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Direct Care Workforce: The Shift towards Nonmedical Services

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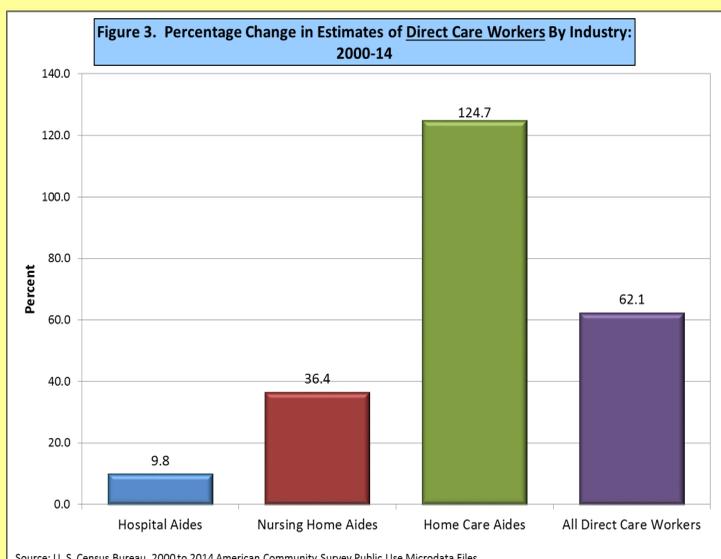
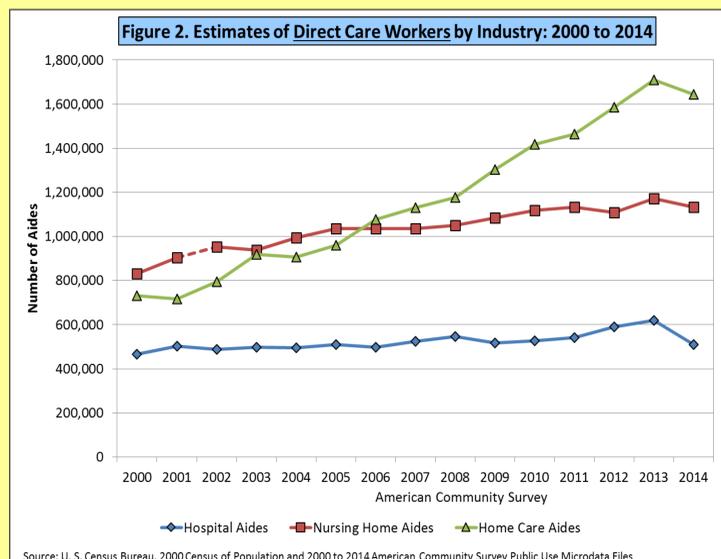
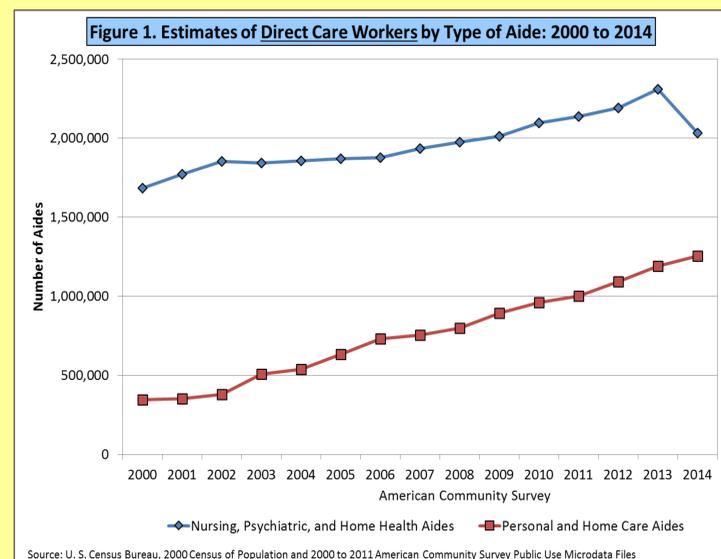
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ABSTRACT Purpose: A shift in the direct care workforce from aides trained to provide medical services to those trained only to provide nonmedical services impacts both providers and consumers of long-term care. Between 2013 and 2014, data from the U.S. Census Bureau show that the number of nursing, psychiatric, and home health aides (who provide medical services) has declined while the number of personal and home care aides (who provide nonmedical services) has increased. This study explores the potential reasons for these trends by comparing these two groups of aides, using data from the 2013 and 2014 American Community Survey (ACS). **Design and Methods:** Data were taken from the 1% Public Use Microdata Sample (PUMS) from the 2014 ACS. Logistic regression was used to compare demographic and employment characteristics of nursing, psychiatric, and home health aides versus personal and home care aides. **Results:** Compared to personal and home care aides, nursing, psychiatric, and home health aides are more likely to be under age 25, female, African American, year-long full-time employees, to have recently married, to be foreign-born, to have moved within the last year, and to have health insurance through their employer. These aides are also less likely to be over age 65, other race, widowed, a non-U.S. citizen, non-English speaking, in poverty, to be Medicare-eligible, to directly pay for health insurance, and to have a disability. **Implications:** These changing characteristics of the direct care workforce are particularly relevant to staffing concerns, given population aging as well as industry trends.



This is an important finding, in part because, as Figures 2 and 3 demonstrate, the growth since 2000 in the direct care workforce has been greater in home care than in any other long-term care industry (i.e. hospitals, nursing homes).

Focusing on the differences between aides who provide medical services (nursing, psychiatric, and home health aides) versus aides who provide non-medical services (personal and home care aides), we find the following trends:

- **Age**—Medical aides are more likely to be under age 25 (and recently married), and are less likely to be over age 65 (or widowed). Medical aides overall are a younger workforce, and these positions can be more accurately described as *entry level* (while non-medical aides can be described as both *entry level* and *exit level* positions).
- **Gender**—Medical aides are more likely to be female; the gendered nature of the direct care workforce is particularly strong in the segment that recruits more highly trained and skilled workers. This may suggest that females are more likely to be recruited to positions perceived as providing entry into nursing or other health-related careers.
- **Race/Ethnicity**—Medical aides are more likely to be African American, less likely to be “other race”, and Hispanic has no statistically significant effect. Medical aides are less likely to be foreign born and non-English speaking. Barriers to employment as medical aides, for immigrant workers in particular, are in evidence.
- **Work**—Medical aides are more likely to be year-long, full time employees and to have health insurance through their employer (and are less likely to directly pay for health insurance). This is in contrast to nonmedical aides, who are more likely to be described as a *casual* workforce (and are also more vulnerable to poverty).

	Sig.	Exp(B)
Under 25 = 1	.000	1.544
65 or older = 1	.069	.857
Female = 1	.000	1.473
Latino = 1	.138	.934
African American/Black = 1	.000	1.731
Other race = 1	.000	.782
Widowed = 1	.005	.838
Divorced = 1	.687	.986
Never married = 1	.325	1.034
Non-citizen = 1	.000	.826
Non-English speaking = 1	.000	.810
Year-round/Full-time = 1	.000	1.382
Education (Ordinal)	.010	.963
Recent divorce = 1	.117	1.182
Recent married = 1	.022	1.225
Recent widowed = 1	.378	1.154
Foreign born = 1	.000	1.203
Move in last year = 1	.048	1.071
Below poverty = 1	.000	.830
Insurance from employer = 1	.000	1.621
Insurance from Medicare = 1	.000	.721
Insurance purchased directly = 1	.023	.914
Insurance from Medicaid = 1	.090	.944
With a disability = 1	.000	.865
Constant	.000	.805

INTRODUCTION

The goal of our study is to track the recent shift in the direct care workforce from medical to nonmedical services by generating profiles of workers in several settings (i.e., hospitals, nursing homes, home health agencies, home care agencies). We prepared the profiles using data from the Public Use Microdata Sample (PUMS) of the 2014 American Community Survey (ACS) and compared them using profiles similar to those presented by Montgomery, et al. (2005). This detailed information about the direct care workforce and the conditions of employment serves several purposes. First, it allows local planners and policy makers to anticipate worker needs. Second, detailed information about characteristics of existing workers is useful in targeting potential workers for future recruitment efforts. Third, knowledge about job characteristics (e.g., types of employers and differential pay scales) provides useful information in developing strategies for attracting, training, and retaining workers in specific industries that employ direct care workers.

DEFINING THE WORKFORCE

In this study we use the definition of the direct care workforce that was developed by Montgomery and her colleagues (Montgomery, Holley, Deichert, & Kosloski, 2005). They used criteria for identifying the direct care workforce that included a combination of industries and occupations. It is necessary to consider industries and occupations simultaneously because some industries include occupations that we do not consider to be part of the direct care workforce such as cooks who work in nursing care facilities. Similarly, there are occupations that may work in an industry that does not provide direct care services.

RESULTS AND DISCUSSION

There are two occupation codes used by the Census Bureau for health care support occupations that we include in this analysis: (1) personal and home care aides and (2) nursing, psychiatric, and home health aides. We do not include other health care support occupations in this definition of the direct care workforce because they either provided more temporary services or required more specialized training.

The industries that we use in our identification of the direct care workforce include: hospitals; nursing care facilities; residential care facilities, without nursing; outpatient care centers; home health care services; individual and family services; and private households. A significant difference in our sample from many other measures of the direct care workforce is the inclusion of private households and self-employed workers.

Other data sources have been characterized by various deficiencies. These include the use of overly broad occupational classifications of workers and relatively small sample sizes (e.g., the Current Population Survey), a lack of detailed demographic information (e.g., BLS Occupational Employment statistics), or an infrequency that does not permit the tracking of meaningful changes (e.g., the decennial Census).

Figure 1 illustrates the recent shift towards nonmedical services in home health care services. Although nursing, psychiatric, and home health aides (who provide medical services) continue to outnumber personal and home care aides (who provide nonmedical services), the gap between these two categories of aides narrowed considerably from 2013 to 2014.

REFERENCES

- Kelly, C.M., Morgan, J.C., & Jason, K. (2013). Home care workers: Interstate differences in training requirements and their implications for quality. *Journal of Applied Social Gerontology*, 32 (7): 804-832.
- Montgomery, R.J.V, Holley, L., Deichert, J., & Kosloski, K. (2005). A profile of home care workers from the 2000 Census: How it changes what we know. *The Gerontologist*, 45 (5): 593-600.