

Addressing New York City's Care Gap

Aligning Workforce Policy
to Support Home- and
Community-Based Care

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Prepared for:
New York City Workforce
Investment Board



The nonprofit **Paraprofessional Healthcare Institute** (PHI) works to strengthen the direct-care workforce within our nation's long-term care system.

PHI's program activities include developing innovative approaches to recruitment, training, and supervision; client-centered caregiving practices; and effective public policy. PHI's premise is that creating quality jobs for direct-care workers is essential to providing high-quality, cost-effective services to long-term care consumers.

In New York City, PHI is part of a network of health care organizations that includes Cooperative Home Care Associates, a worker-owned home care cooperative with 900-plus employees; Independence Care System, a Medicaid-funded managed care program for people living independently with disabilities; and the SKILL Center, a home care training program that trains and employs over 550 home care aides annually.

PHI also runs **The National Clearinghouse on the Direct Care Workforce**, www.PHInational.org/clearinghouse, a resource center informing the movement to improve long-term care by improving job quality for direct-care workers. In addition to collecting and distributing original research, news, and other writings, the Clearinghouse brings together long-term care stakeholders who want to learn from each other.

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This is the right time to design workforce policies that overcome the limitations of today's workforce opportunities in long-term care.



Preface

This paper was authored by the Paraprofessional Healthcare Institute for the New York City Workforce Investment Board to focus attention on an important and long-overlooked segment of workers in New York City—those who provide home- and community-based care to elders and people with disabilities.

With over 100,000 workers in the field and with estimated demand for 30,000 additional home- and community-based direct-care workers by 2012, this workforce category is among the fastest growing in New York City. The industry already provides employment for 1 in 7 low-wage workers in New York City, and essential services for thousands of elderly and disabled members of our community.

To ensure that these jobs are attractive and stable jobs, it is critical that the workforce development world and long-term care industry come together to envision a different future -- one in which the workers who are the heart, face, and hands of home care are rewarded and recognized for their contributions to the community, and our economy.

To this end, we have written this report to inform stakeholders and encourage discussion of specific short-term and long-term policy solutions required to meet the demand for new, qualified, and dedicated workers who will provide essential care for elders and people with disabilities living in New York City.

Although this paper focuses on New York City specifically, many areas of the country face similar “care gaps.” There simply aren’t enough people choosing direct-care occupations to care for a rapidly aging population. We believe that local workforce investment boards are well positioned to help their communities tackle this problem, by working with the long-term care industry to improve the quality of direct-care jobs. By investing in these jobs, local WIBs can improve employment opportunities for low-wage workers while also ensuring that our communities are able to meet their obligation to care for those in need.

Special thanks go to Rick Surpin, president of Independence Care System, and Bonnie Potter, executive director of the NYC Employment and Training Coalition, who provided invaluable insight in reviewing earlier drafts of this work; Christine Rico for guiding the project through to completion; and to Paul Dieterich whose efforts and analysis contributed to the core data presented in this paper.

Additionally, the authors thank Marilyn Shea, executive director of the New York City Workforce Investment Board for funding this project and providing leadership on this important issue.

It is critical to change the long-term care delivery system to respond to the inexorable growth in demand.



I. Summary

New York City is sorely in need of a strategic workforce development policy for its home- and community-based long-term care industry—one that will close the gap between the labor market demands of employers and workers; address the growing needs of one of the country’s largest urban populations of elderly and people with disabilities; and leverage the industry’s efforts at service redesign for the benefit of the thousands of workers employed in the sector.

The stakes are high on every score. In the balance are:

- At least 100,000 *current jobs* in home- and community-based direct care, plus a projected demand for nearly 30,000 *new and replacement positions* over the decade ending in 2012;
- The financial stability of hundreds of long-term care providers; and
- Access to quality services for hundreds of thousands of long-term care recipients.

One out of seven low-income workers in New York City is a home- or community-care worker.

Typically, direct-care occupations in home- and community-based care—usually known by titles such as home health aide and personal care attendant—are ignored by workforce development programs, because the low quality of these jobs makes them appear unworthy of

public investment. Indeed, it is true that the quality of these jobs is generally poor. PHI estimates that *one out of seven low-income workers*¹ in New York City is a home- or community-care worker. Furthermore, most of these jobs lack access to

affordable benefits, offer minimal training, and often provide erratic, part-time work. In addition, supervision is often poor or non-existent, and career paths to higher-paying related work are usually unavailable. As a result, the industry suffers from high rates of “churn,” with turnover typically ranging from 40 to 50 percent annually.²

Recently, however, demographic, economic and political pressures have been steadily mounting to improve these occupations. In New York City, an array of key stakeholders within the industry, including organized labor (SEIU 1199), long-term care employers, and consumers, are working to strengthen these positions,

primarily by increasing direct-care wages and benefits. These efforts recognize that the low quality of direct-care jobs is not an “innate” characteristic of this work, but rather an attribute that can and must be changed if the long-term care industry is to respond successfully to the inexorable growth in demand for its services.

Therefore, timing is critical. The mounting pressure toward improving direct-care jobs, combined with the fact that direct care is one of the largest, high-growth employment sectors in the City’s economy, means that significant strategic opportunities exist right now for investing workforce dollars in these occupations—*precisely with the objective of improving job quality.* Careful injection of current workforce investment resources into innovative training and job redesign for home- and community-based direct-care work can help re-shape the future structure and quality of these vital occupations.

In this issue paper, we review the current state of New York City’s labor market for home- and community-based direct-care workers, and then look at projected

Direct care is one of the largest, high-growth employment sectors in the City’s economy.

The low quality of direct-care jobs is not an “innate” characteristic of this work, but rather an attribute that can and must be changed.

demand and supply conditions over the foreseeable future. Next, we examine the implications of the data for a range of workforce development policies and the potential strategic involvement of the *NYC Workforce Investment Board (WIB)* in implementing those policies.

Finally, we argue that investing in the home- and community-care workforce potentially offers New York City multiple returns: Innovative workforce interventions can impact *tens of thousands of inner-city workers* and, at the same time, help to stabilize New York City's *network of long-term care employers*. Moreover, these interventions can improve the *quality of care received by hundreds of thousands of*

New York City residents who are elderly and disabled. And, finally, such an investment can also foster the economic development of many of New York City's *low-income neighborhoods*, for which direct-care jobs are, increasingly, a mainstay of legitimate employment.



300,000 individuals needing long-term care in New York City receive services annually from home care agencies and community-based providers.



II. New York City’s Caregiver Labor Market: Current Conditions and Outlook

The labor market for caregivers in New York City is under growing demand-driven pressure as the City provides services to one of the largest long-term care populations in the country—the vast majority of whom reside not in institutions, but rather in homes and other community-based settings. Yet, at a time when employers need increasing numbers of direct-care workers, the City’s providers are encountering chronic problems in retaining sufficient numbers of stable, well-trained workers.

It is important to note that the City’s sizeable home-based workforce is divided, about equally, into two segments:

- 1) The “home health aide” portion, which is primarily associated with services provided by licensed home health agencies, which in turn subcontract to Medicare-certified home care agencies (the largest of which by far is the Visiting Nurse Service of New York City), and
- 2) The “home attendant” portion, which is essentially a City-run program that contracts primarily with neighborhood-based nonprofit agencies.³

Although they share much in common, these two segments rely on distinct delivery systems. Furthermore, the home health aide segment, in which direct-care workers provide a limited degree of clinical services to their clients, is currently experiencing a concerted unionization drive by SEIU 1199, whereas the home attendant segment, in which paraprofessionals provide personal care only, has been nearly fully organized by SEIU 1199 for many years.

Demand

Roughly 300,000 individuals needing long-term care in New York City receive services annually from home care agencies and community-based providers.⁴ In contrast, the City’s nursing homes have about 120,000 beds, and adult care and residential facilities offer an additional 40,000 beds. The City’s heavy reliance on home- and community-based long-term care is also apparent in its Medicaid program—approximately two-thirds of the City’s long-term care Medicaid recipients receive *non*-institutional care.⁵

The City's dependence on home- and community-based care settings is only likely to increase under the state's new "Right-Sizing" initiative, which allows the City's institutional providers to exchange nursing home capacity for community-based options. Therefore, expanding the capacity of the City's community-based workforce, at this time, could not be more important. This includes upgrading workforce skills in order to prepare workers to care for consumers in multiple settings, including assisted living, adult day care, and naturally occurring retirement communities.

Accounting for the City's substantial and growing long-term care burden.

The quite substantial size of the City's long-term care population is attributable not only to its large population base, but also to its significantly higher disability rates as compared with other regions in the state and country. For example, in New York City, 12 percent of the non-institutionalized civilian population has two or more disabilities compared to 7 to 9 percent in the rest of the state.⁶ These significant differences in disability rates in turn are tied to important differences in the City's age distribution, its racial and ethnic diversity, and its socioeconomic status as compared with other regions in the state. The highest rates of chronic illness and disability in New York City, for example, occur among three groups with disproportionately high populations—non-Asian minorities, individuals with low socioeconomic status, and the elderly.⁷

About 45 percent of the state's elderly live in New York City.

About 45 percent of the state's elderly live in New York City, and "minorities" already constitute a majority of the City's total population.⁸ Moreover, as a group, people over age 65 in the City have become considerably more racially and ethnically diverse since 1990. In 2000, people of color comprised about half the elderly population, up from 35 percent in 1990.⁹ Statewide, by 2015 the "minority" elderly population is expected to grow substantially, with older African Americans (non-Hispanic) projected to increase by 27 percent, Hispanics by 76 percent, and Asian/Pacific individuals by over 110 percent.

While New York City benefits from an influx of younger people due to immigration, the City's overall population nonetheless is aging, and with that fundamental shift in demographics, long-term caregiving is becoming not only more widespread but more complex. Long-term caregiving must accommodate increasing numbers of individuals who are living longer and have functional limitations due to situations as diverse as cancer, AIDS, cardiovascular disease, diabetes, dementia, obesity, and a variety of cognitive and developmental disabilities. While people

with disabilities have increasing longevity, their care often requires complex medication schedules and treatment, substantial clinical skills, as well as the use of sophisticated technologies—for example, telehealth monitoring, which allows for the communication of vital signs from the home to an off-site clinician. We also know that, in general, people prefer to continue to live in their own homes, and this preference is likely to increase the demand for home-based support services.

Indicators of growing demand for home care workers.

Changes in both the racial/ethnic and age compositions of New York City indicate that the populations most vulnerable to conditions requiring human assistance have been growing and will continue to increase. These demographic shifts are bringing with them a significant increase in the demand for long-term care services. Government occupational projections confirm this assessment: As shown in Table 1, the most recent projections by the New York State Department of Labor indicate that home- and community-based direct-care occupations are at the top of the list of occupations expected to generate the greatest increase in employment, with an increase of approximately 30,000 positions (new and replacement) expected over the decade 2002 to 2012 alone. Indeed, personal and home care aides and home health aides are among the few occupations in the City that meet the “ultimate” test of *both* being *the fastest growing and generating the most job openings*.

As Table 1 indicates, home-based direct-care occupations will account for roughly a third of the employment growth created by the ten top-growth occupations. Of these ten leading occupations, note that seven are relatively low-wage jobs, and of

these, a striking 44 percent are projected to be direct-care positions in home- and community-based care settings.¹⁰

Supply

The New York City region meets its caregiving responsibilities by employing one of the largest direct-care workforces in the country, with an estimated 155,000 workers (including nursing home paraprofessionals) providing frontline care to persons with disabilities, age-related impairments, and chronic illnesses.

Table 1

New York City's Top 10 Occupations with Largest Projected Change in Employment, 2002-2012			
Rank	Occupation	Change in Employment*	% Change
1	Registered Nurses	16,960	23.2 %
2	Personal and Home Care Aides	16,380	31.0 %
3	Home Health Aides	13,700	26.8 %
4	Security Guards	10,700	16.9 %
5	Receptionists and Information Clerks	7,480	20.2 %
6	Nursing Aides, Orderlies, and Attendants	6,800	16.5 %
7	Customer Service Representatives	6,370	12.2 %
8	Janitors and Cleaners, Except Maids and Housekeepers	6,280	6.9 %
9	Accountants and Auditors	6,100	12.6 %
10	Lawyers	6,060	11.6 %

Source: New York State Department of Labor, available at: www.labor.state.ny.us/workforceindustrydata/

* Change in employment refers to the sum of “new positions” and “replacement” positions.

How many direct-care workers are there?

The most recent official count of direct-care workers in New York City is shown in Table 2. Of the City's 155,000 direct-care workers, over two-thirds (69 percent) provide home- and community-based services. The last column of Table 2 makes clear the paramount role that the City region plays in the state's overall direct-care workforce. Of direct-care workers statewide, 57 percent are employed in New York City. More specifically, about half of the state's home health aides are employed in the City and two-thirds of the state's personal care aides.

Notably, the official count presented in Table 2 is likely an underestimate of the City's total direct-care workforce because it does not consistently include self-employed individuals nor individuals employed by temporary staffing agencies. Using occupational data from another government source that includes independent contractors (American Community Survey), the Center for Personal Assistance Services estimates the number of personal care aides in New York State at 147,567 in 2004.¹¹ If approximately 66 percent of these workers are from the City region (as indicated by the proportions found in the last column of Table 2), then the number of personal care aides may total nearly 100,000, bringing the total New York City direct-care workforce to about 200,000.

Of the City's 155,000 direct-care workers, over two-thirds provide home- and community-based services.

Table 2

New York City's Direct-Care Workers, 2001–2004*					
Occupation	Total number of workers by occupation				Direct-care workers in NY City PMSA as a proportion of NY State direct-care
	2001	2002	2003	2004	
Personal care aides	50,520	48,800	47,840	46,910	66%
Home health aides	60,590	55,090	55,830	59,320	57%
Nursing aides and orderlies	45,060	44,990	46,010	48,780	50%
Total	156,170	148,880	149,680	155,010	57%

Source: Bureau of Labor Statistics, U.S. Department of Labor, 2001–2004 Metropolitan Area Occupational Employment and Wage Estimates. Available at: www.bls.gov/oes/home.htm.

***Note:** This table shows the U.S. Bureau of Labor Statistics estimates for the NYC Primary Metropolitan Statistical Area (PMSA) region. This area consists of the following counties: Bronx, Kings, New York, Putnam, Queens, Richmond, Rockland, and Westchester. The PMSA contains three counties that are not typically included in the New York regional definition: Putnam, Rockland, and Westchester.

Who are the City's direct-care workers?

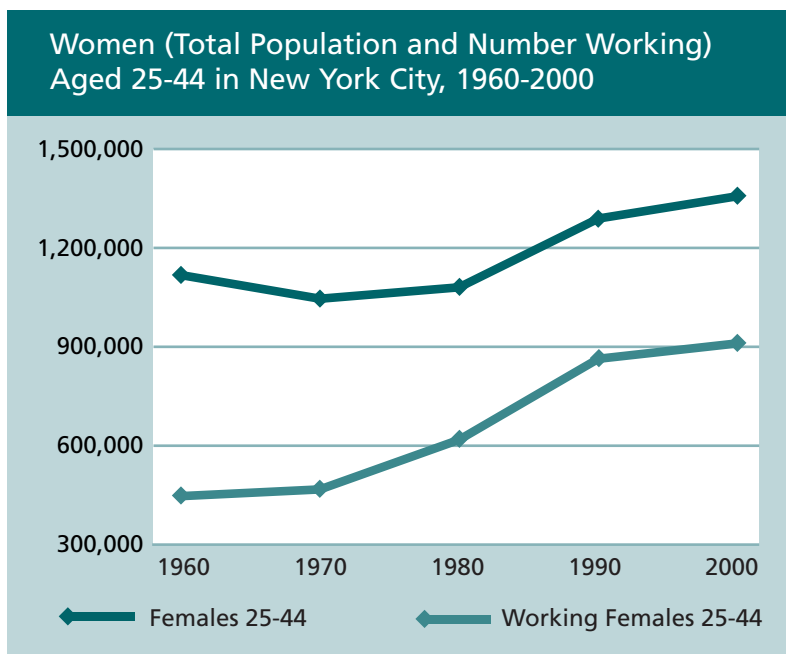
According to the U.S. Census Bureau,¹² for New York State as a whole, the vast majority of direct-care workers are female (on the order of 90 percent); over half of these workers are women of color, and 41 percent are white. Foreign-born workers, many of whom are not citizens, play a central role in the state's direct-care workforce, with just over 50 percent born abroad. In home health services, the percentage of foreign-born workers is nearly two-thirds (63 percent). In home health care, 58 percent of workers report having a high school degree or less. If a profile of the City's workforce were available, we would expect it to show an even higher proportion of non-white, foreign-born workers.

The shrinking pool of traditional caregivers.

From the '60s through the '90s, as New York City's extensive home- and community-based long-term care system developed, it relied on a seemingly infinite supply of low-income women who had few other employment opportunities. Today, the underlying demographics are strikingly different. *In fact, the pool of likely entry-level workers who traditionally have made up the core of the City's direct-care workforce—namely, women in the civilian workforce aged 25 to 44—is projected to decline by 6 percent over the period 2000 to 2010 at the same time that the demand for direct-care workers is projected to increase by 38 percent.*

Figure 1 gives an historical snapshot for New York City of women aged 25 to 44 (both total and in the workforce). From 1960 to 2000, the City benefited from increasing numbers of females in this age group entering the labor force.

Figure 1



Source: U.S. Census data from 1960, 1970, 1980, 1990, 2000

Yet as shown in Figure 2 (see next page), beginning in 2000, the absolute size of this female cohort started to contract and is projected to continue to do so until the end of this decade, when it will likely become stagnant. This traditional core population group is no longer increasing, primarily because the baby boom generation has significantly lower fertility rates compared to those of its parents. Not until 2030 will this female age group re-approach its population level in 2000.¹³

Direct-care jobs remain uncompetitive.

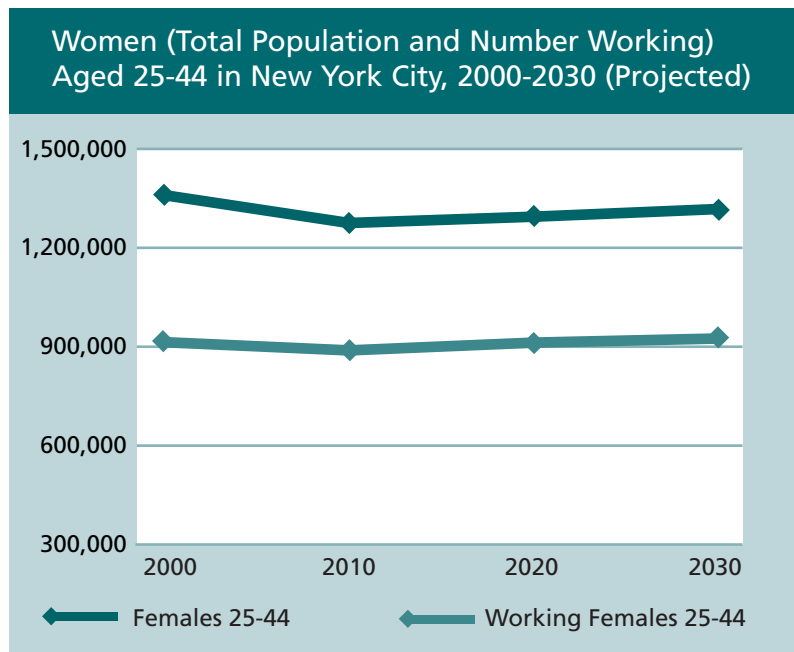
At the same time that sheer demographic forces are aligning to constrain the supply of traditional new entrants into direct-care work, underlying economic dynamics on the supply side also have changed: Direct-care jobs have become relatively less attractive because they do not offer compensation and job quality competitive with the many other opportunities that low-income women now have.

Long-term care employers—particularly those in the “home health care” segment of the industry—report problems retaining workers due to low wages, poor benefits, and erratic, part-time work. In addition, training is limited in terms of hours and scope. As a result, career paths to higher-paying related work usually are not available. All of these factors combine to create an industry with high rates of “churn,” with turnover typically ranging from 40 to 50 percent annually for home health aides and personal care aides.¹⁴

Home-based providers are among the City’s largest employers of low-wage workers.

Despite its limitations, direct-care work is the lynchpin to the livelihood of tens of thousands of low-wage City workers. In fact, *about one out of seven low-income workers in the City is employed in a home- or community-based direct-care occupation.*¹⁵ As shown in Table 3, home- and community-based direct-care workers in New York City outnumber fast food workers, food prep workers, counter attendants, and dining-room and

Figure 2



Source: Population projections were calculated by PHI using data from the NY Statistical Information System (www.nysis.cornell.edu). Labor force projections were calculated by PHI using age- and sex-specific projections from the U.S. Bureau of Labor Statistics for the United States as a whole. See Mitra Toosi, “A Century of Change: U.S. Labor Force from 1950 to 2050,” *Monthly Labor Review* Vol. 125, No. 5. May 2002.

An array of stakeholders are working to strengthen these occupations.

Table 3

Low-Wage Occupations in New York City, 2003: Direct-Care Work is the Second Largest Low-Wage Occupation				
Occupation Title	Employment	Median Hourly Wage	Rank by Wage	Rank by Employment
Occupations up to 20th percentile of the wage distribution (up to \$8.63)				
Retail Salespersons	104,770	\$8.61	8	1
Direct-care Workers, Home & Community Based *	103,670	\$8.38	7	2
Cashiers	73,850	\$7.23	3	3
Combined Food Preparation and Serving Workers, Including Fast Food	25,650	\$6.89	1	4
Sewing Machine Operators	18,050	\$7.26	4	5
Hairdressers, Hairstylists, and Cosmetologists	13,670	\$8.61	8	6
Packers and Packers, Hand	13,200	\$7.81	6	7
Counter Attendants, Cafeteria, Food Concession, and Coffee Shop	12,710	\$7.21	2	8
Dishwashers	12,090	\$7.64	5	9
Occupations between 20th & 30th percentiles of the wage distribution (between \$8.63 and \$10.19)				
Security Guards	65,440	\$9.71	4	1
Waiters and Waitresses	48,230	\$9.33	3	2
Stock Clerks and Order Fillers	38,800	\$8.92	1	3
Food Preparation Workers	30,830	\$10.12	5	4
Team Assemblers	11,260	\$9.33	3	5
Parking Lot Attendants	10,400	\$9.33	3	6
Couriers and Messengers	10,220	\$9.12	2	7

Source: Bureau of Labor Statistics, U.S. Department of Labor, May 2003 Metropolitan Area Occupational Employment and Wage Estimates, available at: www.bls.gov/oes/2003/may/oes_5600.htm.

* Home Health Aides and Personal Home Care Aides

cafeteria attendants combined. Among low-wage occupations (low-wage refers to earning wages at the 20th percentile of the wage distribution or below), the only occupation that comes close to the number of home- and community-based direct-care workers is retail salespersons.

In sum, long-term care providers in New York City—whether they are certified home health agencies, licensed home care agencies, or adult care and residential facilities—are one of the two largest employers of low-wage workers in the City. And as the demand for home- and community-based services continues to increase, the workforces of these employers could soon surpass that of retail employers. These workers already outnumber people employed in two slightly higher paying occupations taken together: security guards and waiters and waitresses.

New York City's Emerging Care Gap

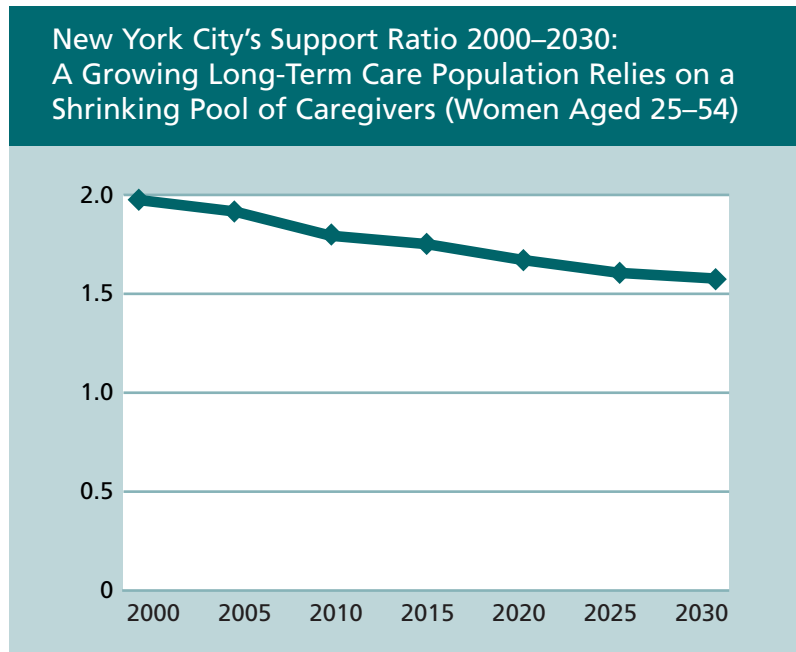
Compared to the period prior to the 1990s, the current decade and beyond present a very different dynamic for the caregiver labor market—one that sets the stage for the emergence of a serious “care gap.” Indeed, according to our analysis, the New York City region evidences the most severe current and projected care gap of any region in the state. This situation is attributable to the City's very substantial and increasing “disability burden,” resulting in a growing long-term care population that will be depending on a shrinking pool of caregivers.

Figure 3 shows a projected decline in the number of New York City's traditional caregivers (women aged 25 to 54) relative to the concurrent growth of the City's long-term care population (those who are elderly and disabled). The declining ratio between those available to provide care and the elderly and disabled long-term care consumers who need care would be even more steep if we limited our analysis to the pool of potential female caregivers between the ages of 25 to 44. We used a larger age grouping of 25 to 54 to include those women most likely to work not only as paid direct-care workers, but also those most likely to serve as family caregivers (e.g., spouses, daughters, and daughters-in-law).

Note that in 2000, there were about two females aged 25–54 for every person needing long-term care. This 2:1 “support ratio” is projected to decline steadily over the next two decades, down to approximately 1.6 caregivers for each long-term care consumer. This declining availability of traditional female caregivers, many of whom provide unpaid care, is only likely to increase the potential demand pressure on the paid workforce.

The implications could not be more clear: The home- and community-care industry must find ways to make direct-care jobs more competitive—that is, these jobs need to be made more attractive relative to other job options—so that the industry can absorb a nearly 50 percent increase in demand.

Figure 3



Sources: Population projections were calculated by PHI using data from the NY Statistical Information System (www.nysis.cornell.edu). Long-term care projections were calculated by PHI using data from the U.S. Census 2000 Disability Module (www.empire.state.ny.us/nysdc/Census2000).

Pressures for change are building.

In response to growing awareness that the poor quality of direct-care jobs limits their competitiveness, an array of stakeholders within the industry—including organized labor (SEIU 1199), long-term care employers, and consumers—is working to strengthen these occupations by improving wages and benefits. Through organizing and advocacy efforts, 1199 has achieved wage gains for direct-care workers in hospitals, nursing homes, and personal care, though not yet at a significant level for home health aides serving people with clinical needs.¹⁶

Direct-care workers also are benefiting from changes in minimum wage laws. In November 2002, Mayor Bloomberg signed into law a living wage ordinance that increased the wages of direct-care workers providing homecare services under the City's Medicaid Personal Care/Home Attendant or Housekeeping Programs (50 cent increments to \$10.00 in July 2006). Additionally, as of January 1, 2005, New York State increased its minimum wage from \$5.15 to \$6.00. The wage increased to \$6.75 per hour on January 1, 2006 and will reach \$7.15 per hour as of January 1, 2007. These upward pressures on wages are an important beginning in making direct-care work in New York City a more competitive occupation.

Wage and benefit changes, however, are only a first step toward addressing the care gap. With New York State's "Right-Sizing" initiative, long-term care policy now emphasizes an expansion of options across a full range of care settings, such as adult day care and assisted living, as well as access to new services such as telehealth monitoring intended to enable elders to remain in their homes. We now

need a workforce policy that can bear the weight of these service delivery system changes. These important changes will ultimately place new and different demands on direct-care workers while offering some new options, making this the right time to design workforce policies that overcome the limitations of today's workforce opportunities in long-term care.



Innovative workforce interventions can improve the quality of care received by hundreds of thousands of New York City residents.



III. Recommendations: Meeting the Employment Needs of Home- and Community-Based Employers through a Direct-Care Workforce Policy

While workforce investment boards across the country are beginning to address the problem of health care worker shortages, direct-care workforce issues in long-term care are often passed over in assessments of high-priority occupations for receiving workforce investment dollars. While that perspective was appropriate in the past, we believe that the direct-care workforce now offers significant workforce development opportunities in New York City.

With the exception of one central criteria—*job quality*—direct-care jobs in home- and community-based care currently meet or exceed all the possible standards of being high-priority occupations for workforce investment dollars: namely, significance or dominance in the sector at issue; relative number of projected job openings; and evidence of worker or skill shortages.

Now, given massive changes in the City’s workforce and long-term care demographics, as well as the desire to care for more people in home- and community-based settings, improved job quality is critical. This is the very dimension that the New York City Workforce Investment Board (WIB) can help forge through a careful injection of targeted workforce dollars.

Re-framing the Home- and Community-Based Care Occupation

We have documented that the direct-care labor market overwhelmingly employs paraprofessionals who receive very low wages, have limited career mobility, and work in jobs that often have poor training, support, and supervision. These negative features mattered less when there was a more ample supply of new labor market entrants. But in an era where the supply of labor will become much more limited, these job attributes limit the attractiveness and competitiveness of these jobs and lead to poor outcomes, such as high turnover, which in turn can be very costly to providers.¹⁷

In sum, direct-care work is in need of a fundamental “make-over.” As New York City’s premier workforce development organization, the New York City WIB is positioned to play a central role in that process, helping to define and shape the future of the City’s home care labor market. The areas in which the investment of WIB resources could substantially impact the quality of direct-care jobs, and as a result, help address New York City’s emerging “care gap,” are outlined below:

- **Supporting job re-design and revamped training and credentialing systems.**

The New York City WIB could encourage workforce activities that include: strengthening entry-level training, improving supervisory support (and thus training for supervisors), re-structuring direct-care worker roles (such as becoming full participants in care teams, with training provided for that role), and building skills related to “customer service” (e.g., problem-solving and cultural sensitivity). Best practice providers in the New York City home care industry have already created “peer trainer” models, “peer mentor” models, and “coaching supervision” models—all of which could be encouraged as the norm within this growing industry.

In addition, systematic opportunities for upgrading skills could be encouraged, perhaps as part of a credentialed, “apprenticeable” framework—which is currently being piloted in several urban centers across the country through the U.S. Department of Labor. Career pathways—particularly “senior aide” positions that reward higher skills and responsibilities, but do not require a nursing degree—could be created, leading to higher-paying caregiver jobs.

- **Strengthening recruitment and selection.**

Although New York City enjoys a growing population of non-native workers, these workers need special supports in order to become stable, high-quality care employees. Many non-native workers require English as a Second Language, and skills training in their native language.

As importantly, the industry requires assistance with improving the selection process for identifying those potential candidates who are most likely to succeed in this challenging work. Although presumed to be a “low-skilled” position, direct-care work—particularly in home- and community-based settings—in fact demands high levels of maturity, communication and problem-solving skills. To slow this occupation’s high rate of turnover, the industry needs assistance in selecting, from the beginning, the “right” type of potential employee. Again, a few industry providers have already developed best practices here, which the New York City WIB could more aggressively disseminate.

Direct-care work demands high levels of maturity, communication, and problem-solving skills.

- **Creating a higher standard for entry-level training.**

The federal government requires only 75 hours of training for the clinically oriented home health care occupation, and has no requirement for the non-clinical personal care worker. New York State has chosen slightly higher requirements.

The New York City WIB could support employer-based training programs that invest more substantive up-front resources in job preparation, particularly focusing on problem-solving and communication skill-building. Also valuable would be supporting “adult learner” training models for direct-care workers, and helping other trainers incorporate these best practices.

- **Creating provider access to retention “investment funds.”**

In addition to systems-change approaches to job re-design and improved training, funding could be made available to innovative providers who would like to invest in a particular retention-improving program, but lack the operating funds to do so. The availability of “start-up” funds would allow providers to make investments in developing and retaining their workforce, and many of these investments would likely realize financial and other returns due to reduced turnover and enhanced worker effort and productivity that result from better jobs. These returns and savings, in turn, could then be used to sustain continued retention investment.

Conclusion: Transforming a Low-Wage, High-Demand Employment Sector

New York City’s home- and community-care industry requires an effective workforce development policy that addresses the need for more workers, for improved training and job re-design, and for a career pathway infrastructure. Taking advantage of these opportunities for change will require strategic and collaborative approaches between employers, organized labor, the City’s Workforce1 Career Centers, training providers, public education institutions, and publicly funded employment intermediaries.

The stakes are high on every score: in the balance are at least 100,000 current jobs, plus the potential for about 30,000 new and replacement positions over the decade; the financial stability of hundreds of long-term care employers; and access to quality services for hundreds of thousands of long-term care recipients.

While the stakes are high, so too is the leverage created by what is undeniably one of the largest and fastest-growing sectors in the New York City economy. Indeed, *given the huge role that home- and community-based direct-care workers play in the City’s low-wage workforce, there may be no more powerful single leverage point for strengthening the City’s local economies than this workforce.*

New York City has long been a leader in program development and expenditures for home- and community-based services. It now has the commensurate opportunity to become a vanguard in workforce development for the long-term care sector that provides those very services.

Endnotes

- ¹ “Low-income workers” refers to workers earning wages at or below the 20th percentile of the wage distribution.
- ² See turnover estimates of NYS Department of Health for home health aides and personal care aides in New York State Register (October 27, 2004) “Revised Rulemaking, Department of Health, Criminal History Record Check of Certain Non-Licensed Nursing Home and Home Care Staff,” available at: www.dos.state.ny.us/info/register/2004/oct27/pdfs/rules.pdf. See similar estimates in Healthcare Association of New York State (January 2002) “Update on the Workforce Shortage Crisis: The Numbers,” Rensselaer, NY: HANYS.
- ³ For a history of this workforce bifurcation, see Michael D. Sparer (1996) *Medicaid and the Limits of State Health Reform* (Philadelphia, PA: Temple University Press).
- ⁴ Including: Certified Home Health Agencies, Licensed Home Care Agencies, the Long-Term Home Health Care Program, Adult Day Health Care, and Social Adult Day Services.
- ⁵ Medicaid figure is from the NYS Department of Health.
- ⁶ Calculated by PHI from U.S. Census 2000 data available at www.empire.state.ny.us/nysdc/Census2000.
- ⁷ Statewide in New York, disability rates among working-age whites and Asians are about 50 percent lower than those for African-Americans, Hispanics, and other non-Asian races, as well as for people of two or more races. Among the elderly, disability rates are about a third lower for whites and Asians compared to other minority racial/ethnic groups.
- ⁸ Individuals who are not white, non-Hispanic constituted 65 percent of the five-borough NYC area, according to Census 2000. Calculated from census data available at www.nyc.gov/html/dcp/html/census/popdiv.html.
- ⁹ The New York City Department of Aging reports that “between 1990 and 2000, the number of minority elderly increased by nearly 141,000 or almost 32 percent, while the number of white non-Hispanic elderly decreased significantly, by 167,000 or 20 percent... Minorities now represent nearly one in every two elderly New Yorkers, compared to one in three in 1990.” New York City Department for the Aging, Office of Management and Policy, Research Unit (Winter 2002) “The Older Population in New York City: Changes in Race, Hispanic Origin and Age, 1990 to 2000.” New York City: New York City Department of Aging, p. 2.
- ¹⁰ Note also that the need for new direct-care positions (including nurses aides) is projected to be more than twice the predicted increase in registered nurse positions, another occupation receiving considerable attention because of labor shortages.
- ¹¹ See New York data available at: http://www.pascenter.org/state_based_stats/acs_workforce_state_2004.php?state=newyork]
- ¹² PHI analysis of 2002 March Supplement of Current Population Statistics, US Census Bureau.
- ¹³ One factor impacting the contribution of this cohort to the overall workforce in New York City is its relatively low labor force participation rate for working-age females which is some 10 percent lower in New York City than in much of the rest of the state. This lower rate is attributable to the region’s higher poverty and disability rates and the fact that the City has a relatively high proportion of Hispanics, with Hispanic women more likely than women from other ethnic groups to stay out of the formal labor force.
- ¹⁴ See turnover estimates of NYS Department of Health in New York State Register (October 27, 2004) “Revised Rulemaking, Department of Health, Criminal History Record Check of Certain Non-Licensed Nursing Home and Home Care Staff,” available at: www.dos.state.ny.us/info/register/2004/oct27/pdfs/rules.pdf. See similar estimates in Healthcare Association of New York State (January 2002) “Update on the Workforce Shortage Crisis: The Numbers,” Rensselaer, NY: HANYS.
- ¹⁵ PHI calculations using data from NYS Department of Labor on the size of the labor force, data from U.S. Bureau of Labor Statistics (Occupational Employment Survey) on wage rates and employment in direct-care occupations, and statistics from the Economic Policy Institute on percentile wage rates. All information is from 2003 and for the New York City PMSA (Primary Metropolitan Statistical Area).
- ¹⁶ Wage increases for these workers to date have been limited to, at most a small (3 percent) add-on to the Medicaid reimbursement rate, an increase that is insufficient to yield wage parity with home attendants providing personal care.
- ¹⁷ Dorie Seavey (Paraprofessional Healthcare Institute)(October 2004) *The Cost of Frontline Turnover in Long-Term Care* Washington, DC: Better Jobs Better Care, IFAS/AAHSA. Available at: www.directcareclearinghouse.org/download/TOCostReport.pdf



NATIONAL CLEARINGHOUSE on the Direct Care Workforce

The National Clearinghouse on the Direct Care Workforce is a resource center informing the movement to improve long-term care for consumers by improving job quality for direct-care workers (home health aides, nursing assistants, personal care and home care attendants, direct support professionals, and others). The Clearinghouse distributes information on public policy, workplace practices, and other issues affecting direct-care workers. It also publishes fact sheets, research reports, and an electronic newsletter, and brings together long-term care consumers, employers, workers, policymakers, and other stakeholders to learn from one another.

Use the National Clearinghouse to:

- Find out about the direct-care workforce in your state.
- Hear directly from direct-care workers about why they do this work and the challenges they face.
- Locate key research findings and policy reports.
- Link to other organizations addressing direct-care workforce issues.
- Share ideas on an on-line bulletin board.

For the best information available on the direct-care workforce, visit www.PHInational.org/clearinghouse.

Order hard copies of this or other publications, by e-mailing: clearinghouse@PHInational.org or calling, toll-free, 866-402-4138.

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