool of workers, many providers and consumers have turned to immigrants as a source of labor. Immigration accounts for 40% of the labor force growth in the United States (24). Almost two thirds of immigrants come to this country for family unification and are not seeking high-skilled employment opportunities. Therefore, they represent a current and future labor pool for the direct care workforce (25). Consequently, policies that limit the entry of low-skilled immigrants, particularly by limiting family-based immigration, may diminish the future pool of home care and personal care workers (3).

Concerns about immigration have been exacerbated by the war on terrorism and the post-9/11 attitude toward immigrants. It is important, however, to recognize

that immigrants reduce the employment opportunities of low-skilled workers in areas where the domestic economy is weak (9). This negative effect, furthermore, tends to fall disproportionately on people of color, many of whom are employed as direct care workers (31). Thus, the role of immigration policy in mitigating recruitment problems in home care remains complex and uncertain.

STATE AND LOCAL INITIATIVES

Recruitment and retention of the direct care workforce has become a priority for many states. Several studies have documented the range of legislative and administrative initiatives that have been explored over the past four years (10, 19, 20). In the 2002 national survey, 37 states reported that nursing assistant and home care aide recruitment and retention were major policy issues [Paraprofessional Healthcare Inst., submitted; (23)]. Even after the recent economic downturn and rising rates of unemployment, the vast majority of states continue to report significant difficulty in recruiting and retaining qualified direct care workers.

Wage Increases

The most prevalent state initiative designed to ameliorate the workforce dilemma is the "wage pass-through" (WPT). Through this type of initiative, a state designates that some portion of a reimbursement increase (typically for Medicaid, but may include other state funding sources) be used specifically to increase wages and/or benefits for direct care workers. WPTs have been implemented either by specifying some dollar amount per hour or per client day to be used for wages/benefits or by requiring that a certain percentage of a reimbursement increase be used for these purposes. In 2000, 18 states approved or had implemented some form of WPT: 9 targeted to home care workers, 6 targeted to nursing home aides only, and 3 targeted to both groups of workers (21).

There have been no evaluations of either the short- or long-term effects of the WPT strategy and differences in outcomes based on variations in the methodology. Consequently, there is no evidence concerning the extent to which this type of initiative has improved recruitment/retention or the quality of the direct care workforce. Most of the WPTs have been "one-shot" strategies and are subject to the vagaries of the state budgets. In addition, most increases have been relatively modest, limiting their effects on the financial status of home care workers. Given the current state budget crises, state policymakers are unlikely to implement WPTs in the near future.

Health Insurance Coverage

The lack of access to benefits, particularly health insurance, has also been identified as a barrier to effective recruitment and retention. Over the past few years, several states have attempted to increase access for this workforce. Most of the activities

have included home care workers as part of the larger low-income workforce that was covered through expansions of State Children's Health Insurance Program (SCHIP) funds. Given the current state budget crises, however, many states are cutting back on these expansions.

New York's Health Care Reform Act of 2000 authorized the establishment of a state-funded health insurance program to cover uninsured home care workers. The legislation, however, only applied to workers in the New York City metropolitan area, a decision attributed to the strong unionization of the direct care workforce in that part of the state. To date, the program has not been implemented, and given the poor budget situation in New York, its future looks dim.

In 1992, through the active intervention of consumers and organized labor, California began to establish county-based public authorities to assist independent home care workers and consumers participating in the state's IHSS program. These quasi-governmental public authorities created registries to help IHSS consumers identify and hire workers and to help potential workers find jobs. Most significantly, they became the "employers of record" for workers by providing them with a mechanism to bargain for improved wages and benefits.

In 1999, San Francisco County's Public Authority created Healthy Workers, a health insurance plan for its home care workers. Health care services are provided through the county's network of providers. Benefits include doctor visits, hospitalizations, pharmacy services, and vision care with few copays. Workers are qualified to participate if they have worked at least 2 months in the IHSS program with a minimum of 25 hours in 1 of those months. The worker contribution to the monthly premium is $3.00, with IHSS covering the rest (approximately $350 per month per enrollee).

Career Ladders

Several states have explored the development of career ladders for direct care workers by establishing job levels in their public programs, their training requirements, or their reimbursement categories (19). Activities have tended to focus on the design of traditional ladders that provide opportunities for career advancement from aide to Licensed Practical Nurse to RN.

Many direct care workers, however, are comfortable with their occupation and have no desire to move up the ladder of professional licensure. They may, however, be interested in developing additional skills and moving into a job specialty with more authority and higher wages. These advancement opportunities are often referred to as a career "lattice" rather than a "ladder" and include such diverse positions as peer mentor, dementia specialist, and medication aide.

In the early 1990s, the New York City Human Resources Administration supported a study that tested the effectiveness of a new home care position: the field support liaison (FSL). Home care workers were hired and trained specifically to visit care attendants in the field in order to identify problems and provide peer support for workers in the community. A case-control study found that agencies

employing FSLs reduced their turnover by 10% over a 2-year period compared with those not using FSLs (6). Unfortunately, this demonstration never became an operational program because of a lack of city and state funding to support these positions.

The Extended Care Career Ladder Initiative (ECCLI) was created and funded by the Massachusetts legislature in 2000 to develop workforce skills training programs and opportunities for advancement for the direct care workforce (26). To achieve its goals, ECCLI encourages partnerships between long-term care providers, educational organizations, and local workforce development agencies. Since its inception, about $14 million has been allocated to support programs for skill development and advancement through career ladders. Providers have used these resources to create peer mentoring programs and clinical specialty areas such as rehabilitation and dementia care. The initiative was originally targeted to certified nursing assistants (CNAs) in nursing homes but has been expanded to home care.

In 1999, California launched the Caregiver Training Initiative that used $25 million of federal WIA and Welfare-to-Work funds to develop innovative ways to recruit, train, and retain home care workers in the IHSS program, as well as CNAs in nursing homes (12). The Private Industry Council of San Francisco, for example, received a $1.3 million grant to work with county welfare agencies, WIBs, the public authority, organized labor, community colleges, and school districts to increase enrollment in the IHSS training programs, to provide training in basic skills and English as a Second Language, and to improve career opportunities for IHSS home care workers through the development of career ladders. The Northern Rural Training and Employment Consortium, made up of 5 local WIBs, received over $2.6 million to provide career ladder training to an estimated 350 Welfare-to-Work recipients, other low-income individuals, dislocated homemakers, and youth who had aged out of the state's foster care program.

In 2001, North Carolina received a $1.6 million Real Choice grant from DHHS' Center for Medicare and Medicaid Services to improve recruitment and retention of home care aides and personal care attendants. (The Real Choice program is a federal initiative to help states expand their home and community-based service programs for people with disabilities.) Grant activities included developing a career ladder for direct care workers and helping to establish a statewide association of workers to enhance their education, professional development, and public image.

Expanding the Labor Pool

Given the current shortage and, more important, projections that the pool of potential workers will continue to shrink over time relative to the increasing demand, states are searching for alternative sources of workers. Some states have been experimenting with options for recruiting high school students through the School to Work Opportunities Act of 1994. Wisconsin, for example, received funds to create a Youth Apprenticeship program for direct care workers in nursing homes and assisted living.

New Jersey, New Mexico, New York, Florida, and Arkansas have been somewhat aggressive in using TANF dollars to help prepare former welfare recipients for direct care jobs. The Riverside County WIB in California used WIA and Welfare-to-Work funds to develop the Migrant Farm Worker and Limited English Proficiency Training Program. This initiative matches local long-term care provider needs for direct care workers with the migrant farm workers' need to increase and stabilize their income.

In 1999, the Wisconsin Bureau of Aging and Long-Term Care Resources awarded grants to 28 counties through its Community Options Program to help expand the home- and community-based workforce. One recipient, the Kenosha County Division on Aging and the Long-Term Care Staffing Task Force used its grant to develop an image campaign to enhance recruitment. The campaign resulted in an increased enrollment in the local technical college's nursing assistant classes, perhaps leading to an expansion of the pool. More recently, the Lancaster County WIB in Pennsylvania created a working group of stakeholders and launched a 10-county media campaign through a partnership with a local TV station to recruit health care workers at all levels. The WIB contributed $100,000 to create the messages, and 34 providers, including 15 long-term care providers, contributed $560,000 to buy airtime for the project by purchasing "employer recognition tags" for each televised message. Although there has been no formal evaluation, preliminary evidence suggests that waiting lists have developed at all the region's allied health training programs following the airing of approximately 30 messages on a weekly basis.

North Carolina used part of its $1.6 million Real Choice grant to develop a public education and awareness campaign entitled "Challenging Careers, Compassionate Hearts." The multimedia activity was designed to improve the image of the direct care worker and to assist with recruitment of workers into home and community-based service jobs.

PROVIDER-BASED INITIATIVES

Providers across the range of long-term care settings have experimented with various interventions to enhance their ability to recruit and retain workers and to develop a quality workforce (26, 27). A review of the literature and discussions with key stakeholders found that most of the activity has been occurring in nursing homes. The vast majority of these initiatives, furthermore, have not been formally evaluated.

In 2002, the U.S. Department of Health and Human Services funded the Institute for the Future of Aging Services (an applied research group within the American Association of Homes and Services for the Aging in Washington, DC) and the Paraprofessional Healthcare Institute (a worker-based research and policy group in the Bronx, New York) to create a database of promising provider practices in recruiting, retaining, and sustaining a quality direct care workforce. Drawing on the literature, discussions with key informants, and interviews with staff from

sites with innovative programs, the project team identified 40 practices that met the following criteria: (*a*) The activity was ongoing and not just a research or demonstration project, (*b*) there was evidence of success based on external evaluations or documented internal assessments, and (*c*) the organization was willing to be contacted by interested parties. The following provides some examples of promising practices currently underway in home care. (For more information, readers can access the provider practice database at http://www.futureofaging.org or http://www.directcareclearinghouse.org.)

Cooperative Home Care Associates (CHCA), a worker-owned and -operated home care agency in the Bronx, New York employs approximately 650 direct care workers serving home care clients in the Bronx and upper Manhattan. Since its inception in 1985, CHCA has developed a five-pronged approach to recruiting, training, and retaining direct care workers. The elements include targeted recruitment (significant upfront assessment and screening), enhanced training (adult learner–centered training, communication, and problem solving and on-the-job training), supportive services (access to full-time counselors and coaching in clinical and life skills), opportunities for personal and professional growth (worker participation in all decisions, career advancement, and leadership development), and wage and benefit enhancements. Of the aides CHCA trained between July 2001 and June 2002, 87% were employed with the agency after 90 days, and 72% were still working there after one year. Despite a doubling of its size since 1998, more than 25% of its workforce has been with CHCA for at least 5 years.

Since 1994, the George G. Glenner School of Dementia Care in San Diego, California has partnered with local Alzheimer's day care centers and home care agencies. The organization, supported primarily by WIA and Welfare-to-Work funds, recruits unemployed individuals, welfare recipients, and other low-income people with the potential to become certified home health aides, provides vocational training to assist enrollees in obtaining certification, provides specialty training in dementia care, assists graduates with internships and job placement, and provides follow-up supports for six months following graduation. Internal evaluations indicate that 80% of the graduates are employed as direct care workers six months after completing the program.

Home Care Associates of Philadelphia, a home care agency that employs approximately 125 home health aides and personal care attendants, developed a four-week entry-level training program that includes the "4Ps." This curriculum breaks down the problem-solving process into four steps. *Paraphrase* teaches trainees to listen actively and ask questions to gain a full understanding. *Pull Back* encourages trainees to gain emotional control in stressful situations. *Present Options* teaches trainees to identify critical facts, brainstorm solutions, consider the consequences, and present options to the client or supervisor. *Pass It On* encourages trainees to pass on important information to a supervisor or others involved in a situation. Current home health aides provide the real-life situations for role-playing and act as models and mentors for the trainees. The 4Ps are also integrated into the everyday interactions between agency staff and between aide and client.

Cooperative Care Inc. is a worker-owned home care agency based in Wautoma, Wisconsin and serves three rural counties. This worker cooperative was founded in 2002 to offer to certified home health aides in rural communities opportunities for high-quality employment, leadership, and profit-sharing. Co-op members are entitled to differential pay for unscheduled work, paid travel time, 9 paid holidays per year and overtime pay, subsidized health insurance for those who work at least 30 hours per week (company pays 75% of the premium), a flexible benefit plan, and subsidized training. The organization's start-up was supported by a state grant and a $125,000 bank loan. The co-op is currently self-supporting through client payments (including a contract with the 3 county-based home care programs) and a $50 initial membership fee.

CONCLUSION

The future of home care will depend, in large part, on the development and support of a quality workforce. Individuals with chronic illness and disabilities may prefer to "age in place" in their own homes and community-based settings, but this will not be possible without qualified, committed home care aides, personal care workers, and other direct care workers to provide the services and to support informal caregivers. Policymakers, providers, and consumers must recognize this "third rail" of home care policy and work in partnerships to create policies and practices that address both recruitment and retention goals. Furthermore, it is not enough to find and retain "warm bodies." The quality of that workforce must also be addressed, and resources must be invested in the training, ongoing education, and supports needed to produce and sustain quality caregivers.

Much of the current knowledge about promising policies and practices comes from the nursing home sector. We need to examine the applicability of various strategies that have been developed in nursing homes to home care and other community-based settings. We know, for example, that the relationship between the nurse supervisor and the nursing assistant significantly affects worker job satisfaction and retention and that some of the "culture change" activities in nursing homes (e.g., the Pioneer Homes, Wellspring) have improved these outcomes by flattening the organizational hierarchy and empowering the frontline workers (26). We do not, however, know what strategies would work best in home care and other community-based settings. Policymakers and providers, therefore, must partner with researchers to conduct demonstrations and evaluations of initiatives designed specifically to enhance the recruitment and retention of home health and home care aides, personal care workers, and attendants. Assuming we identify the optimal set of interventions, we will also need to figure out how to sustain the success over time.

We also need to explore creative ways of developing new pools of workers who can meet the demand for home care services in the future. Large influxes of immigrants or cadres of former welfare recipients will not solve the problem. It

is imperative that we develop and test new strategies for expanding the potential pool, including exposing young students and elderly retirees to the possibility of obtaining quality jobs that improve the lives of people in their care.

The Robert Wood Johnson Foundation and Atlantic Philanthropies recently developed a $15 million grant program to support state-based policy and practice demonstrations in Iowa, North Carolina, Oregon, Pennsylvania, and Vermont, and 8 applied research projects designed to advance our knowledge about long-term care workforce development. The Institute for the Future of Aging Services is serving as the national program office for this project called Better Jobs Better Care (BJBC), and the Paraprofessional Healthcare Institute in the Bronx, New York is the primary technical assistance contractor. It is hoped that BJBC will provide important information about policy and practice strategies that work and do not work in recruiting and retaining a quality direct care workforce. This national program will also provide an opportunity for shared learning across states, providers, and worker organizations and allow wide dissemination of information across long-term care settings.

Ultimately, the public will have to make some decisions about the value of this workforce, including whether these direct care workers deserve a livable wage and adequate benefits. Home health aides, home care and personal care workers, and attendants, together with families and friends, provide the majority of care in this country. Changing the image and rewards of the job are essential for the future development of this workforce.

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LITERATURE CITED

1. Atchley RC. 1996. *Frontline Workers in LTC Recruitment, Retention, and Turnover: Issues in an Era of Rapid Growth.* Oxford, OH: Scripps Gerontol. Cent.
2. Benjamin AE, Matthias RE, Franke T. 2000. Comparing consumer-directed and agency models for providing support services at home. *Health Serv. Res.* 35(1, Pt. II):351–66
3. Camarota SA. 1998. *The Wages of Immigration: The Effects on the Low-Skilled Labor Market.* Washington, DC: Cent. Immigr. Stud.
4. Cousineau MR. 2000. Providing health care insurance to IHHS providers (home care workers) in LA County. Rep. Calif. HealthCare Found. Oakland, CA
5. Crown WH, Ahlburg DA, MacAdam M. 1995. The demographic, employment characteristics of home care aides, and other workers. *Gerontologist* 35(2):162–70
6. Feldman PH. 1993. Work life improvements for home care workers: impact and feasibility. *Gerontologist* 33(1):47–54
7. Feldman PH. 1994. Dead end work or motivating job? Prospects for frontline paraprofessional workers in long-term care. *Generations* 18(3):5–10
8. Feldman PH, Sapienza A, Kane N. 1990. *Who Cares for Them? Workers in the Home Care Industry.* Westport, CT: Greenwood
9. Fix M, Passel JS. 1994. *Immigration and Immigrants: Setting the Record Straight.* Washington, DC: Urban Inst.

10. Gen. Account. Off. 2000. *Nursing Homes: Sustained Efforts are Essential to Realize Potential of the Quality Initiative*. GAO/HEHS-00–197. Washington, DC: Gen. Account. Off.
11. Hams M, Herold N, Lee M, Worters A. 2002. Health insurance access survey of direct care workers in nursing homes and home-based care agencies in Boston, New Bedford/Fall River: Final Rep. Health Care for All, sponsored by the Direct Care Workers Initiative and Paraprofessional Healthcare Institute. Boston, MA
12. Harahan M, Kiefer K, Edelstein S. 2003. State-based initiatives to improve the recruitment and retention of the paraprofessional long-term care workforce. Monogr. Off. Assist. Secr. Plan. Eval., US Dep. Health Hum. Serv., Washington, DC
13. HCIA-Sachs Arthur Andersen LLP. 2000. *The Guide to the Nursing Home Industry*. Baltimore, MD: HCIA
14. Howes C. 2002. The impact of a large wage increase on the workforce stability of IHSS home care workers in San Francisco County. Work. Pap., Univ. Calif. Berkeley Cent. Labor Educ. Res., Berkeley
15. Leon J, Franco S. 1998. Home- and community-based workforce. Final Rep. Henry J. Kaiser Found. Bethesda, MD: Proj. Hope
16. Leon J, Marainen J, Marcotte J. 2001. *Pennsylvania's Frontline Workers in Long-Term Care: The Provider Organization Perspective*. Jenkintown, PA: Polisher Geriatr. Inst. Phila. Geriatr. Cent.
17. Luz C. 2001. *Self-employed caregivers: their motivations, labor conditions, and patterns of decision making related to work selection and tenure*. Unpubl. diss. Univ. Wisconsin, Milwaukee
18. Michigan Assist. Living Assoc. 2001. Mental health provider 2001 Wage Benefit Survey. Michigan Assist. Living Assoc. Lansing, MI
19. North Carolina Div. Facil. Serv. 1999. Comparing state efforts to address the recruitment retention of nurse aide and other paraprofessional aide workers. North Carolina Div. Facil. Serv. http://facility-services.state.nc.us
20. North Carolina Div. Facil. Serv. 2000. Results of a follow-up survey to states on wage supplements for Medicaid and other public settings. http://facility-services.state.nc.us
21. North Carolina Div. Facil. Serv. 2001. Results of a follow-up survey to states on career ladder and other initiatives to address aide recruitment and retention in long-term care settings. North Carolina Div. Facil. Serv. http://facility-services.state.nc.us
22. Dawson S, Surpin R. 2001. Direct Care Health Workers: The Unnecessary Crisis in Long-Term Care. Monogr. Aspen Inst. Washington, DC
23. Paraprofessional Health Inst. North Carolina Dep. Health Hum. Serv. Off. Long Term Care. 2002. Results of the 2002 national survey of state initiatives on the long-term care direct care workforce. Paraprofessional Health Inst. North Carolina Dep. Health Hum. Serv. Off. Long Term Care. http://facility-services.state.nc.us
24. Serv. Empl. Int. Union. 1997. *Caring 'Til it Hurts: Nursing Home Work is Becoming the Most Dangerous Job in America*. Washington, DC: Serv. Empl. Int. Union
25. Stone RI. 2000. *Long-term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the 21st Century*. New York: Milbank Meml. Fund
26. Stone RI, Weiner JM. 2001. Who will care for us? Addressing the long-term care workforce crisis. Monogr. The Urban Inst. Am. Assoc. Homes Serv. Aging. Washington, DC
27. Straker JK, Atchley RC. 1999. *Recruiting and Retaining Frontline Workers in Long-Term Care: Usual Organizational*

Practices in Ohio. Oxford, OH: Scripps Gerontol. Cent.
28. US Bur. Labor Stat. 2000. *The Employment Situation: May 2000*. Washington, DC: U.S. Dep. Labor News
29. US Bur. Labor Stat. 2001. 2001 National occupational employment wage estimates. http://www.bls.gov
30. White M. 1994. Homecare consortium addresses frontline worker issues. *Generations* 18(3):54–56
31. Wilner MA, Wyatt A. 1998. Paraprofessionals on the Front Lines: Improving Their Jobs—Improving the Quality of Long-Term Care. 5th Quality LTC Conf. Backgr. Pap. AARP LTC Initiat. Washington, DC: AARP
32. Wise D.1996. An OSHA you could love. *Bus. Health* Oct.:28–30
33. Wunderlich GS, Sloan F, Davis CK, eds. 1996. *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* Washington, DC: Natl. Acad. Press
34. Yamada Y. 2002. Profile of home care aides, nursing home aides, and hospital aides: historical changes and data recommendations. *Gerontologist* 42(2):199–206
35. Zahrt LM. 1992. The cost of turnover in a home care agency. *Caring* 11(4):60–66

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Special Article

Transforming Direct Care Jobs, Reimagining Long-Term Services and Supports

Kezia Scales PhD *

PHI, Bronx, NY, USA

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A B S T R A C T

The diverse array of individuals who receive long-term services and supports share one common experience, which is the need for assistance with personal care and/or other daily activities. The direct care workers (including nursing assistants, home health aides, and personal care aides) who provide this assistance play a critical role in keeping individuals safe, supporting their health and well-being, and helping prevent adverse outcomes. Yet despite decades of research, advocacy, and incremental policy and practice reform, direct care workers remain inadequately compensated, supported, and respected. Long-standing direct care job quality concerns are linked to high turnover and job vacancy rates in this workforce, which in turn compromise the availability and quality of essential care for older adults and people with disabilities—which has never been more evident than during the COVID-19 pandemic. This special article makes the case for transforming direct care jobs and stabilizing this workforce as a centerpiece of efforts to reimagine long-term services and supports system in the United States, as a public health priority, and as a social justice imperative. Drawing on research evidence and examples from the field, the article demonstrates that a strong, stable direct care workforce requires: a competitive wage and adequate employment benefits for direct care workers; updated training standards and delivery systems that prepare these workers to meet increasingly complex care needs across settings, while also enhancing career mobility and workforce flexibility; investment in well-trained frontline supervisors and peer mentors to help direct care workers navigate their challenging roles; and an elevated position for direct care workers in relation to the interdisciplinary care team. The article concludes by highlighting federal and state policy opportunities to achieve direct care job transformation, as well as discussing research and practice implications.

The long-term services and supports (LTSS) system in the United States is a labyrinthine, fragmented, evolving system comprising different payers and payment streams, regulations and requirements, settings and service models, tools and technologies, and occupational roles. Individual LTSS users' trajectories and experiences also vary widely by need, geographic location, entry point, demographic characteristics, and many other factors. Nonetheless, the majority of LTSS users share a common experience, which is the need for assistance with personal care and/or other daily activities. The direct care workers who provide this assistance play a critical role in keeping individuals safe, supporting their optimal health and well-being, and helping prevent adverse outcomes—yet they remain inadequately compensated, supported, and respected. This special article makes the case for transforming direct care jobs and stabilizing this workforce as a centerpiece of efforts to reimagine LTSS access, quality, and outcomes. The ideas presented here build on decades of direct care workforce research, advocacy, and incremental policy and practice reform[1]—but they are newly energized by the urgency of the workforce crisis; animated by the unprecedented public and political attention on LTSS and direct care jobs; characterized by a coherent perspective on this workforce across occupational roles and settings; and distinguished by an explicit commitment to promoting equity and social justice for all those who receive and provide LTSS.

Profile of the Direct Care Workforce

The direct care workforce comprises 4.6 million personal care aides, home health aides, and nursing assistants who provide essential daily care and support to older adults and people with disabilities across settings.[2] All direct care workers provide assistance with activities of daily living (ADLs) and/or instrumental ADLs, while home

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* Address correspondence to Kezia Scales, PhD, PHI, 400 East Fordham Rd, 11th Floor, Bronx, NY 10458 USA.
E-mail address: kscales@phinational.org.

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health aides and nursing assistants may also perform certain clinical tasks under the supervision of licensed professionals.

As a whole, the direct care workforce outnumbers every other occupational group in the United States, and this workforce is growing rapidly—primarily because of rising demand for LTSS (also known as long-term care).[3] From 2009 to 2019, the direct care workforce increased by 52%, and nearly 1.3 million new direct care jobs will be added from 2019 to 2029.[1] This growth will predominantly occur in home and community-based services (HCBS), while nursing homes are expected to lose about 10,000 nursing assistant positions.

Reflecting the complexity of the LTSS landscape overall, the direct care workforce is highly differentiated. Direct care workers may be hired directly by consumers or employed by home care agencies, assisted living communities, nursing homes, or other providers; their services may be covered by private funds or reimbursed with public dollars through various programs and payment mechanisms; the majority of direct care workers provide LTSS, but many also or alternatively provide post-acute and other types of care; they support older adults, individuals with physical disabilities or intellectual and developmental disabilities, medically fragile children, and/or other populations; and they are subject to different regulations and requirements depending on state and locality, among other factors.

Nonetheless, long-standing recruitment and retention challenges rooted in poor job quality extend across the full direct care workforce, especially in LTSS.[4–7] These challenges have only intensified during the COVID-19 pandemic, as workers have left their jobs because of illness, fear, family responsibilities, economic conditions, and other reasons.[8,9] High turnover[10,11] and job vacancies[12,13] in turn compromise the availability and quality of care for the millions of older adults and people with disabilities who require LTSS[14–16]—rendering direct care workforce improvement an urgent public health issue.[17] Therefore, while recognizing that there are significant variations across the direct care workforce—requiring a range of tailored policy and practice solutions—this article also calls for a coordinated approach (as far as possible) to overcome historic siloes, garner broad-based support, and truly transform direct care jobs. Guided by the conceptual framework in Figure 1, the article focuses on 4 priorities: compensation; training and advancement; supervision and support; and empowerment and inclusion.

Improve Compensation

The direct care workforce predominantly comprises women (87%), people of color (59%), and immigrants (26%).[18] This demographic profile intersects with the historic undervaluing of caregiving labor, ongoing occupational segregation by sex and race/ethnicity, and persistently inadequate investment in LTSS to produce direct care jobs that are egregiously underpaid.[19]

The national median wage for all direct care workers is $13.34 per hour and—because of unstable and/or part-time schedules as well as low wages—median annual earnings are just $20,200.[16] Although direct care wages are relatively low across every state,[20] these national figures nonetheless mask considerable variations among states and between direct care occupations that are driven by payment policies and reimbursement rates (especially in Medicaid, which is the largest single payer of LTSS[21]), minimum wage and other employment laws, and other factors. Further disparities are found within this marginalized workforce by race and sex[22]; notably, women of color in direct care earn the lowest wages and are most likely to live in poverty and require public assistance than white

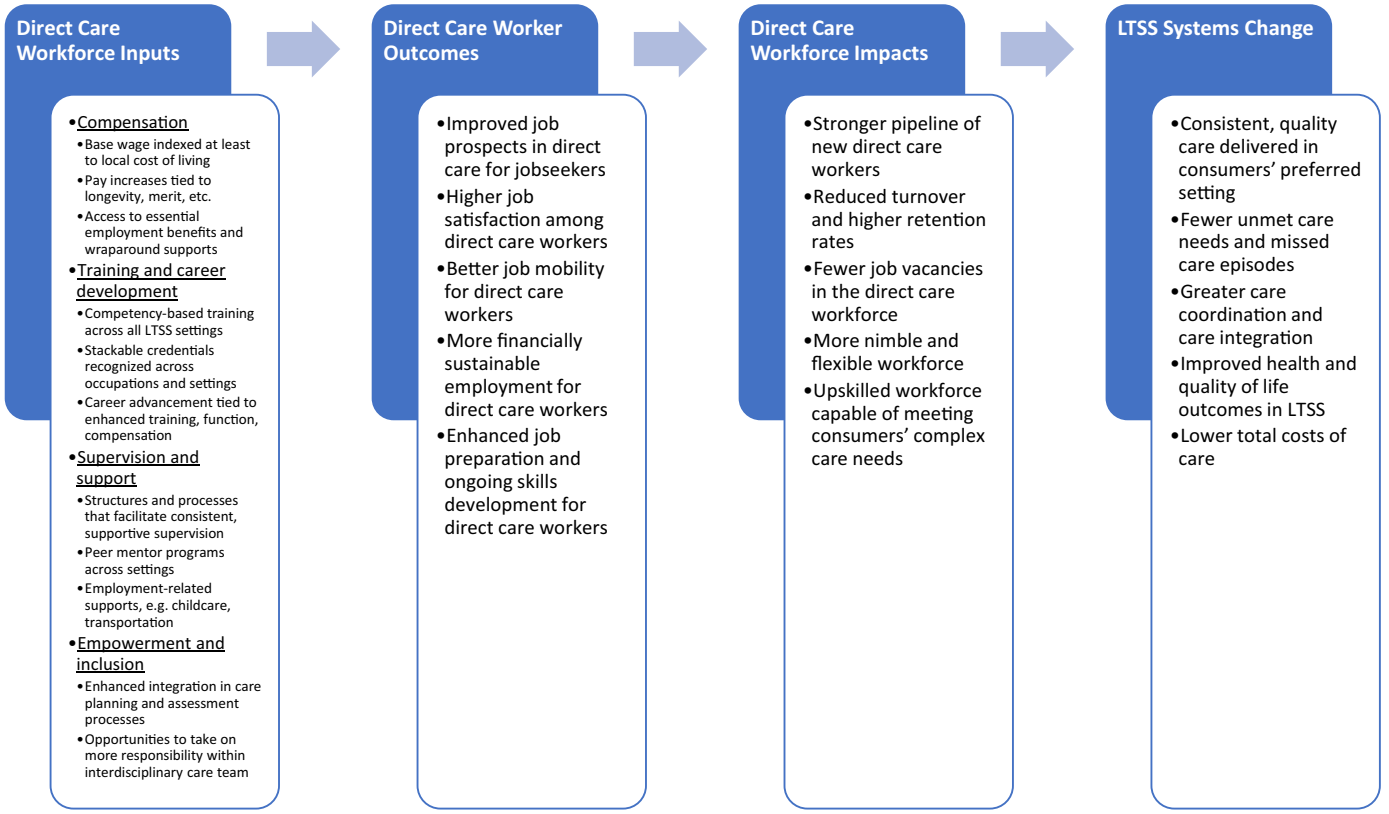

Fig. 1. Direct care workforce transformation in LTSS*. *Adapted from PHI. The 5 Pillars of Job Quality. https://phinational.org/resource/the-5-pillars-of-direct-care-job-quality/. Accessed July 22, 2021.

women or men of any race.[19] People of color are also most likely to work in under-resourced LTSS settings and have been disproportionately impacted by the pandemic.[23]

Inadequate or unstable income makes it difficult for workers to meet basic household needs, achieve secure housing, arrange childcare, and maintain their physical and emotional health, all of which can compromise their employment performance.[24] Moreover, minor fluctuations in hours or wages can threaten eligibility for public assistance, causing further economic instability.[25] Overall, poor compensation perpetuates structural, intergenerational inequities that impact the women and people of color comprising this workforce.

Low wages also undermine the competitiveness of direct care jobs. Analysis of 2019 data shows that median wages for direct care were lower than median wages for every other occupation with similar entry-level requirements.[26] Competition for workers has been accentuated by the COVID-19 pandemic, as employers across sectors are now struggling to fill job openings.[27] LTSS providers and individual consumers who rely on Medicaid have less latitude to offer higher wages or other financial incentives compared to employers in retail, food services, and other competing sectors[19]—and most private-pay consumers already struggle to cover the costs of care, in many cases facing financial hardship over time and eventually spending down to Medicaid eligibility levels.[28] These financial constraints are not universally distributed across LTSS, however. Medicaid reimbursement rates vary significantly between states,[29] which differentially impacts providers' ability to raise wages; nursing homes that serve a higher share of post-acute patients operate on larger margins than those primarily serving long-stay residents,[30] though their profits may be reaped by owners or shareholders rather than reinvested in the workforce and resident care[31]; and many assisted living communities and home care agencies (among other providers) do not rely on public reimbursement,[19] but their workforce investments may still be defined by industry standards and individuals' ability to pay.

Notwithstanding these fiscal constraints, it is clear from the evidence that raising wages (eg, by increasing Medicaid rates with a wage pass-through)[32] would not only improve recruitment and retention[33,34] but also care outcomes. One analysis using quality data from the Centers for Medicare and Medicaid Services (CMS) found that higher wages for nursing assistants in nursing homes were associated with increased income and retention, fewer inspection violations, and lower rates of preventable health outcomes and mortality among residents.[35] Higher wages could also benefit the wider economy: one model found that raising direct care workers' wages to a living wage in 2022 would benefit three-quarters of this workforce, with the cost offset by lower turnover, reduced expenditure on public assistance, increased consumer spending, and higher productivity.[36]

Enhance Training and Career Advancement

Direct care workers support individuals with complex care needs across settings, since the rebalancing of Medicaid-funded services has raised acuity levels in home and community-based settings, while nursing homes have continued to support those with high post-acute and long-term care needs.[19] New payment and service-delivery models designed to improve efficiency and outcomes—including managed care, value-based payment, care coordination and integration programs, and more—have elevated the importance of direct care workers, as they are ideally positioned to monitor individuals' health status, identify changes of condition, trigger clinical interventions, and help avert adverse outcomes.[37]

Yet training standards and practices for direct care workers remain inconsistent and, for the most part, inadequate. The federal entry-level training minimum for nursing assistants and home health aides employed by CMS-certified providers is just 75 hours, although over one-half the states have set higher requirements for nursing assistants at the state level and about one-third have done the same for home health aides (ranging from 80 to 180 hours in each case).[19] (To note, the federal training and certification requirement for nursing assistants in nursing homes has been waived by CMS during the COVID-19 public health emergency.[38]) There is no federal benchmark for personal care aide or residential care aide training, which also leads to wide variation across states. As examples: only 17 states and DC require a minimum number of entry-level training hours for assisted living aides (ranging from 1 to 90 hours); only 14 states have established consistent training standards for all home care agency-employed aides; and 7 states do not regulate personal care aide training at all.[19] Entry-level training programs do not tend to cover the full range of core competencies required for direct care, meaning that "upskilling" interventions are needed to meet contemporary LTSS consumers' needs; additional training is needed, for example, on condition-specific care, infection prevention, emergency management, and cultural and linguistic competence, among other topics.[19] Finally, there is insufficient emphasis in policy and practice on appropriate teaching methods and environments, which undermines training effectiveness and knowledge uptake.[39]

Better training can improve job quality and satisfaction[40–42] and care outcomes[43,44] and, when offered within a formal credentialing framework, can also facilitate career mobility and workforce flexibility.[45] Relatedly, there is also a need for advanced roles in direct care—tied to a recognized credential and higher wage—to retain experienced workers and maximize this workforce within a reimagined LTSS system. Examples include: condition-specific specialist roles, such as diabetes and dementia specialists; care integration or care transition aides, to bridge the gaps between services and settings; and peer mentors and trainers. Although the evidence base on advanced roles in direct care is limited, pilot projects from both HCBS[46] and nursing homes[47] have shown promising outcomes, including higher wages and job satisfaction, reduced emergency department and rehospitalization rates, and lower family caregiver strain. Although many upskilling and career advancement interventions can be implemented within existing nurse delegation rules,[48] updating and aligning these rules across states is another necessary step toward overcoming inequities for direct care workers and LTSS consumers.[49,50]

Further, career advancement opportunities within direct care must be complemented by accessible career pathways from direct care to other health care occupations.[45] The most well-known pathway is from direct care to licensed practical nurse to registered nurse, but this option may not be viable for many direct care workers due to the educational prerequisites, training time, and costs involved.[19] Work-based learning, up-front tuition assistance, micro-credentialing, wraparound supports (to address childcare, transportation, and other needs), and other strategies and approaches are needed to expand opportunities for direct care workers to progress into nursing, therapy, administrative, and other roles.

Strengthen Supervision and Support

Direct care workers, like other health care workers, have been under intense pressure during the COVID-19 pandemic. Along with managing the immediate risks of transmission and infection, they have struggled with increased or inconsistent workloads, inadequate access to personal protective equipment (PPE), limited training and guidelines, and heightened anxiety and grief,[51,52] along with financial hardship, childcare and transportation challenges, family separation, and other personal life stressors.[53] These stressors have exacerbated existing risks for direct care workers,[54,55] which are

disproportionately experienced by workers of color[56]—underscoring the importance of addressing workforce challenges as a matter of social justice.

Combined with the increased job demands and training limitations described above, these challenges indicate the need for better support on the job, with supervision a key mechanism. Evidence from across occupations shows that effective supervisory relationships help mediate job stress and improve job satisfaction,[57] and supervision in LTSS has been identified as a primary driver of job satisfaction, intent to leave, actual turnover, and more.[33,58–62] For example, one study of home health aides found that organizational and supervisory support positively impacted job satisfaction and weakened the negative relationship between job-related stressors and job satisfaction.[63]

Nonetheless, there has been limited research on training and support interventions for LTSS supervisors. As one example from the field, a coaching supervision model that was implemented across 17 nursing homes and home care agencies showed statistically significant improvements in job satisfaction and satisfaction with supervision among nearly 1500 participating direct care staff, as well as garnering an estimated $6000 in cost savings per supervisor (among those reporting efficiencies because of the supervision training).[64]

Peer mentorship programs also show promise as a method for supporting direct care workers while also providing a career advancement opportunity for experienced workers and fostering a collaborative organizational culture. Although more research is needed on peer mentorship programs in LTSS, small studies have shown a promising impact on retention among nursing assistants in nursing homes[65] and among home care workers.[66]

Promote Empowerment and Inclusion

The value of interdisciplinary approaches to caring for those with serious illness across settings is now well-recognized.[67] However, direct care workers have not historically been included in care planning and assessment processes[68,69] and often report that their contributions are overlooked or unrecognized.[70,71] Federal regulations now require nursing assistants' inclusion in the interdisciplinary care team in nursing homes,[72] but implementation of this requirement is hindered by a lack of clear guidelines and accountability.[73] Home health agencies registered with CMS are also required by the federal conditions of participation to include home health aides in the interdisciplinary care team,[74] but their involvement in person-centered care planning is not explicitly named, and there are no similar federal requirements for other segments of the direct care workforce.

Nonetheless, innovative efforts to empower and integrate direct care workers exist. For example, the nursing home culture change movement has produced several team-based models that elevate nursing assistants' status. The Green House homes model, as one example, aims to empower nursing assistants in their direct care role and in relation to clinical partners,[75] which has been shown to create opportunities for more appropriate and timely resident care, depending upon implementation.[76] (To note, there is mixed evidence about whether the "universal worker" approach in Green House homes and other culture change models empowers direct care workers vs increasing their workloads and actually undermining the provision of person-centered care.[69,77]) Evidence from the Nursing Home Culture Change Survey shows a link between nursing assistant empowerment and retention; nursing homes with medium and high levels of empowerment (based on a 7-item scale) had a 44% and 64% greater likelihood of having high retention, respectively, compared with those in the low-empowerment category.[78] The introduction of culture change—including staff empowerment—was also associated in the survey data with significant improvements in key care processes and outcomes among "high practice adopters" and fewer survey deficiencies among other adopters, indicating the implications of staff empowerment for quality improvement as well.[79]

Although more limited, the evidence from HCBS also suggests that empowerment and integration interventions are well-received by participants and are associated with improved wages, confidence, team communication, and care outcomes.[80–82] For example, a pilot program designed to improve care integration and outcomes for home care clients by upskilling direct care workers and enhancing their role on the care team showed promising impacts on medication adherence, emergency department and hospitalization rates, health-related quality of life, and satisfaction with care.[83]

Implications for Research, Policy, and Practice

Reimagining LTSS requires a broad-based commitment to improving the quality of direct care jobs. This commitment must be matched by strategies that span across direct care occupations and LTSS settings to the extent possible—to achieve a strong, stable workforce that is well-prepared to provide competent care where and when needed.

The policy window is now open, given the unprecedented attention on LTSS and the direct care workforce at the federal and state levels. As of late 2021, states are preparing to implement their *American Rescue Plan Act* HCBS spending plans, many of which include investments in direct care workers' compensation, training, career development, and more.[84] Also at the time of writing, Congress is debating the *Build Back Better* reconciliation budget bill,[85] which includes $150 billion to strengthen states' HCBS infrastructure, plus additional funding to improve direct care training and workforce development overall and to secure essential benefits for all workers, including paid leave, affordable childcare, and universal preschool.[86] Although it falls short of President Biden's original "caregiving economy" campaign promise,[87] this bill heralds significant progress toward improving direct care job quality and enhancing LTSS access. In parallel, nursing home policy reform efforts are also underway, with direct implications for nursing assistant jobs; as one key example, the bicameral *Nursing Home Improvement and Accountability Act* introduced in Congress in September 2021 proposes to improve compensation for nursing home staff and set minimum staffing levels, among other provisions.[88]

Consistent with the enhanced federal attention on and investment in LTSS, now is the time for a national direct care workforce strategy. To that end, the US Department of Health and Human Services could convene an advisory council comprising representatives from relevant federal agencies and departments as well as LTSS payers, providers, workforce development experts, worker advocates, consumers and family members, and direct care workers themselves. Among its efforts, the council could develop recommendations for improving direct care workers' compensation; raising competency-based training standards across settings and occupations; establishing recognized career pathways; strengthening supervision in LTSS; enhancing care team integration, including by addressing nurse delegation barriers; and overcoming the substantial gaps in direct care workforce data collection.[89]

These recommendations could be judiciously built into federal funding and accountability mechanisms (eg, as seen in the *Better Care Better Jobs* draft legislation[90]) to promote equity across the country without undermining states' role as the primary locus of LTSS policy and innovation. In parallel, multi-stakeholder workgroups[91] could fulfill a complementary remit at the state level: eg, identifying state-specific workforce priorities, developing strategies and solutions aligned with federal guidance and/or requirements, and monitoring progress over time.

These policy reforms are necessary but far from sufficient for improving direct care jobs and stabilizing the workforce. Because Medicaid is the primary public payer for LTSS, Medicaid policy changes have outsize significance; but changes within Medicare are also required to support the provision of post-acute care across settings, and changes in state licensure and other regulations are needed to address assisted living and other settings and services that fall largely outside the public payment system. In the longer view, a fully reimagined LTSS system will require a transformative financing approach that ensures coverage for eligible individuals (without impoverishing them), builds in job quality for direct care workers, and enhances equity and social justice.[92,93]

In the research arena, the evidence base on the links between direct care workforce interventions, workforce outcomes, and care outcomes must be strengthened. Evidence is especially needed on the impact of wage increases (to identify the wage threshold for recruiting and retaining a sufficient direct care workforce); on the implementation, replication, and scale-up of training, upskilling and advanced role interventions; and on different models of supervision and peer mentorship, with attention to both implementation and impact.

In practice, LTSS providers need more tools and guidance on how to improve direct care job quality and better leverage the skills and expertise of direct care workers to the extent possible within financing and regulatory parameters. Key opportunities include upskilling workers with more condition-specific knowledge and the skills to observe, record, and report changes of condition that may require clinical attention; building structured communication protocols to ensure effective two-way knowledge exchange between frontline caregivers and other clinical providers; creating meaningful opportunities for direct care workers to participate in interdisciplinary care planning and assessment processes; developing internal career pathways for direct care workers; and providing training and ongoing support for supervisors and peer mentors. Finally, employers would benefit from guidance on how to develop partnerships and networks with community-based organizations and public agencies to assist direct care workers in securing affordable childcare, transportation, housing, health care, immigration services, and other essential wraparound supports.

Across all efforts to transform direct care jobs, it is imperative to include direct care workers themselves—centering their experiences and leveraging their insights about how to reimagine this system of care and support.

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References

1. Scales K, Lepore MJ. Always essential: valuing direct care workers in long-term care. Public Policy Aging Rep 2020;30:173–177.
2. PHI. Direct Care Workers in the United States: Key Facts. Bronx, NY: PHI. 2021. https://phinational.org/resource/direct-care-workers-in-the-united-states-key-facts/.
3. Favreault M, Dey J. Long-Term Care Services and Supports for Older Americans: Risks and Financing. Washington, DC: ASPE. 2021. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//142116/ElderLTCrb-rev.pdf. Accessed December 31, 2021.
4. Houseworth J, Pettingell SL, Kramme JE, et al. Predictors of annual and early separations among direct support professionals: national core indicators staff stability survey. Intellect Dev Disabil 2020;58:192–207.
5. Kennedy KA, Applebaum R, Bowblis JR, Straker JK. Organizational factors associated with retention of direct care workers: a comparison of nursing homes and assisted living facilities. Gerontologist 2021;61:530–539.
6. Berridge C, Lima J, Schwartz M, et al. Leadership, staff empowerment, and the retention of nursing assistants: findings from a survey of US nursing homes. J Am Med Dir Assoc 2020;21:1254–1259.
7. Butler SS, Brennan-Ing M, Wardamasky S, Ashley A. Determinants of longer job tenure among home care aides: what makes some stay on the job while others leave? J Appl Gerontol 2014;33:164–188.
8. Campbell S. Will COVID-19 Change Direct Care Employment? New Data Offer Clues. https://phinational.org/will-covid-19-change-direct-care-employment-new-data-offer-clues/. Accessed July 19, 2021.
9. Altarum. April 2021 Health Sector Economic Indicators Briefs. https://altarum.org/publications/april-2021-health-sector-economic-indicators-briefs. Accessed July 19, 2021.
10. Gandhi A, Yu H, Grabowski DC. High nursing staff turnover in nursing homes offers important quality information. Health Aff 2020;40:384–391.
11. Holly R. 'A Huge Victory': Home Care Turnover Remains Stable at 65.2%. Home Health Care News, 2021. https://homehealthcarenews.com/2021/05/a-huge-victory-home-care-turnover-remains-stable-at-65-2/. Accessed July 19, 2021.
12. Galewitz P. With Workers in Short Supply, Seniors Often Wait Months for Home Health Care. NPR, 2021. https://www.npr.org/sections/health-shots/2021/06/30/1010328071/with-workers-in-short-supply-seniors-often-wait-months-for-home-health-care. Accessed July 19, 2021.
13. American Health Care Association/National Center for Assisted Living. State of Nursing Home and Assisted Living Industry: Facing Workforce Challenges. https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/Workforce-Survey-June2020.pdf. Accessed July 19, 2021.
14. Castle NG, Hyer K, Harris JA, Engberg J. Nurse aide retention in nursing homes. Gerontologist 2020;60:885–895.
15. Russell D, Rosati RJ, Peng TR, et al. Continuity in the provider of home health aide services and the likelihood of patient improvement in activities of daily living. Home Health Care Manag Pract 2013;25:6–12.
16. Barry TT, Brannon D, Mor V. Nurse aide empowerment strategies and staff stability: effects on nursing home resident outcomes. Gerontologist 2005;45:309–317.
17. American Public Health Association (APHA). Strengthening the Dementia Care Workforce: A Public Health Priority. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2021/01/13/strengthening-the-dementia-care-workforce. Accessed November 24, 2021.
18. PHI. Workforce Data Center. https://phinational.org/policy-research/workforce-data-center/. Accessed July 19, 2021.
19. Campbell S, Drake ADR, Espinoza R, Scales K. Caring for the Future: The Power and Potential of America's Direct Care Workforce. Bronx, NY: PHI. http://phinational.org/caringforthefuture/, 2021. Accessed December 31, 2021.
20. PHI. Competitive Disadvantage: Direct Care Wages Are Lagging Behind. Bronx, NY: PHI. https://phinational.org/resource/competitive-disadvantage-direct-care-wages-are-lagging-behind/. Accessed November 11, 2021.
21. Congressional Research Service. Who Pays for Long-Term Services and Supports?. https://crsreports.congress.gov/product/pdf/IF/IF10343#:~:text=Figure%201%20shows%20LTSS%20spending,of%20all%20LTSS%20spending%20nationwid. Accessed November 11, 2021.
22. Sloane PD, Yearby R, Konetzka RT, et al. Addressing systemic racism in nursing homes: a time for action. J Am Med Dir Assoc 2021;22:886–892.
23. Shippee TP, Akosionu O, Ng W, et al. COVID-19 pandemic: exacerbating racial/ethnic disparities in long-term services and supports. J Aging Soc Policy 2020;32:323–333.
24. Wadsworth ME. Working with low-income families: lessons learned from basic and applied research on coping with poverty-related stress. J Contemp Psychother 2012;42:17–25.
25. Walther M. Unstable Jobs, Unstable Lives: Low-Wage Work in the United States. https://www.irp.wisc.edu/wp/wp-content/uploads/2018/12/Fact-Sheet-16-2018-UnstableJobs-UnstableLives.pdf. Accessed July 19, 2021.
26. PHI. Competitive Disadvantage: Direct Care Wages Are Lagging Behind. https://phinational.org/resource/competitive-disadvantage-direct-care-wages-are-lagging-behind/. Accessed July 19, 2021.
27. Irwin N. Workers Are Gaining Leverage Over Employers Right Before Our Eyes. The New York Times, 2021. https://www.nytimes.com/2021/06/05/upshot/jobs-rising-wages.html. Accessed July 19, 2021.
28. Johnson RW, Favreault MM. Economic Hardship and Medicaid Enrollment In Later Life: Assessing the Impact of Disability, Health, and Marital Status Shocks. Washington, DC: ASPE. 2021. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//198976/EconHardship.pdf. Accessed December 31, 2021.
29. Murray C, Tourtellotte A, Lipson D, Wysocki A. Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018. Chicago, IL: Mathematica. 2021. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf. 2021. Accessed December 31, 2021.
30. Medicare Payment Advisory Commission (MedPAC). March 2021 Report to the Congress: Medicare Payment Policy. http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf. Accessed November 2, 2021.
31. Meyer H. Nursing Homes' Flawed Business Model Worsens COVID Crisis. AARP, 2020. https://www.aarp.org/caregiving/health/info-2020/covid-19-nursing-homes-failing-business-model.html. Accessed November 24, 2021.
32. Yearby R, Gardner N, Davis S, et al. Wage Pass-Through Report. The Institute for Healing Justice and Equity; 2020.

33. Brannon D, Barry T, Kemper P, et al. Job perceptions and intent to leave among direct care workers: evidence from the Better Jobs Better Care demonstrations. Gerontologist 2007;47:820–829.
34. Howes C. Living wages and retention of homecare workers in San Francisco. Ind Relat 2005;44:139–163.
35. Ruffini K. Worker Earnings, Service Quality, and Firm Profitability: Evidence from Nursing Homes and Minimum Wage Reforms. https://drive.google.com/file/d/1d6vYu_uN9keb9iiT2R5UJihA_61K0Fce/view. Accessed July 19, 2021.
36. Weller C, Almeida B, Cohen M, Stone R. Making Care Work Pay. https://leadingage.org/sites/default/files/Making%20Care%20Work%20Pay%20Report.pdf. Accessed July 19, 2021.
37. Scales K. It is time to resolve the direct care workforce in long-term care. Gerontologist 2021;21:497–504.
38. CMS. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, Updated 5/24/21. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf. Accessed November 24, 2021.
39. Kemeny ME, Mabry JB. Making meaningful improvements to direct care worker training through informed policy: understanding how care setting structure and culture matter. Gerontol Geriatr Educ 2017;38:295–312.
40. Sterling MR, Cho J, Ringel JB, Avgar AC. Heart failure training and job satisfaction: a survey of home care workers caring for adults with heart failure in New York City. Ethn Dis 2020;30:575–582.
41. Han K, Trinkoff AM, Storr CL, et al. Associations between state regulations, training length, perceived quality and job satisfaction among certified nursing assistants: cross-sectional secondary data analysis. Int J Nurs Stud 2014;51:1135–1141.
42. Kim J. Occupational credentials and job qualities of direct care workers: implications for labor shortages. J Labor Res 2020;41:403–420.
43. Eggenberger E, Heimerl K, Bennett MI. Communication skills training in dementia care: a systematic review of effectiveness, training content, and didactic methods in different care settings. Int Psychogeriatr 2013;25:345–358.
44. Kelly CM, Morgan JC, Jason KJ. Home care workers: interstate differences in training requirements and their implications for quality. J Apply Gerontol 2013;32:804–832.
45. Dill JS, Morgan JC. Employability among low-skill workers: organizational expectations and practices in the US health care sector. Hum Relat 2018;71:1001–1022.
46. Russell D, Mola A, Onorato N, et al. Preparing home health aides to serve as health coaches for home care patients with chronic illness: findings and lessons learned from a mixed-method evaluation of two pilot program. Home Health Care Manag Pract 2017;29:191–198.
47. Hostetter M, Klein S. Placing a Higher Value on Direct Care Workers. Transforming Care, 2021. https://www.commonwealthfund.org/publications/2021/jul/placing-higher-value-direct-care-workers?utm_source=alert&utm_medium=email&utm_campaign=Improving%20Health%20Care%20Quality. Accessed July 19, 2021.
48. American Nurses Association. ANA's Principles for Delegation by Registered Nurses to Unlicensed Assistive Personnel (UAP). https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principlesofdelegation.pdf. Accessed November 11, 2021.
49. Spetz J, Stone RI, Chapman SA, Bryant N. Home and community-based workforce for patients with serious illness requires support to meet growing needs. Health Aff 2019;38:902–909.
50. Dudley N, Miller J, Breslin ML, Chapman SA, Spetz J. The impact of nurse delegation regulations on the provision of home care services: a four-state case study. Med Care Res Rev 2021;78:47S–56S.
51. Bandini J, Rollison J, Feistel K, et al. Home care aide safety concerns and job challenges during the COVID-19 pandemic. New Solut 2021;31:20–29.
52. Denny-Brown N, Stone D, Hays B, Gallagher D. COVID-19 Intensifies Nursing Home Workforce Challenges. Mathematica; 2020.
53. Cimarolli V, Bryant N. COVID-19: Experiences of Direct Care Workers in Aging Services. Boston, MA: LeadingAge LTSS Center@ UMass Boston. https://www.ltsscenter.org/wp-content/uploads/2021/02/COVID-Brief-LTSS-Feb-2021_FINAL.pdf. Accessed July 19, 2021.
54. Walton AL, Rogers B. Workplace hazards faced by nursing assistants in the United States: a focused literature review. Int J Environ Res Public Health 2017;14:544.
55. Ejaz FK, Noelker LS, Menne HL, Bagaka's JG. The impact of stress and support on direct care workers' job satisfaction. Gerontologist 2008;48:60–70.
56. Hurtado DA, Sabbath EL, Ertel KA, et al. Racial disparities in job strain among American and immigrant long-term care workers. Int Nurs Rev 2012;59:237–244.
57. Global Happiness Council. Global Happiness Policy Report 2018. https://s3.amazonaws.com/ghc-2018/GlobalHappinessPolicyReport2018.pdf. Accessed July 19, 2021.
58. Choi J, Johantgen M. The importance of supervision in retention of CNAs. Res Nurs Health 2012;35:187–199.
59. Chou RJ-A, Robert SA. Workplace support, role overload, and job satisfaction of direct care workers in assisted living. J Health Soc Behav 2008;49:208–222.
60. Jang Y, Lee AA, Zadrozny M, et al. Determinants of job satisfaction and turnover intent in home health workers: the role of job demands and resources. J Appl Gerontol 2017;36:56–70.
61. Kemper P, Heier B, Barry T, et al. What do direct care workers say would improve their jobs? Differences across settings. Gerontologist 2008;48(suppl_1):17–25.
62. Matthews M, Carsten MK, Ayers DJ, Menachemi N. Determinants of turnover among low wage earners in long term care: the role of manager-employee relationships. Geriatr Nurs 2018;39:407–413.
63. Yoon S, Probst J, DiStefano C. Factors affecting job satisfaction among agency-employed home health aides. Home Health Care Manag Pract 2016;28:57–69.
64. PHI. PHI Coaching Approach Demonstration Yields Positive Outcomes for Employers. Bronx, NY: PHI. 2011. https://phinational.org/wp-content/uploads/2017/07/CCSLevaluation-08052011.pdf. Accessed December 31, 2021.
65. Hegeman C, Hoskinson D, Munro H, et al. Peer mentoring in long-term care: rationale, design, and retention. Gerontol Geriatr Ed 2007;28:77–90.
66. Escandón I, Mayfield M. The Business of Caregiving: Loretto's PACE Central New York Proactively Tackling Retention. Bronx, NY: PHI. 2010. https://gcgj.mit.edu/sites/default/files/imce/resource-uploads/Lorettos.pdf. Accessed July 19, 2021.
67. Van Houtven CH, Hastings SN, Colón-Emeric C. A path to high-quality team-based care for people with serious illness. Health Aff 2019;38:934–940.
68. Stone RI, Bryant NS. The future of the home care workforce: training and supporting aides as members of home-based care teams. J Am Geriatr Soc 2019;67:S444–S448.
69. Parmelee PA, Laszlo MC, Taylor JA. Perceived barriers to effective job performance among nursing assistants in long-term care. J Am Med Dir Assoc 2009;10:559–567.
70. Scalzi CC, Evans LK, Barstow A, Hostvedt K. Barriers and enablers to changing organizational culture in nursing homes. Nurs Adm Q 2006;30:368–372.
71. Caspar S, O'Rourke N. The influence of care provider access to structural empowerment on individualized care in long-term care facilities. J Gerontol B Psychol Sci Soc Sci 2008;63:S255–S256.
72. CMS. Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities. https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities. Accessed July 19, 2021.
73. Travers JL, Caceres BA, Vlahov D, et al. Federal requirements for nursing homes to include certified nursing assistants in resident care planning and interdisciplinary teams: a policy analysis. Nurs Outlook 2021;69:617–625.
74. CMS. Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies. https://www.federalregister.gov/documents/2017/01/13/2017-00283/medicare-and-medicaid-program-conditions-of-participation-for-home-health-agencies. Accessed July 19, 2021.
75. Cohen LW, Zimmerman S, Reed D, et al. The Green House model of nursing home care in design and practice. Health Serv Res 2016;51(Suppl 1):352–377.
76. Bowers BJ, Nolet K. Developing the Green House nursing care team: variations on development and implementation. Gerontologist 2014;54(Suppl 1):S53–S64.
77. Hrybyk RL, Frankowski AC, Nemec M, Peeples AD. "It's a lot!" The universal worker model and dementia care in assisted living. Geriatr Nurs 2021;42:233–239.
78. Berridge C, Tyler DA, Miller SC. Staff empowerment practices and CNA retention: findings from a nationally representative nursing home culture change survey. J Appl Gerontol 2018;37:419–434.
79. Miller SC, Lepore M, Lima JC, et al. Does the introduction of nursing home culture change practices improve quality? J Am Geriatr Soc 2014;62:1675–1682.
80. California Long-Term Care Education Center (CLTCEC). Care Team Integration and Training of Home Care Workers – Impact Study. CLTCEC. 2016. https://cltcec.org/wp-content/uploads/2019/02/CLTCEC-Home-Care-Integration-Training-Project-Brief.pdf. Accessed July 19, 2021.
81. Coffman JM, Chapman SA. Envisioning Enhanced Roles for In-Home Supportive Services Workers in Care Coordination for Consumers with Chronic Conditions: A Concept Paper. San Francisco, CA: Philip R. Lee Institute for Health Policy Studies and the Center for Personal Assistance Services, University of California at San Francisco; and Berkeley, CA: Center for Labor Research and Education, University of California at Berkeley. 2012. https://laborcenter.berkeley.edu/pdf/2012/ihss_12.pdf. Accessed July 19, 2021.
82. Dean KM, Hatfield LA, Jena AB, et al. Preliminary data on a care coordination program for home care recipients. J Am Geriatr Soc 2016;64:1900–1903.
83. Austin-Oser K, Edmiston A, Sussman R. St. John's Enhanced Home Care Pilot Program. https://www.finance.senate.gov/imo/media/doc/Service%20Employees%20International%20Union%20SEIU%20%20Innovations%20in%20Home%20Care%203.pdf. Accessed July 19, 2021.
84. Advancing States. Analysis of State ARPA Plans, 2021. http://www.advancingstates.org/sites/nasuad/files/u34008/ADvancing%20States%20Analysis%20of%20State%20ARPA%20Plans%20-%209.15.21.pdf. Accessed November 24, 2021.
85. The White House. The Build Back Better Framework: President Biden's Plan to Rebuild the Middle Class. https://www.whitehouse.gov/build-back-better/. Accessed November 24, 2021.

86. Espinoza R. Will Congress Finally Transform the Direct Care Job? Generations, 2021. https://generations.asaging.org/will-congress-finally-transform-direct-care-jobs. Accessed July 23, 2021.
87. Biden J. The Biden Plan for Mobilizing American Talent and Heart to Create a 21st Century Caregiving and Education Workforce. Medium, 2021. https://medium.com/@JoeBiden/the-biden-plan-for-mobilizing-american-talent-and-heart-to-create-a-21st-century-caregiving-and-af5ba2a2dfeb. Accessed November 24, 2021.
88. Nursing Home Improvement and Accountability Act of 2021. 117th Congress, 1st Session. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/SNF-PKGE_03_xml_Introduction_signed.pdf. Accessed November 24, 2021.
89. Government Accountability Office (GAO). Long-Term Care Workforce: Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers. Washington, DC: GAO. 2016. https://www.gao.gov/assets/gao-16-718.pdf. Accessed July 19, 2021.
90. Better Care Better Jobs Act (S.2210). 117th Congress, 1st Session. https://www.congress.gov/117/bills/s2210/BILLS-117s2210is.pdf. Accessed November 24, 2021.
91. Cook A. State Workgroups Confront the Direct Care Workforce Crisis. PHI Newsroom. 2019. https://phinational.org/news/state-workgroups-confront-the-direct-care-workforce-crisis/. Accessed November 24, 2021.
92. Favreault M. Incorporating long-term services and supports in health care proposals: Cost and distributional considerations. Washington, DC: Urban Institute. 2020. https://www.urban.org/sites/default/files/publication/102311/incorporating-long-term-services-and-supports-in-health-care-proposals_0.pdf. Accessed November 11, 2021.
93. Lepore M. Financing long-term services and supports. Generations 2019;43:12–19.