Judith Kelley:

I think one of the most difficult things about COVID-19, especially in the spring of 2020, when it was first breaking out, was how hard it was hitting elder people, our grandparents, our aunts, our uncles, our loved ones. Many times folks who were in care facilities and we weren't able to visit them, and people have had to go through some very hard times in not being able to say goodbye or having to communicate through glass, et cetera, et cetera. And it's been one of the most difficult elements of this pandemic has been to see it strikes so hard, the elderly community, and to be separated from one another. COVID-19 has ripped through nursing homes and long-term care facilities in the US. And at its height in North Carolina, four in 10 COVID-19 cases occurred in these kinds of care facilities and obviously, many associated deaths with those cases.

And those facilities are filled, of course, with the most vulnerable people in our society. My guest today says that COVID-19 has painfully unveiled and amplified the problems that have been inherent in long-term care delivery for decades. "COVID-19," he says, "I suppose heightened the risk for staff while magnifying the patient's vulnerabilities as well." I'm Judith Kelley, Dean of the Sanford School of Public Policy at Duke University. And I've invited Nathan Boucher in to discuss this dilemma. Nathan is an assistant research professor here, and he says the time has come to address these systematic problems when it comes to delivering long-term care. So welcome Nathan.

Nathan Boucher:

Thank you very much, Judith. This is great. It's a wonderful Wednesday afternoon out there, but it's just as nice in here with you in my main makeshift home studio.

Judith Kelley:

Sounds good. Sounds good. So let's talk first about the issue. So what is the biggest issues that COVID-19 has revealed when it comes to long-term care?

Nathan Boucher:

Sure, sure. Well, those served by long-term care have, over the course of time and for many decades, these folks that are served by nursing homes and assisted living facilities and other facilities have always had issues with isolation because they're stuck in a facility and a family can't always visit on time or maybe they just come on the holidays. That was amplified tenfold during COVID where frankly, families weren't allowed to visit folks.

Judith Kelley:

Now, I remember reading a story about one woman who only managed to eventually to get in to see her mother in a care facility by taking a job as a dishwasher, essentially in the kitchen of the care facility, which would then allowed her to go say hello to her mom after her job duties were over. But of course, many folks have realized even more that working in these care facilities is also really, really challenging, especially during a time like COVID. So from a staff perspective, what has COVID-19 revealed for us?

Nathan Boucher:

Absolutely. And that's been a longstanding issue as well. Direct care workers, such as nursing assistants, licensed practical nurses, registered nurses, those are the typical type of professionals you're going to see in long-term care facilities, are not generally paid very well and are paid below what you might normally get paid in those very same types of professions in an acute care hospital system. So the

payment system is very different. They, in my opinion, and I'm not the only one who believes this, are undervalued and underpaid, sometimes under trained and under supported in their role, which is back-breaking. And during COVID of course, was even higher risk from a viral infection standpoint. And many of these folks work several jobs and then go home and do caregiving at home. So you can imagine.

Judith Kelley:

Right. And of course, from a perspective of infection, you don't want them to be working different jobs either.

Nathan Boucher:

No, no.

Judith Kelley:

Yeah. Just sticking with the pandemic for a little bit, before we talk about the system more generally, in a recent paper, you called for more uniform public reporting of COVID-19 in these long-term care facilities. What are the numbers we've heard from the different states? How are they gathered and are they not comparable? What's the issue?

Nathan Boucher:

So again, it comes down to, it has improved. So I will put that over the top that it has improved since about this time last year. However, because of the very fractionated nature of long-term care delivery, you have different regulatory oversight. So it's Medicaid for most of those types of facilities, Medicare. Some facilities are only private pay. So payers hold facilities to their feet, to the fire in different ways for reporting. Plus you have the standards organizations such as the joint commission and other organizations that oversee different types of facilities in different ways. And then you have 50 different states. So all states and all health professions, or are, , their standards are maintained and their inspections are done at the state level. So that's 50 state iterations of what's going on.

Judith Kelley:

When we step back now and take a look at the data that we do have now, what has do you know, been the burden on healthcare facilities in terms of outcomes, both for workers and for the residents?

Nathan Boucher:

Well there's burdens of the care itself, especially care that can't be supplemented with family visits. Like if you had family coming to spend some time with individuals that actually tends to offload some of the work to do from the staff. Families can help feed, families can certainly help monitor for safety issues. And it's not that that's their particular job when they're coming to visit mom or dad or grandma, in the facility, but they certainly can play a supplemental role or an adjunctive role. And so that's been zero up until very recently in these facilities, that extra help. And so, it's the burden of doing good care with limited staff, staff who they themselves may be calling out sick because of COVID or just run of the mill family issues, kids being home from school and a direct care worker has to go to work. They can't do that. They can't do their job over Zoom from home while their kid's home from school. So the major staffing issues, that's a really big one.

Judith Kelley:

Are there specific protections that are missing for those folks who work in these facilities?

Nathan Boucher:

Oh, yes. So number one, the average pay ends up being about 10 to $12 an hour for very hard work, work that requires some skill, tons of empathy, backbreaking, physical work to care for individuals who may need all needs taken care of for them. The benefits are often pretty poor in these organizations that employ them. Many times, it's not considered maybe a full-time job, so it doesn't qualify for benefits. That may be purposeful on the part of the employer. And a lot of that is, I wouldn't say that's nefarious actions on the part of the employers, it's that they're working under the umbrella of underpayment and tough regulatory demands pulling them all directions with poor reimbursement rates. So it's a lot of trickle down effect as well.

Judith Kelley:

You say that ageism and ableism, that these have driven the industry into the shadows. What do you mean by that?

Nathan Boucher:

So in our society, and we're not terribly different from other societies when it comes to this, but certainly in the United States, when you've stopped working, when you can no longer do a number of things for yourself, or maybe you need an awful lot of help, our society tends to value you less. What it is, is a mirror back to our own mortality and it makes us feel very uncomfortable when people who are close to us are starting to get a bit more fragile, starting to need more help, aren't as productive or as independent as they once were. People who we saw as giants in our life are now a little more meek.

And I think that scares people an awful lot. And individually, and as a society, we are scared of that. We want somebody else to deal with the problem. Another piece of it is that so many of us have to work until late in life. And if we're sandwiched between our own children and having to care for mom or dad, or another older adult in our family, that's a very tough thing to do. And so therefore, facility care really becomes the default for a lot of American families.

Judith Kelley:

It's interesting that you say that. Part of what's driven this industry into the shadows, as you say, is that we're scared of our own mortality. But it's kind of ironic because you would think that if we are worried about our own mortality, and we are seeing situations for our parents' generation that is scary, wouldn't we want to think about reforming the system?

Nathan Boucher:

You bring up a really good point. Yes, I would think that we would want to invest in the system, if not for the now for our own older folks in our families, for ourselves, even in a selfish way for the future. We we'd want a better system that be standing there ready to take us on when we needed it. But I will say that that is a uniquely American thing is to not plan ahead very well for that type of thing. We seed a different ethos, a different philosophy in other developed nations. And I think that COVID itself highlighted how self-serving and short-sighted some Americans can actually be. Looking out for the flock, looking out for our neighbors, forget that, looking out for strangers, that is something that we don't do easily.

Judith Kelley:

So speaking about the societies, and I think that Japan, for example, has a rapidly aging population that they are always trying to figure out how to care for. And I think many folks have probably seen the various robotic options that they have tried to introduce in caring for the elderly, if nothing else, as a form of companionship. Is technology an option at all? Is telehealth an option? What, if anything, has been moved by the pandemic in how we're thinking about it?

Nathan Boucher:

And I think that's great. And I think the main issue around that is social isolation, companionship. And as we saw the centers for Medicare and Medicaid services finally come about and say, "Oh, well, since we're forced to do telehealth, I guess we'll pay for it." It was a natural experiment that we needed to be forced into. There's been a lot of reticence of how do we maintain quality and will it be the same thing as an in-person visit with a medical provider? And so we had this natural experiment where telehealth actually turns out to work really well for an awful lot of things. It doesn't work well for some things, you can't do surgery over Zoom, right? But it works great for mental and behavioral health. It works good for primary care, even things like dermatology can be done by telehealth.

So alongside that, we have come to realize that society is now, laypersons now outside of healthcare systems, have warmed up to virtual ways of connecting. And so now, not telehealth, but virtual visitation, virtual support and companionship can reduce social isolation. Now what gets in the way of that? Well, it's widespread broadband, it's access to what can be expensive devices. There's rural versus urban issues when it comes to broadband connection and infrastructure. But I definitely think virtual visitation and support can really be helpful in the future with mitigating isolation.

Judith Kelley:

That's interesting. You also say that long-term reform should focus on comprehensive workforce development. So how is that different from what's happening now, or are we not trying to comprehensively develop the workforce?

Nathan Boucher:

Well, going into long-term care settings as a health care provider, at any level, is not terribly appealing. A lot of folks don't want to get out of medical school or a health professions training program and go into primary care. Nevermind go into geriatric medicine or go into gerontology, go into working with older adults or people with disabilities. It's not a very popular line of work to go into. Part of that is because some see it may be as less exciting than some other areas of healthcare delivery. I think there's plenty of excitement personally, that can go on in that environment with older adults. But the reimbursement rates are very low.

So therefore, the pay for healthcare personnel is not very appealing either. And so if we can improve the pay and benefits and different supports and training opportunities, again, valuing it, like we value the acute care hospital system workforce, then I think we would start to move the needle on more individuals going into that line of work, working with older adults and those with disabilities, because they would feel valued through pay, through benefits, through training, through peer support. So I think that's part of the equation.

Judith Kelley:

It certainly is very, very unique work. And I have nothing but admiration for the folks who look off some of my family members who need that kind of care. You got to be a special kind of person to be able to get up every morning and focus 100% on the needs, to be tuned into the needs of the people you're serving, in a really selfless way. It's really quite remarkable. So Nathan, you put forward sort of a big idea. You say we need an age friendly public health system. What do you mean by that?

Nathan Boucher:

Right. So again, it's one that believes that people who are aged have just as much to offer as those who are younger than they are. There is a compendium of wisdom and every one of those aged brains out there, that retired neighbor who, you walk out when you're getting your paper in the morning and wave to every morning, there is a world of knowledge for them to share. Let's figure out ways for them to do that. They should be coming and sharing that lived experience. That's one thing I think we can do to help reform, is bringing that into the classroom for trainees. I think when we talk about, and some of what we've been writing about, is not just reforming long-term care in and of itself, but actually integrating it with other medical systems of care and public health. Public health has long been, at least in the past, had been the bastion of physicians and some other healthcare providers.

It has become kind of isolated from healthcare provision. It used to be, you go to a public health clinic and you get your immunizations, maybe even a primary care checkup. Well now public health has since moved over in the past decades to more surveillance, more lab based endeavors. It still happens that it's more on the ground care in smaller, more rural communities who need that extra bolstering from a public health department. You're seeing more specialized public health type of interventions going on, much of what you need a master's in public health or a PhD to get employed in. What we need to do is bring public health back into the fold with healthcare delivery and long-term care services and supports are a very viable and important, but underfunded part of the healthcare delivery systems that we have here in the United States. So we're looking to try to reintegrate public health paradigms or values with the healthcare systems of care, which include long-term care.

Judith Kelley:

So the integration across systems certainly, that makes a lot of sense and it's appealing. But I'm just still thinking about your comments about us being afraid of seeing what we see in elderly people, and then in terms of their decay or how they're cared for. And then at the same time, your comments that elderly folks often have so much to give. We've moved away from a model in society where we were just more integrated across ages. Should we be rethinking this model where we stow away old people in facilities?

Nathan Boucher:

Well, there are larger tensions in play. It's families having to work, parents having to work one and two and three jobs. And the kids not even being home to hang out with grandma, if she was even there because they're involved in some activities or they're having to be elsewhere. And so that intergenerational transfer of knowledge is not going on in the way that it has been. In some sub groups, some Latinx families, it appears that they tend to value their families a little bit more, want them a little bit closer, want to be more involved in their care. So there are these cultural subsets that have differing opinions. They diverge from the typical American view of aging in a facility, let's let's have somebody else take care of mom or dad because we just can't handle it, we're working too much. We don't feel like we have the skills. We don't have the confidence of for it.

Yes, we love them, but we're pushed to the limits. And so I think that intergenerational sharing of knowledge, of care, I don't know how we shift that back. I don't have an easy answer for that. I will

say that the long-term care services and supports arena has been in the past decade or so, been shifting back to home-based and community-based supports. And so they're starting to fund those better and more easily than care that might otherwise be delivered in a facility. And so it's starting to incentivize through our pocket books, systems of care that are based more at home, at least more community-based where maybe there's an adult day program where mom or dad goes there for a few hours per day and allows folks to work a bit more to make ends meet. It offloads some of that care, provides some respite for the family caregivers. And so that increased funding of home-based and community-based care is, I think, helping to shift it from a cost incentive perspective.

Judith Kelley:

Yeah. Absolutely. Absolutely. This has been fascinating, and I think with so many other things in our society, COVID has pushed us to identify the strengths and the weaknesses in our current operations. Is there anything at all in the new administration's plans that would address any of these issues?

Nathan Boucher:

So the Biden-Harris campaign, and now the administration, has probably been the first campaign and then administration who regularly was putting caregivers on their agenda. And so that recognition is really a boon for those of us that have been working and caregiving issues for older adults. Now, in that conversation, they include caregivers of young children as well. So it's a broad lens on caregiving, but it's an important one because some of those caregivers are doing both. They're caring for youngsters as well as older folks in their lives. And so yes, the new provisions right now during the active Biden administration do have caregiver supports, both financial and also some infrastructure pieces, that will be part of those packages if they pass.

Judith Kelley:

Well, thank you so much for your time today, Nathan.

Nathan Boucher:

Thank you so much. I've really had a good time with this. I love talking about these things.

Judith Kelley:

It shows. And I'm pleased to have had a chance to learn from you. Nathan Boucher is an assistant research professor here at the Sanford School of Public Policy at Duke University. Thank you for joining me. Have a good day to everybody, and I'm Judith Kelley.