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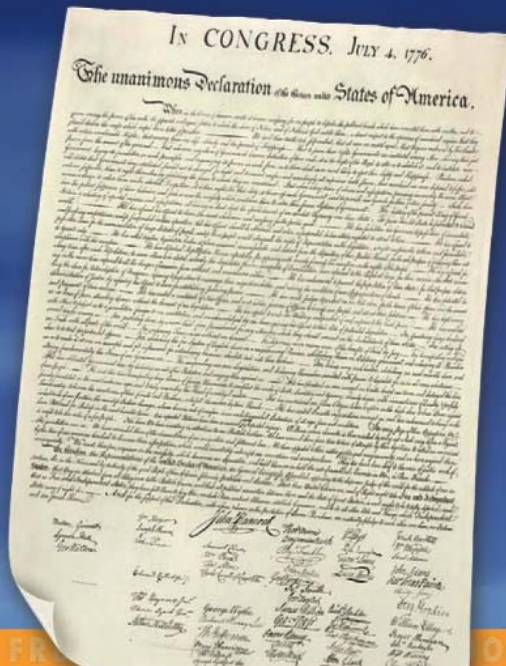
Multidisciplinary Approaches to Labor Law Reform

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with an introduction by Robert B. Reich

Our nation formed when
the founding fathers
signed their names.



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The Social Benefits of Unionization in the Long-Term Care Sector

Introduction

The United States is in the midst of a significant and accelerating crisis in caregiving for its growing population of elderly people and people with disabilities: an acute shortage of and high turnover rates among direct-care workers caused by poverty wages, inadequate training infrastructure, and few opportunities for advancement. This crisis is broadly recognized by policymakers as the key obstacle to providing high-quality and accessible services to the elderly and people with disabilities. This is also a crisis that disproportionately affects women workers and workers of color, who are overrepresented in direct-care occupations.

Against this dire backdrop, labor unions have been amongst the most effective social actors in addressing the workforce crisis in long-term care. Since the late 1990s, unions have organized hundreds of thousands of direct-care workers—mostly in publicly funded homecare. In doing so, they have not only helped workers get better wages and benefits, but have also been leaders in policy innovation to find solutions to a range of challenges facing the homecare system.

The Direct-Care Workforce Crisis

More and more people need paid caregivers. Between 2005 and 2030 the number of adults aged 65 and older will almost double, from 37 million to over 70 million, accounting for an increase from 12 percent of the U.S. population to almost 20 percent (Institute of Medicine, 2008, p. xi). In addition, the explosion of autism, the aging of family caregivers, and other factors will continue to increase the number of people with disabilities in need of support services, though at a slower rate. It is widely recognized in the field that there will be a tremendous growth in demand for direct-care workers who provide most of the services for the elderly and the disabled over the next decade. These services include health services and

assistance with personal care and household activities. The number of direct-care workers as of 2006 is estimated at over three million, and an additional one million new positions will be needed by 2016 (Paraprofessional Healthcare Institute, 2008, p. 1).

However, there are too few people able and willing to work as caregivers, paid or unpaid. The available pool of unpaid family caregivers has been shrinking relative to need, as women's labor force participation has grown and as families have fewer children, resulting in fewer adult children per aging parent. This has led to a growing dependence on paid caregivers, who are overwhelmingly female (89 percent) and are typically between the ages of 25 and 55 (Smith & Baughman, 2007). Yet there is a severe and worsening shortage of paid paraprofessionals—direct-care workers—who perform the bulk of paid long-term care services. This shortage is due in large part to the poor wages and benefits, lack of training and career opportunities, and high levels of physical and emotional stress that are typical of direct-service jobs. These factors contribute to the unacceptably high rates of vacancies and turnover among these occupations, which can, in turn, lead to poor quality of care for patients (Institute of Medicine, 2008). Furthermore, the shift in service delivery from institutional settings to home- and community-based settings creates special challenges in recruiting, training, and keeping workers in the field.

Direct-care jobs contribute to working poverty, especially for women, through low hourly pay and the prevalence of part-time work. In 2005 the median hourly wage for all direct-care workers was \$9.56, about one-third less than the median wage for all U.S. workers (Dawson, 2007). Direct-care workers are more likely to live in poverty and to rely on food stamps than other workers (General Accounting Office, 2001). Women in direct-care jobs are more than twice as likely to be poor than working women in general (Smith & Baughman, 2007).

Many direct-care workers lack access to health and other benefits. Nearly 30 percent of direct-care workers lack health coverage of any kind (Regan, 2008; see also Brady, Himmelstein, & Woolhandler, 2002). They are much less likely than U.S. female workers to have employer-based health insurance, or any insurance at all (Smith & Baughman, 2007). Direct-care workers in home-based settings are much more likely to lack health coverage than are their counterparts in hospitals and nursing homes (Regan, 2008; Smith & Baughman, 2007). Direct-care workers have limited access to sick leave and retirement benefits (Smith & Baughman, 2007).

Low wages contribute to high turnover among direct-care workers. Numerous studies have documented the link between low wages for direct-support workers and high rates of turnover and vacancies.¹ Turnover rates range from 41 percent per year to over 71 percent per year in community settings, compared to a range of 14 to 34 percent in institutional settings (Hewitt & Lakin, 2001). New hire retention is also poor: 80 to 90 percent of

home-health aides leave their jobs within the first two years; 40 to 60 percent leave after less than one year (Paraprofessional Healthcare Institute, 2005).

High turnover undermines the quality of long-term care services. The relationship between turnover and the quality of services for consumers has long been recognized by leading scholars concerned with the direct-support workforce in a variety of care sectors (Hewitt & Lakin, 2001; Braddock & Mitchell, 1992; Zabin, 2006). In some sectors, such as personal-assistance services for the elderly and physically disabled, the length of match between direct-caregiver and consumer—directly related to worker turnover—is used as a direct measure of quality, because this indicator appears consistently in consumer-satisfaction surveys (Reif, 2002). In services for people with developmental disabilities, Hewitt and Lakin note, “lack of continuity makes it extremely difficult to develop and sustain the trusting and familiar relationships that foster personal growth, independence, and self-direction” (Hewitt & Lakin, 2001).

The decentralization of service delivery has increased consumer autonomy but also created major challenges in direct-care workforce development. Over the past several decades, seniors and people with disabilities have successfully advocated for long-term care services that support them to live with dignity in their own homes and communities, rather than in institutional setting such as hospitals, nursing homes, or segregated facilities for people with developmental disabilities. Consequently, direct-care jobs in “non-institutional personal assistance and home health services tripled between 1989 and 2004” (Kaye, Chapman, Newcomer, & Harrington, 2006). The new model allows greater consumer choice in hiring and firing their own support workers. However, the lack of a workforce infrastructure—systems and institutions to facilitate recruitment, training, and retention of qualified workers in the field—combined with high turnover and low wages poses serious challenges for individual consumers. Recipients of publicly funded homecare services in states with low hourly rates have difficulty finding workers. Current training standards for direct-care workers are minimal across the spectrum of long-term care, but particularly deficient for those who provide services in home settings (Institute of Medicine, 2008). Thus there is a need to create economies of scale through systems and institutions for recruiting qualified workers, training them in core competencies, and creating career lattices that entice workers to stay in the field.

Unionization and Its Impact on Consumers and Workers

Recognizing that increased wages and benefits are critical to improving homecare service quality and accessibility, key senior and disability rights groups have partnered with unions and workers in several states to win policy reforms enabling homecare workers who are state-funded but privately employed to join a union. To date, over 430,000 homecare

workers directly hired by consumers have unionized and are bargaining collectively for better labor standards.

Unionized homecare workers are concentrated in the independent provider (IP) model of service delivery. Under this model, individual consumers hire and fire their own homecare workers, who are in turn paid through public funds. Because of this unique employment arrangement, workers are caught in a legal no-man's land in terms of their collective bargaining rights. On the one hand, individual consumer-employers are not in a position to bargain over wages and benefits. On the other hand, such workers do not fall under the scope of public employment relations regulations in the states.

To surmount this barrier, several states have undertaken legislative reforms to grant client-hired, state-paid homecare workers the ability to bargain collectively over wages, benefits, and working conditions. A leading innovation is the homecare public authority, a legal "employer of record" for homecare workers for the purposes of collective bargaining. Usually overseen by an advisory board that includes consumers, such public authorities are also charged with training and recruitment in order to improve service quality and access (Rivas, 2007; Delp & Quan, 2002; Boris & Klein, 2006; Mareschal, 2006). In other cases, the state simply passed a law recognizing a union of homecare workers. These reforms gave workers the ability to negotiate wages, benefits, and working conditions but did not give them public employee status. Significantly, they also preserved consumer choice in hiring and firing their own support workers.

California pioneered the public authority model by first enabling and then mandating the establishment of county-level public authorities for homecare workers paid through its In-Home Support Services (IHSS) program. Since the state legislature passed a series of laws providing for the formation of county-level IHSS public authorities between 1991 and 1993, over 300,000 workers have joined the Service Employees International Union (SEIU) and American Federation of State, County and Municipal Employees (AFSCME) in California. Several other states—Oregon, Washington, Michigan,² Massachusetts, and Missouri—have followed suit by creating statewide public authorities charged with improving the quality of homecare and bargaining with the union representing IPs. Two states gave collective bargaining rights to direct-care workers through other means. Illinois relied on a State Labor Relations Board ruling giving the executive branch discretion in the matter. Ohio granted an anti-trust exemption to in-home care providers paid through Medicaid, effectively treating them as a group of small businesses with which the state would bargain on specified issues.

Unionization of Independent Provider (IP) Direct-Care Workers

Year(s) of Reform	State	Reform via	# Workers Initially Eligible	# Workers Currently Organized
1993–1998	California	legislation	50,000	300,000
2000	Oregon	ballot measure	12,000	12,000
2001	Washington	ballot measure	26,000	26,000
2003 (2004)	Illinois	executive order (codified through legislation)	20,000	20,000
2004	Michigan	regulatory authority	40,000	41,000
2006	Massachusetts	legislation; overrode veto	22,000	25,000
2007	Ohio	executive order	7,000	7,000
2008	Missouri	ballot measure	8,000	na
TOTAL				431,000

While it is difficult to determine the size of this workforce nationally because of under-reporting, we estimate that over 25 percent of publicly funded IPs are unionized. Among agency-employed homecare workers, union density is much lower because of strong employer resistance and the applicability of National Labor Relations Board regulations that create serious obstacles in the path to unionization. One major exception is New York, where homecare workers employed through private, mostly nonprofit agencies under contract with state and local government have organized strong unions. Here, a major strike in 2004 resulted in the unionization of a majority of New York City’s homecare subcontractor agencies.

Thanks to broad political support, homecare workers in these states have been able to successfully negotiate first contracts within a year after having their unions recognized by the relevant public agencies. These contracts not only increase wages and benefits, but contain key measures to improve skill standards, protect stability of care services, and honor consumer choice.

Living Wages and Benefits

Through collective bargaining as well as policy advocacy by consumer and other advocacy groups, unionized homecare workers have been able to win substantial gains in wages and benefits:

- In California, wages and benefits are set by 58 county-level public authorities and thus vary geographically. Nevertheless, union contracts have brought substantial wage increases in most counties. In 2008, 50 counties (all but the poorest rural

locations) paid higher than the recently increased state minimum wage of \$8.00 per hour. Unions have been able to negotiate significantly higher wages in urban counties, both in comparison to pre-unionization locally and relative to the state minimum wage. IHSS workers earned the highest wages in the eight-county San Francisco Bay Area, with most counties offering \$11.50 per hour. Santa Clara County paid a Bay Area and statewide high of \$12.35.³

- In Illinois, SEIU Local 880 won wage increases for homecare workers subsidized through the Department of Rehabilitation Services (DORS) through legislative advocacy even before the union was recognized, up from the \$3.35 an hour minimum wage in 1984 to \$7.00 an hour in 2002. The first union contract, effective in 2003, provided a 34 percent increase over four years, to \$9.35 per hour. The current contract provides for an increase to \$10.45 in July 2009, \$11.20 in July 2010, and \$11.55 in July 2011. Through legislative advocacy, the union has also won a rate increase for homecare agencies that includes a \$1.00 per hour pass-through to increase workers' wages.
- Washington State instituted a groundbreaking stepped wage scale for homecare IPs beginning in July 2006.⁴ Under the 2009–2011 contract, the scale starts at \$10.03 per hour; workers with more experience can earn up to \$11.07. It also offers a \$1.00 per hour differential for workers who mentor other IPs, leading to a maximum hourly wage of \$12.07.⁵ These represent a significant increase over the pre-collective bargaining pay rate of less than \$8.00 an hour (Galloway, 2001).
- The first contract in Massachusetts provided an increase for personal care attendants from the pre-unionization hourly wage of \$10.84 to \$11.60 in July 2008, \$12.00 in July 2009, and \$12.48 in July 2010.⁶

Over time, collective bargaining has also resulted in the significant expansion of health insurance and other benefits for unionized homecare workers:

- The number of California counties offering benefits to IHSS homecare workers has increased over time. Prior to the state's IHSS public authority legislation, IPs had no health insurance access through their jobs. As of 2008, 45 counties offered health insurance; of these, 31 counties also offered dental coverage; and 20 counties offered medical, dental, and vision. A strong majority of IHSS workers are employed in counties that offer health benefits.
- In Oregon, the current contract between SEIU 503 and the Home Care Commission provides employer-paid health insurance to IPs who work 80 or more hours per month.⁷

- In Washington State, collective bargaining first resulted in health benefits for a limited number of homecare workers employed through the Homecare Quality Authority. However, a Taft-Hartley Trust—the SEIU 775 MultiEmployer Health Benefits Trust—was established in 2005. The Trust offers comprehensive medical coverage with dental and vision benefits to IPs who have been employed at least three months and work at least 86 hours per month.
- In Illinois, SEIU Local 880 won health-care access for homecare workers employed through the IP model (through DORS) and through private agencies. Through collective bargaining, the union secured \$57 million in state contributions into a health-care and training fund for DORS homecare workers.⁸ Through legislative advocacy, the union secured a \$1.33 per hour payment to agencies effective July 2008 to be used to provide health insurance coverage for their homecare workers (Kelleher, 2008, p. 11⁹).

Improved Training and Professionalization

Greater training and professionalization—for instance, through credentialing—is required to improve the quality of services to consumers, improve economic mobility for direct-support workers, and improve the retention of direct-support workers. A review of the literature by the Paraprofessional Healthcare Institute found that higher training levels helped long-term care service agencies, particularly homecare agencies, to hire and keep more workers (Paraprofessional Healthcare Institute, 2005). States, particularly those with unionized workforces, have begun to improve homecare worker training. The scope and scale of their efforts (how rigorous the standards and how many workers are trained) varies significantly from state to state, and much still needs to be done to standardize skill standards and expand training programs to adequate scale. Nonetheless, unions representing homecare workers are a critical force in the drive toward such improvements.

Homecare public authorities established by states are also charged with overseeing worker training and setting minimum qualifications, though the content of this responsibility varies between states. Some public authorities rely on union-negotiated and -delivered training programs. In California, where contracts are negotiated at the local level, training provisions also vary widely in scale. Some counties, such as Santa Clara, offer a free and voluntary training program that culminates in basic certification, and/or have union contract provisions for a Job Development Fund that reimburses homecare workers for continued education. In other states, like Washington, public authorities have the responsibility for setting minimum statewide training standards for homecare workers.

The State of Washington has become a leader in the field of homecare worker training and professionalization, in large part because of the efforts of SEIU Local 775, the union that represents long-term care workers including homecare IPs paid by the state. As described above, the union contract with the Homecare Quality Authority established a tiered wage system based on experience, with a \$1.00 per hour differential for mentorship. Local 775 also helped pass legislation, ESSHB 2284, which established the Washington State Long-Term Care Workers Training Workgroup. This body has set up advanced training for long-term care workers, including homecare workers. Finally, Local 775 sponsored Initiative 1029, passed in November 2008 by an overwhelming majority of voters (72.6 percent). Initiative 1029 increases training standards for long-term care workers who provide home health services to seniors and people with disabilities, from 34 hours to 75 hours, equivalent to the current federal standard for certified nursing assistants (CNAs).¹⁰ Homecare workers who provide services for their own parents or children, or who work no more than 20 hours a month for one client, are only required to complete 47 training hours. Initiative 1029 requires state certification and national background checks for homecare workers hired after January 1, 2010. It also provides that the state will pay for training costs and wages for state-subsidized workers. If successfully implemented, the competency-based training and certification system imposed by Initiative 1029 will help to professionalize the state's home-care workforce and improve the quality of care services they provide.

Workforce Stabilization

In advocating for public authorities and collective bargaining for homecare workers, unions and advocacy groups representing seniors and people with disabilities have argued that improvements in compensation and in recruitment, retention, and training systems are necessary to stabilize the homecare workforce in the face of growing need. An initial measure that has been promoted to address workforce stabilization is the worker registration and referral system to assist eligible seniors and people with disabilities with recruitment. Most state laws that establish homecare public authorities also provide for such a registry. Currently, the efficacy of such systems—which require consumer education about their existence—has not been well documented.

However, as we discussed above, there is a demonstrated, strong positive correlation between wage increases and increased workforce retention in the long-term care field, measured as the proportion of direct-care workers who stay in their jobs and in their field over a given time frame.¹¹ Because unions have negotiated substantial improvements in wages and benefits, and also have begun to improve training standards and career pathways for homecare workers, it is reasonable to expect improvement in worker retention. Due to the recent timing of most large-scale unionization events in this sector, research comparing

workforce retention before and after unionization is not available in many states. Nonetheless, available research indicates that wage and benefit increases due to collective bargaining have led to significantly lower worker turnover, greater availability of qualified workers, and shorter gaps in services for consumers.

- A study of IHSS homecare workers in San Francisco (Howes, 2004) analyzed the impact of large wage increases in this newly unionized sector. The study showed that between 1997 and 2001, as wages rose from the minimum wage to \$10.00 per hour plus health and dental benefits, turnover dropped by 30 percent.
- A study commissioned by the Washington State Homecare Quality Council and funded by the Centers for Medicare and Medicaid Services found that (union-negotiated) improvements in wages, health-benefit access, and paid leave, and the implementation of a referral registry system, resulted in several statistically significant beneficial outcomes for consumers. Between 2004 and 2006, turnover declined by 26 percent (Pavelcheck & Mann, 2007, p. 19, Figure 2). The percentage of workers leaving the industry also declined, from 10.36 percent to 8.9 percent (Pavelcheck & Mann, 2007, pp. 7–8). This means that homecare IPs were more likely to stay in the field.

Conclusion

In the homecare sector, unionization has occurred almost exclusively in employment settings that are not regulated by the National Labor Relations Act, but rather are under state public employee labor relations acts, which provide greater protection to workers than the federal law that applies to the private sector. Consequently, most of the workforce stabilization and training benefits of unionized homecare have benefitted seniors and people with disabilities served by publicly funded programs. At the same time, improvements in wages and training are constrained by available public resources. As of this writing, there is growing recognition in the national policy arena—including key federal agencies—of the need for federal policies that can support state-level reforms in investing in the long-term care workforce. The voice of an organized workforce is key to improving direct-support jobs in order to mitigate the long-term care workforce crisis, both through collective bargaining and through partnerships for state and national policy advocacy.

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Endnotes

¹ Many studies show that turnover is negatively correlated with wages in long-term care services. For instance, Lakin's and Braddock's seminal national studies (Lakin & Bruininks, 1981; Braddock & Mitchell, 1992; Larson & Lakin, 1999) use cross-sectional analysis to show the strong relationship between higher wages and lower turnover in developmental disabilities services workers. Wheeler (2002) documented turnover rates of 24 percent in community-care facilities after the two wage pass-throughs in 1999 and 2000.

² The Michigan Quality Community Care Council was created as a partnership between the Michigan Department of Community Health and the Tri-County Aging Consortium under Urban Cooperation Act, Public Act 7 of 1967. Source: Michigan Department of Community Health Beneficiary Eligibility Bulletin, Health Care Eligibility Policy 04-07, November 23, 2004. Retrieved from http://www.michigan.gov/documents/HCEP_04-07_110034_7.pdf

³ Data source: California Association of Public Authorities for IHSS. CAPA Survey on IHSS Wages and Benefits as of October 9, 2008. Retrieved from [http://www.capaihss.org/PDF/CAPA_MOU_Wage_Benefit_Survey_100908\(ps\).pdf](http://www.capaihss.org/PDF/CAPA_MOU_Wage_Benefit_Survey_100908(ps).pdf)

⁴ 2007–2009 Collective Bargaining Agreement by and between the State of Washington and Service Employees International Union 775. Effective July 1, 2005, through June 30, 2007. Retrieved from <http://www.ofm.wa.gov/labor/agreements/05-07/homecare/homecare.pdf>

⁵ Information on 2009–2011 SEIU 775NW contract received from SEIU Long Term Care Division.

⁶ Collective Bargaining Agreement between the Personal Care Assistant (PCA) Quality Home Care Workforce Council and 1199 SEIU Healthcare Workers East. Retrieved from http://www.mass.gov/pca/union/pca_contract.pdf

⁷ Collective Bargaining Agreement between Home Care Commission and Service Employees International Union, Local 503, OPEU. Retrieved from http://www.dhs.state.or.us/spd/tools/cm/homecare/0709_contract.pdf

⁸ “Personal Assistants win healthcare, higher wages with new contract.” SEIU Healthcare Illinois and Indiana. Retrieved from http://www.seiuhealthcareil.in.org/home_care/Personal_Assistants_win_healthcare_higher_wages_with_new_contract.aspx

⁹ See also Illinois Public Act 095-0713, retrieved from <http://www.ilga.gov/legislation/publicacts/95/PDF/095-0713.pdf>

¹⁰ Several states, including California, require many more hours. Many experts and advocates now call for a standard of 200 hours for CNA training.

¹¹ For instance, a study of direct-support workers in developmental disabilities in Wyoming showed that when total compensation rose from \$9.08 per hour in 2001 to \$13.19 by 2004, turnover dropped from 52 percent per year to 32 percent (Lynch, Fortune, Mikesell, & Walling, 2005).

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