



# THE VIEW FROM AAHSA

**W**illiam L. "Larry" Minnix, DMin, took office as president and chief executive officer of the American Association of Homes and Services for the Aging (AAHSA) in January 2001. He recently sat down for an interview with *Health Progress*.

Before coming to AAHSA, Minnix was president and CEO of Wesley Woods, Inc., Atlanta, a comprehensive long-term care program affiliated with the United Methodist Church. He earned his undergraduate and graduate degrees from Emory University, Atlanta, and is an ordained elder of the United Methodist Church.

AAHSA consists of more than 5,600 not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community service organizations. More than half of its members are faith-based organizations.

**You've been AAHSA's leader for about 10 months now. How do you see your role in that organization?**

My role is to lead and to serve. As I see it, my job is to help produce, if you'll allow a metaphor, a kind of symphony. I don't play an instrument; I'm not the conductor; I'm not a section leader. We have the potential for a wonderfully strong, beautiful symphony, and my role is to try to figure out how to bring it together. Like any other, our "symphony" has woodwinds, percussion, brass—and a string section. CHA is the string section; it's the whole string section, a very important part of the orchestra.

**What are some of the other groups in this "symphony"?**

*The  
Organization's New  
Leader  
Discusses the  
Challenges  
and  
Opportunities Facing  
Long-Term  
Care*

The primary groups, of course, are the faith-based groups. I've thought for some time that the faith-based groups philosophically and theologically believe the same things. Unfortunately, though, there's been no coordination of the way they translate their theological and philosophical underpinnings into action plans.

So one of my first steps will be to try to get faith-based leaders together to say that we're going to change care for the elderly and vulnerable and frail; we're going to create a healthy, affordable, ethical long-term care (LTC) program in this country. But we must come together to do that. We don't necessarily need to make a big deal out of it—just come together and do it.

We also need to build relationships with consumer organizations. These would include, for example, the American Association of Retired Persons (AARP) and the National Citizens' Coalition for Nursing Home Reform (NCC-NHR), both of which are very aggressive watchdog groups. I've met with the leaders of these groups and have learned that their organizations are basically interested in the same things we are. (I would want AARP and NCC-NHR looking out for *my* mother, for instance.) As I talk to their leaders, I'm coming to see that whatever differences exist between our groups have to do mainly with technicalities and a need for greater trust. On the big things—meeting the needs of the elderly and the vulnerable—we're in agreement.

**Has there, historically, been some friction between consumer and provider groups?**

Yes, and that's one of the reasons consumer groups were created. We LTC providers were not doing a good job of accounting to the public. We've *got* to be publicly accountable for what we



do. And we're not there yet. But we're perfectly capable of it.

Unfortunately, long-term care is the only health care provider group that has not yet been granted a measure of public accountability based on self-governance. Hospitals have governed themselves for years through the Joint Commission on Accreditation of Healthcare Organizations. Professional member groups, such as the American Medical Association, are also allowed to govern themselves. The federal government doesn't regulate them the way it regulates long-term care.

I suspect that LTC organizations—especially the not-for-profit organizations—have not been assertive enough in this regard. We *have* taken responsibility, but we've done it quietly. AAHSA is a very responsible group; our members are self-accountable.

As an entire field, however, not-for-profit long-term care has been extremely fragmented. As a result, there's been no entire-field approach to self-governance. So we get regulated based on anecdotal horror stories. Now the horror stories *are* real. But we can't afford to get defensive about them. Instead, we've got to be *consumer focused*. If we're focused on taking good care of old and vulnerable people, and also are fair to the people we employ to give the care, then I won't worry about what happens to our various constituent groups. They'll be fine.

Incidentally, the American Health Care Association (AHCA) is another group that we need to relate to in a more constructive way. The AHCA is primarily made up of for-profit nursing homes. I've had numerous meetings with its president, Charles H. Roadman II, MD; he and I have met with U.S. Health and Human Services (HHS) Secretary Tommy G. Thompson to discuss the problems of long-term care. AHCA and AAHSA have worked on a paper in which we describe our common goals. We want that paper to be something that other LTC groups can look at and say, "We agree with those goals." There's significant common ground to be defined with the help of AHCA, on one hand, and consumer

groups such as AARP and NCCNHR, on the other. That's what I mean when I talk about building relationships. It's hard work, but it's got to be done.

#### Government programs for the elderly are also fragmented, aren't they?

Management gurus say that organizations produce exactly what they're designed to produce. So, if you want to change outcomes, you've got to go back upstream to find out where the problem is occurring. If you apply that theory to long-term care in the United States, you discover that there are two to four dozen federally mandated programs serving elderly and disabled people. Medicare and Medicaid are the two biggest, but there are many others.

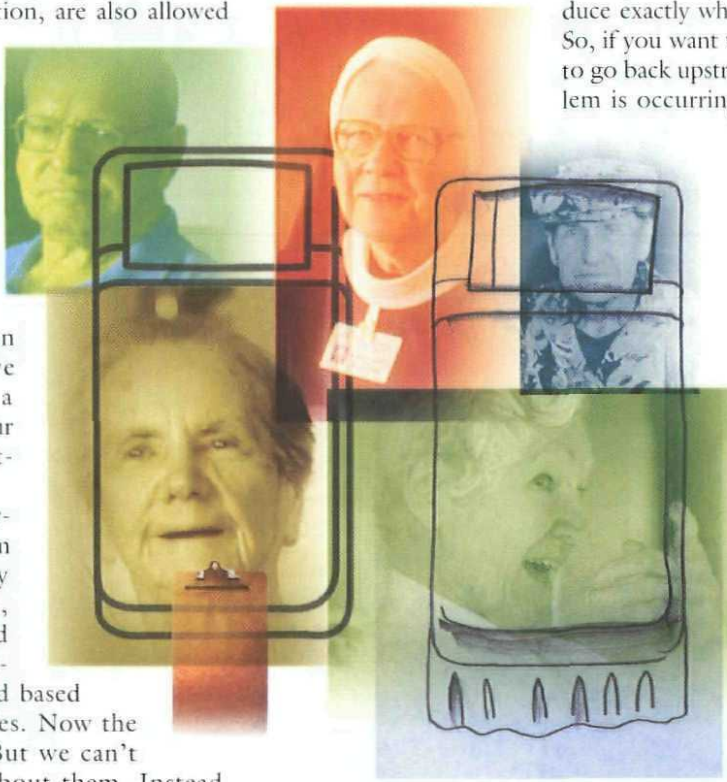
And none of them are coordinated. Absolutely none.

There are no incentives—for either the providers or the government entities overseeing the providers—to encourage them to work together. This fragmentation occurs even in Congress. One set of congressional committees oversees Medicare Part A, another oversees Medicare Part B, still

another oversees low-income housing, and yet another oversees home- and community-based services programs. When you understand that, you begin to see why, when all this comes downstream, it never really comes together in a continuum of care.

Fortunately, members of Congress are beginning to see this fragmentation. A congresswoman recently told me she had experienced it in her own life. Her mother had undergone serious surgery and then had subsequent problems with the wound. The congresswoman had brought her mother to Washington, DC; she was determined to help take care of her, along with performing her regular duties. "Here I am, trying to coordinate all these things," the congresswoman said, "and then suddenly one of my mother's benefits was stopped, and I had to drop everything to go deal with that!"

"You're experiencing what millions of people experience every day," I told her. "You should be





able to pick up the phone and call a number and get solutions to all your LTC problems from one source. The system should be reformed to provide that kind of service.”

What’s more, reform of this kind should not cost huge amounts of money. It will cost *some* money, simply because the population is aging. But great savings can be gained by reengineering the way we provide care for our elderly and disabled. We don’t have to break the bank.

**It seems difficult to get American to acknowledge—let alone tackle—problems related to the care of the aging. Why is this so?**

As a society, we Americans deny the fact of aging. We don’t want to see it and we don’t want to think about it; we feel threatened by it. Our impulse, in fact, is to isolate it and punish it. That, I think, is the underlying psychodynamic. We are still very much an ageist society.

**What kind of basic reforms do you have in mind?**

We must create some form of social insurance for long-term care. Of course, this is an issue fraught with all kinds of ethical, legal, and political problems. Our current system offers few good choices to people approaching old age. Social Security provides minimal benefits, but it certainly doesn’t defray the cost of residence in a nursing home. As a result, people often feel they must either pauperize themselves providing for their care or divest themselves of their savings (usually by giving it to their children) and force some government program to provide that care for them.

Neither option is consistent with human dignity. Some states have made it illegal to divest oneself of property in this way; in Georgia it’s illegal to even *advise* people how to do it. I think we have to begin with the fundamental belief that people should use their own assets to take care of themselves before turning to the taxpayer. On the other hand, people naturally want to protect the estates they’ve worked hard to create.

I think the solution is to make long-term care a private *and* public responsibility. Actually, it’s been a public-private responsibility since 1935, when Social Security was launched, but it needs to be updated. The government should play a role, especially for those people who are unable to do it adequately, and the rest of us should be encouraged—“incentivized,” so to speak—to take responsibility for ourselves through some kind of long-range plan. That’s not a new idea, of course; we just need to think about it differently.



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—MINNIX

Some private LTC insurance products are available now. My wife and I have a policy. If we were to become disabled, that policy would act as a buffer protecting the estate we hope to leave to our children. Under true reform, the government would provide incentives encouraging people to plan their long-term care early. Although it’s the last thing on their minds, 25-year-olds can get LTC insurance very cheaply.

But, however we do it, society must find a way to put some kind of fundamental floor under long-term care.

**You mentioned meeting with HHS Secretary Thompson. Is he open to new thinking along these lines?**

I have found him to be very open. He knows the current system is not working properly. I’ve found the same thing to be true of Housing and Urban Development (HUD) Secretary Mel Martinez. HHS and HUD are the two federal agencies that we at AAHSA relate to most closely. Both men are also very open to how HUD and HHS might work closely with AAHSA members to help elderly people age in place in HUD facilities by creating modestly priced assisted-living facilities.

I’ve told both secretaries that if their departments would relax their regulations a bit and give our members some program flexibility, we could take care of an awful lot of people in home-like settings that are inexpensive in terms of capital investment—in programs such as PACE (Program of All-Inclusive Care for the Elderly), for example.

But the point I want to make here is that Thompson and Martinez are no-nonsense guys. This is our chance. They are asking us to come up with solutions that involve self-responsibility. As for Congress, I’m running into people who want to do the right thing but don’t know exactly what that is. Some members are beginning to develop a vision of what long-term care should be, but their vision is still in the early stages.

**Would you say that helping to develop such a vision is part of your job?**

Absolutely. As Proverbs 29:18 puts it, “Without a vision, the people perish.” We already have the components we need. We have a great hospital system. We’ve got the best physicians in the world. We have wonderful nurses. We have good nursing homes, assisted living, home- and community-based services in almost every neighborhood. Our churches and synagogues remain a



source of the most accessible, least expensive long-term care support imaginable. Put all these ingredients together and we'll fix the problem. We have eggs here, flour there, and milk yonder. It's time to make a cake out of them.

**When you say "church," are you speaking of the Methodist Church? The Catholic Church?**

I mean the church universal. Perhaps it would be better to say "faith-based groups" because we're built on foundations of the Judeo-Christian heritage. There are probably Muslim groups and others that should be included in this category as well. But faith-based groups are the most accessible, the most caring of all those involved in long-term care. Because they are accessible and caring, we should take pains to involve them more deeply than we've done so far.

**What do you see as the really big challenges facing long-term care?**

There's an old Georgia saying: It's hard to drain the swamp when you're up to your rear in alligators. At the moment, four "alligators" are really snapping at our backsides.

The first is Medicaid, which is both inadequately funded and very fragmented. It varies state by state, so there's no real standardization of benefits.

The second "alligator" is staffing. You just can't take care of old folks if you don't have caregivers. We've simply got to make sure that people who work in long-term care receive salaries and benefits comparable to those found in other parts of the economy.

The third problem is the liability crisis, which has now cropped up in several states. In Florida, for example, a series of big judgments against nursing homes caused insurance firms to stop insuring them. Florida's legislature has passed a comprehensive measure to end the crisis, but it will be several more years before state courts settle the lawsuits still remaining before them. Some of these lawsuits are undoubtedly deserved, but many of them are not. So this is a major problem.

The fourth "alligator" is inspection regulations. The current regulation system is punitive. It drives people out of long-term care because they're afraid of the possible criminal and civil fines involved. Hospitals and physicians' offices don't have this kind of regulation. I'll bet there's not a hospital or doctor's office or home health agency in the country that could undergo the scrutiny that LTC facilities face and not come out with similar problems.

Not that we don't need national standards in

**"We need national benchmarks and we need LTC expertise in setting them."**

long-term care; we do. But we've got to have agreement on what the standards are. For example, on the face of it, you might be tempted to say of a nursing home with a number of a patients with bedsores, "That must be a terrible nursing home!" But the real question is not about how many bedsores you see. It's about where and how the sores occurred and about how the facility is responding to them. Did they occur in the nursing home or did the patients come in with them? Does this nursing home accept more patients with bedsores because it has an exceptional wound-care program?

So we need national benchmarks and we need LTC expertise in setting them. The state of the art of defining and improving quality in long-term care in this country remains primitive. Changing that situation is one of our top priorities.

**Are national LTC standards a topic in your conversations with Secretary Thompson?**

Yes. We're looking to the secretary to be the leader on this issue, to work with us to define the standards and help us bring our members in line with them. We don't know whether this will require the modification of existing regulations or the passage of new legislation. It may take some combination of both. However they're set, the standards will have to be something the public can feel comfortable with. Then AAHSA's members will have to agree to be accountable to them. I think most of our members will shine. Those that don't shine will either get better or get out of the business. And there's nothing wrong with that.

**Do for-profit LTC centers agree with AAHSA on the need for national standards?**

Yes. We've held long conversations about it, agreeing that both for-profit and not-for-profit providers are tired of getting branded by the bad providers. We've agreed to stop complaining about that and step forward and do the right thing—the thing we know how to do. That's our big job at this point.

It's a big project, but it can be done. The United States has the technology and the entrepreneurial spirit to get people to the moon and back—and also to monitor their health electronically during the journey. But sometimes we seem to have trouble getting a resident from a nursing home to a local hospital without losing the chart in the process. That makes no sense. And that's why the various provider groups have got to work better together. We can't be "silo" provider groups anymore.



### What is AAHSA's approach to the staffing problem?

We're dealing with it on three fronts.

First, we're seeking government help in "leveling the playing field" on which acute care and LTC facilities compete for staff members. As things stand now, salaries and benefits are significantly higher in the former than in the latter. Because of this, staff members naturally tend to move on to acute care jobs after being trained in a LTC facility. Our members find themselves functioning like a baseball farm system, which is not in the best interest of LTC residents. We're also asking the government to ease immigration restrictions, thereby allowing us to recruit staff members from other countries. That may be more difficult in the short run, given recent events. On the other hand, the terror attacks brought to light the good work of nurses, nursing assistants, and medical personnel in general, so we're seeing greater respect for and attention to the roles of these everyday heroes. This may bode well for the helping professions in terms of career choice and public policy support.

Second, we must improve the way we run our facilities. The Commonwealth Fund has underwritten the study of a new LTC model called "Wellspring," developed by 11 nursing homes in Wisconsin.<sup>1</sup> The model basically reengineers bedside care by empowering staff nurses, encouraging teamwork, and focusing on outcomes. The model gets people involved in *dignity* management rather than urinary continence and bowel management. When a caregiver is in the dignity business instead of the diaper business, he or she increases in self-esteem and becomes a better care provider.

And, third, we're researching best practices. The Wellspring model, when you stop to think about it, is eminently sensible. Nursing homes all over the country are developing teamwork approaches that enable them to recruit and retain talented staff. The rest of us need to hear about these approaches. So AAHSA's research institute is busy looking into them.

### How do we go about "leveling the playing field"?

Nursing assistants must be certified to work in nursing homes. To be certified, they must first go through a training program. But they *don't* have to be certified to work in a hospital. Certified nursing assistants (CNAs) are the backbone of nursing home care. And there used to be plenty of CNAs because hospitals weren't very interested in them. Now things have changed. Hospitals can't hire enough nurses, so CNAs are looking pretty good to them.

"I've learned over the years that people tend not to be interested in long-term care until they need it for their mothers."

Then there's the rural-urban issue. Hospitals between rural and urban areas can use an urban wage index to compete for nurses. Nursing homes can't do that. As a result, we're stuck with basically low-wage indexes.

Nursing in all of its three forms—the direct care provider, the professional, and the technical—are all valuable, and valuable throughout the system. Some may not want to hear it, but this country can't expect to have good long-term care without paying for it. Our friends at NCCNHR like to say, "Good long-term care is expensive, but bad long-term care is *more* expensive."

I recently visited with a congressman who was very proud of having cosponsored a bill to attract and retain nurses and send money to nursing schools and hospitals. "What about long-term care," I asked him. He said he hadn't even thought about it. To his credit, he went back and put long-term care in his bill. This is the kind of thing we've got to get across to people. On average, the public is paying \$5.50 an hour for long-term care—which is probably less than they pay babysitters. That's got to change.

### Do you think that "baby boomers," as they age, will use their political muscle to solve these problems?

I've learned that people tend not to be interested in long-term care until they need it for their mothers. What's changing is that a lot of us *do* need it for our mothers now. In my own circle, I know women who are now looking after two and three family generations. There are increasing numbers of such people, all of whom are voters. I'm finding that if I run into a congressman or congresswoman who has faced this personally, he or she is really interested. Other people still tend to be rather theoretical about it. I suspect that aging "boomers" won't be so theoretical.

### In the future, are we going to need more assisted-living programs and fewer skilled-nursing facilities?

I think nursing homes are going to be taking in people who have higher acuity needs but don't require hospitalization. It's time to put nursing *back* in nursing homes. Skilled nursing facilities are going to be getting residents with more complicated medical problems than they usually see now, which is as it should be.

But that means that people with less complicated problems can either remain in their homes or in some kind of congregate setting. And we've

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got to remember that the vast majority of people *want* to stay at home or at least in a home-like setting. So we need to create what might be called "long-term care without walls."

Many of AAHSA's members are beginning to come up with ways of doing this. The hospice, you know, was the first modern attempt to design care *around* the patient, to deliver it to the place where the patient wants to be. In hospice care, hospitals are used as backups, for the relatively rare occasions when acute care is needed. Long-term care is increasingly going to be adopting hospice philosophy. We talk nowadays about "consumer-directed care," which is basically the same thing.

### AAHSA talks about providing "ethical" long-term care. What is that?

I once had a conversation with a woman whose mother was a resident of one of our nursing homes. She felt guilty about her mother. She thought more should be done for her, but in fact there was nothing more that *could* be done. The mother's health was severely impaired and she was going downhill fast. The daughter remarked to me, "You know, when all this is finally over, I would just like to be able to face myself in the mirror and say, 'I've done the very best I know how to do.'"

Most people in such situations want that. And society should want it, too. As a society, we need to be able to look at ourselves in the mirror and say, "Concerning our vulnerable populations—whether they be children, the elderly, people with developmental disabilities, or chronic illnesses—we're doing the best we know how to do." To me, that's the acid test for an ethical society.

—Gordon Burnside

### NOTES

1. See "Promoting Quality in Nursing Homes: The Wellspring Model," a study underwritten by the Commonwealth Fund, at [www.cmwf.org/programs/elders/reinhard\\_wellspring\\_432.pdf](http://www.cmwf.org/programs/elders/reinhard_wellspring_432.pdf), or contact AAHSA, 202-508-1208.

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I certify that the statements made by me above are correct and complete. *Terry Van Schaik, Editor.*

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