



Aging in Place – Can We Afford It?

By Jerry L. Rhoads – January 2007

The academics have come up with another catch all solution for the Baby Boomers hitting 60 - Aging in Place - where everyone basks in the safety of their own home. "Aging in Place," according to the intellectuals, means that the culture of the past is the home of the future.

If Aging in Place is to have a chance at ever working, many changes must take place in the home and in our society:

1. Fitness and nutrition must be put in place and adhered to.
2. Chronic disease needs to be prevented.
3. Work life cannot end at 65.
4. The home must be set up to accept some disabilities.
5. Transportation for the disabled must be designed for ease of use.
6. Health care insurance must pay for preventing disease and preserving health.
7. The government needs to standardize what they are going to pay for and honor the commitment, regardless of the economics.
8. Wasted resources must be removed from health care practices using technology, payment incentives and care planning.
9. Politicians should not have the final call on allocation of resources.
10. Performance must be the basis for payment, supported by evidence of what the payment is pursuing and attainment of a positive outcome.

The idea that Aging in Place means every home must be a nursing home, an emergency room, a doctor's office and a place to die is not a feasible or rational solution. Here's why:

1. Fitness and Nutrition

The lack of these two intangibles, which causes almost all tangible chronic diseases, are the bane of the health care system in America. Very few Baby Boomers have a commitment to staying fit and avoiding weight problems. However, without some change in the cultural mores for these vital ingredients, the concept of Aging in Place is just another facade. Only 15% of Americans over 65 exercise on a regular basis and 75% are overweight. We are told that most of our problems are genetic ... the aging gene ... the personality gene ... the social gene ... the fat gene ... are to blame for our maladies. As long as we believe this, the more we will believe that the answer is in a pill. We are not aging in place, we are dying in place.

Solution: America's health is dependent on fitness and nutrition. For our society to function in a worldwide competitive market, we must create economic incentives for our citizens to pursue and preserve health. The use of tax deductions for fitness and nutrition expenses is a must. Higher premiums for the unhealthy who pay their own costs are the only way to bring resources in balance with the demand. By taking the employer out of the equation, we put the onus of health care costs on the offenders.

2. Prevention of chronic disease

45% of the health care dollar is spent on the five most prevalent chronic diseases: Diabetes, Obesity, Cardio Vascular Disease, Hypertension, and Lung Disease. No discernible work has been done by the FDA on pharmaceuticals as the perpetrator of medications causing as many chronic diseases as they presume to fix. By destroying the ability of the immune system to ward off common ailments, we are being set up for the dependence on and destruction of the human genome. Looking at the other side of the coin, reduction of prescription drugs and increases in natural remedies allow the body to adapt to the viruses and bacteria that have been around since the beginning of time.

Granted, the life expectancy rose to all time heights until obesity entered the scene. We give credit to the American health care system for the improvement, however, most deaths are attributable to smoking, drinking, criminal acts, wars, sexual transmitted problems, suicide, murder, neglect and abuse. Not until we began treating every malady with a pill did we increase the incidence of conditions like diabetes, vascular constriction, hypertension, cancer, respiratory problems, weight gain, dementia, autism, and birth defects.

Solution: Not every health problem lends itself to medication. Physicians need to become better educated on how to avoid prescriptions, rather than use them as a guesstimate on treating symptoms. The answer includes mandating care plans, eliminating phone orders for drugs, and interacting with elderly patients for their physical, emotional and social restorative functioning.

3. Work life ending at 65

What a concept when, in the past, most people died at the age of 45. The faulty thinking is that if we can live until 65, we should never have to work again. Now that life expectancy is 78, why are we still counting on 65 as the age of retirement? Looking at the new levels for life expectancy, we should be retiring at 98, not 65.

We have trapped our society with empty nesters who are not gainfully occupied, sitting around getting obese, and dependent on prescription drugs. Of course, economically, we cannot afford for anyone to retire unless they are wealthy because our society has left everything to the elite to decide.

The corporate giants, the Federal Government, and the health care professionals all tell us when to retire and have promised the full payment plan through pensions and Social Security. Unfortunately, they miscalculated by a few trillion. According to statistics, the Federal Government is \$26 trillion in the hole right now and the numbers are getting worse each day. Our Senators and Representatives have their health care benefits and retirement plans, thanks to the taxpayer. It is the ordinary taxpayer that does not have a nest egg. They are too busy trying to pay taxes and stay afloat.

Solution: Retirement is not the end all. For a society that is built on productive activities, it makes no sense for people who live to be 90 to be out of the work environment for 25 years. There are plenty of jobs for older Americans if we focus on forming a health preservation culture of more spas, more gyms, more health clubs, more testing, screening and preventive interventions. There are plenty of jobs that can be created by replacing the institutional bias for treatment with proactive plans for preservation.

4. The Home Set-up

99% of homes today are not conducive to handling disabilities, let alone an aging in place society. Aging in Place proposes that all medical services are delivered to the person's home. That means for the low functioning elderly, someone has to be in the home 24 hours per day for the

activities of daily living (ADL's = eating, bathing, dressing, grooming, toileting, walking). This does not come cheap. Also, there can be no stairs in the way of a wheelchair or a walker, carpeting that causes falls, chemicals within reach due to dementia and not knowing what not to drink, or access to stoves or heat controls, due to loss of memory and reasoning.

Solution: The high functioning can be at home to a degree, however, when the ADL's deteriorate, congregate living is the only solution. With this scenario, we still have the problem of fixing meals, going to the store, driving to the doctor and climbing stairs. Some states theorize that they can employ relatives to be at home caregivers. However, what about training for the caregivers? What about the statistic that 80% of the financial and physical abuse toward the elderly in the home is perpetrated by a relative? In effect, if the assisted living and nursing homes were organized around the concept of restoring the elderly so they could live more independently, then Aging in Place might have a future. Right now, we have dying in place.

5. Transportation must be adapted to disabilities of aging

Visual and cognitive impairment are the two most prevalent maladies for the aging population, causing 75% of the accidents for drivers over 65. Since our most accessible mode of transportation is the automobile, adapting the automobile for these physical impairments is not an option. The answer needs to be public transportation, and it must be accessible to wheelchairs, walkers and for low strength usage. In effect, the biggest obstacle for Aging in Place is lack of transportation. In emergencies, we have ambulances. In scheduled situations, we have a neighbor or relative. For mobility, we have nothing. The typical 80 year old should not be driving in traffic and has limited reaction to what is destined to happen ... a red light ... a stop sign ... a child running across a street ... a snow storm ... a rain storm.

Solution: We have congregate living for a reason. We can provide better services using economies of scale, rather than duplicating what can be provided en masse. Again, the current service industry for the elderly must change its infrastructure, not society. It is much quicker for the local nursing home to be required to provide restorative care before they get paid than to devise a more costly method that has no prospects of meeting the demands of the Baby Boomers. All of the discussions should be about modifying the current service mechanism, rather than devising an unattainable goal.

6. Getting Old Insurance

Our current health care system was designed to treat, not prevent or restore. So, the proposal for physicians and hospitals to be in the business of preventing the very thing that puts money in their pockets seems ludicrous to them. However, if we don't change the paradigm, no one will have a job without paying for health care for themselves and for other people. 80% of the current health care dollar is spent in the last two years of people's lives. And, these lives are not admirable. If we only had a concept where we all, from cradle to grave, financed our own health and welfare programs. Then, as we decide to stay healthy, we could save our own money, not our employer's or the Government's money.

Solution: The current talk is about universal health care at no cost to the individual. Letting someone else pay for your poor health decisions is, of course, flawed logic. The cost control that we seek is unattainable because the only person that can exert that control is not paying the bill. How can we totally revamp a system that has been in place for 50 years? Either go broke, then do it because we have to, or be proactive and make a comprehensive change, so we can have the following:

1. Standardized benefits for all Americans (ISO 9000 standards).
2. Mandated processes that require standardized terminology for computerizing and economizing the cost.

3. Meaningful database for diagnostics, evidenced based modeling of the care plan, and execution of care supported by outcome based documentation.
4. Use of the problems and programs in the care plan to determine pay for results.
5. Payment of outcomes to measure the quality of life in our congregate living, assisted living, nursing homes and home care.
6. Care plans for costing the care, billing the outcomes and eliminating wasted resources in facilities (turnover, absenteeism, injury, theft, abuse, neglect, inefficiency, low productivity and poor quality).

The bottom line is to save \$400 to \$600 billion per year in waste, with better quality of life for an aging America.

7. Government commitment

A universal health care program cannot be administered by the Federal and State Governments. Whether it is \$2 trillion or \$4 trillion, it will never be enough. The bureaucracy and 39,000 pages of regulations supporting the taxing and health care systems let the criminals hide and steal.

Most people and providers are honest, however, the current enforcement mentality alleges that everyone is suspect and guilty until proven innocent. This has not worked for the IRS and does not work for CMS (Centers for Medicare & Medicaid Services). Any funding for universal coverage must be administered by private businesses, dedicated to saving money from eliminating waste, and excelling in the prevention of chronic disease and preservation of the health of an aging society.

Solution: The infrastructure exists for the collection and distribution of the American Health Insurance Program. Current HMO's, PPO's, managed care organizations, disease management companies, and health care insurance underwriters all have a vested business interest in making America's health care system better. I propose that they be organized into regional depositories and claims processors, with the authority to review the documentation of the providers with the intent to pay, not deny. The legal authority of Fox v Bowen (due process of law) must be vigorously followed. Budgeting for cash flow and rate setting should also be administered by the private sector.

The same companies doing the claims processing can also do the rate setting. Premiums would be individualized and based on each insured person's ongoing health profile. Discounts for fitness, nutritional compliance, screening, and pursuit of health preservation life styles would be substantial. The universal policy would be capped each year as a percent of GNP, and plans for the elimination of the waste in the system would be quantified and used to stay on budget.

8. Waste patrol according to Deming

Current business practices in health care lend themselves to being hidden on the profit and loss (P/L) statements, and the cost of tangibles are line itemed. However, the cost of intangible waste is not identified on those statements. In the typical nursing home, staff turnover averages 89% or \$250,000 per year in recruiting and retraining costs. Each patient receives 15 to 20 medications daily, based on phone orders from physicians that never see the patient. 50% of patients in nursing homes are re-hospitalized more than four times per year. 50% of staff habitually do not show up on weekends and patients are on their own most of the time. 75% of patients on Medicaid in nursing homes were self reliant all their lives, until they were put on spend down of their assets and became a ward of the State.

Liability insurance has escalated to the point of being prohibitive in some states. Some organizations are paying upwards to \$1 million dollars per year per facility for liability insurance. Most nursing homes have up to 20% excess capacity and do not know how to properly bill for the

medical services they are providing to Medicare patients. Lost billings account for \$250,000 to \$500,000 per facility.

Solution: What if that waste were highlighted by each provider as the object of their management teams to eliminate, or at least reduce each year for the betterment of an aging society? The staff could then be rewarded a percent of the savings and stop being part of the problem. The result would be an end to turnovers, absenteeism, irresponsibility, and theft. What if the line staff were trained and expected to do the right thing when it came to problem resolution at the lowest level? We could save billions, have more fun, and be a better society if employees were listened to and given the latitude to improve their operations.

Here's an example. I met a man in Columbus, Ohio one night watching a Bulls game. He was from Waterloo, Iowa, visiting Columbus to give a speech for the U.S. Chamber of Commerce on management. I was there to present a speech for a nursing home convention. Here is his story: "My company was on the verge of bankruptcy. I did not know what to do to prevent it from going down. It had gotten to me so badly that I decided to just turn it over to the employees and disappear for two weeks. I was running away from the problems. I stayed away for a month. I didn't go near it for 30 days. When I decided to return, I found that the place was still there going strong, and had turned the corner on some of the labor issues. The leader of the employee group told me that it was better because the people were now taking responsibility for their survival, and suggested that I leave again. I left, came back in two months, and things were better yet. Over the next year, I was gone almost all of the time and the business was never better. The bills were getting out, the payables were being paid on time, and the bottom line was positive for the first time in months. To make my story real and believable, I now travel around the country telling business owners that those in the trenches know what to do if you let them do it!"

Therefore, the modern day management solution to health care is to let the problem makers be the problem solvers before the waste gets a chance to materialize.

9. Politicians create problems so they can solve them

Senator Newt Gingrich and Senator Bob Dole insisted on the decentralization of Medicaid, which put 50 states in a spending chaos. 45 of those states have proclaimed Medicaid their biggest financial problem. Now, Senator Gingrich is back, claiming to transform health care so every person in American can be their own insurance company. The mistake we make is assuming that the political system can solve any social or business problem. They cannot. They make them worse by creating obstacles to efficiency, ineffective regulations that impede quality, committees and study groups of academics, grants to colleges, and universities that have never been in the trenches, proposing incremental band aids.

Solution:

Senator Hillary Clinton and Senator Ted Kennedy also do not have the answer by having the Government control everything. It has to be the best of both Enterprise and Government. Enterprise is good at pursuing a profit using any means and Government is good at taxing those means. Why not have the Government mandate the standardized processes and have businesses carry them out? The objectives and procedures are simple:

OBJECTIVES:

- Standardize the National Health Policy.
- Make efficient use of computers for modeling the care and tracking the outcomes.
- Make effective use of people resources by managing each person's personal resources for the preservation of their health and the prevention of chronic disease.
- Allow Medicare and Medicaid programs to be the true safety nets for catastrophic episodes.

- Make coverage for the uninsured and under insured possible by eliminating the hidden costs (waste).
- Use Six Sigma processes to eliminate the waste.

PROCEDURES:

- Eliminate the costly and ineffective enforcement mechanisms that exist. Turn inspectors into Six Sigma consultants who find the providers doing something right, and let the problem makers be the problem solvers.
- Allow provider associations to police their members by providing case management systems to all providers who can communicate the same language. Make the processes fully integrated with the regulatory imperatives for cost effectiveness and quality control.
- Set up a national Department of Quality Control, replacing the current ineffective Centers for Medicare and Medicaid (CMS) organization. Allow the Social Security Administration to enforce the National Health Policy.
- Take the budgeting for health care away from the Office of Management and Budget. Instead, have private companies who administer the collection and disbursement of the premiums, propose the national health care budget. The companies would be responsible for setting the premiums for all Americans and managing the savings accounts for each individual.
- Focus America on fitness, nutrition, and health preservation as a national priority. The goal by the year 2015 will be to match future health care costs with health care savings accounts, based on age, health profiles, and earnings from investments.
- Redirect the medical, nursing, and therapy schools to teach the pursuit of outcome approaches for the purpose of solving the malpractice insurance escalation. Insure that quality of life is based on health preservation, not on the pursuit of treatment. Medicine needs to be a deductive process, based on evidence of causation and projected outcomes.

10. Performance Based Payment

Measurable restorative goals for each problem exhibited by the patient will establish the platform for performance based payment. The deductive care planning processes replacing inductive "rule out theory" and "least invasive treatment" strategies will convert the practitioners to problem solvers. Currently, the primary physician's hands are tied by the reimbursement methods. The Relative Value Units (RVU) system is an averaging payment method that pays for treatment, not outcomes. This is also true of the Diagnosis Related Groups (DRG) system for hospitals, the Resource Utilization Groups (RUG's) system for skilled nursing facilities, the OASIS system for home care, and Outpatient Prospective Payment System (OPPS) for outpatient services. All of these payment methods must be supported by regulatory provisos and threats, which encourage up-coding and hunting for the best rate, rather than the best outcome.

In 2005, physicians were paid \$211 billion dollars for their share of the expanding pie. Hospitals received \$616 billion and nursing homes \$121 billion. Why isn't this plenty of money? Why don't we have plenty of people resources? Because we have no standardized system for planning the use of resources and no measuring stick for assessing the effectiveness of the workers' performance.

Solution:

Pay for the outcome for each problem in the plan of care for each discipline. The use of case management software to blueprint the care and plan the duration of the care can also become the

basis for payment. The use of computerized models of care based on medical diagnosis, nursing diagnosis, interventions and goals can be used to direct the care. Hold the clinicians accountable for their time and motion, so the costs and quality are controlled, and have that be the basis for paying them. Savings will be generated by focusing the care on results, not on payment. Practice, then, can drive reimbursement for the first time ever. The clinicians can be paid fairly, timely, and without fear of reprisal. There will be no need for the extension fraud and abuse infrastructure that now exist, which claim to have caught most of the health care professionals plotting on how to game the system. Wouldn't it be refreshing to catch the providers doing something right for a change?

In conclusion, better care for less money must be the #1 priority, so we can insure everyone in America. This is not only admirable, it is a necessity for an aging population that is still dependent on its medicine to survive. Hopefully, that dependence will change to health preservation and prevention of chronic disease so that we can all afford retirement.