

Life on the Homecare Front

By David Rolf

Integrating a workforce and a field of care into the modern healthcare system—and the modern economy.

Homecare workers perform all tasks needed for daily living, from bathing elderly or disabled clients, to preparing their meals, organizing schedules, transporting them to appointments, and administering medications. It is difficult, isolating, and often underappreciated work, requiring a range of skills from heavy lifting to coping with end-of-life issues. Homecare workers are poorly paid and, particularly in non-unionized states, they usually receive no sick days, no retirement plan, and no health insurance. Workers frequently are on call twenty-four hours a day.

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Yet homecare generally has not been integrated into the healthcare system or field of care. Until about thirty years ago, long-term care did not meaningfully exist as a field of care because female family members often took care of elders at home. Now, with 10,000 baby boomers turning age 65 every day, our nation will need an additional *1 million* new homecare aides to begin

working at these challenging and underpaid jobs across the next ten years (Paraprofessional Healthcare Institute [PHI], 2015a).

Homecare Workers, Wages, and Unionizing

Although homecare workers are professional healthcare providers, they tend to work in the shadows—socially isolated and lacking many of the protections of a traditional job. Homecare historically has been a “hidden workforce,” conflated legally and in the popular imagination with homemakers and domestic servants. Nearly all homecare workers are women; they are more likely than average to be people of color and-or immigrants (Shierholz, 2013), have little job security, and are vulnerable to exploitation. Homecare aides earn a median income of only \$13,000 per year (PHI, 2015a).

Remarkably, it was not until 2015 that homecare workers were brought under the protection of the Fair Labor Standards Act (FLSA). The FLSA now requires that covered workers are given the minimum wage and overtime pay, among other standard employment guarantees. Babysitting is not covered by the FLSA—but healthcare work is—and now homecare workers are recognized as the profes-

→ABSTRACT Although homecare workers are professional healthcare providers, they tend to work in the shadows, socially isolated and lacking workplace protections. They are mainly women, often people of color or immigrants, and make on average \$13,000 per year. In 2015, they were brought under the protection of the Fair Labor Standards Act, to be given minimum wage and overtime pay, although many work part time. This article describes the fight to improve homecare wages and working conditions through unionization, and its effect on service delivery, and describes several pro-worker initiatives to address pay gaps, training, and workplace protections. | **key words:** *homecare workers, unionization, Fair Labor Standards Act, minimum wage*

sionals that they are. As the U.S. Department of Labor stated in its 2015 ruling: “As more individuals receive services at home rather than in nursing homes or other institutions, workers who provide home care services . . . perform increasingly skilled duties. Today, direct care workers are for the most part not the elder sitters that Congress envisioned when it enacted the companionship services exemption in 1974, but are instead professional caregivers” (U.S. Department of Labor, 2015).

Despite the essential nature of the work they do for older adults and people living with disabilities, and despite their recent inclusion in the FLSA, many homecare workers still remain in employment-law limbo. Like so many workers in the “1099 economy” who lack a clear employer to bargain with, many homecare workers are considered independent contractors. Particularly in publicly funded “consumer-directed” homecare programs—many of which allow the hiring of family members—clients have the ability to hire and fire their personal care aides, but do not have full control over the workers’ pay and benefits. Instead, state and federal authorities—in particular, the state-federal Medicaid system—control workers’ pay, benefits, and employment status.

Beginning in the 1980s in California and Illinois, consumer-directed homecare aides (also known as individual providers or IP) took a stand against this situation—specifically, low wages and on-the-job exploitation. Workers began to petition the state Medicaid system for employee status and bargaining rights. After a long fight, in February 1999, 74,000 homecare workers in Los Angeles County voted to join the Service Employees International Union (SEIU). It was the biggest organizing victory for the U.S. labor movement since workers at Ford’s River Rouge plant joined the United Auto Workers in 1941.

Similar organizing efforts in other California counties and growth in the homecare sector have now brought the total number of union-

represented consumer-directed homecare workers in California to more than 280,000. The key to unionization for Medicaid-reimbursed homecare aides, as journalist David Moberg wrote, “has been using political pressure to change the laws or win executive orders to render the state or some new public entity the employer for purposes of bargaining” (Moberg, 2005).

The fight to improve homecare wages and working conditions through union representation soon spread across the country, and continues to the present day. Campaigns by SEIU and the American Federation of State, County and Municipal Employees adapted the California model to other states, including Connecticut, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Ohio, Oregon, Pennsylvania, Vermont, and Washington. Homecare workers in the private sector also have won union representation under more traditional labor laws in Illinois, Indiana, Montana, Nevada, New York, and Washington.

By 2015, more than 600,000 homecare workers were represented by labor unions, the majority of whom work within consumer-directed programs. In most states, wages increased and workers won health insurance and workers’ compensation insurance for the first time. In some states, the new unions negotiated longevity-based pay scales, employer-paid training, mileage reimbursement, dental and vision insurance, paid time off, and overtime protection. Here in Washington State, the average wage for state-employed union homecare workers will rise to \$14.37 under the current union contract—plus a highly unusual package of comprehensive benefits—compared to a nationwide average of \$9.61 an hour (PHI, 2015b). Nationally, one survey found that unionized homecare workers were paid 16 percent more than non-union aides (PHI, 2015a).

Unionization’s Effect on Care Delivery

These successes had a deep impact, in a number of ways, on how long-term care was delivered:

homecare workers were recognized as legitimate healthcare professionals and they began to receive healthcare benefits, regulatory oversight, and employment law protections. They were able to lobby and bargain directly with the state over compensation, working conditions, and professional development and training, bringing more Medicaid funds into the industry to increase the quality of care.

The fight to improve homecare wages and working conditions through union representation continues today.

Unionization also created a professionalized structure of long-term-care delivery that did not require significant capital investment or costly, decentralized, and small-scale administrative structures (like those found in the nursing home industry). The result was significant savings to state governments and the ability of elders (and others requiring care) to remain in their own homes, supported by a well-trained, caring professional. The fundamental element that drove these changes was caregivers' ability to be represented by a labor union: unions provided the organizational capacity and structure for workers to bargain with their state government—an assist that they would not have had acting as individuals.

Unfortunately, homecare workers' hard-won bargaining and representational rights are being systematically challenged across the country. Anti-union politicians are attacking homecare unions, the most serious example being the 2012 evisceration of IP homecare workers' union rights in Michigan. Other anti-union "right to work" forces also won a major victory at the Supreme Court in last year's *Harris v. Quinn* decision: The ruling found that due to Illinois homecare workers' unique employment status (in which employer responsibilities are divided between individual consumers and the government), the workers are permitted to opt out of

paying union dues—even while SEIU is still representing them.

What these anti-worker, anti-healthcare organizations, and politicians seem to hope is that before long, homecare unions will be unable to effectively represent workers. As a result, wages and benefits likely will begin to fall again. We can expect that similar challenges will continue to erode the progress that has been made in long-term care, and so must formulate alternative mechanisms that protect workers' rights, allow for the continued growth of strong worker organizations, and clear a path for lifting caregivers out of poverty.

Positive Responses Challenge Anti-Union Efforts

As advocates for workers figure out this changing business and political landscape, several positive responses have developed, benefitting workers and the elders they serve.

The Training Partnership

The Training Partnership in Washington State has pioneered programs that create an upward spiral of competency and pay (see Steven Dawson's article on SEIU on page 88). The Training Partnership is a nonprofit founded by SEIU, in partnership with employers and the State of Washington. It takes a two-pronged approach: first, training homecare workers to deliver high-quality care; and second, helping homecare union members to earn their fair share of the savings achieved by avoiding more expensive emergency and hospital care. The Training Partnership's ultimate goal is to increase job quality for the workforce, composed of mostly working poor women, by reducing extremely high turnover rates (currently exceeding 60 percent annually) and building equitable career pathways for future workers.

The Training Partnership also has created common ground between parents who provide care to their disabled children, and other homecare workers. Labor has all too often found

itself at odds with the parent-powered disability community over issues of training and other workforce standards. The Training Partnership's Community Network members collaborate on curriculum development and explore ways to strengthen the long-term-care workforce; members from the disability community include the Washington State Developmental Disabilities Council and ARC of Washington, which advocates for people with intellectual and developmental disabilities.

The Training Partnership clearly has the backing of Washington State citizens: voters have twice passed state ballot initiatives by high margins in support of higher training and certification standards, as well as background checks for homecare aides. High-quality workforce programs also will help the homecare workforce continually adapt its skills to an ever-changing workplace, just as all workers in the modern economy will need help staying ahead of the technological change curve.

The Training Partnership also is experimenting with ways to improve care through technology. Connected Care is a pilot program that measures how technology can elevate the role of homecare aides. By linking the homecare worker to their client's healthcare team, the Training Partnership hopes to show improved client health and reduced health costs. The pilot program uses Observe and Report Technology to connect homecare aides directly to providers' health monitoring systems. Preliminary data suggest the potential for improved homecare aide engagement with use of mobile technologies.

Charissa Raynor, executive director of the Training Partnership, notes that the typical homecare aide “doesn't have a structural, systematic way to report that information to the [primary] care team. And if she wants to call up the care team . . . she would probably be dismissed.” Because programs such as Connected Care aim to prevent conditions through early detection and identifying appropriate care for on-the-spot treatment, clients should enjoy

better health and fewer doctor and emergency room visits. Ultimately, Raynor hopes that “some savings can be reallocated back into [homecare workers'] wages” (Chen, 2015).

Some new on-demand technology platforms also are increasing worker pay while reaching for a higher quality consumer and client experience. Washington State recently funded an effort to create an online platform to help clients connect directly with homecare workers. Savings are achieved not by keeping labor costs low—the workers are paid fair wages—but by cutting out the “middleman” and by growing the market beyond Medicaid and dual eligible clients to include private pay, non-Medicaid-Medicare consumers.

Cooperative Home Care Associates

A second important model has developed in the South Bronx: Cooperative Home Care Associates (CHCA) is a for-profit, worker-owned company employing more than 2,000 homecare aides—now the largest worker cooperative in the United States. An affiliate of PHI, CHCA was founded thirty years ago, initially as a welfare-to-work initiative, and now has become a highly respected quality leader in New York State's homecare industry. In 2003, the homecare aides of CHCA voted to unionize with SEIU's Local 1199. Together, CHCA, PHI, and 1199 have forged a range of innovative partnerships, including organizing the only labor-management committee within the vast New York City homecare industry.

For many years, CHCA also has hosted its own employer-embedded training program, which enrolls 640 inner-city women annually, providing graduates a dual Home Health Aide/Personal Care Aide certificate—and guaranteeing every enrollee a job upon graduation. Aides are employed either at the cooperative or at Partners in Care, the licensed homecare affiliate of the Visiting Nurse Service of New York. The typical individual enrolling in CHCA's training program is a non-native-born woman who is unemployed, with total annual income of \$6,000 (including

public cash benefits) in the year prior to enrollment. The average reading level is 6th grade, with a quarter of the 640 enrollees having a reading level of 4th grade or less.

Even with these employment challenges, CHCA enrollees have among the highest employment and retention rates compared to other New York City workforce development training programs: 84 percent of CHCA enrollees are employed (compared to 47 percent for similar programs) and 65 percent remain employed at the one-year mark (compared to 37 percent for similar programs) (PHI, 2015c).

Another changing aspect in the homecare landscape is managed care. As mentioned in Steven Dawson's article about the direct care workforce (see page 38), federal and state governments have pushed the creation of "managed care" insurance companies to replace traditional Medicaid and Medicare programs for long-term-care clients. Managed care companies are given a fixed amount of public dollars per client per month, and significant leeway to control costs as they see fit. Though the transition to managed care is still in progress, it won't be long before it is the norm.

Managed care companies generally have not shown much willingness to improve sub-par wages and working conditions for long-term-care workers. So a new front has opened in the fight for higher standards: managing the managed care companies. As states begin to delegate responsibility for long-term care via Medicaid and Medicare, they are no longer the primary drivers of job quality in long-term care (unless states take matters into their hands legislatively).

Addressing the Care Gap

Yet workforce and healthcare advocates still need to address the care gap in a legacy fee-for-service world that doesn't connect homecare workers with the rest of a client's healthcare team, including primary care physicians, specialists, and pharmacists. Fortunately, there has been some progress in integrating

long-term care into the healthcare system, as more decision makers recognize the positive impact of a properly trained and empowered homecare aide in preventing downstream healthcare issues for clients.

In Michigan, MI Health Link has launched an effort to coordinate care for more than 230,000 Michigan residents whose healthcare is paid for by Medicare and Medicaid. These "dual eligible" individuals often are caught in a confusing tangle of fee-for-service coverage. MI Health Link offers one plan and one card for healthcare, behavioral healthcare, home- and community-based services, long-term care, nursing home care, and medications. Link members have a care coordinator who helps to connect clients with the health services they need, including making appointments and arranging for transportation. Crucially, the coordinator also ensures that all of their clients' health providers are working together to deliver the best possible care.


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ConcertoHealth has opened four clinics in Detroit to provide care for dual eligible residents. As in the MI Health Link program, a patient is assigned a care coordinator at their Concerto clinic. The coordinator is a medical professional or social worker who makes regular calls to set up appointments, answer questions about a patient's chronic conditions, schedule transportation to and from doctor appointments, sort out insurance confusion, and connect patients with social services outside the office, such as Meals on Wheels. ConcertoHealth also offers in-home services, with caregivers able to deliver medication and provide treatment as needed in the client's home.

These innovations in workforce development and healthcare delivery are positive for both cli-

ents and homecare aides. Homecare workers, unions like SEIU, and pro-worker initiatives such as CHCA and the Training Partnership have made aggressive and innovative strides in addressing the gaps in pay, training, and workplace protections. These improvements are doubly important because more and more jobs in the modern economy are going to look like those in homecare.

We recognize, however, that the majority of the nation's homecare workers have no path to significantly higher wages, benefits, or a union. We must keep working toward solutions to make homecare into a "job of the future" rather than a low-end job in the "race to the bottom" modern economy. Homecare does not need to be a low-wage sector that offers more and more jobs at poverty wages. It can instead be a model for the future of providing quality care to older adults and people living with disabilities.

For as Michelle Chen said in *The Nation* in October 2015: "As the industry moves toward more cost-efficient, community-based care, jobs are increasingly oriented toward social support and human relationships, which are ultimately mediated through front-line workers. Labor can raise a voice in shaping how care is delivered, prioritizing worker empowerment and social equity, rather than the industry's bottom line. A responsive health system is about more than cutting-edge medicine: It requires a workforce that cares about the people they serve, their profession, and fellow workers" (Chen, 2015). 

David Rolf is the president of SEIU 775 in Seattle, Washington, representing homecare and nursing home workers in Washington State and Montana. He also serves as international vice president of SEIU.

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