Research Letter

Registered Nurse Migration to the United States and the Impact on Long-Term Care

To the Editor:

The worsening shortage of registered nurses (RNs) will further burden long-term care (LTC) settings in the United States. In a recent survey, 94% of nursing homes (NHs) and 81% of assisted living communities reported staffing shortages; 73% and 59%, respectively, reported that their workforce situation worsened during COVID-19.1 More than 46 million older adults aged ≥65 years live in the United States, with 90 million expected by 2050.2 Rapid population aging drives demand for RNs in LTC, and migration of foreign-educated nurses (FENs) is critical to help address nursing shortages.3 Systematic and equitable integration of FENs into the LTC workforce requires deeper understanding of their contributions and impact on care. Because research about these phenomena is limited, we synthesized literature about factors influencing nurse migration to the United States and how FENs impacted LTC.

Methodology

Using Whittemore and Knaff’s4 methodology, we searched these concepts: nursing, migration/emigration/foreign, and long-term care facilities—United States articles published between 2000 and 2021 from academic databases (PubMed, CINAHL, SCOPUS), Google Scholar, and policy websites (World Health Organization, Pan American Health Organization, International Organization for Migration, LeadingAge University of Massachusetts Boston, and Organization for Economic Co-operation and Development) from January-March 2021. Selected were articles published in English and full text excluding dissertations, narrative/systematic reviews, and articles excluding RNs. We evaluated 23 articles using Gough’s Weight of Evidence Framework.5

Results

Three policy papers provided data from the United States, English-speaking (ES) Caribbean, and the Philippines. Twenty scientific studies provided data from United States (n = 12), ES Caribbean (n = 4), Philippines (n = 2), Kenya (n = 1), and Zimbabwe (n = 1). Most studies used quantitative cross-sectional designs (n = 13), then qualitative (n = 4) or mixed/multimethod approaches (n = 3). Evidence appraisal showed 78% (n = 18) high- and 22% (n = 5) medium-quality articles (Table 1). Socioeconomic factors,6–9,11,12,14,22,28 workplace characteristics,6–9,14,16,22 and contextual factors9,11,13,28 together drive nurse migration to the United States. Proportions of FENs in LTC ranged between >12% in NHs11,24 and 25% in home care.10 Most FENs migrated from the Philippines,10,20,27 India,10 Haiti,10 Jamaica,10 and ES Caribbean.15 Originating country factors driving nurse migration include socioeconomic (limited employment opportunities, poor remuneration); workplace characteristics (heavy workload, insufficient resources, poor nursing leadership); and contextual (immigration policies, gender expectations of women, colonialism). FENs’ mixed professional experiences in LTC are impacted by their racial and ethnic identities.11,17–19 Typically, FENs worked longer hours, earning higher incomes than non-FENs,10,11 but in some NHs, Black FENs and other immigrants worked significantly more hours but earned less than White colleagues.19 Although most FENs are multilingual,20 this sometimes has a negative impact as language and accent differences may hinder professional advancement.11 Evidence suggested discrimination of Filipino FENs, and health professionals who owned government-funded facilities and who received low federal reimbursements per resident were harassed by racist comments from federal/state agents.21

Increased FEN staffing had primarily positive associations with health outcomes.22,23 Increased FEN staffing positively impacted NH Patient Safety Culture (PSC).21 LTC employers consistently described FENs’ strong work ethic and critical role in filling staffing needs.12,13,24 FENs and other immigrant workers had a 7.6% increased probability of staying in the LTC workforce relative to US workers.22 NHs in high-immigrant regions had significantly reduced falls, activities of daily living decline, pain, and catheter use but higher rates of pressure ulcers.23 One study suggests NH quality indicator performance varies by FENs’ country of origin.21

Discussion

LTC employers typically have favorable views of FENs, consistent with mainly positive associations between FEN staffing, work environment, and quality indicators. As FENs integrate into the workforce in US LTC settings, positive impacts on workplace culture and dynamics can be expected. Additional English-language support for some FENs and, when necessary, appropriate cultural and racial sensitivity training among LTC workers seems indicated. Most FENs migrating to the United States are females from racial and ethnic minority groups who are vulnerable to being placed in racialized hierarchies. These findings suggest the need to equitably support FENs as part of building workforce capacity for improving LTC by providing culturally sensitive orientation and preceptorship, fair employment contracts, and creating inclusive work environments.

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1525-8610/© 2021 AMDA – The Society for Post-Acute and Long-Term Care Medicine.
Understanding of FEN-related issues in LTC is limited because no study examined FEN staffing in the rapidly growing subsector of community-based LTC, and studies inadequately captured perspectives of health policy makers and LTC administrators who will continue to influence recruitment and staffing policies during and post COVID-19. The importance of this first integrative review of factors driving nurse migration to the United States and FENs’ impact on LTC is amplified because staffing shortages everywhere may be exacerbated during a global pandemic. The United States will likely remain dependent on FENs, so additional research can inform policy interventions to improve nurse retention and health outcomes for increasingly diverse LTC residents in the United States.

Acknowledgments

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28. Lansiquot et al, 201215
30. Ortiga & Macabagas, 202113

*Health policy articles.

1Gough’s weight of evidence framework: 1 – coherence and integrity of the evidence in its own terms; 2 – appropriateness of the form of evidence in answering research questions; 3 – relevance of the evidence in answering the research questions; 4 – overall assessment of study contribution to answering the research questions; H – high; M – medium; L – low.

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<tr>
<th>Lead Author/s</th>
<th>Level of Analysis</th>
<th>Gough’s Weight of Evidence</th>
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<tbody>
<tr>
<td>Perrin et al, 2007</td>
<td>Individual-level</td>
<td>H-M-M-M</td>
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<td>Hurtado et al, 2012</td>
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<td>H-H-M-M</td>
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<tr>
<td>Furtado &amp; Ortega, 2018</td>
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<td>H-H-H-H</td>
</tr>
<tr>
<td>Nazareno, 2016</td>
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<td>H-H-H-H</td>
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<td>Ortiz &amp; Macabagas, 2021</td>
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<td>H-H-M-M</td>
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Table 1
Level of Analysis and Weight of Evidence


28. Bryant N. Filling the Care Gap: Integrating Foreign-Born Nurses and Personal Care Assistants Into the Field of Long-Term Services and Support. University of Massachusetts, LTSS Center; 2018.

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