

# Responding to the Realities of an Aging Society

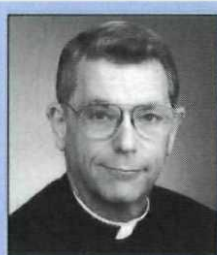
BY REV. MICHAEL D. PLACE, STD

**I**n a talk to the American Health Planning Association, I identified an urgent challenge facing not-for-profit healthcare: the aging of America. I noted that I believe that Catholic, and indeed all not-for-profit, healthcare organizations, with their long tradition of identifying the needs of the community and responding to them, are ideally prepared to respond to the needs of the elderly. I have developed a personal perspective on the elements of an effective response by looking at the historical and current context within which we are called to act.

Catholic healthcare has provided a range of services for the aging and chronically ill since the first sisters came to the United States in 1727. But our nation's healthcare system has focused primarily on treating and curing discrete episodes of acute illness. Compelling figures make it apparent that this focus on acute care is no longer appropriate. More than 33 million people in the United States are over the age of 65; 3.5 million of these are 85 or older. About 100 million people have chronic illnesses, which require care over prolonged periods.

To address the new realities of our aging society, I believe the healthcare system must undergo a major reorientation. We must think in terms of a continuum of care that covers periods of wellness and illness in multiple aspects. In designing appropriate care, our attention should reach beyond hospitals, nursing homes, and physicians' offices to housing programs for the elderly and disabled, to their homes, and even to the congregations where they worship.

Catholic and other not-for-profit organizations can lead the way toward a radically reconfigured system—weaving a seamless fabric that allows the aging and chronically ill to receive treatment and be supported physically, emotionally, socially, and spiritually, whether they are in their homes or an institution. Weaving this fabric of community support will force us to grapple with variations in the conditions of aging and chronically ill persons; changing needs; and the delivery of care outside



*Fr. Place is president and chief executive officer, Catholic Health Association, St. Louis.*

*This column is adapted from a presentation to the American Health Planning Association, July 16, 1998.*

the usual boundaries of medical institutions, with a reliance on nonprofessional assistance.

## VARIETY OF CONDITIONS

Although some 100 million of our 256 million citizens suffer from long-term and chronic conditions, the elderly and chronically ill do not make up a homogeneous group. Persons with long-term conditions (defined as lasting 90 days or more) can experience a variety of pathways: some ultimately recover; some face a downward trajectory, although at individual and often unpredictable rates; some may be relatively stable. And elderly persons' activity levels, vitality, and health status vary greatly. Thus the delivery system's response must be highly personalized, flexible, and integrated.

## CHANGING AND INTERLOCKING NEEDS

Any long-term condition may be punctuated by episodes of acute illness, the treatment of which must be integrated with care for the ongoing condition. In addition to acute episodes, chronic conditions are frequently accompanied by functional limits on activities of daily living that require the assistance of a device or another person. There is a danger, particularly for the elderly, of frailty begetting frailty. Poor vision may lead to a fall, which may require a hip replacement, which in turn may produce chronic infection or permanently reduced mobility.

## HOUSING AND CARE DELIVERY

Housing and living arrangements are critical to the optimal functioning of persons with chronic conditions. We know that many aging and chronically ill persons are able to remain in their homes and communities because family and friends provide needed care, often at great personal sacrifice. A continuum of care must recognize and support these caregivers and address living and social arrangements. Catholic hospitals and long-term care facilities should consider developing housing programs as part of their continuum of care. The Catholic Health Association (CHA) and Catholic



Charities USA are working to help their organizations become more involved in such programs.

### LEADING THE TRANSITION

Developing a true continuum-of-care delivery system depends on our ability to meet four challenges:

**Integration of Providers** Integration does not have to mean common ownership, but it does entail a high degree of coordination across providers. It also means a redefinition of the term "provider" to include such entities as senior housing, adult day care, geriatric assessment, home care, adult foster care, congregate meals, telemedicine, and all the high- and low-technology services that are being developed in not-for-profit health and human service organizations.

Loretto, a Catholic social service organization in Syracuse, NY, exemplifies the possibilities of creative partnering. Loretto, which has provided housing and nursing services to indigent, homeless, and disabled elderly for 70 years, has formed partnerships with a hospital, a physician group, the city, Catholic Charities, the Knights of Malta, and many other groups to provide services to their clients.

**New Organizational Systems** A continuum of care will require new governance structures; coordinated clinical care; integrated information systems; and innovative improvement mechanisms. In coordinating our clinical care, we need to build on what we have learned about case management and find models most appropriate to our organizations and the persons we serve. A case manager or team of managers is critical to the care process. In Minnesota, two faith-based healthcare organizations, the Catholic Benedictine Health System and the Evangelical Lutheran Good Samaritan Society, formed an alliance of their 90 facilities to offer a continuum of long-term care to managed care enrollees. An innovative joint management council steers the alliance.

**New Financing Systems** The fragmentation of financing and, in particular, the usually rigid distinction between "medical" care services and "personal" care services must be overcome. The current patchwork of coverages, eligibility requirements, and funding sources—both governmental and private sector—presents an impenetrable maze for both the patient and those who seek to help. Integrated financing will require us to better understand the true cost of care delivery and to pool funding sources from the various payers.

The Sisters of Providence Health System, which serves several Northwestern states, has taken a bold and innovative approach by integrating the finances of its various programs within geographic areas. Hospitals, nursing homes, hospice pro-

*We need  
to identify  
legislative  
and  
regulatory  
barriers to  
providing a  
seamless  
continuum  
of care.*

grams, PACE (Program for All-Inclusive Care of the Elderly) sites, and assisted living centers in the same region all share a common bottom line.

**Leveraging Community Strengths** Most aging and chronically ill persons are not in our hospitals or nursing homes, but in their own homes. To help serve the growing aging population, we must bolster existing community structures that support them. Catholic Charities and CHA are developing operating guidelines for hospitals and nursing homes that want to work with parishes and other faith congregations using some of the many models already in place. For instance, two Catholic hospitals in Cincinnati are working with parishes to train volunteers to help home-bound elderly through home visits, telephone reassurance, transportation to medical appointments, help with daily chores, and referrals to community services.

**Advocacy** We need to identify legislative and regulatory barriers to providing a seamless continuum of care. Federal and state policies often work against integration of care. For example, Medicare encourages care in hospitals or other institutions, when other, more appropriate settings would better serve the person. For persons dually eligible for Medicare and Medicaid—the frailest and poorest of the aged—it is important that federal and state policies and funding be restructured so that consumers can more easily navigate the system and healthcare organizations can provide services more efficiently and effectively.

We also must advocate for public support of research into the problems of aging, chronic illness, and how to improve healthcare delivery systems. I can think of no higher priority than uncovering the cause and finding effective treatment and management of Alzheimer's disease.

Finally, we need support for demonstrations of improved models of delivering services for the aging and chronically ill. Clearly, the traditional approach of treating all critical illness in hospitals and providing all long-term care services in nursing homes is not in the best interests of persons needing care and the communities we serve. For one thing, it does not support individual autonomy. For another, it is simply too expensive. I believe the not-for-profit healthcare community will develop innovative approaches to care—as we have faced other challenges—but we need government support in terms of both funding and latitude.

Leading the transition to a continuum of care will require that we reassert the unique identity of our institutions as entities whose sole focus is on serving the individual and the community. The result will be a stronger Catholic healthcare ministry that is strategically well positioned to serve elderly and chronically ill persons and fulfill its mission to meet people's needs. □