Roles Performed by Migrant Care Workers When their Older Care Recipients are Hospitalized

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International Conference on Evidence-based Policy in Long-term Care
London 5 - 8 September 2012

Paper outline

- Background:

  (1)The long-term care insurance law

  (2) migrant care workers in the long-term care industry in Israel
- Goals of the study
- Methods
- Findings
- Conclusions

The Long-term Care Insurance Law In Israel : Goals and Principles

The Long-Term Care Insurance (LTCI) law was enacted in 1986 and implemented in 1988.

The major aims of the law are twofold:

- (a) To enable frail elderly people to age in place.
- (b) To sustain, support, supplement, and encourage family caregivers to assume responsibility for their elderly family members as long as they can.

Principles of the LTCI Law

Eligibility criteria:

(1) Official age of retirement - 62 for women and 67 for men.

(2) Inhabitants of Israel - Nationality is Israeli and live in Israel.

(3) Cognitively impaired and/or physically frail - Need assistance with ADLs and IADLs.

(4) Live in their homes in the community - If a person is admitted into a long-term care facility s/he is no longer eligible to receive the LTCI benefit.

(5) Undergo an income test- The threshold is quite generous so that the vast majority of frail elderly people meet the income test.

Principles of the Law

(b) Dependency assessment

1. Applicants have to undergo a dependency assessment.
2. The assessment is translated into a total score with the minimum threshold for eligibility of 2.5 scores (range 2.5-11 scores).
3. The sum of scores determines the level of benefit that a person will receive.

Principles of the LTCI Law

(c)Levels of benefits

1. 9.75, 16, and 18 weekly hours of homecare services, depending on the severity of the functional status.
2. Many beneficiaries hire migrant live-in homecare workers who are available around the clock but have to cover the difference between the benefit rate and the worker's monthly wage .
3. Those who relinquish the employment of a migrant live-in care worker can receive some 3-4 extra weekly care hours (19 or 22 hours instead of 16 or 18, respectively).

(d) In-kind vs. Cash benefits

Benefits are in-kind only and services are supplied through registered and licensed for-profit and non-profit organizations.

e) Package of services

Homecare services, visits to adult daycare centers, connection to an alarm system, laundry services, and diapers are supplied to those who are incontinent.

Migrant Homecare Workers

•Migrant workers in elder care in Israel is a significant factor in enabling frail elderly people to age in place.

•Currently there are about 152,000 older persons who receive long-tern care benefits under the LTCIL.

•There are about 52,000 migrant live-in care workers with the vast majority providing care to frail older adults.

Hospitalizations among Frail Older People

•As older adults age, they increasingly use more health care services, including in-patient care.

•The majority (56%) of patients in internal medicine wards in hospitals in Israel are older patients aged 65 and over, although they compose only 10% of the general population.

•Their total bed-days are 40% of the total bed-days in hospitals (Ministry of Health, 2010).

•Many of those older adults who are hospitalized are functionally disabled and bedridden or are cognitively impaired.

•The nursing staff in the hospital wards is unable to meet their intensive and extensive care needs (basic daily activities, companionship, and surveillance) due to shortage in manpower and work overload.

Migrant care Workers Provide Care to Frail Older People during Hospitalization

•Many hospitalized older persons receive personal care from their migrant care workers during hospitalization.

•They actually replace family members who are unavailable or cannot stay many hours at the hospital.

This is a new phenomenon that is rapidly spreading

Research Questions

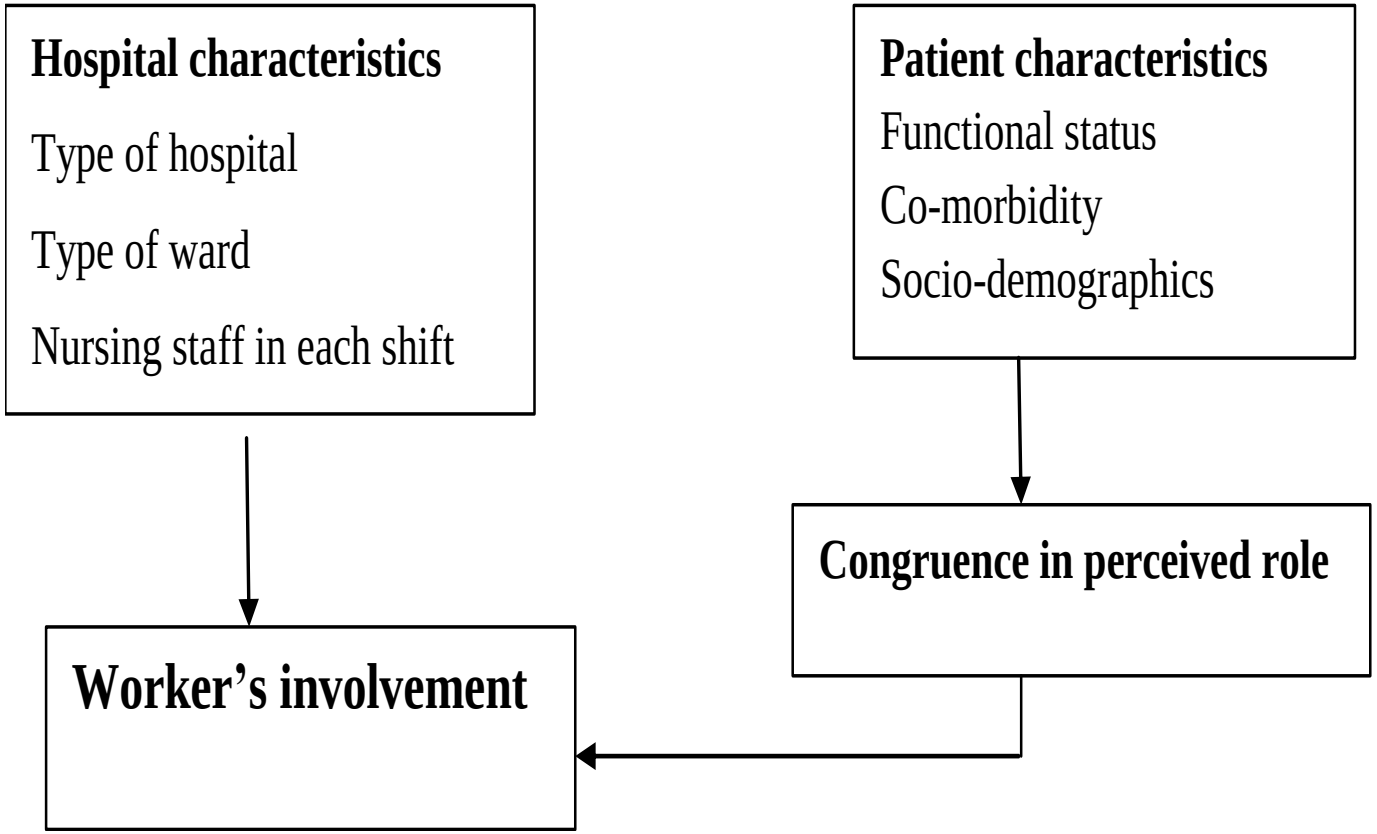
(a) What are the tasks that family caregivers and migrant carers perceive the latter should perform and to what extent is there congruence in their perceived roles?

(b) What are the actual tasks that migrant care workers perform in hospital wards?

(c) Are there differences between hospitals and wards with regard to tasks performed by migrant care workers?

(d) What are the factors that explain the types of tasks and overall involvement of migrant care workers in providing care to older hospitalized patients?

Research model



Methods

- *Sample*
- The study was conducted in internal medicine and geriatric wards in two big hospitals, one governmental and the second non-governmental in central Israel.
- The governmental hospital included 6 internal medicine wards and 4 geriatric wards with 350 beds. The non-governmental hospital included 5 internal medicine and 2 geriatric wards with 290 beds.
- A convenience sample that included 535 dyads of family caregivers and migrant care workers was recruited.
- All caregivers of patients whose older family members were hospitalized between August 2010 and February 2012 were approached and were asked to participate in the study. Only those who gave their consent were interviewed.
- Inclusion criteria were: older patients aged 65 and over who were staying at least 2 days in the ward, hospitalized either in an internal medicine ward or in a geriatric ward and had a migrant live-in care worker who was proficient either in English, Russian, or in Hebrew.
- The study underwent review by the institutional review boards of each of the two hospitals (Helsinki Committees).

Methods

Measures

Outcome variables

- *Involvement of the migrant live-in care worker in care provision* – Based on Bellou-Milona, et al., (2002) that included 3 items (e.g., measuring temperature, giving a massage), and on the In-Hospital Informal Care Questionnaire (IHICQ) (Sapoutzi-Krepia et al., 2008a) that included 30 items (e.g., washing, dressing, information to the staff, monitoring inhalation/oxygen, wound treatment), a measure that included 33 tasks was constructed. For each item the paid worker was asked how frequently he or she performed each task with scores ranging from 0 (not at all) to 4 (everyday). Scores were summed, with a total ranging from 0 to 132- higher scores indicating higher levels of involvement. Internal consistency Cronbach's alpha was good (α=.83).
- *Types of tasks* - The 33 tasks were classified into 5 categories that included: personal care (12 items), nursing care (7 items), emotional support and companionship (7 items), making the bed (2 items), and collaboration with the medical staff (5 items).

Methods

Measures

Independent variables

- *Type of hospital and ward*- coded governmental versus non-governmental; internal medicine versus geriatric.
- *Nursing staff in each shift* -The interviewer asked the head nurse in each ward how many nurses worked in each shift on a regular basis.
- *Congruence in perceived roles of the migrant carer*- The list of 33 tasks was used to examine perceived roles. For each task the family caregiver and the migrant worker were asked if they perceived that the paid worker should perform each of these tasks with dichotomous answers (1=yes and 0=no). Based on the answers of the two carers, a new variable was constructed; for each item the answers of the two carers were compared. If both answers were the same then it was coded as 1 (=congruence) or 0 (=incongruence) when they gave different answers. Scores were summed and ranged from 0 to 33 with higher scores indicating higher congruence in perceived roles.
- *Characteristics of the older patient*- Functional status, co-morbidity, socio-demographics and relationships to family caregiver.
- *Covariates*- Socio-demographics of the family caregiver and the migrant carer,

Methods

Data collection

- Two structured questionnaires were used; one for the primary caregivers and one for the migrant care workers.
- Interviews with migrant care workers were conducted in the wards in Hebrew (82.9%), English (15.1%), and Russian (2%).
- All primary caregivers were interviewed in Hebrew. Those respondents who preferred to complete the questionnaires were given questionnaires and completed them on site (10.1%); those who were unavailable were contacted and interviewed via telephone (16.1%).

Results

Table1: Socio-demographic characteristics of the respondents and care recipients.

Variable	Primary caregivers (N=535)			Migrant care workers (N=535)			Care recipients (N=535)		
	%	M	SD	%	M	SD	%	M	SD
Age (years)		56.28	11.59		36.74	7.52		83.43	7.13
Gender									
Female	59.6			77.6			63.9		
Education (years)									
No formal education	0			0			24.1		
1-8	6.4			13.1			31.2		
9-12	44.3			47.6			31.2		
13+	49.3			39.3			13.4		
Marital status									
Married/lives with a partner	81.7			57.9			29.5		
Widowed	3.7			2.8			66.4		
Divorced/separated	9.2			7.5			3.4		
Never married	5.4			31.8			0.7		
Place of birth									
Europe/America	22.7			12.1			48.1		
Asia/Africa	8.2			87.9			39.7		
Israel	69.3			0			12.2		
Years in Israel[a]		15.24	24.71		3.41	2.30		50.60	23.07
Employment status									
Unemployed	36.6								
Employed	63.4								

Results

Table1: *Socio-demographic characteristics of the respondents and care recipients*. (continued)

Variable	Primary caregivers (N=535)			Migrant care workers (N=535)			Care recipient (N=535)		
	%	M	SD	%	M	SD	%	M	SD
Number of children		2.66	1.41						
Relationship to older patient									
Spouse	18.9								
Son/daughter	72.0								
Son/daughter-in-law	3.9								
Grandchild	2.1								
Others	3. 1								
Living arrangement									
Alone							1.9		
Spouse							5.7		
Child							0.6		
Migrant care worker							62.3		
Family member and care worker							26.9		
Nursing home							2.6		

Results

Congruence in perceived roles

- Kapa scores showed that except for 3 tasks: surveillance, providing information to the nursing staff and providing emotional support to the care recipients, there were significant differences in the perceived tasks of migrant care workers in hospitals.
- Incongruence ranged from 10%-40%, depending on type of task.
- Total scores for congruence in perceived roles ranged from 0 (total incongruence) to 33 (total congruence) with a mean of 23.53 (SD=5.36)

Results

Table 2a. Roles performed by migrant care workers in hospitals

Roles	% of carers who performed at least one task	Range of scores	M	SD
Personal care & Surveillance	99.8	0-54	35.85	10.86
Making the bed	81.1	0-5	3.61	2.06
Nursing/medical care	91.8	0-20	7.69	5.12
Collaboration with the nursing staff	91.8	0-16	9.92	4.29
Companion and escort	99.1	0-24	12.87	4.99
Total level of involvement		1-122	71.88	20.88

Results

Table 2: *Tasks performed by paid carers by hospital and ward (ANOVA).*

Variable	Government +Internal		Government + Geriatric		Non-Government +Internal Medicine		Non-Government + Geriatric		F
	M	SD	M	SD	M	SD	M	SD	
Personal care	7.21	2.75	**7.91**	2.11	8.59	2.81	**9.28**	2.03	14.20***
Nursing care	**3.61**	1.86	3.13	1.52	3.41	1.58	**3.84**	1.49	3.29*
Companion and errands	4.57	1.33	**5.09**	1.19	4.68	1.40	**5.55**	1.06	12.12***
Collaboration with medical staff	2.01	.76	**2.11**	.74	2.40	.70	**2.34**	.37	28.44***
Making the bed	1.41	.86	**1.64**	.73	1.41	.84	**1.95**	.32	10.86***

*p<.05, ***p<.001

Results

Table 3: Regression analysis of factors explaining care workers' involvement in care provision.

	Model 1			Model 2			Model 3		
Variable	B	SE	β	B	SE	β	B	SE	β
Care worker's length of stay in Israel	.07	.03	.09*	.08	.03	.09*	.07	.03	.09*
Caregiver's age	-.22	.08	-.11**	-.22	.08	-.11**	-.15	.08	-.08*
Number of children of caregiver	-1.18	.67	-.08	-.79	.63	-.05	-.37	.61	-.02
Care recipient's length of stay in Israel	-.09	.04.	-.10*	-.08	.04	-.09*	-.06	.04	-.06
Type of hospital				-13.55	1.84	-.31***	-12.17	1.77	-.28***
Type of ward				6.81	2.37	.15**	5.40	2.27	.12*
Number of nursing staff in the afternoon shift				1.88	1.17	.08	1.61	1.12	.07
Congruence							1.17	.16	.28***
R^2		.04			.15			.23	
F		5.21***			13.28***			19.05***	

*p<.05, **p<.01, ***p<.001

Conclusions

- Migrant care workers play a significant role in supporting frail older people when the latter are hospitalized.
- Migrant care workers' involvement in care provision to their care recipients significantly varied by type of hospital and ward. This necessitates further investigation.
- From a policy and practice perspective, the study highlights the need for hospitals to explicitly determine their policies with regard to family and private care workers' involvement.
- This also raises questions about those frail older patients whose families cannot afford to hire private care workers to monitor and supplement the care provided by the ward's nursing staff. Who will care for them? Will they receive a poorer quality of care when they are hospitalized? Are their families more involved in caring for them when there is not a paid carer?

These questions must be addressed and guidelines should be provided by all stakeholders connected with this issue.

Thank you for your attention!

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