The Aging of America: Issues in Long-term Care

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Even for those steeped in gerontology, the statistics reflecting the phenomenon we call "the aging of America" are nothing short of awe-inspiring. With the American population as a whole slated to grow by a third over the next few decades, the population over 85 will grow by an astounding 400 percent. And that, of course, is the population most in need of long-term care, with over 20 percent already residing in nursing facilities. Many of us are aware of the fact that, by the year 2050, 20 percent of all Americans will be over the age of 65. How many realize that, at the same time, five out of every 100 Americans will be over 85 (up from less than 1/10th of 1 percent as recently as 30 years ago)?

Don't Let the Numbers Fool You

There are four basic types of long-term housing and care for seniors. For want of common definitions, we can call them categories A, B, C and D. Category A (referred to by some as "independent living" or "active adult"; by others as "age-restricted" or "age-qualified") is essentially real estate. Amenities may exist (golf courses, swimming pools, gardens and walking paths), but there are usually no services provided. Category B, often referred to as "congregate living" or "congregate care," offers services—usually unrelated to frailty or health status—including housekeeping, transportation or common meals.

Only with the delivery of healthcare services do we begin to see the attributes that distinguish categories C and D, commonly referred to as assisted living and nursing facilities. The distinctions, particularly between categories A and B on the one hand and C and D on the other, are critical. They differ not only with respect to the very basic dissimilarities in their service packages, but in terms of the age and preferences of their customers as well. Differences in health status are obvious, as is the correlation of health status with age. Age differential at admission between categories A/B and C/D is significant.

Customers for categories A and B are looking for changes in lifestyle; those in categories C and D for help in the basic activities of daily living. Big difference. And that, in turn, stimulates the biggest difference of all – the actual decision-maker. Because the final decision-maker for selecting either assisting living or nursing home care is not the resident, but the resident's family. On the other hand, it is the resident who makes the choice for independent living or congregate care.

These are very basic demographic realities which only very recently became obvious to assisted living operators. Many assisted living operators made two basic mistakes: They lumped all the elderly into one category and failed to see the crucial distinctions within the senior populations. And, to a very considerable extent, they focused on the wrong customer. The end result was a saturation of services for the C/D category.

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Let's look first at the failure to distinguish among the elderly. By viewing the elderly as a homogeneous group consisting of all seniors over the age of 65, assisted living failed to see the "pig in the python." A term common in the jargon of demographers, the "pig in the python" is a way of characterizing the movement through time of the large growth in the American population following the close of World War Two. These are the so-called "baby boomers." Assuming they were swallowed whole by our apocryphal python in 1945, they would not, given average ages at admission, be beating on the doors of assisted living communities until the year 2030 (at the earliest). True, given the pent-up demand for this new product line, the market was reasonably large in the 1990s and could absorb the initial new capacity. But nowhere near as large as those looking at an undifferentiated seniors population might (and, in reality, did) assume. The real growth in seniors housing and care, at least in the foreseeable future, will be (and was) in categories A/B, not in C/D.

And, unlike categories A/B where growth will occur in the Sunbelt, the growth in categories C/D will occur in the hometowns of the residents' children. Sunrise, a very successful assisted living company, has made a practice of selecting sites for new development, not in communities with large populations of seniors making at least $25,000 per year, but in communities of adult children making $75,000 per year. Sunrise, unlike many contemporaries, understood early who the customer was. It is the kids, not the parents, who make the choice (just like nursing homes) for assisted living. And Sunrise has not, as a result, experienced the downturn so characteristic of the rest of the industry.

So, what about demographics? Important? Absolutely! But only if carefully analyzed. Like so many social phenomena, demography makes for complicated social science. But, as a social phenomenon, demographics can be a useful tool for predicting the nexus between population characteristics and customer markets. But the devil is in the details, and failure to distinguish among those details can make for a very mischievous brew.

The Restructuring of Long-term Care

In the late 1980s and early 1990s the concept of "aging in place" became the mantra for those who would argue the overriding value of home and community-based long-term care services. To "age in place" was a wonderful concept! There was no need to be "institutionalized," no need to suffer under the psychological burden of "transfer trauma." You could simply remain in your own home, your own "place," as it were.

At its root, the concept has real appeal and has driven much of the restructuring of long-term care over the past two decades. Americans do wish to remain in their own homes as long as practically possible. That is a very legitimate and understandable desire. Accomplishing that goal without bringing harm to the recipient of services is the real issue.

There is the potential for harm—and more than minimal harm—that can surface on a number of fronts. "Aging in place" can become a quality-of-care problem; it can become a marketing issue; it can occasion operational difficulties; and it can, ultimately, raise legal concerns.

In reality, it is the long-term care customer's condition that will determine need; need that will determine service; service that will define setting. If a provider can accommodate to any condition, adjust to any need occasioned by that condition, and provide all services responsive to that need—then it makes little difference whether that provider is licensed as home care, assisted living, adult day care or nursing facility.

Therein lies the dilemma. How many providers can really do that? Early in its current life cycle, many in assisted living made that promise to their customers, a promise many also found they had to break. Indeed, average turnover in assisted living facilities approximates 50 percent per year. And the setting in which most outgoing residents are placed is the nursing facility—not really what those customers had in mind when reviewing the assisted living facility's brochures. I'm reading one now: " Whatever their requirements, now or in the future, we will offer our residents the necessary care and services. As residents' needs or conditions change over time, their Care Plans change accordingly." Pretty direct, yet unlikely to be fulfilled. Because, as we noted before, those changes in condition will occasion changes in need, which will require changes in service.

Confronted with a change in condition which might precipitate needs and services more typically associated with a nursing facility, an assisted living community really has only three options available: 1) do nothing; 2) attempt to provide nursing services; or 3) discharge the resident. Most facilities opt for number three. But a distressingly large number choose options one or two.

Number one is a recipe for disaster (a disaster which, in all likelihood, will entail tort litigation). Number two would appear the most desirable, at least from the customer's point of view, but it is an option fraught with financial pitfalls. Jim Moore, one of assisted living's most respected consultants, refers to this approach as the "one million dollar wake up call." Adding just 60

minutes of assistance per day for just 40 percent of the typical community's residents will cause an additional $123,000 in expenses. If unable to cover those additional expenses with higher prices, traditional valuation methodologies will show a decrease in the value of that community to the tune of $1.4 million.

Coming to Terms with Quality in Long-term Care

Quality care in America's nursing homes has, beyond a doubt, become the most contentious issue in contemporary long-term care. The issue has polarized the political process, created an environment working at cross-purposes with the very goal of enhancing quality, and threatened the underpinnings of an entire industry. And, most surprisingly, it has done so with all participants to the debate espousing essentially the same goals. It has divided those who should be allies. Clearly, something is wrong here.

Absent some common understanding of how we measure quality, how can we expect to join forces both to improve it as well as fund it?

The industry, for its part, must accept the reality of the problem. It must openly admit to the presence of poor providers and accept responsibility for working to eradicate their practices and, if necessary, to eradicate the providers themselves. Few in the industry are unaware of the "bad apples." But equally few are willing to say so publicly.

The problem is that accepting the reality of "poor performance" and being able to define it in a commonly acceptable fashion are two separate issues altogether. Therein, perhaps, lies the reluctance of even good providers to publicly accept the reality of their less-benign brethren. It is here that government must play a role. If the provider community chooses, after years of official silence, to take on the responsibility of working to rid itself of those who give all a bad name, then there must be some assurance that the definition of poor care is understood and accepted by all.

The issue of measurement is critical to the entire debate. Absent some common understanding of how we measure quality, how can we expect to join forces both to improve it as well as fund it? Avedis Donabedian, in his seminal work on quality assessment, posited three measures of quality:

- structure (the resources available to provide care),
- process (the adherence to procedures) and
- outcomes (the actual condition achieved by the patient).

Our system of measurement is still oriented primarily toward structure and process and less toward outcomes. But that approach has two major disadvantages, as has been eloquently pointed out by Rosalie and Bob Kane in a recent publication co-authored with Dick Ladd, ***The Heart of Long-term Care***:

> "(1) The majority of the regulations are based not on empirical evidence of what activities are associated with better outcomes but on professional judgments, which quickly approach dogma. (2) Strict statements about what should be done for whom become rapidly restrictive at a time when long-term care dearly needs innovation and creativity. Especially because so little has been proven about how to

deliver the best care (and there is every likelihood that more than one way is available to achieve this end), it is premature to ossify the process."

Yet ossify the process we have, and we have accompanied it with an enforcement system which has worked counter to the very goals the process was designed to foster. Punishment is a most appropriate reaction to those who have abused and neglected their patients. However, for those who have inadvertently acted contrary to "professional judgments," punishment (absent adverse outcomes) is totally inappropriate. For it will create the very atmosphere in our nursing facilities which all should abhor, an atmosphere attractive only to those whose interests are in mercenary return rather than professional fulfillment. One of the most difficult labor markets in recent memory is a direct result of the atmosphere of fear engendered by a system whose end result can only work to the detriment of patient care. Buildings do not provide care. People provide care. And, when 25 percent fewer candidates sit for licensure exams as long-term care administrators, are we seeing the handwriting on the wall?

Assisted living shares with nursing homes the problematic reliance on a labor force which is scarce, under-trained and volatile. Contributing to the competitive price advantage enjoyed by assisted living is the somewhat more robust nature of its clientele. They are not as frail and present fewer co-morbidities. But they require staff attention, nonetheless. And we skimp on staff at our own peril. Staffing becomes even more critical as a building (with its residents) ages. While cross-training of staff, with an eye on the "universal worker," is one approach to dealing with the issue, that approach can only partially alleviate the problem. A more permanent solution will be more difficult to come by.

The Long-Term Care Imperative: Baby Boomers and Beyond

There is an issue lurking in the wings that, if not successfully addressed, might lead us 20 to 30 years hence to refer to these as the good old days: long-term care financing. We're not talking about reimbursement, which is the method and amount of payment for an individual long-term care service, but financing, which is the system and resources assigned by society to cover the totality of long-term care costs.

The system in place today is actually a strange amalgam of public and private resources, and is as much an accident of history as it is a cohesive and comprehensive method of financial support. Its predominant feature is a welfare program (Medicaid) that was never envisioned as the primary funding mechanism for long-term care. It assumed that role because of a feature called "spend down," which provided nursing home services to those whose costs for healthcare impoverished them to the extent that they became financially eligible for the benefit. In so doing, of course, it also perverted the long-term care continuum by steering these newly impoverished Americans toward the institutional setting that most would prefer not to utilize.

Inappropriate as Medicaid might be as society's primary long-term care financing mechanism, it, too, is experiencing fiscal pressures sufficiently serious to call its continued viability into question. Medicaid is jointly financed by the federal and state governments. For most states, in fact, Medicaid is the fastest growing budget component. There are serious questions about whether states can continue to bear the burden of Medicaid's long-term care responsibilities, especially as those responsibilities squeeze other claimants on state funds (for example, corrections facilities, infrastructure and education). Vibrant state economies have been the rule, rather than the exception, over the past seven years, and the Medicaid squeeze on state budgets has been bearable. When those seven years of feast are supplanted by famine, however (and economic good times are cyclical), can the states keep up? And if they can't, will long-term care be among the first programs on the chopping bloc?

The Future of LTC Delivery and Financing

A number of programs have been developed and tested over the past 30 years in an attempt to better structure the financing and delivery of care, particularly long-term care, for America's seniors. Most of them focused on the need to better coordinate and integrate the services provided. They did so through one of two basic, but very dissimilar, approaches: case management (the brokerage model) or the direct provision of services (the consolidated model).

Brokerage approaches have had only limited success. One reason for that is thought to be the difficulty of identifying high-risk patients for whom home and community-based services would be most cost-effective. Another is their failure to integrate funding sources

Consolidated models, such as Evercare, Social Health Maintenance Organizations (S/HMOs) and Programs of All-Inclusive Care for the Elderly (PACE), have done a better job of targeting recipients and integrating funding. And their results have been more promising. But they, too, have their limitations and challenges. Evercare, for example, is a nursing home-based approach to care integration, which manages acute care financing and care delivery for residents. It is appropriately focused on case management and the use of geriatric specialists (resulting in a significant decline in hospital admissions). But, since its clientele already reside in nursing facilities and the program assumes no responsibility for custodial care, the program is limited in terms of its applicability to a broader population and is not likely to be a significant solution to the problems of long-term care delivery and financing.

S/HMOs don't have that flaw. They were established in 1982 as part of a demonstration to bring both service providers and funding streams (Medicare and Medicaid) together. Unlike Evercare, however, their services are not oriented toward the institutionalized recipient of care. Indeed, their problem is the converse. In setting a limit on annual expenditures for any of its clientele, the S/HMO cannot financially cover the typical long-term stay in a nursing facility and, therefore, effectively denies the benefit. It is true that

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S/HMOs (incorporated into the Medicare+Choice program in the Balanced Budget Act of 1997) have shown dramatic reductions in admissions to nursing facilities (by as much as 29 percent, when compared with non-S/HMO programs). But their financial limitations make them, like Evercare, unlikely solutions to the problems of long-term care.

Their limitations notwithstanding, Evercare and S/HMOs have served us well. One can look at PACE not as a stark contrast to them, but as an evolution from them. In PACE (as is also true of S/HMOs) the concept of integrating the services needed by the client into a comprehensive package of care is facilitated by capitating payments to the programs. In this respect, PACE is clearly the more advanced of the two programs. By focusing on seniors eligible for both Medicare and Medicaid, it receives a single capitated payment from both programs. The dysfunctional compartmentalization of the elderly occasioned by separate funding streams (and separate management of that funding) is not a problem for PACE eligibles. This integration of financing gives PACE the flexibility to provide services that are needed, not just those that are reimbursable. Nor does it have the financial or programmatic limits of S/HMOs and Evercare, which limited their applicability to long-term custodial care.

The PACE program's focus on interdisciplinary assessment, care planning and intervention (delivering services deemed necessary for the client, not just those enumerated in obscure regulations) has resulted in even more dramatic reductions in nursing facility use than even those experienced by S/HMOs. While PACE clients become so only when certified by the state as being nursing-facility eligible, there are PACE programs with actual admissions to facilities as low as 5 to 10 percent. Early detection and early intervention (with the service most appropriate to the client's needs) have resulted in a dramatic reduction in the use of facility-based care. Indeed, the program's successes led Congress in 1997 to establish PACE as a permanent provider type under Medicare, with authorization for 60 such programs across the country.

Yet even PACE has its problems that, despite its documented successes, have kept it from becoming the major player it might yet become in the long-term care arena. Enrollees in most of the 20-some PACE programs number only in the hundreds. The smallest, that associated with my university, has less than 100. (I'm not sure I could sleep nights were I managing a capitated program in which the risks of potentially high-cost enrollees needed to be spread over such a small number of "lives.")

The small number of enrollees is just one of the three major problems facing the PACE program. Failure to effectively address those problems might lead the program to be perpetually relegated to what even one of its staunchest proponents refers to as "boutique long-term care."

PACE has also experienced difficulties in recruiting primary care physicians. Appropriately trained and motivated physicians are an indispensable part of the PACE equation. While certification in geriatrics is not a requirement for

physician involvement in PACE, an understanding of the principles of geriatric care is, including an appreciation for working within the interdisciplinary team.

The third major challenge facing PACE is developmental in nature. Bringing up a PACE site takes time and money. Programs have consumed from three to five years in the development phase, with about $1.5 million in capital expenditures prior to enrolling the first client. Thus, one of the PACE challenges will be to partner with other providers, with the development phase focused on repositioning existing facilities rather than creating them from scratch.

For all their problems, programs such as PACE might well carry the seeds of a potentially successful approach to reversing the inadequacies of current long-term care financing and delivery. PACE creates cohesion where there was fragmentation, awareness where there was confusion, access where there were barriers. PACE shows the value of a coordinated, interdisciplinary approach to providing services to patients with diverse needs. PACE has shown the value of holistic medicine, the hallmark of geriatric care. And PACE changes the focus of both funding and delivery toward the recipient of service and away from the provider of that service.

Perhaps the greatest lesson to be learned from PACE is to treat the client as the focus. Treat the entire client as the focus.

PACE exhibits high levels of customer satisfaction, marked by low rates of dis-enrollment. PACE reduces both nursing facility and hospital utilization, with a hospital length-of-stay of 4.9 days (compared with the Medicare average of 7.6) and drops the average of 7.6 medications per resident in the typical nursing facility to 5.5 for the PACE population.

Perhaps the greatest lesson to be learned from PACE is to treat the client as the focus. Treat the entire client as the focus. Withstand the urge to force the recipient of care into forms comfortable to the practitioner, the bureaucrat, the financier. Make the term "holistic" something more than jargon. Make the patient more object than subject of our attentions. Make his or her needs, not ours, the ultimate goal of our endeavors. Then we just might have a system that works.

Making Assisted Living Facilities More Affordable

Of all the issues confronting the burgeoning assisted living industry, the question of affordability takes center stage. Why, it is asked, should those with less resources be steered toward nursing homes when equally appropriate care is available in assisted living? Shouldn't public funds be available to subsidize assisted living, just as it is available for the support of skilled nursing? Indeed, wouldn't both government (the primary payer of nursing home care) and the customer benefit from this less expensive and more accommodating approach to the delivery of long-term care services?

Unfortunately, it's not that simple. First of all, assisted living isn't necessarily that much less expensive than comparable nursing home care. When compar-

ing apples and apples (i.e., recipients of long-term care services with the same levels of frailty and co-morbidities), the cost savings between nursing facilities and assisted living all but disappear. (My mother's case is a prime example: At her level of need, the cost of care in a nursing facility would likely be less than what she is paying now in assisted living.)

Some might further contend that the role of the Medicaid safety net should not be as readily available for services which are largely "social" in nature, but should be reserved for those more serious healthcare needs reflected in the care provided a nursing home resident. And finally, the skeptics would argue, since when does the public owe me something just because I want it? I might prefer to get around town in a BMW, but does society really owe me more than good public transportation?

When looking at the issues of affordability one has to begin with the two aspects of a community's operations that determine the price needed to cover that community's costs. These are development activities (which include financing and construction) and facility operations. These two areas generate the costs of a project, and it is only by reducing those costs can one can make the product more affordable.

In the development area one can look for cheaper land, or even have it donated by a philanthropic organization. One can look to tax-subsidized financing, perhaps by using tax credits available to those building low-income housing. One can engage in value-engineering, a euphemism in the building trade for lower cost materials or fewer amenities. But none of these options will have an appreciable impact on the ultimate cost to the consumer. Development costs, when amortized over the life of the assisted living community, are relatively insignificant when compared to the more critical of the cost factors: operations.

The challenge is even more daunting in the operations area. The bulk of operational costs are for manpower. Since assisted living is already competitive with nursing facilities in how much (or, more appropriately, how little) it pays staff, shaving salaries is a recipe for higher turnover. And reducing personnel is a recipe for the scandals attendant to inadequate care.

In a nutshell, it's nigh on impossible to make assisted living affordable. Mom pays what mom pays because that's what it costs to provide the service she demands. Reduce the cost, and the product that has attracted her (and hundreds of thousands like her) will be commensurately diminished. That's not what the proponents of affordability have in mind.

What affordability really gets down to, therefore, is subsidization. If you can't reduce the costs, get someone else (other than the consumer) to pay for them. In reality, even some of the development options listed above are nothing more than subsidization: Donated land is a subsidy. Tax-favored financing is a subsidy.

The only hope for affordability on the operations side is subsidization. In this case, subsidization occurs through public financing programs such as public housing vouchers or Medicaid waivers. There's nothing wrong with that as long as we're clear on the fact that we really aren't making assisted living affordable. We're simply using tax dollars to help pay for it on behalf of individuals who can't afford to pay for it on their own.

While that form of subsidization may actually be appropriate for those on the lowest rungs of the nation's economic ladder, what about those in the middle? I'm not talking about those households with disposable incomes exceeding $25,000 (some 22% of American households headed by someone over the age of 75). Nor the 34% of such households with incomes under $10,000, many of which will be eligible for public financing. The real issue of affordability continues to stand for the remaining 4.3 million households, which are neither fish nor fowl.

The news, however, is less discouraging than we might think. The $25,000 benchmark exists more in the minds of those developing proposals for new assisted living properties than it does in the actions of those residing in those properties. In two recent studies conducted for the National Investment Center for the Seniors Housing and Care Industries (NIC), it was discovered that, the $25,000 benchmark notwithstanding, two-thirds of assisted living residents didn't have those types of disposable income. They had less. In some cases, considerably less.

How did they afford the price of care? Two ways. One, they were also subsidized—in this case, by their adult children. Many American children, often disinclined to substitute their own resources for Medicaid dollars when it comes to nursing home care for their parents, are more than willing to pay for that care when provided in an assisted living community. The second method of paying for assisted living by those without the disposable income necessary to afford it is by "spending down." Borrowed from terminology common to Medicaid eligibility determinations, spend down simply means that fixed assets (e.g., one's house) are transformed into disposable income.

Between 1984 and 1999, the median net worth among households headed by persons aged 65 or older increased by 69 percent. Seventy-three percent of households headed by someone over 75 own a residence with a median value of $80,000. Over 90 percent have non-financial assets (other than real estate) with a median value of $79,000. By the mid-1990s, America's seniors showed every willingness to "spend down" some of that net worth to purchase assisted living services.

Subsidization and spending down, taken together, explain the underlying weaknesses in the $25,000 benchmark. Obviously, assisted living is eminently more affordable to "middle class" seniors than previously assumed. While its price might have been higher than conventional wisdom thought affordable, its perceived value is clearly not. What seniors see in assisted living is an environment for the delivery of long-term care services that they find desirable, and worthy of liquidating their assets to purchase. They have been joined in those transactions by their children.

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That more seniors have not taken advantage of a service many of their peers have found so attractive is perhaps less a function of affordability than it is of understanding. Other studies undertaken by NIC have shown an incredible lack of familiarity, both by seniors as well as their children, with the assisted living product. That issue is perhaps where we should begin to direct our attention.

This article is compiled from a series of columns:

Willging P. (2000) Aging in place: coming home to roost?, *Caring for the Ages* 2(2).

Willging P. (2000) Assisted living: day of reckoning?, *Caring for the Ages* 1(7).

Willging P. (2000) Coming to terms with quality in long-term care, *Caring for the Ages* 1(5).

Willging P. (2001) Demographics: don't let the numbers fool you, *Caring for the Ages* 2(7).

Willging P. (2000) How to make ALFs more affordable, *Caring for the Ages* 2(1).

Willging P. (2000) The future of LTC delivery and financing: order out of chaos?, *Caring for the Ages* 1(9).

Willging P. (2000) The long-term care imperative: baby boomers and beyond, *Caring for the Ages* 1(6).