The Graying of America

BY REV. MICHAEL D. PLACE, STD

The world's population is in the midst of a remarkable transition from a state of high birth and death rates to one of low birth and death rates. We are witnesses to—and many of us are participants in—a stunning growth in the number and proportion of older persons in society. In the history of civilization, there has never been such a rapid, large, and ubiquitous shift in population dynamics. For example:

- One of every 10 persons in the world is now 60 or older; by 2050, one out of five will be 60 years or older; and by 2150, one out of three persons will be 60 or older.
- In the United States our over-65 population will grow from 12 percent to 20 percent within the next three decades—more than doubling our elderly population, from 32 to 70 million.
- Our elderly population will not only be greater in numbers, it will also be older. Twenty million seniors will be over 85 by the end of the first two decades of the new millennium.[1]

The transition to an older world is of profound significance to the Catholic Church because we Catholics believe that society must respect life at every stage of development, treating all people with the dignity they deserve as children of God. That dignity requires that people have the opportunity for self-fulfillment at every age, that they retain their independence, that they receive the care they need, and that they participate in the decisions that affect them. As Christians, we do not think of the elderly as a group apart from the rest of society.

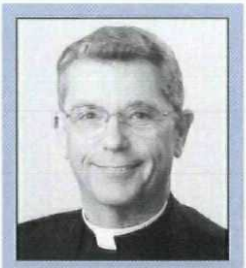
The sheer enormity of these changes and their expected impact on health care and other social resources can overwhelm us to the point that we despair or simply "turn off" and try to ignore the subject. In short, we may see only the challenges, and not the opportunities, God has set before us.

A Basis in Catholic Health Care Values

The perspective of the Catholic health care ministry is founded in our faith-based values. These are, if you will, our "operating principles" derived from Jesus' fundamental injunction to carry on his caring, healing, and reconciling presence in the world. Allow me to summarize them briefly:

- Every person is the subject of human dignity.
- Health care is a service to people in need and an essential good.
- Health care must serve the common good.
- There is a special duty to care for the poor and vulnerable.
- There must be responsible stewardship of resources.
- To the greatest degree practicable, administration must be carried out at the level of organization closest to those to be served (subsidiarity).

These core values form our response to the challenge and the opportunity presented by our aging society. I will discuss these responses in terms of four categories, recognizing that, as with all such divisions, the boundaries, while useful, are somewhat arbitrary.



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The Response of Catholic Health Care Institutions

Catholic health care institutions can become more open and better prepared to meet the needs of the elderly population. First, our institutions must reflect on, re-establish, and re-commit themselves to their mission. As membership in religious orders has declined, lay personnel of all faiths have assumed management and staffing roles, and market pressures threaten to overshadow traditional commitments, attention to first principles is of critical importance. This means recognizing and integrating into all that we do the essentially religious nature of the action of providing health care. Only if we are clear about our fundamental purpose, and express it in every aspect of our organization, can we effectively contribute to and benefit from serving the elderly.

Next, our institutions must examine their relationships with their communities in a systematic way, particularly in terms of programs and services for the elderly. Those who provide Catholic health

care feel they are making significant contributions to their communities. Catholic institutions can test these convictions through use of planning tools such as the Catholic Health Association's (CHA) Social Accountability Budget, which provides a step-by-step process for planning and reporting community benefits, especially services to the most vulnerable.

Such internal reviews, however, should also be complemented by an equally candid effort to understand how the community views the institution's contributions. This evaluation is critical. An institution may feel it is doing everything "right" in its own terms, but still not be fully connected to the needs of the elderly in ways that the community considers important. Without knowing who we are and what our communities need, the transformations needed to address the aging phenomenon will be more difficult, perhaps impossible to make.

Finally, Catholic institutions need to develop effective and appropriate partnerships. Some existing partnerships have been products of marketplace pressures. As employers and insurers increasingly require geographic breadth and a full range of services from health care delivery systems, health care institutions-both horizontal and vertical-have formed various alliances in order to remain viable and to continue to serve their communities. These alliances typically take place among health care facilities such as hospitals and nursing homes and can present a variety of challenges to the maintenance of mission.

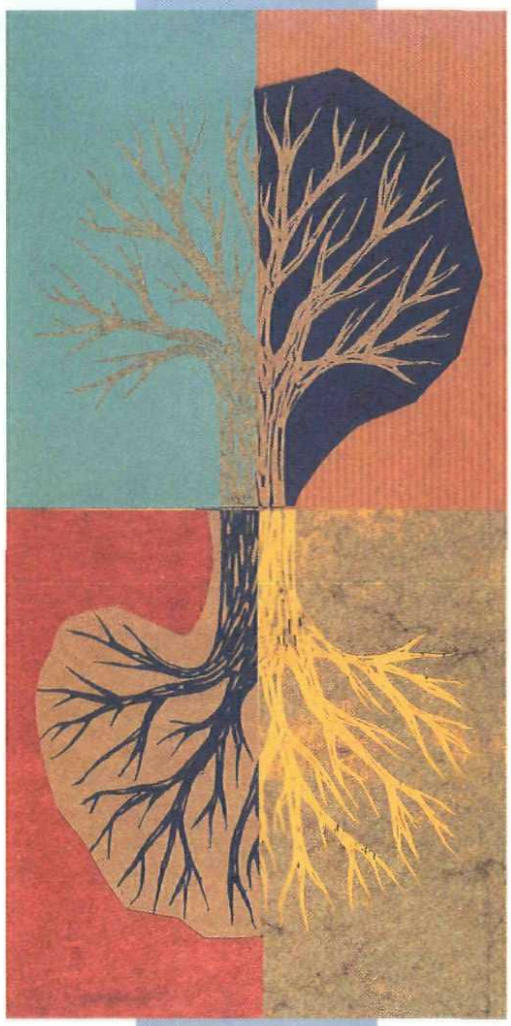

Illustration by José Ortega

Creating a Continuum Through Partnership and Leadership

Our nation's health care and social service delivery systems must undergo a major reorientation to address the new realities of our aging society. Catholic institutions and agencies, based on their long tradition of identifying the needs of the community and responding to them, are ideally suited to lead the way. We must begin to think in terms of a continuum of care that encompasses extended periods of wellness and illness, rather than of episodes of care. And we must think and act beyond the walls of traditional acute health care institutions to include housing and other community-based services.

Health and healing include a wholeness that is not only physical and emotional, but also spiritual and social. The "continuum," then, involves both the inner and outer dimensions of existence. Our task is to match the services of the outer continuum of care with each individual's inner array of aspirations and needs. To accomplish this, our concern for persons in a continuum of care should begin with the individual and extend to his or her family and neighbors. 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.

Our current health care and social service delivery systems are not well suited to this task. In fact, we often have parallel delivery systems serving the same person and connecting only haphazardly. Our responsibility is to weave 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.

Significant movement in this direction has occurred within the church. Since 1995, the Catholic healing and caring ministries have been engaged in the *New Covenant* initiative, whose aim is to increase collaboration among the various ministries of the church concerned with health and human services. Catholic Charities USA and CHA have led this effort.

A multitude of good reasons to increase collaboration between and among our ministries exist, but the call to respond to the growing age wave should transform what has been an important and vital effort into an effort of the highest priority for us all. In addition to our faith-based missions and the need of the times, two other factors lead me to this conclusion:

We are uniquely qualified to create the necessary continuum of care. We have a common faith and complementary missions. We are present throughout the country offering every form of health and social service.[2] We provide these services to persons in need, regardless of their religious beliefs.

We have the resources, the structures, and the know-how to create the continuum of care that our elderly and our communities need and, through the *New Covenant* initiative, we have already created a process to help make it happen.

We can and should assume a leadership role in responding to this defining demographic event.

Components of the Continuum

The aging of our population and its consequences impel us to intensify our efforts to develop innovative approaches to enhancing health and well-being—approaches that are more holistic and reach beyond both organizational boundaries and facility walls. In addition to marshaling our internal resources effectively, we must recognize that the goal we have set will call for our most creative and committed energies. Those of us in health care will be required to grapple with issues that, although present to varying degrees in the acute care system, predominate in a chronic care system. These include wide variations in chronic care populations and the problems that afflict them, the delivery of care outside the usual boundaries of medical institutions, and reliance on volunteers and others to assist in that delivery.

The variety and unpredictability of chronic disease conditions also mean that the response to the individual must be highly personalized, flexible, and integrated. A continuum of care must address the whole person, including living arrangements, social situations, and chronic conditions and illnesses. It must be able to react appropriately and quickly as circumstances change and must be designed to provide continuity of care over extended periods of time. This response will require those of us whose perspectives are primarily hospital-focused or nursing home-focused to make substantial adjustments—to create a truly person-centered approach to care delivery.

Developing such a true continuum of care will depend on our ability to meet four challenges:

Integration of providers. Integration need not mean common ownership, but it does mean a high degree of coordination across providers of care. It requires an inclusive understanding of the term "provider" to encompass 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 health and human service organizations.

New organizational systems. A continuum of care cannot be implemented in seriatim. It will require not only a sufficient configuration of providers but also new governance structures, coordinated clinical care, integrated information systems, and innovative quality improvement mechanisms. In coordinating our clinical care, we need to build on what we have learned about case management—the good and the bad—and find models most appropriate to our organizations and the persons we serve. A care manager or team of managers is critical to the care process.

Leveraging community strengths. As noted earlier, most aging and chronically ill persons are not in our hospitals or nursing homes, but in their own homes. If we are to help serve the growing aging populations, we need to be sure we do not supplant existing informal community structures that support them. Rather, we want to support community resources.

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-often presents an impenetrable maze to both the patient and to 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. Finally, we need to find a way to address the needs of the great majority of elderly who cannot afford long-term care insurance but are too well off financially to qualify for Medicaid unless they impoverish themselves.

The fragmentation of eldercare financing must be overcome.

A Public Policy Agenda

The challenges we in Catholic health and social services face in coordinating and collaborating services, in part, reflect problems in the structure and funding of state and federal programs. Medicare, Medicaid, community health centers, and programs for the aging are funded by a variety of agencies that have little connection to one another and often have little flexibility.

The challenges we face also reflect the lack of adequate public funding for the needs of the elderly. Improved flexibility and coordination of public programs, while essential, are not enough. Inventiveness and creativity can only stretch limited resources so far. Simply stated, federal and state governments must allocate more financial resources if we are to have even a minimum of care, let alone a continuum of care, for our growing senior population. Public funding of current elder care services is inadequate. Nursing homes, for example, are severely underpaid by most Medicaid programs. As a result, many nursing homes cannot afford sufficient numbers of well-trained staff to provide optimal service. As Monsignor Charles J. Fahey of Fordham University's Third Age Center has observed, because nursing home payments allow for only modest wages, the current system is effectively subsidized by poor people who work as home health and nursing home aides.[3]

Two additional aspects of the public agenda

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REFLECTIONS

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deserve particular emphasis. Research on diseases that particularly affect the elderly, such as Alzheimer's, must be a priority. The research agenda, however, should not be limited to specific diseases. For instance, we need to learn more about how to adjust the home environment of elderly persons to help them avoid dependency-creating events such as falls. Research and development of new technologies may extend the period in which the elderly can live independently.

Finally, prevention both in terms of research and application should also be prominent on the public agenda. We recognize that, with aging, limitations on life and activity increase for most people. This recognition, however, should not imply a passive acceptance of conditions that preventive measures could address.

Advocacy is an essential function for improving our ability to serve aging and chronically ill persons.

Such an effort would be independent of, but would ultimately complement, our ongoing advocacy for accessible and affordable health care coverage for all. We recognize that, even with universal health care, many of the housing, day care, and social services that are essential parts of the care continuum would still not be addressed. □

The preceding is adapted from "The Graying of America: Ethical and Policy Implications for the Church and Nation," the Hillenmeyer Lecture that Fr. Place delivered at Thomas More College on April 23, 2001. The full text is available at www.chausa.org/prespage/hillenmeyer.asp or by contacting CHA order processing at 314-253-3458.

NOTES

1. C. Evashwick and T. J. Holt, *Integrating Long-Term Care, Acute Care, and Housing*, The Catholic Health Association, St. Louis, 2000.
2. The Catholic Health Association, *Profile of a Community Partner: Building Networks with Catholic Charities*, St. Louis, November 1996.
3. C.J. Fahey, *The Policy Agenda for Long-Term Care*, Draft 3, November 12, 1999, at http://www.fordham.edu/thirdage/ethics001.htm.

RESIDENT-CENTERED CARE

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cent to the residents' family rooms function as staff workstations. In the old building, the old nurses' station was eliminated and cabinets in each family room now function as staff work space.

Surprisingly, constructing the new building was the easy part of the renovation. The real challenge for Teresian House staff was adjusting to their new work space amid the residents as well as to their place in the new organizational structure, which now centers on a team-based approach.

The concept of a leader directing a team of staff representing all departments replaced the idea of an RN manager of a floor with supplemental help from various departments. In keeping with our vision, this leader is called the resident-centered care coordinator (RCC). He or she is trained as a mini-administrator and has overall responsibility for a 40- to 50-resident unit. The RCC leads a team consisting of an RN, an LPN, nurses' aides, resident assistants, a social worker, an activities coordinator, and housekeepers. This team performs all the tasks necessary to address resident needs on an assigned floor.

Each team reviews all the tasks performed for residents and collaborates on a list of global duties, defined as tasks that can be performed by any team member as long as the task does not exceed the scope of his or her job description. The scenario of a resident turning on a call light is a good example of these global duties. Any member of the unit team can *answer* a call light. The person answering the light may not be qualified to bring the resident to the bathroom or to administer medication, but that person may move a box of tissues closer, pull a shade down, or alert the nurse to a request for pain medication. In addition to lowering the noise level on the floor, the prompt answering of call lights illustrates one advantage of the team approach, which is quick and efficient response to resident requests.

To prepare the team to care for individual resident needs, a preadmission assessment form is used. Completed by the resident and family before admission, this form lists items such as medications the prospective resident receives, preferences for meal and bath times, placement of bed, and interest in church and other outside activities. By reviewing the information on this assessment, the unit team can form a picture of the resident's life in the community and use it as a basis for an individualized care plan.

The preadmission assessment form also reflects our shift in focus from the medical model—requiring the resident to fit into the established routines of the facility—to a focus on the facility accommodating, as much as possible, the routines of the resident.

The physical and organizational changes implemented by Teresian House have resulted in profound psychological, social, and spiritual benefits for the residents. The cluster concept enables the different personalities and interests of each resident to blossom. Large parties and gatherings still happen occasionally, but the day-to-day activities center in a homelike group. With few exceptions, residents are now allowed to age in one place, eliminating the fear of being sent to another floor when physical capabilities diminish. Replacing the institutional aura with the more homelike environment allows for more family-oriented gatherings. Residents are now more relaxed and interact more with staff and other residents. Each floor can cite numerous anecdotes of the positive effects of this new environment.

Of course, not every change was met with wholehearted enthusiasm, and not every change succeeded. Some staff members left because they did not agree with performing global duties that they believed were beneath their educational level. In some instances, prepared budget line items (especially food) went beyond set parameters and had to be brought back in line by careful monitoring. Nevertheless, our fundamental belief that benefits for the residents would result from the practice of resident-centered care was a beacon for our journey and remains our hope for the future. □

NOTES

1. Lorretta Pastva, *The Carmelite Sisters for the Aged and Infirm*, Editions du Signe, Strasbourg, France, 2000, p. 4.

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