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long-term care

Confronting Today's
Challenges



This publication by Carol Raphael is one of a series of three briefs that identify how research has improved long-term care service delivery and policy in the past and how it might continue to do so in the future. Each brief is based on key themes that emerged from a 2002 conference on building the field of long-term care, which was sponsored by AARP, the Agency for Healthcare Research and Quality (AHRQ), the Retirement Research Foundation, and The Robert Wood Johnson Foundation.

Carol Raphael is president and chief executive officer of the Visiting Nurse Service of New York, the largest nonprofit home care agency in the United States. Ms. Raphael championed the creation of the agency's Center for Home Care Policy and Research, which was established in 1993. The Center has become the national leader in home care research.

The long-term care system is a large, complex configuration of services that has developed over a relatively short time. In many ways, health services research has contributed to the field as it has evolved. The growth of alternatives to institutional care, including home- and community-based care, partially stemmed from demonstration projects such as the National Long-Term Care Demonstration sponsored by the federal government.¹ Activities of daily living (ADL) measures, which emerged from the research of Sidney Katz, helped to reframe thinking about the treatment of recipients of long-term care.²

As the long-term care system continues to grow and change, new challenges arise, providing ample opportunities for new research to be conducted and for existing research to be applied in innovative ways. Workforce shortages, questions about how to measure and deliver quality care, a lack of integration of care, and unstable financing are among the central challenges facing the field of long-term care.

These challenges will be exacerbated as the population ages. Thus, the need for research is more critical now than ever.

The Baby Boom generation will begin retiring in 2010, and the number of people aged 85 and older—those most likely to require long-term care—will double by 2020.³

Workforce Shortages

Demand for long-term care exceeds the supply of qualified workers who can deliver those services, resulting in severe workforce shortages. The scarcity of nurses and paraprofessional workers, who provide most of the care in long-term care settings, is found in nursing homes and in agencies that provide home- and community-based care. Currently, 91 percent of nursing homes lack an adequate number of staff for basic care, and the vacancy rate for nurses in home care is about 12 percent annually.⁴ By 2010, some estimate that there will be a 30 percent shortage of aides in long-term care.⁵

Rapid turnover among home care workers also contributes to inconsistent and often inadequate staffing levels. Annual turnover rates of certified nurses' aides approach 100 percent in nursing homes. In home health care, turnover rates are 21 percent nationwide for nurses⁶ and 28 percent for home health aides.⁷



Factors such as immigration patterns, trends in the retail and services sectors of the economy, and the availability of other employment options for women may hinder the ability of long-term care providers to attract new nurses and paraprofessionals. Job dissatisfaction is also a widespread problem. Home health nurses have a very complex and demanding job: they must manage care for patients with multiple conditions, keep up with rapid advances in medicine and technology, and learn how to navigate family dynamics.⁸

Yet paraprofessional work remains a low-wage occupation with few or no benefits. Home health aides earn on average between \$10,000 and \$14,000 per year. High injury rates, minimal job security, little support, and limited opportunity for advancement also contribute to job dissatisfaction.

Quality

A great success of health care research has been the development of instruments to measure outcomes of care provided by nursing facilities and home health agencies as

a gauge of quality. The desired outcomes themselves are not clear, however. Is a good quality outcome restoration, rehabilitation, compensation, maintenance of function, or prevention of decline? Until there is consensus about what constitutes quality care, it is difficult to assess whether the measurement tools are adequate. In addition, there are no means by which quality of care can be compared across various long-term care settings.⁹

Further complicating the quest for quality long-term care is the lack of clarity about which changes to the health care system might lead to higher quality encounters between caregivers and patients. Evidence on the effectiveness of system changes is scarce, and existing clinical information is not necessarily translatable to specific applications that can improve quality system-wide.

Moreover, enhancing the quality of long-term care is in some ways more complex than enhancing the quality of acute care. Improvement efforts in acute care focus on achieving specific health outcomes and eliminating medical errors. In long-term care, however, providers must manage complex cases involving patients with multiple health conditions. Long-term care has

more actors and operates at the intersection of the medical, social, and housing terrains. With home health, in particular, care is highly decentralized, with as many sites of care as there are patients.

Integration of Care

In 1998, almost 20 percent of Medicare beneficiaries received care in more than one setting¹⁰—a statistic that underscores the need to coordinate and integrate care for patients who move from one setting to the next. In the 1990s, many hoped that managed care could help integrate acute and long-term care and improve care for chronically ill patients. However, it has not been entirely successful in doing so.

Others believed that mergers and consolidations of health care institutions would create integrated systems of acute and long-term care. This, too, failed to happen. In fact, over the last decade, increased provider competition has often prevented the building of long-term collaborative relationships that are necessary to create smooth transitions for patients when they leave one health care setting for another.

Two recent changes in Medicare payment promoted fragmentation in the long-term care system. First, the Medicare budget

cuts that started with the Balanced Budget Act of 1997 forced providers to focus on financial survival and discouraged experimentation with new models of care.

Second, Medicare's new prospective payment systems (PPS) for long-term and post-acute care organizations reinforced existing isolation among care settings.

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PPS created separate systems for reimbursing services depending on the site where care is provided. For long-term care, these sites include nursing homes, home health care, rehabilitation facilities, and long-term care hospitals. By creating incentives for providers to focus more narrowly on their own site and financial survival, PPS has intensified the health care system's orientation to single sites of care rather than to the entire care process, which may take place in multiple settings. Ultimately, greater fragmentation in the long-term care system makes it more difficult for patients and family caregivers to transition from one source of care to the next.

Financing

Public dollars dominate financing in long-term care. The largest source of public funds comes from Medicaid, which accounts for 45 percent of all long-term care spending, though state Medicaid spending, eligibility, and coverage vary.¹¹

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Medicaid expenditures make up an average of 15 percent of state budgets, and spending is estimated to grow at an annual rate of 8 to 9 percent in the coming years.¹² As budget shortfalls hit statehouses as a result of the weak economy, however, two-thirds of states have begun cutting Medicaid benefits, increasing co-payments, restricting eligibility, or removing people from the rolls.¹³

Medicare continues to influence long-term care financing, and it has taken on a greater role recently. In 1998, Medicare funded 11 percent of all nursing home costs, up from 2 percent in 1985.¹⁴ It currently funds 27 percent of all home health care. Recently, Medicare introduced prospective payments for post-acute care, which were intended to control increases in Medicare spending. Instead of being

paid on the basis of the actual costs of the services they render, providers are now given fixed payments for a given service. For patients who need home health care, Medicare moved to restrict its benefit to the post-acute period.

A Role for Long-Term Care Research

Health services research can make a critical difference in each of the areas highlighted in this brief. It can provide tools for understanding and improving care and care processes. Research can advance and explore new models of care, test methods for spreading knowledge about best practices throughout institutions, provide leaders and policymakers with evidence to make informed decisions, and much more. In addition to producing new evidence, researchers can communicate and reframe existing knowledge to be more relevant to the current issues. ▶

Endnotes

- 1 Carcagno, G.J. and P. Kemper. "Evaluation of the National Long Term Care Demonstration: Overview of the Channeling Demonstration and Its Evaluation," *Health Services Research*, Vol. 23, No. 1, 1988, pp. 1–22.
- 2 Katz, S. "Assessing Self-Maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living," *Journal of the American Geriatrics Society*, Vol. 31, No. 12, 1983, pp. 721–7.

- 3 Bureau of Labor Statistics. 2000 census data.
- 4 Out of Many One and Seniors USA Web site, www.oomo.org/seniors_usa1.htm.
- 5 Paraprofessional Healthcare Institute Web site, www.paraprofessional.org.
- 6 Pindus, N. et al. *Skill Shortages and Mismatches in Nursing-Related Health Care Employment*. Washington, DC: The Urban Institute, April 2002.
- 7 Testimony by William J. Scanlon, director, health care issues, U.S. General Accounting Office, to the Committee on Health, Education, Labor and Pensions, U.S. Senate, May 17, 2001.
- 8 Kimball, B. and E. O'Neill, *Health Care's Human Crisis: The American Nursing Shortage*. Princeton, NJ: The Robert Wood Johnson Foundation, April 2002.
- 9 Institute of Medicine. *Improving the Quality of Long-Term Care*. Washington, DC: The National Academies Press, 2000.
- 10 The Henry J. Kaiser Family Foundation Web site, www.kff.org/content/2001/2253/2253.pdf
- 11 John F. Kennedy School of Government/ The Commonwealth Fund's Bipartisan Congressional Health Policy Conference. *In Pursuit of Long-Term Care: Ensuring Access, Coverage, and Quality*, January 2002.
- 12 Kaiser Commission on Medicaid and the Uninsured policy brief: *The Role of Medicaid in State Budgets*. Washington, DC: The Henry J. Kaiser Family Foundation, October 2001.
- 13 Pear, R. "Most States Cutting Back on Medicaid, Survey Finds," *The New York Times*, January 14, 2003.
- 14 Centers for Medicare and Medicaid Services Web site, www.cms.gov.



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