Economic Policy Institute

The state of the residential long-term care industry

A comprehensive look at employment levels, demographics, wages, benefits, and poverty rates of workers in the industry

Report • By Sebastian Martinez Hickey, Marokey Sawo, and Julia Wolfe • July 27, 2022

Economic Policy Institute • Washington, DC

View this report at epi.org/249221

What this report finds: Workers in residential long-term care facilities face low pay and poor working conditions. This report provides data on employment levels, demographics, compensation, poverty rates, and unionization of these workers, among other data. The data show that Black women and immigrant women are especially likely to be working in this essential but underpaid workforce.

Why it matters: Employment levels in the long-term care industry have failed to meet demand, and the shortfall is expected to grow. Yet long-term care workers do not receive adequate pay or supports for their work. Many live in poverty or near poverty. If we are to ensure that those who need care receive quality care, we must be able to attract more workers to this profession and ensure that those workers have the pay, benefits, and supports they need.

What can be done about it: Public funding can ensure higher pay, better staffing levels, and improved working conditions for workers, as well as more access to quality services for residents. In addition, policymakers can pass legislation to raise the minimum wage and strengthen protections for workers seeking to organize a union. States and localities can also establish industry-specific worker standards boards to recommend changes to industry minimum wages and working conditions.

SECTIONS

1. Prior to the COVID-19 pandemic, the residential long-term care industry was growing rapidly, but still failed to meet demand • 5
2. Demographic breakdown of residential long-term care workers • 12
3. Pay and other working conditions of long-term care workers • 16
4. The structural issues that fuel some of the realities in the long-term care industry • 30
5. Unions of long-term care workers improve wages, working conditions, and quality of care • 34
6. Public financing is critical for guaranteeing access to care services • 37
7. Conclusion and policy recommendations • 38

Notes • 40
References • 41

The COVID-19 pandemic has shined a bright light on the challenges facing workers in the residential long-term care (LTC) industry: inadequate staffing, training, personal protective equipment (PPE), pay, and job quality that results in high rates of turnover. Combined with an unchecked profit-seeking business model in many long-term care facilities, this has led to horrific outcomes for residents and staff during the pandemic. As of May 1, 2022, more than 200,000 long-term care facility residents and workers have died from COVID-19 (Chidambaram 2022).

Conditions were even more dire for Black and Latinx communities. Early in the pandemic, the *New York Times* reported that nursing homes with higher shares of Black and Latinx[1] residents were more likely to have experienced

COVID-19 cases (Gebeloff et al. 2020). These disparities persisted even when accounting for factors such as population density and nursing home size. The underlying issues of poor job quality for workers and poor living conditions for residents existed in this industry prior to the pandemic. Nonetheless, the current heightened awareness of the dire conditions in long-term services and support facilities presents an opportunity to spotlight and improve working and living conditions for residential long-term care workers and residents and connect them to front-of-mind public health concerns.

The residential long-term care industry is composed of a wide range of establishments serving different populations with different needs. This includes nursing homes, residential facilities for people with intellectual or development disabilities, facilities for people with mental health or substance abuse illnesses, assisted living facilities for the elderly, and continuing care facilities for the elderly. At the same time, residential long-term care is just one component of our much larger care infrastructure, which often relies on labor that is chronically undervalued and often entirely unpaid.

By the numbers

Among residential long-term care workers:

- **80.9%** are women
- **22.4%** are Black women
- **12.8%** are immigrant women
- **$15.22** is the median hourly pay
- **6.9%** are covered by a union contract

Among all workers:

- **47.4%** are women
- **6.5%** are Black women
- **7.2%** are immigrant women
- **$20.07** is the median hourly pay
- **11.9%** are covered by a union contract

People receive long-term services and support (LTSS) or other care services for a variety of reasons. As people age or experience chronic illness and disability, many need a range of services such as assistance with bathing, dressing, toilet care, shopping, preparing meals, housekeeping, and managing medications. Or people need shorter-term services in the immediate aftermath of an illness, injury, or medical procedure.

These services are delivered in a range of settings, depending not only on people's needs and preferences, but also on what they are able to access and afford. While some can receive services in their homes or communities, others move into residential settings, such as nursing homes or assisted living facilities. Still others may receive care in a combination of the above settings, including from their families, in-home care workers, and the staff at a residential care facility.

Care work can be incredibly taxing, both mentally and physically. In addition to monitoring health, planning care, administering treatments, dressing, shopping, preparing meals, and housekeeping, care workers perform many other tasks that can be physically demanding. LTSS direct care workers are expected to use their own bodies to move patients many times a day—including in and out of bed, to and from the bathroom, and in and out of bathing chairs. As a result of the high physical demands of this work, nursing assistants

(one of the occupations included in the "direct care workers" occupation group) experience significantly higher rates of on-the-job injuries (PHI 2021). Residents may be stressed or uncomfortable when these tasks are being performed, which can be socially and emotionally taxing for both caregivers and care recipients.

For too long, our society has devalued the elderly and people with disabilities as well as the workers who help them lead more enriched and independent lives. As we explain in this report, it is no coincidence that women—particularly women of color and immigrants—perform much of this hands-on care work, both paid and unpaid, in homes and in residential long-term care settings.

Policy that underinvests in services and resources for workers and patients in long-term care settings reflects and reinforces the anti-Blackness, racism, sexism, xenophobia, and ableism that both groups encounter. This results simultaneously in high costs to families for these services, and low wages and job quality for the workers who care, clean, and cook for residents of nursing homes and residential care facilities.

In this report, we first document recent employment trends in the residential long-term care industry, including decades of growth that has still failed to meet demand and pandemic-related disruptions. Next, we profile the workers in this industry, showing the extent to which this industry relies on paying low wages and inadequate benefits to workers with historically limited economic opportunities. We also discuss how underinvestment in care work is the direct result of ableist, racist, xenophobic, and sexist structures and policy choices in the U.S.

Finally, we describe interventions that will ensure long-term care services are accessible, affordable, safe, and enriching for those who need it, in a setting that reflects recipients' preferences, while simultaneously improving wages and working conditions in this industry. In particular, we discuss how to empower residential long-term care workers to unionize to push for improvement.

Key findings:

- Prior to the pandemic, employment in the residential long-term care industry, meaning nursing homes or residential care facilities, was increasing rapidly but failing to meet demand. During the pandemic, this industry experienced sharp job losses and employment is still nearly 400,000 below pre-pandemic levels.
- A large majority of residential long-term care workers (80.9%) are women. This includes a disproportionate employment of Black women (who make up 22.4% of this industry compared with 6.5% of the overall workforce) and immigrant women (12.8%[2] compared with 7.2% of the overall workforce).
- The typical (median) worker in the residential long-term care industry is paid $15.22 per hour, compared with the median worker in the overall workforce who is paid $20.07.
    - Hourly wages and annual incomes are especially low for direct care,[3] food service, and cleaning and maintenance workers.

    - Within the residential long-term care industry, Black, Latinx, and multiracial and Native American workers are paid lower hourly wages than white workers.
- Workers in the residential long-term care industry are less likely than other workers to have access to employer-sponsored retirement plans (24.7% compared with 35.1%) or health insurance (45.4% compared with 50.7%). Benefits access rates are especially low for women and non-U.S. citizens in this industry.
- Workers in this industry are slightly more likely to work multiple jobs than the overall workforce (6.6% compared with 5.1%), especially direct care workers and licensed practical nurses (both 7.2%), as well as Black workers (8.0%) and Asian American and Pacific Islander workers (7.9%).
- Workers in the residential long-term care industry have lower union coverage rates than the overall workforce (6.9% compared with 11.9%). Unionization provides a pathway to better wages and benefits. Research has also shown that unionized facilities have been safer for both workers and residents during COVID.

Definitions of terms used in this report

Residential long-term care industry throughout this report refers to nursing homes and residential care facility industries.[4] While we present data on the residential long-term care industry in aggregate throughout this report, it is not a monolith. The facilities that make up this industry serve different roles and different populations.

- **Nursing homes** are primarily engaged in providing 24-hour skilled nursing services to residents, who may be elderly, disabled, or recovering from a medical procedure.
- **Residential care facilities** refers to a wider range of establishments, including residential facilities for people with intellectual or developmental disabilities, facilities for people with mental health or substance abuse illnesses, assisted living facilities for the elderly, and continuing care facilities for the elderly (which offer a range of services, support, and skilled nursing). While they make up a small share of this industry, other establishments such as orphanages, group homes for the hearing or visually impaired, and halfway group homes for people transitioning out of incarceration are also included in the category of residential care facilities.

People may also receive long-term services and support in other settings, such as private homes and adult day care centers, but those are not the focus of this report.

Long-term services and supports (LTSS) are health and social services provided to individuals who need assistance with daily living activities, such as bathing,

dressing, toilet care, shopping, preparing meals, housekeeping, and managing medications.

Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides." These workers provide individuals with LTSS and many, such as certified nursing assistants (CNAs) or home health aides, undergo extensive training. While direct care workers who work in private homes often also provide services such as preparing meals, cleaning, and doing laundry, in residential long-term care settings these tasks are generally performed by specialized workers in food service and cleaning or other occupations.

Registered nurses (RNs) and **licensed practical nurses (LPNs)** are both licensed nurses who can perform tasks such as distributing oral medications, checking blood sugar levels and vital signs, and assisting with daily living activities. RNs can carry out additional responsibilities, such as performing physical exams, collecting blood samples, administering IV medications, and coordinating treatment (Jividen 2021).

Home- and community-based services (HCBS) are Medicaid-funded LTSS that are delivered in a recipient's home or a community setting, as opposed to a nursing home or other institutional facility. Home-based services are not the focus of this report, but some residential care facilities could be considered community-based for Medicaid purposes if they meet standards for promoting community integration.[5]

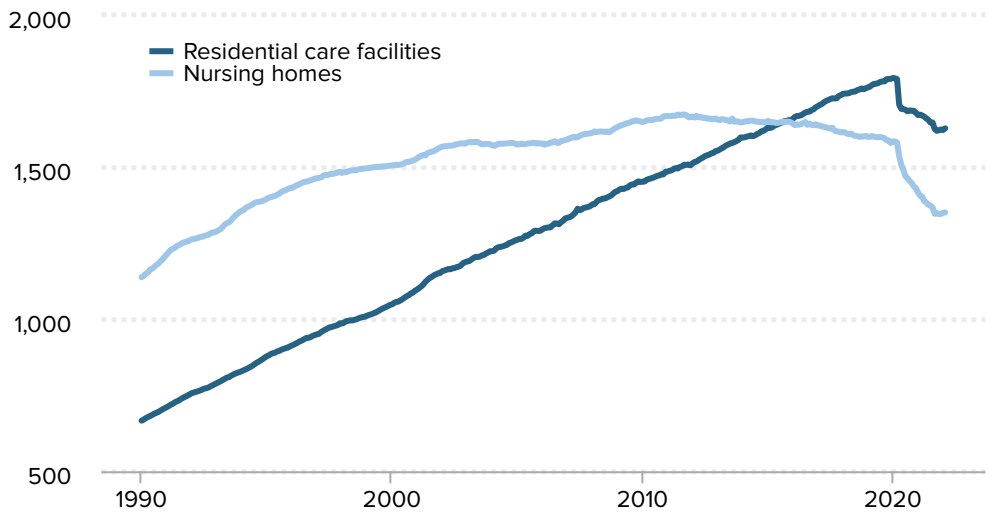
Prior to the COVID-19 pandemic, the residential long-term care industry was growing rapidly, but still failed to meet demand

The residential long-term care industry has experienced rapid growth over the last three decades, reflecting the increased demand for LTSS as the population of older adults has grown and life expectancies have increased for people with disabilities and chronic conditions (Campbell et al. 2021). Since 1990, the share of the adult population that was 65 or older increased from 15.5% to 21.5%.[6] Between January 1990, when the Bureau of Labor Statistics (BLS) first began tracking employment in the long-term care industry, and February 2020, just prior to the onset of the COVID-19 pandemic, private-sector employment in the industry increased by 1.6 million jobs. That 87.1% increase is substantially more dramatic than the 42.4% job growth in the private sector overall.

Figure A

Residential long-term care employment had been growing steadily until 2020, but has yet to recover from the pandemic

Nursing home and residential care facility employment, 1990–2022 (thousands)



Notes: For definitions of nursing homes and residential care facilities, see extended notes.

Source: Bureau of Labor Statistics (BLS) Current Employment Statistics, Establishment Survey (CES) public data series.

Economic Policy Institute

Employment growth has been far larger and steadier in residential care facilities compared with nursing homes, as shown in **Figure A**. Employment in nursing homes peaked in September 2011 at 1.7 million and then slowly declined over the next eight years. Residential care facilities, however, experienced steady job growth from 1990 to 2020 and surpassed nursing home employment in 2015.

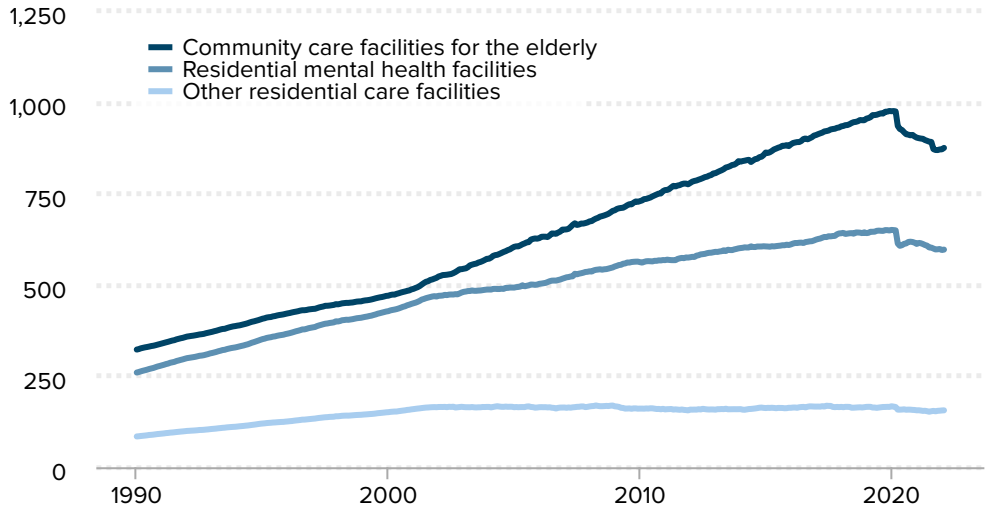
Within the residential care facility industry, the detailed industry "community care facilities for the elderly" accounted for most of the jobs and experienced the fastest growth since the 1990s, which is shown in **Figure B**. This industry includes both assisted living facilities and continuing care retirement communities (such as assisted living facilities that have skilled nursing available on site). The residential mental health facilities industry, which includes residential facilities for people with intellectual or development disabilities and for people with mental health or substance abuse illnesses, also saw steady job growth during this period, while employment in "other residential care facilities" has been flat for the last two decades. Examples of employers in that detailed industry include group homes for the hearing or visually impaired, orphanages, and group homes for people transitioning out of incarceration.

Despite this rapid growth, employment levels in the residential long-term care industry and other sectors that provide LTSS have still failed to meet demand (Stone and Wiener 2001; PCPID 2017; Harrington et al. 2018). By one estimate, without intervention there will be a

Figure B

Growth in community care for the elderly fueled employment increases within the residential care facility industry

Residential care facility employment by detailed industry, 1990–2022 (thousands)



Notes: For definitions of detailed industries, see extended notes.

Source: Bureau of Labor Statistics (BLS) Current Employment Statistics, Establishment Survey (CES) public data series.

Economic Policy Institute

shortage of 51,000 direct care workers across settings by 2030, which will widen to 355,000 by 2040 (a calculation that does not include the other occupations involved in the broader long-term care sector) (Osterman 2017). In addition to younger people who have disabilities or medical conditions that require LTSS, most older adults will also make use of these services at some point. Of adults who turned 65 between 2015 and 2019, an anticipated 52.3% will receive LTSS at some point, with 13.9% receiving LTSS that last for five years or more (Favreault and Dey 2016).

Staffing levels and quality of services are also harmed by high turnover in this industry (Gandhi, Yu, and Gabrowski 2021; Harrington et al. 2018). High turnover at a nursing home or other care site can mean that residents receive care from less experienced workers or are not able to develop a good relationship with their care providers. Lower-quality services can negatively impact residents' health; higher turnover among residential long-term care workers is associated with a higher likelihood of receiving public health citations for infection spread (Loomer et al. 2021). Low wages, inadequate benefits, and challenging working conditions all feed into this crisis of LTSS provision (PCPID 2017).

Ensuring that LTSS are available, affordable, and high-quality has important implications for ensuring racial equity in health care and aging. Disparities in socioeconomic status, exposure to chronic stress, access to preventative care, and quality of health care all

contribute to higher rates of chronic health conditions among Black and Latinx communities (Moore 2019). As a result, older Black and Latinx adults tend to require more acute care. As of 2018, 12% and 11%, respectively, of Latinx and Black adults who are 65 or older required support with activities of daily living, while their white counterparts were half as likely (6%) to have those same needs (Campbell et al. 2021). The needs of older adults of color as well as older immigrants will become even greater as demographic trends shift. Between 2016 and 2060, the U.S. population share of older adults who are people of color is expected to increase from 23% to 45%, while the share who are immigrants will increase from 14% to 23% (PHI 2021).

The COVID-19 pandemic decimated residential long-term care employment

In addition to failing to meet pre-pandemic demand for LTSS, the residential long-term care industry is still facing severe employment declines in the wake of the COVID-19 pandemic. While the initial shocks from the pandemic were felt economywide, the private sector overall has now nearly recovered and is sitting just 0.9% below its pre-pandemic employment level as of February 2022. However, employment in the residential long-term care industry has not recovered as quickly.

Figures A and B illustrate that as of February 2022, nursing homes still face a 14.7% shortfall from their February 2020 employment levels. Residential care facilities have not fared much better, with employment in that detailed industry still down 9.2%. The total residential long-term care job loss of 397,600 since February 2020 accounts for about one-third (34.8%) of the private-sector jobs lost over that period.

Some of the drop-off in nursing home employment is likely related to a decline in the demand for nursing home services. The higher risk of catching COVID-19 in a community setting has led some to choose home care over residential long-term care. As of the fourth quarter of 2020, the occupancy rate in nursing homes was estimated at 75%, an 11-percentage-point drop relative to the first quarter of 2020 (Miller 2021).

Large numbers of workers have left the residential long-term care industry in response to the particularly unsafe and strenuous working conditions they faced during the COVID-19 pandemic. This worsened the staffing shortages in the industry, which harms residents and makes the jobs of the remaining workers much more demanding and stressful than they already were. The crisis has, in some cases, forced employers to pay higher wages to their workers and some unions have been able to secure hazard pay for their workers (Fernandez 2021; Aase Haugen Homes 2020). However, some residential long-term care employers have also expanded their use of nursing staffing firms to patch over shortages (Muoio 2021; Stulick 2021). Workers from staffing firms are a poor substitute for full-time employees since building relationships with residents and on-the-job experience over time is crucial to residents' well-being and quality of life.

State-level residential long-term care employment changes

Figure C shows the 2021 residential long-term care industry employment levels for states for which those data are available, as well as the pre-pandemic employment growth. (To view the interactive map, click here.) Between 1990 and 2019, 15 states saw employment in residential long-term care at least double: Utah (242.4% increase), Arizona (222.5%), Hawaii (152.9%), Alaska (143.8%), Oregon (137.1%), South Carolina (134.6%), Idaho (129.9%), Delaware (126.4%), Virginia (120.6%), Tennessee (115.3%), Maryland (108.2%), North Carolina (107.4%), Alabama (106.4%), Florida (100.8%), and Colorado (100.5%). Figure C also displays the employment shortfalls faced by the residential long-term care industry in 2021 relative to 2019. Of the states with available data, only Alaska's residential long-term care industry has recovered to its pre-pandemic employment level, with Rhode Island (down 16.3%), Mississippi (-15.7%), Alabama (-15.5%), Michigan (-15.1%), North Carolina (-14.3%), and Delaware (-14.2%) faring the worst.

Supplemental data on state-level employment in this industry between 1990 and 2021 are available in this workbook.

The residential long-term care industry relies on the contributions of nurses, direct care workers, cleaners, and food service workers

So far, we have been discussing the number of *jobs* in the private-sector residential long-term care industry. We now shift to describing the *workers* who are employed in the overall residential long-term care industry as their primary job. We focus on their job quality, including breakouts for the primary occupation groups within this industry where possible.[7] We also shift from taking a long view of employment trends to looking at a snapshot of residential long-term care workers.

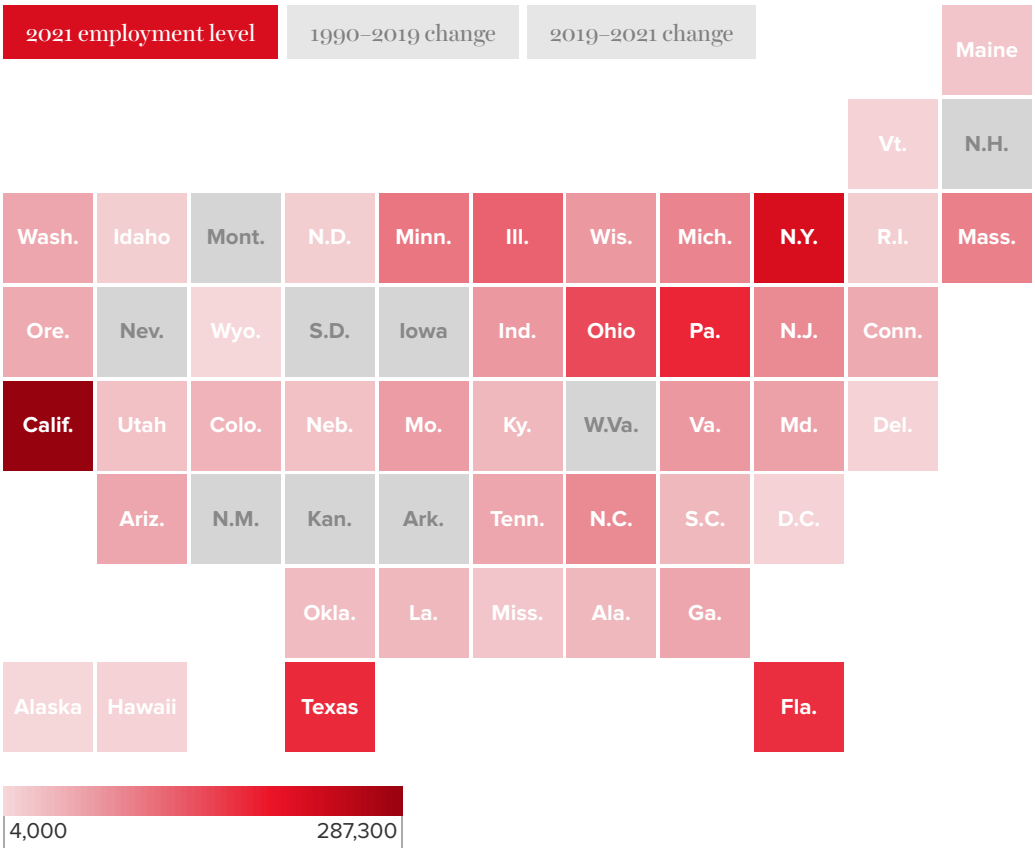
The data presented below predate the COVID-19 pandemic. Using pre-pandemic data allows for an adequate sample for this analysis and captures the state of the "typical" residential long-term care workforce, absent the shock of the pandemic. While we present data on the residential long-term care industry in aggregate throughout this report, this can obscure differences within this broad industry. Where it is both relevant and possible (given limits in both sample size and the level of detail for industry categories), we do present data on nursing homes and residential care facilities separately (although within the latter detailed industry, there are still a range of facilities included).

The overall residential long-term care workforce is made up of a range of nurses, direct care professionals, and staff who provide meals, activities, and other services to residents. However, there are differences in the occupational composition of the workers at nursing homes and residential care facilities, as shown in **Figure D**.

Figure C

In almost every state, residential long-term care employment has not recovered to pre-pandemic levels

Residential long-term care 2021 employment levels and change from 1990–2021 and 2019–2021, by state



Note: Nursing and residential care facilities data not available for some states.

Source: Bureau of Labor Statistics' (BLS) Current Employment Statistics, Establishment Survey (CES) public data series.

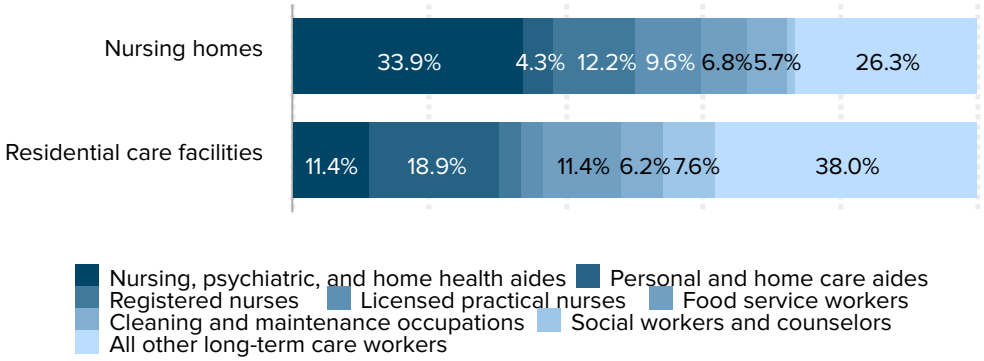
Economic Policy Institute

Because the residents of nursing homes have more acute medical needs, about 1 in 5 workers (21.8%) in this industry are either RNs or LPNs compared with just 6.4% of workers in residential care facilities. The differing care needs of residents in these two detailed industries is also evident in the makeup of the direct care workforce, which is made up of the two occupation groups "nursing, psychiatric, and home health aides" and "personal and home care aides." In nursing homes, a full third of the workforce (33.9%) is in the former occupation group and just 4.3% are in the latter. In the residential care industry, both direct care occupation groups are well represented, but they make up a slightly smaller share of the workforce overall, with nursing, psychiatric, and home health workers accounting for approximately 1 in 10 workers (11.4%) and personal and home care workers making up nearly one-fifth (18.9%) of the industry. Residential care facilities also employ a substantial number of social workers and counselors, unlike nursing homes.

Figure D

Residential long-term care workers provide a range of nursing and long-term services and supports

Share of the residential long-term care workforce in selected occupations



Note: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata.

Source: Authors' analysis of Current Population Survey 2015–2019 microdata.

Economic Policy Institute

Direct service professionals, who work to facilitate independence and community inclusion for people with intellectual and developmental disabilities, do not have their own statistical occupational category. While many of them are within the definition of the direct care worker occupation, some fall under other categories (PCPID 2017). For example, some are primarily concerned with facilitating errands, providing education and enrichment, or connecting people with community resources or employment. These workers help people with intellectual and developmental disabilities connect to their communities in a variety of ways, including through recreational activities, civic engagement, faith, and friendship.

In addition to those workers who provide LTSS directly to individual residents, about 6% of the workers in each of the residential long-term care detailed industries are dedicated to keeping individual living spaces and communal areas clean and well maintained by providing housekeeping and janitorial services, doing laundry, making repairs, and groundskeeping. Food service workers—who account for 11.4% and 6.8%, respectively, of residential care facility and nursing home workers—prepare, cook, serve, deliver, and clean up after meals. In addition to the occupation groups we highlight in our statistics, there are other workers who play an important role in providing support to residential long-term care residents, including through organizing activities and outings, providing physical or occupational therapy, leading fitness classes, and driving residents to errands, doctor's appointments, or group activities.

Demographic breakdown of residential long-term care workers

The gendered nature of the residential long-term care industry

As is true among care workers broadly, workers in the residential long-term care industry are overwhelmingly women. **Figure E** shows the distribution of workers across several occupation and industry breakdowns. Whereas women make up an estimated 47.4% of all workers across the U.S. economy, they account for a remarkable 80.9% of all workers in the residential long-term care industry. Within this industry, women account for 83.9% of nursing home workers and 75.1% of residential care facility workers.

This gender-based concentration is especially acute within some of the most common occupations in the residential long-term care industry. Women are most concentrated as LPNs, RNs, and direct care workers (accounting for 91.0%, 89.4%, and 88.5% of these categories, respectively). Although most men in this industry work as nurses or nursing and personal care assistant workers, they make up larger shares of food service and cleaning and maintenance workers, where they account for about a third of workers (34.3% and 33.7%, respectively).

Racial and gender breakdown of long-term care workers

Figure F shows the racial composition of women in the same set of occupation and industry breakdowns previously discussed. Black and Latinx women are disproportionately present in almost all the categories relative to their shares across the U.S. economy.

The concentration is sharpest for Black women. Whereas they account for 6.5% of the U.S. workforce, Black women make up 22.4% of workers in the residential long-term care industry. Among top occupations in the industry, they are most concentrated among direct care workers, where they make up 32.7% of workers, five times their share in the U.S. economy.

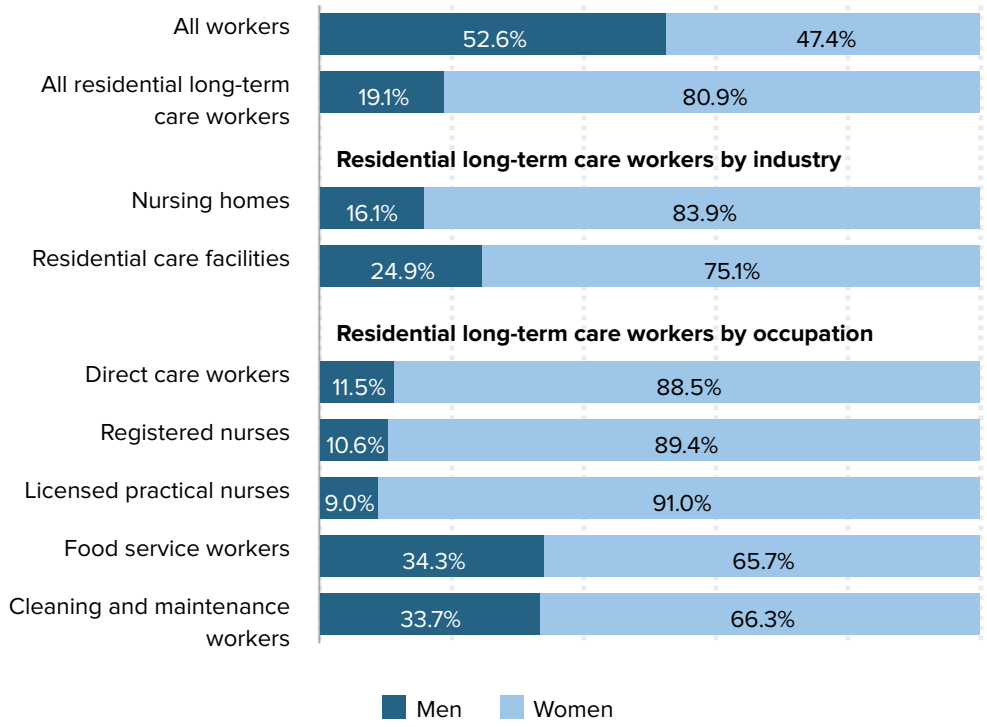
Latinx women are most concentrated among cleaning and maintenance and direct care workers, where they make up 14.6% and 11.5% of workers, respectively, relative to their share of 7.4% in the overall economy. Asian American and Pacific Islander (AAPI) women are most present among RNs, where they account for 6.2% of workers relative to their share of 3.2% in the U.S. economy. Similarly, white women are concentrated in RN and LPN roles.

Although men are underrepresented in the residential long-term care industry relative to

Figure E

The vast majority of residential long-term care workers are women

Gender composition of the residential long-term care workforce, overall and by occupation group, compared with the overall workforce



Notes: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. AAPI stands for Asian American and Pacific Islander. "Residential long-term care workers" refers to workers in nursing homes and residential care facilities. Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides." For definitions of detailed industries, see extended notes.

Source: Authors' analysis of 2015–2019 Current Population Survey microdata.

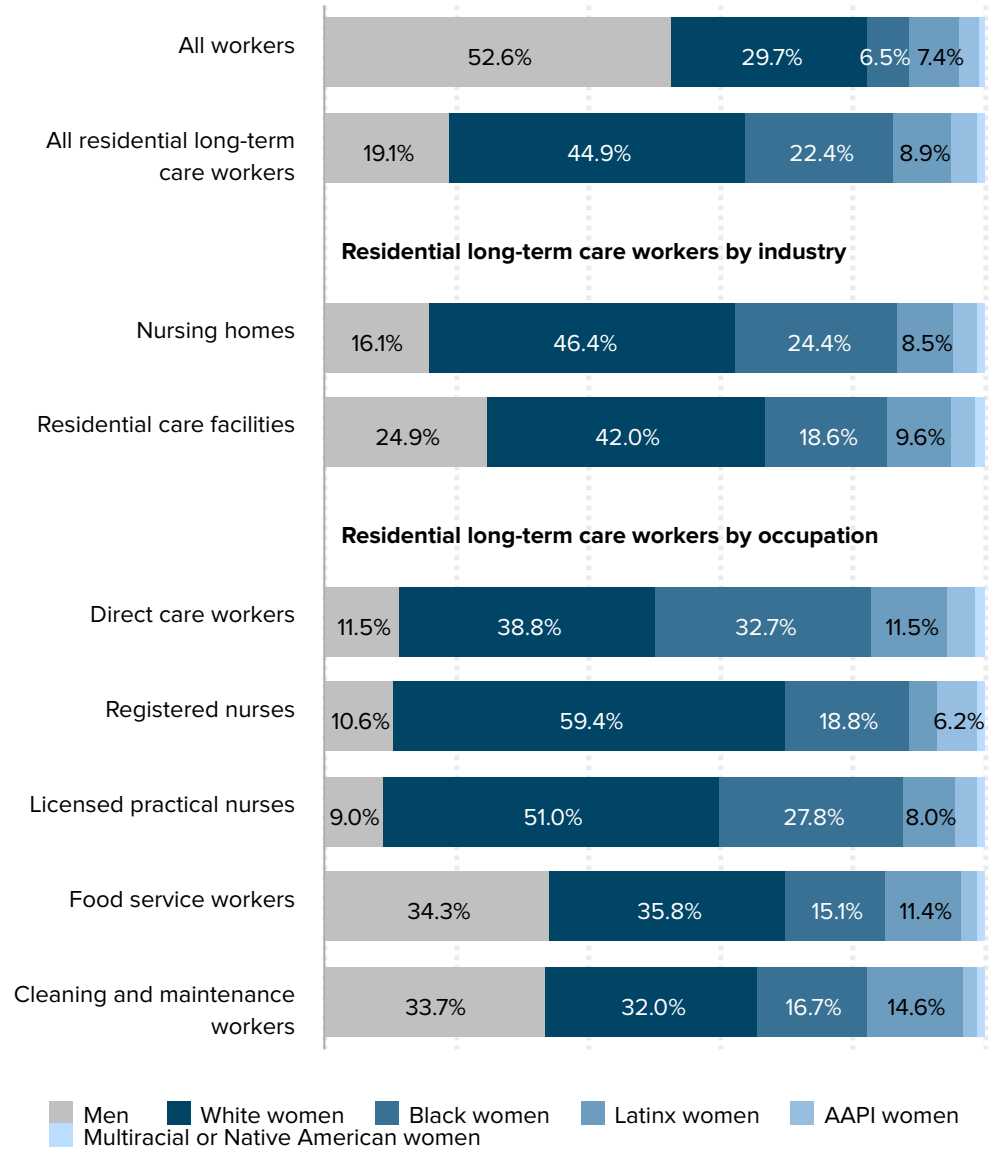
Economic Policy Institute

their overall share in the U.S. economy, there is a racial pattern as to which men work in the industry. **Figure G** shows the share of each race/ethnicity and gender group that work across various occupations in this industry. Most striking is the degree to which Black women and other women are concentrated in the industry relative to men. Whereas 0.6% of white men in the economy work in residential long-term care facilities, this share is almost 11 times as high for Black women: An estimated 6.2% of all Black women in the labor force work in the residential long-term care industry. Among men, Black men are most likely to work in residential long-term care, where they are more than 2.5 times as likely as white men to work in the industry.

Figure F

One-third of the residential long-term care workforce are women of color

Gender and race/ethnicity composition of residential long-term care workforce, overall and by occupation group, compared with the overall workforce



Notes: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. AAPI stands for Asian American and Pacific Islander. "Residential long-term care workers" refers to workers in nursing homes and residential care facilities. Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides." For definitions of detailed industries, see extended notes.

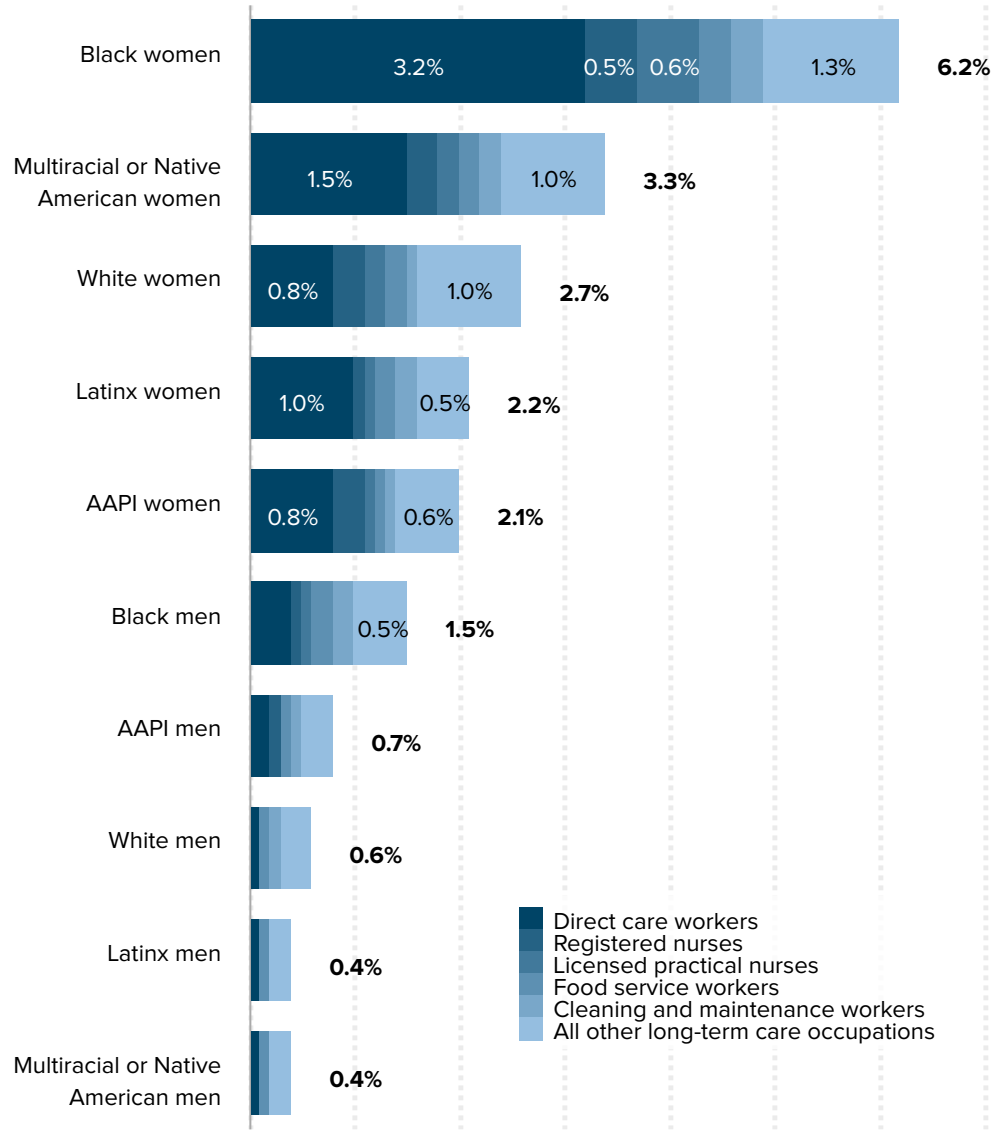
Source: Authors' analysis of 2015–2019 Current Population Survey microdata.

Economic Policy Institute

Figure G

More than 6% of all Black women workers work in residential long-term care

Share of workers in each gender and race/ethnicity group that work in residential long-term care, total and broken down by selected occupations



Notes: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. AAPI stands for Asian American and Pacific Islander. Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides."

Source: Authors' analysis of 2015–2019 Current Population Survey microdata.

Economic Policy Institute

Examining data on immigrants in the long-term care workforce

Immigrant status is another dimension that continues to be an important determinant of who works in residential long-term care. For this discussion, "immigrants" refers to both people who are not U.S. citizens and those who are naturalized U.S. citizens, i.e., people who are currently U.S. citizens but were not U.S. citizens at birth.

Immigrant women, both those who are naturalized U.S. citizens and those who are not U.S. citizens, are overrepresented in the residential long-term care industry relative to their shares in the overall U.S. economy. The opposite is true for immigrant men: Relative to their representation in the overall workforce, men who are naturalized U.S. citizens or noncitizens are actually underrepresented in the residential long-term care industry overall and among the most common occupations within the industry.

Figure H shows the shares of immigrants in the overall residential long-term care industry workforce, in top occupations within the industry, and in the overall U.S. workforce, broken out by gender and citizenship status. Whereas women who are naturalized U.S. citizens account for an estimated 3.9% of the U.S. labor market, they make up nearly twice that share (7.5%) among people who work in residential long-term care. A similar pattern holds for women who are not U.S. citizens, who make up 3.3% of the labor force overall but 5.3% of residential long-term care workers. In the residential long-term care industry, women who are naturalized citizens are most concentrated in direct care occupations, whereas noncitizen women are overrepresented in cleaning and maintenance staff jobs, where they account for over three times their share in the overall workforce.

Supplemental state-level data on the gender, race/ethnicity, and citizenship status of residential long-term care workers is available in this workbook.

Pay and other working conditions of long-term care workers

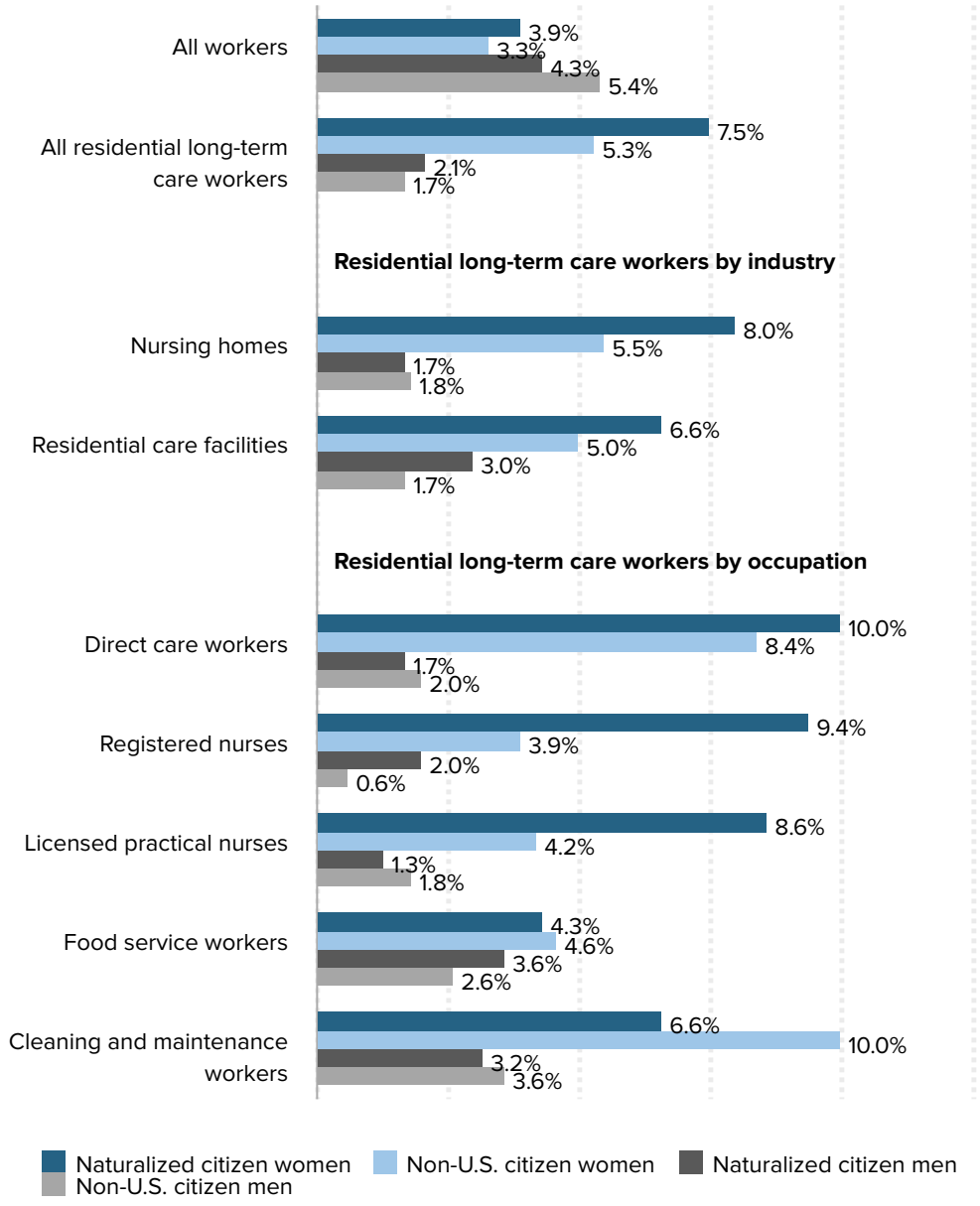
Wages and income

As shown in **Figure I**, the median wage of residential long-term care workers based on 2015–2019 data adjusted into 2021 dollars was $15.22—significantly lower than the median wage of $20.07 among all workers throughout the economy. Figure I also shows the gender-based wage disparities present in the residential long-term care industry. Across the industry, the median hourly wage for men is $16.32, compared with $14.98 for women. This trend persists even in higher-paying residential long-term care roles. Among the industry occupations with the highest employment shares, LPNs and RNs are the highest paid. The median wage for male RNs is estimated as $30.28 per hour, compared

Figure H

The residential long-term care industry disproportionately employs immigrant women

Shares of immigrants in the residential long-term care workforce, in specific occupation groups within that workforce, and in the overall workforce, by gender and citizenship status



Notes: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides."

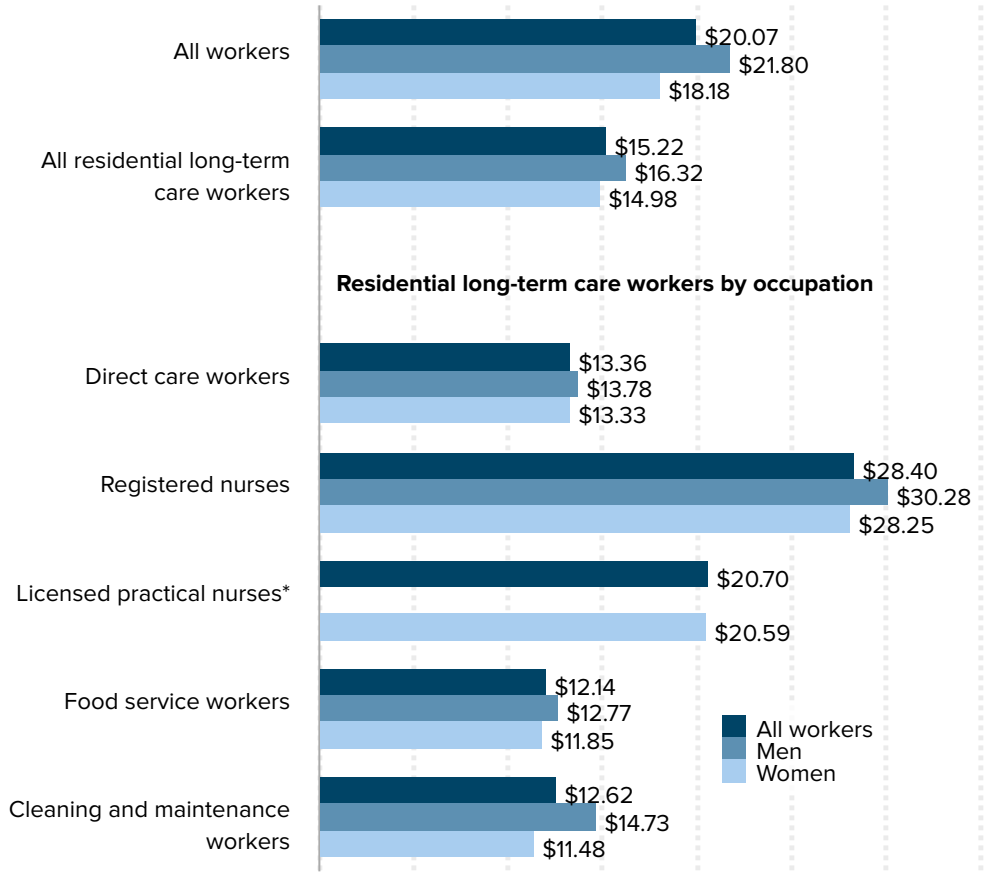
Source: Authors' analysis of 2015–2019 Current Population Survey microdata.

Economic Policy Institute

Figure I

Workers in the residential long-term care industry are paid less than workers in other industries

Median real hourly wages for the overall workforce, residential long-term care workers, and workers in selected long-term care occupations, by gender



* Due to sample size constraints, value for men in the licensed practical nurses occupation is omitted.

Notes: All values in 2021 dollars. To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides."

Source: Authors' analysis of 2015–2019 Current Population Survey Outgoing Rotation Group microdata.

Economic Policy Institute

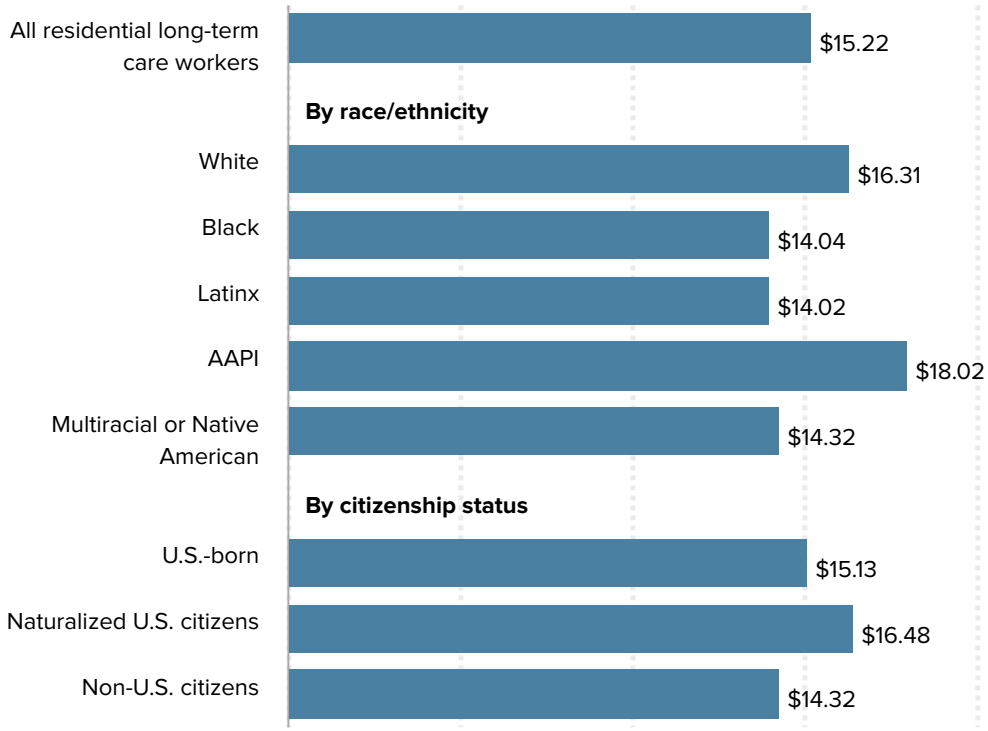
with $28.25 for female RNs.

The above discussion of the demographics of residential long-term care workers shows that women are sharply concentrated in the residential long-term care industry. This reality, however, is layered for some women. Not only are Black and Latinx women overrepresented in the residential long-term care industry overall, they are even more highly concentrated in low-wage occupations within that industry (shown in Figure F). In contrast, white women are more concentrated in the higher-paying occupations of RNs and LPNs, where they account for 59.4% and 51.0% of workers in these occupations,

Figure J

Black, Latinx, and multiracial or Native American workers earn less than their white counterparts

Median real hourly wages for residential long-term care workers, by race/ethnicity and citizenship status



Notes: AAPI stands for Asian American and Pacific Islander. All values in 2021 dollars. To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata.

Source: Authors' analysis of 2015–2019 Current Population Survey Outgoing Rotation Group microdata.

Economic Policy Institute

respectively. This racial segregation even within an industry dominated by women workers emphasizes the importance of analysis that considers the intersection of race/ethnicity and gender.

Supplemental state-level data on the median wages of residential long-term care workers is available in this workbook.

Figure J illustrates wage disparities within the residential long-term care industry by race/ethnicity and citizenship status. Black, Latinx, and multiracial and Native American workers are typically paid less than white workers in this industry. Their median hourly wages are $14.04, $14.02, and $14.32, respectively, compared with a median wage of $16.31 for white workers. This difference in hourly pay translates, for example, to full-time, full-year Black workers receiving about $4,700 less than white workers in this industry annually.

The median naturalized citizen worker in this industry earns $16.48 in hourly wages

(compared with $15.13 for a U.S.-born worker), while the typical non-U.S. citizen earns $14.32 an hour. The higher wages for naturalized citizens likely reflect their greater likelihood, relative to noncitizens, of working in the higher-paying RN and LPN occupations (see Figures H and I). The lower median wage for noncitizen workers is consistent with their higher concentration in the lower-paying direct care (10.4%) and cleaning and maintenance (13.6%) occupations relative to their share in the industry overall (7.0%). (See Figure H.[8])

Annual wage earnings follow similar patterns as hourly wages, though the wage gap between people who work in residential long-term care and workers across the U.S. economy is slightly more pronounced due to the prevalence of part-time work in this industry. The median hourly wage of $15.22 across all residential long-term care workers is about 75% of the median across the U.S. economy of $20.07 (Figure I). In **Figure K**, residential long-term care workers' overall median annual earnings of $30,984 is about 72% of the median annual earnings across the U.S. workforce of $43,169.[9] Direct care, food services, and cleaning and maintenance workers typically have even lower annual earnings than other residential long-term care workers.

The racial/ethnic and immigration-based disparities seen in hourly wages are also present in annual earnings, as shown in **Figure L**. Black workers in this industry, on average, work two more hours per week than white workers (39.0 compared with 37.1),[10] but the hourly wage gap is so large that even with this increase in hours, Black workers still earn 9.3% less annually.

Benefits coverage

In addition to facing low wages, residential long-term care industry workers have below-average coverage rates for both employer-provided retirement and health insurance benefits.

Coverage rates for each of these benefits are already suboptimal across the total workforce. Just one-third (35.1%) of workers have employer-provided retirement plans and only half (50.7%) are covered by employer-provided health insurance benefits, as shown in **Figure M**.[11]

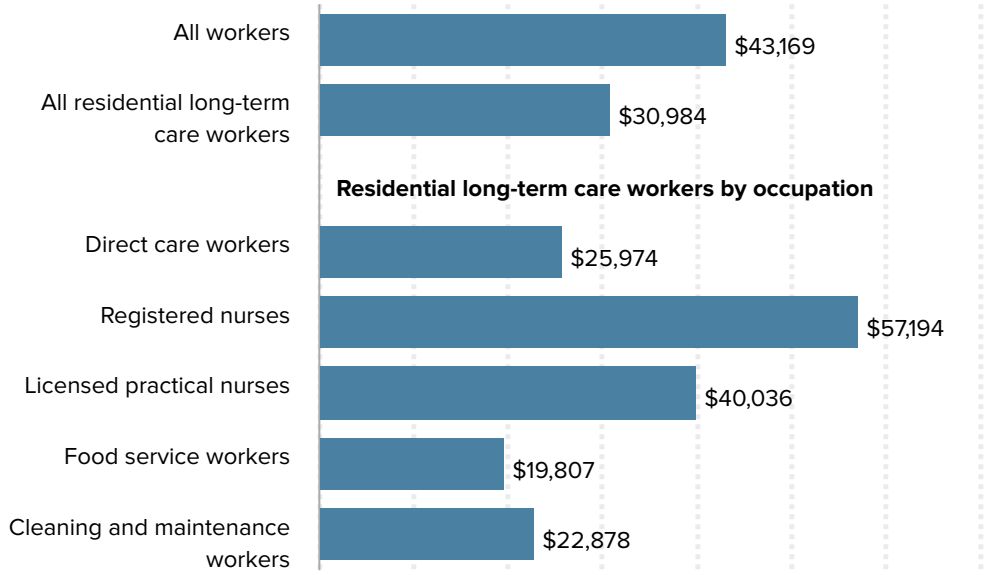
Access to benefits is even lower in the residential long-term care industry, where 45.4% of workers are covered by employer-provided health insurance benefits and only one-quarter of employees (24.7%) have employer-provided retirement benefits.

While RNs and LPNs in this industry both have employer-provided health insurance benefit coverage rates near or above the rate for the overall workforce, LPNs still fall short of workers overall in terms of employer-provided retirement benefits. The employer-provided retirement benefit coverage rates for direct care and food service workers are around half of the rate for all workers (18.9% and 16.1%, respectively). Even when only comparing them with the overall residential long-term care workforce, direct care, food service, and cleaning and maintenance workers within this industry all have especially low rates of employer-provided health insurance benefit coverage. This is especially concerning for

Figure K

Among residential long-term care workers, direct care, food services, and cleaning and maintenance workers have particularly low annual earnings

Median annual earnings for the overall workforce, residential long-term care workers, and selected residential long-term care occupations



Notes: All values in 2021 dollars. To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides."

Source: Authors' analysis of 2015–2019 Current Population Survey Annual Social and Economic Supplement microdata.

Economic Policy Institute

the cleaning and maintenance workers, who tend to be older and therefore at higher risk of certain health issues and illnesses including COVID-19. The median age of these workers is 50 while the median age of the overall workforce is 41.[12]

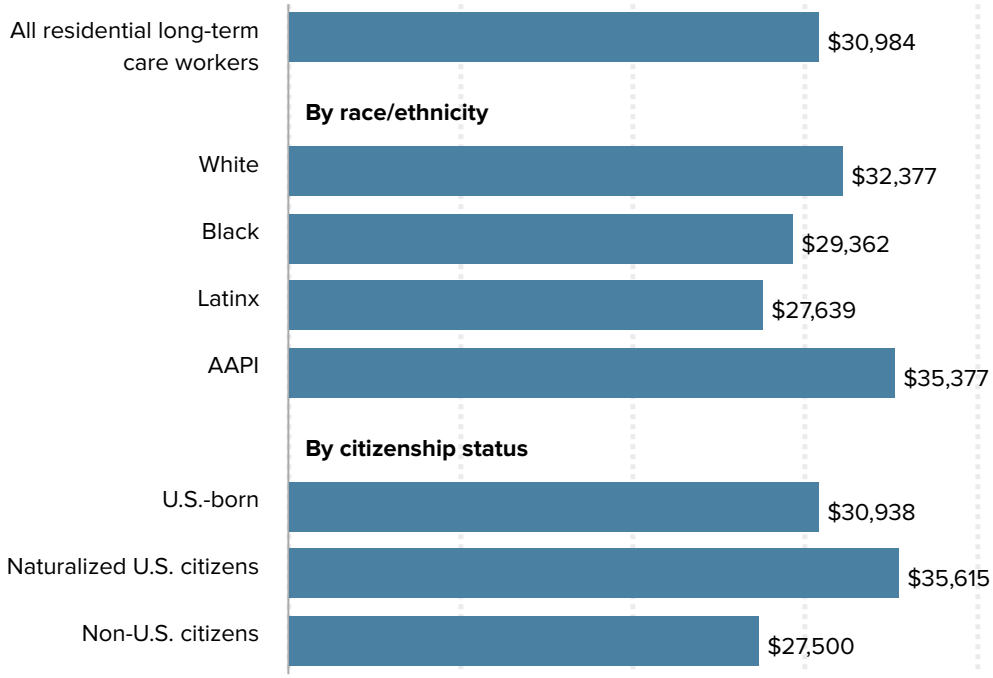
Noncitizen workers are less likely to receive benefits from residential long-term care employers than are U.S.-born and naturalized citizens, as shown in **Figure N**. Only 20.1% of noncitizen workers receive employer-provided retirement benefits and 40.8% receive employer-provided health care benefits, compared with 24.6% and 45.0%, respectively, for U.S.-born workers.

Across racial and ethnic groups, workers have similar rates of employer-provided health insurance benefits coverage, with AAPI workers being the most likely to have employer-provided health insurance benefits. However, there are disparities when it comes to retirement coverage, with just 1 in 5 Black and Latinx residential long-term care workers (21.2% and 20.6%, respectively) having employer-provided retirement benefits, compared with over a quarter of white and AAPI workers (27.4% and 25.7%).

Figure L

Black and Latinx residential long-term care workers have lower annual earnings than white and AAPI workers

Median annual earnings of residential long-term care workers by race/ethnicity and citizenship status



Notes: AAPI stands for Asian American and Pacific Islander. All values in 2021 dollars. To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata.

Source: Authors' analysis of 2015–2019 Current Population Survey Annual Social and Economic Supplement microdata.

Economic Policy Institute

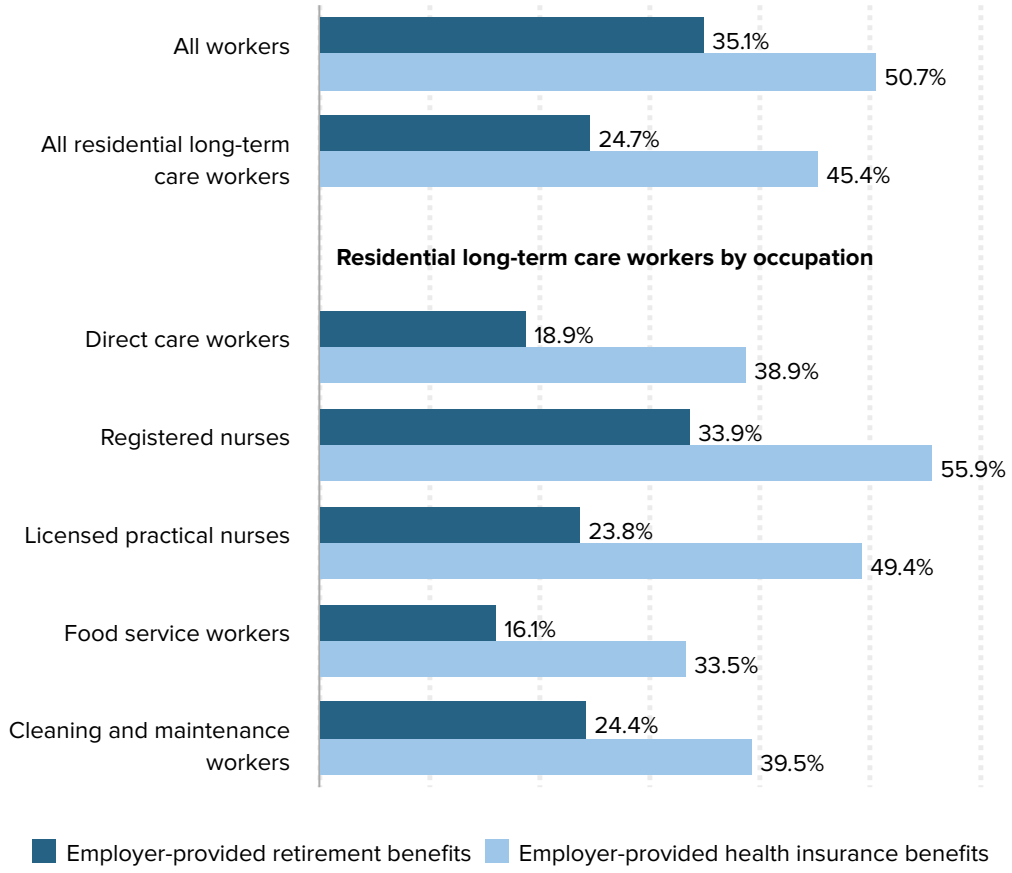
Black, Latinx, and non-U.S. citizen workers are overrepresented in occupations with lower benefits coverage. For instance, Black and Latinx residential long-term care workers are concentrated in direct care work (see Figure F), where only 18.9% of workers have an employer-sponsored retirement plan and 38.9% have employer-sponsored health insurance. Latinx workers and non-U.S. citizen workers are particularly likely to work in food service and cleaning and maintenance occupations (see Figures F and H) where access to employer-sponsored retirement and health insurance benefits is below the industry average.

Figure N also shows the clear gender imbalance in employer benefits, with women being less likely than men to receive employer-provided retirement and health insurance benefits.

Figure M

Residential long-term care workers are less likely than workers in general to be covered by employer-provided benefits

Share of workers with access to employer-provided benefits in the overall workforce, among residential long-term care workers, and in selected long-term care occupations



Notes: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides."

Source: Authors' analysis of 2015–2019 Current Population Survey Annual Social and Economic Supplement microdata.

Economic Policy Institute

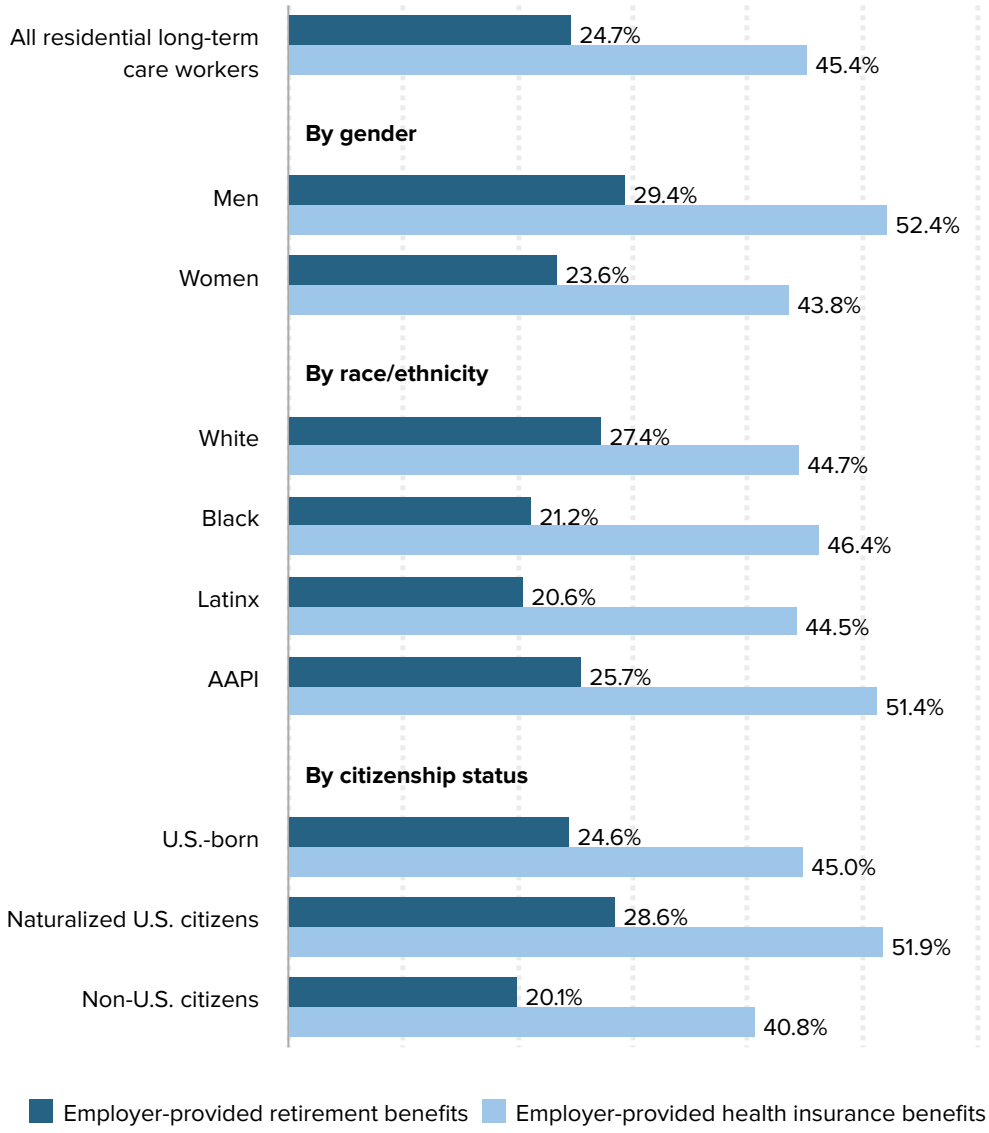
Poverty rates

These low wages and rates of benefits coverage translate into elevated poverty rates for residential long-term care workers and their families, especially for the workers in lower-paid occupations. **Figure O** displays the poverty rates and twice-poverty rates, meaning the share of workers whose family income is below twice the official poverty line, for residential long-term care workers by occupation group.

Figure N

Women and non-U.S. citizens are less likely to have benefits than other residential long-term care workers

Share of residential long-term care workers with access to employer-provided benefits, by gender, race/ethnicity, and citizenship status



Notes: AAPI stands for Asian American and Pacific Islander. To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. For definitions of citizenship status, see extended notes.

Source: Authors' analysis of 2015–2019 Current Population Survey Annual Social and Economic Supplement microdata.

Economic Policy Institute

Poverty rates for the residential long-term care industry are higher than for the overall workforce. More than 1 in 10 direct care (10.4%), food service (10.1%), and cleaning and

maintenance workers (14.6%) live in poverty.[13]

Since poverty thresholds set in the 1960s have not been revised to reflect low-income families' changing shares of necessary spending, researchers often use the twice-poverty rate as a better benchmark for whether a family is able to make ends meet. More than a quarter (27.6%) of residential long-term care workers and their families fall below this threshold, which is 10 percentage points higher than the overall twice-poverty rate of 17.7%. In particular, just over one-third of food service workers (36.5%) and about 2 in 5 direct care (40.6%) and cleaning and maintenance workers (39.1%) have incomes below the twice-poverty level.

We again see that Black and Latinx workers and women in this industry are particularly economically vulnerable, as illustrated by **Figure P**. The poverty rate for women is twice as high as for men (8.0% vs. 3.9%) and their twice-poverty rate is more than 10 percentage points higher (29.6% vs. 19.0%). One in 10 Black and Latinx (11.7% and 10.0%, respectively) residential long-term care workers lives in poverty, a rate twice as high as for their white peers (4.8%). The twice-poverty rate for Black residential long-term care workers is also double that of white workers, with two in five Black workers (39.4%) falling below that threshold, compared with 1 in 5 white workers (21.1%). Latinx workers also face an especially high twice-poverty rate of about one-third (34.6%).

Part-time work and multiple job holding may increase economic insecurity for long-term care workers

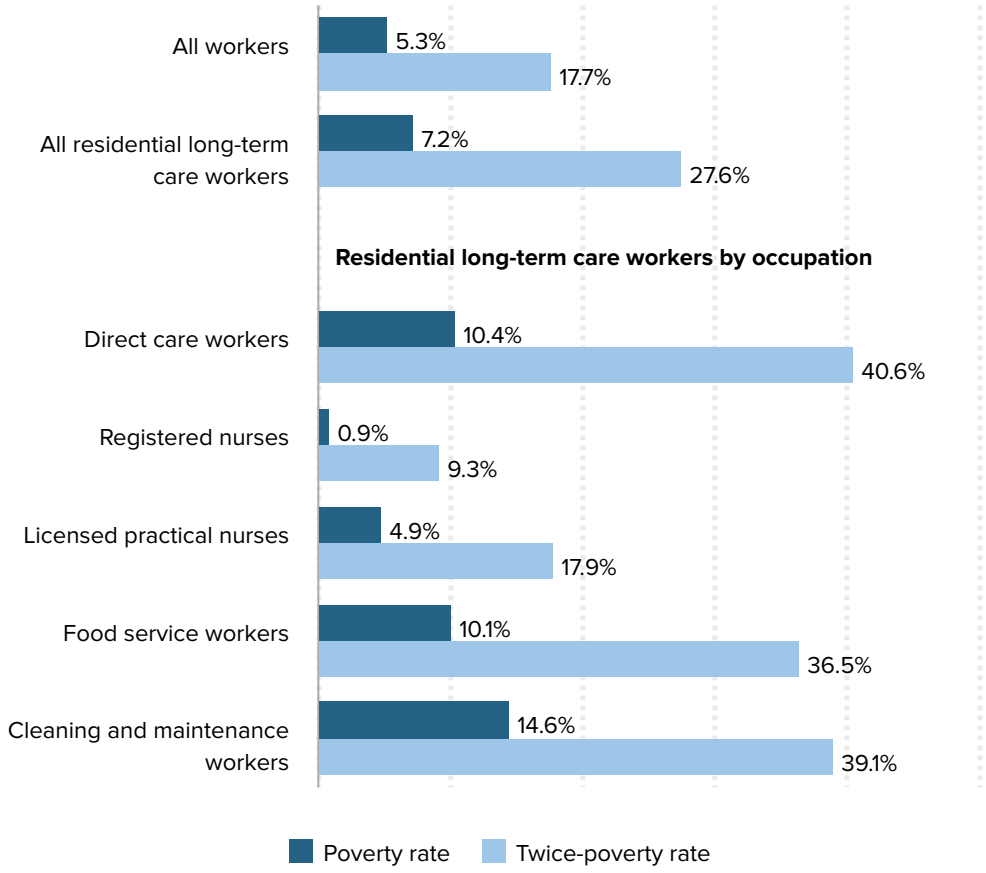
Workers who are unable to make ends meet from their primary job frequently take on additional work, if they are able to find it. Given the low wages and financial strain many residential long-term care workers face, it is unsurprising that holding multiple jobs is common within some residential long-term care occupations. Holding multiple part-time jobs, however, can still leave workers ineligible for workplace benefits and without adequate income. Part-time workers typically have lower hourly wages, so even if they pick up additional hours at a different job, they will still likely have lower incomes than their full-time peers (Golden 2020). This is compounded by much lower rates of benefits access. In the total workforce, fewer than half of part-time workers have access to retirement benefits (42%) and fewer than a quarter (23%) have access to medical care benefits, compared with 81% and 88%, respectively, of full-time workers (BLS 2021). **Figure Q** shows that workers who are employed in the residential long-term care industry as their primary job are somewhat more likely than the overall workforce to hold multiple jobs (6.6% vs. 5.1%). Direct care workers and LPNs are especially likely to fall into this category, with 7.2% of them holding at least one other job.

During the COVID-19 pandemic, the reliance on multiple job holders was particularly problematic since exposure in one workplace could lead a worker to expose their co-workers and residents at another workplace (Bates, Spetz, and Wagner 2022). That being said, transmitting viruses and other illnesses is a concern at residential long-term

Figure O

More than a quarter of residential long-term care workers are struggling to make ends meet

Poverty and twice-poverty rates for the overall workforce, residential long-term care workers, and workers in selected residential long-term care occupations



Notes: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. AAPI stands for Asian American and Pacific Islander. Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides." For definition of poverty rate and twice-poverty rate, see extended notes.

Source: Authors' analysis of 2015–2019 Current Population Survey Annual Social and Economic Supplement microdata.

Economic Policy Institute

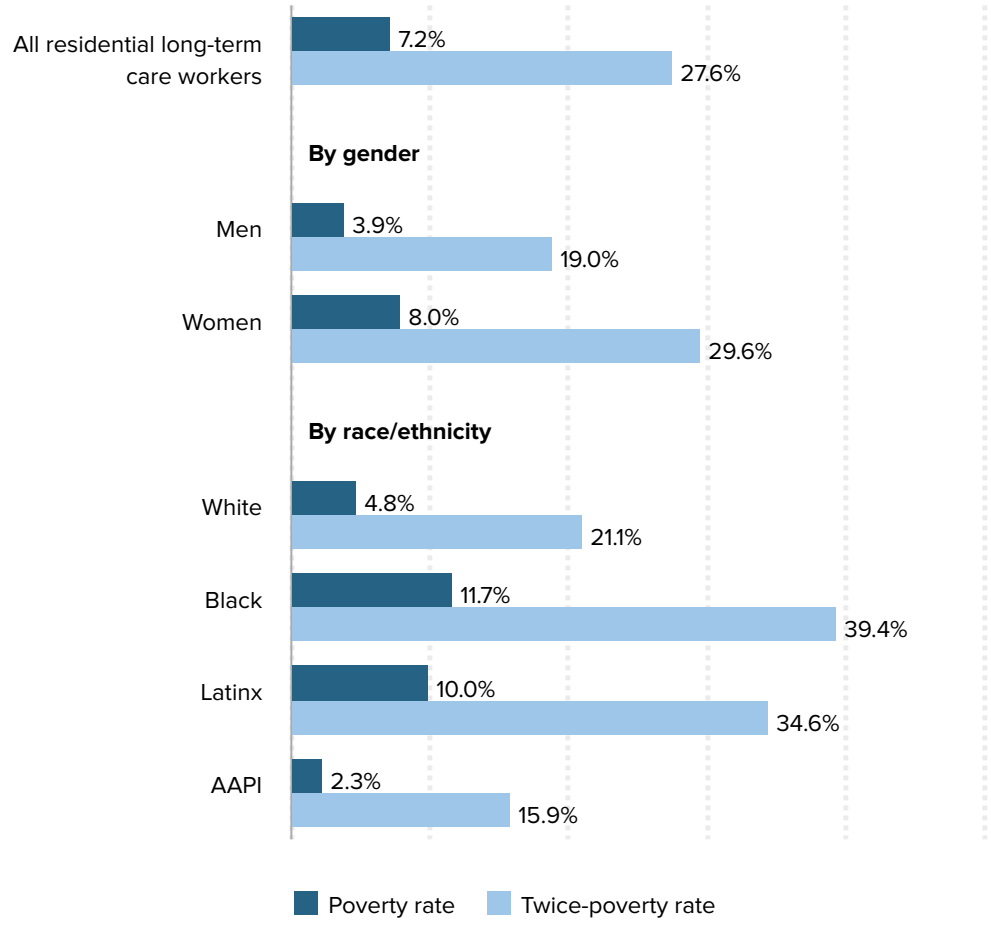
care facilities even outside of a pandemic. This is especially concerning for direct care workers and nurses, who have close contact with residents. Ensuring that interested workers receive full-time hours would improve the economic security of these workers while simultaneously helping protect LTC residents and workers from COVID-19, the flu, and other transmissible diseases.

Black, AAPI, and immigrant residential long-term care workers are all especially likely to be multiple job holders, as illustrated by **Figure R**. While U.S.-born workers in this industry are

Figure P

Roughly 1 in 10 Black and Latinx residential long-term care workers lives in poverty

Poverty and twice-poverty rates for residential long-term care workers, by gender and race/ethnicity



Note: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. AAPI stands for Asian American and Pacific Islander. Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides." For definition of poverty rate and twice-poverty rate, see extended notes.

Source: Authors' analysis of 2015–2019 Current Population Survey Annual Social and Economic Supplement microdata.

Economic Policy Institute

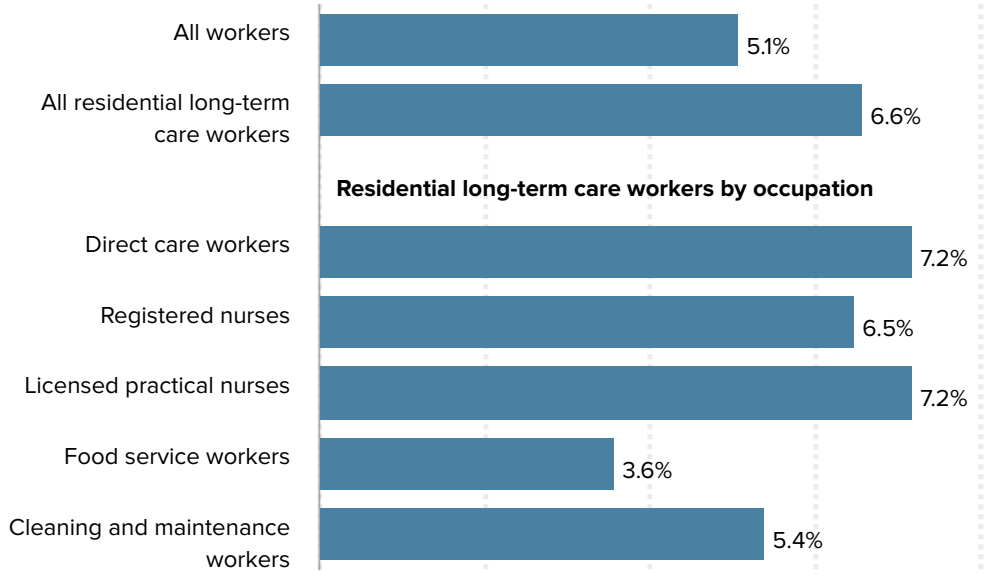
still more likely than the overall workforce to hold more than one job (6.2% compared with 5.1% overall; see Figure Q), this trend is even more pronounced for naturalized U.S. citizens and workers who are not U.S. citizens (9.5% and 7.0%, respectively). About 8% of Black and AAPI workers in residential long-term care facilities hold at least one additional job, a higher share than their white, Latinx, and multiracial and Native American peers.

Workers in some residential long-term care occupations are more likely than the overall

Figure Q

Residential long-term care nurses and direct care workers are more likely than workers in general to work multiple jobs

Share of workers who work multiple jobs in the overall workforce, among residential long-term care workers, and in selected long-term care occupations



Notes: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. Direct care workers are those in the occupational categories "nursing, psychiatric, and home health aides" and "personal and home care aides."

Source: Authors' analysis of 2015–2019 Current Population Survey microdata.

Economic Policy Institute

workforce to be getting fewer hours than they would like on the job. **Figure S** presents the share of workers who are part time. Here, part time is defined as working less than 35 hours at all jobs combined, rather than being part time at one job in particular. "Part time for economic reasons" refers to workers who would prefer to work full-time hours but have only been able to find part-time work ("involuntarily part time").

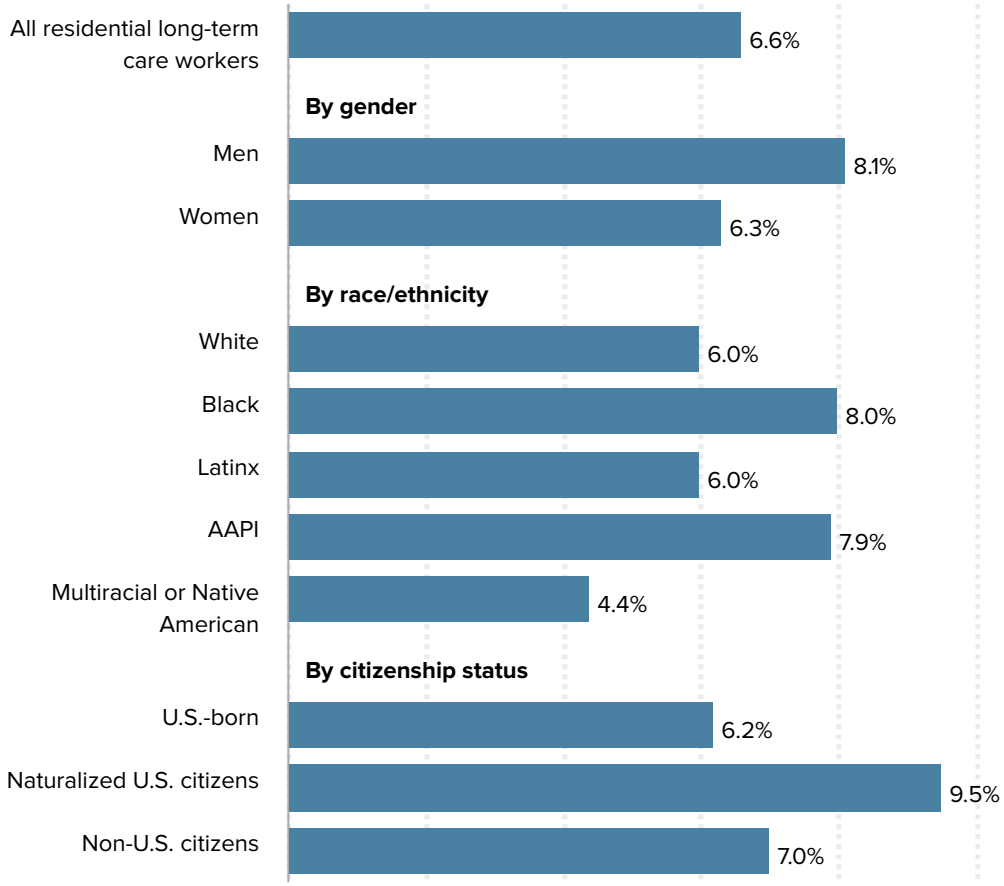
Food service and cleaning and maintenance workers in the residential long-term care industry are especially likely to be involuntarily part time, with 6.4% and 7.1%, respectively, of these workers reporting that they would rather work full time compared with 4.2% of the workforce overall. Troublingly, the part-time hourly wage penalty that workers face is even larger for workers who are involuntarily part time than it is for workers who prefer a part-time schedule (Golden 2020).

More than 2 in 5 food service workers (41.3%) who work in residential long-term care communities work fewer than 35 hours a week, either voluntarily or involuntarily, nearly double the share of the total workforce (22.7%). Despite these elevated rates of part-time work, food service workers are less likely than others in this industry to hold multiple jobs. This may reflect difficulties these workers face in pursuing additional employment. It is also

Figure R

Naturalized U.S. citizens, men, Black, and AAPI residential long-term care workers are especially likely to hold multiple jobs

Share of residential long-term care workers who work multiple jobs, by gender, race/ethnicity, and citizenship status



Notes: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. AAPI stands for Asian American and Pacific Islander.

Source: Authors' analysis of 2015–2019 Current Population Survey microdata.

Economic Policy Institute

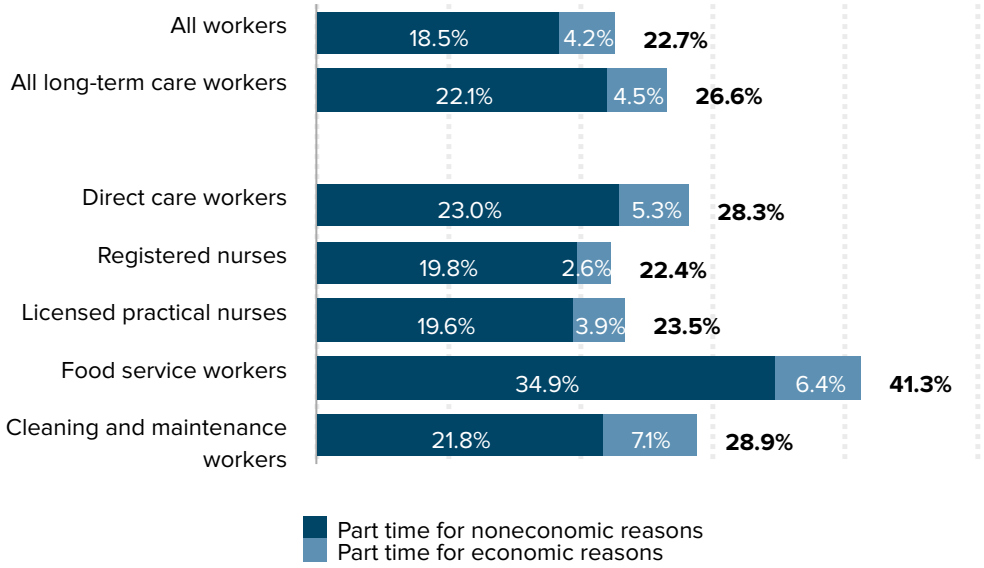
worth noting that this occupation has a particularly high share of young workers who may be juggling employment and education. More than a quarter (27.2%) of these workers are under 23, compared with 1 in 10 workers in the overall residential long-term care workforce and just 8.7% of all workers.[14]

While immigrant workers are more likely to have full-time status than U.S.-born workers (Espinoza 2017), job quality for immigrant workers still tends to be worse than for U.S.-born workers. Immigrant workers are more likely to experience longer hours and work the night shift (Global Ageing Network 2018), while also being more likely to hold multiple jobs (Figure R).

Figure S

Direct care, food service, and cleaning and maintenance workers in residential long-term care are more likely than the average worker to be working part time but want full-time hours

Share of workers who are part time for economic or noneconomic reasons in the overall workforce, among residential long-term care workers, and in selected long-term care occupations



Notes: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. "Part time for economic reasons" refers to workers who would prefer to work full-time hours but have only been able to find part-time work ("involuntarily part time").

Source: Authors' analysis of 2015–2019 Current Population Survey microdata.

Economic Policy Institute

The structural issues that fuel some of the realities in the long-term care industry

Those who keep residential long-term care facilities running in critical day-to-day operations do work that is essential for human survival and dignity. Yet their pay, working conditions, and social status do not reflect or adequately reward their vital contributions. This paradox relates largely to who residential long-term care workers are, the work they do, and who they attend to.

As described in this report, residential long-term care workers are overwhelming women and disproportionately Black, Latinx, and immigrants. The data presented in this report also illustrate the gender, racial, and immigration-based disparities in pay and benefit

access within the residential long-term care industry. There is a strong body of research discussing the discrimination and conditions that Black, Latinx, AAPI, and Native American workers, immigrants, and women face in the labor market because of their various identities. These disparities in economic outcomes serve to preserve hierarchies, especially the racial hierarchy of white supremacy, and are the direct result of gatekeeping higher-pay and higher-status occupations, keeping pay low for occupations marginalized groups are concentrated in, and discriminating in hiring processes even when the nominal requirements to enter an occupation are met (Wilson and Darity 2022). At the same time, the older adults and people with disabilities who receive LTSS are subject to ableism that systematically devalues their needs as well as the workers who help to meet them.

To understand why the devaluing of LTSS partly drives the conditions that residential long-term care workers face on the job, we first need to connect the residential long-term care industry to care work more generally. While not all workers in the residential long-term care industry are in care-specific occupations such as nursing or direct care, care work is still the defining, overarching feature of the industry. While in-home direct care workers may perform tasks ranging from administering medicine to preparing meals to doing laundry, in the residential long-term care industry those latter tasks are often performed by workers in specialized food service or cleaning occupations. In short, what has become the broader care economy is rooted in work that humans have always needed to survive and thrive across generations.

Gender inequality underpins the undervaluing of care work

For a long time, care work has mostly been done by women within households as unpaid labor. We continue to see elements of this today. Detailed research, including the works of Coffey et al. (2020), Addati et al. (2018), and Connelly and Kongar (2017), shows that across the world, women do significantly more care work than men, in both paid care occupations and unpaid care work. In a detailed examination of care work and its workforce, the International Labor Organization estimates that within the paid care economy, women make up two-thirds of the workforce globally (Addati et al. 2018).

A body of empirical research has identified what is called a care wage penalty, i.e., the lower pay care workers receive that cannot be explained by typical factors. Budig, Hodges, and England (2019) examine how care workers' pay remains low even when compared with noncare workers with similar years of experience and education. They also estimate the existence and magnitude of a care penalty across a few factors. The authors estimate that the wage penalty ranges from 6% to 23%, depending on the combination of gender and type of care occupation. This reality is layered on top of the wage penalty women face in the broader labor market because of sexism. Research shows that the gender wage gap remains sizable and has shrunk little in the past three decades (Gould 2022).

Race/ethnicity and immigration status are also key contributors to the undervaluing of care work

Understanding how long-term care in the U.S. is undervalued requires recognizing that the sexism that devalues this work also intersects with racism and xenophobia. The concentration of exploited groups in care occupations is intertwined with the devaluation of care work as a profession. In the U.S., Black, Latinx, AAPI, and Native American women, especially Black women, have a long history of being negatively incentivized, coerced, or forced to provide care to others that dates back to slavery (Glenn 2012). As detailed research by Jones (2010) and Donovan (1987) has shown, enslaved Black women forcibly did a myriad of care work to keep enslavers and their families alive, including cooking, cleaning, and providing child care for their enslavers' children.

After the abolition of slavery, all this care work remained necessary. What followed was a gradual creation of a precarious low-wage care industry with jobs mostly held by Black, Mexican American, and Chinese American women (Glenn 1985; 1992). The sexism, anti-Blackness, and xenophobia directed toward these women and their work had significant long-term structural, legislative, and policy impacts, and continues to be reflected today in who does care work and the conditions they face.

The precarity of care work overall has been and continues to be the culmination of intentional policy choices, including the deliberate exclusion of care workers from landmark labor standard legislation. Historically, we can see this in the evolution of paid care work in the U.S. and how early paid care workers were treated under legal reforms. This racial- and gender-motivated maltreatment of these workers translated into a lack of protection and abysmal pay in these roles.

For example, domestic workers were excluded from most New Deal reforms, such as the Fair Labor Standards Act of 1938, and denied access to unemployment insurance and other social insurance benefits provided to other workers (KFF 2015; Wolfe et al. 2020; Edwards 2020). While the focus of this report is the residential long-term care workforce, which fully excludes domestic workers, the early challenges that domestic workers faced had consequences for new classes of care workers whose work occurs outside of the household.

Xenophobia continues to shape the residential long-term care workforce

In wealthy Western countries, there is a growing trend of care work being performed by immigrants, particularly immigrant women (King-Dejardin 2019). The aging populations of wealthy countries have increased the demand for residential long-term care services, while job quality for care workers remains poor. In these countries, immigrant workers are

more likely than native-born workers to fill these jobs, perhaps because they have fewer economic options. Immigrant women providing care services follows a historical pattern of women from disadvantaged racial and ethnic groups providing care services for more powerful social groups (Razavi 2007).

While care work is undervalued, so are immigrants themselves. Many immigrant workers in residential long-term care have higher education qualifications than is required for the work they perform, but since international licenses are often not recognized in the U.S., they may find themselves with few options. In particular, foreign-trained nurses may end up in lower-paying jobs, such as personal care assistants (Global Ageing Network 2018).

Immigrant workers in the residential long-term care industry come from many different nations of origin, including Mexico, countries in Central America, Jamaica and the Caribbean, and the Philippines (Espinoza 2017). Unlike many other countries, the U.S. has no specific immigration policy for potential long-term care workers, including nurses, while almost all immigrant visas for "skilled" workers (via the H-1B program) are reserved for highly educated foreign workers in sectors such as technology and medical research.[15] Most immigrant residential long-term care workers enter the U.S. via family reunification, refugee asylum, or green card lottery and then find their way into long-term care jobs through word-of-mouth from families, friends, and communities (Leutz 2010).

Undocumented immigrants make up approximately 4% of nursing home workers, roughly in line with the share of undocumented immigrants in the population at large (Zallman et al. 2019). However, in nursing home support occupations such as housekeeping, construction, and maintenance, the share of undocumented immigrants is greater, at 13.1%.

Immigrant workers occupy not only a disproportionate role in an industry with generally poor working conditions, but also provide a disproportionate amount of its most challenging labor. There is considerable evidence that compared with U.S.-born workers, immigrant workers throughout the long-term care industry work more hours, are more likely to work overtime, and are more likely to work unpopular shifts such as night shifts (King-Dejardin 2019).

In addition, immigrant workers also often contend with cultural barriers, language differences, and discrimination that make their work more challenging. Xenophobia and racism can lead to discriminatory and abusive behavior by residents and colleagues toward immigrant workers. Simultaneously, overcoming language barriers can be very important for developing the personal relationships between residents and caregivers.

However, it is deeply flawed to view immigrant workers' diverse cultural backgrounds as detrimental to the quality of their work. Indeed, a diverse residential long-term workforce can be an asset to employers and a benefit for residents. Across many different areas of health care, consumers of health services show a preference for workers who share their race, ethnicity, or cultural background (Bates, Amah, and Coffman 2018). As the population of older Americans continues to grow more diverse, the diverse cultural backgrounds of immigrant workers should be seen as a means to provide culturally competent care that meets the needs of different residents.

Immigrant workers make important contributions to the residential long-term care industry. Ensuring that they are compensated fairly for their work is essential to creating an equitable industry.

Ableism reinforces the devaluation of care workers and their labor

The devaluation of LTSS is also a function of not just who *performs* these services, but also who *receives* them. Public underinvestment in long-term services and support and the undervaluing of the labor of those who perform it reflect the ableism that disabled residents of residential long-term care facilities face.

Altiraifi (2019) defines ableism as "structural and interpersonal oppression experienced by people with disabilities or those presumed or determined to be disabled." Relatedly, there is a social component to disability, in which "disability refers to a socially constructed system that categorizes, values, and ranks bodies and minds as normative or marginal" (Altiraifi 2019).

Thus, those who receive LTSS because of disability or age are not seen or treated as equal members of society. Therefore, the labor rendered to provide the support and services they need is necessarily devalued. As a result, there is a close link between care workers and people with disabilities and older adults as subjects of an overlapping marginalization—and, indeed, for some care workers who are themselves disabled, this connection is even more profound (Chang 2017).

These ableist narratives and policies devalue and dehumanize people receiving LTSS in ways that are inextricably linked to the systems that devalue care workers' labor. Consequently, the fight for better working conditions and pay for care workers is inseparable from also centering and improving conditions for people with disabilities and older adults (Novack and Cokley 2020).

Unions of long-term care workers improve wages, working conditions, and quality of care

Improving pay and work conditions for residential long-term care workers is paramount to addressing the intertwined discrimination and economic penalties that both care workers and care recipients face. One major obstacle to making these improvements is the fundamental imbalance in bargaining power between workers and their employers in nearly every corner of the labor market, including long-term care, that depresses worker wages and limits their voice on the job.

For Black, Latinx, AAPI, Native American and multiracial workers, immigrants, and women,

who make up significant shares of the residential long-term care workforce, the occupational segregation and discrimination they face in the labor market further exacerbate the obstacles to securing fair compensation. Occupational segregation for Black, Latinx, and immigrant workers into low-wage occupations, and long-standing racial disparities in unemployment, mean that they are less likely to be able to secure a better-paying or safer job, making it more difficult for them to credibly refuse or leave a poor-quality job (Wilson and Darity 2022). This limitation of their outside job options also weakens their ability to push for positive changes in their own workplace by leveraging another job offer.

Collective bargaining through a union can be a powerful force for leveling the power between workers and employers and improving job quality. Although unions are not widespread across the industry, many residential long-term care workers are unionized and bargain for better wages, benefits, and working conditions. As **Figure T** shows, 6.9% of residential long-term care workers are currently unionized, significantly lower than the 11.9% share of unionized workers in the overall workforce. Union coverage rates in this industry are lower for white workers (5.3%) compared with Black (9.6%), Latinx (7.3%), and AAPI workers (9.6%).

Unionization is shown to boost wages for all workers by about 10% relative to nonunion workers in similar occupations who have about the same amount of education and experience. That wage premium is significantly larger for Black and Latinx workers (Banerjee et al. 2021). When Black and Latinx workers have had the chance to unionize, it has led to increased wages and reduced disparities. Black, Latinx, AAPI, and Native American and multiracial workers in particular benefit from union contracts that create greater transparency and consistency through defined policies and pay structures (Wilson and Darity 2022).

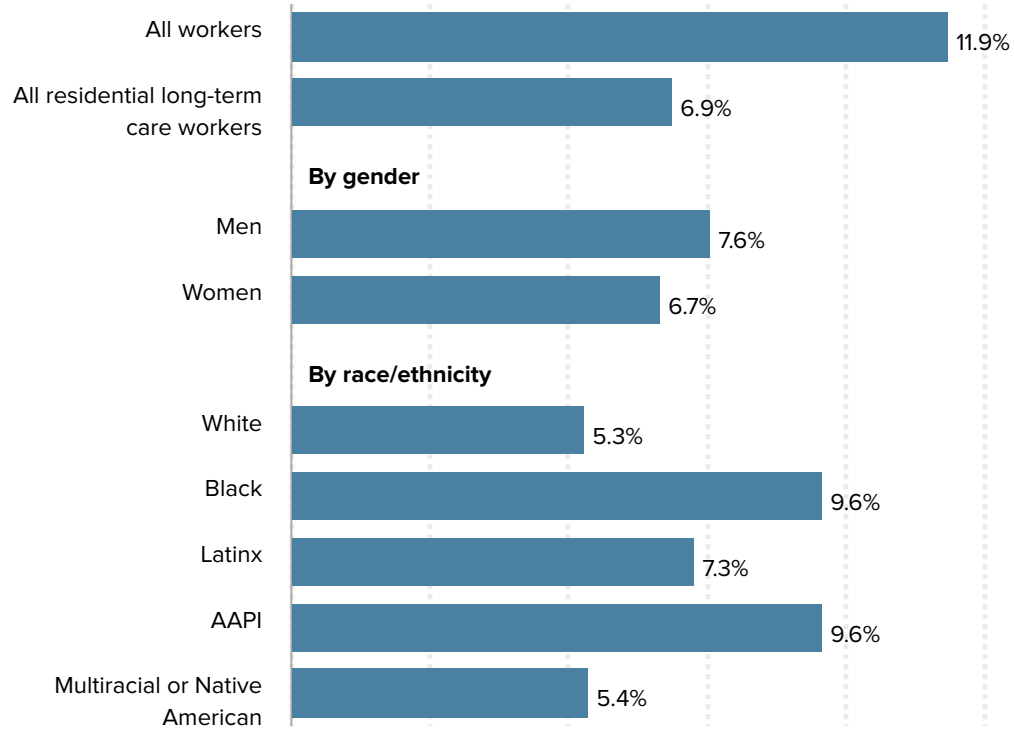
When unions convey benefits to residential long-term care workers, it translates to better experiences for the residents they care for. When unionized residential long-term care facilities raise compensation and improve job quality, they experience lower staff turnover than nonunion ones (Temple, Dobbs, and Andel 2009). As discussed earlier, the long-term care industry is notorious for its extremely high turnover rate due to poor job quality, and this turnover results in worse conditions for residents (Gandhi, Yu, and Gabrowski 2021; Loomer et al. 2021).

Unions are also an important resource for developing a skilled, long-term care workforce through training and apprenticeship programs. For instance, in Connecticut a partnership between long-term care facilities, the New England Health Care Employees Union, and the SEIU 1199 Training Fund provides a CNA apprenticeship program (Backus 2021). In Washington state, the SEIU 775 Benefits Group is the second-largest educational institution in the state by enrollment, offering required training and continuing education options for personal care aides (Campbell 2020). Unionized long-term care sites are associated with greater worker productivity, likely because unions increase worker retention and skill level (Sojourner et al. 2015). Unionized care workers are also strong advocates for staffing standards to ensure that residents receive adequate services. Some union contracts include policies that allow workers time off to advocate for increased

Figure T

Black, Latinx, and AAPI residential long-term care workers are more likely to be covered by a union contract than their white counterparts

Share of residential long-term care workers who are covered by a union contract, by gender and race/ethnicity



Notes: To ensure sufficient sample sizes and reflect the "normal" pre-pandemic state of this industry, this figure draws from pooled 2015–2019 microdata. AAPI stands for Asian American and Pacific Islander. Union coverage includes workers in a union or covered by a union contract.

Source: Authors' analysis of 2015–2019 Current Population Survey microdata.

Economic Policy Institute

Medicaid reimbursement rates for the benefit of nursing home owners, workers, and residents (Avalon Health Care 2021; IAHCF 2020).

Like all workers, those in the residential long-term care industry who hope to organize a union must contend with weak labor laws that favor employers, so-called right-to-work[16] laws reducing union resources in many states, and increased use of independent contracting and staffing agencies that make it difficult to organize. Another added challenge to organizing is the rapid growth in the number of separate sites where long-term care occurs, which is attributable to more people receiving care in smaller home- and community-based (HCBS) settings. Between 2007 and 2017, the home care and long-term care industries added 34,700 new establishments/employers, the majority of which were home care as opposed to nursing homes and other residential facilities (McCall 2020).

Although workers and residents at smaller facilities and in home care also stand to benefit from unionization, in general, long-term care sites with more residents and larger staffs are more likely to be unionized (Sojourner et al. 2010). Because of the growing number of long-term care communities, organization must occur at significantly more locations simultaneously in order to maintain current long-term care union rates.

The health and safety benefits of unionized long-term care workplaces became even more evident during the pandemic. A study of nursing homes from April 2022 found that unionized nursing homes throughout the U.S. had 10.8% lower resident COVID-19 mortality rates and 6.8% lower worker COVID-19 infection rates due to increased access to PPE, higher staff-to-patient ratios, greater access to paid sick leave, and lower worker turnover (Dean et al. 2022).

Public financing is critical for guaranteeing access to care services

Because public financing already plays a role in funding long-term services and support, policymakers have an important role in ensuring there is adequate funding to meet the rising levels of service needs while simultaneously raising pay and benefits access for workers.

Currently, most LTSS are covered only by Medicaid, which is a means-tested program targeting people in poverty, and not Medicare, which is a universal program covering older adults. A social insurance program that does not require middle-income service recipients to deplete their savings before getting publicly financed help (as Medicaid does) would help to expand access to LTSS and help to spread across the population both the risks and rewards of saving for the possibility of needing LTSS (Cole 2021). Funding LTSS is an area in which state policymakers need not wait on federal action. In fact, Washington state has already established a long-term care trust that will provide a lifetime benefit of up to $36,500 for people needing support with activities of daily living.[17]

Policy decisions also affect the settings in which people can receive publicly funded care and LTSS. Originally, Medicaid covered LTSS only if they were provided in an institutional setting such as a nursing home (Campbell et al. 2021).[18] A series of legislative actions and Supreme Court decisions between 1970 and 1999 expanded Medicaid coverage of HCBS. Consequently, the share of LTSS Medicaid spending that went to HCBS increased from 10% in the early 1980s to 57% by 2016 (Campbell et al. 2021). Although this shift is substantial, there is still bias toward institutional settings like nursing homes because nearly all HCBS coverage by Medicaid is still optional for states (O'Malley Watts, Musumeci, and Ammula 2022).

While some residential care facilities are considered community-based for Medicaid purposes, the terms are not synonymous, and many residential care facilities are considered institutional settings. Building a more affordable, equitable, and dignified care economy requires expanding public funding in a way that will ensure access to LTSS in

any setting, with a particular focus on expanding funding for LTSS in homes and communities.

Conclusion and policy recommendations

The deficiencies in access, quality of care, and quality of life for residents and their families are inseparable from the struggles and deficiencies in job quality, societal recognition, public funding, and voice on the job for long-term care workers. Only when workers, care recipients, and their families stand together in solidarity can the U.S. overcome its short-sightedness to secure the services and job quality necessary for a dignified collective future. This includes allocating enough funding to ensure higher pay, better staffing levels, and improved working conditions for workers *and* more access to quality services for residents. Building a better, more robust industry also means recognizing and remedying the connections between the systems of oppression that underpin the current system and ensuring that long-term care workers are not subjected to racism, sexism, and xenophobia from employers or residents. Some tactics include strengthening state and federal enforcement of civil rights and anti-discrimination laws (see Wilson and Darity 2022 for more on this), improving pathways to unionization, and encouraging employers to complete equity and anti-discrimination trainings for themselves and their staff members.

Policymakers can act by passing laws that that make broad improvements for workers, such as raising the minimum wage and strengthening protections for workers who are organizing a union. When workers try to organize a union, they often face employer pushback in the form of illegal discipline, firings, and coercion, as well as legal but unfair (and often costly) anti-union campaigns (McNicholas et al. 2019). The Protecting the Right to Organize (PRO) Act[19] is an important piece of federal legislation that would greatly improve protections for workers as they organize. Additionally, minimum wage increases improve outcomes and reduce worker turnover among nursing home staff, resulting in lower rates of preventable health conditions and mortality (Ruffini 2022). These improvements will also likely attract more workers to the industry, therefore helping address projected shortfalls in the number of residential long-term care workers needed in the coming years.

States and localities can also establish industry-specific worker standards boards to recommend changes to industry minimum wages and working conditions. Worker standards boards allow workers to have a seat at the table alongside employers, advocates, and government agencies to shape the regulation of their industry by conducting investigations and developing policy recommendations. Michigan established a worker standards board for nursing homes in 2021, while Nevada has a similar board for home care workers (Michigan Governor's Office 2021; NVDHHS 2021). Unlike other advisory bodies, worker standards boards may have the authority to fast-track their recommendations into action by obligating the governing body to review a recommendation within a certain time period, or even automatically incorporating a recommendation when a certain threshold of the board is in favor of a policy (Andrias,

Madland, and Wall 2019). Worker standards boards exist for many different industries, but since nursing homes are regulated by many different governmental agencies, they also provide an important medium for collaborating on complex regulatory issues.

In some states, policymakers were jolted into action by the dire conditions for care workers in general resulting from the COVID-19 pandemic. For example, New Hampshire and Arkansas both instituted temporary pay increases for Medicaid-funded direct care workers in homes, communities, and institutional settings, amounting to weekly pay increases of $300 and $125–$500, respectively (Rosbrow-Telem 2020; Arkansas Governor's Office 2020). While these raises are much needed, long-term care workers require permanent and more sweeping compensation improvements. State governments may use federal funds from the American Recovery Plan to provide an initial influx of resources to raise wages for long-term care workers. For example, when policymakers in Colorado sought to raise hourly wages to $15 for all state-funded direct care workers (which includes those in HCBS settings), they used American Recovery Plan funds to pay for the resulting initial increase in Medicaid costs (Colorado Governor's Office 2021). State Medicaid programs can also establish directed payments or rate increases specifically to increase wages and benefits at nursing facilities. For instance, in 2022, Oregon established an Enhanced Wage Add-on Program that increased CNAs' starting hourly wage to $17 at nursing facilities (OR DHS 2022).

Those who provide quality care and attend to the full humanity of residents require livable wages and working conditions. These elements also attract and retain an experienced and committed workforce, whether they work in homes, communities, or residential settings. And all of those can be achieved only with adequate public funding that simultaneously improves conditions for care workers *and* ensures adequate care access and quality for those in need, regardless of their income or wealth level.

Notes

1. "Latinx" is a gender-neutral term that may be used interchangeably with Latino/Latina or Hispanic. These terms are commonly used to describe the large and diverse group of Americans who trace their origin or ancestry to a Spanish-speaking country or region (or a non-Spanish-speaking Latin American country, such as Brazil), and may include Americans of Mexican, Cuban, Caribbean, Central American, or South American descent, among others. It also includes the residents of Puerto Rico, a U.S. territory (Gould, Perez, and Wilson 2020).

2. "Immigrant women" includes both naturalized U.S. citizens (7.5%) and non-U.S. citizens (5.3%).

3. See "Definitions of terms" below for a detailed description of the category "Direct care workers."

4. In official government data sources, the residential long-term care industry is referred to as "nursing and residential care facilities" and includes NAICS codes 6231 (Nursing Care Facilities), 6232 (Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities), 6233 (Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly), and 6239 (Other Residential Care Facilities). The latter three NAICS codes make up the category we call "residential care facilities."

5. For more information on what settings are considered home- or community-based, see *Issue Brief: Implementation of the Home- and Community-Based Services Settings Rule* (MACPAC 2019).

6. Data are from published BLS Current Population Survey data series and are for the civilian noninstitutional population ages 16 and older between 1990 and 2021.

7. While there are certainly long-term care workers who are employed by governments, the available data do not allow us to separate those employment levels out from other public-sector industries. Statistics describing the workers in the long-term care sector throughout the remainder of the report include both private- and public-sector workers.

8. We add the shares for noncitizen men and noncitizen women from Figure H to get the total noncitizen shares.

9. Median annual income is calculated using Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) microdata.

10. Average weekly hours are calculated using Current Population Survey (CPS) Basic microdata.

11. Benefit coverage rates are calculated using Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) microdata.

12. Median ages and share of workers who are 50 or older are calculated using Current Population Survey (CPS) Basic microdata.

13. Poverty rates are calculated using Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) microdata.

14. Authors' analysis of Current Population Survey Basic microdata.

15. The H1-B visa program provides temporary, nonimmigrant U.S. work visas for college-educated workers and fashion models from abroad. For more information about the program, see Costa 2017.

16. Right-to-work (RTW) laws do not confer any sort of right to a job. Rather, they make it illegal for a group of unionized workers to negotiate a collective bargaining contract (a contract governing workplace wages, benefits, and working conditions) that includes "fair share fees." A contract with fair share fees requires all employees who enjoy the contract's benefits to pay their share of the costs of negotiating and enforcing it (Cooper and Wolfe 2021).

17. WA HB 1087.

18. Medicare does not cover most LTSS.

19. By making it illegal for hostile employers to interfere with an election process, the PRO Act will allow workers who want a union to bring that form of democracy into their workplace (Moore 2021).

References

Aase Haugen Homes. 2020. Aase Haugen Homes, Inc & SEIU Local 199 2020–2022 Collective Bargaining Agreement. Accessed February 2022.

Addati, Laura, Umberto Cattaneo, Valeria Esquivel, and Isabel Valarino. 2018. *Care Work and Care Jobs for the Future of Decent Work*. Geneva: International Labour Organization, June 2018.

Altiraifi, Azza. 2019. *Advancing Economic Security for People with Disabilities*. Center for American Progress, July 2019.

Andrias, Kate, David Madland, and Malkie Wall. 2019. *A How-To Guide for State and Local Workers' Boards*. Center for American Progress, December 2019.

Arkansas Governor's Office. 2020. "Governor Hutchinson Announces CMS Approval of Additional Pay for Eligible LTSS Direct Care Workers Due to COVID-19 Emergency" (press release). April 15, 2020.

Avalon Health Care. 2021. Avalon & SEIU Local 504 2021–2024 Collective Bargaining Agreement. Accessed February 2022.

Backus, Lisa. 2021. "Apprenticeships Grow Nursing Home Workforce, Partnership with Union." *CT News Junkie*, November 17, 2021.

Banerjee, Asha, Margaret Poydock, Celine McNicholas, Ihna Mangundayao, and Ali Sait. 2021. *Unions Are Not Only Good for Workers, They're Good for Communities and for Democracy*. Economic Policy Institute, December 2021.

Bates, Timothy, Ginachukwu Amah, and Janet Coffman. 2018. *Racial/Ethnic Diversity in The Long-Term Care Workforce*. University of California San Francisco, April 2018.

Bates, Timothy, Joanne Spetz, and Laura Wagner. 2022. *Characteristics of Multiple Job Holders in Long-Term Care*. UCSF Health Workforce Research Center on Long-Term Care, February 2022.

Budig, Michelle J., Melissa J. Hodges, and Paula England. 2019. "Wages of Nurturant and Reproductive Care Workers: Individual and Job Characteristics, Occupational Closure, and Wage-Equalizing Institutions." *Social Problems* 66, no. 2: 294–319. https://doi.org/10.1093/socpro/spy007.

Bureau of Labor Statistics (BLS). 2021. "Employee Benefits in the United States – March 2021" (news release). September 23, 2021.

Campbell, Stephen. 2020. *We Can Do Better: How Our Broken Long-Term Care System Undermines Care*. PHI, April 2020.

Campbell, Stephen, Angelina Del Reio Drake, Robert Espinoza, Kezia Scales. 2021. *Caring for the Future: The Power and Potential of America's Direct Care Workforce*. PHI, January 2021.

Chang, Grace. 2017. "Inevitable Intersections: Care, Work, and Citizenship." In *Disabling Domesticity*, edited by Michael Rembis, 163–194. New York: Palgrave Macmillan.

Chidambaram, Priya. 2022. "Over 200,000 Residents and Staff in Long-Term Care Facilities Have Died from COVID-19." Kaiser Family Foundation, February 3, 2022.

Coffey, Clare, Patricia Espinoza Revollo, Rowan Harvey, Max Lawson, Anam Parvez Butt, Kim Piaget, Diana Sarosi, and Julie Thekkudan. 2020. *Time to Care: Unpaid and Underpaid Care Work and the Global Inequality Crisis*. Oxfam, January 2020.

Cole, Bethany. 2021. "A Step Towards Universal LTSS? Biden's $400 Billion Long-Term Care Proposal." National Academy of Social Insurance, April 20, 2021.

Colorado Governor's Office. 2021. "JBC Approves Polis-Primavera Administration Plan to Raise Minimum Wage for Colorado's Direct Care Workers to $15/hour" (press release). September 21, 2021.

Connelly, Rachel, and Ebru Kongar, eds. 2017. *Gender and Time Use in a Global Context: The Economics of Employment and Unpaid Labor*. United States: Palgrave Macmillan.

Cooper, David, and Julia Wolfe. 2021. *So-Called Right-to-Work Is Wrong for Montana*. Economic Policy Institute, February 2021.

Costa, Daniel. 2017. *H-1B Visa Needs Reform to Make It Fairer to Migrant and American Workers* (fact sheet). Economic Policy Institute, April 2017.

Dean, Adam, Jamie McCallum, Atheendar Venkataramani, and Simeon Kimmel. 2022. "Resident Mortality and Worker Infection Rates from COVID-19 Lower in Union Than Nonunion US Nursing Homes, 2020–21." *Health Affairs* 39, no. 11: 751–759. https://doi.org/10.1377/hlthaff.2021.01687.

Donovan, Rebecca. 1987. "Home Care Work: A Legacy of Slavery in U.S. Health Care." *Affilia* 2, no.3: 33–44. https://doi.org/10.1177/088610998700200304.

Edwards, Kathryn A. 2020. "'Holes Just Big Enough': Unemployment's History with Black Workers." *RAND Blog*, RAND website, October 5, 2020.

Espinoza, Robert. 2017. *Immigrants and the Direct Care Workforce*. PHI, June 2017.

Favreault, Melissa, and Judith Dey. 2016. *Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief*. Office of the Assistant Secretary for Planning and Evaluation, revised February 2016.

Fernandez, Marisa. 2021. "America's Nursing Homes Fight to Find Enough Caregivers." *Axios*, June 9, 2021.

Gandhi, Ashvin, Huizi Yu, and David C. Grabowski. 2021. "High Nursing Staff Turnover in Nursing Homes Offers Important Quality Information." *Health Affairs* 40, no. 3. https://doi.org/10.1377/hlthaff.2020.00957.

Gebeloff, Robert, Danielle Ivory, Matt Richtel, Mitch Smith, Karen Yourish, Scott Dance, Jackie Fortiér, Elly Yu, and Molly Parker. 2020. "The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes." *New York Times*, May 21, 2020.

Glenn, Evelyn Nakano. 1985. "Racial Ethnic Women's Labor: The Intersection of Race, Gender and Class Oppression." *Review of Radical Political Economics* 17, no. 3: 86–108. https://doi.org/10.1177/048661348501700306.

Glenn, Evelyn Nakano. 1992. "From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor." *Signs: Journal of Women in Culture and Society* 18, no. 1: 1–43.

Glenn, Evelyn Nakano. 2012. *Forced to Care: Coercion and Caregiving in America*. Cambridge, Mass.: Harvard Univ. Press.

Global Ageing Network. 2018. *Filling the Care Gap: Integrating Foreign-Born Nurses and Personal Care Assistants into the Field of Long-Term Services and Supports*. Global Ageing Network and LeadingAge LTSS Center @UMASS Boston, October 2018.

Golden, Lonnie. 2020. *Part-Time Workers Pay a Big-Time Penalty*. Economic Policy Institute, February 2020.

Gould, Elise. 2022. "Equal Pay Day: There Has Been Little Progress in Closing the Gender Wage Gap." *Working Economics Blog* (Economic Policy Institute), March 10, 2022.

Gould, Elise, Daniel Perez, and Valerie Wilson. 2020. Latinx Workers—Particularly Women—Face Devastating Job Losses in the COVID-19 Recession. Economic Policy Institute, December 2020.

Harrington, Charlene, Helen Carrillo, Rachel Garfield, and Ellen Squires. 2018. *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016*. Kaiser Family Foundation, April 2018.

Illinois Association of Health Care Facilities (IAHCF). 2020. *Contract Adjustment Agreement for Collective Bargaining Agreement SEIU Healthcare Illinois and Indiana and Illinois Association of Health Care Facilities*. Accessed February 2022.

Jividen, Sarah. 2021. "What Are the Differences Between an RN and LPN?" *Nurse.org*, July 15, 2021.

Jones, Jacqueline. 2010. *Labor of Love, Labor of Sorrow: Black Women, Work and the Family, from Slavery to the Present*. New York: Basic Books.

Kaiser Family Foundation (KFF). 2015. "Long-Term Care in the United States: A Timeline." August 2015.

King-Dejardin, Amelita. 2019. *The Social Construction of Migrant Care Work: At the Intersection of Care, Migration and Gender*. International Labour Organization, March 2019.

Leutz, Walter. 2010. "The Changing Face of Long-Term Care and How a New Immigrant Workforce Will Shape Its Future." *Generations: Journal of the American Society on Aging* 34, no. 4: 89–96.

Loomer, Lacey, David Grabowski, Huizi Yu, and Ashvin Gandhi. 2021. "Association Between Nursing Home Staff Turnover and Infection Control Citations." *Health Services Research* 57, no. 2: 322–332. https://doi.org/10.1111/1475-6773.13877.

McCall, Stephen. 2020. *Growth and Fragmentation in the Long-Term Care Industry* (fact sheet). PHI, April 2020.

McNicholas, Celine, Margaret Poydock, Julia Wolfe, Ben Zipperer, Gordon Lafer, and Lola Loustaunau. 2019. *Unlawful: U.S. Employers Are Charged with Violating Federal Law in 41.5% of All Union Election Campaigns*. Economic Policy Institute, December 2019.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. Implementation of the Home- and Community-Based Services Settings Rule. December 2019.

Michigan Governor's Office. 2021. "Gov. Whitmer Signs Executive Order Establishing Nursing Home Workforce Stabilization Council" (press release). December 14, 2021.

Miller, Mark. 2021. "Turning Away from Nursing Homes, to What?" *New York Times*, April 1, 2021.

Moore, Kyle. 2019. "Linking Racial Stratification and Poor Health Outcomes to Economic Inequality in the United States." Washington Center for Equitable Growth, March 28, 2019.

Moore, Kyle. 2021. "Labor Rights and Civil Rights." Economic Policy Institute, June 2021.

Muoio, Dave. 2021. "Staffing Shortages Force Long-Term Care Facilities to Limit Admissions, Hire Agency Workers." *Fierce Healthcare*, September 22, 2021.

Nevada Department of Health and Human Services (NVDHHS). 2021. "Home Care Employment Standards Board" (web page). Accessed April 2022.

Novack, Valerie, and Rebecca Cokley. 2020. "Investing in Home and Community-Based Care During the Coronavirus Pandemic and Future Disasters." Center for American Progress, June 2020.

O'Malley Watts, Molly, MaryBeth Musumeci, and Meghana Ammula. 2022. *State Policy Choices About Medicaid Home and Community-Based Services amid the Pandemic*. Kaiser Family Foundation, March 2022.

Oregon Department of Human Services (OR DHS). 2022. "Enhanced Wage Add-on Program." Accessed May 2022.

Osterman, Paul. 2017. *Who Will Care for Us?: Long-Term Care and the Long-Term Workforce.* Russell Sage Foundation.

PHI. 2021. *Direct Care Workers in the United States: Key Facts*. September 2021.

President's Committee for People with Intellectual Disabilities (PCPID). 2017. *America's Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy*.

Razavi, Shahra. 2007. *The Political and Social Economy of Care in a Development Context: Conceptual Issues, Research Questions and Policy Options*. United Nations Research Institute for Social Development, June 2007.

Rosbrow-Telem, Laura. 2020. "NH First State to Offer COVID Stipend to Long-term Care Workers." *Public News Service*, April 17, 2020.

Ruffini, Krista. 2022. "Worker Earnings, Service Quality, and Firm Profitability: Evidence from Nursing Homes and Minimum Wage Reforms." *Review of Economics and Statistics*, Working Paper, April 25, 2022.

Sojourner, Aaron, Brigham Frandsen, Robert Town, David Grabowski, and Min Chen. 2015. "Impacts of Unionization on Quality and Productivity: Regression Discontinuity Evidence from Nursing Homes." *Industrial and Labor Relations Review* 68, no. 4: 771–806. https://doi.org/10.1177/0019793915586380.

Sojourner, Aaron, David C. Grabowski, Min Chen, and Robert Town. 2010. "Trends in Unionization of Nursing Homes." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 47, no. 4: 331–342. https://doi.org/10.5034/inquiryjrnl_47.04.331.

Stone, Robyn, and Joshua Wiener. 2001. *Who Will Care For Us?: Addressing the Long-Term Care Workforce Crisis*. Office of the Assistant Secretary for Planning and Evaluation (APSE), April 2001.

Stulick, Amy. 2021. "Nursing Homes Use of Staffing Agencies Soars During Pandemic as Workforce Crisis Deepens." *Skilled Nursing News*, June 2021.

Temple, April, Debra Dobbs, and Ross Andel. 2009. "Exploring Correlates of Turnover Among Nursing Assistants in the National Nursing Home Survey." *Health Care Management Review* 34, no. 2: 182–190. https://doi.org/10.1097/HMR.0b013e31819c8b11.

Wilson, Valerie, and William Darity Jr. 2022. *Understanding Black-White Disparities in Labor Market Outcomes Requires Models That Account for Persistent Discrimination and Unequal Bargaining Power*. Economic Policy Institute, March 2022.

Wolfe, Julia, Jori Kandra, Lora Engdahl, and Heidi Shierholz. 2020. *Domestic Workers Chartbook: A Comprehensive Look at the Demographics, Wages, Benefits, and Poverty Rates of the Professionals Who Care for Our Family Members and Clean Our Homes.* Economic Policy Institute, May 2020.

Zallman, Leah, Karen Finnegan, David Himmelstein, Sharon Touw, and Steffie Woolhandler. 2019. "Care for America's Elderly and Disabled People Relies on Immigrant Labor." *Health Affairs* 38, no. 6: 919–926.