



Improving Career Opportunities for Immigrant Women In-Home Care Workers



INSTITUTE FOR
WOMEN'S POLICY RESEARCH

About This Report

This report is one of two studies conducted in collaboration with the Caring Across Generations Campaign by the Institute for Women's Policy Research on ways to improve working conditions experienced by low-income immigrant women doing in-home care work in the United States. *Improving Career Opportunities for Immigrant Women In-Home Care Workers* addresses the lack of job mobility and skill development many immigrant women care workers face, based on expert interviews and a review of existing research. It provides examples of coursework, training, and career ladder programs that target the specific needs of immigrant women domestic care workers, and discusses how such programs can also benefit the elderly and disabled individuals who utilized in-home care services. The other report, *Increasing Pathways to Legal Status for Immigrant In-Home Care Workers* (Hess and Henrici 2013), examines the limitations of the U.S. immigration system for undocumented immigrant women care workers and discusses ways they might obtain legal status once in the United States or acquire legal documentation for entry.

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The Institute for Women's Policy Research (IWPR) conducts rigorous research and disseminates its findings to address the needs of women, promote public dialogue, and strengthen families, communities, and societies. The Institute works with policymakers, scholars, and public interest groups to design, execute, and disseminate research that illuminates economic and social policy issues affecting women and their families, and to build a network of individuals and organizations that conduct and use women-oriented policy research. IWPR's work is supported by foundation grants, government grants and contracts, donations from individuals, and contributions from organizations and corporations. IWPR is a 501(c)(3) tax-exempt organization that also works in affiliation with the women's studies, and public administration and public policy programs at The George Washington University.

About Caring Across Generations

Caring Across Generations is a national campaign to bring Americans together across generation and issue to build a culture of care in which our elders and people with disabilities and the workers who care for and support them can all live with dignity and respect. The campaign is anchored by a coalition of local and national organizations, including: research and policy groups, unions, women's organizations, aging organizations, disability rights organizations, direct care worker organizations, and domestic worker organizations. Caring Across Generations aims to win the creation of two million new good jobs in home care, improve the quality of existing and future care jobs, and build a comprehensive system of care that supports all Americans as we age and live with disability. The campaign is fiscally sponsored by Bend the Arc a 501(c)(3) organization, and is funded through foundation grants, coalition member grants, and individual donors. For a full leadership and coalition list please go to www.caringacrossgenerations.org.

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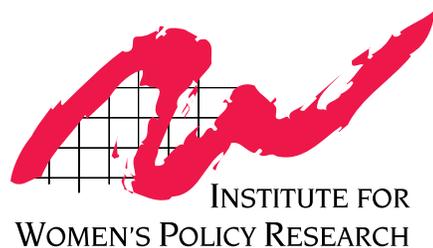
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Improving Career Opportunities for Immigrant Women In-Home Care Workers

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Executive Summary

Low-income immigrant women constitute a large part of the rapidly growing workforce that provides assistance to individuals with disabilities, the chronically ill, and the elderly in need of personal care within private residences. At the same time, immigrant women in-home care workers face impediments to their own economic stability and mobility. If unaddressed, these obstacles can also affect the care that immigrant women workers are able to provide. Both paid and unpaid care providers at this time are primarily women, as are the majority of care recipients. The question of how to improve working conditions as well as the quality of care provided is very much a feminist issue, and one that also touches on immigration, health care, and labor in general. This report combines a critical consideration of existing training inadequacies with a description of programs and practices found to be especially helpful to foreign-born women in care work, and makes recommendations to improve both current in-home care jobs and future opportunities for immigrant women.

Improving Career Opportunities for Immigrant Women In-Home Care Workers is one of two IWPR studies focused on ways to improve labor conditions and rights among immigrant women in home care work. This report addresses the lack of employment options and career mobility that many foreign-born women who are care workers—particularly those with limited English proficiency—face within their jobs helping others. Using original expert interviews and an extensive review of the literature, IWPR’s research discusses the need to increase access to high-quality training that specifically targets the needs of immigrant women care workers. Such efforts can help them support themselves and their families through the critically valuable labor of providing assistance in homes to those who are disabled, chronically ill, or elderly and in need of help.

The literature shows that, for the majority of foreign-born women who work to provide in-home care, the work they do is satisfying and significant to them. IWPR’s and other researchers’ analyses of the data show, however, that career preparation and related wages are insufficient for many of the demands of employment in care work. The level of salaries and, if available, benefits are not enough to sustain workers in this field, much less enable them to continue to pursue their own professional development. This report describes how conditions for immigrant women employed as in-home care workers, as well as for those who receive care, can be improved through: systematic training and practical coursework that builds, when necessary, on English-as-a-Second Language (ESL); financial supports for training; and national standards and regulations, that also cover independently employed care workers.

Improving Career Opportunities provides examples of existing coursework, training, and career ladder programs aimed at the particular needs of immigrant women domestic care workers. The objective of this report is to share critical information and recommendations with policymakers, advocates, and the general public while strengthening support across the United States both for low-income immigrant women and for those who seek assistance within their homes.

“Low-income immigrant women constitute a large part of the rapidly growing workforce that provides assistance to individuals with disabilities, the chronically ill, and the elderly in need of personal care within private residences.”

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I. Introduction

Immigrant women form a significant part of the in-home care workforce across the United States. Despite the rapid growth of the in-home care workforce, the women who provide this labor often find securing regular employment with family-sustaining wages to be challenging. Both foreign-born¹ care aides² and their clients say that limited worker skill and preparation, including in the English language, can be one of the barriers to maintaining quality employment and care (Martin et al. 2009; Paraprofessional Healthcare Institute [PHI] 2004).

Immigrant in-home care aides often play a critical role in the lives of their clients. But they sometimes work in hazardous and stressful circumstances for only minimal pay and with little to no opportunity for professional development (Burnham and Theodore 2012; Martin et al. 2009). The need for the provision of care disproportionately burdens women across the United States and affects their quality of life and health at every life stage, particularly among women of color and the foreign-born (Bianchi, Folbre, and Wolf 2012; Glenn 2010). Improving labor wages, career options, and working conditions for all women who provide domestic direct care has become an important feminist issue that also impacts those who seek care for their loved ones (Folbre, Howes, and Leana 2012; Henrici, Pasha, and Khurana 2012). This issue is generally linked to areas of health care, employment, safety, and immigration, as well as independent living, aging, and disability rights (Altman and Pannell 2012).

This report summarizes material from expert interviews and recent research literature concerning education, training, and career opportunities of particular of relevance to immigrant women in-home care workers. While the U.S. federal government has begun to evaluate training services for home aides in general (U.S. Department of Health and Human Services Administration 2012), it is important to ensure that foreign-born women doing this work are not left behind. Immigrant women's labor conditions and household economies would especially benefit from more regular employment at higher wages with greater options for upward job mobility. As this report discusses, specific types of adult education and training such as English-as-a-Second-Language (ESL) classes can have a critical impact on the many immigrant women who are in-home care workers and on those to whom they provide assistance.

Demand for in-home care workers has been rising in the United States since the 1980s (Boris and Klein 2006; Seavey and Marquand 2011) and is predicted to expand rapidly through 2020.³ This growth has been fueled, in part, by public policies established to help persons who are elderly, or who have chronic illnesses or disabilities, continue to live within their own homes (Glenn 2010; Institute of Medicine 2008). The Older Americans Act, first passed in 1965 and reauthorized in 2006, "was enacted to help older adults remain in their homes and communities" (U.S. Government Accountability Office 2011). Meanwhile, in 1999, the U.S. Supreme Court ruled that under the Americans with Disabilities Act (ADA) persons with disabilities including those who are elderly may not be compelled to live in an institution and are entitled to make their own arrangements for where they wish to live, and that states must seek resources for community integration.⁴

"Immigrant in-home care aides often play a critical role in the lives of their clients. But they sometimes work in hazardous and stressful circumstances, for only minimal pay, and with little to no opportunity for professional development."

1 The terms "immigrant" and "foreign-born" are used interchangeably in this report to refer to individuals born outside the United States who were not U.S. citizens at birth.

2 Home health and personal care aides are two types of direct care workers. Direct care workers as a larger occupational category include all low-skilled workers who provide care to the elderly and to individuals of all ages with disabilities or chronic illnesses in a variety of settings, including private homes, institutional facilities, and community-based settings such as retirement communities (Martin et al. 2009). Although some personal care and home health aides provide assistance in residential facilities, most work within their clients' homes (U.S. Department of Labor 2012a). This report focuses on the home health and personal care aides who work within the homes of their clients.

3 The growth rate for home health and personal care aide jobs between 2010 and 2020 is projected to be 70 percent, "much faster than average"; home health and personal care aides might "help with activities such as bathing and dressing, and they provide services such as light housekeeping. In some states, home health aides may be able to give a client medication or check the client's vital signs under the direction of a nurse or other health care practitioner" (U.S. Department of Labor 2012a).

4 *Olmstead v. L.C.* 527 U.S. 581 (1999); for additional information, see U.S. Department of Health and Human Services. Administration for Children and Families. 2000. "The Olmstead Decision: Assuring Access to Community Living for the Disabled." <<http://www.acf.hhs.gov/programs/add/otherpublications/olmstead.html>> (accessed April 11, 2012).

“All women can benefit from better conditions for the immigrant women employed in care work.”

A related factor possibly contributing to the growth of in-home care is the expanding availability of devices and supports that do not require highly-skilled or institutional medical administration or supervision. Access to these technologies enables more people with chronic illnesses and/or disabilities, as well as the elderly, to remain in their homes with only client-monitored in-home care assistance (Glenn 2010).

In addition, changing U.S. family relations and geographical mobility now call for domestic care to be provided increasingly by individuals other than relatives and neighbors (Boris and Klein 2006; Institute of Medicine 2008). Demographic shifts also have fostered an availability of persons—including among those who are foreign-born—willing to provide in-home assistance to others (Boris and Lewis 2006; Ewing 2012a).

At the same time, as individuals and families make use of policies and resources to facilitate non-institutional living arrangements, rising numbers of women are increasing their participation in the U.S. workforce. Women’s increased workforce participation puts additional demands on women beyond their traditional role as the primary caregiver within the household and increases the demand for at least supplemental contracted care assistance from both native- and foreign-born workers (Boris and Lewis 2006; Glenn 2010).

Policies, technologies, and demographic changes thus have combined to drive the growth of in-home care jobs. Unfortunately, the combination has not provided either a sustainable workforce to meet the demand (U.S. Government Accountability Office 2011) or a sustainable level of wages, benefits, and opportunities for the in-home workers, especially for those who are immigrant women (Chang 2000; Hondagneu-Sotelo 2001; Martin et al. 2009). During the 1980s through the 1990s, public policy and popular concern with respect to in-home care tended to concentrate on whether and to what extent the U.S. public health insurance system might cover a household’s care costs (Stone 2004). More recently, attention has expanded to include the job conditions and wages of domestic care workers (Glenn 2010; Martin et al. 2009; Solis 2011), including among the foreign-born (Martin et al. 2009)

All women can benefit from better conditions for the immigrant women employed in care work. Two-thirds of the unpaid caregivers (66 percent) who provide in-home assistance with or without support from wage-earning aides are also women (National Alliance for Caregiving and AARP 2009). In addition, while men are taking on more unpaid care than in the past, women continue to spend relatively more time on caregiving than men (Family Caregiver Alliance 2011). The need for more and better in-home assistance has become a health and labor issue for those who receive or require direct care for themselves or their loved ones, those who are paid to give it, and those who provide the unpaid assistance. For instance, many caregivers are themselves older (with an average age of 48) and their own health may be poor or only fair with part of their stress stemming from their need to juggle salaried employment and caregiving (Family Caregiver Alliance 2011; U.S. Department of Health and Human Services 2011).

While the work is often very fulfilling, in-home aides can face problematic, and even abusive, labor conditions. Both care workers and care recipients might face direct health risks as well as financial strain, if trustworthy relations have not been established between them. Finding ways to improve the sustainability of the workforce, as well as of their wages and work opportunities, can help both those providing the care and those receiving it (Andersen 2009; Clare 2005). The principal issue is that, even as the call for direct care help has intensified over recent decades, individuals willing to do the work often continue to face low and unreliable salaries, as well as insufficient insurance coverage for their own health care. Workers’ health care is particularly important in the care work field where the work can be straining and can involve working overtime hours (Institute of Medicine 2008; PHI 2011; Smith and Boughman 2007a, b).

Unstable or poor work conditions may arise, in part, because arrangements between care aides and those who need assistance can be varied and haphazard rather than well-planned and formally established. Worker contracts and payments may be set up directly with the client or consumer of the service, through private employment agencies, or through public home-care organizations (Martin et al. 2009).

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While the biggest source of public payment for care is through Medicaid (O'Brien and Elias 2004), an underestimated number of in-home care workers reportedly are self-employed and contracted directly by the client or clients, any number of whom might be ineligible for Medicaid, pay out-of-pocket, and not report the expenses (Martin et al. 2009; PHI 2011). Compounding this complexity within arrangements and protections for both clients and workers, variations exist among the states regarding allowable public-private combinations and among the levels of wages to be paid (Dresser and Pagac 2010; Institute of Medicine 2008).

The federal Fair Labor Standards Act (FLSA) continues to exempt employers from paying minimum wages and overtime benefits to care workers who provide what is considered as personal and unskilled assistance, classifying them as “companions” (Boris and Klein 2012; Forhan 2010; Smith 2009). The U.S. Department of Labor proposes to address this inequity (Boris and Klein 2012; Solis 2011). But, until that change takes effect, the exemption for all employers of care workers classified as “companions,” including institutional agencies that subcontract in-home workers, remains in place—allowing wages for personal care and home health aides to remain low (Sonn, Ruckelshaus, and Leberstein 2011).

Another, quite possibly related, concern for both clients and aides is the turnover rate throughout the home health and personal care workforce (Baughman and Smith 2008; Stone 2004), although exact figures and causes are unknown (PHI and Institute for the Future of Aging Services 2005). Retention in all types of direct care work is critical since many clients will generally need such assistance—possibly with greater intensity over time—for the remainder of their lives.

Some research has explored retention rates among direct care workers who are employed in nursing homes (Institute of Medicine 2008). Those investigations suggest that, in addition to the disincentive of low wages (Smith and Baughman 2007a), relatively high turnover among institutionally based care workers has to do with disrespectful management styles (Institute of Medicine 2008). Further study is needed regarding in-home job conditions in which the client, supervisor, and contractor might be all the same person (Appelbaum and Leana 2011; Martin et al. 2009).

Meanwhile, other research shows that a central reason among all types of direct care workers for leaving a job is a sense of not feeling sufficiently trained for the varied responsibilities and chores involved (PHI 2004). Among in-home aides, both workers and their clients state that they would prefer additional skills and preparation to improve conditions (Martin et al. 2009). It is difficult for in-home care workers to both find and maintain consistent work with high retention (Altstadt 2011; Baughman and Smith 2008). But relevant skill training and educational development could improve those conditions.

Adding regulations and standards for training, education, and employment for immigrant women in-home care workers might lower turnover, raise wages, increase benefits and other work protections, and help women in general with the caregiving responsibilities for families and friends (Folbre, Howes, and Leana 2012).⁵ At the same time, such additions could increase costs both to clients and workers.

As a report by CLASP and the National Council of State Directors of Adult Education on financing low-income adult education states, “Despite the fact that at least 93 million adults in the U.S. may need basic skills services to improve their economic prospects, funding for these services [including ESL, basic literacy, and rudimentary academic coursework] is stagnating at the federal level and being slashed in statehouses and state agencies across the country” (Foster 2012). It can be expensive and difficult for adult women with limited English or literacy to pursue basic educational opportunities along a recommended “career pathway (Gozdziak and Bump 2008). But a career path approach is reportedly likelier than rudimentary skill training to be professionally rewarding, particularly for low-income adults (Fein 2012). Since finding ways to cover costs for training, whether publicly or privately, is helpful, this report focuses on programs within relatively less expensive institutions and discusses other affordable options.

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⁵ Informal caregivers are usually family members and neighbors of the elderly and sick (Institute of Medicine 2008).

II. The Women Doing the Work

In an analysis of Current Population Survey (CPS) data, IWPR finds that 90 percent of home health and personal care aides in the United States are women and 56 percent are women of color. Among all men and women in-home aides, 36 percent have dependent children, 19 percent are single parents, and 59 percent have only a high school diploma or less. Nearly a third, or 28 percent, of personal care and home health aides are foreign-born and of those, 60 percent are from Latin America and the Caribbean (Institute for Women's Policy Research 2012b).⁶

Women who work in the home care industry—especially those who are foreign-born—face multiple challenges. One challenge that in-home aides often encounter is relatively low income and lack of benefits for their work. According to the U.S. Department of Labor, the in-home care worker occupations of home health and personal care aides together in 2010 had a median annual income of only \$20,170 (U.S. Department of Labor 2012a); the 2010 poverty threshold for a family of three with one child under 18 years old was \$17,552 (U.S. Census 2011). In addition, IWPR analysis of 2010 American Community Service (ACS) data shows that only 37 percent of women in-home aides have health coverage through the current or former employer or union, or through the current or former employer or union of a family member (Institute for Women's Policy Research 2012a).

A second concern is the risk of abuse (Andolan et al. 2010). A lack of wage and job mobility can undermine an ability to protest effectively or leave for a job with better career options (Andersen 2009), potentially encouraging exploitation—particularly of aides with limited English language skills (Hondagneu-Sotelo 2001).

For those who are foreign-born, citizenship status forms a particular third challenge since it can affect the lack of mobility, access to benefits, and education options for many in-home aides (Ruiz Ruelas and Castañeda 2011). Most direct care workers in the United States with immigration documents obtained family unification-type visas (Martin et al. 2009). Having a permanent residency of any kind—through family-sponsored, diversity, humanitarian, or employment visas—grants immigrant women certain benefits compared with a temporary work visa. Direct care workers who instead have work authorization visas typically have temporary rather than permanent visas, limiting job mobility (Chishti 2011). Those with permanent status generally have greater job mobility.

Recent economic analysis calculating the potential income difference between a permanent U.S. work visa, which allows greater career mobility, and a temporary work visa shows “an annual wage gain of about \$11,860” (Mukhopadhyay and Oxborrow 2012, 2). Between workers in the United States with no education beyond high school and those with even some postsecondary education, average annual earnings increase from \$24,000 to \$37,000 (Carnevale et al. 2011).

Certain means-tested U.S. benefits and the publicly subsidized adult basic education, literacy, and English language courses supported through the Workforce Investment Act (WIA) Title II that many foreign-born women need are available to immigrants with permanent residency or specific work authorizations (U.S. Department of Labor 2010b). However, excluding the job training supported through WIA Title I, eligibility to most means-tested benefits for immigrants under federal law has been limited to those who can document that they have consistently resided in the United States for five years, with important exceptions such as for persons admitted as refugees (Code of Federal Regulations, title 8, sec. 1613). The majority of foreign-born in-home aides immigrated to the United States before 2005 (87 percent), while a significant segment of the population currently working in these occupations (12 percent) arrived in 2006 or later (Institute for Women's Policy Research 2012b).

Immigrant women in-home care workers under current U.S. policy do essential labor in jobs for which there is growing demand (Ewing 2012b) yet remain limited in their wages, benefits, supports, and career ladder options (Andersen 2009; Chishti 2011; Fremstad 2011). To ensure that the full spectrum of care is available for those who require it to live independently, and that quality preparation and compensation are accessible for all of those who directly provide that care, the U.S. domestic care system needs change (Institute of Medicine 2008).

⁶ Of the foreign-born reportedly living in the United States in 2010, 51 percent were women (Batalova and Lee 2012).

III. Current Skills of Direct Care Workers

Both their clients and direct care workers themselves would prefer that aides have more skill training and job preparation (PHI 2004). Many direct care workers want to know more about a range of non-medical issues or to receive safety instruction about, for example, healthier ways to do tasks such as lift or move a client. All of these topics can be of particular significance for those workers who are recent immigrants, especially those with limited English language skills; at the same time, special skills are necessary for any instructors to provide effective adult-level education to those whose English might be limited and who might not be familiar with dominant U.S. cultures (Doyle and Timonen 2009; Oni 2007/08).

Under current regulations, certain workers may be employed with little preparation; while others must be certified, but exclusively in medical care, regardless of language skills. Independently contracted individuals may be employed to work as personal and home care providers without training, certification, or a high school diploma.⁷ For these in-home care aides, wages and job duties might be set informally and be supervised only by the client (Appelbaum and Leana 2011); rules vary among states (Seavey and Marquand 2011).

In contrast, direct care workers paid through either Medicare, Medicaid, or any other federal program who have the occupation title of “home health aides” must have a minimum level of preparation similar to that of Certified Nursing Aides (CNAs), in some states called “Certified Nursing Assistants” (U.S. Department of Labor 2012b, c). Similar to CNAs, home health aides must be able to pass a competency examination in specific areas, such as safely helping a person to eat and move from a bed to a chair, and reading and reporting vital signs (*Code of Federal Regulations*, title 42, sec. 484.4). Federal regulations for these workers require a minimum of 75 hours combined classroom and practical training, 16 hours of which must be supervised practical training (*Code of Federal Regulations*, title 42, sec. 484.4).

Although both trained and untrained personal and home health aides might have additional, non-health care duties, such as house cleaning and cooking, preparation in those skills remains optional depending on the state. At the same time, despite their certification, home health aides are not allowed to give medication or check vital signs for a client except in certain states and then only under the “direction of a nurse or other healthcare practitioner” (U.S. Department of Labor 2012a).

Most care work experts regard even the 75 credit hours needed for home health aides to pass their certifying exam to be insufficient for the range of situations that can occur as a part of in-home assistance and health care (Institute of Medicine 2008; PHI 2008b). The training hours and content that certified home health aides receive are set by the relevant agency in each state, and 23 states have instituted requirements for personal care aides and additional credit hour requirements for home health aides (National Council of State Boards of Nursing 2012; Institute of Medicine 2008; PHI 2012a, b; PHI 2012). As a result, those workers and health care recipients whose activities or family members are in more than one state currently may encounter multiple structures and regulations affecting in-home employment and care.

Requiring increased training and certification for all in-home labor could improve the quality and consistency of care immigrant women working as aides give their clients, as well as encourage higher retention rates among these workers (Andersen 2009; Leutz 2007). That strategy could be problematic for clients who need in-home personal aides without in-home health care: for example, someone who might want meals prepared without medical interventions (U.S. Government Accountability Office 2011). For this reason, in making this approach feasible, it would be critical to include optional levels of training and education within a nationally standard framework while also involving clients directly in choosing appropriate levels and, where possible, in providing individualized training.

⁷ U.S. Department of Labor. Bureau of Labor Statistics. 2011. 2010 Standard Occupational Classification System. <<http://www.bls.gov/soc/home.htm#classification>> (accessed January 17, 2012).

U.S. Department of Labor. Bureau of Labor Statistics. 2012a. “Home Health and Personal Care Aides.” Occupational Outlook Handbook. <<http://www.bls.gov/ooh/healthcare/home-health-and-personal-care-aides.htm>> (accessed October 23, 2012).

Currently, most models for career pathways that improve options for low-wage adult care workers remain focused on health industry jobs. This generally medicalized focus in career path programs facilitates the subsidization, in part, of costs for higher levels of training and education, and for higher levels of wages and benefits, through medical coverage programs and through added demand for staffing outside of residences and within hospitals and other institutions. A recent federal initiative to study demonstration training programs for distinct personal care, as well as home health care, is an important advance (U.S. Department of Health and Human Services Administration 2012): Additional alternative career pathways can help raise wages available to care workers, including those who provide personal assistance and those with some health care responsibility.

Adopting basic standards in language skill, education, job training, interpersonal skill, and home care ethics seems advisable to improve both the quality of care for consumers and job quality and mobility for all in-home workers, although a high school diploma along with an exam-based certification could be viewed as sufficient to reach a basic level of home care aide. This certification would not require the supervision of a medical professional and, in fact, might be administered by the individual or agency employer-client along with additional personalized training.

With this flexibility in mind, along with a feminist concern for social justice for all of the women who provide in-home care, making in-home care work better should also include resources for preparing the significant proportion of those workers who do not have high school degrees and who need qualified instructors in literacy and ESL.⁸

Some of the subjects that women and men going into direct care want to know more about include how to effectively:

1. care for and communicate with someone from a different ethnic, generational, or racial background (PHI 2004);
2. respond when subjected to unfair or abusive conditions (PHI 2004);
3. make care more “person-centered” (Feinberg 2012; Folkemer and Coleman 2006);
4. make decisions in terms of established care work standards (Booth, Roy, and Jenkins 2005);
5. resolve conflicts (Booth, Roy, and Jenkins, 2005);
6. use computer skills to continue to access information to help clients (Booth, Roy, and Jenkins, 2005);
7. prioritize the widely divergent chores around the house with which the client might want help (Booth, Roy, and Jenkins 2005);
8. mitigate physical pain to help clients who might be dying or living with a chronic but untreatable condition (Booth, Roy, and Jenkins 2005); and
9. manage emotions regarding clients who, because of age, illness, or condition could suffer or die while under the care of the worker (Baughman and Smith 2008; Booth, Roy, and Jenkins 2005).

Of additional concern among aides is the need for ongoing preparation and access to accurate information, particularly related to health and health care among home health aides in particular. Many training and employment health care agencies provide pamphlets with quick facts and need-to-know instruction for direct care workers. Research shows, however, that often clients get inconsistent and possibly dangerous “information” and advice from popular television or Internet sources. Another recommendation then is for career pathway programs to include library and computer training and access in order to provide in-home aides with better sources that could help both them and their clients (Cooper and Urquhart 2005; Condelli et al. 2010, ⁹).

⁸ The National Reporting System (NRS) for Adult Education, developed by the U.S. Department of Education’s Division of Adult Education and Literacy (DAEL), helps manage the reporting and analysis of learner outcomes from federally-funded adult education, literacy, and English-as-a-Second Language (ESL) instruction. Analysis of the most recent data concerning adult ESL learners, from 2003–2004, shows that the number of instructional hours had a greater impact on NRS level gain when measured by standardized scores than the instructional intensity. While too many variables prevent researchers from being able to state precisely the number of instruction hours that make the critical difference for adults learning ESL, a minimum of 80 to 100 hours between pretesting and post-testing has been recommended (Young 2007).

IV. Career Pathway Programs

Successful workforce preparation programs focus on job readiness and retention skills as well as basic education, English proficiency, and technical training (...). Beyond job readiness training, any job advancement strategy must have access to post secondary education and training as its core guiding principle. To advance to a high-wage job, individuals must acquire the necessary education and skills (Poppe, Strawn, and Martinson 2004, 53).

Specifically with respect to care work jobs and careers, while moving basic training and education for all in-home care workers to a national level of standardization might be advisable (Appelbaum and Leana 2011), variations in state and local levels of demand for workers and availability of education financing remain a concern. Aside from differences in demand for workers across the United States (PHI 2012c), differences in training and educational program capacity are also significant.

During the past decade, certain localities, states, and regions have taken note of the characteristics and needs of the immigrant women already doing direct in-home health care work and have set up systems of training and education attempting to improve foreign-born workers' lives and those of their clients while responding to regional workforce demands. Several programs now include, or offer, basic courses for students who do not have high school degrees, work part- or full-time, have their own household care work responsibilities for children and/or others, and whose English literacy and language skills are limited (Bragg et al. 2007; Community Research Partners 2008).

The following section of this report considers key components for, and model examples of, career pathways that have been examined and recommended as replicable and scalable in order to improve work conditions and quality for immigrant women in-home care workers. The focus is both on those women who are just starting out as care workers, and those who wish to increase their wages and employment opportunities through additional training and education.

Key Components of Career Pathway Programs for Immigrant Women In-Home Care Workers

One issue to remember is that a significant percentage of all the women who are doing in-home care currently lack a basic education and, in some cases, the preparation for taking classes: IWPR analysis of CPS data shows that one-fifth, or 20 percent, of in-home care workers have not completed high school (Institute for Women's Policy Research 2012b). Using National Assessment of Adult Literacy (NAAL) data, IWPR also finds that low literacy has a particularly negative impact on the earnings of women in the United States (Herard, Miller, Henrici, and Gault 2012). In addition, a direct correlation has been reported between literacy levels and duration and type of employment, hours worked, and wages earned in all fields (Bruno, Jin, and Norris 2010).

In other words, for their job conditions to improve, some of the immigrant women already doing direct care work and those seeking that employment will first need to take adult basic education and literacy classes (Bruno, Jin, and Norris 2010) as well as "bridge" classes that can help adults unfamiliar with being students to become ready for job training and college-level coursework before taking career-relevant classes (Bragg et al. 2007; Community Research Partners 2008; National Skills Coalition 2011b).

For the non-native English speakers, these bridge classes need to include qualified Limited English Preparation and Cultural Competency courses (Bruno, Jin, and Norris 2010; McHugh and Chalinor 2011; Martin et al. 2009). Experts who have examined ways to improve education, training, and integration among low-income immigrants in the United States argue that such fundamental courses are more effective when tied to work-relevant vocabulary and activities.

This specialized form of instruction itself then necessitates a "training of the trainers" (Community Research Partners 2008; Doyle and Timonen 2009; Oni 2007/08; PHI 2004).

Scholarly literature concerning model programs to train, educate, and retain a quality workforce of foreign-born women to do in-home care reveals certain common elements. For immigrant domestic care workers, educational and employment programs should include methods to:

1. subsidize or cover the costs of the training, coursework, and certification (Booth, Roy, and Jenkins 2005; Holl et al. 2009; McFarlane and McClean 2003; McHugh and Challinor 2011; Pennsylvania Intra-Governmental Council on Long Term Care 2001);
2. provide paid internships, apprenticeships, or on-the-job classes (that might include ESL and literacy) and occupational training (Booth, Roy, and Jenkins 2005; Holl et al. 2009; McFarlane and McClean 2003; Pennsylvania Intra-Governmental Council on Long Term Care 2001; PHI 2004);
3. maintain peer support and consistent advising of the trainees (Booth, Roy, and Jenkins 2005; McHugh and Challinor 2011; Pennsylvania Intra-Governmental Council on Long Term Care 2001; PHI 2004);
4. provide child care vouchers or subsidies (Booth, Roy, and Jenkins 2005; McFarlane and McClean 2003; McHugh and Challinor 2011; Pennsylvania Intra-Governmental Council on Long Term Care 2001);
5. provide housing and transportation vouchers or subsidies (Holl et al. 2009; Pennsylvania Intra-Governmental Council on Long Term Care 2001); and
6. show respect for domestic care workers by asking them what benefits and opportunities they most would value and engaging workers in the training (Pennsylvania Intra-Governmental Council on Long Term Care 2001; PHI 2004).

These training elements have been shown to improve conditions for both workers and their clients. Additionally, specific “stackable” steps should be developed that form points at which trainees may stop, and that provide further connections along a career pathway. These clearly defined stackable options can help evaluators and employers to measure and know when higher salaries or other rewards are expected, and trainees and workers to be able to demonstrate their qualifications (Appelbaum and Leana 2011).

Once language skills have been addressed, training and education can be provided by the work agency or on-the-job with the client or clients; through community-based or other nonprofits; or through community college or other postsecondary institutional instruction. At present in the United States there is a push for an increase in health care-related degrees, both at the professional and direct care levels, including within the latter category the personal care and home health aide occupations. Community and technical colleges in particular are expanding their roles in these training and education areas. In fact, some experts in training and career development argue that “community colleges are poised in many areas to serve as the foundation for a comprehensive job advancement strategy” (Poppe, Strawn, and Martinson 2004, 54).

Many of those in the care work field and those seeking higher standards for related training and education argue that the most successful programs include a mix of in class and on-the-job learning, and suggest that the combination be available at each stage along the pathway. Such a combination requires not only solid leadership, but coordination and collaboration among private, public, professional, and community-level entities as well as between those who are seeking the training and those who will become their clients (Bray, Painter and Rosin 2011; Bragg et al. 2007; Dillon and Young 2003; National Skills Coalition 2011a, b).

The following are examples of the high level of partnership and flexibility considered ideal for immigrant women in-home care workers. Although all but one of these existing and proposed examples build toward licensing in medical fields, they could be replicated within other systems to provide the skills, training, and educational opportunities for the sustainable wages and benefits that immigrant women in-home aides should have even without a medical focus or certification. These programs tend to center around city or community colleges, in partnership with significant other institutions and organizations, so that student-workers can obtain needed services and instruction.

Career Pathways for Immigrant Women In-Home Care Workers – Training Programs with English-as-a-Second Language or Citizenship Components

Carreras en Salud

Instituto del Progreso Latino (IPL) in Chicago is the home of the highly regarded Carreras en Salud⁹ (Bragg et al. 2007), started in 2005 through an IPL partnership with National Council of La Raza (NCLR) and Association House, itself founded in 1899 to help immigrants better adapt and with their health and safety. Carreras-IPL operates as a bilingual health care career pathway that helps individuals with limited English proficiency prepare for, and move into, Licensed Practical Nurse (LPN) positions. According to a comparative study on career pathway programs, as of 2007, 423 students had participated in Carreras-IPL and the pilot group had a 73 percent completion, licensure, and employment rate (Bragg et al. 2007, 29). As of 2009, “Carreras had a licensing/certification rate of 95 percent for its 358 Licensed Practical Nurse (LPN) and Certified Nursing Assistance (CNA) graduates, and a placement rate of 100 percent for the 343 LPNs and CNAs. LPNs had an average wage gain of 150 percent, from an average annual salary of \$18,720 as a CNA to \$46,800 as an LPN” (Estrada 2010).

The mission of Carreras-IPL is to address the academic and language gaps that prevent Latino/as from participating in the health care sector. Carreras-IPL prepares Latino/as to not only become bilingual CNAs and LPNs, but also to help these workers advance into better-paying jobs as LPNs and Registered Nurses (RNs). Carreras-IPL involves seven levels at which individuals can enter based upon their English proficiency and educational readiness; each level takes at least 16 weeks to complete. Although most classes are taught in English, instructors for the lowest-level ESL course and pre-CNA course are bilingual, in order to make these foundational classes as accessible as possible. In addition, ESL instructors at all levels contextualize their courses, integrating medical terminology and concepts into the curriculum to better prepare students for employment. Students can exit the pathway at any time and return to it later (Bragg et al. 2007).

Over 90 percent of Carreras-IPL students are low-income adult women, many of whom have dependent children.¹⁰ Some students are single, and some already work either part- or full-time to provide for their families. All credentials in the Carreras-IPL program, including the RN certification, are “stackable”: each certification builds upon the next, and, at each major benchmark, students can leave the pathway with an employable credential, of particular importance for students with caregiving and care work responsibilities that might interrupt educational programs. The program’s curriculum is also modularized with each component aligning with other parts of the career ladder (Bragg et al. 2007).

Partnerships with local community colleges, employers, and other nonprofit organizations appear to be crucial to the success of Carreras-IPL and that of its students. The Association House provides case management during pre-LPN classes. The Humboldt Park Vocational Educational Center of Wright College—one of Chicago’s seven “city colleges”— administers Pre-LPN levels, to transition students to the LPN level at Wilbur Wright College. Carreras-IPL also affiliates with Truman College in order to provide RN training for LPN students interested in further education.

Meanwhile, employer partners provide clinical and practicum sites, practicum instructors, and job placement for program graduates. Carreras-IPL also partners with Spanish media and faith-based organizations to help with recruitment (Bragg et al. 2007).

In addition to the Carreras program, IPL offers bridge classes that include bilingual adult education in ESL, the high school equivalency examination General Educational Development (GED) preparation, and Spanish literacy. Youth and adult students also can receive essential services including counseling, job placement, citizenship test training, and financial instruction. A bridge program that could be of particular help to low-income immigrant women as they seek classes and career development is that of *Mujer Avanzando*, which helps single mothers who are earning between \$10,000–14,000 a year with career pathway counseling and training; wealth creation, asset development, and financial literacy; leadership development; and child care services (Bragg et al. 2007).

9 Instituto del Progreso Latino. 2012. “Workforce Development.” <http://www.idpl.org/idpl_workforce_dev.html> (accessed March 5, 2012).

10 IWPR communication with IPL staff

Carreras-IPL is a large-scale program that operates well in part because it is partnered within an even wider set of training and services that can help immigrant women in-home care workers.

Center for Immigrant Education and Training (CIET)

La Guardia Community College houses the Center for Immigrant Education and Training (CIET) among a cluster of Adult Continuing Education programs to help “low-income Queens immigrants and their families.”¹¹ CIET is linked to a Workforce Education Center, Career Development Center, Green Jobs, and Employment and Career Services Center.

CIET specifically targets the workforce and career development of foreign-born workers. According to CIET’s website description, the program model anticipates that trainees who are immigrants will benefit from curricula material concerning U.S. culture as well as from English language and conversation skills specific to a chosen career focus. CIET also teaches trainees to better hunt for additional or new employment opportunities while studying and practicing those job-relevant English vocabulary items and “soft skills.”

An aspect of career development at CIET, which may be unique, is the effort to incorporate trainees’ existing skills including those from their nations of origin within career development.

Like Carreras-IPL, CIET is focused on stackable medical health careers and helps interested trainees connect rudimentary language instruction to curricula toward certification at appropriate colleges and universities.

Express Care

Most training programs are exclusively focused on medical careers toward which home health aides might aim, and relatively few focus on training that is of immediate help to immigrant women. Yet, personal care aides, who do not necessarily provide assistance that is directly related to health or medical treatment, are also in demand and immigrant women may fill those jobs. As noted, the U.S. federal government recently began support for testing and evaluating demonstration programs in both home health and personal care training (U.S. Department of Health and Human Services 2012). Express Care has provided classes for low-income immigrants to become either type of aide, as well as in English-as-a-Second Language since 2003 in Northern Virginia.¹²

Extended Care Career Ladder Initiative (ECCLI)

In Massachusetts, state legislation in 2000 created the now highly praised training and educational career pathway, Extended Care Career Ladder Initiative (ECCLI), as part of the state Nursing Home Quality Initiative to improve long-term care. Operated by the Commonwealth Corporation, ECCLI promotes collaboration among different sectors involved with improving long-term care such as local workforce investment boards, community-based organizations, and career centers. Community colleges are also part of this partnership, so that a network of community college educational institutions and systems conduct the off-site training and education (Dillon and Young 2003). A qualitative evaluation of the program in 2007 commented that, until the initiative was launched, many employers were unaware of the low level of English proficiency among direct care workers and that ECCLI’s funds for employers to provide ESL classes to staff have had positive effects in the work being done and in more effective institutional communications (Singh 2007).

Importantly, ECCLI includes training specific to the growing majority of direct care aides in homes even as it retains a focus on those within institutional settings.

Ohio Stackable Certificates

Ohio Stackable Certificates is a state-wide program proposed in 2008 and recommended by state-level commissions based on research that combines the elements of existing models of more conventional health care career pathways and the Ohio workforce development needs. The model would begin with an assessment of the student. If the individual is found to be below an eighth-grade level in English and/or math, s/he proceeds to the building block of adult basic education, contextualized “with health care terminology and skills and wraparound services” (Community Research Partners 2008, 24).

11 CIET website: <<http://www.laguardia.edu/ciet/>> (accessed October 31, 2012).

12 Express Care website: <http://www.expresscare.org> (accessed October 31, 2012).

Once the person tests at a level at or above an eighth-grade level but still below the GED assessment, the next step or stackable block is that of State Tested Nurse Assistant training—which includes relevant ESL skill development. The trainee then would proceed up these levels with English and math development assessed and acquired accordingly, through the Patient Care Technician, LPN, and RN stages with on-the-job experience combined with formal instruction. According to the proposal, once a person achieves the education level above that of an LPN to become an RN, significant wage increase is possible for a student in Ohio. The level of education required for an RN is one year of college following an advanced technical certificate (Community Research Partners 2008).

The program is recommended because it involves active engagement and collaboration among health care employers and supervisors; community colleges and other institutions; instructors and those who administer assessments; and trainees and their patients/clients.

Career Pathways for In-Home Care Workers—Training Programs without English-as-a-Second Language or Citizenship Components

The following models are also health care specific but are relevant because of their emphasis on cooperation and partnerships, as well as flexibility. At the same time, these programs would need additional English skill and bridge steps to be fully useful to immigrant women in-home aides.

Cooperative Home Care Associates (CHCA)

Founded in 1987 in the South Bronx, Cooperative Home Care Associates (CHCA) employs and trains over 1600 home health aides in New York City (PHI 2010). Those interested in becoming caregivers with CHCA are encouraged to join the training program the association operates in conjunction with the Paraprofessionals Health Institute (PHI). Entrance to the program requires an orientation, a skills assessment, an interview and a counseling session. Once accepted, caregivers participate in four weeks of in-house training—a total of 150 hours (PHI 2010). The training is based on a “learning” centered approach wherein students take part in interactive activities such role plays and case studies in order to learn practical skill sets. The four week training is then followed by three months of on-the-job training where caregivers are not only paired with a peer mentor, but also provided supplementary training in case management and clinical skills (PHI 2010). After graduating from training, care workers are eligible for full job placement by CHCA. The association contracts with New York agencies and private employers to provide quality jobs at the highest possible salary and benefit levels (Cooperative Home Health Care Associates 2007). Monetary incentives are also provided to aides who refer others to CHCA.

Paraprofessional Healthcare Institute (PHI)

The Paraprofessional Healthcare Institute (PHI) in New York City is a non-profit affiliate of CHCA where it supports the organization’s recruitment and training efforts. Through its SKILL Center, PHI, however, trains its own supervisors and peer mentors and helps manage home care, assisted living facilities, and nursing homes throughout New York (Leutz 2007). In addition, PHI specializes in developing innovative approaches to recruitment, training—such as the “PHI Coaching Approach”—and supervision for other agencies that employ direct care workers (PHI 2008a). PHI directed trainings consist of five elements:

1. A learner-centered approach that encourages aspiring caregivers to develop critical-thinking skills while studying health care and provides hands-on training in clinical/personal care skills.
2. Three to five weeks of full-time curriculum.
3. Three to six months of on-the-job training and support.
4. Peer support and mentoring from more experienced employees.
5. An employment counselor to help with job placement and access to additional services such as transitional public benefits.

Additionally, PHI trains to deal with a range of complex, care-related issues, including health care emergencies, depressed clients, and angry relatives—topics that are rarely, if ever, addressed by traditional training methods (PHI 2003).

Career Pathways for Institutional Settings

Most of the programs that appear within scholarly literature as potential models for health care training and development have courses and techniques useful only for women workers who 1) already have some preparation and education and whose English is at the eighth grade level or above; 2) want to turn to more medicalized health care along their pathways; and 3) might want the option to move out of in-home work and into institutional settings.

Nine such programs are briefly described here; despite their higher-level requirements and institutional health care limitations, each of these programs has creative elements that could be implemented by organizations and institutions seeking to help in-home care workers with limited English and other education.

Baltimore Alliance for Careers in Healthcare (BACH)

The Baltimore Alliance for Careers in Healthcare (BACH) was developed in 2005 to address pressing labor shortages in Baltimore, Maryland's health care industry. BACH was founded by seven hospitals, including Mercy Medical Center and Johns Hopkins Medical Center; local two- and four-year colleges; the Baltimore School System; regional municipal workforce agencies; and community-based and philanthropic organizations. BACH is an industry-education-community-government partnership that started out by designing career pathway programs for five of the participating hospitals in order to show how employees at lower levels could advance to higher paying jobs within those institutions. Employers and alliance members then worked together and pooled resources, to increase career coaching for hospital workers and provide professional development for coaches (Wilson 2010). In addition, BACH started a program that trained non-clinical staff to become "nurse extenders," who are clinical workers assisting nurses with wound care and other responsibilities. Nurse extenders are often trained in long-term care facilities become employed almost exclusively at the Alliance's member hospitals; in-home workers and those students or workers who are non-native English speakers are not particularly helped by this model although its creative partnering and planning may be replicable for others' programs (Baltimore Alliance for Careers in Health Care 2007; Wilson 2010).

District 1199C Training and Upgrading Fund

District 1199C Training and Upgrading Fund is a Philadelphia-based labor-management partnership that has been working for over 40 years to provide affordable training for community members looking to enter health care professions. An affiliate of Local 1199C, American Federation of State, County, and Municipal Workers, and the National Union of Hospital and Health Care Employees, the Training and Upgrading fund operates the county's only union-based school of practical nursing where students can either enroll in a 20-month part-time training program to become a licensed practical nurse or take part in a shorter training program to become a nurse's aide (Wilson 2010). Reduced and/or free tuition is available to training fund members and young adults between 17 and 21. Both programs include career coaching and instruction in academic and clinical skills. They also provide support for students who wish to continue their postsecondary education and become RNs (Wilson 2010).

District 1199C Training and Upgrading Fund has a three-step program for those seeking to enter and advance in the field of behavioral health. First, students must enroll in the Fund's Behavioral Health Technician Program, a 21-credit program that the Fund and Philadelphia University co-operate. Students who successfully complete the program and are recommended by the training provider are then eligible to enroll in Philadelphia University's certificate program for behavioral health. This 30-credit certificate requires students to complete three additional courses at Philadelphia University, including an introductory psychology class and a behavioral psychology classes. Students who have successfully completed the Fund's technician program can also choose to pursue an Associate's Degree in Health and Human Services from Philadelphia University (District 1199C 2007).

Maricopa Community College

Maricopa Community College in Arizona state has developed an innovative approach to creating linked career pathways for students in its health information technology program. Maricopa has partnered with local health care providers to design a sequence of four credit-bearing certificates leading to an associate's degree in health information technology that allow students—many of whom are working adults—to complete their degree in more doable “chunks,” leaving and re-entering school after each certificate (Community Research Partners 2008).

Owensboro Community and Technical College

The state of Kentucky has tested various programs involving community and technical colleges for its state Career Pathways initiative (Community Research Partners 2008; Owensboro Community and Technical College 2012). In particular, Owensboro Community and Technical College has developed an accelerated nursing degree program for employees at the lower levels of hospital employment, such as nursing aids, pharmacy technicians, and unit clerks. As a partnership between the college and the Owensboro Medical Health System (OMHS), the nursing degrees program was created to address OMHS's need for an additional 500 RNs by 2015. The program reduces the time necessary to complete an associate's degree to about three years for a full-time employee. In addition, paid release time, employer provided tuition assistance, as well as on-site and online classes help students to better balance employment and academic demands. Students also receive thorough advising, case management, and peer support to help them identify and overcome barriers that might interfere with the completion of their degrees (Owensboro Community and Technical College 2012; Wilson 2010). Perhaps most importantly, the program incorporates an intensive, individual developmental math curriculum that addresses the math deficiencies that might discourage potential candidates from pursuing a career in nursing. A grantee of both Jobs to Careers and Breaking Through—national projects to help community colleges build better access to occupational and technical degrees for low literacy adults—the program has a 75–89 percent retention rate, and as of 2010, 75 percent of students were expected to earn their RN credentials (Wilson 2010).

Partners Healthcare Training and Employment Program

Partners Healthcare in Boston created the Partners Healthcare Training and Employment Program as part of an effort to respond to shortages in key staff positions, such as nurses, radiation technologists, and allied health occupations. Boston residents who enroll in the Employment Program receive job training, placement in jobs at affiliate hospitals—including Brigham and Women's Hospital and Massachusetts General Hospital—and career development (Wilson 2010). This is a part of Partners Healthcare's larger three-tiered pipeline approach to workforce training and development, with programs that target youth, community residents, and existing hospital employees. As part of this mission, Partners Healthcare launched the Partners Career and Workforce Development Program (PCWD) in 2003. Operating as both “a community pipeline” and professional development program for incumbent employees, PCWD provides professional development for workers throughout the Partners system. PCWD includes, among other resources, a career development Website, a workforce development manager who provides technical assistance, and career coaches who help support incoming and incumbent workers (Wilson 2010). These supports, in tandem with the Employment and Training Program, work towards the goal of helping low-income individuals enter and advance in health care professions (Partners Health Care 2012).

Pickaway-Ross Career and Technology Center

Like Maricopa College, Pickaway-Ross Career and Technology Center in Chillicothe, Ohio, appears as a model for course “chunking” and career pathways in health care programs. Over the past decade, Pickaway has formed closer ties to several local colleges, including the Chillicothe branch campus of Ohio University, to allow its adult learners to receive college credit for hands-on training in the health care field (Community Research Partners 2008).

Southeast Arkansas College

Southeast Arkansas College¹³ has created its highly touted and replicated “Fast Track” model as part of the state’s Temporary Assistance for Needy Families-funded programming in order to address the academic gaps and challenges exhibited by low-testing students, many of whom are parents, who seek credentials in LPN or other allied health professions (Community Research Partners 2008). The program’s accelerated developmental education curriculum responds to the anticipated earnings loss for employed students and to students with caregiving responsibilities by reducing the time needed for remedial education requirements to one semester. That semester also incorporates college-level math and science prerequisites, and is immediately followed by a one-year, interdisciplinary Practical Nursing track (Wilson 2010). Like the developmental education course, the nursing track is delivered in two sessions—the first is a series of four eight-week sessions followed by a sixteen-week module. This design is intended to help students maintain their outside employment and anticipated other responsibilities while aggressively pursuing postsecondary credentials to improve economic security (Wilson 2010). Students also receive comprehensive advising and support from Southeast Arkansas, both of which are considered by the administrators to be crucial to the program’s success (Henrici n.d.). As of 1996, the program had a 96 percent completion rate (Wilson 2010), and “Fast Track participants are four times more likely to complete developmental education than students in traditional remedial courses.” In the case of this program, while the level of education both starts out higher than many of the in-home aides might be prepared to undertake and continues on to a level that might take the direct care workers out of the home and into institutions only, the key component that might form a model to be emulated elsewhere, at lower levels of education, is that of flexible and accelerated coursework that maintains industry quality standards.

Stanley Street Treatment and Resources

Finally, through a partnership with Trundy Institute of Addiction Counseling and Bristol Community College, and assistance from the public-private health care workforce initiative of Jobs to Careers operated by Jobs For the Future, Stanley Street Treatment and Resources (SSTAR) in Massachusetts started a training program to help entry-level employees advance into frontline health care workers.

The program, begun in response to a staff shortage, uses on-site instruction and workplace-based curricula to train employees within addiction counseling, group facilitation and family intervention (Wilson 2010). Supervisors were deeply involved in training, and workers modeled therapeutic practices, such as journaling, from their work with clients as part of their coursework. In addition, students—all of whom were incumbent workers—formed study groups and offered additional peer support to help each other prepare for the certification exam. All involved in the training program graduated the 270-hour course, and all but one earned their certification in drug and addictions counseling. As a result, SSTAR has increased the level of care, decreased client waiting lists, and increased revenue for workers specialized in this type of care—both the combination of flexible, relevant training and peer counseling seem to recommend this program (Rogers and Wagner 2010; Wilson 2010).

Recommended Other Components for Training & Certification of Direct Care Workers

An example of a pathway that could form a model at least for home health aides if not personal aides is that for training and retaining Direct Support Professionals (DSPs), who specialize in assisting persons with mental disabilities, although the majority of DSPs work within institutional rather than in-home settings. The DSP system forms a model to consider for improving job conditions for other in-home care workers because of its clearly formulated code of ethics and standardized ways to obtain more accreditation and certification at three levels along a career pathway (National Alliance for Direct Support Professionals 2011a, b). In contrast to personal care and home health aides, in-home and all other DSPs have nationally standardized training and apprenticeship programs with guidelines approved in 2010 by the U.S. Department of Labor’s

13 Southeast Arkansas College. 2012. <<http://www.seark.edu/>> (accessed April 2, 2012). <<http://www.seark.edu/academic-programs/nursing-and-allied-health>>

Employment and Training Administration (ETA).

The standards were developed through ETA's Office of Apprenticeship at the request of the National Alliance for Direct Support Professionals and the American Network of Community Options and Resources. NADSP and ANCOR are partnering with ETA on addressing the need for quality, competency-based instruction models to help establish career pathways for the direct support professional occupation. The Registered Apprenticeship program utilizes a competency-based model that allows apprentices to earn interim credentials based on the demonstration of specific skills (U.S. Department of Labor 2010a).

Unfortunately, despite having this certification system in place, DSPs continue to leave employment they might otherwise find rewarding because of a lack of compensation (Ebenstein 2007/8). William Ebenstein, University Dean for Health and Human Services and Director of the JFK Jr. Institute for Worker Education, City University of New York, states that:

The problems facing low-wage workers in our field [of Direct Support Professionals] are similar to those confronting workers in related health and human services occupations. We need to forge an alliance with other stakeholders, including representatives of the long-term care field and organized labor, in the effort to provide a living wage, offer decent health benefits, and expand access to higher education. All these elements must be in play to achieve a stable, well-educated professional frontline workforce (2007/8, 14).

To make sure that a career pathway system successfully improves conditions and opportunities for immigrant women in-home care workers—whether home health or personal aides—a method also is needed to ensure that employers actually reward with better wages and benefits those workers who satisfactorily continue to train and certify (Ebenstein 2007/8).¹⁴ Although it might not yet have in place a method of making sure employers acknowledge certification levels with appropriate pay and benefits, the DSP system with its code of ethics and nationally standardized tiered career pathway is a potential model for other direct care worker training programs and policies. At the same time, the DSP system is the result of extensive public and private partnerships, which is an approach noted by many evaluators and scholars as being essential to all successful career programs (Bray, Painter, and Rosin 2011).

Components of Career Pathway Programs from Non U.S.-Based Training & Career Development for In-Home Care Work

Any increased learning is of benefit for multiple reasons, not the least of which is that higher levels of preparation and certification can and should lead to higher wages and other improvements for the in-home care worker. “Access to higher education is the only true way to professionalize the workforce and gain a measure of economic security for dedicated, competent staff” (Ebenstein 2007/8, 14). Whether that education is obtained in standard form through a conventional four-year institution or through a mix of community colleges and on-the-job instruction, affordable access to it is part of improving conditions for in-home direct care workers and their clients.

The United States can learn from direct care training policies implemented in other countries in order to develop better domestic career pathway opportunities and regulations for in-home care workers. England uses the Qualifications and Credit Framework to provide different levels of certifiable training; if the United States could have universally-recognized certifications that demonstrate the level of training a care worker has received then perhaps in-home care work would be more regulated and perhaps less exploitable (Appelbaum and Leana 2011). Even more specific to in-home care work careers, Japanese law requires different amounts and types of training for in-home or community-based care than for institutional care workers (Yamada and Sekiya 2003).

14 The Direct Support Professionals Fairness and Security Act of 2007 (H.R. 1279) was proposed in order to legislate equitable wages between private and public agencies for workers providing care to those with disabilities within institutions; the bill was not enacted.

Training programs integrated throughout other nations may also give the U.S. government or organizations ideas for integrated or accessible training. Local home tutoring in direct care work is available in Italy, although there are no certification requirements to focus or standardize this training (Colombo et al. 2011). The Satellite Technology Training Project, implemented in Australia uses satellite television to broadcast training lessons into 100 small aged-care homes. Although the training so far has focused on “risk management approach,” such as food, fire, and manual handling safety, with the structure for satellite training in place, the programming in other subject areas might be added for workers in rural areas or those who lack transportation or childcare (Booth, Roy, and Jenkins 2005).

Paying for Care Worker Training & Career Opportunities

One concern with adding training and education requirements and options for domestic care work occupations is that most immigrant in-home direct care workers currently receive relatively low wages (Baughman and Smith 2008; Solis 2011) and live in extremely low-income households while being restricted from transitioning jobs and ineligible for subsidized supports including training and education (Andersen 2009). If the costs and restrictions for training remain too high to cover them, immigrant women may continue to go without formal preparation in health care in order to take, temporarily, any job at all.

The other side of the problem is that, if wages rise as they should along with training and educational levels, and long-term in-home (as opposed to either short-term or institutional) care continues to have limited coverage by Medicare or Medicaid, then families and agencies will keep hiring untrained workers, or workers only for short periods of time, potentially jeopardizing the health and safety of the clients in need of help (PHI 2004).

The Foundation for California Community Colleges offers two health care education programs—the Nursing Resource Center and the Nursing Educational Investment Fund—that work to increase access to institutions that train health care professionals in California.

The Nursing Resource Center is a collection of web-based services that connects students, schools of nursing, clinical agencies, and hospitals to make placements easier and expose new opportunities in nursing. The Nursing Educational Investment Fund is a \$15 million investment fund that the Foundation uses to issue grants to projects that support community college nursing education programs. Currently, these programs do not include direct care workers or funding for ESL, child care, and other supports for low-income immigrant working women (Foundation for California Community Colleges 2012).

Proposals have been put forward as part of health care reform in the United States to improve the long-term in-home care subsidies covered through Medicaid and Medicare, and perhaps future proposals will include support for training and other related costs. To improve conditions for the workers along with the quality of their labor, opportunities for training and education should be increased but also subsidized (whether through employer options or other methods). At the same time, eligibility for subsidized training and adult education as well as career ladder mobility needs to be part of an immigration reform for those providing direct in-home care in the United States.

Personal care workers who do not want a health care emphasis in their skill development might receive on-the-job training from clients or agencies and use performance measures other than health-related certification as the basis for wage increases. This type of training could also be subsidized; various models of provision and payment for at least partially publicly-supported training exist across the United States although more funding and continued evaluations for these programs seem needed (King 2004; Lerman, McKernan, and Riegg 2004).

V. Conclusion

A focus on the independence, health, and safety of aging, chronically ill, and disabled populations across the nation has been expanded to a concern for the job and career quality of all those who provide assistance (Institute of Medicine 2008). By addressing the need for improved job quality for immigrant women in-home care workers today we can contribute to the better quality of life of all in the future (Henrici, Pasha, and Khurana 2012; Michel 2011).

Despite difficult working conditions and hazards, those employed in direct care tend to find their jobs important and enjoyable (Arteaga et al. 2002; Clare 2005; Martin and King 2008; Moskos and Martin 2005). In order to build on this satisfaction while being able to improve their circumstances and support their families, immigrant women in-home aides need access to affordable or subsidized training and education should they choose to pursue those.

Such programs will succeed only if they include flexible, “stackable” curricula involving fully-developed partnerships among all of the institutions and agencies that can help provide the training and education along with wraparound supports and services such as childcare and transportation. Also critical are the foundational components that many foreign-born women direct care workers require, including ESL and basic education such as in math. In addition, systems need to be in place to ensure that salaries and benefits will rise along with the in-home care worker’s qualifications.

For those women who choose career pathway programs, these also must include steps toward higher levels of preparation that can help provide the chance to move to new positions of greater responsibility and even better income. At the same time, non-medicalized pathways and training subsidies are needed.

A concern for keeping health care and other costs affordable needs to be balanced with the need to ensure high quality care and good labor conditions for immigrant women workers. By improving standards for in-home care jobs, increasing affordable training opportunities, and establishing clear trajectories of upward job mobility for in-home care providers who are foreign-born, the care sector can play a strong role in creating sustainable employment for particularly vulnerable workers and addressing the growing need for professional and reliable in-home care.

“A concern for keeping health care and other costs affordable needs to be balanced with the need to ensure high quality care and good labor conditions for immigrant women workers.”

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