

With Help from Afar:

THE ROLE OF IMMIGRANT HOME HEALTH
AIDES IN MEETING THE GROWING DEMAND
FOR LONG-TERM SERVICES AND SUPPORTS

ISSUE
BRIEF


center for applied research



With Help from Afar: THE ROLE OF IMMIGRANT HOME HEALTH AIDES IN MEETING THE GROWING DEMAND FOR LONG-TERM SERVICES AND SUPPORTS

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The LeadingAge Center for Applied Research bridges practice, policy and research to advance high-quality health, housing and supportive services for America's aging population. The Center's three signature objectives are to advance quality of aging services, develop a high-performing workforce, and enhance resident options through services and supports. Through applied research, the Center creates an evidence-base to improve policy and practice.

The Center for Applied Research is part of LeadingAge, an association of 6,000 not-for-profit organizations dedicated to expanding the world of possibilities for aging.

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About This Brief

The demand for long-term services and supports among older people and people with disabilities is growing faster than the pool of workers who provide that care. Researchers predict that an expanded immigrant direct care workforce presents one solution to meeting future workforce needs. This brief relies on the 2007 National Home Health Aide Survey (NHHAS) to describe:

- *The characteristics of immigrant home health aides who are currently employed by Medicare- and Medicaid-certified or state-licensed home health and hospice agencies.*
- *The potential role that immigrant direct care workers could play in filling vacancies in home health and other direct care jobs.*
- *How current and proposed U.S. immigration policy affects immigrant workers and American families.*
- *The policy and practice implications of an expanded immigrant direct care workforce.*

Introduction

Direct care workers—including home health aides, hospice aides, certified nurse aides and personal care aides—are the primary providers of paid, hands-on long-term care in the United States. These workers deliver a broad range of everyday supports, including daily assistance with meal preparation, medications, bathing and dressing, as well as transportation to social and medically related activities. They make it possible for more than 13 million older Americans and Americans with disabilities to live meaningful lives in their homes and communities and remain connected to their families.

Increased life expectancies and the projected growth of the older population have created a significant demand for the type of long-term services and supports that direct care workers provide. This demand for services and supports comes at a time when the population in need of care is increasingly frail and the long-term care system is grappling with

quality-of-care concerns. Yet, as illustrated by the statistics in the box below, the current demand for long-term care is growing faster than the pool of workers who provide that care.

The sheer number of workers needed to care for an aging population with increased chronic care needs makes it imperative that new sources of workers be considered. Most researchers predict that an expanded immigrant direct long-term care labor pool presents one solution to meeting future workforce needs.¹

This research brief provides a descriptive profile of home health aide immigrant workers who are currently employed by Medicare- and/or Medicaid-certified or state-licensed home health and hospice agencies. The brief also considers the potential role that immigrants can play in filling future vacancies in home health and other direct care jobs.

By the Numbers: Demands and Challenges of an Aging Population

A growing older population: *The number of people aged 65 and older in the United States is expected to nearly double from 41.4 million in 2011 to 72 million by 2030. The number of persons 85 years and older is expected to increase from 5.5 million in 2010 to 19 million by 2050.*^{2,3}

A need for workers: *The U.S. will need over 1.5 million new direct care positions by 2018.⁴ The most rapid employment growth is expected to occur in services for older adults and persons with disabilities, as well as home health care services.⁵*

A shrinking pool of workers: *The Bureau of Labor Statistics estimates that U.S. demand for home health aides will increase rapidly between 2010 and 2020.⁶ However, the shortage of labor and high turnover rates in the long-term care sector has been shown to reduce the availability of workers and the quality of care while increasing rates of institutionalization.⁷*

About the Study Sample

This brief relies on the 2007 National Home Health Aide Survey (NHHAS),⁸ which describes home health aide immigrant characteristics and employment characteristics. The NHHAS is a national probability survey of home health aides conducted as a supplement to the National Home and Hospice Care Survey. More information about the surveys is available at: www.cdc.gov/nchs/nhhcs.htm.

The study sample:

- Includes “immigrants,” who are defined as non-U.S. citizens or citizens through naturalization. A total of 241 immigrants (a weighted sample of 23,027) responded to the NHHAS and represent 14.5% of all home health workers in the study sample.
- Represents a subset of the total home health workforce. The sample includes home health aide

immigrant workers employed by Medicare- and/or Medicaid- certified or state-licensed home health and hospice agencies. The sampling frame did not include (1) workers employed by unlicensed agencies or (2) independent providers who were hired directly by consumers or their families and who did not provide support with activities of daily living.

- Represented 14.5% of immigrant home health aides, even though foreign-born women make up at least 20% of the documented direct care workforce. This finding is not surprising because more immigrant workers are employed in private households⁹ than in home health, nursing or residential care settings.¹⁰ Workers in these private households are not likely to be included in our sample. Instead, workers in our sample are likely to be legal immigrants because their employment is publicly financed and requires specific reporting standards.

A Profile of Immigrant Home Health Workers

As the following descriptive profile illustrates, the majority of immigrant home health workers in the study sample were married females of color who were over age 45, had some college education, but earned less per hour than the average U.S. worker.

Overall, immigrant home health workers in this study were satisfied with their jobs and very confident in their ability to do those jobs. Research on other immigrant direct care workers confirms these findings.^{11,12}

Here's a closer look at the findings.

Gender and Age: The majority of immigrant home health workers were female and they tended to be older. More than half (57.4%) were 45 years and older.

Race/Ethnicity: Immigrant home health workers primarily identified themselves as:

- “Black” (48.4%).
- “Other” (34.7%).
- Hispanic (28.5%).
- White (16.8%).

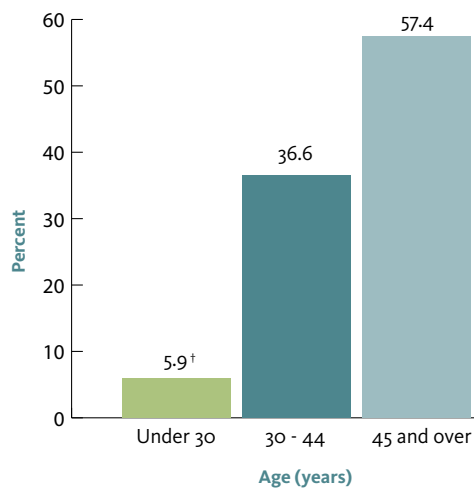
Marital Status: Among immigrant home health workers:

- 54.2% were married or lived with their partner.
- 36.9% were separated, divorced or widowed.

Education: Many immigrant home health workers had some level of higher education. For example:

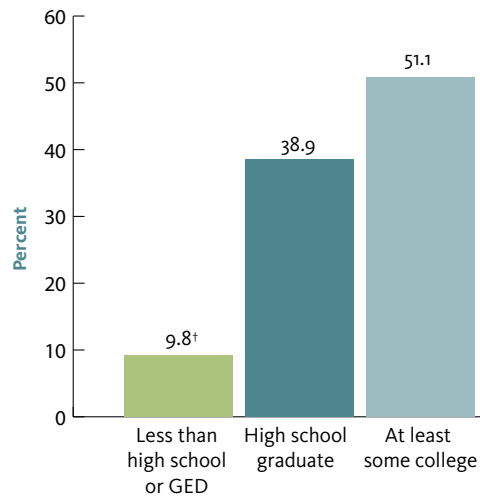
- 51.1% had at least some college education.
- 38.9% were high school graduates.

FIGURE 1 *Age of Immigrant Home Health Workers*



† The estimate is unreliable.

FIGURE 2 *Education of Immigrant Home Health Workers*



† The estimate is unreliable.

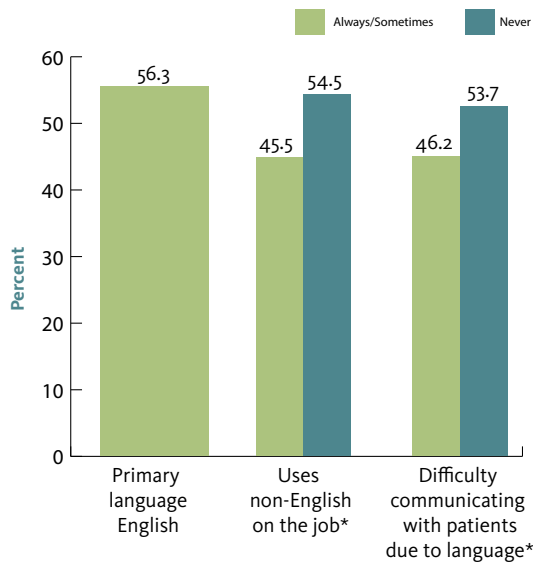
Income: Almost three-quarters of immigrant home health workers had household incomes of less than \$50,000 per year.

- 37.3% had household incomes between \$10,000 and \$29,999.
- 31.8% had household incomes between \$30,000 and \$49,999.

Language: More than half of immigrant home health workers (56.3%) reported their primary language as English. Among those who spoke more than one language:

- 45.5% reported that they always or sometimes used a language other than English on the job.
- 46.2% reported that they had experienced communication problems with care recipients due to language issues.

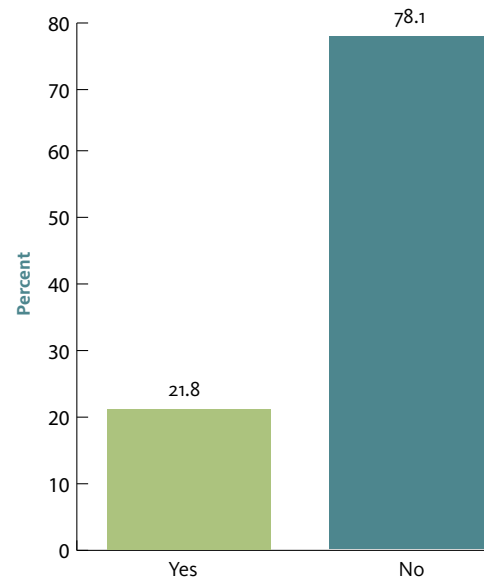
FIGURE 3 *Language/Communication Difficulty of Immigrant Home Health Workers*



*Among those who speak more than one language

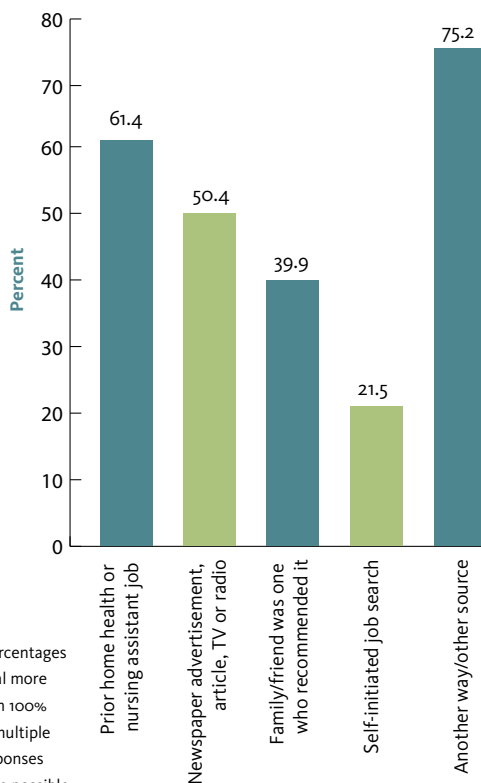
Discrimination: More than one-fifth (21.8%) of immigrant home health aides perceived they had experienced discrimination¹³ and language-related communication barriers at work because of their race or ethnicity.

FIGURE 4 *Perceived Discrimination Because of Race/Ethnicity among Immigrant Home Health Aides*



Recruitment: Most immigrant home health aides found their job through prior work as a home health aide or nursing assistant, through newspaper or other media, and/or through a family member or friend.

FIGURE 5 *How Immigrant Home Health Workers Find Jobs*



Training: Immigrant home health workers reported experiencing a mix of training approaches.

- 73% reported that their initial training was a “combination of hands-on training and classroom study.”
- Approximately one-quarter reported only hands-on training or only classroom study.

Wages, Work Hours and Benefits: Immigrant home health workers were paid for an average of 32.6 hours per week. The average hourly rate for “immigrant home health aides” in this study was unreliable.

The greatest portion of immigrant home health aides received extra pay associated with:

- Working holidays (68.7%).
- Pensions (49.6%).
- Paid holidays off (48.9%).
- Other paid time off, vacation or personal days (46.8%).
- Paid sick days (45.2%).

One-third or less of immigrant home health workers received additional benefits such as:

- Tuition reimbursement or subsidy.
- Bonuses.
- Time off for good work.
- Paid childcare, subsidies or assistance.

Almost two-thirds of immigrant home health aides reported that their agencies offered health insurance coverage. More than half (54.1%) of those respondents participated in health insurance offered by their employing agencies.

Job Confidence and Job Satisfaction: Overall, immigrant home health aides were satisfied with their jobs and were very confident in their ability to do the job.

- 70% were very confident in their ability to do the job.
- One-fifth was somewhat confident in their ability to do the job.

Immigration Policy in the United States

Immigrants could have a potential role to play in helping the United States fill future vacancies in home health and other direct care jobs. However, whether immigrants can fulfill this potential will be dictated by U.S. immigration policies.

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.¹⁴

Legal permanent workers: Workers granted legal permanency are commonly referred to as “green card holders.” These workers are permitted to live and work in the United States if they meet certain criteria, including family reunification, diversity, humanitarian interests and/or employment.¹⁵ After 5 years, individuals with a green card may opt to become naturalized U.S. citizens.

There are five permanent worker visa preference categories¹⁶:

1. Persons with extraordinary ability in the sciences, arts, education, business or athletics.
2. Persons holding advanced degrees.
3. Professionals and skilled workers.
4. Certain religious workers, employees of certain U.S. Foreign Service posts, retired employees of international organizations, and other classes.
5. Business investors who meet certain criteria, including employing at least 10 full-time U.S. workers.¹⁷

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 2 years of work experience. However, the EB-3 visa also includes an “other category” for all lesser skilled workers who meet eligibility criteria on a temporary basis.¹⁸ EB-3 visas are capped at 5,000 workers per year.¹⁹

Legal temporary workers: Legal temporary workers can enter the U.S. for a defined period of time. Temporary work programs may lead to permanent status. There are three types of temporary employment-based visas:

- **H-1B** employment-based visas are granted to highly skilled workers in such fields as science, medicine and health, engineering, math, law and computer programming.
- **H-2A** employment visas are granted to temporary or seasonal agricultural workers when employers anticipate a shortage of domestic workers.
- **H-2B** employment visas are granted to temporary non-agricultural workers when employers anticipate a one-time need for seasonal or other short-term workers.

There are no temporary visas currently designated for direct care workers.

Unauthorized workers: Unauthorized workers account for an estimated 11 million individuals. Most of these workers find their way into low-skilled jobs in private households. They include housekeeping, grounds maintenance, restaurant, construction and direct care workers.²⁰

Direct care workers typically enter the U.S. through family reunification, as refugees, through a green card lottery, or for unauthorized work.²¹ An estimated 79% of direct care workers are legal.²² Foreign-born women make up at least 20% of the documented direct care workforce.^{23,24} Unauthorized workers account for nearly 21% of the documented direct care workforce.^{25,26}

Immigration Reform: Senate Bill 744

The U.S. Senate approved a proposal for comprehensive immigration reform on June 27, 2013. Senate Bill 744 (S. 744) was offered by a bipartisan group of senators.²⁷

The reform bill included major provisions to:

1. Create a pathway to citizenship for 11 million unauthorized immigrants.
2. Reform legal immigration by reducing current visa backlogs and fast-tracking permanent resident status for immigrants who have graduated from U.S. universities with advanced degrees in science, technology, engineering or math.
3. Develop an employment verification system that all employers would use to confirm employee work authorization.
4. Improve work visa options for low-skill agricultural and non-agricultural workers.²⁸

The Congressional Budget Office (CBO) reports that, if passed, S.744 would have reduced the deficit and grown the economy. CBO estimates that:

- Fixing our immigration system would reduce federal deficits by about \$200 billion over the next 10 years, and about \$700 billion in the second decade.²⁹
- The additional taxes paid by new and legalized immigrants would offset any new spending.
- The immigration bill would strengthen the solvency of the Social Security Trust Fund.³⁰

Until Congress passes comprehensive immigration reform, states will continue to take matters into their own hands. The National Conference of State Legislators reports that, in 2012 alone, more than 983 immigration-related bills and resolutions were introduced in 46 states, the District of Columbia and Puerto Rico.³¹

States are leading legislative efforts to make it harder for businesses to hire unauthorized workers. Most commonly, states have imposed regulations requiring employers to use the federal E-Verify system to confirm a worker's immigration status.³² More recently, governors are stepping out ahead of legislatures by issuing executive orders that crack down on illegal immigration.³³

Discussion

Immigration Reform, the Direct Care Worker and American Families

Any change to the structure of immigration policy—whether that change entails comprehensive reform or piecemeal restrictions—has the potential to profoundly shape the circumstances of direct care workers and the demand for long-term care. Yet, prior immigration reform debates and proposals have not considered workforce planning needs or contemplated immigration as a primary tool for managing labor markets.³⁴

For example, immigrant direct care workers have filled existing labor shortages in cases where employers have had difficulty finding U.S.-born workers.³⁵ Historically, however, 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. Concerns that immigrants are less qualified or less skilled at long-term caregiving are largely unfounded.³⁶

Predictions of strong workforce growth in the long-term sector, in general, and in the direct care workforce, in particular, suggest a clear need to consider options that may include an immigration visa pathway to admission.

Structural changes in immigration policy do not only affect the lives of immigrants. They may also affect the lives of American families. Home health aides, who provide daily hands-on care, make it possible for older Americans and Americans with disabilities to live meaningful lives in their homes and communities and remain connected to their families. As such, these workers comprise an integral part of a family household.

Policy Implications

Policies that limit the entry of low-skilled workers may diminish the future labor pool of direct care workers in long-term care. Research suggests that any change to the structure of immigration policy might consider reforming the U.S. visa system through a variety of steps, including:

1. **Increase pathways to legal status** for undocumented immigrants interested in providing long-term care for the elderly and for persons with disabilities.
2. **Increase pathways for legal temporary workers** who are interested in providing long-term care, so they can enter the U.S. for a defined period of time. This option may involve developing a new, temporary visa category for low-skilled direct care workers who meet certain qualifications.³⁷ As with other temporary visa programs, this option may also offer extensions of stay or transitions to permanency. This strategy is similar to temporary visas that are currently provided for agricultural (H-2A) and non-agricultural (H-2B) workers.
3. **Consider a “provisional visa” alternative for workers** of all skill levels, including direct care workers. This option would allow the immigration system to readily respond to current and emerging demands for workers by making adjustments according to labor demands.^{38,39}
4. **Create an alternative “hybrid model” path to admission.**⁴⁰ The federal government and states would share authority for selecting immigrants to the U.S. The federal government could determine the number of visas permitted, based on specific criteria. States could use a point system to assess and address their states’ labor shortages.⁴¹
5. **Pursue an aggressive immigration strategy** to permit an influx of low-wage workers to fill vacancies for direct care jobs.⁴² Several countries have begun to adopt this approach, which potentially allows the number of new workers in the labor pool to be increased without drawing workers away from other industries. Immigration rules have already been loosened in the health

care sector to address severe nursing⁴³ or physician shortages in hospitals and, to a lesser extent, nursing homes.⁴⁴ However, little attention has been paid to direct care workers.

6. **Create a new “W” non-agricultural visa program** for less-skilled, non-seasonal, non-agricultural workers. This reform, proposed in S. 744,⁴⁵ held promise to address the need to expand a labor pool of low-skilled workers, like home health aides. Under this program, workers would be admitted for a 3-year period, renewable for another 3-year period, and would be required to work for registered non-agricultural employers in registered positions. A new Bureau of Immigration and Labor Market Research would supervise the program and would identify occupation shortages and provide recommendations. The visa cap under this program would fluctuate between 20,000 and 200,000. Employers would be required to recruit U.S. workers for their positions, attest that working conditions would not be adversely affected, and confirm that there are no U.S. workers available for the jobs.⁴⁶

Practice Implications

While immigration reform remains in the hands of federal and state legislators, employers in the long-term care sector may take practical steps to enhance the role that immigrant home health workers play in the delivery of long-term services and supports. These actions fall into several categories:

Cultural diversity: Employers should think about cultural diversity as an “asset, rather than a deficit.”⁴⁷ These employers can create more culturally diverse work environments by strengthening training programs and workplace policies to better accommodate language and cultural differences, and to improve worker assimilation. Employers may also adopt policies and practices that value employee diversity.

Training programs: Training programs should be sensitive to the needs of immigrant direct care workers. Cultural competence—the ability to interact effectively with people of different cultures and socioeconomic backgrounds—should be required training for all direct care workers. Training programs can:

- Be tailored to meet the needs of individuals with limited English ability. English as a Second Language training can emphasize the terminology used in direct care work⁴⁸ and/or designate mentors to provide a more in-depth orientation for immigrant workers who need to improve language and cultural understanding.⁴⁹
- Incorporate information to help immigrant workers navigate the immigration system, find housing or prepare for higher education.⁵⁰

Past efforts to train and prepare immigrants for careers in direct care have been limited. However, provisions in the Patient Protection and Affordable Care Act (ACA) of 2010 enhance training and development programs for individuals working in the long-term care sector. ACA-authorized demonstration programs are currently developing training curricula, certification programs and core competencies—including improved cultural understanding—for direct care workers.⁵¹

Competencies: The Centers for Medicare and Medicaid Services (CMS) National Direct Service Workforce Resource Center has helped states and employers take a more unified approach to competency development and training. CMS worked with several partners to identify core competencies, including “cultural competence” and other specialization competencies across sectors. These competencies may serve as a foundation for policy and practice guidance.⁵²

Cultural sensitivity: Employers can demonstrate a higher level of sensitivity to cultural differences by incorporating policies and practices that value employee diversity. These policies and practices may include:

- Acknowledging and appreciating diversity.
- Understanding how services are shaped by the organizational culture.
- Addressing issues that arise with cross-cultural interactions.
- Incorporating cultural knowledge into the delivery and receipt of services.⁵³
- Extending staff “cultural competency” training to include non-verbal communication and

appropriate responses to discriminatory comments and actions. Research suggests that this approach is most effective.⁵⁴

- Encouraging advancement and training opportunities that better utilize immigrants’ skills, knowledge and strong educational backgrounds. These opportunities may include creating more challenging work opportunities and/or transforming a job to better fit an individual’s skill set.⁵⁵

Recruitment: Recruitment efforts directed toward immigrant home health aides should focus primarily on tapping into local family and community ties. Other studies confirm that immigrants find jobs through word-of-mouth from families, friends and communities.⁵⁶

Conclusion

America’s aging society is setting the course for a major expansion of long-term care. The demand for direct care occupations is outpacing supply dramatically. Labor shortages will only get worse as more seniors and persons with disabilities need care.

Currently, native-born direct care workers are not meeting the demand for long-term care in the United States. To fill this gap, immigrant workers have become an integral and growing part of the long-term care workforce.

The U.S. will need many economic and social reforms to address the needs of an aging population. The sheer number of workers needed to care for the future population of older adults makes it imperative that new sources of workers be considered.

An expanded immigrant direct long-term care labor pool presents one solution to meeting the future needs of our society. But any legislative reform of our immigration system must take a forward-looking perspective, since the resulting immigration policies will likely govern for decades. The last reform occurred in 1986.⁵⁷

Changes in immigration policy that favor the expansion of the immigrant workforce might take into account:

- How the admission system currently supplies workers.
- Our current knowledge about the prevalence of workforce shortages and demand.
- The need to integrate immigrants linguistically, civically and economically.

A new immigration system that recognizes these important priorities, as well as the need for policies to stabilize the direct care workforce, will help to build the American economy and strengthen families.

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- ⁴⁵ Immigration Policy Center. (2013). *A guide to S.744: Understanding the Senate Immigration Bill*. Retrieved from www.immigrationpolicy.org/special-reports/guide-s744-understanding-2013-senate-immigration-bill.
- ⁴⁶ Immigration Policy Center, 2013.
- ⁴⁷ Leutz, W., 2010-2011.
- ⁴⁸ Leutz, W., 2010-2011.
- ⁴⁹ Priester, R. & Reinardy, J. R. 2003. Recruiting immigrants for long-term care nursing positions. *Journal of Aging & Social Policy*, 15(4), 1-19.
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- ⁵¹ United States congressional Senate. Patient Protection and Affordable Care Act of 2010. 111th Congress, 2nd session , HR 3590. Washington: GPO, Print. 2012.
- ⁵² For more information on the CMS National Direct Service Workforce Resource Center go to www.dswresourcecenter.org/tiki-index.php.
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- ⁵⁴ Parker, V.A. and Geron, S.M. (2007). Cultural competence in nursing homes, *Gerontology and Geriatrics Education*, 18(2), 37-54.; Brown, C.V., Burns, J.A. (2008). Immigration and the direct long-term care workforce: Implications for education and policy. *Gerontology and Geriatrics Education*, 29(2), 172-188.
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- ⁵⁷ Meyers, D. (2008). Thinking ahead about our immigrant future: New trends and mutual benefits in our aging society. Retrieved from www.immigrationpolicy.org/sites/default/files/docs/Thinking%20Ahead%201-08.pdf.