Supporting and Sustaining the Home Care Workforce

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Jeanette M. Zoeckler, PhD, MPH	**Director of Preventive Services** **Occupational Health Clinical Center, Syracuse NY** **SUNY Upstate Medical University**
Rosemary K. Sokas, MD, MOH	Georgetown University
Amy Hagopian, PhD	University of Washington School of Public Health
Mary Beth Morrissey, PhD, MPH, JD	Fordham University Global Health Care Innovation Management Center
Rossana Coto-Batres, MSW	Northeast NY Coalition for Occupational Safety and Health
Emma K. Tsui, PhD, MPH	CUNY Graduate School of Public Health & Health Policy
Naoko Muramatsu, PhD, MHSA	University of Illinois at Chicago School of Public Health

EXECUTIVE SUMMARY

The rapidly aging U.S. population, increased costs for long-term institutional care, and individual preferences for remaining at home have made homecare services one of the fastest growing industries in the United States. Home Care Workers, also known as Home Health Aides, Personal Care Aides, Home Care Aides, Personal Care Attendants, Direct Care Workers in the home setting, or Homemakers, are paid caregivers who provide essential medical and non-medical assistance to older or disabled clients, enabling them to remain in their homes. These services include performance of simple procedures as an extension of therapy or nursing services that are ordered by the physician and permitted to perform under State law, personal care services (e.g., bathing, dressing, transferring), and routine housekeeping (e.g., laundry, grocery shopping, preparing meals). However, home care work is low-paid, isolated, stressful and hazardous. Workers often piece together part-time work for different clients, resulting in less than full-time status, and typically have few or no benefits, such as paid sick leave, paid vacation time, employer-provided healthcare insurance or pension plans. They may work for home care agencies or, depending on

state regulations, may be hired directly by the client, although they are typically paid through Medicare/Medicaid funds. Regardless of payment mechanism, wages average less than $12 per hour, and worker turnover rates are correspondingly high. Home Care Workers are disproportionately female, African American, immigrant, and are older than the general population. Although under-reporting is widespread, studies have found high rates of work-related illness and injury among this working population. While workers report personal satisfaction and find intrinsic meaning in their work, they also cite stressors such as exclusion from care plan decision-making and lack of respect for their contributions. Policy interventions that we are recommending are expressed well in current legislation being advanced by Senator Rachel May. These Bills, if passed, will have high impact on systems that foster worker protections and increase job quality in both rural and urban New York State geographies. Bills are: S1508, S1177, S958, S597, S4412, S5374, S6640, S4222, S554, S6664, S6203(passed), S6740(passed**).** Themes include**:**

- improved funding mechanisms to promote living wages with benefits
- legislation to foster unionization
- research on enhancing career pathways through enhanced service delivery, such as nutritional counseling or mild exercise programs
- paid job training
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- creating funding mechanisms to support home care workers' health and safety research
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PROBLEM STATEMENT

Demand for home care is rising. The number of individuals needing long-term, in-home care in the United States is rapidly increasing. By 2050, the number of adults older than 65 is expected to nearly double from 48 million to 88 million, with many needing care as they age.[1] One AARP study found 87% of adults aged 65 and older prefer to stay in their current home and community as opposed to moving into institutions or relatives' homes.[2] Currently, an estimated 575,000 more direct support professionals need to enter the workforce each year to meet the home care needs of people with intellectual or developmental disabilities (ID/DD) and their families. That number is anticipated to grow annually through 2030.[3] Factors such as population growth, increased life expectancy among individuals living with ID/DD, and aging of those individuals' family caretakers are all expected to contribute to growing demand.[3]

Home care is often preferable to in-patient care. Every year, more than 3.3 million re-hospitalizations occur in the United States, resulting in costs of $41 billion. In the United States, the rate of hospital readmission for adults 65 or older who are Medicare recipients is 24.8%, accounting for $15 billion of Medicare expenses.[4] Quality home care is cost-effective for taxpayers. Properly trained home care workers (HCWs) can care for these individuals at home, preventing the need for institutionalization.

Home care work is one of the nation's fastest-growing occupations, yet pay, benefits and working conditions remain exploitative. The home care field is estimated to add almost 1.2 million jobs in the next decade,[5] with the workforce expected to grow by 36% between 2018 and 2028[1,2] nearly four times the rate of total employment growth.[2] Generally, these workers are paid caregivers who provide both medical and non-medical assistance with daily tasks, such as eating, dressing, bathing, medication compliance, and also providing social support.[1,5] In response to the rising demand for home care, more than three-quarters of states have named HCW recruitment and retention as a major policy issue.[6] Currently, HCWs lack incentives to enter and remain in the workforce, contributing to a HCW shortage. Conservative estimates suggest turnover rates of one in three HCWs each year, with some studies reporting half of workers leave the profession each year.[6] Primary reasons for leaving were (1) insufficient rate of pay, (2) not enough paid hours, (3) lack of benefits and (4) pursuit of better career opportunities.[6] Rapid turnover among HCWs undermines quality of care for older persons and persons with disabilities, while creating instability in the lives of caregivers.

The majority of HCWs are women (89%) and/or people of color (58%), and more than one-quarter are immigrants (26%).[1] Nearly one-quarter of HCWs live below the federal poverty line, and more than half rely on some sort of public assistance. With wages consistently below a living wage, HCWs' economic vulnerability makes illness and injury more dangerous, as many do not have paid sick leave or earn enough money to take time off. [6,7]

Home care workers face challenges in work organization. Home care work imposes highly physical and emotional demands upon the workforce. HCWs often experience erratic and challenging schedules. Two-thirds of HCWs work only part-time or part-year in response to clients' changing needs.[8] Care plans for clients are often interrupted by unpredictable hospitalizations, admissions to long-term care facilities, and deaths. Other common scheduling practices faced by workers include receiving schedules one day in advance of shifts, being required to work overnight or on weekends, and working split shifts. The isolation inherent to working in a private home reduces opportunities for supervisor support and for

appropriate health and safety interventions. Although many home care workers find meaning and purpose in their work, they are often frustrated by their exclusion from care plan decisions and their lack of training relevant to their daily challenges on the job, such as inadequate hours of work; work plans that fail to address client needs; and/or uncompensated travel time between clients. Furthermore, HCWs frequently have to cope with the stress of caring for persons who are older and struggling with disabilities often without adequate training.[8,9] Home care work often involves bearing witness to the deterioration and death of the persons HCWs serve, which can cause emotional and mental health strain.[10, 11] Additional stressors may arise from family members who may introduce hazards or additional task demands. Better attention to work organization within home care agency structures would mitigate these job-related strains.[9]

Home care workers experience high rates of illness and injury. The 2007 National Home Health Aide Survey found that 18.5% of respondents experienced one or more injuries in the preceding year.[12] In a study of Washington State workers' compensation claims from 2003 to 2007, HCWs filed 1,375 claims per 10,000 full-time equivalents (FTEs) compared to 862 claims filed per 10,000 FTEs in other industries.[13] Other large surveys of HCWs have identified occupational risk factors to be associated and with neck, back and shoulder musculoskeletal disorders, and with depression. [14, 15] Overextension injuries are common in home care settings due to improper workloads, postural strain, and unfeasible technological fixes.[16] HCWs are exposed to blood borne pathogens, infectious and communicable diseases, as well as community-associated microorganisms, including multidrug resistant organisms that are often not identified or diagnosed in the home care setting.[17] In addition, HCWs encounter unique hazards not present in the institutional setting such as aggressive household pets, pest infestation, neighborhood violence and drug activity, household chemicals, firearms, clutter, small working spaces for moving clients with impaired mobility, poorly maintained stairs, absent handrails, or icy walkways, in addition to stressful interpersonal interactions, all in a setting that is isolated from co-workers and from supervisors.[14, 15, 18]

Falls are a leading cause of both fatal and non-fatal traumatic injuries in the workplace and the leading cause of unintentional injuries in the home.[18] Twelve percent of 741 HCWs surveyed reported a slip, trip, or fall in the previous year, 58% of whom reported falling to the ground and 18% requiring medical attention.[18] The rate of nonfatal assaults to workers in the "healthcare and social assistance" industry in 2012 was 15.1 per 10,000 FTEs compared to 4.0 per 10,000 FTEs in the private sector as a whole. When violence occurs in the isolated

home setting, the consequences can be severe, and even fatal. In a cross-sectional study of home care workers' health outcomes, more than half the participants (n=1,214) reported experiencing either verbal aggression or workplace violence.[19] This exposure was associated with higher stress levels, higher incidence of depressive symptoms, sleep problems and burnout.[20] HCWs face serious health effects from assaults especially when working with patients with dementia or Alzheimer's disease.[21]

OSHA must create standards, worker protections associated with union membership, and mechanisms for employer response to HCW's complaints, whether through union, cooperative or individual workers themselves. Without clear action from OSHA, HCWs will continue to be at risk for infectious disease transmission (including coronavirus exposure), develop serious injuries, illnesses, burnout, and the resultant higher turnover rates.

EVIDENCE-BASED STRATEGIES TO ADDRESS THE PROBLEM

Advance Worker' Health through Establishing OSHA Standards Related to HCW. Given that HCW will continue to be in high demand, resolving deeply entrenched recruitment/retention issues is imperative. Strategies for improving overall job quality include raising wages, providing benefits and improving work organization to reduce stressors and reduce short-staffing. In addition, strategies must include steps to improve occupational safety and health, especially by promulgating government occupational health standards, emphasizing relevant training, removing barriers to unions and experimenting with worker owned cooperatives. As in other industries, OSHA should implement specific standards for Ergonomics (potentially modeled after New York State's Safe Patient Handling Law), and Workplace Violence. In light of the Coronavirus Pandemic an emergency infectious disease standard should also be immediately enacted (potentially modeled on California), with a strong focus on personal protective equipment provision for home care workers.

Increase and Standardize Federal and State Training Requirements. Standardized training requirements for HCWs benefit both consumers and caregivers.[8] Better training programs would improve quality of care and worker retention, while reducing patient hospitalizations, worker injuries, and medical costs. Currently, however, policies regarding training requirements vary by state and type of HCW, reflecting a fragmented system. The National Academy of Medicine in 2008 recommended certifying home health aides, raising total training hours to 120.[8] Implementing this decade-old recommendation, with a dedicated federal funding source, would improve care for consumers and increase worker retention.

Remove Barriers to Forming Unions. Failing to protect workers' rights to organize undermines the safety and health of workers, contributes to wage suppression, and threatens health insurance coverage.[23] Unions also improve societal public health by decreasing income disparities.[24,25] Unions protect the health of a diverse workforce in many sectors. Nearly half (46%) of America's 16 million unionized workers are women. Workers who identify as black are more likely to be represented by a union (14.5%) compared to white workers (12.5%).[26] Unions increase wages the most for workers earning the lowest wages, decreasing income disparities for women, people of color and those with lower educational attainment.[27,28]

Union membership can provide empowerment, purpose, and social support.[27] HCW's unionization could provide a platform to voice the issues that are important for them, gain collective power to bargain and win better work conditions.[28] Unions also support training and mentorship. In accordance with collective bargaining agreements, multi-employer benefit trust funds (Taft-Hartley Trusts) can be established for unionized HCWs for the purpose of creating access to more affordable health care with greater worker control.

Home Care Worker-Owned Cooperatives as a Potential Solution. Incentivizing and supporting the creation of home care cooperatives may be a viable strategy for improving worker satisfaction and retention. Cooperatives are democratically-controlled organizations run by individuals with shared interests to meet their common social and economic needs.[29] By pooling resources and building connections, members of cooperatives are able to establish and retain control of the business.[29,30]

Research suggests cooperatives can give worker-owners access to better wages, benefits, and training opportunities when compared to private firms. Case studies of successful HCW cooperatives show considerable promise for the model. For example, Cooperative Home Care Associates (CHCA) in New York City reports providing higher wages and better benefits than private home care firms. CHCA also claims a turnover rate of about one in five annually, while the industry average is one in three.[6,31] Although worker-owners already benefited from this collective power, in 2004 CHCA voted to join the SEIU 1199 union in hopes that the partnership could promote improvements for workers industry-wide.[32]

Evidence from cooperative case studies shows increased trust and social capital leads to improved retention rates, and cooperatives lose fewer resources recruiting and training new hires.[29-33] Cooperatives offer employees coordinated and consistent scheduling, and employee-owners can decide how to balance the number of employees with full or part-time schedules.

Employee collaboration in a cooperative business model provides opportunities for relationship building, participation on decision making, and ultimately reduce worker isolation and provide better work-support.[33]. Increased trust and autonomy decreases HCWs' exposure to work-related hazards.[32,33] While reported results of cooperatives are encouraging, more research is needed to determine the impact of the cooperative models on recruitment and retention on a national scale.

More Research on Home Care Workers. HCWs are an understudied group. Expanding research to include their voices and understand their role in the evolution of home care is critical to developing effective programs and policies.[34] We recommend research in the following areas:

1. ***Private Pay Workforce*** **-** Relative to the home care workforce paid through public funds, the private pay workforce is under-researched. Better understanding these workers may facilitate the creation of better support systems and lead to improved home care services for clients.
2. ***Cost-Effectiveness Analyses*** **-** Future cost-effectiveness studies could focus on home care in relationship to: hospitalization, Medicare/Medicaid expenditures, and the financial effects of paid and unpaid home care provision on family caregivers
3. ***Unique Barriers to Union Formation*** – Beyond the traditional barriers, research should address the gap in our understanding about why unions struggle to organize home care workers. Research should consider factors such as worker non-co-location and institutional hierarchies.
4. ***Training Effectiveness*** **-** Effective training improves client care outcomes and job satisfaction for HCWs, but the quality of training has not been extensively researched. Research on which training mechanisms are most effective would help recruit and retain workers and improve patient safety.
5. ***Worker Owned Home Care Cooperatives*** **–** Demonstration projects will determine best practices, evaluation methods, and provide a comprehensive set of health outcomes.

Effective policy interventions are expressed well in current legislation being advanced by Senator Rachel May. These Bills, if passed, will have high impact on systems that foster worker protections and increase job quality in both rural and urban NYS. Bills are: S1508, S1177, S958, S597, S4412, S5374,S6640, S4222, S554, S6664, S6203 (passed), S6740(passed**).** Themes include**:**

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REFERENCES

1. Paraprofessional Healthcare Institute. U.S. Home Care Workers: Key Facts. New York; 2016. http://www.census.gov/programs-surveys/acs/data/pums.html. Accessed November 20, 2017.
2. Hartmann H, Hayes J. The Growing Need for Home Care Workers: Improving a Low-Paid, Female-Dominated Occupation and the Conditions of its Immigrant Workers. *Public Policy Aging Rep*. 2017;27(3):88-95. doi:10.1093/ppar/prx017.
3. United States Department of Health and Human Services. President's Committee for People with Intellectual Disabilities Washington, D.C. 20447. (2017) .Report to the President 2017, America's Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy. https://acl.gov/sites/default/files/programs/2018-02/2017%20PCPID%20Full%20Report_0.PDF Accessed February 2, 2020.
4. Jencks SF, Williams MV, Coleman EA (2009) Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*. 2009 Apr 2; 360(14):1418-28.
5. Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Home Health Aides and Personal Care Aides. (2017) ttps://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm (visited February 1, 2020).
6. Banijamali S, Jacoby D, Hagopian A. Characteristics of Home Care Workers Who Leave Their Jobs: A Cross-Sectional Study of Job Satisfaction and Turnover in Washington State. *Home Health Care Serv Q*. 2014;33(3):137-158. doi:10.1080/01621424.2014.929068.
7. Glenn EN. *Forced to Care : Coercion and Caregiving in America*. Harvard University Press; 2012.
8. Rowe JW, Berkman L, Fried L, Fulmer T, Jackson J, Naylor M, Novelli W, Olshansky J, Stone, R. Preparing for better health and health care for an aging population: a vital direction for health and health care. 2016; *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. doi: 10.31478/201609n
9. Zoeckler J. (2017). Occupational Stress among Home Health Care Workers: Integrating Worker and Agency Level Factors. *New Solutions: A Journal of Environmental and Occupational Health Policy.* 2018 Feb;27(4):524-542. doi: 10.1177/1048291117742678. Epub 2017 Nov 23.
10. Boerner K, Burack OR, Jopp DS, Mock SE. Grief after patient death: direct care staff in nursing homes and homecare. *J Pain Symptom Manage*.2015;49(2):214-222. doi:10.1016/j.jpainsymman.2014.05.023
11. Tsui EK, Franzosa E, Cribbs KA, Baron S. Home Care Workers' Experiences of Client Death and Disenfranchised Grief. *Qual Health Res*. September 2018:1049732318800461. doi:10.1177/1049732318800461
12. McCaughey D, McGhan G, Kim J, Brannon D, Leroy H, Jablonski R. Workforce Implications of Injury Among Home Health Workers: Evidence From the National Home Health Aide Survey. *Gerontologist*. 2012;52(4):493-505. doi:10.1093/geront/gnr133.
13. Howard N, Adams D. An Analysis of Injuries Among Home Health Care Workers Using the Washington State Workers' Compensation Claims Database. *Home Health Care Serv Q*. 2010;29(2):55-74. doi:10.1080/01621424.2010.493435.
14. Markkanen P, Quinn M, Galligan C, Sama S, Brouillette N, Okyere D. Characterizing the nature of home care work and occupational hazards: A Developmental intervention study. *Am J Ind Med*. 2014;57(4):445-457. doi:10.1002/ajim.22287.
15. Quinn M, Markkanen P, Galligan C, et al. 2014. 0317 quantifying hazardous occupational exposures and injuries in home care: results from the safe home care survey. *Occup Environ Med, 71 Suppl 1*, A39. doi: 10.1136/oemed-2014-102362.120
16. Galinsky T, Waters T, & Malit B. 2001. Overexertion injuries in home health care workers and the need for ergonomics. *Home Health Care Serv Q, 20*(3), 57-73. doi: 10.1300/J027v20n03_04
17. Rhinehart E. 2001. 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Infection Control in Home Care. CDC *Emerging Infectious Diseases*. Theme Issue. 2001;7(2).
18. Muramatsu N, Sokas RK, Chakraborty A, Zanoni JP, Lipscomb J. Slips, trips, and falls among home care aides: a mixed methods study. *Journal of Occupational and Environmental Medicine* 2018;60(9):796-8004.
19. Hanson GC, Perrin NA, Moss H, Laharnar N, Glass N. (2015) Workplace violence against homecare workers and its relationship with workers health outcomes: a cross-sectional study. *BMC Public Health* 15: 11 Published online 2015 Jan doi: 10.1186/s12889-014-1340-7
20. Muramatsu N, Sokas RK, Lukyanova, VV, Zanoni, JP. Perceived stress and health among home care aides: caring for older clients in a medicaid-funded home care program. *Journal of Health Care for the Poor and Underserved*. 2019; 30(2):721-738.
21. Galinsky T, Feng HA, Streit J, Brightwell W, Pierson K, Parsons K, Proctor C. 2010. Risk factors associated with patient assaults of home healthcare workers. *Rehabil Nurs, 35*(5), 206-215.

22. Ozga M. Survey: Home Care Worker Turnover Topped 60 Percent in 2014 - PHI. Paraprofessional Healthcare Institute National. https://phinational.org/survey-home-care-worker-turnover-topped-60-percent-in-2014/. Published 2015. Accessed January 27, 2018.
23. Gerrick KJ. An Inquiry into Unionizing Home Healthcare Workers : Benefits for Workers and Patients. *Am J Law Med*. 2003;29.
24. American Public Health Association. APHA Policy 20068: Resolution on the Right for Employee Free Choice to Form Unions: American Public Health Association. APHA Policy Statement 9204: Labor Unions and Health.
25. Rosenfeld J, Denice P, Laird J. Union decline lowers wages of nonunion workers: The overlooked reason why wages are stuck and inequality is growing. Economic Policy Institute. https://www.epi.org/publication/union-decline-lowers-wages-of-nonunion-workers-the-overlooked-reason-why-wages-are-stuck-and-inequality-is-growing/. Published August 30, 2016. Accessed January 23, 2018.
26. Hagedorn J, Paras CA, Greenwich H, Hagopian A. The role of labor unions in creating working conditions that promote public health. *Am J Public Health*. 2016;106(6):989-995. doi:10.2105/AJPH.2016.303138.
27. Bivens J, Engldahl L, Gould E, et al. How today's unions help working people: Giving workers the power to improve their jobs and unrig the economy. Economic Policy Institute. https://www.epi.org/publication/how-todays-unions-help-working-people-giving-workers-the-power-to-improve-their-jobs-and-unrig-the-economy/. Published August 24, 2017. Accessed January 23, 2018.
28. Malinowski B, Minkler M, Stock L. Labor unions: A public health institution. *Am J Public Health*. 2015;105(2):261-271. doi:10.2105/AJPH.2014.302309.
29. Majee W. Cooperatives, the Brewing Pots for Social Capital! An Exploration of Social Capital Creation in a Worker-Owner Homecare Cooperative. University of Wisconsin, Milwaukee; 2008. https://community-wealth.org/content/cooperatives-brewing-pots-social-capital-exploration-social-capital-creation-worker-owner. Accessed January 23, 2018.
30. Majee W, Hoyt A. Building Community Trust Through Cooperatives: A Case Study of a Worker-Owned Homecare Cooperative. *J Community Pract*. 2009;17(4):444-463. doi:10.1080/10705420903299995.
31. Conway M, Rodat J. Cooperative Home Care Associates: A Case Study of a Sectoral Employment Development Approach. The Aspen Institute; 2002. https://www.aspeninstitute.org/publications/cooperative-home-care-associates-case-study-sectoral-employment-development-approach/. Accessed January 23, 2018.
32. USDA Rural Development. Cooperative Programs. https://www.rd.usda.gov/programs-services/all-programs/cooperative-programs. Accessed January 23, 2018.
33. Cheney G, Santa Cruz I, Peredo AM, Nazareno E. Worker cooperatives as an organizational alternative: Challenges, achievements and promise in business governance and ownership. *Organization*. 2014;21(5):591-603. doi:10.1177/1350508414539784.