

Testimony of
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On Behalf of the
American Geriatrics Society

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Hearing on Long Term Care

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Chairman Johnson, Congressman Stark and Members of the Subcommittee. Thank you for inviting me to testify today on a critical issue – long term care.

I am Dr. Meghan Gerety, a Board certified geriatrician and Professor of Medicine at the University of Texas Health Sciences Center at San Antonio and Associate Chief of Staff and Service Line Manager for Geriatrics and Extended Care at the South Texas Veterans Health Care System. I have had a geriatric practice for twenty years and have practiced and overseen health care in virtually every form of long term care. I have experience in surveying nursing homes, serving as a nursing home and home care medical director and have provided care to many persons in assisted living facilities.

I currently serve as President of the American Geriatrics Society. I appreciate the opportunity to participate in today's hearing on behalf of the American Geriatrics Society (AGS), an organization of over 7,000 geriatricians and other health care professionals dedicated to the care of older adults.

Geriatricians are physicians who specialize in caring for older persons in all settings of care. Geriatric medicine promotes preventive care and care management that helps patients maintain functional independence in performing daily activities and improves their overall quality of life. When maintenance of function is not possible, geriatricians seek to optimize quality of life in the context of limited functioning. With an interdisciplinary approach to medicine, geriatricians typically work with a coordinated team of other providers, caring for the most complex and frail of the elderly population.

Many geriatricians spend part or all of their time in long term care settings, including a broad range of medical, social, personal care and supportive services provided to persons with limitations in basic and instrumental activities of daily living (ADLs), such as bathing, dressing, or eating. It is important to recognize that we cannot define long term care as a list of settings or as a set of defined services. Equally important to understand, it is not possible to accurately predict a person's long term care choices by knowing his or her diseases, functional status, or cognitive abilities. Instead, one must have a comprehensive picture not only of these factors but also social resources (the scope and depth of the caregiving network), psychological states, and personal preferences. At the present time, our current, fragmented long term care system too often creates an artificial gap between the medical components of long term care and the equally as important non-medical components. In a long term care population, medical needs and supportive care are inextricably intertwined.

Today I will focus on the following areas:

- Long term care: The past and present
- Long term care policy: How we allocate resources
- Comprehensive assessment: A method to assess needs
- Attaining an adequate long term care workforce
- Long term care: Costly but often inefficient
- Modernization: Using successful intervention studies to shape long-term care
- The Baby Boomers and the future

Long term care– The Past and Present

When employed properly, long term care services can serve many purposes. Long term care can complete essential medical care begun in acute care hospitals, smooth the transitions between hospital and nursing home or nursing home to home, fill unmet need for basic or instrumental

activities of daily living, defer the need for institutional care, provide relief to caregivers, and prevent unnecessary hospitalizations and emergency room visits. As it is structured in our nation, however, long term care has yet to fulfill its potential. As we face the demographic imperative of the aging baby boomers (a group to which I proudly belong) it is imperative that we organize long term care to fulfill its potential over the next 40 years after which most of us will be gone and need will decline.

Our current long term care system is not well designed to provide ongoing support of chronically ill, functionally impaired persons. A woman reaching age 65 can now expect almost twenty additional years of life, but over five of those years are likely to be spent with some degree of disability, and she has a 40 percent chance of spending some time in a nursing home. Interestingly, despite an increase in the number of aged persons, nursing home use has remained relatively static during the last decade, a fact which may in part be explained by older persons preferences for other long term care settings such as assisted living and in part by slight declines in disability rates in old age.

Today, unpaid family caregivers provide most long term care informally, but many persons must rely on formal or paid care as a supplement or a sole source of care. Unfortunately, our nation's system of long term care is neither integrated nor comprehensive, but rather a fragmented patchwork of payers, providers and settings, government and private programs, and formal (paid) and informal (unpaid) caregivers. This mix of programs provides varying services and often has confusing and differing eligibility criteria, enrollment processes, access points and financing systems. Access to long term care varies significantly from state to state and from payer to payer. Today, we face the challenge of modernizing care to include proven methods, accommodate consumer expectations, incorporate new technologies, and maximizing the partnership between private and public sources of funding.

This is best explained through a common patient example. An 88 year-old woman lives in her home, falls and breaks her hip. She is sent to the hospital where Medicare covers her care. Following her surgery, she is sent to a nursing home for rehabilitation, also covered by Medicare. However, when her therapy is completed she is less independent and therefore cannot return to her home. She qualifies for Medicaid coverage in the nursing facility, but NOT for enhanced services that would allow her to return safely home. After several months at the nursing home, she develops a urinary tract infection and needs antibiotics and IV therapy. Unfortunately, Medicaid will not cover this service in the nursing home, but Medicare will cover it in the hospital. The woman is transferred back to the hospital. This chaotic, payment-driven approach to care is played out thousands of times each day throughout the country. It does not serve the patient well.

Long term care today is undergoing a transformation similar to that experienced by acute care over the last two decades. As acute care was, long term care today is still largely provided in institutional settings with only a few states spending more on home- and community-based care than on nursing homes. Many long term care payment systems have become resource-based rather than charge-based, forcing providers to carefully evaluate the mix, intensity and duration of services that can be offered, resulting in marked variations in service availability and quality across the nation.

At the same time, providers and consumers have come to understand that services once thought to be safe only within institutional walls can be safely, more economically, and more comfortably provided in home- and community-based settings. Consumers of care, their families and caregivers are no longer satisfied accepting the settings and services that some agency or authority prescribes. Instead, they expect services that fill the needs they perceive and services that are more easily consumer-directed or modified. Long term care financing and eligibility

systems have not yet adapted to changes in the public's attitudes or to the expanded array of long term care settings, services and technologies. In many ways, while long term care delivery has evolved, our public policy and financing have remained static. Public policy must adopt a paradigm shift that acknowledges these changes; updating and reforming the long term care system of today.

Long term care Policy: How we allocate resources

At the present time, publicly and privately funded long term care systems do not have a coherent method of allocating resources across programs or targeting services according to an individual's need or potential benefit. Instead, any person who satisfies eligibility criteria is entitled to receive a service package that often is not matched to need or titrated to potential benefit. Despite their recognition of the importance of institutional and home-and community-based long term care services, there is no consensus among private or public payers about the role of these services, the population to which they should be targeted, or the scope and duration of services that should be provided. Long term care services are popular with consumers and have been codified in statute and regulation as entitlements to eligible persons who have severe functional impairments, skilled needs, or who are at risk for institutionalization. The status quo has become ingrained and made changes in eligibility for, targeting of, or defined limitations of scope or amount of long term care difficult to propose or evaluate.

One interesting approach to allocation of long term care resources, as proposed by William Weissert in a recent *Journal of Aging and Health* article, would be to characterize the eligible long term care population with respect to different types of risk, e.g., risk of hospitalization, functional decline and/or institutionalization. Each of these risk profiles may benefit from different intensities and mixes of services. For instance, those at risk of hospitalization may require more nursing than unskilled care. The plan of care might include a focus on patient/caregiver education and illness management. In contrast, moderately frail persons at risk for functional decline may benefit from rehabilitation-oriented interventions that restore function and lower risk for decline or institutionalization. Persons at the highest risk for institutionalization (those with more functional disabilities who require heavier care) may be able to defer institutionalization if more home care provides sufficient unskilled services to meet functional needs.

First, under this system, the government would establish clear financing for services for persons with long term care needs. Once eligibility for services has been established, a systematic method could be used to 'titrate' services on the basis of risk of adverse outcomes, effectiveness of the in-home services of mitigating the risk, and the value (or cost) of the outcome to be avoided. Long term care providers could be provided with an individual patient's profile of estimated risks of death, functional decline, hospitalization and nursing home admission. A projected budget could be developed based on each person's risk of each of the outcomes and a plan of care developed within that budget. For instance, persons at high risk of institutionalization (the most costly outcome) would have a higher monthly budget for care than persons at low risk. A person with high risk of all of the adverse outcomes: hospitalization, institutionalization, functional decline and death would have the highest budget.

Our current long term care system would make such a system difficult to propose or to evaluate. Most significantly, the current system utilizes a cliff approach whereby Medicaid covers the majority of long term-care services for persons in nursing homes. Those who do not meet the eligibility criteria for spend down or the limited Medicare benefits do not receive government-financed long term care. Medicaid is not a satisfactory solution. It's a critical safety net, but we need to find a more comprehensive and even way to meet the long term care needs so the burden doesn't fall to the states. We must change this approach through the development of a

meaningful long term care benefit for all that need it. The reallocation of resources discussed above could help defray some of the costs of such a benefit.

Comprehensive assessment – a method to assess needs

The AGS believes that a comprehensive assessment by qualified providers of geriatric care should precede the prescription of long term care. Often long term care services are allocated according to eligibility, rather than being based on a care plan derived from a comprehensive assessment that evaluates needs, elicits preferences, and establishes goals. For any person, it is very difficult to create a package of long term care services that addresses both medically necessary care for illnesses and supportive care for the functional deficits that are the consequence of disease. The package should also address personal preferences for care design.

The ability to perform assessment is limited by the different eligibility criteria and different methods of resource allocation employed by the States and the federal government. Medicare provides short-term nursing home care for persons recovering from acute illness and injury and provides medically necessary skilled home health care services to homebound Medicare beneficiaries. Personal care and homemaker services are restricted to situations in which they are incident to the skilled care needs and in cases where they facilitate treatment or to maintain health. So, Medicare home care largely focuses on medical needs and does not support the functional needs that are present in many persons requiring long-term care. States provide nursing home care for very low income persons who meet minimum functional criteria. Access to Medicaid funded alternatives to nursing home care, such as in-home personal care or chore services, adult day health care or care in assisted living settings is highly variable from State to State. Hence a person who requires both skilled care and personal care must rely on a patchwork of programs that are not integrated, not based on identified needs or treatment goals. Too often, the program fragmentation deters appropriate assessment to promote the highest level of quality care and patient choice.

Long term care – An adequate workforce

We are faced with growing work force shortages in all long term care settings. The AGS highly values direct caregivers in our nation's nursing homes, home care agencies and other long term care settings. Not only must they have the requisite knowledge and skills, but also their attitudes while delivering hands-on care can influence the success of care and affect quality of life for vulnerable elders. Compassionate, competent care must be our goal.

National policy and action will be required to create and maintain a workforce qualified to deliver skilled, competent compassionate geriatric care. There is already a shortage of physicians, nurses, social workers, and personal care providers who are trained in geriatric care. Unless action is taken to meet future need, drastic shortages will occur over the next decade. Our current long term care financing system is not designed to support a work force sufficient in numbers, skills, stability, and commitment to geriatric care. To increase recruitment into geriatric disciplines, trainees must envision a bright future in geriatric care, have role models who enjoy their work and feel satisfied with their lifestyle. Given the current low recruitment rates, measures to “jump-start” recruitment into the geriatrics disciplines are justified and are urgently needed. The measures should include loan-repayment for geriatric trainees and support for advanced fellowships to train geriatricians in research, administrative, and educational skills.

Long term care is costly but often ineffective

About 10 million people in the U.S. need long term care, with about two-thirds of this population comprised of the elderly. Most of these individuals live in the home and community, but as their

needs progress they may require long term nursing home care. According to the Centers for Medicare and Medicaid Services (CMS), national health expenditures for nursing home and home care were approximately \$139 billion dollars in 2002. Of that cost, approximately 55% is funded by the Federal and State Governments, 32% comes from out of pocket payments by consumers and 11% from private insurance. Although long term care insurance vehicles are increasing in number, a relatively small number of individuals have purchased such insurance.

Long term care insurance is not yet a viable option for many Americans. Private options tend to be less appropriate for those with modest means. Tax incentives for private long term care insurance primarily benefit the higher income. Additionally, premiums are often unpredictable over the long term. Long term care insurance premiums often increase dramatically as individuals age, meaning that people drop their policies just when they need them most. In fact, as a baby boomer and a geriatrician I have neglected to purchase a long term care policy because it is of limited value.

Despite these large expenditures described above, our fragmented system is inefficient, costly and lead to poor outcomes. Lack of coordination among settings and providers of care is a serious problem. Often there is inadequate transmission of information among providers, inadequate assessment of patient needs, poor care during transitions, and both under-and over-medication and health care utilization. Vulnerable persons often find themselves in long term care programs that use a 'one size fits all' approach where services are not matched to their needs or available in a timely fashion when need arises. The absence of flexibility in long term care programs poses a barrier to 'just in time care' which has the potential to prevent hospitalization or emergency room care.

The current system lacks proper incentives for promoting alternative delivery systems. For instance, many consumers have indicated a preference for care in the home and community. But, our current system of financing has a strong institutional bias. While the majority of persons with long term care needs (83 percent) live in the community, 78 percent of their help is from unpaid sources such as family and friends. Government financing as well as long term care insurance favors institutional settings. Congress should promote alternative delivery systems, such as early intervention and care management in nursing homes and the community, as well as greater use of home and community based care when appropriate.

The long term care system needs modernization and we urge Congress to thoughtfully consider these issues before enacting sweeping change in long term care programs. Improvement in the long term care delivery systems requires innovation and investment in development and testing of new models of care. We urge Congress to fund evaluation of new models of long term care and use the results to modernize the system.

Modernization: Using successful intervention studies to shape long term care

To achieve improvements in functioning and achieve reductions in avoidable health care utilization, long term care programs must have the flexibility to pattern themselves after proven interventions. The most effective models of care incorporate coordinated interdisciplinary team care. Although most nursing homes and home and community-based services are delivered under a plan of care approved by a physician, there is no real integration of health care professionals and personal care providers into a functioning interdisciplinary team that coordinates medical, social, rehabilitative, and other services. Case management models that use either nursing or social work personnel that are not members of integrated teams do not appear to either avoid costs or promote function. In the last decade, numerous examples of models of care that are characterized by integrated interdisciplinary teams have emerged. Policy

makers in a position to influence the direction of home and community based services may wish to incorporate lessons learned from these trials.

One model of care is based on comprehensive geriatric assessment. In this model an integrated interdisciplinary team assesses the patient and, in consultation with the patient and caregiver, develops a plan of care. Part or all of the assessment may be conducted at home and home visits may be a part of the intervention.

A different and successful model of care targets short-term home care services not toward meeting needs for ADL support or skilled care, but rather to the mitigation of specific risks or conditions. An interdisciplinary assessment followed by a twelve-week intervention to reduce risk of falls was highly successful in reducing fall risk by almost one-third. A highly focused short-term rehabilitation intervention in the home has been shown to significantly reduce the risk of functional decline in persons who are only moderately frail and have not yet developed significant ADL disability. These interventions suggest that highly focused, intensive, short-term, home-based care can be successful in addressing common geriatric conditions and preventing functional decline, often in persons who would not meet either skilled need or disability criteria for home and community based long term care. Despite these positive outcomes, today's long term care system is not structured to permit such uses of home care or rehabilitation services.

Long term care and Baby Boomers – The Future

Long term care needs will explode in the next few decades as baby boomers like me age. Baby boomers are less likely to be satisfied with a narrow range of long term care programs or to be forced into one size fits all programs like traditional nursing home or home care. We are informed consumers and expect to be able to pick and choose among services to select those that we feel may best meet our needs. Indeed the long term care marketplace is evolving quickly and providing an large array of available services: assisted living, retirement communities, personal assistants, shopping and transportation services, personal care homes among others. Baby boomers have increasing sophistication about program characteristics such as quality indicators, and are willing to embrace new technologies such as telehealth.

The challenge to today's policy makers will be how to most effectively marry public and private funding for long term care. How can we encourage the purchase of long term care insurance? What is the optimum cost-sharing methodology that will permit access to necessary care, encourage participation of families and caregivers in care, and discourage over-utilization? What public policies will support the development and maintenance of a workforce of providers highly skilled in geriatric care? What set of regulations and policies will give long term care providers the flexibility to target resources according to need and to potential benefit? What is the appropriate mix of provider directed and consumer directed care? All of these questions will need careful deliberation by public and private entities as we move to modernize the system.

The American Geriatrics Society would like to work with the Subcommittee to resolve these issues. We thank you for including us in today's important hearing.