CREATING A GOOD COUNTRY TO GROW OLD IN

RUTH KATZ

We'll all have deeply emotional COVID stories as we process the personal impact of this crisis. I know exactly where I was when I heard for the first time, in early March, about a direct care staff member dying of COVID-19. Such an innocent time; I thought that would be a one-time outlier. No. Like before and after September 11, coronavirus will change us forever.

For those of us dedicated to advocating for healthy aging and fighting ageism through the national organization of LeadingAge, this has especially troubling consequences. I will not forget bursting into tears with a LeadingAge state staffer who called asking what we could do for an assisted living provider who requested the county health department to come out and test a symptomatic resident and the health department staff person said: "We aren't going to come test again out there. You're long-term care. If one person has it, everyone has it."

We built a post-terrorism government and culture, driven by our intimate personal reactions after those planes hit the World Trade Center. We are going to use these COVID-19 moments to build and finance a delivery system that works for older people who need support for basic daily activities, to live their best lives.

PASSIONATE SERVICE, IN THE FACE OF HORRIFIC ODDS

There are some stunning stories among the LeadingAge membership of nimbleness, hope and fortitude against fears, struggles, grief. So many stories of "sleepovers" — like the staff of a memory unit in Georgia who moved onto the campus of their life plan community (a continuing care retirement community) to protect the older adults they care for as well as their own families.

Such creative problem solving: Joy's House, an adult day program in Indiana, shut down by coronavirus, found ways to virtually support clients and their families. The United Church Homes provider who gave every resident cups with fertilizer and seeds to grow plants in their apartments.

So many ways to bring prayer and tradition to people in isolation, like the remote church services at Covenant Village in North Carolina, where residents sheltering in place can receive communion. Like the virtual Seder, complete with a coronavirus Haggadah — the prayer book used for the Seder, customized for the challenges coronavirus presents and the lessons about overcoming these challenges — at Covia in California. Or, Stoddard Baptist Home in Washington, D.C., sponsoring a weekly "prayer for the world" call for health care providers, each with a different guest pastor.

So much willingness to still grab joy where we can find it. Presbyterian Homes and Services in Minnesota, where three aides each dialed a resident's family member and brought a cake with candles and surprised a resident on his birthday. Or the dances at Jewish Home Family in New Jersey that happen every time a resident recovers from COVID, is discharged from where they were receiving coronavirus care, and comes home to independent living.

PERSONAL RECOVERY, CARE SYSTEM REIMAGINING

A passion to serve and the energy to keep on problem solving take a toll though. One LeadingAge community leader in Massachusetts, asked how he was doing, said "I am tired, my soul is hurt, but I will recover to a place I can live with. But I will never be the same." It will take a long time and a lot of work before we resolve our personal shock and trauma, each at our own pace. But we have to keep trying.

Our responsibility to leap on the opportunity to reimagine aging services cannot wait. The coronavirus crisis has exposed the soft underbelly of aging services and long-term services and supports in the United States. We must do more than reopen. It's on us to recover and reimagine.

We aren't going back to the way things were before. Those in the middle of the crisis, those with a passion for serving older people must take the reins and create a system that is, in fact, a rational system. Apparently, the money was there; we never had the political will to attend to aging services with this kind of tenacity before. We are spending billions — trillions? — to jerry-rig temporary, wobbly solutions; we could spend a lot less and get it right in the first place. And maybe avoid having to go back and cobble another solution together to address the next crisis.

NOT JUST NURSING HOMES — A CONTINUUM OF CARE

Providers across the continuum are struggling against this scourge, the worst health care crisis to hit the country, and certainly to hit aging services, in our lifetime. Sure, nursing home residents and staff are front and center. The pandemic has also challenged other people who provide and receive aging services in assisted living, memory care, life plan communities, HUD-assisted affordable senior housing, hospice, home health, home- and community-based services, including adult day and Programs of All-Inclusive Care for the Elderly (PACE) — not a corner is untouched.

While millions have been infected by the virus, already frail, vulnerable older people are more likely to get very sick and die of it. Aging services providers are fighting valiantly, doing everything they can to beat it back and help the people they care for — and the staff who care for them — stay healthy and safe. They struggle against some gaps in how we care for older people.

THE SYSTEM IS BROKEN

The struggle is real. Issues have come up in every corner of aging services. The gaps that were sitting there in plain sight before have been made more apparent to more people by the "coronavirus trifecta" of inadequate personal protective equipment (PPE), lack of access to viable testing supplies and workforce shortages at a crisis level.

- **There are not enough staff to care for people and wages are woefully inadequate.** Average pay for frontline workers in nursing homes, for example, is $11 an hour. Then, COVID. Early in the pandemic we started hearing about work shifts beginning and no staff showing up to work. The reasons varied — school closed and no childcare, fear of getting sick, not wanting to work without adequate PPE, or actually being COVID-positive themselves. In response, we've heard of calling in emergency teams, the national guard staffing the facility or, the most disruptive choice, moving every resident to another community. The assisted living provider who, over a one-month period, went from no positive diagnoses among staff and residents, to all but two staff testing positive and most residents having to move to new homes. The provider closed permanently.

- **Inadequate access for aging services providers to PPE and testing are endemic of a bigger problem — the federal government has a responsibility to lead on aging and long-term care services, as it does on health.** The regulatory system isn't working to assure that people can lead quality lives, or even to keep people safe. The current nursing home regulatory and enforcement system was established 34 years ago based on a landmark report by the Institute of Medicine (now part of the National Academies of Science, Engineering and Medicine). Today, the US spends over $170 billion a year on nursing home care, yet many quality issues identified in a 1974 Senate Aging Committee report persist. This quality system isn't working. Testifying before the Senate Special Aging Committee on aging and COVID-19, Tamara Konetzka reported on her research finding of no meaningful relationship between nursing home quality and the probability of at least one COVID-19 case or death.

- **Reimbursement rates don't cover basic needs.** State Medicaid rates for long-term services and supports already didn't cover the cost of nursing home care, for example. It is unclear whether adult day service providers, who provide care for sometimes $70 dollars a day, will be able to reopen; these providers had no reserves to fall back on.

- **Home- and community-based services are a lower priority for funding and provide a limited safety net.** For all our talk — and all policymakers' talk — about the importance of home- and community-based services, or HCBS, we have provided only limited alternatives for older adults, particularly those with cognitive impairments. The adult day services that a quarter of a million older people, many with dementia, received prior to the coronavirus crisis, may have

been the linchpin that enabled family members to work as well as care for their loved one instead of turning to out-of-home residential care.

■ **Only one in three people eligible for HUD-assisted affordable housing gets that housing.** The others wait for two, three or more years and some die before they get it. Fewer than half of sites have the resources to employ a service coordinator. The evidence is clear that combining some wellness and care coordinator services with independent living for low-income older people can allow them to stay healthy and independent in the community and keep them out of nursing homes, sometimes for good.

CHANGES CONTEMPLATED FOR YEARS, REALIZED IN AN INSTANT

We already knew what to do. Many experts and observers in the long-term care arena have been proposing and advocating for change for years – but aging services were either too invisible, didn't rise to the top of the list for action, took a back seat to larger health care concerns or there simply wasn't the political will.

Somehow, though, when the COVID crisis emerged, we figured out how to pay frontline workers more, how to come up with "hardship pay" and bonuses for newly christened "heroes on the front lines" of long-term care and aging services. The hope, the passion, the creativity — the love — all shine through. People have always done this work because they have a calling to help others.

Equally unexpected, Centers for Medicare and Medicaid Services regulators acted deftly to waive routine survey activity. Despite not having to report comprehensive staffing data through the Payroll Based Journaling system (that tracks staff hours), nursing home providers were able to serve meals one by one to residents in isolation and assist individual residents with technology to enable family virtual visits.

State agency nursing home surveyors in many states realized they could save lives by working collaboratively instead of punitively with providers on infection control. Acknowledging that state Medicaid rates to long-term care providers are inadequate to cover the cost of care, states temporarily increased nursing home and some home- and community-based services rates.

HHS offered states enormous flexibility to waive regulatory restrictions. Under normal circumstances, pre-COVID, in order to receive Medicare-covered post-acute rehabilitation services in a skilled nursing facility, an individual had to have at least a three-day stay in a hospital. Many who were in the hospital for less than three days and went on to receive skilled nursing facility rehabilitation services were shocked to find that Medicare wasn't going to cover that rehab. Providing Medicare coverage for nursing home stays without a prior three-day hospital stay was a game changer, allowing people with COVID-19 to receive care in these settings without unnecessary public spending.

Permitting Medicare reimbursement for services provided via telehealth meant health care providers could see and treat patients without both parties being unnecessarily exposed to potential infection (with the notable and unfortunate exception of home health). Many are wondering why it took so long.

Congress and governors recognized the important role of nursing homes and other aging services providers and created authorities for them to establish and operate dedicated COVID units.

It became obvious that frail older people living independently in HUD-assisted affordable housing needed help from service coordinators, so Congress invested money to provide them. USDA rural housing leaders found an existing regulatory authority to hire service coordinators in all buildings.

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CREATING A RATIONAL AGING SERVICES SYSTEM

This is all possible. Instead of adding costly patches to the existing array of aging services providers and settings, why not build an organized system that will work for people at all income levels and is paid for in a logical systematic way? It is always going to cost more and be less durable to patch

things together in a rush in the middle of an epic emergency.

Howard Gleckman, a long-time student of long-term care structural, delivery and financing reform, suggests conceptually starting "from scratch." Of course, we cannot, nor should we, erase current services and supports. What Gleckman implies, though, is that we mustn't be constrained by current structures, especially if they aren't working.[2]

Building on what works is a good approach. In fact, we can build on these nimble, quickly authorized "COVID changes." We have an opportunity to make the United States a good country to grow old in. We can join the rest of the developed world and embrace government policies that recognize that about 50% of us will need functional supports to live our best lives sometime before we die.[3]

Establishing in the next Congressional stimulus legislation a post-COVID 19 bipartisan Congressional commission on the future of aging services that LeadingAge recommends is a bold and meaningful first step.

The crisis has pushed our failing aging services infrastructure into the spotlight. The creativity, persistence and mission-commitment of aging services providers is going to guide us to a new way of organizing, delivering and paying for services that ensure that older people and their families can access, afford and use the care they need to live their best lives. The bipartisan commission will push policymakers to take the necessary steps, so that we don't ever again have to underwrite expensive, temporary measures after a crisis hits.

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NOTES

1. Tamara Konetzka's testimony, https://www.aging.senate.gov/imo/media/doc/SCA_Konetzka_05_21_20.pdf.
2. For more, see Howard Gleckman's website, for instance: https://howardgleckman.com/2020/06/09/how-to-redesign-long-term-care-for-older-adults-after-covid-19/.
3. See the Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care at HHS, for instance: https://aspe.hhs.gov/basic-report/what-lifetime-risk-needing-and-receiving-long-term-services-and-supports.

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