



**FLORIDA POLICY EXCHANGE  
CENTER ON AGING**

*A Multi-University Consortium  
at the University of South Florida*

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# AGING RESEARCH & POLICY REPORT

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## IN THIS ISSUE

The staff of the Policy Center extends a warm welcome to Dr. Gema Hernandez who was appointed Secretary of the DoEA by Governor Jeb Bush earlier this year. Dr. Hernandez has extensive experience in the field of aging as both a practitioner and an academic, and is well prepared to provide the kind of leadership Florida will need on aging issues in the 21st Century.

This issue of the ARPR contains five articles addressing a wide range of policy issues affecting the elderly. The first article is a broad overview and critique of current long-term care policies and practice. The article concludes with a series of policy recommendations designed to make long-term care more consumer oriented.

The article by Mary Oakley makes the case for limiting the number of nursing home beds in some parts of Florida and building up an array of home- and community-based (HCB) alternatives. She clearly demonstrates the need for a more integrated approach to allocating nursing home and HCB resources across the state.

The article by Sandy Reynolds analyzes several health and economic characteristics of the baby-boomer generation. She uses this analysis to raise some interesting questions

*continued on page 3, column 2*

## FROM THE DIRECTOR Long-Term Care in the 21st Century

We do not have a coherent system of long-term care services for the frail elderly who are largely dependent on publicly supported services. Over 80% of the public funding for long-term care is tied up in Medicaid spending for nursing home care, leaving relatively few federal and state resources available for community-based programs which the elderly and their families prefer. No one should have been surprised that the Medicare home health program would eventually become a medicalized substitute for the missing home- and community-based long-term care programs.

In the absence of in-home services, which could also be provided in congregate living settings, the pressure to use the Medicare home health program to keep frail elderly persons with physical and mental impairments out of nursing homes was too great to resist. As a result, a substantial part of the program became what the public wanted—a community-based long-term care program. The Congressional effort to contain the costs of the program (1997 Balanced Budget Act) by limiting it more strictly to its original purpose (short-term acute care services) is likely to have unintended consequences, such as increased nursing home admissions. This is particularly true of states like Florida with high Medicare home health care expenditures. In Florida more than \$1.4 billion was spent on Medicare home health care in 1996, which was

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**TABLE OF CONTENTS**

From the Director - Long-Term Care in the 21st Century <b>Larry Polivka</b> . . . . .	<b>1</b>
Controlling Nursing Home Bed Supply Must be Part of the Pain to Promote Aging in Place <b>Mary Lucier Oakley</b> . . . . .	<b>18</b>
Changing Patterns in Health and Economic Status: The Impact on Baby Boomers' Retirement Planning <b>Sandra L. Reynolds</b> . . . . .	<b>23</b>
Mental Health Service Needs and cost of Care for Adults Residing in Florida's Assisted Living Facilities <b>Marion Becker, Paul Stiles and Lawrence Schonfeld</b> . . . . .	<b>.31</b>
Elder Abuse in the Context of Intrafamily Violence: A Case Study in Identification, Interventions and Prevention <b>Max B. Rothman, Burton Dunlop, Kathrine M. Condon and Kellye S. Hebert</b> . . . . .	<b>.37</b>

***In this issue - continued from page 1***

important study of mental health service needs among residents of assisted living facilities (ALFs). This study has played a critical role in focusing attention on an issue that has been overlooked by policy makers for several years.

The fifth and final article by Max Rothman, Burton Dunlop, Katherine Condon and Kellye Herbert is a summary of findings from a study of elder abuse policy and practices in southeast Florida. Elder abuse, like the mental health service needs of assisted living residents is an often overlooked issue that affects the lives of thousands of vulnerable individuals. The authors use the findings from their research as the basis for several recommendations regarding changes in a number of current adult protective services practices and procedures.

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more than all other state and federal spending on long-term care services in Florida.

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*With the aging of the baby-boom generation, which will have proportionately fewer children and spouses, and the growing participation of women in the labor force, the informal system is likely to shrink, leaving more frail elderly persons on their own.*

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The Medicare home health misadventure is just one example of the confusion that affects current long-term care policy. We have long been spared the full impact of the gaps and inconsistencies in the way we do long-term care by the fact that family (mainly wives and daughters) and friends, or what we call the informal sector, provide most of the care. It is becoming increasingly clearer, however, that we have reached the limits of what the informal sector can absorb. With the aging of the baby-boom generation, which will have proportionately fewer children and spouses, and the growing participation of women in the labor force, the informal system is likely to shrink, leaving more frail elderly persons on their own. The projected growth in the number of people with long-term care insurance and other private resources and declining disability rates may cushion the effects somewhat of decreasing capacity in the informal sector. The huge growth, however, in the number of older people in the first three decades of the next century will generate steady increases in the need for privately and publicly supported long-term care services for at least the next fifty years.

These trends are accelerating faster in Florida than in any other state. We will have to think more coherently about how to provide long-term care and we will have to address the need for major policy changes. We already know,

however inchoately, that federal and state governments cannot afford a continuing dependency on institutional care and ignoring this pending crisis is no longer a politically feasible alternative.

There are, of course, many different ways of thinking about how to make our long-term care policy and service system more rational and consumer friendly. I have come to the position over the last several years that states and the federal government should collaborate to construct a system that is as consumer-directed as possible, based on voucher or cash benefits determined by the levels of care and financial assistance needed, with built in protection against exploitation and fraud. But, consumer-directed care, which would not be simple to implement, is not designed to meet the needs of everyone requiring long-term care; other services will also be necessary.

Any effort to make qualitative changes in current long-term care policy should be informed by answers to the following set of questions. Although I am raising these questions in the context of Florida's long-term care policy, they are also questions that other states will have to address in the next few years and that only a handful have begun to grapple with earnestly.

**Question 1 - What are the projected levels of need for publicly supported long-term care over the next several years and to what extent have publicly supported services kept pace with the need for services over the past several years?**

A computer-simulation model developed in 1996 showed that the number of elderly in Florida needing publicly supported long-term care services because of physical and cognitive impairments will grow by over 42%

Table 1. ALL LONG-TERM CARE APPROPRIATIONS 1982-1996

Fiscal Year	Community Programs	Percent of Total	Nursing Home Care	Percent of Total	GR & Trust Total
83-84	81,315,362	23.2%	269,008,562	76.8%	350,323,924
86-87	105,819,020	19.9%	427,028,483	80.1%	532,847,503
89-90	135,531,309	15.6%	735,244,757	84.4%	870,776,066
92-93	150,232,861	12.6%	1,040,998,430	87.4%	1,191,231,291
95-96	185,267,912	11.3%	1,447,710,026	88.7%	1,632,977,938

between 1995 and 2010, from 281,489 to 400,978 persons. If the current pattern of nursing home dependent long-term care spending is maintained through 2010, public spending on long-term care is projected to increase by \$3 billion in constant (inflation-adjusted) dollars. The major reason for this increase is that 85 percent of the projected spending would be for nursing home care, which is the most expensive form of long-term care. Funding for the less expensive and more preferred (by the elderly) home- and community-based programs has either stagnated or declined in age 75+ per capita value over the last several years. On the other hand, funding for the Medicaid nursing home program has increased by over 100% since 1990, with increases of \$100 to \$200 million annually. The only community-based program receiving increases over the past several years is the Medicaid Home- and Community-Based Waiver program. These trends have actually made Florida more dependent on nursing homes for the delivery of long-term care than fifteen years ago.

*...the number of elderly in Florida needing publicly supported long-term care services because of physical and cognitive impairments will grow by over 42% between 1995 and 2010, from 281,489 to 400,978 persons.*

It should also be noted that according to data from the AHEAD study, which were shown in the last issue of the ARPR, 30 to 40% of Florida's frail elderly population is not currently receiving any assistance, including private, informal help, with one or more activity of daily living (ADLs which include eating, toileting, dressing)<sup>1</sup> A more efficient, cost-effective long term care system (less dependent on nursing homes) would allow the state to reduce this level of unmet need by offering more home and community based services, as Oregon has been able to do over the last 10 years.<sup>2</sup>

Table 1 compares appropriations for all community programs and nursing home care from 1983 through 1996 in unadjusted dollars. The numbers in this table clearly demonstrate the growing dominance of nursing homes in Florida's long-term care system. In 1983, appropriations for nursing homes constituted 77% of all long-term care appropriations. By 1996, this percentage had grown to 88% and the home- and community-based services had shrunk to 11.3%.

According to the State Long Term Care Profiles Report, 1996 (Ladd, 1999), Florida ranked 49th among states in total per capita (65+) spending on home- and community-based services for older adults in 1996, down from 38th in the nation in 1992, with an

average per person 65+ expenditure of \$60.20, compared to a national average of \$247.35. This large discrepancy in spending was analyzed and a report was prepared by Mary Oakley, based on Ladd's published data.

"Total expenditures for HCBS are comprised of Medicaid funded, state general revenue funded, and Older American Act funded programs that provide supportive services for older adults, such as in-home personal care assistance, housekeeping and chore services, home delivered meals, case management and adult day care programs. Table 2 shows Florida's per capita spending levels by funding category in comparison with the U.S. in 1996, the most recent year for which complete information is available."

"The size of the gap between the state and the nation in component spending, varies considerably per the funding categories listed in Table 2."

"The closest comparison between Florida and U.S. per capita 65+ outlays is for Older Americans Act programs. These federal dollar distributions in the state amounted to 84% of the national per capita expenditure. Per capita 65+ spending in Florida for general revenue funded HCBS programs (mainly the statewide Community Care for

the Elderly and Home Care for the Elderly programs in Florida) was 63% of the U.S. average."

"The greatest discrepancy by far, explaining the bulk of the shortfall between Florida and U.S. spending on HCBS, is in the category of Medicaid expenditures, which is the predominant funding source for HCBS nationwide. Florida's per capita 65+ spending level for all Medicaid funded HCBS of \$29.87 was only 15% of the \$197.30 spent in the U.S. overall in this category."

Florida increased its funding of community-based services since 1990 through the HCBS waiver from \$12 million in 1990 to over \$30 million in 1996. Many other states, however, increased their HCBS waiver spending at a much higher rate during this period.

The State of Florida lost ground between 1992 and 1996 in terms of the amount spent on HCBS in relation to state (Medicaid) expenditures for nursing home care. In 1992, 17.1% of all public (non-Medicare) dollars spent on long-term care went toward HCBS in Florida. In 1996, the HCBS portion of the long-term care public funding pie shrunk to 12.3%, a 28% decrease. In contrast to Florida, nationwide HCBS expenditures represented over 20% of all public long-term care outlays in 1996.

Table 2. Total HCBS Spending Per Person Age 65+ and Age 85+ by Funding Category in 1996, Florida and the United States.

	Florida		United States	
	per 65+	per 85+	per 65+	per 85+
Medicaid (state and federal cost-sharing)	\$29.87	\$282.77	\$197.30	\$1,776.06
State General Revenue	\$25.13	\$237.83	\$39.58	\$356.27
Older Americans Act (federal)	\$5.20	\$49.26	\$6.19	\$55.72
<b>Total HCBS Spending per Capita</b>	<b>\$60.20</b>	<b>\$569.86</b>	<b>\$243.07</b>	<b>\$2,188.05</b>

Data Source: State Long Term Care Profiles Report, 1996 (April, 1999), Richard Ladd with R.L. Kane and R.A. Kane, Division of Health Services Research and Policy, School of Public Health, University of Minnesota.

***These data suggest that the state has missed an opportunity to make qualitative changes in Florida's long-term care system by not sustaining the expansion of HCBS alternatives over the last several years, while simultaneously limiting the growth of Medicaid-funded nursing home beds. This missed opportunity is made even more egregious by what we have learned about the cost-effectiveness of HCBS programs from recent research.***

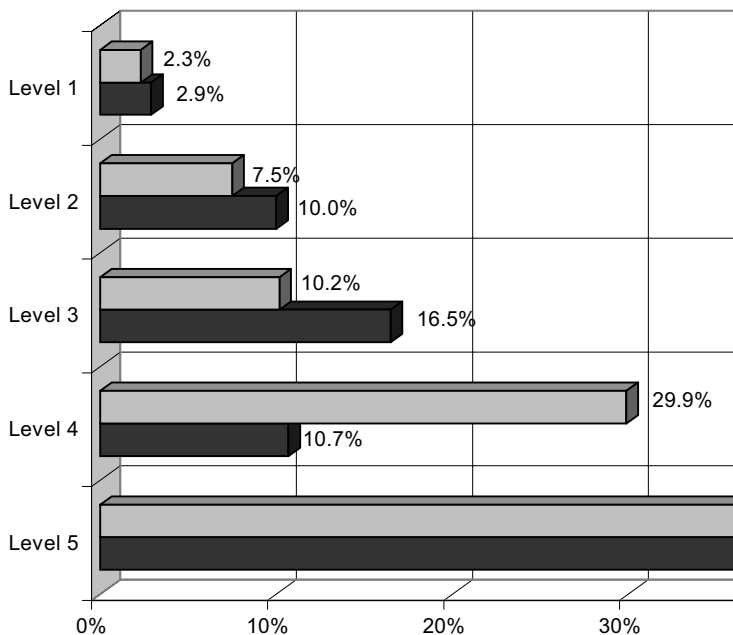
**Question 2 - What do we know about the relative effectiveness of alternative policies and programs and how do current policies and programs compare with what we know about consumer preferences and the cost-effectiveness of programs?**

Home- and community-based programs, if properly funded and administered, are cost-effective alternatives to nursing homes and are overwhelmingly preferred by the elderly to

institutional care. Research results reported by the Florida Policy Exchange Center on Aging and the Southeast Florida Center on Aging showed that many of those served in Florida's current array of in-home and residential care programs are as physically and cognitively impaired as the average nursing home patient. The level of impairment tends to be particularly high among the portion of Florida's HCBS clients who live with an informal caregiver, according to a Policy Center analysis led by Mary Oakley that compared this client subset with Florida's nursing home population (see Figure 1).

The comparison of Florida's long-stay nursing home population and in-home care clients who have informal caregivers was made using a subset of 1996 survey data from a two-stage random statewide sample totaling more than 2,500 long-term care

**Figure 1. Florida Long-Stay Nursing Home (NH) Residents (HCBS) Clients Who Have Informal Caregivers by Functional Impairment Level**



\*Level 1. "Least Impaired": No to mild cognitive impairment and zero ADLs  
 Level 2. "Mildly Impaired": No to mild cognitive impairment and 1-2 ADLs  
 Level 3. "Moderately Impaired": No to mild cognitive impairment and 3 ADLs  
 Level 4. "Seriously Impaired": No to mild cognitive impairment and 4-5 ADLs  
 Level 5. "Most Severely Impaired": Moderate cognitive impairment and 4-5 ADLs (ADLs considered: bathing, dressing, transferring, toileting, and eating.)

recipients age 60+. This study, conducted by the Florida Policy Exchange Center on Aging and the Southeast Florida Center on Aging at Florida International University for the Commission on Long-Term Care in Florida, extracted information in the field from standardized assessments (the Minimum Data Set in nursing homes and the Department of Elder Affairs Comprehensive Client Assessment Instrument for the HCBS sample).

Half of Florida's nursing home residents (short-term rehabilitation patients excluded) require assistance with all five activities of daily living, and 40% of the state's HCBS clients who have informal caregivers also need help with all five ADLs (bathing, dressing, toileting, transferring, and eating). When considering the specific amount of assistance needed with individual ADLs among the very impaired, the HCBS sample was found to have a substantially higher percentage needing total help than was found in the nursing home sample. The HCBS clients who live with informal caregivers are also more likely to have severe cognitive impairment than nursing home residents (Polivka, Dunlop, Brooks, 1996).

When ADL and cognitive impairment is considered in combination, according to a progressive "functional impairment level" 5-point scale displayed and explained in Figure 1, the similarities between the nursing home and HCBS with family caregiver populations can be more fully appreciated. Indeed, the HCBS clients have the highest percent in the "most severely impaired" category (Level 5) (59.8% versus 50.2% in the nursing home sample). The complete distribution of HCBS clients with a caregiver in the functional impairment levels displayed in Figure 1 leaves little room for doubt that the majority served would be at great risk of institutional placement were it not for the combined efforts

of the informal and formal care received. These findings clearly show that the capacity of home- and community-based programs in Florida are serving large numbers of seriously impaired elderly.

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*...studies have shown that there is substantial potential for cost-effective and improved long-term care in the expansion of well-designed and administered home- and community-based programs.*

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Other studies have shown that there is substantial potential for cost-effective and improved long-term care in the expansion of well-designed and administered home- and community-based programs. These studies have found that by targeting certain services to high-risk recipients in appropriate quantities (number of nurse visits, hours of homemaker services, etc.) community programs may reduce nursing home use. Findings reported in articles by Jette, *et al.* and Crawford (1995), Harrow, *et al.* (1995), Greene *et al.* (1995) Weissert (1995), Weissert *et al.* (1997), Miller, *et al.* (1998), and Rhoades (1998) address the policy question of what mix of client and service characteristics produces the most cost-effective results in terms of avoiding unnecessary institutionalization. The results of their research indicate that targeting a combination of social and health care services to those at substantial risk of nursing home placement can reduce nursing home use substantially.

A study that Alecith, Lutzky and Corea (1996) prepared for AARP found that by serving 75% of its publicly financed long-

term care clients in the community, Oregon was able to serve 39% fewer people in nursing homes than would have occurred without the build up of community-based alternatives.

Several studies have examined Florida data to determine the effect of nursing home and alternative care supply factors on utilization of long-term care. Han, Barrilleaux & Quadagno (1996) examined personal and county level characteristics of 54,120 adult Medicaid recipients and found that an increase in the supply of nursing home beds decreased the likelihood that an individual would receive home and community based services. Also, as the supply of HCBS providers increased, the likelihood that an individual would receive HCBS increased (and the likelihood that an individual would receive nursing home care decreased).

Similar results were found in a Policy Center analysis (Weber, 1999) utilizing data from the Florida Long-Term Care Elder Population Profiles Survey, which collected information on 2,200 long-term care recipients in the State of Florida. Data were collected in 1995 from recipients of HCBS, assisted living facilities as well as skilled nursing facilities. Individual data were matched with county level data to explore the effects of supply on the type of long-term care an individual received. Results showed that an increase in nursing home bed supply decreased an elderly individual's likelihood of residing in and ALF or receiving HCBS. In addition, an increase in ALF beds increased one's chance of residing in an ALF and an increase in HCBS expenditures (CCE, HCE and Medicaid ADA Waiver) increased one's chance of receiving these services. The increases in alternatives clearly decreased the likelihood that an individual would have to receive care in a nursing home. These studies demonstrate

that a decrease in nursing home bed supply, as well as an increase in funding for alternatives, can reduce institutional bias and allow people to receive the type of care that is not only more cost-effective but is preferred by those in need (see also Oakley's article in this issue).

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*One cannot escape the irony in the contrast between what we have learned about the cost-effectiveness of community based alternatives to institutional long-term care over the last several years and the state's increased dependency on nursing homes.*

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One cannot escape the irony in the contrast between what we have learned about the cost-effectiveness of community based alternatives to institutional long-term care over the last several years and the state's increased dependency on nursing homes.

**Question 3 - How can we use what we know about the current and future need for long-term care services and the relative cost-effectiveness of home- and community-based programs to more efficiently meet the need for long-term care services in the future?**

While Florida is the bellwether state regarding aging demographics, we could hardly be further from a leadership position in terms of home- and community-based programming, ranking 49th among states in HCBS per capita funding levels. Nevertheless, there is a solid infrastructure

on which to build. The state's home- and community-based service system is apparently doing the most with the money it has.

In my judgment, the state should now attempt to reverse the trend toward greater reliance on nursing homes in the provision of long-term care and recover the ground that has been lost over the last several years in the home- and community-based sector by pursuing a comprehensive strategy featuring the following initiatives:

### **Recommendation One: Funding.**

Funds from the tobacco settlement and the projected increases in the Medicaid nursing home line item should be used to support the recommended expansions of the in-home and assisted living programs (recommendations 2 & 3). Governor Bush's 1999-2000 budget recommendations moved in this direction by including \$27 million in new funds for expansion of the CCE and other HCBS programs. The Legislature responded to the Governor's proposal by providing over \$19 million in increased funding for HCB service programs. This level of new funding should be gradually, but substantially, increased over the next several fiscal years according to a long-term care budget plan initiated by the Governor and negotiated with the Legislature. The plan should articulate a twofold mission of limiting the growth of nursing home beds and increasing the availability of the kinds of home- and community-based care the elderly prefer and that we know how to provide cost-effectively.

In order for Florida to catch up with national trends and reverse the 1990s trend toward greater dependency on institutional care, the state must be prepared to hold down nursing home expansion and increase spending on HCBS programs by \$30-50

million, annually, for the next several years. The level of increase in HCBS funding would still be less than half of the annual increase in the Medicaid nursing home program over the past several years. This step should be taken as a necessary condition for beginning to shift resources from nursing homes to HCBS in a relatively systematic and analytically informed fashion. The expansion of the Medicaid HCBS waiver should, of course, play a major role in any effort to increase HCBS by the levels recommended here. Total waiver funding exceeds \$55 million in FY 1999-2000, including the funds from the assisted living waiver. This is still only 22% of the \$250 million in HCBS waiver funding for Florida's developmentally disabled programs. These programs have benefitted from efforts to maximize waiver funding since the mid 1980s and have received over \$200 million from all sources in new funding for FY 1999-2000.

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*We have sufficient evidence supporting the relative cost effectiveness of HCBS alternatives to nursing home care to begin using a substantial portion of the funding for the Medicaid nursing home program to support the expansion of the HCBS program.*

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We have sufficient evidence supporting the relative cost effectiveness of HCBS alternatives to nursing home care to begin using a substantial portion of the projected increases in funding for the Medicaid nursing home program to support the expansion of the HCBS program. Per diem costs for nursing home care should be expected to increase as the service needs

of a steadily more impaired nursing home population increase. One approach to creating the analytical context for shifting Medicaid dollars into home- and community-based programs would be to include home- and community-based care in the Medicaid nursing home estimating conference in order to systematically delineate the relationship between the expansion of home- and community-based programs and the reduced need for nursing home beds.

### **Recommendation Two: In-Home Services and Consumer Directed Care.**

The state should provide large annual increases in the Home Care for the Elderly (HCE) and Community-Care for the Elderly (CCE) programs for the next several years. The HCE program reimburses caregivers an average of \$105 a month for the purchase of an array of services and goods, which helps several thousand highly impaired, low-income elderly to remain at home, rather than be moved to a more expensive, more restrictive setting. This program, which gives caregivers and care receivers considerable discretion in deciding how best to meet the needs of the care receivers, constitutes the foundation for a major expansion of "consumer-directed" long-term care. HCE, however, has lost 25% of its age 75+ per capita value since 1991.

Several states already have very substantial consumer-directed or supervised home care programs, most of which serve both the elderly and younger disabled population. California spent \$524.5 million on such programs in 1996, mainly through the long established and highly regarded Independent Health and Social Services Program (IHSS), Michigan \$112 million, Washington \$53.7 million, Oregon \$53 million, Minnesota \$29.5 million, New York \$21.1 million, Illinois \$18.5 million and Colorado \$14.7 million. In fact, half of all HCBS expenditures in California and

Michigan, and over 30% in Oregon, Washington and Minnesota, are for consumer-directed/supervised programs.

In addition to rapidly increasing overall funding for HCE over the next several years, the programs should also be modified to allow increases in monthly rates based on levels of care required and the financial status of the family. Even if \$500 a month were required to keep a severely impaired person in her own home with a caregiver, this amount would be less than 20 percent of the cost of placing her in a nursing home. Given the proven capacity of this program to serve seriously impaired persons with caregivers in a cost-effective manner, it should be increased by 25 - 30% annually (\$4 to 5 million) for the next several years and modified to make it more thoroughly and comprehensively consumer directed.

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*Consumer directed care options, including cash benefits, could theoretically be incorporated into any state or federally funded long-term or chronic-care program serving persons of*

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About half of those receiving CCE services have no caregivers and are impaired enough to put them at risk of institutionalization in the absence of services and a caregiver. They also have low incomes, but are often not eligible for Medicaid because they have assets in excess of the meager eligibility thresholds. The steady decline in CCE funding over the last seven years means that a very large and growing number of frail elderly persons with few informal care resources are being left with little, if any, support in the community.

The CCE program received its first increase since 1990 just this year.

Consumer directed care options, including cash benefits, could theoretically be incorporated into any state or federally funded long-term or chronic-care program serving persons of all ages and many disabilities. Generally, disabled persons would have a choice of a case-managed service-benefit or a monthly cash allowance of a monetary value lower than the service benefit. To be eligible for the monthly income supplement an individual with a disability would have to show in some predetermined way that she could effectively use the extra income to meet her long-term support needs. Consumers would be able to spend the money in ways they best see fit. They might choose to purchase services from a home care agency or referral service at current rates, pay a friend or a relative to provide personal assistance services, make needed home modifications, move to an assisted living facility, or other new housing arrangement.

The counseling component would involve an assessment of need, consumer information and advice about the various services, financing and housing options available. Area Agencies on Aging and other public or private organizations or individuals that do not have a vested financial interest in the decisions made by the consumers would provide the counseling service. The purpose would be to provide consumers and their families with the information and assistance they need to make their own decisions and manage their own care.

Consumers who want something more than counseling, as described above, would still have the option of purchasing case management or care coordination services from social workers or other providers. Case management or guardianship services also would be appropriate for persons who are not mentally competent and/or do not have family

members that can be relied upon to make these sorts of decisions for them.

Florida is part of a four state consumer directed care demonstration project funded by the federal government and the Robert Wood Johnson (RWJ) Foundation. The results of the evaluation of the project will be available in three to four years and should prove very useful in the design of larger initiatives. I do not think, however, that Florida needs to wait until then to begin expanding and modifying ACE with a focus on its potential to become a large consumer directed care program. The recent evaluation (Doty, P., Benjamine, T. et al) of the California IHSS program clearly shows that consumer directed care for even seriously impaired elderly persons is a cost effective method of providing community-based long-term care.

### **Recommendation Three: Medicaid Waiver Services.**

The state should continue expansion of the Medicaid Home- and Community-Based Waiver Program and increase the average annual per-client expenditure rate. The Medicaid Home- and Community-Based Waiver Program is the only home- and community-based program that has grown significantly since 1991. The program now receives \$40 million annually and serves 10,000 clients, or \$3,500 per client each year. This is substantially more than per-client expenditures in the CCE program, but falls short of the levels most experts think is necessary to maintain a seriously impaired elderly person in the community who is genuinely at risk of nursing home placement, especially in the absence of a regular, reliable caregiver. In the Arizona Long-Term Care System, the average annual per-client expenditure in the community-based programs exceeds \$9,000; and in the

Wisconsin Community Options Program, the annual per client expenditure exceeds \$7,000. The Waiver program's annual average per-client expenditure rate should be doubled over the next three-to-five years and a per-client expenditure cap should be set at 80% of the Medicaid nursing home rate.

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*Compared to several other states, Florida has a very limited community-residential program for publicly supported residents, which totaled less than \$30 million in 1998.*

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The state should work with other states to persuade the federal government (HCFA) to allow them to adjust their waivers to include consumer directed care initiatives. California's success with the In-Home Support Services (IHSS) program should be evidence enough that this approach is a cost-effective method of providing long-term care services to a substantial number of seriously impaired elderly persons.

#### **Recommendation Four: Assisted Living.**

The ALF program has the potential to become a cost-effective alternative to nursing homes if effectively administered and adequately funded.

Compared to several other states, Florida has a very limited community-residential program for publicly supported residents, which totaled less than \$30 million in 1998. For example, California spends \$481 million, Wisconsin \$115 million, Michigan \$78 million, Oregon \$52 million and North Carolina \$45 million. In terms of monthly cost per case, Florida spent only \$149, compared to \$581 in

California, \$615 in Michigan and Oregon and a national average of \$484.

One result of inadequate funding for the state supported assisted living program on total long-term care spending in Florida is that for:

...thousands each year, the move to a nursing home occurs only because of the unavailability or insufficiency of public financial support for a continued stay in an ALF, whereas the Medicaid program will foot the bill in a nursing home.

This observation is based on findings from an extensive survey of assisted living facilities (n=698) conducted by the Policy Center in 1994. Respondents were asked the following question:

"During the past 12 months, how many private-pay residents [and state-supported OSS clients -- asked separately] have transferred permanently to a nursing home due to a lack of ability to pay (out-of-pocket) for a continued stay in your ALF, whereas their nursing home stay would be covered by Medicaid?"

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*...3,000 people in one year alone who could have been cared for at a lower cost in the community but went to live in nursing homes instead for financial reasons alone*

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Mary Oakley (formerly Brooks), who conducted the study, notes that:

Respondents were instructed to "count in this number only those residents who were 'medically' eligible for a continued stay in the ALF at the time of transfer to the

nursing home." From this information it was conservatively estimated that a total of approximately 3,000 residents were sent from ALFs throughout Florida that year to become Medicaid-sponsored nursing home residents. That is 3,000 people in one year alone who could have been cared for at a lower cost in the community but went to live in nursing homes instead for financial reasons alone, not because they required skilled nursing care.

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***Medicaid waiver funds should be maximized in the development of the multitiered payment system and current monitoring and regulatory programs should be modified to focus on quality-of-life and quality-care outcomes.***

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It must be emphasized that these potentially avoidable nursing home transfers were directly attributed to economic issues and are clearly not due to the ALF industry's unwillingness or inability to retain residents with heavy custodial care needs. Indeed, a distribution analysis of the 1996 Florida Long-Term Care Elder Population Profiles Survey data showed that 88% of the ALFs randomly selected to be participants in this study had one or more residents in the highest functional impairment level categories. That means the resident had self-care deficits in four or five (out of five) ADLs and/or was severely cognitively impaired. (Brooks, 1997)

In order to take full advantage of assisted living as an alternative to nursing homes, the state should increase the base cost for ALF

payments to \$850 a month and implement a tiered-payment system based on the level of care required by the resident with a top-end tier paying about \$2,200 a month. Medicaid waiver funds should be maximized in the development of the multitiered payment system and current monitoring and regulatory programs should be modified to focus on quality-of-life and quality-care outcomes. As the state expands the assisted living program as an alternative to institutional care, policy makers and advocates should not lose sight of the fact that the fundamental rationale for this program is based on a deep commitment to resident autonomy, privacy, and dignity.

The state should seriously consider introducing more consumer control into the ALF and Adult Family Care (see recommendation 5) programs by experimenting with a voucher program that would allow OSS, and, with federal approval, waiver residents to exercise more choice in the selection of a facility.

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***The state should consider developing an aging network-based managed long-term care project based on the community-based service networks...***

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**Recommendation Five: Adult Foster Care.**

The Department of Elder Affairs should conduct a study designed to determine the potential for the Adult Family Care Home Program (AFCH) to serve as an alternative to nursing home care. The study should specifically identify changes in the program that would be necessary before seriously impaired residents could be placed in them.

The study should also include an assessment of the feasibility of developing a foster care program with service components comparable in design to the ECC program. The rapid growth of the middle-income and more affluent frail elderly may substantially stimulate marketing of these services to private-pay consumers. For example, 70% of Oregon's 10,000 foster home beds for the frail elderly are occupied by private-pay residents who can afford the cost of foster home care but who could not afford the \$3,000+ monthly cost of nursing home care.

#### **Recommendation Six: Managed Care.**

The state should consider developing an aging network-based managed long-term care project based on the community-based service networks that have been operating since the late 1970s and represent a wealth of experiences with, and knowledge of, the chronic- and long-term care needs of the elderly. Furthermore, in some counties HMOs may not be available to establish managed long-term care systems for several more years and the only alternative may be an aging network-based approach, provided that the Area Agencies on Aging and provider groups can develop the capacity to link efficiently with the acute care system.

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*Mental health services for the elderly have suffered an even more precipitous decline in funding than the home-and community -based long-term care programs over the last ten years.*

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As managed long-term care programs, including the state demonstration projects in West Palm Beach and Orange counties, become more established, the state should

consider conducting a demonstration designed to test the relationship between managed care and a consumer control-oriented approach to long-term care. The state will soon begin implementation of a Robert Wood Johnson-funded cash and counseling project which, in combination with the capitated nursing home diversion project, could provide the framework for a managed care/consumer control project designed to test mechanisms for merging the cost-containment, efficiency-oriented features of managed care with the client autonomy-oriented features of a consumer-control model.

#### **Recommendation Seven: Nursing Home CON Modification.**

CON policy should be changed to hold in check the growth in nursing home bed supply in the areas where it is now exceedingly high (per 1,000 Medicaid eligibles age 65+), while the availability of affordable home- and community-based long-term care services is increased. This new policy is an essential part of a comprehensive strategy to begin reducing the state's reliance on nursing home care for its older Medicaid-eligible population.

#### **Recommendation Eight: Mental Health Services and Long-Term Care.**

Mental health services for the elderly have suffered an even more precipitous decline in funding than the home-and community -based long-term care programs over the last ten years. Between the late 1970s and 1990 the state constructed a relatively substantial infrastructure for the delivery of mental health services to the age 65+ population, including the statewide Geriatric Residential Treatment Centers. This infrastructure largely disappeared from most areas of the state during the last ten years. Just as home- and

community-based long-term care services declined while research findings demonstrating their cost effectiveness were growing, mental health services for older persons have virtually disappeared while research demonstrating their efficacy in treating depression among the elderly and reducing the need for institutional care and the need for services (high suicide rates among men over 70) has grown steadily.

Any systematic effort to transform Florida's long-term care system, qualitatively, must include an initiative to reverse the pernicious decline in mental health services for older persons.

I think one of the most compelling reasons for increasing state and federal funding for mental health services for older people, especially those with impairments, is that these services, if provided in sufficient amounts, could help many persons remain in the community and avoid institutional care. The best methods of ensuring that new funding would be used for this purpose (i.e. avoiding unnecessary institutional care) may be to fund mental health services in the Department of Elder Affairs where they could be integrated into the Community Care and Home Care for the Elderly programs. This strategy would help insure that the most at risk elderly receive mental health services and that the cost effectiveness of these services are enhanced by exploiting their potential to reduce avoidable institutional care. This strategy recognizes that the impaired elderly served through the DoEA programs are precisely the elderly who are most likely to suffer from chronic depression and other mental health problems.

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*Implementation of these recommendations would qualitatively change the nature of Florida's long-term care system over the next four years by expanding and improving in-home and community-based services.*

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Implementation of these recommendations would qualitatively change the nature of Florida's long-term care system over the next four years by expanding and improving in-home and community-based services. Not only do the elderly and their families vastly prefer these services over nursing homes, they are also more cost-effective than nursing homes if properly designed and administered. In the short-term, the reconstruction of Florida's long-term care system will require some increases in total spending for long-term care services. However, in the long-term (four to five years, possibly sooner), the state would be in a much better position to contain long-term care spending than it is now with the Medicaid nursing home budget consuming 89% of all state expenditures for long-term care. Oregon, for example, has been able to hold the increase in age 65+ per capita nursing home expenditures to 1% since 1992, compared to a national average annual increase of 5%. Oregon achieved this level of cost-containment by tripling the size of its home- and community-based sector since 1985 and ending the construction of new nursing home beds in 1990.

As I attempted to demonstrate in my description of long-term care expenditure trends in Florida, little momentum for long-term care change has been generated over the past decade. We can be hopeful, however, because we do have more

evidence in support of the cost-effectiveness of home- and community-based long-term care services than we had ten years ago and because the state has a Governor who is committed to making qualitative changes in the current long-term care system. There is also a growing awareness on the part of baby boomers that their parents have far fewer long-term care choices than they will want for themselves. Nonetheless, I am concerned that if Florida does not immediately take advantage of the fact that state revenues are in better shape than they have been since 1980, by making large investments in HCB programs and systematically shifting resources from institutional to community-based care, our last best chance to qualitatively change the long-term care system may be lost for years.

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**CONTROLLING NURSING HOME BED SUPPLY MUST BE PART OF THE PLAN TO PROMOTE AGING IN PLACE**

By Mary Lucier Oakley\*

It's encouraging that Florida's Governor has expressed a commitment to expand alternatives to living in a nursing home. Having top-level support of aging in place as a policy goal is important if the state is to take on the task of making the substantive changes in long-term care programming needed to achieve this goal. After all, the incremental improvements made thus far to Florida's long-term care system have resulted in little real progress overall. The problems inherent in the system today are fundamentally the same as those identified in the keynote address of an advocacy workshop held in 1975 in Tampa — twenty-four years ago.

An overview of current efforts in this state addressed to long-term care for impaired elderly suggest such efforts are biased toward the institution, are in the main simplistic, and reveal as yet no systematic approach to reducing inappropriate or unnecessary institutionalization of elderly requiring long-term care.

William G. Bell, Ph.D. (1975)<sup>1</sup>

The purpose of the 1975 workshop was to draw attention to the need "to develop an integrated approach which assures elderly a choice of either entering an institution or remaining at home in the event of need for long-term care."<sup>2</sup> A generation has passed; yet this need still exists.

The research findings summarized in this article explain why it is necessary to establish an integrated approach to long-term care programming. This approach would take into account all elements of the long-term care system and put an end to the practice of planning separately for institutional care needs

and programs that offer an alternative to nursing homes. Because the supply of nursing home beds has such a strong influence on how long-term care systems operate, plans to promote aging in place in the community will falter if institutional capacity is ignored. It is not enough to increase alternatives to institutionalization without taking stock of nursing home beds as well.

There are two main reasons why the control of nursing home bed supply is a critical component of a comprehensive strategy to increase the opportunity for older adults to age in place in Florida.

**Reason #1: Bed supply drives nursing home utilization, particularly among the poor. This effect is costly.**

Nursing home bed supply and utilization are inextricably linked. Utilization can occur only if beds are present. But just how much nursing home usage occurs in a given area is not a constant; it is instead a function of bed supply. Institutionalization rates rise and fall according to whether nursing home bed supply levels are relatively high or low.

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*In a 1984 study of the 50 states, Harrington and Swan found that the relative supply of nursing home beds was the most consistent predictor of a state's Medicaid nursing home utilization rate and thus public expenditures.*

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A 1989 RAND study of the nation's metropolitan statistical areas consistently found that a larger supply of nursing home beds resulted in higher utilization rates.<sup>3</sup> Bed supply and Medicaid outlays for nursing home care are also related. In a 1984 study of the 50 states, Harrington and Swan found that the relative supply of nursing home beds was the most consistent predictor of a state's Medicaid nursing home utilization rate and thus public

\*Formerly Mary Lucier Brooks.

expenditures.<sup>4</sup> And it happens that during the 1980's, when this state experienced an explosive expansion in nursing home bed supply, Florida's growth rate for state nursing home expenditures was the highest in the country.<sup>5</sup>

In keeping with the results of nationwide studies, an analysis recently completed at the Florida Policy Exchange Center on Aging of nursing home supply and utilization across Florida's counties in 1996 revealed an exceedingly strong relationship between bed supply and rates of institutionalization in the state. Indeed, the two variables, the number of beds per 1,000 age 65+ and the percentage of the 65+ population residing in nursing homes, are nearly perfectly correlated in Florida (.996,  $p < .001$ , and a perfect correlation is equal to 1). The higher the bed supply, the higher the percentage of older adults in nursing homes.

The percentage of the total population age 65+ residing in nursing homes runs in a comparatively contained range across Florida's 67 counties. Where not zero (five counties have no nursing homes), institutionalization rates ranged from .85% to 9.42%, with a mean of 3.3% in the state overall in 1996. Institutionalization rates among low-income older adults, however, were another matter entirely.

Institutionalization rates specifically among the Medicaid eligible population age 65+ were found to be extremely broad-ranging and on the average astoundingly high — from 6% to over 50% in Florida's counties. The mean percentage in the state of the low-income older adult population (i.e., Medicaid eligible) residing in nursing homes was 23.9% in 1996, fully seven times higher than the mean institutionalization rate among older Floridians in general.

This marked disparity in institutionalization rates between low-income elders and older adults overall in Florida is not a recent phenomenon. This pattern was evident in a study conducted in Florida in 1971, published in *The Gerontologist* (Bell, 1973), that noted, "the data suggest a strong tendency toward over institutionalization of low-income elderly when

measured against their ratio in the general aging population of the state."<sup>6</sup>

Institutionalization rates among low-income older adults are highly sensitive to nursing home supply levels, particularly as measured by the number of beds per 1,000 Medicaid eligible population age 65+. In the 33 Florida counties with bed ratios above the state median supply level (according to this measure), an average of 31.8% of Medicaid eligibles age 65+ resided in nursing homes in 1996. In the other half of Florida's counties with supply levels below the median, the Medicaid eligible population in nursing homes averaged 15.6% — half the rate of the higher supply counties.\*

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### *The relative rate of institutionalization within the Medicaid eligible population has a sizeable impact on annual state expenditures for nursing home care in the county.*

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The relative rate of institutionalization within the Medicaid eligible population has a sizeable impact on annual state expenditures for nursing home care in the county. Where these institutionalization rates are above the median, Medicaid nursing home expenditures averaged \$7,001 per capita among the counties' entire Medicaid eligible population age 65+. In the counties where institutionalization and bed supply rates were below the median, a mean of \$4,343 was spent on a per capita basis, or \$2,658 fewer dollars per Medicaid eligible older adult in 1996. Among Florida's counties, these

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\*The areas of high nursing home bed supply, according to this measure, tend to be the affluent counties such as Sarasota where there are 868 nursing home beds per 1,000 Medicaid eligibles age 65+. In stark contrast, far less affluent Dade county has only 92 beds per 1,000 Medicaid eligibles age 65+. In Sarasota, 41% of the county's Medicaid eligibles age 65+ resided in nursing homes versus 6% in Dade county in 1996, according to the Policy Center's analysis.

per capita state expenditures range from below \$2,000 to over \$10,000 (with a state mean of \$5,692) and are significantly correlated with the number of nursing home beds per 1,000 Medicaid eligible age 65+.

It has been postulated that nursing home supply creates its own “demand,” or induces utilization.<sup>7</sup> This can occur when third-party reimbursement is more readily available for nursing home care than for alternative forms of long-term care, or if alternatives are relatively scarce or offer an insufficient intensity of services to meet care needs. This phenomenon is not well understood, and it would be useful to find out exactly why and how a built bed becomes a filled bed, seemingly no matter how many beds there are. What is most important, however, is to recognize that there is an undeniable connection between nursing home bed supply and utilization, particularly among the poor. And this connection must be recognized in the context of long-term care planning and policy-making.

**Reason #2: State-funded home and community based programs do work to reduce nursing home utilization. They work best, however, when nursing home bed supply is constrained.**

Once regarded by many as an addition to and not a replacement for nursing home care, community-based long-term care options can be effective in reducing nursing home utilization. A 1998 study of nursing home use throughout the U.S. (based on National Medical Expenditure Survey data) found that those who received community-based long-term care showed a significant decreased demand for nursing home care.

For both the private pay and Medicaid populations the odds of entering a nursing home are decreased by close to 90% if the sample person has received informal or formal community-based long-term care as compared to a sample person who has not received formal community-based long-term care.

Jeffrey Rhoades (1998)<sup>8</sup>

Analysis of the Policy Center’s Florida counties long-term care database for base year 1996 reveals that state funded alternatives to nursing home care appear to have a counteracting effect on institutionalization among Medicaid eligible older adults in the state. In general there is a statistically significant negative correlation, or inverse relationship, between the percentage of low-income older adults in nursing homes and state expenditures at the county level on in-home care programs, specifically Community Care for the Elderly (CCE), Home Care for the Elderly (HCE), and the Medicaid waiver in-home care program. A significant inverse relationship was also found with spending under the Older Americans Act (federal dollars that fund home delivered meals and other community-based supportive services). Additionally, the relative supply of assisted living facility beds allocated to state-supported clients, namely Optional State Supplementation (OSS) beds, was also significantly negatively correlated with institutionalization rates among Medicaid eligibles age 65+ in Florida. While these results do not speak to causality, this pattern looks promising.

Although the relative availability of home- and community-based services (HCBS) could be said to have a mitigating effect on institutionalization rates in the state as a whole, the influence is either greatly enhanced or disappears depending on the local nursing home bed supply level. And it is in the lower bedded areas where HCBS has the greatest measurable effect.

Where nursing home bed supply is lower (among the 34 counties with supply per Medicaid eligibles below the median), the negative correlations are the strongest between state spending on HCBS and the percentage of low-income older adults in nursing homes. Among the counties with bed supplies above the median, however, any influence HCBS may have on reducing Medicaid nursing home utilization among low-

income elders was not evident in this analysis. In fact, significant positive correlations were found in the higher bedded areas between these variables (that is, spending on HCBS and institutionalization rates among the poor move in the same direction in these areas).

This curious finding is not unique to the state of Florida. A similar analysis was done by University of North Carolina researchers in 1993 using county level long-term care supply data.<sup>9</sup> Testing for a possible substitution effect in the state between HCBS and nursing home care, the researchers concluded that the greater potential for substitution seemed to be in the areas of North Carolina where nursing home beds were less available. Matching the pattern found in Florida, there was a significant negative correlation between public spending on HCBS and nursing home bed supply (a proxy for institutionalization rates) in the counties where bed supply was the lowest. Conversely and consistent with the findings in Florida, a significant positive correlation was found between supply levels of HCBS and nursing home beds in the counties where bed supply was highest.

These observations point to a need for additional research, to fully interpret the findings, but signal that increased public spending on HCBS may not lead to a reduction in nursing home utilization rates in areas with large institutional bed capacity. This could perhaps lend credence to the cautionary message included in a 1996 report by the Florida Office of Program Policy Analysis and Government Accountability (OPPAGA) on the Certificate of Need Program for nursing homes.

Unless increases in the availability of state funded community-based services are tied to decreases in the use of Medicaid for long term nursing home care, community based services are likely to be used by some individuals who may not have otherwise gone in to nursing homes.

OPPAGA (1996)<sup>10</sup>

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*Holding institutional bed supply to lower limits is evidently an essential ingredient of a successful strategy to reduce dependence on nursing homes through increasing the availability of long-term care alternatives (HCBS).*

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## Conclusion

Holding institutional bed supply to lower limits is evidently an essential ingredient of a successful strategy to reduce dependence on nursing homes through increasing the availability of long-term care alternatives (HCBS). But it is also important that alternatives offer an adequate level of support. In order to offer older adults a true choice between entering a nursing home and remaining at home to receive long-term care services, levels of support available in both settings should be comparable. To increase the opportunity to age in place it is not sufficient to simply serve more people through HCBS; we need to serve people more.

The higher level of service that is necessary to adequately support very frail older adults at home and in assisted living facilities could be readily funded if the state recognized HCBS as a substitution for nursing home care and budgeted for these programs accordingly. As recommended by OPPAGA in a 1998 report, "The Certificate of Need program could be used to facilitate the state's ability to shift resources from nursing homes to alternatives if certificate of need decisions were tied to a detailed plan for expanding Medicaid-funded, community-based services."<sup>11</sup>

From 1980 to 1998, the growth in nursing home bed supply in Florida has been twice as

high as the rate of increase in the state's older adult population. In that time span the number of nursing home beds increased 129% while the state's population age 65+ increased 63%.<sup>12</sup> A 23% expansion in nursing home bed supply is projected to occur between 1995 and 2005.<sup>13</sup> It would be well warranted at this point to determine if all additional institutional capacity planned for is truly necessary.

Several other states have seen the need to take active measures to reduce existing nursing home bed supply while expanding their HCBS infrastructure, including Nebraska which offers cash grants to providers to take nursing home beds off-line.<sup>14</sup> Florida is fortunate in that we simply need to hold the line with current capacity and curb only projected growth in bed supply.

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*If for every nursing home bed that can be backed out of the list of the thousands forecasted to be built, the HCBS budget is bolstered by the average amount the state would have spent in support of that bed, long-term care policy in Florida would get out of its quarter of a century holding pattern in a hurry.*

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If for every nursing home bed that can be backed out of the list of the thousands forecasted to be built, the HCBS budget is bolstered by the average amount the state would have spent in support of that bed, long-term care policy in Florida would get out of its quarter of a century holding pattern in a hurry.

Nursing homes are still needed, no doubt. But its time to answer the call of the elder

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**CHANGING PATTERNS IN HEALTH AND ECONOMIC STATUS: THE IMPACT ON BABY BOOMERS' RETIREMENT PLANNING**  
**Sandra L. Reynolds, PhD**

The subject of trends in health among our older population is one that has received significant press coverage in recent years. Whether older adults are living longer and healthier, or longer and less healthy, has enormous potential to affect policy discussions covering such topics as future Medicare and Social Security funding, long-term care services, delivery, and funding, and many other areas.

Although we know that life expectancy continues to increase for older adults, there is some debate about the condition in which they will age. Most researchers agree that there was a general deterioration in the health of older adults in the 1970s (Colvez & Blanchet, 1981; Crimmins, 1987; Verbrugge, 1984; Ycas, 1987a, 1987b). The debate continues, however, about the extent to which improvement in health was observed in the late 1980s and early 1990s. While some researchers found improvement in health and functioning (Manton, Corder, & Stallard, 1993, 1997; Crimmins, Saito, & Ingegneri, 1997; Crimmins, Saito, & Reynolds, 1997), others have found a more complex picture, with improvement in some areas, and deterioration in others (Crimmins, Saito, & Reynolds, 1997; Crimmins, Reynolds, & Saito, 1999; Reynolds, Crimmins, & Saito, 1998).

In addition, one major policy change was enacted in the 1980s that was predicated on the assumption that health and functioning were improving – the increase in the age eligibility for Social Security, to 66 now, and 67 in the next century. The questions arise, then, about how confident we can be about older adults' increasing ability to work, as well as whether the improvements observed during the 1980s will continue into the next century.

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## Methods

This paper examines trends in diseases and disability among the older working-age population (ages 50-69) and among birth cohorts (ages 30-69), using the 1992 through 1993 National Health Interview Surveys (NHIS). Two principal resources are used, "Trends in Health and Ability to Work Among the Older Working Age Population" (Crimmins, Reynolds, & Saito, 1999), and "Cohort Differences in Disability and Disease Presence" (Reynolds, Crimmins, & Saito, 1998). More detailed information on the methodology used in this paper can be obtained from these two sources.

The NHIS samples the general population each year in an effort to monitor the health and functioning of all Americans. The NHIS questions used in these analyses were "does a

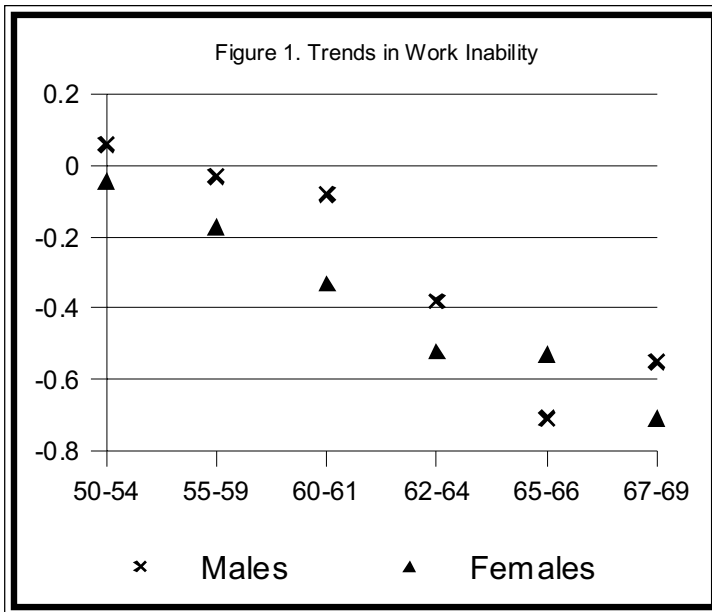
physical or health problem keep [you] from ..." or "limit the amount or type of" .... (usual activity, for males; working, for females). In addition, the NHIS divides the total sample into six subsamples to ask questions about the presence of chronic conditions from six bodily systems: bone/connective tissue, respiratory, nervous, digestive, endocrine/metabolic, and cardiovascular. For the trends in the ability to work (Crimmins, Reynolds, & Saito, 1999), we calculated the proportion of the males and females aged 50-69 (n=approx. 227,000) reporting either inability or limitation in ability to work, as well as the prevalence of arthritis, diabetes, cerebro/cardiovascular diseases, musculoskeletal disorders, mental disorders, and respiratory diseases, and ran regressions against the amount of time since 1981. In addition, individual level regressions were run, controlling for age, education, race, gender, and occupation.

In the cohort analysis (Reynolds, Crimmins, & Saito, 1998), we constructed 3-year centered birth cohorts using ages 30-69, which resulted in cohorts born between 1916 and 1958. Similar analyses were conducted on work disability and the prevalences of diseases and conditions.

## Results

### *Time trends in work disability*

Figure 1 shows the results of the regression of each age group on the ability to work, against time (defined as the number of years since 1981). In the thirteen years surveyed, only males aged 50-54 showed a slight increase in work disability, and that increase is not significant. In all other age groups, work disability decreases, although significantly only from age 62 on. Females show generally the same trend, although improvement in ability to work is significant for all, excepting only the age groups 50-54 and 60-61.



*Trends in chronic conditions and impact on ability to work*

Table 1 displays changes in selected diseases and chronic conditions, as well as the respondent’s estimation of whether the disease/condition contributed to work limitations. The results are quite interesting – only in the case of arthritis does the impact on the ability to work decrease along with the prevalence of the disease.

1982-1993 changes in:	Disease Prevalence	Probability that the Disease Limits the Ability to Work
Arthritis	-.02	-.02
Cardiovascular Diseases	-.02	-.05
Diabetes	unchanged	.03
Musculoskeletal Disorders	unchanged	.03
Mental Disorders	unchanged	.05
Respiratory Diseases	0.02	-.02

Cardiovascular diseases decrease in prevalence by 2%, but the probability that they limit work ability decreases by 5%. This may be due to a number of factors, including improved treatment, better workplace accommodation, and increased knowledge of lifestyle factors that make possible quicker recovery and improvement in functioning. For diabetes and musculoskeletal disorders, the prevalence was unchanged, but the negative impact on ability to work increased by 3%. The implication is that adults with these

conditions have more difficulty functioning in the workplace than those with the cardiovascular diseases.

In terms of mental disorders, again the prevalence was unchanged, but the negative impact on ability to work increased by 5%, leading one to assume that having a mental disorder makes working even more problematic, perhaps because employees and employers are better able and/or more willing to accommodate physical problems than mental. Finally, although the prevalence of respiratory diseases increases, their impact on the ability to work diminishes over the 13-year period. The implication is that people are better able to cope with respiratory conditions, perhaps due to improvements in allergens and other respiratory therapies.

*Cohort differences in work disability*

Figure 2 shows the results of the calculation of the proportion of the 30-69 year old population (birth cohorts from 1916 through 1958) who report being unable to work. Once again, we see that the trends for males and females are largely similar, with a steady decrease in work disability until the baby boom cohorts. Beginning with the 1943 birth cohort, there is a fairly steady rise in work disability for both males and females.

At the same time, we examine the prevalence of a variety of diseases. With research question #2 in mind, Table 2 presents the trends in disease/condition prevalence among only the baby boom cohorts, 1946-1958. Among

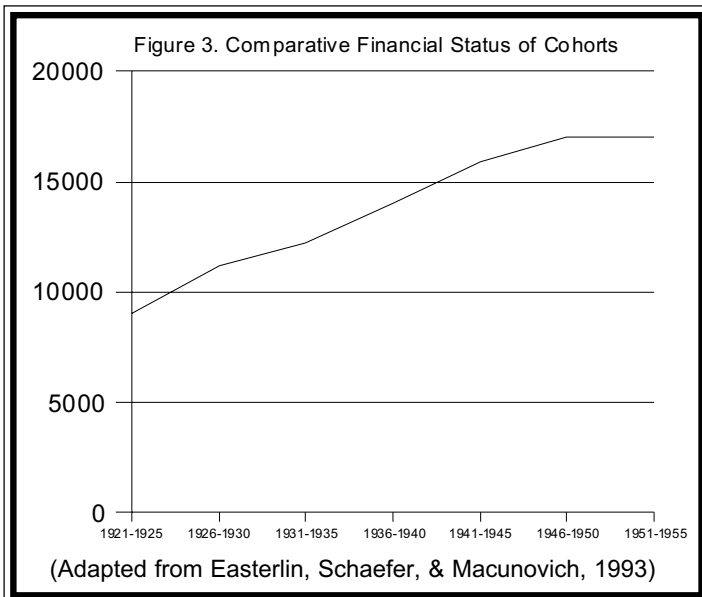
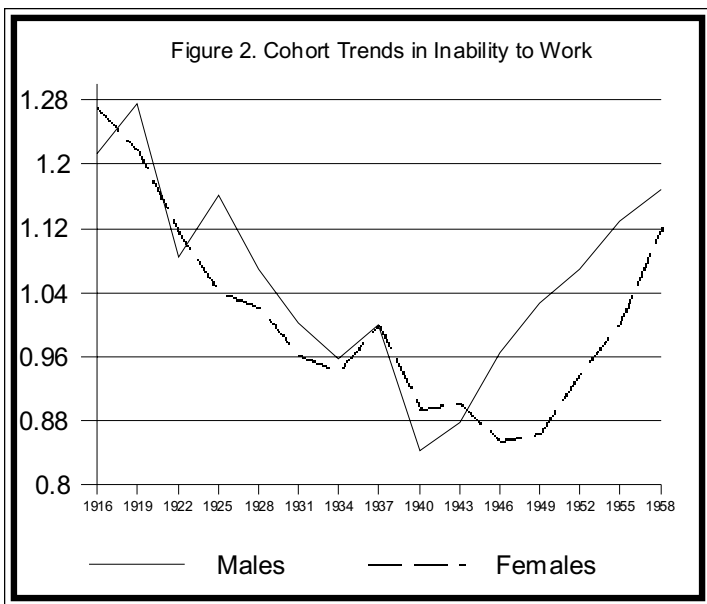


Table 2. Changes in Prevalence of Diseases/Conditions, by Gender

*p<.05	Steady Decreases	Steady Increases
Arthritis*	Males, Females	
Asthma		Males, Females
Bronchitis		Males
Cardiovascular*	Males, Females	
Diabetes	Females	
Emphysema	Males	Females
Mental Disorders		Males
Musculoskeletal Disorders*		Males, Females
Orthopedic ' Impairments*		Males, Females

(for information on the methodology and operationalization of concepts, see *ibid*).

the significant results, we find that arthritis and cardiovascular diseases decrease in prevalence for both males and females. Unfortunately, we also find significant increases in the prevalence of asthma, musculoskeletal disorders and orthopedic impairments.

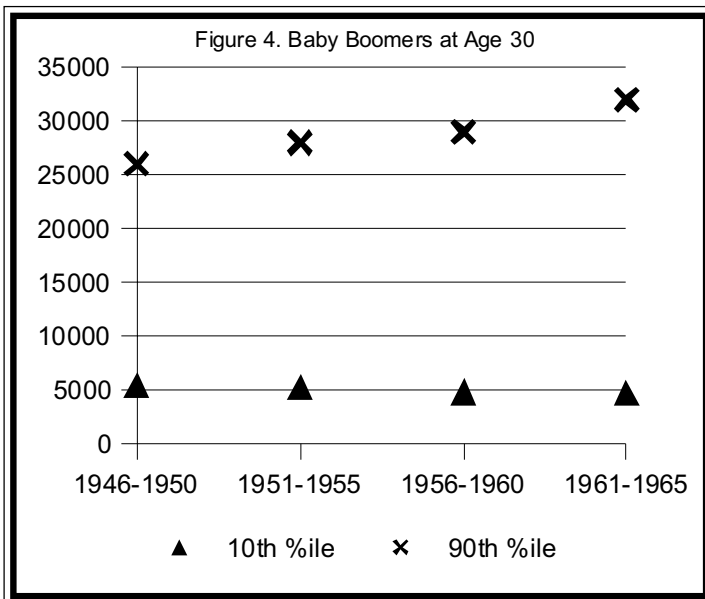
*Potential impact on prospects for the baby boomers*

In 1993, Richard Easterlin and colleagues wrote a provocative paper on the financial prospects of baby boomers in their retirement (Easterlin, Schaefer, & Macunovich, 1993). Figure 3 charts the major findings of this article regarding the

income per adult equivalent of cohorts ranging from 1921-1925 to 1951-1955 (for information on the methodology and operationalization of concepts, see *ibid*).

Displayed are the data at age 40, showing the relative income for the various cohorts, using CPI-indexed figures from the 1965 to 1990 Current Population Surveys. It is clear that, for early born cohorts, there is a steady increase in earning power for adults at age 40. It is also clear that this steady increase does not exist for the baby boomers. For the cohorts born from 1946 on, there is a distinct leveling off of income.

Calculations of this type also were made on measures of wealth, with the only major difference that the baby boomers are significantly less well off than their parents in terms of the value of real estate. However, according to Easterlin and colleagues, the boomers have made this up in other assets. These figures represent the baby boomers in the aggregate, however. When we examine the results of income per adult equivalent for the upper and lower economic strata, we find confirmation of the often expressed fears that the rift between the haves and the have-nots in our society is widening (Figure 4). In spite of the fact that the baby boomers, overall, experience a leveling off of income, in fact the most affluent of boomers continue to increase in earning power, while the least affluent lose ground.



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Income, savings, investments and pension coverage are very uneven among the baby boomers, and it would seem that many of them will have substantial difficulty maintaining living standards in retirement comparable to their pre-retirement years. Consider the following.

- Almost half of all baby boomers lack pension coverage. Among those with coverage, the majority now have defined contribution plans. The percentage with defined benefits plans has been declining since 1984.
- Boomers' incomes are more unequal than those in preceding generations. Over the last 20 years, the percentage of

boomers earning less than \$30,000 grew from 23% to 30%, those earning \$30,000 to \$50,000 fell from 29% to 23%, those earning \$50,000 - \$75,000 fell from 26% to 22%, while those earning over \$75,000 grew from 13% to 20%.

- Most boomer households have few financial assets. Median net worth, excluding home equity, was less than \$2,500 for the bottom 40% in income distribution in 1992, \$8,500 for the bottom 60%, \$15,000 for the fourth quartile of boomers, and was only \$45,000 for those in the top 20% of income. Even when home equity is included, the net worth of the bottom 60% is barely \$30,000. For the top 20% however, net worth reached \$120,000.
- The financial assets held by the typical boomer were worth only \$10,000 and only 20% of the boomers had more than \$25,000 in financial assets in 1993. The bottom 25% of the boomers have liabilities that exceed their assets (--\$951) and even the top 10% had only \$66,000 in financial assets.

The growth of the stock market during the 1990s undoubtedly increased the assets of boomers and we need more recent data than those reported here. It is not likely, however, that the bull market has qualitatively changed the financial status of most baby boomers. Only 20% of the population has significant market investments and it is generally estimated that 70% of the wealth generated by the market since 1990 has gone to the top 20% of the households in the income distribution and most of this to the top 5%. These facts in combination with a traditional family low savings

rate among U.S. households do not support the view that most boomers are qualitatively better off now than in the early 1990s.

Wage stagnation and declining availability of health and retirement benefits at least partially reflect changing trends in the U.S. labor market and in other developed countries that may have significant implications for the future of Social Security and Medicare. New forms and patterns of employment are emerging as increasingly fewer workers are employed by the same firm throughout their work lives. A growing number of workers are employed part time as contract workers or they are self-employed, which relieves management of having to pay for health care, pensions and other benefits.

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*If these trends continue to grow, then we can expect more workers in the future, particularly the youngest baby boomers and those in the generation following the baby boomers, to reach retirement with less savings and smaller pension accumulations...*

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Many workers who call themselves consultants may, in fact, be contract workers who move from one employer to another and rarely work for one employer for more than a year.

Few part-time and self-employed workers have the kind of pension and health benefits enjoyed by full-time, vested employees of large public agencies and private corporations, nor are they as likely to receive regular pay

increases that permit them to stay ahead of inflation and accumulate substantial savings. Many analysts expect these employment patterns to become more common over the next several years as increasing global competition and the weakening of labor unions exerts greater downward pressure on wages and shrinks benefit packages. If these trends continue to grow, then we can expect more workers in the future, particularly the youngest baby boomers and those in the generation following the baby boomers, to reach retirement with less savings and smaller pension accumulations (at the same time, fewer revenues flowing into the Social Security trust fund) than current retirees and those retiring over the next 30 years. This would produce a real crisis in funding entitlements, even as there is greater need for them. This could mean that within 25 years there will be substantially more retirees dependent on public resources than at any time before.

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Many baby boomers will be better prepared financially to manage their retirement years than their parents were and could use a substantial reserve of private savings and pension benefits to compensate for modest reductions in their social security benefits. The increased capacity, however, of many baby boomers to provide for their own retirement needs should be weighted against the potential increase in the number of people who are only intermittently involved or loosely connected to the labor market (i.e., part-time, temporary, and self-employed workers) as conventionally understood. The latter are likely to have fewer private retirement resources and may be even more dependent on Social Security, Medicare, and Medicaid (for long-term care) than their parents were.

## SUMMARY AND POLICY IMPLICATIONS

Although work disability increases with age, we find evidence that in the 1980s and early 1990s, work disability has decreased, particularly for those in their 60s. At the same time, we find corroborating evidence that the presence of “killer” diseases, such as heart disease and stroke, has diminished. For birth cohorts, we find generally the same picture, as work disability decreases for the cohorts born up until the mid-1940s, or for adults who would be in an age range in the 50s and older. Thus, we find general confirmation of an increasingly healthy group of older adults, until we reach the baby boom cohorts.

For the baby boomers, however, the results are less encouraging. Although the baby boom cohorts in our study are only in the ages of 30 to approximately 45, they already exhibit higher rates of work disability, and higher rates of at least two conditions that could have a major impact on their continuing ability to work – musculoskeletal disorders and orthopedic impairments. The baby boom cohort,

however, will be the cohort for whom the age eligibility for Social Security will be 66 to 67. This calls into serious question how confident we can be in using encouraging but inconsistent improvement in the health of today’s older adults as a basis for projecting the health of the aging baby boomers.

Results not reported here, but included in Reynolds, Crimmins, & Saito (1998) indicate also that the deterioration in musculoskeletal and orthopedic problems noted in the baby boom cohorts is largely found in those of lower socioeconomic status, particularly among males. For these people, preservation of Medicare and Medicaid benefits will be increasingly important, as these adults will be at risk both for diminished income, and higher medical expenses.

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In addition, the economic prospects for the baby boom cohort appear to be, at best, mixed. While in the aggregate, the baby boom is doing no worse than previous generations, for the least affluent boomers the economic picture looks less encouraging. This factor could be crucial, as these are the very people who are the most likely to lose out, should efforts to privatize Social Security succeed. There is simply no way of getting around the fact that, for a significant portion of our future older adults, Social Security benefits will remain the most important, and in

many cases the sole, source of income in retirement. For these baby boomers, retirement planning is heartbreakingly simple – get out and vote to ensure the survival of Social Security as it currently exists, however fine-tuned it needs to be.

For baby boomers who are affluent enough to save and invest, retirement planning is more of a challenge. They must plan on living longer, which means that, whether they are in their 30s, 40s, or 50s, they need to invest for the long-term, and that means the stock market. The other message is that they may not be able to plan on “living better.” Higher work disability rates translate into a need to save more now, while they can. However, baby boomers might also consider investing in either long-term care insurance and/or disability insurance – now, while their relatively young age makes such policies affordable.

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## MENTAL HEALTH SERVICE NEEDS AND COST OF CARE FOR ADULTS RESIDING IN FLORIDA'S ASSISTED LIVING FACILITIES

Marion Becker, Paul Stiles and Lawrence Schonfeld

### Background

Meeting the health and mental health needs of aging "baby boomers" will be one of the greatest challenges we face in the 21<sup>st</sup> century. Reports from the field indicate that financial investment in mental health care is falling substantially in both private and public sectors. As noted by Manderscheid (1998, p. 233) "badly needed resources for care provision are eroding from mental health at a rapid rate...without immediate and coordinated effort by all groups in the mental health field, this situation has the potential to enfeeble, or even trivialize, mental health care over the longer term". Of particular concern to mental health advocates are the special needs of elderly adults who have serious mental, emotional, and, behavioral healthcare needs. Of elderly living independently, research

annually (H.R. Report 102-852). There is an urgent need for mental health research about appropriate settings for the care of the elderly and the pathways by which older adults are admitted and discharged to state hospitals and other residential settings. While there have been some gains in services for elders in the last decade, there are recurrent problems. As noted by Gatz there is:

1. Lack of parity between health and mental health care in services, training, and research.
2. Imposition of an acute-care medical model on financing, programming, and research approaches to the chronic conditions of mental illness.
3. Government disincentives against providing preventive and early intervention services.
4. Fragmentation, turfism, and lack of leadership in policy making, financing, training, and mental health programs for older adults.
5. Over-reliance on inpatient (custodial) treatment.

### Assisted Living in Florida

In Florida, as elsewhere in the nation, the sheer growth of the ALF industry serving frail, cognitively impaired and mentally ill residents has raised concerns among providers, regulators and advocates. Over the past decade, costs and the population in need of assisted living settings have grown rapidly. Emerging concerns about the adequacy of services provided to residents residing in ALFs have persisted and are amplified by the popular press. Initially, the primary use of assisted living was for wealthy elderly in need of assistance with activities of daily living and health care needs.

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demonstrates that an estimated 22% have a mental disorder (Gatz, Kasl-Godley & Karel, 1996). Between 2% and 10% of older adults abuse alcohol (Adams & Smith-Cox, 1997, Schonfeld & Dupree, 1999) and an alarming 21% of adults over the age of 60 hospitalized for medical problems have a diagnosis of alcoholism, with related costs of \$60 billion

However, with the availability of Medicaid coverage, assisted living settings became a resource for all seniors, including those with mental illness. ALFs provide housing, meals, and personal assistance to elders and persons with physical and mental disabilities who need support to live in the community but do not require institutionalization. In contrast to institutional settings, ALFs are subject to very little regulation. This is in keeping with the goal of promoting a low cost alternative to institutionalization.

### ALF Bed Availability

In November 1996, the Florida Legislature reported that the state had 1,914 licensed ALFs, with capacities ranging from a single bed to 600 beds. These facilities, licensed in 1996 for a total of 62,202 beds, are located throughout the state of Florida. Most are small, with 16 or fewer beds, and many are in single-family houses in residential neighborhoods (Office of Program Policy, 1997).

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Although the total number of ALF beds in Florida is growing, the number of OSS-allocated beds in the state is currently decreasing. The total number of ALF beds increased between March 1996 and September 1997 by 2,648 (from 62,018 to 64,816); at the same time, the number of OSS-allocated beds dropped by 412 (from 10,866 to 10,454). The percentage of ALFs that accept OSS clients has remained constant at 49%, but the total number of state-

funded clients these ALFs accept has declined. ALF providers say that due to inadequate reimbursement, beds once available to OSS clients are now being given to private paying residents or left vacant. We speculate that state supported residents with mental illness will be rejected by ALFs in increasing numbers as long as the state reimbursement rate is perceived to be less than the actual cost of care and/or below the fee-for-service rate for private-pay residents.

### Legislative Response

In 1995, in order to address concerns about the mental health needs of ALF residents, the Florida Legislature enacted a law requiring ALFs that serve mental health residents to obtain a limited mental health license in addition to the standard license required of all ALFs. This law required that ALF facility staff receive two-to-eight hours of training in mental health subjects such as major mental illness diagnosis and behavior management techniques. This new license requirement and increased regulation was not accompanied by an increase in funding. Although the additional training requirements are of obvious potential benefit, ALF operators see them as an additional expense and burden. Although well intended, the new licensing requirement may actually act as a barrier to ALF placement for OSS residents with mental illness. In response to the growing concerns (described above), the Florida Legislature mandated that the Department of Children and Families, in cooperation with the Agency for Health Care Administration, establish a workgroup to study the mental health services that OSS residents residing in ALFs receive and need. The current investigation was undertaken in response to that mandate.

### Methods

The investigation included two interrelated sub-studies, a mental health utilization and cost analysis and an exploratory needs assessment. We report here on findings from the utilization and cost analysis. Our main objective was to determine the demographic characteristics of

state-supported individuals residing in Florida's ALFs and to examine the pattern and cost of mental health services they receive. To accomplish study objectives, we analyzed data from the state Medicare claims files and the Florida Statewide Integrated Data Set (IDS) in the year 6/1/96 through 5/31/97.

## Findings

Of the 7,982 OSS recipients living in ALFs, 3,924 (49%) had a Medicaid mental health service claim. Demographic information and service costs for those 3,924 individuals are compared to all non-ALF residing Medicaid eligible individuals who had at least one Medicaid mental health claim in the study time period. See Tables 1-5.

Consistent with other findings in mental health, data indicate that slightly more women than men receive mental health services funded by Medicaid.

Table 2 shows that there are proportionally fewer minorities in ALFs compared to mental health service users statewide. There are apparently 8% fewer blacks and almost 7% fewer Hispanic individuals, although these differences may in part be accounted for by the large disparity in the "other" category.

Of particular interest in Table 3 is the high number (45.7%) of mental health service users under age 21 who, as expected, do not reside in ALFs. [Also of note is the

	Oss-Supported Mental Health Service Users Residing in ALFs		All Medical Eligible Mental Health Service Users Statewide	
Gender	# Persons	Percent	# Persons	Percent
Female	196	50.1%	69,219	52.6%
Male	1,958	49.9	62,297	47.4
<b>Total</b>	<b>3,924</b>	<b>100.0%</b>	<b>131,516</b>	<b>100.0%</b>

	Oss-Supported Mental Health Service Users Residing in ALFs		All Medical Eligible Mental Health Service Users Statewide	
RACE	# Persons	Percent	# Persons	Percent
White	2,280	58.1%	66,556	50.6%
Black	785	20.0	36,854	28.0
Native American	1	0.0	53	0.0
Asian/Pacific Islander	2	0.1	123	0.1
Hispanic	39	1.0	10,309	7.8
Other	817	20.8	17,621	13.4
<b>Total</b>	<b>3,924</b>	<b>100.0%</b>	<b>131,516</b>	<b>100.0%</b>

	Oss-Supported Mental Health Service Users Residing in ALFs		All Medical Eligible Mental Health Service Users Statewide	
AGE	# Persons	Percent	# Persons	Percent
0-20	36	0.9%	60,098	45.7%
21-35	579	14.8	22,934	17.4
36-50	1,288	32.8	26,818	20.4
51-65	981	25.0	13,228	10.1
66-80	697	17.8	5,472	4.2
81+	343	8.7	2,966	2.3
<b>Total</b>	<b>3,924</b>	<b>100.0%</b>	<b>131,516</b>	<b>100.0%</b>

fact that 26.5% of OSS-supported mental health service users in ALFs over age 65 compared to 6.5% of all Medicaid eligible mental health service users over 65 residing in the community.] Given that the population of Floridians over 65 is about 20% and growing, these data demonstrate both the under-representation of elderly with mental health problems in the community and the large concentration of those elderly in ALFs. This 26.5% actually under-represents the true proportion of elderly with mental illness in ALFs because Medicare data and private-pay service recipients are not included.

As shown in Table 4a, OSS clients residing in ALFs receive a significant amount of Medicaid service (\$23 million in the year 6/1/96 through 5/31/97). This

<b>TABLE 4a</b>				
<b>OSS-Supported ALF Residents</b>				
<b>Mental Health Service Users</b> n=3,924				<b>All OSS-Supported ALF Residents</b> n=7,982
<b>COSTS*</b>	<b># Persons Using Service</b>	<b>Total Annual Cost</b>	<b>Average Annual Cost per User</b>	<b>Average Annual Cost Per Resident**</b>
Targeted Case Management	2,302	\$ 2,904,756	\$1,262	\$ 364
Community Mental Health	3,195	11,237,646	3,517	1,408
Inpatient	1,241	8,874,490	7,151	1,112
Physicians Services	845	392,486	464	49
<b>Total</b>	<b>3,924</b>	<b>\$23,432,480</b>	<b>\$5,966</b>	<b>\$2,936</b>

<b>TABLE 4b</b>			
<b>All Medicaid-Eligible Mental Health Service Users</b> State- wide (Non-ALF Residents, Age 18+) n=74,809			
<b>COSTS*</b>	<b># Persons Using Service</b>	<b>Total Annual Cost</b>	<b>Average Annual Cost per User</b>
Targeted Case Management	21,842	\$ 22,326,000	\$1,022
Community Mental Health	53,249	63,375,000	1,190
Inpatient	19,110	78,580,000	4,113
Physicians Services	15,330	4,562,000	298
<b>Total</b>	<b>74,809</b>	<b>\$169,072,000</b>	<b>\$2,260</b>

compares to \$169 million for Medicaid mental health service users not in ALFs (Table 4b). The ALF residents on average incur more than twice the cost of mental health services (\$5,966 vs. \$2,260). It is important to bear in mind that these data do not include Medicare expenditures, medication costs, HMO costs, or out-of-pocket dollars, so they necessarily underestimate total costs and do not reflect service use or cost of mental health care provided to individuals not receiving Medicaid. The underestimation of mental health cost is greatest for elderly because Medicare costs are not reflected (Medicare is the primary payer for many of the services provided for elderly). Pharmacy charges not included are likely to be significant. The cost of medication could add another 25% to the annual costs of care.

The most costly Medicaid-funded service provided to OSS-supported residents of ALFs was community mental health services (\$11 million), at an average annual cost of \$3,517 per service user and

\$1,408 when averaged across all OSS-supported ALF residents. This was followed by the cost of inpatient care (\$8.9 million), which averaged \$7,151 per user and \$1,112 across all residents. Targeted case management (\$2.9 million) averaged \$1,262 annually for users and \$364 across all residents. Physician services were least costly, averaging \$464 per user and \$49 across all residents.

As can be seen from Tables 5a and 5b, elderly individuals residing in ALFs receive more service than those residing in the community. Average annual cost for each mental health service user over the age of 65 is \$4,627 compared to \$1,897 per user not residing in

TABLE 5a				
	# Persons Using Service		Average Annual Cost per User	
ALF Residents	Age 18-64	Age 65+	Age 18-64	Age 65+
Targeted Case Management	2,104	384	\$1,379	\$ 957
Community Mental Health	1,742	692	5,395	6,743
Inpatient	1,014	277	7,002	4,009
Physician Services	*2,185	*321	470	351
<b>Total</b>	<b>2,806</b>	<b>1,209</b>	<b>\$6,788</b>	<b>\$4,627</b>

TABLE 5b				
	# Persons Using Service		Average Annual Cost per User	
Persons Not in ALFs	Age 18-64	Age 65+	Age 18-64	Age 65+
Targeted Case Management	17,745	1,310	\$1,062	\$ 874
Community Mental Health	22,861	2,468	3,228	5,016
Inpatient	13,230	1,735	4,155	1,557
Physician Services	*38,259	*2,100	294	218
<b>Total</b>	<b>51,081</b>	<b>6,374</b>	<b>\$2,206</b>	<b>\$1,897</b>

\*Includes some patients counted twice.

an ALF. When comparing services provided for targeted case management, community mental health, and physician services, elderly residents residing both in ALFs and in the community receive fewer services than individuals under the age of 65 (see Tables 5a & 5b).

## Conclusions and Recommendations

Meeting the health and mental health needs of older adults is one of the greatest challenges we face at the millennium. Assisted living policy is a crucial issue because of the important role ALF's play in the continuum of long-term care for elderly persons with severe mental illness. While the introduction of Medicaid reimbursement in 1965 sparked the tremendous growth of the nursing home industry, the rapid growth of ALFs reflects significant unmet demand and competition for housing and services among older persons with disabilities. If the state wishes to ensure the availability of ALF beds for OSS clients, it must address the factors contributing to their decline.

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In this study OSS-supported ALF residents received more than twice the mental health services provided to persons with mental problems not residing in ALFs. This finding may reflect average differences in illness severity. It nonetheless documents the fact that ALF residents are receiving a significant amount of mental health care. Given the reported concerns about negative outcomes for the ALF population, it leaves open to question the effectiveness of services provided.

Clearly, in Florida and nationwide, the demand for assisted living facilities is high and will continue to grow. If mental health outcomes are to be improved for ALF residents and the opportunities to place persons with severe mental illness in ALFs are to be maintained, additional research on service needs, staff training, and the ALF oversight process are needed. Study findings lead to recommendations that 1) the OSS payment to ALF's be increased, 2) the State develop a case-mix adjusted payment schedule for ALFs, 3) the mental health system support to ALF's, be increased 4) ALF staff receive additional training, 5) there be increased surveillance and quality-of-care monitoring, and 6) consumer-oriented standards and quality indicators be developed.

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**Elder Abuse in the Context of Intrafamily Violence: A Case Study in Identification, Intervention and Prevention**

Max B. Rothman, Burton Dunlop, Kathrine M. Condon & Kellye S. Hebert

**Purpose of the Study**

Traditionally, elder abuse has been a low priority issue in many communities. It is often overshadowed by more dramatic cases of child abuse and domestic violence (i.e., spouse abuse). Occasionally, a high profile case in a nursing home or assisted living facility attracts public attention; but domestic elder abuse, typically involving family members in the home, has been the subject of scant public discussion or study.

Consequently, public policy and intervention programs established at the state and local levels to address this social problem have been almost exclusively reactive, with little attention devoted to systemic analysis of case data and the development of optimal policies to treat or to prevent its occurrence. This is the case in Florida as well as, it appears, in most other states.

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*The study reported here was designed to assist the community, including public entities with responsibility for addressing elder abuse, to move “ahead of the curve” in their understanding and treatment of this problem.*

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The study reported here was designed to assist the community, including public entities with responsibility for addressing elder abuse, to move “ahead of the curve” in their understanding

and treatment of this problem. Department of Children and Families (DCF) District 11, which encompasses Miami-Dade County, was selected as a case study for examining ways in which data collected and computerized during the course of abuse investigations and service intervention might be used to broaden understanding of the nature of elder abuse in the County, including any connection between elder abuse and other forms of intrafamily violence. This study can result in the design of more targeted interventions and even prevention strategies through a clearer understanding of the profile of elder abuse locally. Although based on a case study of one large urban area, findings should have potential relevance not only for other localities in Florida but for other parts of the country as well.

The existing literature on risk factors associated with abuse was consulted in order to pinpoint case data which should be computerized and made easily retrievable for policy and program planners. The cause of elder abuse, unquestionably, is multifaceted and a full explanation remains elusive. However, it is possible to describe the elements most commonly uncovered in abuse episodes that get reported, i.e., victim characteristics, perpetrator characteristics, and the history and dynamics of their interaction. This knowledge, in turn, has led to the identification of specific risk factors for abuse, although the precise relative importance of these factors in leading to actual abuse is unknown. According to the literature, risk factors include elders' lack of social support and history, of past abuse and abusers' interpersonal and intrapersonal problems, including financial dependency on the victim.

In addition to risk factors for elder abuse implied by the research literature, another interest of this project was the extent to which multigenerational violence within the same family occurs more or less contemporaneously and,

thus, the degree to which occurrence of other forms of intrafamilial violence could be used as a risk indicator or predictor of elder abuse in that family. If other abuse is related to elder abuse and its occurrence can be pinpointed, it would become possible to monitor elders living in these households and to develop preventive measures.

Elder abuse carries very serious consequences and hence deserves much greater research and policy attention. In order to begin to address these issues, the study was organized according to the following broad questions:

- How much elder abuse exists in Miami-Dade County and how does it compare with estimated levels of abuse across the United States?
- What are the profiles of victims and perpetrators in these cases? How do cases differ by race and ethnicity?
- What is known about risk factors that are associated with elder abuse and to what extent are they congruent with risk factors associated with other forms of family abuse?
- Can risk indicators be developed from case data collected by DCF and other agencies to help improve their ability to respond more effectively to abuse cases, and to collaborate in the development of strategies for outreach, public education and targeting of resources?
- What are the community resources that are used to address elder abuse in Miami-Dade County? Are they appropriate in addressing violence issues in the household?

- What additional training, especially that surrounding the observation and recording of risk indicators, is needed by staff in the various agencies with responsibilities in this area?

## Methods

Answers to these questions were pursued through three principal methods: 1 ) interviews with 27 key informants in DCF, County Police and Fire Rescue units, the courts, the State Attorney's Office and various service providers; 2) search of the leading research literature on elder abuse and other forms of family violence; and 3) descriptive analysis of hand-tabulated closed spouse abuse and elder abuse cases from the files of the Miami-Dade County Police and a fuller statistical analysis of closed child abuse and elder abuse cases from computerized data files at DCF.

## Conclusions

Several conclusions pertinent to policy were drawn in this assessment of domestic elder abuse identification, prevention and intervention in Miami-Dade County, Florida. As indicated by the literature review provided here, elder abuse, not unlike other forms of intrafamily violence, carries serious consequences for its victims and deserves much greater focused research and policy attention. However, as is the case in most other states, Florida's public policy and intervention programs were found to be almost exclusively reactive and the model underlying service intervention is decidedly inadequate for reducing the occurrence or reoccurrence of abuse. As a result, DCF expends considerable resources carrying out repeated investigations involving the same victims and perpetrators (30 percent of new reports, and more than one-third (34.6%) of substantiated cases involved persons who had been subjects of at least one previous investigation within the past 12 months). Moreover, because virtually no

attention is paid to analysis of aggregated case data, which could provide valuable insights on the characteristics of the treatment population, development of preventative strategies is impeded further. Optimal program planning can be realized, however, only if collection and computerization of case data is expanded to include abuse risk indicators.

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Hotline counselors and APS staff need to be trained in data-collection procedures, so that they both know how to record data accurately and understand its importance. Training is very much needed in a number of other areas as well, not only for DCF staff, but for personnel from other agencies involved with elder abuse and domestic violence. These include the police, fire rescue, courts, State's Attorney office, and the domestic violence network. Notably, DCF staff need training in domestic violence issues and resources, as well as in evidence presentation and court procedures so that the chances of prosecution of perpetrators is enhanced. To enhance the likelihood that episodes of abuse do get reported to, and are accepted by, DCF, Hotline counselors need training in culturally-sensitive ways of eliciting key information for reports from a culturally diverse population.

A comparison of the estimated elder abuse incidence rate in the U.S. in 1996, with the rate for Miami-Dade County from analysis of DCF District 11 APS case data for the period July

1997 through June 1998, revealed a significantly lower estimated incidence rate in Miami-Dade County than in the country as a whole. This suggests that there may be significant under-reporting of actual maltreatment cases here. The percentage of reported cases which involve black victims is disproportionately high, a fact which, according to the literature, may reflect their greater likelihood of contacting authorities about abuse. However, over half of the elders in the county are of Hispanic origin and the research literature indicates that Hispanic persons are less likely to report abuse than are most other ethnic groups.

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Another factor that may help explain the apparently low elder abuse incidence level in the county is widely-reported difficulty experienced by reporters in getting their calls of abuse accepted by Hotline counselors. Language is a barrier, as there are times during which no counselors who speak Spanish, French or Creole are available to receive calls. This situation can discourage would-be reporters from even attempting to report abuse. Also, ignorance regarding responsibility for and the mechanics of reporting abuse is undoubtedly exacerbated by the existence of multiple languages and cultures.

Analysis of cases investigated by DCF revealed several characteristics of elder abuse unique to Miami-Dade County, including an

apparently higher incidence of exploitation relative to other forms of maltreatment and greater involvement of females as perpetrators than is the case nationally. Also, arrests and prosecutions of perpetrators proved to be rare events. Moreover, perpetrators are significantly younger here than nationally, i.e., there are more children, grandchildren and persons other than the spouse who are committing abuse. These, as well as other findings, point to the need for collection and computerization of measures of ethnicity and other risk indicators identified in the literature in order to understand the characteristics of abuse episodes and participants, address training needs, and develop preventive strategies.

One of the objectives of this project was to determine the level of correlation that exists between elder abuse and other intrafamily violence. However, the inconclusive nature of the available data on child abuse and elder abuse maintained by DCF (only 8 cases could be identified over a 20-month period) points to an important weakness in the current system of data collection. Moreover, the independent functioning of the elder abuse and spouse abuse treatment systems, accompanied by separate forms of data-collection and storage, permit only very limited data convergence and comparisons. In addition, it appears that both systems effectively leave out healthy older persons aged 60-74 who are in abusive relationships, but are not frail enough to qualify under the statute as victims of elder abuse. These persons, by-and-large, are not served by the domestic violence network either.

As a consequence, better data on familial relationships and other measures that allow linkage across at least the databases maintained by DCF would help address gaps in data-collection, preventive strategies, and services for abused elders within the familial context. Also, several projects in other states

show promise for effectively addressing elder abuse within the framework of domestic violence. Community alliances that bring together diverse agencies to address the various forms of intrafamily violence also appear to improve the delivery of service to victims of elder abuse.

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From the research literature, it is becoming increasingly clear that elder abuse is not all one cloth, but that the various forms of abuse, i.e., physical, emotional, neglect and exploitation, involve different dynamics and that interventions will have to be tailored to these differences in order to be effective. Unfortunately, the number of cases from one DCF district was not large enough to permit separate analyses of abuse by type. Thus, the analysis reported here, while valuable, may mask important knowledge that analysis of a statewide database would reveal.

A series of recommendations follows that address the above-mentioned shortcomings and other issues surrounding the current system for addressing elder abuse in Miami-Dade County as well as state-wide.

### **Recommendations**

Based on the findings and conclusions documented in this report the following recommendations have been designed to stimulate further dialogue on these issues and to chart a course for implementation of specific strategies:

1. The policies and practices of the Florida Abuse Hotline should be evaluated to improve responsiveness to reports of abuse, to insure language and cultural competency, and to determine overall effectiveness.
2. Data on ethnicity should be included in case files and recorded in the computerized file.
3. Data on family relationships, more detailed victim and perpetrator characteristics, and site of alleged abuse also should be included in case files and recorded in the computerized file.
4. Potential issues of confidentiality should be resolved where possible by means of encrypted coding to insure maximum sharing of data among agencies and to facilitate further research.
5. Primary agencies with responsibilities for identification, investigation, intervention, treatment and prosecution of elder abuse should continue to explore ways of establishing a common data base to facilitate routine exchange of case information and summary data.
6. The Department of Children and Families and United Home Care Services should analyze case profiles on a regular basis in order to expand their knowledge about types of abuse, characteristics of victims and perpetrators, location of incidents of abuse, and other important data. This information also should be shared with police departments, State Attorney's Office and other interested agencies and organizations.
7. The Department of Children and Families should support creation of an Adult Protection Team recommended by the Adult Protection Team Task Force in District 11. If this proves infeasible fiscally, DCF should seek funding to contract for these specialized services on an as needed basis. To the degree allowed by statute authorizing this team, this initiative should be designed to deal with remedial treatment of perpetrators as a means of ameliorating the abusive situation for victims.
8. The Adult Protection Team Task Force should become a community-wide Alliance Against Elder Abuse and be expanded to include the Alliance on Aging, Inc., United Home Care Services, Inc., and other interested agencies and organizations.
9. The Department of Children and Families and the Department of Elder Affairs should jointly develop and fund new program initiatives based on the domestic violence model of treatment of abuse, including specialized shelters, support groups, family counseling and other appropriate services.
10. The two departments, in collaboration with interested community agencies, should initiate an elder abuse prevention and community education strategy directed both at health professionals and the public-at-large.
11. Prosecution of elder abuse perpetrators should be based on probable cause, not the availability of a victim willing to prosecute.
12. The Department of Children and Families and the Department of Elder Affairs should establish a standardized community-wide system of training on issues of elder abuse, not only for Hotline Counselors and district staff, but also for police and fire rescue officials, prosecutors, court personnel, health and social services workers, staff of nursing homes and assisted living facilities as well as home based care agencies, and service agency personnel in the domestic violence field.

13. A public awareness campaign should be developed that includes information about what constitutes abuse, how to recognize it, how and where to report it, what happens when a report is made, and resources available to assist victims. The District 11 DCF website ([http://www.state.fl.us/cf\\_web/districts/11/](http://www.state.fl.us/cf_web/districts/11/)) has an excellent description of relevant information in an easy-to-read question and answer format. Culturally-sensitive information should also be distributed via more widely accessible media and specifically targeted to minority audiences. Because of the importance of religious institutions in these communities, effective outreach and education should actively involve churches and clergy throughout the community.

differences. Similar research should be conducted in institutional settings statewide to insure development of a comprehensive strategy to combat all forms of elder abuse.

To accomplish the above recommended activities, including maintenance of the liaison function with community agencies such as the courts, State Attorney's Office and police, as well as to maintain caseload size at appropriate levels, DCF should undertake a comprehensive assessment of staffing needs. (Such an assessment was not within the purview of the study reported here.)

In preparation for addressing the issue of APS staff turnover and the attendant resources consumed by the need to train new staff, DCF or the legislature should conduct a thorough evaluation of the competitiveness of APS salary levels. (The study reported here was not designed to address this issue.)

There should be statewide research on the issues identified in this report in order to verify findings and conclusions and to further examine data on: risk indicators of abuse by abuse type, profiles of victims and perpetrators, and community efforts at prevention and service, including the identification of regional

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### **The USF Training Academy on Aging at the Florida Policy Exchange Center on Aging**

The USF Training Academy on Aging was established in July 1998 to coordinate the university's approach to providing high quality, affordable and accessible training to public and private organizations serving elders in the Tampa Bay region. The Academy is a collaborative initiative involving the Florida Policy Exchange Center on Aging, Departments of Gerontology and Social Work, Institute on Aging, the Suncoast Gerontology Center, the Colleges of Nursing and Public Health, the Division of Lifelong Learning and the Louis de la Parte Florida Mental Health Institute. Combining the skills and expertise of the USF divisions will foster collaboration among the faculty and staff of the Departments of Medicine, Public Health, Arts and Sciences and Business to develop and provide professional training in areas such as long-term care, housing, case management, care-giving issues, etc. to staff of residential care facilities, case management agencies, state social service employees and health care providers, including hospitals, hospice, home health agencies, aging network organizations and managed care organizations.

**Examples of credit and non-credit courses that will be coordinated by the Academy include:**

- Behavior Management
- Case Management
- Caregiving Issues
- Cognitive Assessment
- HIV/AIDS Training
- Medication Management
- Mental Health Issues
- Sociological Aspects of Aging
- Death and Dying
- Diagnosis and Treatment of Alzheimers

**Examples of Certificate Programs include:**

- Not-for Profit Management Certificate (non-credit)
- Graduate Certificate in Gerontology (18 credits)
- Advanced Graduate Certificate in Gerontology (15 credits)
- Advanced Nurse Practitioner Certificate

***The Academy's Director is Dr. Kathryn Hyer***

### ***Florida Data Center on Aging***

The Florida Data Center on Aging is a new addition to the Florida Policy Exchange Center on Aging. Because it is a part of FPECA, the future roles of the Data Center are still being shaped.

The Data Center is a repository and resource center for data collections that relate to older populations, especially older Floridians. The data resources are made accessible to researchers at the University of South Florida and other collaborating universities. The Data Center also provides technical support in the areas of data management, statistical analysis, and research design to FPECA. One of the current priorities for the Data Center is the publication of an Older Floridian Almanac.

The Data Center is currently providing technical assistance under a contract with the Florida Medicaid Program to assist Florida Medicaid and the Florida Department of Elder Affairs (DOEA) with long-term care planning. The Data Center is linking and analyzing Medicaid enrollment data with information from DOEA on long-term care services for program evaluation purposes..

The Director of the Data Center is **Glenn E. Mitchell II, Ph.D.** Dr. Mitchell comes to FPECA from the Florida Agency for Health Care Administration where he served as AHCA Administrator for the Methodology and Special Studies Section of the State Center for Health Statistics. Previously, he was an Assistant Professor at Florida State University. Dr. Mitchell is now hiring staff to assist with the current mission and anticipated needs of the Data Center.

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