The Triple Knot of Long-Term Care in the United States: Long-Term Care Financing, Delivery and Workforce Policy[1]

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Abstract

The U.S. is currently in the midst of a serious debate about the future of immigration policy in the U.S. Any change has the potential to profoundly shape the circumstances of direct care workers and the demand for Long-Term Care LTC. Yet prior immigration reform debates and proposals have not considered workforce planning needs or contemplated immigration as a primary tool for managing labor markets. Historically, the U.S. has elected not to import lesser skilled workers for the purpose of employment because these workers compete directly with other vulnerable low-wage workers. Prediction of strong job growth in this sector, however, suggests a clear need to consider options that may include an immigration visa pathway to admission. Policies that limit the entry of low skilled workers may diminish the future labor pool of direct care workers in LTC. Options under exploration include 1) increasing pathways to legal status for undocumented immigrants; 2) increasing pathways for legal temporary workers with the option to offer extensions of stay or transitions to permanency; 3) pursuing an aggressive immigration strategy to permit an influx of low-wage workers to fill vacancies for direct care jobs; and 4) creating a new visa program for less-skilled, non-seasonal, non-agricultural workers. This latter option was proposed in Congress in 2013, but movement on any reforms has stalled.

Key words :
Long-Term Care LTC, LTC Financing, Delivery System Efforts, The Role of Immigrant Workers, The Turnover Challenge, The Recruitment Challenge, Public Policy Solutions

1) This article was presented as "Robyn Stone' Traple Knot of Long Term Care on the US for Cheju talk" at the 15th Peace Island Forum (October 13, 2016) at Jeju National University of South Korea.

Introduction

In 2012 the population aged 65 or older was approximately 14 percent of the U.S. population; by 2030, however, one in five Americans are projected to be elderly. In 2030, the population aged 65+ is expected to be 72 million and 83 million by 2050, double the size of this age group today. The number of individuals aged 85 and older--the group most likely to need long-term care (LTC)--is s expected to increase fivefold over the next 40 years.

LTC encompasses a broad range of services and supports intended primarily to help chronically disabled elderly individuals to function as independently as possible for as long as possible. Services provide assistance with basic activities of daily living (ADLs) such as dressing, bathing and toileting, and instrumental activities of daily living (IADLs) such as household chores, life management tasks, and transportation. These services include both hands on care and standby, supervisory human assistance. An increasing proportion of individuals needing LTC are medically complex, requiring attention to their medical and functional needs arising from multiple chronic conditions (e.g., heart disease, diabetes) as well as management of problem behaviors resulting from dementia. Individuals needing LTC may also need intense short-term medical, rehabilitative and therapeutic care following a hospitalization--referred to as post-acute care in the U.S.

Approximately 12.5 million people of all ages in the U.S. today need some type of LTC services or supports. Almost seven million of these individuals are aged 65 or older; 5.4 million live at home or in some other type of community-based setting and 1.3 million are nursing home residents. The proportion of elderly individuals needing LTC (defined as having limitations in two or more ADLs) increases substantially with age. Only five percent of those aged 65 to 69 are disabled, compared to 23 percent of those in the 80 to 84 year old category and 38 percent of those aged 85-89.

LTC Financing

Financing of LTC is a patchwork of funding sources. It is important to note that the vast majority of these services and supports is provided "free" by family members and friends. In 2013 about 40 million family caregivers provided an estimated 37 billion hours of care to an adult with limitations in daily activities. The estimated economic value of their unpaid contributions was approximately $470 billion, up from an estimated $450 billion in 2009 (Reinhard, Feinberg, Choula and Houser, 2015).

In 2013, total national spending on formal LTC was $310 billion (Reaves and Musumeci, 2015). The largest source of financing was the Medicaid program, representing 51 percent of funding for these services. Other sources include 21 percent public (Department of Veterans Affairs, Older Americans Act, other state dollars, etc.), eight percent private LTC insurance, and 19 percent private, out-of-pocket. In 2014, on average, nursing facility care was $87,600. Generally, home and community-based services (HCBS) are less expensive than institution-based LTC, but may still represent a major financial burden for individuals and their families. In 2014, on average, a year of home health aide services (at $20/hour, 44 hours/week) cost almost $45,800 and adult day care (at $65/day, 5 days/week) totaled $16,900. The average elderly individual cannot afford to cover the cost of LTC, particularly if the need for service lasts for an extended period of time. A large proportion of these people, therefore, must rely on public resources.

Medicaid, a jointly federal and state funded, state administered health insurance program for the poor, is required to provide coverage for nursing home care for elderly and younger disabled people who meet financial eligibility requirements (low income and negligible assets); states have the option of paying for non-institutional HCBS. Federal spending makes up slightly more than half the program costs; States pay a portion of all Medicaid costs and receive matching Federal funds (with rates determined at the state level). Spending on HCBS varied widely in 2013, from 21 to 78 percent of total LTC Medicaid dollars.

Overall, there has been tremendous growth in the HCBS spending, representing 46 percent of total Medicaid LTSS in 2013 and reflecting a major "rebalancing" of the LTC system from nursing homes to home care and other residential options. Although HCBS options have been available through Medicaid since the early 1980s, the recent expansion has been spurred on by two activities--one legal and one legislative. In 1999, the U.S. Supreme Court's Olmstead decision required that people with disabilities have the option of receiving services in the least restrictive environment. The Centers for Medicare and Medicaid Services (CMS), which administers the program at the federal level, made the HCBS waiver process very flexible and invested millions of dollars in state grants to encourage a shift from nursing home care. More recently, the Affordable Care Act (ACA) provided incentive for states to expand HCBS options even further, including the "Money Follows the Person" program that has helped to move thousands of elderly and younger people out of nursing homes into the community.

Despite over 30 years of a private LTC insurance

market, this strategy only represents a small fraction of current financing and has not grown over the three decades. The ACA established the Community Living Assistance Services and Supports (CLASS) program that was designed to provide working adults the opportunity to offset the costs of future long-term services and supports needs. CLASS was intended to be a national, voluntary insurance program for purchasing LTC coverage, financed by individual premium contributions, but concerns about solvency and adequacy of the cash benefit led to the program's repeal by the American Taxpayer Relief Act of 2013. This law established a time-limited bipartisan Commission on LTC that released a report in 2013. The Final Report outlines several service delivery, workforce, and financing policy recommendations, e.g., establishing integrated care teams, using technology-enhanced data sharing across care settings and among providers, training family caregivers, finding a sustainable balance of public and private financing for LTSS. While the Commission recommended that future work be carried out through a national advisory committee, no such committee has been convened to date, although numerous public and private stakeholders remain interested in advancing the national LTC agenda.

Delivery System Efforts

The LTC delivery system is a patchwork of providers and settings. The modern nursing home industry in the U.S. developed, in large part, in response to Medicaid becoming the major public payer in the 1970s. In 2010, there were 15,683 nursing homes with approximately 1.7 million beds certified by Medicaid and/or Medicare (the social insurance program that covers health care, including post-acute care, for the elderly and some younger people with disabilities). The Nursing Home Reform Act, passed way back in 1987, established quality standards for nursing homes that emphasized the importance of resident-centered care. A growing movement, known as "culture change", catalyzed by providers in the Pioneer Network, has worked to radically transform the nursing home environment (Miller et al., 2010). Most of the initiatives involve substantial physical redesign, from hospital-like to home-like, the development of small households or neighborhoods and changing staffing patterns to promote continuity of care and resident direction. To date, most of the activity in this area has occurred among non-profit organizations, although the majority of nursing homes are for-profit. Many of the principles, including resident direction and empowerment and consistent assignment of staff, have become more commonplace in this sector overall.

HCBS is a catch-all phrase that refers to a wide range of noninstitutional LTC settings, including the private homes/apartments of care recipients or their families and various types of residential alternatives. This latter category encompasses places and care arrangements that provide housing and services to older adults with varying degrees of disability and LTC need. Although there is no single agreed upon definition of assisted living, the term is used to connote a residential setting that provides 24 hour supervision, provision and oversight of personal and supportive services, health-related service, social services, recreational activities, meals, housekeeping, laundry and transportation. Other residential options include smaller group settings including board and care homes, adult foster care and adult family care. These settings are regulated at the state or local level and vary in nomenclature as well a size and services offered.

Another HCBS setting is the adult day center, where people in need of LTC go for social activities, meals and snacks, personal care, therapeutic activities, health monitoring, medication management, emergency respite for families and caregiver support services. One study estimated that there are more than 4600 adult day service providers in the U.S., serving approximately 260,000 participants and their family caregivers on any given day (Metlife, 2010).

The services delivered in these various settings tend to be funded in silos and on a fee-for-service basis. Recently, however, there has been growing interest and experimentation in the development of more integrated, coordinated systems of LTC where the providers receive some type of financial incentive and assume more risk. Recognizing that the LTC population also has multiple medical care needs, policymakers and providers have begun to focus attention on models that integrate acute, primary, and chronic care and LTC for this population. They are exploring options that coordinate the care more seamlessly across providers and are investigating how more integrated or "bundled" payments can help to achieve more efficiency, lower costs and better quality of care. These efforts are in the nascent stage and are being supported primarily through federal and state demonstration activities.

Who Provides LTC

As noted above, most LTC in The U.S. is provided by unpaid family members, friends and neighbors. The formal care system is composed of licensed personnel, facility and agency-based direct care workers and self-employed direct care workers who

are hired directly by consumers and their families. The licensed professionals include physicians (primarily medical directors of nursing homes and home health agencies), nurses (nurse practitioners, registered nurses who are typically directors of nursing, and licensed practical nurses who are often the frontline supervisors), social workers, occupational and physical therapists, and consultant pharmacists. Licensed staff also includes nursing home administrators and other top-level managers who oversee the operations of LTC organizations.

It is, however, the direct care workers--nursing assistants, home health and homecare aides --who provide the bulk of formal LTC across all settings. They are responsible for helping frail and disabled elderly to carry out the most intimate and basic ADLs. These workers also have the closest relationships with residents or clients and their families and are engaged in emotional as well as physical and cuing support. In 2013, there were an estimated 4.2 million direct care workers in the U.S.--1.4 million nursing assistants, 807,000 home health aides, 1.1 million personal care aides and another 800,000 self-employed "independent" workers in home care.

This workforce is almost entirely female; the average nursing assistant is in her mid-to-late thirties while the mean age of the home care worker is 46 years. Unlike their licensed counterparts, direct care workers are part of a low wage workforce. In 2014, the median hourly wage for nursing assistants was $12.07, $10.28 for home health aides, and $9.83 for personal care aides, substantially below the $17.09 estimate for all workers in the U.S. (BLS, 2014). At least one out of five have incomes below the federal poverty level and many rely on two or more publicly subsidized benefits including Medicaid (the means-tested health insurance program for the poor) and food stamps (providing vouchers to purchase commodities).

The Role of Immigrant Workers

The direct care workforce is very diverse culturally and ethnically. Data from 2009 indicate that 49 percent of all direct care workers were white, non-Hispanic, 28 percent were African-American, 16 percent were Hispanic and seven percent were part of another racial or ethnic group. A growing percentage of this workforce is an immigrant population. Almost one in four workers were born in another country; almost one in four home health aides and one in five nursing home assistants are foreign born (Martin et al., 2009). One study of immigrant home health workers conducted by this researcher and using a nationally representative sample from 2007 (LeadingAge, 2014) found that 16.8 percent of these foreign born aides were white, 48.4% were black, 28.5% were Hispanic and the remaining 34.7% were categorized as "other". A little over half of these workers had at least some college education; 57.4 % were at least 45 years old. Approximately 45% reported that they always or sometimes used a language other than English on the job, and 46% reported that they had experienced communication problems with care recipients due to language issues. More than one in five of these immigrant workers reported that they had experienced some type of discrimination because of their race or ethnicity.

Currently, individuals who are not U.S. citizens may enter and gain permission to work in the United States through three pathways: 1) legal permanent admission, 2) legal temporary admission, or 3) unauthorized work. The permanent and temporary classes of admission to this country admit substantial numbers of professional healthcare providers but do not target lesser-skilled individuals. Most immigrant direct care workers who qualify for a permanent employment visa do so under an EB-3 visa. This visa is primarily reserved for skilled workers with a bachelor's degree and two years of work experience. This visa does include an "other" category for all lesser skilled workers who meet eligibility criteria on a temporary basis. The EB-3 visas are capped at 5,000 workers per year. Direct care workers typically enter the U.S. via family reunification, as refugees, through a green card lottery or for unauthorized work (Leutz, 2010-2011). An estimated 79 percent of direct care workers are legal (Martin et al., 2009). Twenty-nine percent of direct care workers across all settings come from the Caribbean and approximately one in five immigrated from Mexico or Central America. Legal entrants make up the bulk of the foreign born in the professional LTC workforce, while unauthorized, illegal workers comprise a substantial percentage of the direct care workforce (Martin et al., 2009). The single largest group of unauthorized direct care workers is of Hispanic or Caribbean origin; one out of five is from Africa.

Foreign born LTC workers are considerably more likely than other workers to live and work within the central cities of metropolitan areas. Three quarters of foreign born direct care workers live in just 24 metropolitan areas, particularly New York City, Los Angeles and Chicago. They are somewhat older than their native born counterparts. Two thirds of immigrant direct care workers have been in the country for at least 10 years. One half of foreign born nursing assistants/home health aides and 44 percent of the home care/personal care aides are naturalized citizens.

Foreign born care workers tend to have lower rates of unemployment than their native counterparts and earn more than native-born workers. In 2007,

the average weekly earnings for immigrant home care/personal care aides were $380 compared with $341 for their native-born peers. Similarly, foreign born nursing home/home health aides earned, on average, $533 per week, compared with $432 for those born in the U.S. This difference could not be accounted for by number of hours worked and educational differences (Martin et al., 2009). Field work conducted by the research team suggests that immigrant workers may command higher wages because they tend to have longer tenure with their employer.

Challenges to Developing a Stable, Competent Workforce

There are a number of challenges the U.S. is facing with respect to the aging of its population and the demand for a quality direct care workforce.

The Turnover Challenge

Problems with high turnover rates have plagued the LTC sector for decades. In 2012, turnover rates among nursing assistants employed in nursing homes was 51.5 percent (AHCA, 2013); no comparable national estimates are available for home health or personal care aides but anecdotal evidence indicates that rates are also high for this segment of the direct care workforce. High turnover rates are expensive for employers, workers and ultimately elderly consumers and their families. There is also evidence that turnover and the instability that ensues affect quality of care delivered to the LTC population and the quality of life that individuals and their families experience. A growing body of research has identified several key factors associated with high turnover including low wages and inadequate benefits, poor and supervision, lack of empowerment, perceived value and career opportunities, high injury rates, and lack of consistent assignment to specific residents or clients to ensure continuity of care and ongoing relationship building. Stronger local economies also contribute to increased turnover, as these low wage workers leave for better jobs in more competitive retail and service sectors.

The Recruitment Challenge

As the status of the local economic markets ebbed and flowed over the past few decades, there would be concern about hiring direct care workers whenever there was an economic upswing and unemployment rates were low. Providers, policymakers and even consumers seemed to be happy with finding "warm bodies" to fill these LTC jobs. But several trends have begun to shift the focus from just hiring staff to hiring and retaining quality staff. As the evidence grows in support of the relationship between quality staff and quality outcomes, stakeholders are beginning to pay attention to the recruitment of knowledgeable staff with the skills and the competencies to deliver good care. Payment and delivery reforms are creating new integrated and coordinated models of care that require quality staff across the entire workforce, from administrators to clinicians to frontline caregivers. Nursing assistants, home health and personal care aides must go beyond the basics to understand the complex medical and social needs of today's frail elderly population, including a growing population of individuals with multiple chronic conditions and dementia. They also need to understand the intricacies of end of life care. Home health and personal care aide jobs are among the fastest growing occupations with demand expected to increase 49 percent by 2022.

The long-term challenge is even more worrisome. Just as the baby boomers reach age 75 and over by 2030, the number of women in the age group most likely to be in direct care jobs is expected to decline. At the same time, the availability of family caregivers is also expected to decline due to a combination of factors including increased and extended female labor force participation, higher rates of childlessness among baby boomers and increased divorce rates among this population. Consequently, the U.S. will experience more demand for direct care workers and less people available to fill the jobs. Policymakers, providers and consumers, therefore, are recognizing the importance of developing a pipeline.

Several barriers, however, impede the development of this pipeline. First, the LTC sector, and nursing homes in particular, is not valued by society and is often stereotyped in the media as an "unsafe environment where old people go to die". Consequently, many individuals are not attracted to the sector and it is often referred to as the "accidental profession". As noted earlier, wages and benefits are inadequate for all staff but especially for direct care workers; comparable jobs in acute care and primary care settings are compensated at a much higher level. Reimbursement through Medicaid, which represents the major payer for LTC in the U.S., varies across states and in general is viewed as inadequate to meet the staffing needs of the providers in the nursing home and HCBS sectors.

Training requirements are either low or nonexistent. Nursing assistants and home health aides employed in Medicare or Medicaid certified nursing homes or agencies are required to have only 75 hours of training and home care or personal care

aides have no federal requirements at all; states vary in the extent to which they require additional hours of training for nursing assistants/home health aides and any training for home care or personal care aides. In service training for incumbent workers is also inadequate and the workforce at all levels is not being prepared to deliver care in the new service delivery models that are emerging as a result of the ACA and other health reform efforts. Even when there is a commitment to training, there is often a dearth of faculty to develop the curricula and provide the education.

Public Policy Solutions

Policymakers at the federal and state levels are exploring a number of different strategies to address the challenges to both successful recruitment and retention of a quality LTC workforce.

Compensation and Benefits

There is currently a debate at the federal level about whether the U.S. should raise the minimum wage nationally to $15.00 per hour. A number of cities including Seattle, San Francisco and Los Angeles have already increased the minimum wage as have a number of large companies such as Walmart. States have also explored wage enhancements through their Medicaid programs (referred to as" pass-throughs" where increased payments are passed directly to support wages for nursing assistants or home care aides), although these often are one time efforts rather than systemic in nature. A number of state Medicaid programs have instituted "pay for performance" reimbursement schemes that provide additional payments to nursing homes that have been able to demonstrate significant workforce improvements within culture change activities. The ACA has significantly increased access to health insurance coverage for low and modest income workers, which may help home care/personal care aides who were not poor enough to qualify for Medicaid to obtain insurance for themselves and their dependents.

Training

The federal government recently invested $35 million in 44 grants that are creating new geriatric education centers across the country. These programs, which historically were limited to training health care professionals, now have a mandate to train direct care workers and family caregivers. The Affordable Care Act supported a 6-state demonstration--the Personal/Home Care Aide State Training (PHCAST) program--that was designed to recruit and train qualified aides in transportable skills and to strengthen the direct care workforce. Grantees were funded to develop and implement curricula in 10 mandated core competencies, support trainees and provide certification to those completing the curricula successfully. While operationalized in different ways, all of the programs developed partnerships between local community colleges, other vocational training entities and home care agencies to provide both didactic and on-the-job training to both incumbent workers and new job candidates. Several models also partnered with local high schools and targeted displaced older workers who were interested in second careers. Most provided career ladders, allowing the credits accrued in the programs to be applied to training that leads to higher-level jobs in the LTC sector.

The U.S. Department of Labor recently awarded multi-sector grants to support new apprenticeship programs; the LTC sector was included in this initiative. In Washington State, the Service Employees International Union (SEIU) partnered with policymakers and providers to create a statewide home care/personal care training program, the largest in the country. The program is competency-based and addresses the development of soft skills as well as more clinical skills and knowledge. This program also includes wrap around services and supports to assist these primarily low wage earners in challenges such as finding child care, transportation and managing their finances. A Minnesota aging services association developed a health support specialist apprenticeship, designed as a career ladder for nursing assistants in nursing homes interested in career development as managers.

Regulatory Efforts

Nursing homes are regulated at the federal level through an annual survey and certification process administered by state agencies. The U.S. Department of Health and Human Services has just proposed new rules that would require that homes demonstrate the competencies of their staff as well as adequacy of staffing relative to resident acuity levels and occupancy. Quality Improvement Organizations (QIOs), funded by the federal government to provide technical assistance to nursing home and home health providers, have been charged with helping these organizations to use evidence-based practices to empower direct care staff through incorporation of these workers into care teams, involving these aides in clinical documentation and continuous quality improvement efforts and enhancing their job responsibilities in specialty areas (e.g., dementia care, medication

management, pain management, palliative care). A number of states have loosened their scope of practice regulations, particularly in nursing, to allow for more delegation of tasks to aides. QIOs have also been working with LTC providers to institute consistent assignment to ensure, to the extent possible, that residents or home care clients receive services from the same aides over time.

Immigration Policy

The U.S. is currently in the midst of a serious debate about the future of immigration policy in the U.S. Any change has the potential to profoundly shape the circumstances of direct care workers and the demand for LTC. Yet prior immigration reform debates and proposals have not considered workforce planning needs or contemplated immigration as a primary tool for managing labor markets. Historically, the U.S. has elected not to import lesser skilled workers for the purpose of employment because these workers compete directly with other vulnerable low-wage workers. Prediction of strong job growth in this sector, however, suggests a clear need to consider options that may include an immigration visa pathway to admission.

Policies that limit the entry of low skilled workers may diminish the future labor pool of direct care workers in LTC. Options under exploration include 1) increasing pathways to legal status for undocumented immigrants; 2) increasing pathways for legal temporary workers with the option to offer extensions of stay or transitions to permanency; 3) pursuing an aggressive immigration strategy to permit an influx of low-wage workers to fill vacancies for direct care jobs; and 4) creating a new visa program for less-skilled, non-seasonal, non-agricultural workers. This latter option was proposed in Congress in 2013, but movement on any reforms has stalled.

While immigration reform remains in the hands of federal and state legislators, employers in the LTC sector may take practical steps to enhance the role that immigrant nursing home and home care aides play in the delivery of critically needed services. Employers need to think of cultural diversity as an asset, rather than a deficit. Training programs should be sensitive to the needs of immigrant workers and cultural competence--the ability to interact effectively with people of different cultural, racial and ethnic backgrounds--should be required for all direct care workers. Finally, recruitment efforts directed toward immigrant direct care workers should focus primarily on tapping into local family and community ties. Immigrants find these jobs through word- of- mouth from families, friends and neighbors; it is here that recruitment activities need to be strengthened.

Receiving Date: April 4, 2016
Reviewing Date: April 14 & 18, 2016
Reporting Date of Article Appearance: April 25, 2016