1-1-2016

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Direct Care Workforce: The Shift towards Nonmedical Services

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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, 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.

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). The census data for identifying the direct care workforce that included a combination of industries and occupations. It is necessary to consider industries and occupations that are also more vulnerable to poverty.

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; home care centers; 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 (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.

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REFERENCES


RESULTS AND DISCUSSION

Figure 1 illustrates the recent shift towards nonmedical services in home care health 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.