HOME- AND COMMUNITY-BASED CARE

A SUPPLEMENT, NOT A SUBSTITUTE, FOR NURSING HOME CARE

Herbert P. Weiss, M.A., N.H.A.

July, 1997

Introduction

The reallocation of Medicaid dollars from nursing home care to home health care has caused growing concern for those who seek to continue the provision of much needed nursing home care. In an effort to obtain definitive answers to the questions raised by the growing push toward home care, Rhode Island Health Care Association commissioned Herbert P. Weiss, NHA, to research the trend. His report concludes that home- and community-based care does not reduce nursing home utilization, nor does it reduce overall long term care costs. This report helps to clarify some of the serious implications of funding home care at the expense of nursing home care.

About the Author...

Herbert P. Weiss, M.A., N.H.A. writes, edits and consults in the aging and health care field. He is the 1994 winner of the American College of Health Care Administrators' 1994 Journalism Award, recognizing his outstanding journalistic contributions to the field of aging. In January 1997, he was selected as one of *McKnight LTC News's* "100 Most Influential People in Long-Term Care."

Professionally, Herb Weiss teaches gerontology courses at the University of Rhode Island. He was a former aging specialist to United States Senator Larry Pressler (R-SD) and was appointed to serve on the Rhode Island Advisory Commission on Aging. He has been a member of the Periodical Correspondents Association for admission to the U.S. Senate and House Galleries; a professional member of Sigma Phi Omega Honor Society in Gerontology; and a former member of the Board of Directors of the Maryland Coalition of Long-Term Health Care Providers, the Adult Health Development Program of the University of Maryland, and the Rhode Island-based Alliance for Better Nursing Home Care. In addition, he has been appointed to the editorial advisory boards of *Contemporary Long-Term Care, The Journal of Long-Term Care Administrators, McKnight's Long-Term Care News, Aging Network News, and the Brown Long-Term Care Quality Letter.* Herb Weiss has published more than 150 articles on aging and health care issues.

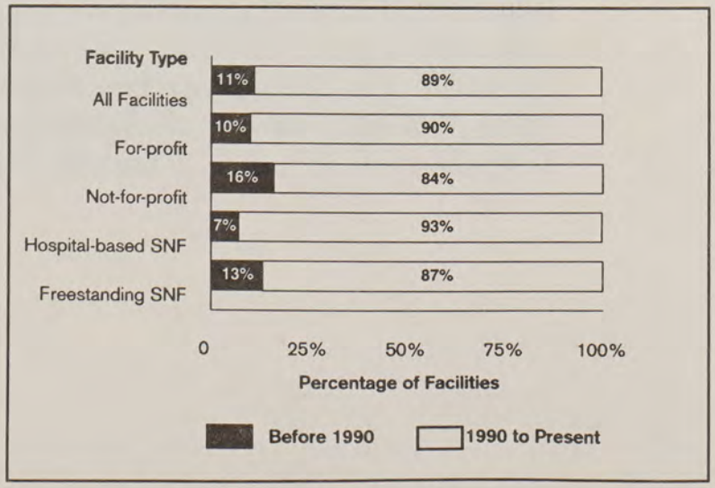
HOME- AND COMMUNITY-BASED CARE, A SUPPLEMENT, NOT A SUBSTITUTE, FOR NURSING HOME CARE

The skyrocketing elderly population, combined with double digit growth in Medicaid spending, plus recent federal efforts to block-grant Medicaid funds, has increased federal and state scrutiny of how Medicaid dollars are spent. Fierce budget battles are erupting across the nation. Elderly consumers and providers are coming together during legislative sessions to debate the merits of reallocating Medicaid monies from nursing homes to home health care in an attempt to lower program costs.

Numerous government studies, pilot projects and demonstration programs conducted over a 30-year period indicate that, despite evidence showing that home- and community-based services do lower costs on a per patient basis, these savings do not directly create overall savings for state Medicaid programs. Rising Medicaid costs can be controlled only if home- and community-based services reduce nursing home use and researchers have shown that such a reduction has not occurred due to a variety of factors. For instance, research studies indicate that home- and community-based care is most often used as an add on service, not a substitute for nursing facility care. Therefore, home- and community-based care cannot and should not be viewed as a substitute for the increasingly skilled care provided by nursing facilities.

"Although home- and community-based services should be adequately funded, now is not the time to take away resources from a growing number of frail elderly who require nursing home care."

Although home- and community- based services should be adequately funded, now is not the time to take away resources from a growing number of frail elderly who require nursing home care. While some reports (Harrington *et al.*, 1997; Ladd *et al.*, 1995) show that Rhode Island nursing home residents have acuity levels less than the national average, Rhode Island acuity is trending upward as the state's nursing home population grows older and hospitals continue to discharge patients "quicker and sicker" and in need of rehabilitation. In fact, over the past few years, a growing number of Rhode Island nursing homes have established subacute care units to take care of these patients. In caring for the sickest and frailest among the population in need of labor intensive 24-hour, skilled supervision, nursing homes should and will continue to play an important role in the long term care delivery system.



When Subacute Units Were Opened
Source: AHCA (1996). "Facts and Trends", Washington, D.C., p.6

A Growing Number of Elderly Need Long Term Care Services

In 1997, long term care is near the top of federal and state public policy agendas, as the first of 76 million baby boomers (people born between 1946 and 1964) reach their 50th birthday. By the year 2000, virtually all baby boomers will personally confront this policy issue firsthand as they will be forced to find long term care services for elderly parents.

Reflecting national trends, a high percentage of Rhode Island's population is aged; the state has the nation's third largest proportion of persons over age 65. The population's fastest growing segment consists of people over age 85, whose needs for long term care are particularly acute. (R.I. Department of Elderly Affairs, 1997)

A 1993 Census Bureau report estimates the likelihood of being admitted to a nursing home increases dramatically with age. Currently the oldest old (age 85 an over) comprises 53% of the total current nursing facility population of 1.6 million. This age group in nursing facilities is estimated to triple from 1990 to 2050 (AHCA).

RHODE ISLAND POPULATION PROJECTIONS BY AGE						
TOTAL	YEAR					
POPULATION	1995	2000	2005	2010	2015	2020
<5	66,128	64,872	58,204	55,843	57,396	63,711
5-14	128,341	132,345	131,963	124,195	115,269	114,616
15-24	139,120	145,384	153,502	157,795	157,676	150,083
25-34	153,655	129,675	118,060	124,583	132,987	137,578
35-44	162,295	166,989	150,895	127,253	115,896	122,693
45-54	117,424	138,620	157,868	162,837	147,289	124,176
55-64	80,410	89,500	110,542	130,949	149,632	154,567
65-74	82,711	73,423	68,465	77,003	95,732	113,702
75+	66,240	71,155	72,680	70,790	69,961	75,456
TOTAL	996,324	1,011,963	1,022,179	1,031,248	1,041,838	1,056,582

Rhode Island Department of Elderly Affairs, 1997

Spending Medicaid Dollars for Long Term Care Services

Medicaid pays the medical costs of more than 31 million low income persons. Of this total, slightly more than one-fourth (8 million) consists of elderly people who have physical and developmental disabilities and who therefore receive long term care services under this federal/state program. In 1993, nearly one-third (approximately $42 billion) of the nation's Medicaid monies was spent on long term care services. (U.S. General Accounting Office, 1994, pp. 1, 3)

To control costs, the federal government has since 1981 allowed states to experiment with Medicaid waivers, including service delivery models that increasingly emphasize home- and community-based care rather than institutionalized care. These alternate services include home health care, homemaker help and personal care, Meals on Wheels programs, respite care, and adult day care. Since May 1994, states operated 195 approved waiver programs and had applications pending for 34 more. (U.S. General Accounting Office, 1994, p. 5)

According to a 1995 survey conducted by the U.S. National Center for Health Statistics, approximately 5 percent of Americans over the age of 65 now reside in nursing homes, which have been the primary providers of long term care services. (U.S. Department of Health and Human Services, 1997). In 1995, states spent more than 81 percent of their Medicaid long term care dollars for institutional services; 19 percent of such dollars was allocated to home- and community- based services. (Burwell, 1996)

In fiscal year 1997, about $225 million of Rhode Island's $242 million long term care Medicaid funds paid for 24-hour comprehensive care given to 10,000 nursing home residents. In addition to Rhode Island's 10,000 nursing home residents, approximately 11,500 elderly who live at home experience difficulty with performing three or more activities of daily living (ADLs), far more than the typical home care recipient. (American Health Care Association, 1996, p. 10, R.I. Department of Elderly Affairs, 1993, p.74) These people are obviously prime candidates for residency in a nursing home.

Serious Medical Problems Are Treated in Nursing Homes

Proponents of expanded home care services argue that such care would substantially substitute for costly nursing homes. These advocates believe that most nursing home residents require only custodial assistance and can care for themselves with minimal assistance at home, thereby legitimizing less costly alternatives to institutionalization. However, most nursing home residents are frail and require nursing care and rehabilitation therapies that, because of changes in Medicare's reimbursement of acute care, are more intensive than was the case a decade ago. (Hallfors, 1993, p. 6)

"Up to 88 percent of all nursing home residents exhibit some form of mental health problems, including dementia."

National studies find that nursing home residents often suffer multiple chronic problems and need assistance with activities of daily living (ADLs). Today's residents need help with an average of 3.9 ADLs which include eating, bathing, toileting, dressing and transferring from bed to wheelchair. (American Health Care Association, 1996, p.9) By comparison, patients in the community need assistance with only 2.5 ADLs. (U.S. Department of Health and Human Services)

"Regardless of the physical illness cited in a resident's medical chart, a contributing factor in most nursing home admissions is a problem with mood, behavior, or cognition that limits self care or makes home care virtually impossible." (Lombardo *et al.*, 1996, p. 6) Up to 88 percent of all nursing home residents exhibit some form of mental health problems, including dementia. (Smyer *et al.*, 1994) According to a national report, the average percent of U.S. residents reported with dementia was 40.5 percent in 1995, in Rhode Island that figure was 48.5 percent. (Harrington, C., *et. al.*, 1997, p. 27) "In Rhode Island, nursing facilities provide a good quality of service to a range of very impaired elderly and disabled adults, many who suffer from some form of mental problems including dementia, making home-based services impractical or inefficient." (Long Term Care Coordinating Council, 1994)

Bruce Vladeck, former president of the United Hospital Fund of New York and most recently administrator of the Health Care Financing Administration, described in 1989 a demographic trend indicating that nursing homes would increasingly be taking care of "pretty ill and pretty disabled" residents. He noted that "almost all residents have multiple, serious medical problems; perhaps as many as half [of these residents] have significant cognitive impairments."

Vladeck called for "a continued reliance on nursing homes to care for at least those who are most impaired or most lacking [in] other supports." (Vladeck, 1989, p. 215) He also declared that "of all functionally impaired elderly persons, those most likely to use institutional services are those with the weakest family supports, the lowest incomes, and those who are most socially isolated." (Vladeck, 1989, p. 217)

"Despite the growing number of frail elderly people being cared for in their homes, a growing number of these individuals need intensive care and supervision that can be provided only in a nursing facility."

Despite the growing number of frail elderly people being cared for in their homes, a growing number of these individuals need intensive care and supervision that can be provided only in a nursing facility. Regulatory oversight of quality of care is more assured in these facilities as opposed to the patient's home.

Besides treating frail residents with mental health problems, nursing facilities are quickly moving into the subacute care market. In

response to this trend, facilities have established special AIDS, Alzheimer's and rehabilitation units to care either for residents with serious medical needs that cannot be accommodated in a home setting, or for medically complex patients who would otherwise have to be treated in an expensive acute care setting. Today, medically complex patients admitted to 470 subacute care beds in 17 Rhode Island facilities receive a multitude of services, including intravenous therapy, tube feedings, complex wound management, respiratory car, injections and rehabilitation for orthopedic and stroke patients. (Rhode Island Health Care Association, 1997)

Cost Effective Home Care: Myth or Reality?

More than 30 years of research have not shown home- and community-based care to be more economical or more effective than nursing facilities in providing long term care services. (Weissert, 1991, p. 68) A sampling of these studies follows.

No Decrease in Total LTC Costs

Research indicates that providing home care services does *not* decrease total long term care costs. Studies that have analyzed demonstration projects found that the "savings" from reduced nursing home usage were offset by the extra costs of home care (e.g., case management and community services). (U.S. Department of Health and Human Services, 1986, p. 13; Weissert, Cready and Pawelak, 1988; Thornton, Dunstan and Kemper, 1988)

An evaluation of the federally funded National Channeling Demonstration Projects, implemented at 10 sites nationwide between 1981 and 1985, found that increased home care services even when used as a substitute for nursing home care cause little reduction in total long term care expenditures. Although these multimillion dollar demonstration projects expanded home care services ostensibly to lower costs, studies of this federal initiative estimated that health and long term care costs increased by 14 to 28 percent because community-based services did not replace nursing home and hospital care. (U.S. General Accounting Office, 1987) One subsequent study pegged the increase at 18 percent. (Kemper et al., 1988, p. 166)

Research findings indicate a variety of reasons why community care increased overall use of health services as well as total expenditures.

Home care services are viewed as an add on service. According to Weissert, most of the elderly tend to use home and community care as an add on to existing care rather than as a substitute for nursing home care. (Weissert, 1985, p. 424) Studies of the National Channeling Demonstration Projects found that most of the elderly receiving community-based services were not at risk for institutionalization and would have stayed out of nursing homes without community care. (Weissert, 1985, p. 424; Wooldridge and Schore, 1988, p. 119)

When home- and community-based services are expanded, a "woodwork effect" is created, attracting new users who "come out of the woodwork" to take advantage of the new benefit. Thus, "the costs associated with large increases in home care more than offset small reductions in nursing home use." (Wiener and Harris, 1990, p. 32)

Nursing home stays are short. Only a small number of persons who enter nursing homes remain for long periods; in most cases, patients who are admitted either die within a short period or are discharged to another setting. (Vladeck, 1989, p. 217) "Estimates are that between 46 percent and 64 percent of nursing home stays last less than one year, and that between 26 percent and 45 percent last less than three months." (Wiener and Harris, 1990, p. 31) According to other researchers, patients who reside in a facility for more than three years account for only about 20 percent of admissions but 70 percent of total patient days. (Wiener and Harris, 1990, p. 31) Finally, one study found that approximately 25

percent of nursing home residents go back to their own homes, with an additional 3 percent moving into retirement homes. (Weissert, 1985, p. 424)

Community care has not been shown to be effective in reducing nursing home costs. Research studies conclude that the effect on institutionalization rates is usually too small. The savings that typically result from reduced nursing home usage are too small to offset increased community-based costs. (Weissert, 1985, p. 426; Hallfors, 1993, p. 8; Greene, et al., 1993)

Naive at best is the policymakers' notion that providing home- and community-based care will reduce costs because some elderly prefer it and will use it as a substitute for nursing homes. Patients who choose home- and community-based care are often not those at high risk for admittance to nursing homes; thus, total long term care costs may continue to rise. (Sanger, 1995, p. 4)

On the other hand, using home care as a primary care service rather than as a supportive service caused home care costs to consume about 63 percent of all Medicaid dollars spent on home care in New York. Home care became the fastest growing item on the state's $13.9 billion Medicaid budget, doubling to $2.4 billion in just four years. (Reimbursement Bulletin, 1993)

Few elderly are at high risk for institutionalization. Most nursing home admissions are tied to being unmarried and to dependence on assistance with ADLs; few elderly receiving home health care meet these criteria. (Weissert, 1985, p. 426; Weissert and Hedrick, 1994, p. 352) "As a group, home care patients are about five years younger than nursing home residents, and they suffer few risk factors for nursing home use. More home care patients are married, fewer have multiple dependencies in activities of daily living, fewer suffer mental disorders." (Weissert and Hedrick, 1994, p.352) To be a cost effective substitute for nursing home care, community-based services must be targeted to elderly individuals who, without such care, would become long term residents of nursing facilities. (Greene et al., 1993)

Screening costs are high. Applicants must be carefully screened to determine their high risk status and their appropriate placement in a nursing facility. Screening and assessment costs are a major economic component of community care programs. (Weissert, 1985, p. 427; Weissert, 1991, p. 69) Most researchers agree that proper screening and eligibility policies for waiver programs might be key factors to produce overall savings.

Changes in health status are limited. Community-based services improve patient and caregiver satisfaction; however, research studies find that such services do not produce better outcome benefits in terms of longevity, physical or mental functioning, or level of social activities. (Weissert, 1985, p. 428; Hallfors, 1993, p. 8; Sanger, 1995, p. 4)

"Naive at best is the policymakers' notion that providing home- and community-based care will reduce costs because some elderly prefer it and will use it as a substitute for nursing homes."

In addition, not to be ignored is the fact that numerous problems can and do emerge regarding the provision of informal home care. Most elderly prefer to receive care in their most comfortable and familiar setting: their homes. However, numerous obstacles, eg., physical or mental limitations; lack of financial resources; poor relationships between elderly people and their family; and child care duties might prevent informal caregivers from providing care. Furthermore, research findings indicate that modest amounts of paid home care do not change the amount of care provided by informal caregivers (i.e., family and friends) who will choose to provide the same amount of care. (Wiener and Hanley, 1992, p. 88)

Conclusions

Research findings indicate that home- and community-based care do not reduce nursing home utilization. Further, home- and community-based care cannot be justified as cost effective or as ways to improve clinical efficacy and health outcomes.

Elderly persons with functional impairments who reside in the community but do not require skilled nursing care and are not severely disabled are good candidates for home- and community-based services. However, structural changes in the health care delivery system coupled with demographic changes are driving up the numbers of frail elderly nursing facility residents who require intensive skilled care, support and supervision. Keeping these individuals in their homes is not the most appropriate option; they are best served in nursing facilities.

REFERENCES

American Health Care Association (1996). "Facts and Trends,"Washington D.C.

Burwell, B. (1996). "Medicaid long-term Care Expenditures in FY1995." Memorandum from The MEDSTAT GROUP, Cambridge, Mass. Cited by Alecxih, L.B. and Corea, J. (1996). Estimated Cost Savings From the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States. AARP Public Policy Institute. Washington, D.C.

Choices, (1997). "FY 98 Legislation & $8 Million Budget Proposal." Providence, RI.

Greene, V.L.; Lovely, M.E.; and Ondrich, J.I. (1993). "Do COMMUNITY BASED Long Term Care Services Reduce Nursing Home Use?" Journal of Human Resources, Vol. 28 (2).

Hallfors, D.D., (1993). "State Policy Issues in Long Term Care for Frail Elders, Center for Vulnerable Populations," Institute for Health Policy, Brandeis University. Waltham, Mass.

Kemper, P. (1988). "The Evaluation of the National long-term Care Demonstration," Health Services Research, Vol. 23 (1), pp. 161-174.

Ladd, R.C., Kane, R.L., and Nielson, W.J. (1995). "States LTC Profiles Report," Institute for Health Service Research, School of Public Health, University of Minnesota.

Lombardo, N.B.; Fogel, B.S.; Robinson, G.K.; and Weiss, H.P. (1996). "Overcoming Barriers to Mental Health Care," Hebrew Rehabilitation Center for the Aged, Research and Training Institute, Boston, Mass.

Long Term Care Coordinating Council, (1994). "Long Term Care Plan for Rhode Island: 1995-2000. Working Together: Making All The Pieces Fit," Office of the Lt. Governor, Providence, RI.

Reimbursement Bulletin. (February 16, 1993). "New York Officials Sound Alarm Over Burgeoning Home Care Bill," Vol. 5 (17). Cited in AHCA background paper, "Home Care & Nursing Home Care: Serving Separate Populations."

R.I. Department of Elderly Affairs, (1997). FY 1998 budget presentation.

R.I. Department of Elderly Affairs, (1994). Rhode Island Profiles.

Rhode Island Health Care Association, (1997). Phone survey.

Sanger, M.A. and Arling, G.(1995). A Review of Community-Based Long Term Care with Emphasis on Wisconsin's Community Options Program. Network for Health Policy Research.

Smyer, M.A; Shea, D.G.; and Streit, A. (1994). "The Provision and Use of Mental Health Services in Nursing Homes: Results from the National Expenditure Survey," The American Journal of Public Health, Vol. 84.

Thornton, C.; Dunstan, S.M.; and Kemper, P. (1988). "The Effect of Channeling on Health and long-term Care Costs," Health Services Research, Vol. 23 (1), pp. 129-142.

U.S. Department of Health and Human Services (March 28, 1994). "Advance Data," No. 247; and HCFA OSCAR data.

U.S. Department of Health and Human Services (January 23, 1997). "Advance Data," No. 280.

U.S. Department of Health and Human Services (May 1986). "The Evaluation of the National long-term Care Demonstration: Final Report/Executive Summary," report prepared by Mathematica Policy Research, Inc.

U.S. Government Accounting Office. (1987). "Medicaid: Determining the Cost Effectiveness of Home and Community-Based Care Services." GAO/HRD-87-61.

U.S. Government Accounting Office. (1994). "Medicaid Long Term Care: Successful State Efforts to Expand Home Services While Limiting Costs." GAO/HEHS-94-167.

Vladeck, Bruce. (1989). "Long Term Care for the Elderly: The Future of Nursing Homes," Western Journal of Medicine, Vol. 150 (2), pp. 215-220.

Weissert, W.G.. (Summer 1991). "A New Policy Agenda for Home Care," Health Affairs, pp. 67-77.

Weissert, W.G., Cready, C.M., & Pawelak, J.E. (1988). "The Past and Future of Home and Community based long-term Care," The Milbank Quarterly, Vol. 66 (2), pp. 309-388.

Weissert, W.G. (1985). "Seven Reasons Why It Is So Difficult to Make Community Based LTC Effective," Health Services Research, Vol. 20 (4), pp. 423-433.

Wiener, J.M., and Harris, K.M. (1990). "Myths and Realities: Why Most of What Everybody Knows About long-term Care is Wrong," The Brookings Review, pp. 29-34.

Wooldridge, J., and Schore, J. (1988). "The Effect of Channeling on the Use of Nursing Homes, Hospitals, and Other Medical Services," Health Services Research, Vol. 23 (1), p. 119130.

rihca

Setting The Pace In Nursing Home Care

57 Kilvert Street, Warwick, RI 02886-1009
401-732-9333 • Fax: 401-739-3103