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## Career Ladders in Health Care Support Occupations

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### Introduction

Traditionally, economic development experts and policymakers have advocated for public investment in the development and expansion of export-oriented sectors, such as manufacturing. However, research shows that there is a growing importance of “aggregate job growth in local-serving activities and the potential for certain local-serving sectors to serve as job generators and diversifiers of regional economies” (Markusen and Schrock 2009, 27)<sup>i</sup>. The health care sector is a combination of local-serving and export-oriented goods and services.

While the health care industry provides services to local residents, it also exports goods and services due to technological advancements and specialization. The Mayo Clinic in Rochester, Minnesota is a prime example of a health care institution that is local-serving and export-oriented: it provides medical services locally and attracts patients from outside the region.<sup>ii</sup> The institution’s specialization in treating difficult medical conditions and its vast research efforts contribute to the export of knowledge and innovation in developing new and improved diagnostic tools, medications, devices, and treatment protocols.<sup>iii</sup>

Other economic benefits of the health care sector are the indirect and induced impacts that spill across various industries. These include employment in retail, finance and insurance, real estate and rental, administrative and waste management, and manufacturing, among others.<sup>iv</sup> The health care industry as a whole has been growing over the past decade and is likely to be a driver of economic activity as our population grows, ages, and as medical advances extend our productive lives.<sup>v</sup> Moreover, the passage of the Affordable Care Act (ACA) will contribute to the rise in demand for health care services.

### The Problem

Practitioner and technical services occupations, which include physicians, registered nurses, physician assistants, dieticians, to list a few, are generally

<sup>i</sup> Markusen and Schrock 2009.

<sup>ii</sup> *Ibid.* and Fitzgerald, 2002.

<sup>iii</sup> <http://www.mayo.edu/research/about/overview>

<sup>iv</sup> Cooper et al. 2012, 16.

<sup>v</sup> *Ibid.*, p 3.

The UCLA Institute for Research on Labor and Employment supports faculty and graduate student research on employment and labor topics in a variety of academic disciplines.

The Institute also sponsors colloquia, conferences and other public programming, is home to the undergraduate minor in Labor and Workplace Studies at UCLA, and carries out educational outreach on workplace issues to constituencies outside the university.

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high-wage jobs, with an average annual wage of \$86,990 in California (2010 estimates).<sup>vi</sup> On the other hand, health care support jobs are commonly low paying with an average wage of \$30,600 (2010 estimates).<sup>vii</sup> Occupations in this subsector include home health aides, nursing assistants, pharmacy aides, and medical transcriptionists, among others<sup>viii</sup> (see tables 1 and 2 for a complete list of health care support occupations).

**A key problem is the fragmentation between the practitioner and technical services and health care support occupations. There is an absence of career ladders that help people in low-wage health care support occupations move into higher wage health care support jobs and further up into practitioner and technical services positions.** Developing career ladders is an important area for policy makers to focus on, as health care support jobs have high turnover due to arduous working conditions, little pay and the lack of opportunity to ascend. Workers in this subsector move from one job to the next, without acquiring new significant skills.<sup>ix</sup> This is particularly prevalent in long-term care. High turnover is a contributing factor in the degradation of the quality of services to vulnerable groups of people—the elderly, disabled and those with long-term chronic illness. This area of care, which is highly dependent on nursing assistants and home health aides, should be given particular attention as there will be a mounting demand for long-term care services by baby boomers, those born between the years of 1946 and 1964.

There are two key areas that need to be addressed. First, it is important to improve the conditions of work for low wage health care support workers in order to encourage people to consider these occupations as career options. Furthermore, improving working conditions will result in lower turnover rates and thus improve the quality of care. Secondly, these jobs should be viewed as stepping-stones to better jobs through the creation of career ladders. As the demand for health care services will rise with the implementation of the ACA, there will be a need for workers to fill positions across the health care industry—practitioner/technical and support occupations. Hence, creating career ladders will be critical to filling the demand for services, ensuring that people are gainfully employed, and there is a well trained, experienced and well-paid workforce.

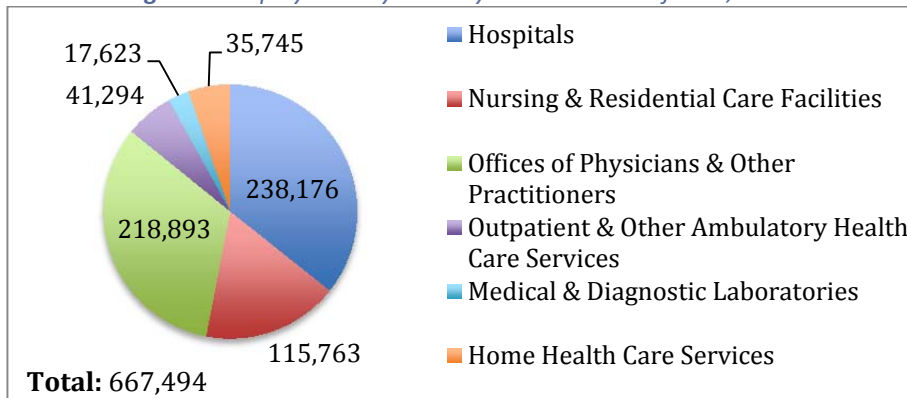
This memorandum is addressed to the Office of Mayor Garcetti, the Los Angeles City and Los Angeles County Workforce Investment Boards (WIBs), and the Los Angeles Economic and Workforce Development Department (EWDD). These offices play an important role on issues of workforce and economic development and can spearhead the effort to support and improve the jobs at the bottom of the rung of a growing and health care industry in our region. In what follows, we first provide the sectoral and occupational context. Next we describe potential strategies and conclude with three key recommendations that should be considered for implementation.

## **Sectoral and Occupational Context**

### *Employment in Southern California*

In 2010, the health care industry provided over **667,494 jobs** in Los Angeles, Orange, Riverside, San Bernardino, Ventura and Santa Barbara Counties combined.<sup>x</sup> Hospitals employed the highest number of people with employment in home health care services being the lowest. Figure 1 provides a breakdown of employment by industry. It shows that nursing and residential care facilities and home health care services combined, employed 151,508 people. This is 22.7 percent of the overall jobs in the region's health care sector.

**Figure 1. Employment by industry in Southern California, 2010<sup>xi</sup>**



If broken down by occupation, a significant portion of the overall jobs in Southern California’s health care sector is support occupations (see table 1). Nursing, medical, dental assistants and home health aides are the top four occupations comprising 76.9 percent of health care support jobs. Nursing assistants and home health aides make up 41.8 percent of health care support jobs.

**Table 1. Health care support jobs in Southern California, May 2013 estimates<sup>xii</sup>**

Occupations	Employment
Home Health Aides (3)	21,860
Psychiatric Aides	1,280
Nursing Assistants (1)	55,960
Orderlies	2,280
Occupational Therapy Assistants	1,170
Occupational Therapy Aides	370
Physical Therapist Assistants	2,910
Physical Therapist Aides	3,420
Massage Therapists	4,540
Dental Assistants (4)	19,810
Medical Assistants (2)	45,380
Medical Equipment Preparers	3,010
Medical Transcriptionists	1,940
Pharmacy Aides	4,110
Veterinary Assistants and Laboratory Animal Caretakers	4,860
Phlebotomists	6,590
Healthcare Support Workers, All Other	6,510
<b>TOTAL</b>	<b>186,000</b>

*Employment in Los Angeles and surrounding areas*

As of May 2013, in nonmetropolitan and metropolitan areas of Los Angeles, Long Beach and Glendale, there were over 95,000 people employed in health care support occupations. Within this geographic region, once again, nursing, medical, dental assistants and home health aides comprised the majority of

the subsector at 79 percent. Home health aides and nursing assistants make up 43.2 percent of the overall health care support jobs.

The median hourly wage ranged from \$11.82 to \$17.31, with home health aides being paid the least, followed by nursing assistants (see table 2). For a family of four, all of these occupations pay above the 2014 federal poverty line of \$23,850.<sup>xiii</sup> Hence, if there is only one earner for a family of four, who is employed as a home health aide, that family is not be eligible for public assistance programs. And if that individual did fall below the federal poverty line, s/he would qualify for public assistance while working full-time.

**Table 2. Health care support jobs in metropolitan and nonmetropolitan Los Angeles, Long Beach, Glendale, May 2013<sup>xiv</sup>**

Occupations	Employment	Median hourly wage	Annual mean wage
Home Health Aides (4)	10,170	\$11.82	\$28,570
Psychiatric Aides	740	\$13.02	\$27,640
Nursing Assistants (1)	31,030	\$13.14	\$28,510
Orderlies	1,340	\$14.16	\$31,890
Occupational Therapy Assistants	310	\$32.73	\$67,100
Occupational Therapy Aides	220	\$14.48	\$35,760
Physical Therapist Assistants	1,020	\$29.60	\$59,400
Physical Therapist Aides	1,360	\$12.83	\$28,040
Massage Therapists	2,130	\$14.76	\$36,270
Dental Assistants (3)	10,510	\$17.31	\$36,880
Medical Assistants (2)	23,650	\$14.97	\$32,210
Medical Equipment Preparers	1,320	\$18.32	\$39,370
Medical Transcriptionists	1,130	\$24.32	\$49,880
Pharmacy Aides	2,130	\$10.71	\$26,040
Veterinary Assistants and Laboratory Animal Caretakers	2,120	\$13.20	\$28,960
Phlebotomists	3,380	\$17.59	\$37,060
Healthcare Support Workers, All Other	2,820	\$18.40	\$38,840
<b>TOTAL</b>	<b>95,380</b>	<b>\$15.38</b>	<b>\$32,000</b>

### Projected growth

Within health care support jobs, California's Employment Development Department (EDD) projects that home health aide positions will increase by 49.4 percent between 2010 and 2020 in Los Angeles County.<sup>xv</sup> A report by the University of California, Berkeley, specifically highlights the growing importance of long-term care (LTC) jobs as our population ages (see box 1). It is projected that California's elderly population will expand approximately 44 percent by 2023.<sup>xvi</sup> In Los Angeles County, the number of those 65 years and older will increase by 38 percent over the next decade, while those 85 and older will rise by 25 percent.<sup>xvii</sup> The County of Los Angeles Community and Senior Services and the City of Los Angeles Department of Aging have projected that the number of county residents over age 60 will double over the next 20 years, going from a current estimate of 1.5 million to almost 3 million.<sup>xviii</sup>

**Box 1. What is long-term care?<sup>xix</sup>**

Long-term care (LTC) is support for individuals with chronic illnesses or disabilities. It is the help that people need when physical or mental illness impairs their capacity to perform typical tasks of everyday life (e.g., bathing, transferring, eating). Long-term care can be provided at home, in the community, in assisted living or in a nursing home.

In 2010, slightly less than half (43 percent) of public funding for LTC in California was spent on institutional care, most (82 percent) of which was provided in a nursing home, although institutional care was also provided in intermediate care and mental health facilities. Non-institutional care includes a variety of different types of services but typically includes care provided within one's home or in the community.

*Source: Falconi and Dow 2013, 2.*

*Characteristics of health care support jobs*

We focus on the lowest paying jobs in the subsector: nursing assistants and home health aides. These occupations comprise a large part of the long-term care industry. Nursing assistants work in nursing homes, assisted living, hospices, hospitals, community based long-term care, correctional institutions, and other long-term care settings.<sup>xx</sup> They work as part of a healthcare team under the supervision of licensed practical or licensed vocational nurses and registered nurses.<sup>xxi</sup> Nursing assistants must complete a state-approved education program and must pass their state's competency exam to become certified.<sup>xxii</sup>

Home health aides mostly work in a client's home and others work in small group homes or larger care communities. According to the U.S. Bureau of Labor Statistics Occupational Outlook Handbook, some home health aides go to the same home every day or week for months or even years. Some visit four or five clients in the same day, while others work only with one client all day. This may involve working with other aides in shifts so that the client always has an aide. They help people in hospices and day services programs, and also help people with disabilities go to work and stay engaged in their communities. There are no formal education requirements for home health aides, but most aides have a high school diploma.<sup>xxiii</sup>

Because they frequently lift people and do other physically demanding tasks, on-the-job injuries are more common for nursing assistants and home health aides than for most other occupations.<sup>xxiv</sup> The BLS Occupational Outlook Handbook explains that these workers must guard against back injury because they often move clients into and out of bed, or help them to stand or walk. In addition, home health aides frequently work with clients who have cognitive impairments or mental health issues and who may display difficult or violent behaviors.<sup>xxv</sup> Aides also face hazards from minor infections and exposure to communicable diseases, but can avoid infections by following proper procedures.<sup>xxvi</sup>

Women of color predominantly hold health care support jobs.<sup>xxvii</sup> Nursing, psychiatric and home health aides are the number one ranked jobs for people of color in the health care sector, specifically Black/non-Hispanic (26.2 %), American Indian/Alaska Native (15.4 %), and Hispanic (13.8 %) (see appendix A). As these jobs lack career ladders, people of minority ethnic/racial groups are disproportionately affected in terms of upward mobility in the health care sector.

An analysis of a nursing home setting indicates that the concentration of work is at the bottom rungs of wage and skills.<sup>xxviii</sup> The majority of workers are paraprofessionals and moving up from nursing assistants to licensed practical nurse (LPN) and other jobs is difficult, because the educational requirements for LPNs and regulation limiting certain functions, such as discharging medication or assessing patient conditions.<sup>xxix</sup> Moreover, it is rare that nursing homes hire internally for licensed nursing positions or other professional and technical services occupations.<sup>xxx</sup>

### *Relationship to government*

An important aspect of the industrial context is the role that government plays. The labor market and the industry have a close relationship with the government, in which the government determines two-thirds of the industry's revenue stream, which comes through Medicaid and Medicare-set reimbursements of patients.<sup>xxxi</sup> The government also regulates different aspects of the jobs from physical design and patient diet to certification of direct care workers.<sup>xxxii</sup> This role of government is especially important in California as Governor Jerry Brown cut the total allowable hours of care for In-Home Supportive Services (IHSS) consumers by 8 percent in July 2013.<sup>xxxiii</sup> In the 2014-2015 budget, the 2013 reduction was scaled back to 7 percent effective July 1, 2014, and the budget agreement left this cut in place. Moreover, for the 2014-2015 budget, Governor Brown had proposed restrictions on the number of hours that home health aides can work after the U.S. Department of Labor declared new regulations last year that In-Home Supportive Services (IHSS) workers would be eligible for overtime pay, effective next January. The Governor had initially proposed in his 2014-15 budget that IHSS workers would be legally prohibited from working more than forty hours a week to prevent the federal rule from pushing program costs.<sup>xxxiv</sup> This would have directly affected the workers and consumers. Workers may need to work more than forty hours a week, depending on the consumers' needs but would have not been able to and if they did work beyond the forty hours, they would not have been compensated for the additional time. This is especially important if an individual is providing for a family member in their home on a full-time basis, or around the clock. However, after pressure from labor unions, consumers, workers, and advocacy organizations, the initial proposal was not included in the 2014-2015 state budget. These examples demonstrate the significant role the government plays in shaping this industry.

### **What can be done?—Strategies**

As the population ages, and more people are covered under the ACA, there will be a rise in the demand for health care services. We recommend paying closer attention to filling this demand by developing career ladders to help people move up within health care support occupations and into practitioner and technical services positions. As health care support sector jobs tend to be dead-end low-wage jobs with indecent working conditions, the workers and consumers suffer as a result of low productivity and high turnover rates.

We propose a regional sectoral approach to change the characteristics of the existing health care support jobs and create new well-paying jobs. It is imperative that this sectoral approach be comprehensive and focus on developing career ladders that help people move from the lower rungs of occupational hierarchy into professional and technical positions. The characteristics of this model include (Clark and Dawson 1995, 7 via Wilson 2009, 48):

- (a) Targeting a particular occupation within an industry: health care support jobs that have a projected growth (nursing assistants and home health aides).
- (b) Become a valued actor within the industry;

- (c) Assisting low income people obtain decent employment; and
- (d) Creating systemic change within the specified labor market including increased access for disadvantaged workers, and/or increase demand for high skills

With regards to the regional approach, we encourage the City of Los Angeles to take a lead in bringing together administrations of surrounding municipalities and other stakeholders. Specifically, we recommend a regional alliance comprised of employers, local governments and worker and community-based organizations (CBOs) to develop career ladders within health care support jobs and develop a well-trained, qualified and well-paid workforce capable of meeting the increasing demand for health care services, especially in long-term care throughout Southern California.

As part of this sectoral strategy, intermediaries will play a critical role.<sup>xxxv</sup> The two intermediaries that we propose as key players are community colleges and labor unions. Labor unions, specifically Services Employees International Union-United Long-term Care Workers (SEIU- ULTCW), are particularly significant in Southern California, as they have organized the home health workers for over two decades. Worker representation will allow for a democratic process in which employers and workers can reach agreements for training and working conditions—e.g., decent wages, benefits, reasonable work demands advancement opportunities and respect on the job, all of which have been identified as important factors by workers and workforce development specialists.<sup>xxxvi</sup> CBOs will be important actors in connecting new entrants in the health care sector to occupations with career ladders. For the purposes of this memo, we will focus on community colleges and labor unions, as we seek to address the fragmentation between health care support and professional and technical positions. We further elaborate on these recommendations below.

### *Regional approach*

New York State has taken the regional approach on a wider scale and established Regional Economic Development Councils. These Councils bring together higher education, businesses, community leaders, and key state agencies to identify strategic priorities for economic development. We recommend that this approach be applied among local municipalities in the region of Southern California (see box 2 to learn more about New York’s regional councils).

#### **Box 2. New York State’s Regional Economic Development Councils.**

The New York State Executive Budget (2011-2012) established 10 Regional Economic Development Councils, chaired by Lieutenant Governor Robert Duffy, to create a more regionally based approach to allocating economic development funding and to act as one stop shops for all State-supported economic development and business assistance programs in each region. Strategies to revitalize different parts of the state depend upon numerous factors unique to each region and that the best ideas come from the people who live in those regions.

Governor Cuomo proposed a process that will include and engage local stakeholders in developing and executing sustainable long-term, regional economic development strategies. The councils will be supported with \$130 million in capital, reprogrammed from existing resources.

Each Council is chaired by the Lt. Governor and led by the Regional Director of Empire State Development Corporation (ESDC). The Councils bring together higher education, business, community leaders, and key State agencies (Department of Labor, Department of Environmental Conservation, Department of Transportation, and the State University of New York) to identify



key priorities for economic development (public/private partnership). A “bottom up” approach is used for each region to capitalize on its core strengths and focus on job creation. Strategies are based on the specific industry clusters in each region. The first round of competitive grant awards was announced in December 2011. Performance will be monitored to maintain accountability. Common themes will include regionalization, sector/industry clusters, career development for youth, private/public partnerships, and competition for resources.

With a new city administration, there is a great opportunity to cultivate relationships between the governments of surrounding municipalities. Through collaboration, local municipalities together can develop alliances between health care sector employers, labor unions and community colleges, and other stake holders across the region with the goal to establish career ladders with a uniform structure and training curricula. The long-term scope of the region will have to be identified by the key leaders and stakeholders. But for the purposes of piloting such an approach, we recommend that the region just include Los Angeles County, which in itself is very large, geographically and population-wise. Building an alliance or collaborative that brings together employers (along with other stakeholders) has three key advantages as discussed by Randall Wilson (2009) in his study of career ladders in the long-term care subsector. While Wilson specifically discusses the advantages for developing alliances among employers, these advantages translate into alliances that include other key stakeholders, not just employers.

First, assembling employers in a consortia or an alliance helps businesses reach economies of scale, which is unavailable to individual firms. Second, alliances “of employers offer *economies of scope* by enabling project sponsors to learn about and respond to the shared needs of a number of firms” (Wilson 2009, 57). Lastly, network structures help “cooperating firms identify common problems and create common solutions” (*ibid.*). Through the sharing of information and “creation of dense networks among employers and labor market organizations help the industry become embedded in the community and in the regional economy” (*ibid.*). Moreover, the sharing of resources, e.g. instructors and training curricula, can help employers overcome their reluctance to invest in training their workers.<sup>xxxvii</sup> The Los Angeles City and the Los Angeles County WIBs, which already have key stakeholders as members, can help build a regional alliance focused on the growing health care industry.

#### *Intermediaries: Community colleges and labor unions*

There are some successful examples of community colleges and labor unions playing a critical role in the creation and establishment of career ladder programs. However, these are on a small scale or a firm-by-firm basis. SEIU-ULTCW has helped develop and implement the California Long-term Care Education (CLTCE) Centers, throughout California. While some are located at health care facilities, a majority of them are off-site at community colleges, CLTCE offices and other non-profit organizations. Furthermore, their courses range from G.E.D. preparation to adult English, Spanish and Math, and some career-related courses that are limited to CPR, certified nursing assistant (CNA), and medical billing.<sup>xxxviii</sup> While these courses are needed, they are not sufficient in helping workers gain advanced skills that will help them climb up to higher wage health care support and professional positions. The classes are not offered at the workplace, where workers can easily participate. This is an important factor to consider as one of the key barriers to moving up in positions is for workers to juggle full-time work and going to school.

One notable program is the Cape Cod Hospital career ladder program. This program was established through an agreement with SEIU Local 767 and offers classes to union members in health care support

positions in order to gain the advanced skills and move into better-paying positions. Eighty percent of all job openings at Cape Cod Hospital are promotions from lower positions.<sup>xxxix</sup> Joan Fitzgerald (2000) describes the program as such:

*Working with the joint labor-management committee to develop the courses has helped human-resource staff re-evaluate the precise skill requirements of occupations. Two courses that underpin further training, medical terminology and computer data entry, are taught on site by community college staff. The program is designed to make continuing education as easy as possible. Courses are offered between shifts—meaning that employees can quit one hour early or start one hour later to take a class offered on site. Thus, the hospital and the employee each donate an hour to continuing education. This deal is only available for courses offered on site, which are basic education classes. There is a \$25 fee for courses, which is refunded on completion of the course.*

We propose that the Los Angeles City Administration help bring together employers and SEIU-ULTCW, which represents long-term care workers in nursing homes and home health aides, and community colleges. There are two key community college districts (CCDs), Los Angeles and Long Beach, with a total of eleven community colleges (nine in L.A. and one in Long Beach). We recommend that municipalities work with the CCDs to identify community colleges that can provide on-site and on-campus courses that meet the training needs of the employers and workers. Particular attention should be given to disadvantaged communities, such as South and East Los Angeles, where the corresponding educational institutions are Los Angeles Southwest and East Los Angeles Community Colleges. South Los Angeles is an important area because of the opening of the new MLK-Harbor Hospital and the need for jobs by area residents.

The role of unions in health care support jobs is critical. Paraprofessional positions that are unionized pay more than the average nonunion position. Research shows that “just being unionized, with no career ladders improves averages wages by almost 20 percent” (Fitzgerald 2000). As seen in the Cape Cod Hospital case, unions can help establish career ladder programs as part of their collective bargaining agreements. Allowing a space for workers to have a voice ensures that classes are offered at times when workers can participate and workers can help identify gaps in curricula through their own work experience, thus improving the quality of the curricula and the quality of care.

While it is easy to state that workers should be given a voice in determining their conditions in the workplace and allowed to participate equally in informing and developing career ladder programs, there are limitations. Power relations cannot be ignored as part of these recommendations. Thus, an important point to address is that Los Angeles’s new City Administration must make a good faith effort in ensuring that the voices of workers and businesses are equally considered. This is especially important, as the Workforce Investment Act (WIA) requires that a majority of WIB members be representatives of businesses in the local area and the state (for state level WIBs).<sup>xi</sup> Thus, the proposed recommendations call for a regional sectoral focused collaborative that includes the key stakeholders who are given equal representation. Locally and regionally, municipalities can forego the limitations imposed by the WIA on WIBs. This will take local political will to develop a regional collaborative in which stakeholders are equally represented.

### *How will employers benefit?*

Career ladder programs that are comprehensive and help people move into better paying occupations in the medical field also help employers. The industry has normalized the treatment of health care support

workers as casualized labor. However, research and experience shows that when occupations such as home health aides and nursing assistants are treated as professional occupations with structures that help workers ascend in their careers, there is much less turnover and fewer job vacancies.<sup>xli</sup> Fitzgerald (2000) in her research highlights the experience of Cooperative Home Care Associates (CHCA) in Bronx, NY. They found that through CHCA's job upgrading program, there was much less turnover (18 percent) in comparison to their counterparts. Moreover, there is better quality of care when care workers, who over time become familiar with their client's condition(s) and have a chance to develop a stable client-provider relationship, provide for clients consistently.

Low employee turnover rates and fewer vacancies also result in decreasing monetary costs for employers. For example Karl Pillemer (1996 via Wilson 2009) found that high vacancies and turnover rates create replacement costs of approximately \$4,000 per workers. Wilson notes "these costs include recruitment, selection, training of new staff, payment of overtime, and use of staffing agencies (Heinrich 2001), as well as reduce productivity (Atchley 1996)" (Wilson 2009, 38). The work of staff members who are in stable working conditions is disrupted and morale among workers declines.<sup>xlii</sup>

Career ladder programs also serve as recruitment tools for employers. Because a significant percentage of health care support workers leave early on due to lack of upward career opportunities,<sup>xliii</sup> training programs that improve a worker's career prospects means that there are more people willing to take such difficult work. The notion that they will eventually move up into better paying positions helps people view health care support occupations as stepping stones. Employers have to make a good faith effort to ensure that their employees take advantage of such programs in order to maintain a steady supply of trained labor.

### Synopsis of key recommendations

To conclude, the growth in health care sector provides an opportunity to improve health care support jobs. We propose three key recommendations based on a comprehensive sectoral approach for the Los Angeles City and County Workforce Investment Boards, the Office of Mayor Garcetti and Los Angeles Economic and Workforce Development Department.

- *Regional alliances:* We propose that the new City Administration collaborate with other municipalities to ensure the sustainability of the health care industry, improve access to quality jobs and improve the quality of care, especially in the health care support subsector. In the fall of 2013, Mayor Garcetti shared his proposal to adopt a regional approach to help the city's economy grow.<sup>xliiv</sup> A regional approach, in which all stakeholders have an equal representation and which aims to improve low-wage health care jobs is a concrete recommendation that should be considered for implementation.
- *Community colleges as intermediaries:* Existing community colleges already have the infrastructure, organizational systems and access to a pool of instructors, which is more beneficial than establishing new programs through various non-profit organizations. As municipalities face financial challenges, industry, government and policy experts can utilize the existing resources and educational infrastructure. Los Angeles and its surrounding municipalities have a coordinated network of community colleges organized into districts. We propose that the stakeholders build off of the California Long-term Care Education Centers and provide classes on-site and on-campus. These classes should gear towards helping workers climb up the

career ladder. Employers, workers and the community college instructors should inform the development of uniform curricula.

- *Labor unions as intermediaries*: Labor unions represent workers and are important actors in workforce development. They enable workers to collectively engage in improving their working conditions and wages, in turn contributing to improving production processes/quality of care. SEIU-ULTCW has organized long-term care workers since the 1980s. Union members can play the important role of developing and incorporating career ladder programs as part of their collective bargaining agreements. This ensures that workers are able to access and benefit from these programs, whether on- or off-site. Lastly, having worker representation in the development of career ladder programs can improve the quality of the curricula and training methods, as workers share their experiences of working with clients.

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<sup>vi</sup> *Ibid.*, p 5.

<sup>vii</sup> *Ibid.*

<sup>viii</sup> *Ibid.*

<sup>ix</sup> Wilson 2009.

<sup>x</sup> Cooper et al. 2010, 5.

<sup>xi</sup> *Ibid.*, 3.

<sup>xii</sup> U.S. Bureau of Labor Statistics. Summation of Estimates: Metropolitan and Nonmetropolitan Areas: San Diego-Carlsbad-San Marcos, Riverside-San Bernardino-Ontario, Los Angeles, Long Beach, Santa Ana.

<sup>xiii</sup> Office of The Assistant Secretary for Planning and Evaluation. U.S. Department of Health and Human Services. Accessed June 7, 2014. <http://aspe.hhs.gov/poverty/14poverty.cfm>.

<sup>xiv</sup> U.S. Bureau of Labor Statistics.

<sup>xv</sup> State of California Employment Development Department.

<sup>xvi</sup> Falconi and Dow 2013.

<sup>xvii</sup> Abram 2013.

<sup>xviii</sup> Los Angeles County Housing Resource Center.

<sup>xix</sup> Falconi and Dow 2013.

<sup>xx</sup> [http://explorehealthcareers.org/en/Career/120/Nurses\\_AideNursing\\_Assistant](http://explorehealthcareers.org/en/Career/120/Nurses_AideNursing_Assistant).

<sup>xxi</sup> Occupational Outlook Handbook. <http://www.bls.gov/ooh/healthcare/nursing-assistants.htm#tab-1>.

<sup>xxii</sup> *Ibid.*

<sup>xxiii</sup> Occupational Outlook Handbook. <http://www.bls.gov/ooh/healthcare/home-health-aides.htm>.

<sup>xxiv</sup> *Ibid.* and <http://www.bls.gov/ooh/healthcare/nursing-assistants.htm#tab-1>.

<sup>xxv</sup> Occupational Outlook Handbook. <http://www.bls.gov/ooh/healthcare/home-health-aides.htm>.

<sup>xxvi</sup> *Ibid.* and <http://www.bls.gov/ooh/healthcare/nursing-assistants.htm#tab-1>.

<sup>xxvii</sup> Frogner, and Spetz 2013.

<sup>xxviii</sup> Wilson 2009, 36.

<sup>xxix</sup> *Ibid.*

<sup>xxx</sup> *Ibid.*

<sup>xxxi</sup> Wilson 2009.

<sup>xxxii</sup> Pear 2001 via Wilson 2009.

<sup>xxxiii</sup> California Budget Report 2014.

<sup>xxxiv</sup> Walters 2014.

<sup>xxxv</sup> Moss and Tilly 2001.

<sup>xxxvi</sup> Fitzgerald 2000.

<sup>xxxvii</sup> Parker and Rogers 1999 via Wilson 2009.

<sup>xxxviii</sup> CLTCE. <https://www.cltcec.org/tc/>.

<sup>xxxix</sup> Fitzgerald 2000.

<sup>xl</sup> Workforce Investment Act of 1998, §117.

<sup>xli</sup> "Vacancy rates among caregivers are also high. In the state hosting the project to be examined here, one in ten nurse aide positions was unfilled at the time of the research; other states reported vacancies topping 20 percent

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(Decker et al. 2003; Heinrich 2001; Scanlon 2001). Over three in four states (76%) surveyed reported that direct care worker vacancies were “very serious” or “serious” (Harmuth and Dyson 2005). Three-fourths of nursing homes in Pennsylvania reported staff shortages of nurse aides in 2000 (Leon, Marainen, and Marcotte 2001). Eighty percent of all nursing assistants nationally leave the profession within their first year, typically in the first 90 days (Kauffman 2001). Employment spells at individual long-term care workplaces are short, averaging just under 10 months, with a median spell of five months (Smith and Baughman 2007)” (Wilson 2009, 38).

<sup>xlii</sup> Wilson 2009, 38.

<sup>xliii</sup> “Why do nursing aides leave their jobs with such frequency? The literature cites varying causes and metrics of turnover, but low pay and benefits are central, as is poor conditions of work. The latter include high workloads (due to short-staffing), lack of recognition and respect, and the high physical and emotional demands of the job. In the short-run, the strength of the local economy, and its effects on labor supply and demand in long-term care, is a “strong predictor of turnover rates in nursing homes” and other care settings, such as home health agencies (Banaszak-Holl and Hines, cited in Stone and Wiener 2001:17). And pointedly, for the initiative under review here, “the lack of opportunities for career advancement” was cited as a factor preventing nursing assistants from staying in their jobs longer (Wunderlich and Kohler 2000)” (Wilson 2009, 39).

<sup>xliiv</sup> Wilcox 2013.

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Appendix A, Top 10 most common health care occupations, by Race/Ethnicity, 2011

Occupation	Race/ethnicity													
	All		White, non-Hispanic		Black, non-Hispanic		Hispanic		Asian/Pacific Islander		American Indian/Alaska Native		Other race/	
	Rank	Share	Rank	Share	Rank	Share	Rank	Share	Rank	Share	Rank	Share	Rank	Share
Registered nurses	1	14.1%	1	16.2%	2	9.1%	4	7.0%	1	17.9%	2	8.9%	2	12.0%
Nursing, psychiatric, and home health aides	2	11.8%	2	8.5%	1	26.2%	1	13.8%	3	7.9%	1	15.4%	1	14.6%
Physicians and surgeons	3	4.4%	3	4.6%	9	1.5%	9	2.3%	2	12.4%	10	1.2%	3	5.5%
Information and records clerks	3	4.4%	4	4.3%	6	3.4%	3	7.1%	5	3.0%	4	4.1%	4	4.9%
Medical assistants and other health care support occupations, except dental assistants	4	4.0%	7	3.6%	5	4.2%	2	7.5%	5	3.0%	5	3.5%	5	4.5%
Secretaries and administrative assistants	5	3.5%	5	4.0%	7	2.5%	7	3.3%	10	1.7%	5	3.5%	8	2.8%
Licensed practical and licensed vocational nurses	6	3.3%	8	3.2%	4	5.1%	10	2.2%	9	1.9%	6	3.2%	9	2.7%
Medical and health services managers	7	3.2%	6	3.7%	8	2.3%	9	2.3%	8	2.2%	8	2.2%	7	3.3%
Personal care aides	8	3.0%	10	2.2%	3	5.4%	5	4.2%	5	3.0%	3	7.8%	6	4.2%
Health diagnosing and treating practitioner support technician	9	2.4%	9	2.3%	8	2.3%	8	2.7%	7	2.3%	7	2.3%	11	1.9%
Clinical laboratory technologists and technicians	10	1.7%	2	1.6%	9	1.5%	11	1.4%	6	2.9%	8	2.2%	12	1.8%

Note: Full ranking by race/ethnicity available upon request. Shares are based on all occupation categories within the health industry. Rankings are based on the subset of health care occupation categories. Missing rankings are as follows: Black, non-Hispanic: Rank Diagnostic Related Technologists and Technicians; Hispanic: Rank 6 Dental Assistants; Asian/Pacific Islander: Rank 4 Pharmacists; American Indian/Alaska Native: Rank 7 Dental Assistants (tied), Rank 9 Diagnostic Related Technologists and Technicians; other race/ethnicity: Rank 10: Dental Assistants.

Source: Frogner et al. 2013, 13

