

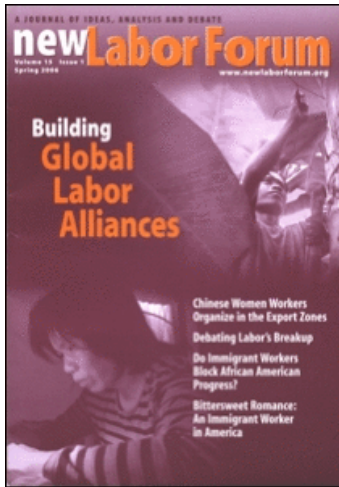
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By Eileen Boris
and Jennifer Klein

LABOR ON THE HOME FRONT

Unionizing Home-Based Care Workers

ONCE KNOWN AS “THE INVISIBLE WORKFORCE,” THE NATION’S 1.4 MILLION HOME HEALTH care aides and 1.8 million home child care providers are changing the face of organized labor. These frontline caregivers meet the personal needs of those requiring assistance, from children, to the elderly, to the disabled. Dispropor-

tionately African American, Latina, and immigrant women, these low-waged workers seized national attention in 1999 when 74,000 Los Angeles home health care aides voted to enter the Service Employees International Union (SEIU), pulling off the largest successful union drive since the sit-down strikes of the Great Depression.¹ Six years later, nearly 50,000 Illinois home child care providers followed in their footsteps.

In less than a decade, hundreds of thousands of home-based care workers have entered into coalitions with parents, senior citizens, and disability activists. They poured into SEIU,

American Federation of State, County, and Municipal Employees (AFSCME), and American Federation of Teachers (AFT), but also responded to the community organizing efforts of the Association of Community Organizations for Reform Now (ACORN), local grassroots groups, such as Brooklyn’s Families United for Racial and Economic Equality (FUREE), and occupational associations, such as Milwaukee’s Providers Taking Action. They asked for respect, dignity, higher wages, and improved conditions for the users of their services. They sought “a stable job for adults so

we can provide consistent care for children,” explained Chicago activist Angenita Tanner.²

Only three percent of the child care workforce was unionized in 2004, but eleven states have authorized home-based child care unionization since 2005; three—Illinois, Oregon, and Washington—have signed contracts. They have gained a wide range of benefits, from health insurance and increased subsidy payments to professional training, grievance procedures, and health and safety regulations.³ Home health care attendants continue to win victories, recently in Iowa, Massachusetts, and Ohio. Discounting the underground economy of home health care aides, about thirty-five percent of the home health care labor force now belongs to unions.⁴

The story of how home health care attendants and child care providers gained recognition as performing the care work of the welfare state illuminates the challenges of organizing a shifting service sector, especially one in which the home is the workplace and both recipients and workers move in and out of public assistance. These workers provide services for those receiving Supplemental Security Income, Medicaid, or Temporary Aid to Needy Families, but usually are not recognized as public employees. Because “public sources of revenue . . . are used to fund contracts,” explains Catherine Sullivan, SEIU’s Coordinator for Long-Term Care, “a political organizing program is essential to win improvements.”⁵

Lacking concentrated workforces, home-based care unions have turned to traditional community organization tactics, developing drives that more closely resemble political campaigns and neighborhood outreach movements than worksite efforts. They initially gained the right to organize through legislation and ex-

ecutive orders. They had to define an employer for collective bargaining purposes, pushing the government to take responsibility for this sector’s working conditions and pay, while inventing new forms of primarily public representation. They had to increase state funding for services and obtain higher reimbursement rates. Success has come, but not easily.

STRUCTURE OF THE CARE WORK SECTOR

THE CONTOURS OF HOME-BASED CARE WORK HAVE mainly been shaped by three arenas—the public hospital, the welfare system, and the domestic services market. With origins in New Deal work relief for unemployed African American domestics, home health care developed as a social welfare service for those living on public assistance or on very low incomes, similar to the population targeted for the workforce. The state sent a visiting housekeeper or homemaker into homes where incapacitated mothers or wives needed assistance caring for other family members.

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Home health care as an occupation grew with the expansion of post-World War II old age and disability support. Public welfare departments directly employed “homemakers” and contracted with private family welfare

agencies. Despite intentions otherwise, these jobs, along with other forms of domestic labor, remained outside the scope of labor law and workers' compensation. When the clientele changed from families with young children to the elderly, disabled, and chronically ill, a new part-time and casualized structure emerged. Unlike children, adult clients required an aide for either a few hours or night-time shifts, making it difficult for workers to patch together a standard work day.

State funding was crucial since government agencies have the power to authorize services, determine payment rates, and cut paychecks. When the federal government curtailed social welfare monies in the 1970s and 1980s, states and localities coped through cost-shifting, privatization of services, and "flexible" labor policies.

New York and California developed the standard models for delivering home health care. New York City reclassified its workforce

Discounting the underground economy of home health care aides, about 35 percent of the home care labor force belongs to unions.

into independent providers and then vendorized the service through non-profit and proprietary agencies. California developed a three-tier system that gave counties the choice to hire workers, classify them as independent contractors, or contract the labor to agencies.

Government payments, half of the national expenditure on home-based care, boosted a for-profit industry, with the number of agencies jumping tenfold during the first half of the 1980s.⁶

State policy also affected labor conditions among home-based child care providers, who receive a per capita reimbursement from the state after undergoing inspection and licensure. As distinguished from day care centers, this form of child care occurs in the provider's home, where parents drop off their children. Since children arrive and leave at different times, providers can work as many as 20 hours a day. State funding of the job hadn't addressed its low pay, long hours, and nonexistent benefits. Dominated by poor women of color, this workforce has overlapped with that of home health care. Providers often have been either home health care attendants themselves, or the friends, relatives, and neighbors of home health care workers.⁷

From the 1970s, the number of home-based providers declined relative to other forms of child care, until welfare reform in 1996 reshaped the industry. Now welfare recipients were to care at home for the children of other mothers, who then would be able to enter the labor market as home health aides, nurse's aides, and related service workers. Using newly available federal monies to supply vouchers to parents, local and state governments subsidized payments to vendors, directly reimbursing providers.

But when the 2001 recession hit, as sociologist Ellen Reese has shown, states cut back child care programs. Capping eligibility at even lower incomes, they upped co-payments, reduced slots, and slashed overall funding, in-

cluding reimbursement rates. This scale-back exacerbated the meagerness of hourly wages that had already been rock-bottom in a highly under-compensated industry. Many states set payment for subsidized child care at two-thirds of private costs, further impoverishing providers. Hourly earnings dropped below the minimum wage.⁸

As with other service industries, the employment relation in home health and child care involves a “third party”—the client or consumer. But a fourth party, the state, has a huge impact on the service relationship in the care work sector. Since a determination by a social worker or a budget shortfall leads welfare departments to cut a client’s hours, the state wields considerable power over the caregiver-client relationship. So do for-profit and non-profit agencies whose Taylorizing of the work process can be akin to abandoning a person in the middle of a bath just because time is up. When public or private agencies fail to pay providers, they generate turnover, jeopardizing the availability of quality care.

THE CHALLENGES OF ORGANIZING A HOME-BASED WORKFORCE

ORGANIZING THE HOME-BASED LABOR FORCE has always been fraught with multiple hurdles. The architecture of U.S. union representation has rested on two assumptions: an unambiguous employer-employee relationship and a shared worksite. Neither condition exists for home-based care workers, who have stood outside the labor law, first as domestics, and then as independent contractors, small business-people, or elder companions. The lack of

clear employment status has revolved around several questions. Was the worker an employee or contractor? Was the actual employer/vendor a consumer, or local or state agency? Should the work be full-time or casual? Could a relative be employed? As unionizing care work in-

The home workplace . . . exacerbated confusion over employment status.

herently entails a rethinking of the traditional collective bargaining equation, successful organizing strategies have called for novel forms of community-based mobilization and state support.

The home, traditionally associated with privacy and intimacy, only exacerbated confusion over employment status. There are no hiring halls, management meetings, standardized apprenticeship programs, or typical eight-hour work days. Often paid through a dual-party check sent directly to the client, workers didn’t even come to the same place to collect wages.

In the child care sector, the dispersal of the labor was even looser. Providers worked in their own homes, further obfuscating the notion of a “workplace,” which American law and culture has always defined against and in opposition to the home. Classified as small businesses, child care providers’ attempts at collaboration were subject to antitrust laws, prohibiting the setting of standard rates and other collective agreements.⁹

Home health care workers were once considered public employees until the government began contracting their services in order to

bypass overtime requirements, contain unionization, and deny responsibility for their working conditions. In the 1960s, New York City homemakers organized with social workers as part of AFSCME Local 371. The union relied on political action, public appeals, and legislative lobbying to address both pay and client well-being. The city responded by downsizing the workforce, reclassifying workers as independent contractors and, after 1970, relying on vendor schemes.¹⁰ Child care providers lacked even the vendor agency mechanism, enabling states to more easily label them as small business entrepreneurs.

The racialized feminization of the labor itself results in low pay; yet wages, hours, and benefits remain linked to anxiety about public budgets. Collective bargaining always have faced reimbursement caps set by the state. When taxpayers feel that the undeserving receive special services, they seek funding cuts; when politicians need to balance a budget, they eliminate services for those with less power.

Given the public welfare squeeze, clients and workers did not necessarily see their interests as mutual, presenting another hurdle for unions. Under many state programs, the road to “independence” for one group—desperate parents and disabled people—seemed to necessitate the care workers’ self-sacrifice and lack of economic security. Disability activists vigorously fought to choose, train, and control the attendants who made their independent living possible. Their struggle in the 1970s to maintain services in California, for example, helped enact the independent contractor structure that hampered unionization and maximized job insecurity. Unions would have to overcome suspicions that empowering work-

ers meant a loss of independence and security for consumers.

ORGANIZING AROUND THE OBSTACLES: UNION STRATEGIES

UNIONIZING HOME-BASED CARE WORKERS INTENSIFIED in the 1970s as part of a larger effort to organize poor women. The new social movement unionism sponsored numerous demonstrations, membership meetings, and political education. In the mid-1970s, civil rights organizing focused on the status of domestic workers, whose movement soon intersected with rising service sector unionism. Civil rights groups and the SEIU together lobbied New York State to pass collective bargaining legislation for household workers, a tactic pursued a generation later by child care providers.

After passage in 1977, SEIU’s flagship local, 32B-32J, launched a Household Workers Organizing Committee in New York City. Initially looking for cleaners, it found home attendants working for the city’s vendor agencies. The United Domestic Workers of America

Wages, hours, and benefits remain linked to anxiety about public budgets.

(UDWA), inspired by the United Farmworkers, similarly sought to organize domestics but won its first victory from a manpower agency which ran San Diego County’s In-Home Support Services (IHSS). But first it had to con-

vince county supervisors to increase funding. Using a community organizing model, UDWA visited women at bus stops, conducted house meetings, established neighborhood committees, and put together a Domestic Workers Service Center. Unions of hospital and nursing home aides discovered, as did SEIU 250 in the Bay Area and 1199 in New York City, that workers moonlighted as home attendants, encouraging new campaigns.

Unions first argued that these workers were public employees, but faced with vendorization, 1199 and 32B-32J had to focus on individual agencies in an attempt to sign enough cards to call National Labor Relations Board (NLRB) elections among an ever-shifting labor force. This strategy soon succumbed to the hassle of having to define bargaining units for small groups of workers while state budgets constrained agencies from negotiating real wage increases.

1199, however, knew how to turn workplace organizing drives into political campaigns. In 1987, it launched (with AFSCME) the “Campaign for Justice for Home Care Workers,” joining forces with non-profit vendor agencies to press for greater appropriations from Albany. A year later, after unprecedented negotiation with Governor Mario Cuomo, the state allocated more funds to home health care, resulting in a 53% wage increase, health insurance, and guaranteed days off.¹¹

This political deal was not enough to resolve the ambiguities of employment that hampered long-term rights and job security. SEIU tried to address the classification obstacle through legal challenges in California. Despite

favorable lower court decisions, the State Court of Appeals eventually ruled in 1990 that the state and counties were not employers.¹² SEIU would have to press for a political resolution that would go beyond the personalism of the Cuomo negotiations.

Given the public welfare squeeze, clients and workers did not necessarily see their interests as mutual.

A pivotal institutional innovation in home-based care organizing emerged in California. Governors of both parties had routinely used IHSS as a political punching bag during the state’s annual budget battles. But in the early 1990s, home health care workers politically organized with consumers, who feared cutbacks of the resources that enabled so many disabled and elderly people to live independently at home. In 1992, their efforts secured legislation that established county-level public authorities, the advent of which would overcome key obstacles to home health care organizing. The public authority, which includes consumers, serves as the bargaining entity for IHSS independent providers; central registries were to collect and maintain the names of the workforce members. This political victory finally provided the tools and momentum for home health care union organizing; most counties went with the public authority, although there has been much variation in the negotiated rates.

SEIU further developed this model in

other states, challenging the fragmentation of county-level bargaining. In Oregon, SEIU secured a list of names of all independent contractors from the governor's office to begin organizing; it joined with seniors' rights activists to campaign for a ballot initiative establishing a state commission for all home health care workers and a constitutional amendment granting them the right to form unions and bargain collectively. The successful 2003 initiative extended collective bargaining for "the first time" through a popular vote. The following year, 13,000 workers won their union and, with help from seniors, state funding for the commission.¹³ Washington and Michigan have since followed this state-level approach.

SEIU's Sullivan confirms that these breakthroughs "provided a model that has been duplicated with very minor adjustments in other states." Also essential to the model was its consumer direction, allowing consumers to select and manage workers in their homes. In 2006, the Massachusetts legislature created a "Quality Home Care Workforce Council," with the state and its consumers constituting joint employers. A coalition of workers and members of the disability community made this possible. SEIU partnerships with independent living centers and the AARP are ultimately spurring new forms of organization, such as the Virginia Association of Personal Care Attendants.

As it continues its ongoing battle to legislate occupational standards, establish joint funds for training, and develop internal education programs, SEIU is now tackling the emerging gap between the societal need for long-term care and the available workforce. The objective is to upgrade the status of the home-based job without raising its bar for entry; to

protect against worker injury while enhancing consumers' dignity and independence.

Lessons learned from home health care organizing struggles have influenced the mobilization of home-based child care providers, but prior models of organizing laid the primary groundwork for this sector. Since the 1970s, early childhood and pre-school education teachers had lobbied for improved training, pay, and standards. In the 1990s, the Washington, D.C. Center for the Child Care Workforce initiated a "Worthy Wage Campaign," which designated May Day for raising awareness of working conditions. Advocates developed provider associations, which advanced the formation of a common identity, while minimizing isolation.

Meanwhile, aides and teachers in day care centers and Head Start programs joined AFSCME, UAW, SEIU, AFT, Teamsters, and the Painters' Union. Providers became connected to each other in a way that wasn't initially the case for home health attendants; still, the child care unions would need to turn to community-based organizing and the state in order to succeed.

With close ties to ACORN, a track record of community advocacy, involvement in electoral politics, and a focus on the legislative process, SEIU 880 in Illinois was poised to organize home child care providers. Since the early 1980s, it had sustained a union of low-waged women of color without the "benefit" of formal recognition or a NLRB election through direct action militancy on discrete issues, such as securing paycheck deductions or grievance procedures.

Following welfare reform in 1996, some 880 members became home child care providers and requested union representation. Apply-

ing lessons from home care organizing, 880 overcame dispersal by obtaining lists of providers from the state, calling and visiting potential recruits, holding house meetings, and mobilizing existing provider associations. In 1999, their efforts led to a legislated increase in the payment rate.

In 2003, Democratic Governor Rod Blagojevich, newly elected with SEIU support, granted collective bargaining rights to home health attendants previously classified as independent contractors. Within months, the Illinois legislature responded to 880's massive lobbying and codified his executive order into law.¹⁴ In December 2005, child care providers won state support using similar arguments. The resulting three-year \$70 million contract included an average 35% increase in daily rates, health-care coverage in the third year, and training incentives.¹⁵

State officials have resisted identifying child care providers as public employees, but unions aim to place their work within the public realm. AFSCME faulted its occasional rival SEIU for "lowering" the standards for public employment through its acceptance of merely a quasi-employment relationship with the state. But, despite seeking full classification as state employees, AFSCME's own campaigns have followed similar patterns of political mobilization.

A 2005 executive order from Oregon Governor Ted Kulongoski (a Democrat) paved the way for direct negotiations between state agencies and Council 75, Child Care Providers Together (CCPT)/AFSCME. A year later, CCPT's contract included a "Provider Bill of Rights." This measure upheld "the right to be treated as a professional with courtesy, dignity, consideration and respect" irrespective of race, religion,

sexual orientation, disability, marital status, and political or union affiliation, while protecting the confidentiality of provider files. While negotiated raises require legislative action, other aspects of the contract—lower parental co-payments, direct deposit of subsidy payments, and a voice in training—usually do not.¹⁶ In Washington, the state not only raised wages and contributed a significant \$555 a month for health insurance, but it increased payments to those caring for infants or laboring outside the realm of standard hours.¹⁷ In 2006, AFSCME and SEIU agreed to stop competing with each other; 3,700 Pennsylvania providers subsequently voted to join Child Care Providers United, an AFSCME-SEIU joint venture in November 2007. Eight thousand Ohio providers also voted to join AFSCME in April 2008.¹⁸

Child care advocates had once seen formal professionalization as an alternative to unionization, but today's unionists now view it as a potentially necessary antidote to low wages. As Randi Weingarten, President of New York City's AFT affiliate, the United Federation of Teachers (UFT), explains, "It's an educational issue and a moral issue and an economic justice issue." Providers echo such sentiments, associating unionization, decent pay, and benefits with being "recognized as professionals."

In partnership with ACORN, UFT has organized New York City's home-based child care providers. The grassroots organizing of FUREE first brought providers and parents together in 2001, to unite against child care funding cutbacks aimed at women on public assistance. This association with the welfare system would influence later struggles. As one state legislator explained in 2006, "These are the people who are allowing many of our women to get off of welfare and get a job. It is completely unfair to

ask these same people to treat our children with dignity when they are not treated with the same level of respect.”¹⁹ Raising careworker wages appeared more as an antipoverty policy than as a question of worker rights.

As with home health care, using the state as a battleground facilitated unionization for child care providers. New York Governor George Pataki vetoed union-enabling legislation in 2006, but his successor Eliot Spitzer, brought into office with union support, authorized collective bargaining a year later.²⁰ In October 2007, workers elected to join UFT, a victory hailed as “the largest successful unionization campaign in the city since the 1960s.” UFT currently represents about 28,000 home-based care providers as it prepares to negotiate a contract with the state for higher pay, health insurance, and paid vacations. Last February, another 17,000 providers elsewhere in the state

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voted to become part of the AFSCME affiliate, CSEA/Child Care Providers Together-New York.²¹ Home health care workers prevailed when they linked better care with better wages.

When they do the same, home-based child care providers can also make a case for the additional payoff of enhanced performance once children reach school-age.

CONCLUSION

HOME-BASED CARE WORKERS ARE ORGANIZABLE, in spite of a host of unique obstacles. It requires reaching out to and communicating with workers who speak many different languages. It involves a heightened vigilance over the twists and turns of state policy, keeping a watchful eye on public budgets, and combating assumptions that a cheap workforce can offer a viable alternative to institutional care. Unions will have to deal with the fundamental question of how to revalue this labor, still assumed to be the unpaid obligation of wives, mothers, and daughters, or the racially stigmatized work of poor women of color, and justified on the basis that recipients need care no matter what, that denial and self-sacrifice are essential to the “ethic of care.”

Connecting better jobs with better care, home health and child care workers are challenging the old industrial model of centralized sites and antagonistic labor relations. They continue to rely on the welfare state location of their labor and on coalition politics—joint efforts with the beneficiaries of these services, whether parents or other family members, senior advocates, or independent living centers—to strengthen a social movement for home care. According to SEIU Healthcare Deputy Director Steven Ward: “Home care organizing is social movement organizing, made possible by the joint efforts of consumers and workers.”²² Amid recent

gains in wages and resources, these struggles are raising recognition of the value of care work, while re-imagining the home as a dignified place of employment. Still up for discussion is the character of the resulting unions: whether

they can foster participation, solidarity, and workers' consciousness among those members who may see themselves as caregivers first, rather than traditional workers. ■

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