Direct Care Alliance, Inc.

Direct Care Alliance Policy Brief No. 5

Better Jobs for In-Home Direct Care Workers[1]

Laura Dresser and Adrienne Pagac, Center on Wisconsin Strategy

1. Direct Care in Homes: the Work, the Workers

Each day, in every community across our nation—farm and city, North and South—workers arrive at homes to provide care and support that makes independent living possible for seniors and individuals living with disabilities. From bathing and positioning to cooking and cleaning, these workers—the in-home direct care workforce—are on the frontlines of the nation's long-term care system. Their work is critical to the quality of life, independence and well-being of people who are disabled, frail, and elderly who rely on their services and support; to the peace of mind of their client's family members; and to both the public and private health care systems, which rely on these workers to be the hands-on care and support for clients and patients.

The workers are a cornerstone of our nation's long-term care system and help make it more cost effective; they provide a stronger foundation for quality of life for clients, patients, and families. They also bring home some of the lowest wages and benefits in the country. In fact, many of these workers are explicitly and/or effectively outside the basic labor protections, including minimum wage and overtime, which protect nearly all other workers. The standards in these jobs are the product of a complex web of federal and state Medicare and Medicaid policy, and pressures of the national health care system. Neither trade nor technological change—two factors consistently credited with driving down standards in the U.S. labor market—have restructured health care work in the home in profound ways.

Over the last decade, despite longstanding status as quintessential low-wage work, in-home direct care workers have generated significant and inspiring innovations to improve job quality. Unionization of home health has provided some of the labor movement's most significant membership increases in recent years, delivering substantial wage and benefits improvements for more than 300,000 workers. Coop models have emerged for direct care work, proving that better wages and working conditions are possible in these positions. And advocacy campaigns for home health workers have increased awareness of these jobs and won significant policy victories to help promote the interests of the workers doing them.

This paper sheds light on the issues facing this workforce; offers data on the in-home care workforce, wages and benefits in the jobs; and discusses issues related to working conditions and labor law. We focus on in-home workers not only because they face some of the worst wages and working conditions in the direct care workforce, but also because they represent the fastest growing

October 2010

This is the fifth in a series of policy briefs about the direct care workforce in long-term care issued by the Direct Care Alliance (DCA). This series was conceived at a meeting of labor economists, lawyers, long-term care researchers, and other experts convened by the DCA and funded by the Russell Sage Foundation. Editorial committee: Nancy Folbre, Vera Salter, Leonila Vega.

The Direct Care Alliance

The Direct Care Alliance is the national advocacy voice of direct care workers. We empower workers to speak out for better wages, benefits, respect, and working conditions, so more people can commit to direct care as a career. We also convene powerful allies nationwide to build consensus for change.

The Work: In-Home Direct Care, Defined

In this paper, we are focusing most specifically on the subset of "direct care workers" who work inside other people's homes. The nature of their work means that these workers can be hard to identify and may often be undercounted. First, the employers in this sector can be hard to find especially when the employer is the client. These employers are explicitly left out of nationally representative employer surveys. On the worker side, some in-home providers may be wary of reporting their work even on a survey, as they keep the work officially off the books. For these reasons, this is a set of jobs that is notoriously difficult to count.

Additionally, disparate occupational and industrial definitions, as well as counting methodologies used in the Current Population Survey (CPS) and the Occupational Employment Statistics (OES), also create a challenge. While in the OES, the Bureau of Labor Statistics (BLS) currently separates nursing and psychiatric aides from home health aides, the CPS categorizes those in the same occupation. As such, for the broad counts of the occupations, we stick with BLS definitions and reported results, which separate home health from nursing aides, and thus provide a better count of jobs, and not surprisingly, a larger count than our CPS analysis yields.

For analysis of the demographics, wages, and benefits of the in-home direct care workforce, we must utilize the CPS. We draw from these two occupations:

- Nursing, psychiatric, and home health aides (CPS Occupational Code 3600)
- Personal and home care aides (CPS Occupational Code 4610)

But because the CPS does not differentiate among nursing, psychiatric, and home health aides, we must use the best possible industrial screens to separate those care workers who labor in homes from those who work in institutional settings. To do so, we limit the sample to only those workers employed in two industries:

- Home Health Care Services (CPS Industrial Code 8170/NAICS 6126)
- Private Households (CPS Industrial Code 9290/NAICS 814)

Generally speaking, home health aides deliver hands-on care: moving, bathing, dressing, and otherwise physically assisting clients, along with basic health-related services, like pulse rate and temperature. Personal and home care aides provide supportive services in the home: cooking, cleaning, and attending to clients' needs.

segment of it, and organizing by these workers has generated important improvements in job quality. We provide information on why low wages and benefits for in-home care workers are a social problem, not just a struggle for those who have to live on the wages. Finally, we offer a description of the key strategies that have worked to improve the jobs. Because these workers provide service of great social value, examination of that work and strategies to improve it should inspire interest from groups outside the field itself.

Some 1.7 million workers hold jobs in in-home direct care.[2] Using our more restrictive definition which narrows our focus to those employed in the home health care services and private households industries, better guaranteeing we're looking at in-home workers, we identify roughly three-quarters of a million workers who provide care and support to people in their homes. The large majority of these—nearly 650,000—are employed by home health care services firms. Another 130,000 work directly for clients and are found in the private households industry. This industrial distinction has more to do with state policy than with worker or client choice. In many states, elderly services and services to adults with disabilities are provided through a network of agencies (and so these workers are found in the "home health care services" industry). In others, states pay for services, but clients select workers. In these states, in-home care providers are much more likely to be in the private households industry. Some states have a mix of employment structures which include both agencies and direct client/worker contracting, sometimes on the basis of local policy, sometimes the result of state rules on funding streams. The private pay market also works through both models (sometimes clients or their families hire and pay directly, others may hire through an agency).

Longer lifespan, the aging of baby boomers, and restructuring of American health care all work together to ensure projected growth for these jobs. Aging of the population is the most obvious lever for growing demand for in-home care workers. Also important, states and private health systems have and will continue to seek cost savings in the provision of care. That, mostly likely, means less institutional care and more home-based care. It also means shorter stays in acute care and skilled nursing rehab facilities. In fact, BLS projects that a significant share of the growth in all health care support occupa-

tions, nearly 30 percent, will result from the ever-expanding demand for home health aides. The forecast also suggests that this occupation will add the second-highest number of jobs of any occupation in the economy and will have the third-highest rate of growth. Personal and home care aides will experience considerable growth as well; of the 1 million jobs expected over the next ten years in personal care and service occupations, personal and home care aides will comprise 375,000 of them, or nearly 38 percent of the total projected growth.

Table 1: In-Home Direct Care Jobs, and Their Projected Growth
Source: *Monthly Labor Review*[3]

Occupation	Employment		Change, 2008–2018	
	2008	2018	Number	Percent
Home Health Aides	921,700	1,382,600	460,900	50.0
Personal & Home Care Aides	817,200	1,193,000	375,800	46.0

The Workers

The majority of workers providing hands-on care in homes are, not surprisingly, women. Nearly 9 in 10 in-home care workers are women, making this one of the most gender-segregated occupations in the nation.[4] Additionally, women of color, women who aren't citizens, and women without high school degrees are much more likely to hold these jobs. For example, while just 9.6 percent of the national workforce has no high school degree, fully one in five in-home direct care workers has no high school degree. Though Hispanics represent less than 15 percent of the total labor force, they are one-fifth of the workforce in home-based direct care. Additionally, it is likely that these in-home workers are older than the broader labor force.[5]

Table 2: In-Home Care—The Workers
Source: Center on Wisconsin Strategy analysis of Current Population Survey data, 2009

Industry	Percent Female	Percent Black	Percent Hispanic	Percent Non-Citizen	Percent Less Than High School
Home Health Care Services	90.2	29.6	18.8	14.1	21.0
Private Households	88.3	13.0	26.1	17.8	21.6
In-Home Care Total	89.9	26.8	20.0	14.7	21.1
U.S. TOTAL WORKFORCE	**46.7**	**11.2**	**14.8**	**9.1**	**9.6**

2. Problems with the Jobs: Wages, Income, Benefits and Working Conditions in In-Home Direct Care

Poor job quality is indisputable for in-home direct care workers: wages are extremely low and benefits non-existent, and even basic labor standards do not effectively cover many of these workers. Table 3 summarizes wage and benefit data for the in-home direct care workforce.

Workers caring in the home earn some of the lowest wages in the economy. In 2009, the median wage for these workers was $9.50, just below the 20th percentile wage ($9.83 per hour) and just three-fifths the national median ($15.95 per hour).[6] Providing just over $19,000 in annual income (in the unlikely case where the job offers full-time year-round employment), these jobs can't keep a family of four out of poverty. These are exceedingly low wages.

Low and chronically unstable hours combine with low wages to generate low income for the workforce. When clients don't want services—they're out of town, or in the hospital, for example—many workers don't receive pay. That means that income can be unpredictable, and that juggling schedules of clients, or time spent trying to fill a slot when a client no longer needs services, can push income down even further. This is especially true for those who work directly for clients (rather than for an agency). However, even with an agency, often the emphasis is on clients' wishes or needs rather than ensuring a stable schedule and income for workers. A significant share of direct care work is characterized by underemployment—over forty percent of direct care workers work less than full-time.[7]

Though these workers help provide health care, very few receive health insurance as a benefit from their job. Just 24 percent of in-home workers with at least half-time year-round work or more get health insurance through their employment, compared with 55 percent of the national workforce (Table 3). Direct care workers employed by home health care agencies have the greatest access to employer health insurance; one in four workers report having employer-provided

Table 3: Employment, Wages, and Benefits of In-Home Workers, 2009
Source: Center on Wisconsin Strategy analysis of Current Population Survey data, 2009, and Economic Policy Institute analysis of Current Population Survey data for national median wage.

Industry	Total Employed	Median Wage (2008 $)	Percent with Health Care Provided/ Subsidized by Employer	Percent with Employer-Provided/ Accessed Pensions
Home Health Care Services	649,580	9.50	24.9	13.7
Private Households	130,236	10.00	17.4	1.6
In-Home Care Industries, Combined	779,816	9.50	23.7	11.8
Nursing Care Facilities and Residential Care Facilities, Combined	1,007,257	10.50	45.0	26.5
U.S. TOTAL WORKFORCE	**145,277,316**	**16.01**	**55.0**	**46.0**

health insurance, compared with less than one in five in the private households market. The majority of these workers then must rely on spouses or public insurance programs for coverage, and many do. Even so, one in four direct care workers have no coverage at all.[8]

The pension picture is even more grim, despite year-round employment at least half-time. Just over one in 10 home health workers participate in an employer pension plan. Upon reaching retirement age, these workers will rely solely on Social Security. Beyond pension and health care benefits, other benefit levels also tend to be incredibly low. Paid vacation and sick leave are rare.[9]

The more broadly defined direct care worker certainly faces low-wage and benefit packages; however, the in-home workforce is clearly behind even the weak standard established in more institutional settings. In-home workers earn lower hourly wages (a median of $9.50 per hour in-home compared to $10.50 per hour in residential and nursing facilities). The real difference is in benefits, however. Direct care providers in institutional settings are more likely to receive health care through their employer (45 percent do, as opposed to 24 percent of in-home workers), and are more than twice as likely to participate in employer-based pension plans (27 percent in residential and nursing facilities, compared to 12 percent of in-home workers.)

Additionally, many in-home direct care workers do not benefit from wage and overtime protections. The Fair Labor Standards Act (FLSA) of 1938, which guarantees basic labor standards for the vast majority of workers, specifically exempted "any employee employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves."[10] Though domestic workers were granted FLSA protections by Congress in 1974, workers that provide companionship services to the elderly and disabled were denied those same protections by the Department of Labor in 1975.

Long-time home health aide Evelyn Coke challenged the exemption in Long Island Care at Home, Ltd. v. Coke, which went to the Supreme Court. In June 2007, the U.S. Supreme Court upheld the exemption; in-home health workers continue to lack overtime protections.[11]

Whatever the formal laws on the books, however, the very structure of many of the jobs makes defending basic labor standards in them difficult. Perhaps especially in the private pay market, deals are made directly between workers and their clients. Neither is likely to understand the employment relationship definitions or the basic wage, hours, and safety standards that employment should carry. These workers are working outside the basic labor framework both explicitly—through the overtime exemption—and effectively, as when workers and employers do not even understand the regulations of their employment relationship.

3. In-Home Direct Care: Unique Jobs, Unique Challenges to Improving Job Quality

By any standard, from wages and benefits to labor law, the in-home direct care workforce lies near the bottom of the American labor market. For the workers, of course, that's a problem on its own. But it's a problem for the rest of us, too. These are the workers who provide us and the people we love comfort and support at our times of greatest need. These are the workers providing the resources that allow people to live independently in their communities. These are also the workers with the most

consistent contact with some of the most frail and needy and expensive clients in the health care system. Quality of life, strength of community, and health care cost savings are all in the hands of these workers.

Likewise, the low quality of the jobs is a real problem not just for workers, but for clients, patients, family members and communities, too. Low-quality jobs lead to higher turnover and that disrupts the relationship that clients rely on for support and care. High turnover is tied to low morale, absenteeism, and "burn out"—frequent turnover requires existing care workers to work overtime which makes them "susceptible to exhaustion, increased mistakes and decreasing quality of performance."[12] For consumers, turnover can mean a disruption of care or inadequate care (as the direct care workforce is stretched too thin) or denial of care altogether.[13]

And the contradiction between the social value and the pay package will continue to grow into the future if the means to systematically improve these jobs are not found. The aging of the baby boomers drives that demand: "The 55-years-and-older age group consumes significantly more health care and social assistance services than any other age group. As a result, jobs in health care and social assistance are expected to have the fastest rate of growth over the next 10 years, adding a projected 4.0 million new wage and salary jobs, or 27 percent of all new nonagricultural wage and salary jobs (emphasis added)."[14] Pressure on state health care budgets and increasing health care coverage in national health care reform will also likely continue the shift from institutional to community-based care and increase the demand for these workers as well.

Key Features of In-Home Care Work

In-home care workers need better wages, working conditions, and benefits. But the very structure of the work makes it hard to organize and improve. There are at least three features of in-home work relevant to the question of organizing and improving it: the work is inherently isolated and autonomous; the work is inherently intimate, building strong connections with clients but few connections with other workers; and the work is socially perceived as inherently "women's" work, and often the provenance of women of color with few alternatives.

Both the good and the bad of direct care work derives from its combination of isolation and autonomy. For some workers, isolation is evident before a job is secured, as obtaining work requires a one-to-one deal with the client. From the time a job connection is established, working in the home is essentially a solitary endeavor. If co-workers or supervisors exist at all, they are remote. There is no "water cooler," or the relationship-building and problem-solving that can happen at a more standard worksite. There is no natural community for support, for checking on what's reasonable, for seeing a pattern of problems. Perhaps more importantly, there is no one there to observe the situation and defend the worker if a client accuses him or her of something, makes unreasonable demands, or treats him or her unacceptably. These workers, some without the resources provided by years of education or native facility with English, face their clients alone.

But for many, "isolation" is also "independence and autonomy." Many in-home direct care workers prefer the autonomy and self-reliance of individual work. There are no co-workers to slow you down, no supervisor to stare over your shoulder, no one to second-guess your decisions or approaches. And there's no office gossip or in-fighting. Home health workers with prior experience in nursing homes state a preference for the autonomy and relationships they can build in home health care settings.[15] Within broad parameters, they can decide what order to do tasks in, stay a bit longer, or provide extra service. Indeed, a 1999 study in the area around Dane County, Wisconsin, documented lower rates of both pay and turnover in home health compared to nursing homes.[16] Clearly for some, autonomy and independence in home health helped make up for the lower wages.

The most isolated workers may be those in-home care workers with just one client. Multiple clients, by contrast, provide a more diverse base of demand and allow the worker to check standards in one situation against another. Multiple clients can also minimize the financial impact of a lost client and income. But multiple clients can also come with heavy scheduling, transportation and other logistical issues. (See Dawson and Surpin 2001 for discussion.)

In-home care workers employed by an agency may be (but are not necessarily) less isolated as well. They may get training, assignments, and supervision from a central source. But this connection can often be quite weak, with the worker never hearing from the agency unless the schedule changes.

Direct care work in the home is also inherently inti-

mate, as the lines between work and personal relationships are consistently crossed. The direct care worker is often presumed to be or treated as “a part of the family.” The workers develop a deep store of information about clients’ lives; many develop strong affection for their clients.

Like isolation, intimacy is a double-edged sword. For many care and support providers, the relationship to the client is a critical element of job quality. Workers develop strong connections to their clients. The bond makes the work rewarding, and the quality of care received can be higher when relationships are stronger.

Even so, intimacy raises many problems for workers. Being “part of the family” can be both fulfilling and demeaning. The expectations and presumptions of clients can creep and expand, leaving the worker hard-pressed to draw a boundary. This is perhaps especially true in the private pay market when exact definitions about what should and should not be included in the work are hard sometimes to discern and difficult to navigate. While a home health aide may know that s/he is not supposed to do laundry, saying no to a frail client can be very difficult, especially when the bond with the client is strong.

In general, the more hours with a single client, the more intimate the relationship. But even less intensive hours with a family can create deep intimacy. Caring for a frail or dying person, even just a few hours a day, may be the most deeply intimate work, requiring the client, the client’s family, and the care provider to develop a strong relationship of trust.

For many workers, autonomy and relationships can be the work’s greatest rewards. But the isolation and the intimacy can also lead to higher levels of exploitation and instability in the jobs.

These jobs carry a legacy of low status. In part, this has to do with the fact that women, usually mothers, have done this work, and done it for free. Care work in the home is often not seen as “real work” and therefore is not paid as such. Sexism and the consistently low social value placed on women’s work is clearly a core issue in wage setting.

Additionally, this work has often been the domain of women of color and immigrants. They continue to be overrepresented in these home health jobs. And these workers tend to have fewer external options in the labor market that could leverage improvements on the job.

Labor market factors push wages down in two ways here. First, the work is considered to be of very low worth and is paid as such. Second, the women workers who hold the jobs—women of color and immigrants—have fewer opportunities outside these in-home jobs.

The shared traits of isolated, intimate, and undervalued work go a long way toward explaining why these jobs can be extremely hard to improve. Extremely low wages and poor job quality invariably lead to high turnover.[17] The workers may have weak professional identity; the worker may identify more with his or her client than with other in-home workers. And worksites are not only isolated but also widely dispersed. Collective action to improve wages of in-home work often requires building collective identity, but several factors stand directly in the way of building collective voice: extremely small work units (most often a unit of one), very low social value and little professional identity, and high turnover.

4. Improving Wage and Benefits of the In-Home Direct Care Workforce

Any successful strategy to improve in-home direct care job quality will necessarily bring more money to the field. Often this will require some collective sense of identity among members of the workforce. In some ways, improving in-home work is both as straightforward and as difficult as that.

Collective Identity and Resources

The very isolation of the workers pushes squarely against collective identity. It is only in conversation and connection with others that these workers begin to understand their own situation in a larger context. Further, given their often strong connection to clients, workers need some collective connection both to remind them that their project is not only about their own position and to help them think more broadly about how improving the conditions of their work could actually improve their service to the client. Collective action can also make visible this otherwise socially invisible work and force the issues of value and wages into public discourse. Without collective action, the work is too easily discussed in terms of anecdotal experience rather than collective reality.

The second obvious and necessary ingredient for improving in-home direct care jobs is money. The low social value of the work, and the relatively weaker external opportunities for many of the workers who do it, mean

that the collective consciousness needs to be directed at raising wages—and that takes money. Because of this, the most salient strategy to create a collective identity is to carefully target the employer. Though identifying the employer might seem simple, in-home workers are often confounded by this first step.

Public funds are central to the home health system. Indeed, the majority of financing of long-term care comes from Medicaid and Medicare and as more long-term care moves into the home, these public dollars are increasingly important to home health jobs.[18] But the definition of "employer," can remain contentious and contested. In some places, the client is able to select and hire the care worker, while the state or local unit of government directs Medicaid and/or Medicare money to the care worker. In some instances, the payment for work goes directly from the state to the care worker; in others the client receives and redirects the money to the care worker.[19] Other insurance providers may also work this way, providing payment while still allowing consumer choice in hiring. Given the very heavy public investment in home health care, these workers have much to gain from finding ways to identify the public sector as their employer.

Another important question when it comes to creating identity and leveraging money is related but distinct: is there a significant public good being produced by the in-home workers? Direct care workers have a strong positive argument here. The shift from institutional to home-based care for individuals who are frail, elderly, and developmentally disabled over the last generation has been premised on promoting better health and well-being for clients, while also having the potential to save the state money. The home health workers who make such a shift possible are the point at which these larger public medical systems touch the client. In fact, the quality of the care provided is directly and clearly related to the quality of jobs the system supports. Finding more money for these home health workers, whether employed through agencies or as independent contractors, hinges not only on finding the public money already in the system but also on making arguments for the public good that the workers provide.

What Has Worked to Improve In-Home Care Work?

In-home direct care jobs have been "bad" jobs for a very long time in the U.S. But innovative thinking about how to organize and improve these jobs has begun to produce meaningful results. Unions, cooperatives, advocacy campaigns, and legal strategies have all made progress toward improving these jobs.

Unions and Public Authority Strategies

The development of the public authority model is the most influential innovation in in-home work. The roots of the model go back to the 1980s, when Service Employees International Union (SEIU) was first trying to organize personal care assistants in California's In-Home Supportive Services home care program. In 1987, the court found that neither the state nor the county was an "employer" for the home care workers. At that point, SEIU began pursuing a legislative and advocacy strategy to establish a public authority to serve as "employer of record" for purposes of bargaining. The county-based public authorities finally redefined the home health providers as workers and established a legal employment relationship between the county and them. "[T]he public authority, which made the local or state government into an employer to bargain with, became the mechanism to end the fiction of the home care worker as independent contractor and cut through obfuscations stemming from home care's place within the welfare state."[20]

The public authority model in home health has had some dramatic successes. Most famously, in 1999, 74,000 home care workers joined SEIU in Los Angeles, marking the largest union organizing victory since the 1940s. The model in California has spread to nearly all counties in the state. Oregon and Washington also have public authorities, and all together at least 400,000 workers on the Pacific Coast are now union members and employees of public authorities. Wage and benefits gains for many (but not all) of these home health workers have been substantial. Home care workers have also gained the right to organize in Illinois, Michigan, Massachusetts, and New York (see Schneider 2003 for a summary).

These public authority strategies leverage both the public dollars in long-term care and the public good produced by it. Labor has played a leading role in developing the model, but it has been joint work with consumer advocates that has made the progress possible. In the public authority states, consumer and worker advocates have joined together because of the strong links between job and care quality. Their common interest in decent standards for the jobs and their influence on public policy has secured a new

model in this previously invisible sector of work.

Public authority strategies have effectively promoted the interests of in-home care workers, but they have run into multiple and sometimes surprising road blocks. Indeed, spreading the model within California to in-home workers who assist the independent living of persons with developmental disabilities has been extremely slow-going because the independent contractor model is not as prevalent in that sector in California. Public authority strategies work best where in-home health care work is all arranged through independent contracting. In many states, however, agencies hire home health workers to provide in-home care. If work is organized through agencies, then there is no need for a public authority to serve as the employer of record; the agency already holds the title. The public authority model also requires political support from a strong labor and consumer coalition. In some states, that coalition may not have sufficient leverage to secure the executive orders and/or legislation required to get the process going. Despite these challenges, public authority strategies remain the most effective means for the improvement of in-home care employment.

Worker Cooperatives

As SEIU was developing the public authority strategy in Illinois and California, another project to improve home health jobs was established in the Bronx. Cooperative Home Care Associates (CHCA) was established as part of a community-based economic development program to create jobs through worker-owned firms. Since its genesis in 1985, CHCA has grown in both scale and advocacy ambition. The organization "anchors a national cooperative network generating over $60 million annually in revenue and creating quality jobs for over 1,600 individuals".[21]

Modeled after CHCA, the Department of Health and Human Services in Waushara County, Wisconsin, collaborated with the USDA, the State of Wisconsin Division of Long Term Care Personnel and other stakeholders, to set up Cooperative Care. Cooperative Care is a member-owned cooperative designed to provide in-home services for the residents of rural communities in the east-central region of the state who are frail, elderly, or disabled. Worker-owners receive better wages and benefits than other direct care workers and turnover at Cooperative Care is extremely low. Since its inception in 2001, according to an analysis by a regional Rural Health Research Center, no workers have left the coop—a noteworthy outcome given the 40-60 percent turnover at other home care businesses according to the USDA's estimate.[22]

These enterprises alone do not approach the scale of impact that the public authority models do. But they are critical in at least three ways. First, the very existence of a direct care business model with different priorities and higher quality jobs proves that a different way of designing and rewarding these jobs is possible. Second, and probably more importantly, these coops often enter directly into advocacy and policy making, bringing the voice and needs of workers more centrally into debates on job quality in their industries. Third, in their advocacy, the care-focused coops have continued to help build the consumer/worker coalitions that better jobs require.

Advocacy Campaigns and Litigation

Bringing workers together around an agenda of job improvement is another approach to improving the jobs. The advocacy must capture public attention and make issues of compensation explicit. Most public authority campaigns start out with a labor/consumer coalition and advocacy agenda, before they secure the changes needed to build the public authority model. But many coalitions have been formed around a more general agenda of job quality and have pursued other strategies as well.

The Direct Care Alliance (DCA), a nation- and statewide coalition of direct care workers, employers and the individuals who utilize their services, has been working to secure fair pay for direct care workers since 2007. Following the June 2007 Supreme Court ruling against Evelyn Coke, DCA undertook a campaign to obtain legislative and regulatory changes to FLSA in order to secure wage and overtime protections for direct care workers. In addition to its own letters to then-President-Elect Obama and Secretary of Labor, Hilda Solis, which called for better wages and the extension of FLSA protections to those working in home care, DCA successfully enlisted the support of 15 U.S. Senators and 37 members of the House to Sec. Solis with a call to end the exemption. Members of DCA, along with direct care workers, also lobbied the Department of Labor in person, urging it to extend wage and overtime protections to home care workers. Finally, DCA formally partnered with PHI's Policy Works, PHI's national strategy center that works to improve national- and state-level policy affecting the direct care workforce, to launch the Cam-

paign for Fair Pay. In 2010, the Department of Labor added the issue of FLSA exemptions to its regulatory agenda.[23] Most recently, DCA played an instrumental role in supporting the introduction of the Direct Care Workforce Empowerment Act (H.R. 5902/S. 3696) in the House and Senate.[24]

DCA's advocacy campaign and work towards bettering the lives of the direct care workforce, in part, rests upon the success of its training and capacity-building initiative, the Voices Institute, which imparts "leadership, advocacy, and organizational development skills crucial to [direct care workers themselves], allowing them a decision making role with other stakeholders in the development of direct care work."[25] Informed by the belief that worker involvement is essential to the development of the organization's goals and objectives, DCA's Voices Institute equips direct care workers with the expertise necessary to advocate directly on behalf of their profession; plan statewide conferences on issues relevant to direct care work, develop and advance policy suggestions; and interest other key stakeholders and state officials in working to improve the outcomes for those employed in direct care.[26] While empowering workers through the Voices Institute, DCA also aims to strengthen their position through its development of a national credentialing program that gives direct care workers the opportunity to demonstrate and improve their skills.[27]

The Pennsylvania Direct Care Worker Association (PDCWA), founded in 2006 with help from the Better Jobs Better Care Project and PHI, is one of the oldest direct care worker associations in the country. Since inception, they have grown to include 700-plus members from across Pennsylvania and its Board of Directors is comprised of workers themselves. PDCWA aims to improve the quality of care for persons who are elderly, living with disabilities, chronically or terminally ill by delivering educational instruction to the state's direct care profession, and offering support to the workforce.

Often litigation is a useful tool as well, especially when deployed in the context of increasing advocacy around the jobs. Parties of Medicaid-eligible individuals have brought cases before federal courts to challenge state Medicaid payment policies and payment rates for home and community-based services. The lawsuits hinge upon whether Medicaid beneficiaries are able to receive reliable care when state Medicaid payments made for direct care work are too low to provide for a sufficient workforce; simply put, the wages for direct care work are too low to recruit or retain individuals into the occupations which could result in a possible care shortage and thus violate federal Medicaid law which stipulates the provision of dependable care.[28] Failure to provide competitive wages to pre-existing or potential members of the direct care workforce has also been found to be a violation of the Americans with Disabilities Act (ADA) too. Such policy decisions lead to care shortages, thereby "limiting [the ability of persons with disabilities] to maintain their social and economic independence and depriving them of a real choice between home and institutional care."[29] Relatedly, attempts have been made by provider associations at the state level to challenge the HCBS reimbursement rates set by state Medicaid offices for failing to keep up with the costs of care.[30] In April 2010, New York City home care workers filed a class-action suit against their employer for failure to pay them due wages and overtime, seeking financial redress along with assurances that their employer would obey New York state wage and hour laws in the future.[31]

Though legal proceedings can provide some resolution to the problems facing direct care workers, bringing much needed attention to these issues in the public domain, it is not without cost. Resolution in the courts takes time and cases require financial resources and sustained advocacy over many years.[32]

Conclusion

Direct care workers contribute every day to the quality of life of countless Americans. They do critical work but often lack basic labor protections or decent wage and benefits standards. And while the work remains underpaid, many in the field are working hard to improve the jobs, and their innovations have brought real gains to workers. The growing solidarity among direct care workers and their clients can continue to pave the road toward broader adoption of these positive strategies. The way ahead will be difficult, however. The recession that began in late 2007 has exhausted state budgets. The anemic recovery has produced few jobs and very little by way of relief for state resources. When state budgets are pressed, cuts in these programs are inevitable. Costly means of improving the jobs may be, at least in this budget cycle, off the table. But we should defend the progress that has been made, and continue developing the advocacy campaigns and worker/consumer coalitions necessary to improve home-based direct care.

End Notes

[1] This paper draws heavily from "Cleaning and Caring in the Home: Shared Problems? Shared Possibilities?," of the Labor and Employment Relations Association Research Volume, *The Gloves-Off Economy: Labor Standards at the Bottom of America's Labor Market*, edited by Annette Bernhardt, Heather Boushey, Laura Dresser, and Chris Tilly.© Copyright 2008 Labor and Employment Relations Association, Champaign, IL. Thanks to Candace Howes, Leonila Vega, and Aaron Pickering for detailed comments and suggestions on previous drafts of the paper.

[2] Bureau of Labor Statistics. 2010. "Home Health Aides & Personal & Home Care Aides." *Occupational Outlook Handbook 2010-2011 Edition*. U.S. Department of Labor. Accessed at http://www.bls.gov/oco/ocos326.htm, August 17, 2010.

[3] Lacey, T. Alan and Benjamin Wright. 2009. "Occupational employment projections to 2018." *Monthly Labor Review*, 132, 11.

[4] Hegewisch, Ariane and Hannah Liepmann. 2010. *The Gender Wage Gap by Occupation*. Institute for Women's Policy Research. Updated April. Accessed at http://www.iwpr.org/pdf/C350a.pdf on August 17, 2010.

[5] PHI. 2010. *Older Direct-Care Workers: Key Facts and Trends*. April 2010. Accessed on August 17, 2010 at http://directcareclearinghouse.org/download/PHI%20Older%20DCW%20Analysis%20April%202010.pdf.

[6] Economic Policy Institute analysis of Current Population Survey data, 2010.

[7] PHI. 2010. *Facts: Who Are Direct-Care Workers?* Updated February, accessed on August 17, 2010 at http://directcareclearinghouse.org/download/NCDCW%20Fact%20Sheet-1.pdf.

[8] PHI. 2009. *Facts: Health Care Coverage for Direct-Care Workers: 2008 Data Update*. Updated December and accessed on August 17, 2010 at http://www.directcareclearinghouse.org/download/PHI-447%20Fact-Sheet4_singles.pdf.

[9] Families and Work Institute. 2006. "What Do We Know About Entry-Level, Hourly Employees?" *Supporting Entry-Level, Hourly Employees—Research Brief No. 1*. Accessed on August 17, 2010 at http://familiesandwork.org/site/research/reports/brief1.pdf.

[10] Legal Information Institute, Cornell University Law School, accessed on July 6, 2010 at http://www.law.cornell.edu/uscode/29/usc_sec_29_00000213----000-.html.

[11] National Women's Law Center. "Supreme Court Rules Minimum Wage, Overtime Protections Don't Apply to Home Care Workers." 2007. Accessed July 7, 2010 at http://www.nwlc.org/press-release/supreme-court-rules-minimum-wage-overtime-protections-dont-apply-home-care-workers.

[12] Hewitt, Amy and K. Charlie Lakin. 2001. *Issues in the Direct Support Workforce and their Connections to the Growth, Sustainability and Quality of Community Supports*. Research and Training Center on Community Living – University of Minnesota. May. Accessed on August 17, 2010 at http://rtc.umn.edu/docs/hcfa.pdf.

[13] Dawson, Steven L. and Rick Surpin. 2001. *Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care*. The Aspen Institute. May. Accessed on August 17, 2010 at http://directcareclearinghouse.org/download/Aspen.pdf.

[14] Dohm, Arlene and Lynn Shniper. 2007. "Occupational employment projections to 2016." *Monthly Labor Review*, 130, 11.

[15] Dresser, Laura, Dori Lange, and Alison Sirkus. 1999 *Improving Retention of Front-line Caregivers in Dane County*. Center on Wisconsin Strategy. Accessed on August 17, 2010 at http://www.cows.org/pdf/rp-jwf-retent.pdf.

[16] *Ibid*.

[17] Smith, Kristin and Reagan Baughman. 2007. "Low Wages Prevalent in Direct Care and Child Care Workforce." *Carsey Institute Policy Brief No. 7*. Summer. Accessed on August 17, 2010 at http://www.carseyinstitute.unh.edu/publications/PB_caregivers.pdf.

[18] Komisar, Harriet L. and Lee Shirey Thompson. 2007. *Fact Sheet: National Spending for Long-Term Care*. Georgetown University Long-Term Care Financing Project. Accessed on August 18, 2010 at http://ltc.georgetown.edu/pdfs/natspendfeb07.pdf.

[19] Boris, Eileen and Jennifer Klein. 2006. "Organizing Home Care: Low-Waged Workers in the Welfare State." *Politics and Society*, 34, 1.

[20] *Ibid*.

[21] Cooperative Home Care Associates. 2007. "About Us." Accessed on August 18, 2010 at http://www.chcany.org/index-1.html.

[22] Gamm, Larry D., and Hutchison, Linnae L. eds. 2004. *Rural Healthy People 2010: A Companion Document to Healthy People to 2010. Volume 3*. College Station, Texas: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.

[23] Direct Care Alliance, Inc. "Fair Pay for Quality Care". Accessed on July 12, 2010 at http://www.directcarealliance.org/index.cfm?pageId=538.

[24] Direct Care Alliance. 2010 *Congressional Agenda*. Accessed on August 18, 2010 at http://www.directcarealliance.org/_data/global/images/CongressionalAgenda_final.pdf.

[25] Direct Care Alliance Evaluation for Atlantic Philanthropies. 2009.

[26] *Ibid*.

[27] *Ibid*.

[28] Ruckelshaus, Catherine and Sarah Leberstein. 2010. "NYC Home Care Workers File Class Action Against Home Care Agency." National Employment Law Project. Accessed on July 19, 2010 at http://www.nelp.org/page/-/Justice/2010/HomecareClassAction.pdf?nocdn=1.

[29] *Ball v. Rodgers*, 2009 U.S. Dist. LEXIS 45331 (Dist. Ariz. April 24, 2009).

[30] Seavey, Dorie and Vera Salter. 2006. *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants*. AARP Public Policy Institute. Accessed on August 18, 2010 at http://assets.aarp.org/rgcenter/il/2006_18_care.pdf.

[31] Ruckelshaus, Catherine and Sarah Leberstein. 2010. "NYC Home Care Workers File Class Action Against Home Care Agency." National Employment Law Project. Accessed on July 19, 2010 at http://www.nelp.org/page/-/Justice/2010/HomecareClassAction.pdf?nocdn=1.

[32] Seavey and Salter, 2006, *ibid*.

Acknowledgment

We are grateful to the Russell Sage Foundation, whose generous support made both our initial meeting and this policy brief series possible.

We are also grateful to the following for their invaluable ideas and input:

Randy Albelda, University of Massachusetts, Boston
Eileen Appelbaum, Rutgers University
Christine Bishop, Brandeis University
Aixa Cintron Velez, Russell Sage Foundation
Hector Cordero-Guzman, Ford Foundation
Laura Dresser, Center on Wisconsin Strategy
Mignon Duffy, University of Massachusetts, Lowell
Roy Gedat, Direct Care Alliance
Janet Gornick, CUNY Graduate Center
Candace Howes, Connecticut College
David Kieffer, Service Employees International Union
Carrie Leana, University of Pittsburgh
Nancy McKenzie, Hunter College
Eric Wanner, Russell Sage Foundation
Kelly Westphalen, Russell Sage Foundation