Closing the Gaps: Opportunities for Aging Well

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Introduction

Older adults are an asset to Michigan communities for the inestimable wisdom, lived history, and culture they impart as well as the positive economic impact they have on our communities. We are all impoverished by their loss, but not equally so. During the first 14 months of the COVID-19 pandemic, nearly 114,000 American children lost a parent or custodial grandparent.[1,2] And the disproportionate loss of older people of color (people of Black, Hispanic, and indigenous descent) and veterans, COVID-19 only compounded alarming disparities in healthcare quality and access to vital services that plagued these communities long before the current pandemic.[3]

Yet, some positive change might have come out of the loss experienced during COVID-19. As a result of the pandemic, the federal government changed Medicaid policy to benefit older adults; the State of Michigan is considering rebalancing its Medicaid investment away from institutional care toward the home- and community-based services older adults overwhelmingly desire; the American Rescue Plan Act (ARPA) of 2021 earmarked billions in funding for badly needed one-time investment in our state; and Michigan's Direct Care Workforce Taskforce conducted research for a forthcoming report that will help to focus this federal investment and advocates' efforts where they are needed most.

In short, Michiganders have a once-in-a-lifetime opportunity to envision, fund, and realize a future where all older adults can access the healthcare, services, and supports they need without exception. As the following report will show, this opportunity is, in fact, a conscientious choice between two potential futures. The first—where access to care is limited to a homogenous and wealthy few who can afford and access the care they need—is our current trajectory. Without change, this future is exceedingly likely. Yet it is not inevitable. The second, more inspiring future, is a real possibility. It may look something like the best practices highlighted in the following pages: improved broadband internet and expanded telehealth; smaller and more numerous community-based alternative housing options for older adults; greater availability of direct care workers and support for family caregivers; and integrated use of appropriate technologies to bring institutional-quality care to the comfort of one's home (without the price tag or life disruption of an emergency room visit).

We can't change the past. But we must seize the present opportunity for our elders, our children, and ourselves. After all, the future we re-envision together today is the future we will live in tomorrow.

Priorities Moving Forward

Investment in Home- and Community Based Services Saves Lives and Improves Quality of Life

Long Waitlists: Current Challenges with Nursing Home Level Care Availability

Institutional care is rarely a desirable alternative when a person has access to ample HCBS. Yet Michigan disproportionately invests its Medicaid LTSS dollars in institutional care, to the detriment of HCBS—in 2016, the state ranked 45th (below the national average) in its proportion of LTSS expenditures in HCBS.[4,5,6,7] According to MDHHS, in 2017, 57 percent of Michigan's Medicaid LTSS expenditures supported institutional care facilities, while only 43 percent of expenditures supported HCBS.[8] As a result, when older adults attempt to access HCBS, many are relegated to waitlists due to high demand for care and undermatched supply for programs like PACE, MI Choice, Area Agencies on Aging (AAAs), and others. Many others go to nursing homes by default.

From 2015 to 2021, the waitlist for AAA-provided in-home services funded through Medicaid has averaged 5,100 clients, with half waiting six months or longer for services.[9] Of Michigan's 16 AAA regions, only one region did not have a waitlist and only five had waitlists of fewer than 100 older adults.[10] More worrisome, older adults who remain on waitlists are five times more likely to end up in nursing homes, if a nursing home is available at all.[11]

Older adults who prefer not to, or cannot, rely on family caregivers should be able to consider HCBS as a care option. Greater support for HCBS could provide access to high-quality services in older adults' preferred setting, improve person-centered coordination, and allow older adults to remain in their homes.[12] It's also cheaper and safer. AAAs can provide in-home services for an average annual cost of only $1,250, compared to more than $100,000 for traditional nursing homes,[13,14,15,16] and older adults are at reduced risk of contracting communicable diseases like COVID-19 in smaller, community-based care settings. After all, nursing homes are not hermetically sealed, and studies show that community-based factors are more predictive of negative outcomes than nursing home quality itself.[17,18] These facts have sparked worldwide calls for a shift to home and community-based care as a primary public health strategy for contagion prevention.[19]

Alternative Futures for Nursing Home Level Care: The Green House® Model

Nontraditional, smaller-size programs employing the Green House® model, for example, better protect at-risk older adults than do traditional nursing homes by limiting staff assignments to the same residents and placing residents in private rooms.[20] During the COVID-19 pandemic, infection and death rates have been higher in nursing homes than among the general population[21] and higher than among residents of nursing home regional hubs for COVID-19 patients,[22] Program of All-inclusive Care for the Elderly (PACE) participants,[23] as well as Green House® and other nontraditional nursing home residents.

There are more than 300 Green Houses® across 32 states. Each typically lodges only ten to 12 residents. Green Houses® intentionally create smaller, individualized spaces—smaller building footprint, private rooms and bathrooms, and a central entry. Exemplary Green Houses® like Porter Hills Village in West Michigan and Presbyterian Villages in Southeast Michigan both offer a myriad of options for older adults with unique needs and coordinate with multiple state and federal programs, including Medicare, Medicaid, and PACE.

Located in Detroit's Thome Rivertown Neighborhood, Presbyterian Villages established the country's first PACE Green Houses® in 2017.[24] In Grand Rapids, Porter Hills Village has taken an innovative approach to the Green House® model's concept of a small, home-like setting by developing the first LEED-certified standalone homes not located on an existing nursing home

campus. In addition to the trademark private resident rooms and connected private baths, each skilled nursing standalone home comprises a modern hearth area that combines the living, dining, and kitchen spaces, a library, and a staff work area modeled after a home office.[25] Through strides in innovation, collaboration, and person-centered care, Michigan has been a national pioneer in Green House® model development since 2017—a leadership role we should expand to continue benefitting Michigan's aging population.

The Green House® project has been hailed as a successful alternative nursing home care model not only because of its lower COVID-19 incidence and mortality rates, but also because it reduces preventable hospitalizations and improves residents' quality of life.

Consistent, universal staff assignments performing continuity of care also naturally limits widespread interpersonal interaction. The same staff are assigned to the same residents to avoid a parade of staff with individualized tasks. The improved quality of life over traditional nursing homes could also result from many Green Houses® being operated by nonprofit organizations and paying their certified nursing assistants more than traditional nursing homes. It is worth noting that Green Houses® tend to serve fewer people with COVID-19 comorbidities.[26]

Rebalancing Medicaid LTSS dollars into HCBS could lower hospital readmission rates as well as provide better physical health and LTSS benefits coordination and quality for high-cost, high-needs populations.[27]

Telehealth Access: Current Challenges with Hospital Care

Providing older adults with the right resources, in the right setting, at the right time is crucial to preventing unnecessary institutional care. Intentional and widespread access to assistive technology, along with its incorporation into older adults' care plans, could significantly improve their health outcomes and quality of life by preventing emergency room (ER) visits and hospital readmissions and decreasing the cost of care.[28] Having access to equipment and remote personnel to help gauge vital organ functioning and address mental and physical health crises can translate to immediate support for older adults and their caregivers.

Normalization of telehealth could lower the risk of COVID-19 exposure, reduce the burden and cost of travel, improve access to care, lower out-of-pocket costs, and reduce unnecessary hospitalization and nursing home care. In the long run, successful and regular assistive technology use establishes trust in the technology—and older adults' confidence using it correctly—which can better support HCBS and aging in place.[29] For DCWs, greater assistive technology utilization can help with recruiting and job training, supplement more strenuous daily tasks, and encourage accurate recordkeeping and communication.[30] Continuous

participation in telehealth services could also help older adults (and their caregivers) monitor and maintain their health while on the waitlist for HCBS and potentially avoid nursing home or VA admission altogether.

Limited access to HCBS was a key contributing factor to veteran COVID-19 mortality. Nearly four in five Michigan veterans (78 percent) are older adults (age 50 or older), compared to less than 7 percent of Michigan residents as a whole.[1][31,32,33] COVID-19 was lethal for many Michigan veterans, including women veterans, who were particularly hard hit. Women veterans who contracted COVID-19 had a mortality risk four times higher than women veterans who did not.[34]

Prior to the COVID-19 pandemic, only 14 percent of U.S. Department of Veterans Affairs (VA) care was provided virtually.[35] During the pandemic, VA hospitals simply could not keep up with in-person demand. When critical care capacity became strained during the peak of the pandemic, care suffered. Veterans treated in the VA intensive care units (ICUs) during periods of peak COVID-19 ICU demand had a nearly twofold increased risk of mortality compared with those treated during periods of low demand.[36]

Greater availability of—and pandemic-induced push for—telehealth technology use has increased, but mostly for younger, higher-educated, non-rural white patients. During summer 2020, research measuring telehealth use in the upper Midwest showed that patients who are older, live in rural settings, and are self-pay or uninsured status are less likely populations to utilize telehealth services.[37] Additionally, many within communities of color were unlikely to have a medical video visit, including Asian, Black, and Hispanic patients.[38] American Indian/Alaskan Native patients were more likely to use telehealth services, along with patients supported by Medicare and Medicaid.[39]

By June 2020, 58 percent of VA care was provided virtually—a promising 44 percent increase from before the pandemic.[40] Also promising is that patients with lower income, higher disability, and more chronic conditions were more likely to receive virtual care during the pandemic.[41] However, more than two in five veterans still lack access to virtual care, and veterans with low utilization of VA services before the pandemic were less likely to navigate the transition to virtual care.[42] Older veterans, veterans in rural locations, and those with lower income may be particularly vulnerable to the negative impacts caused by the digital divide—lack of technology access and inability to navigate that technology—and may face larger barriers to care while sheltering in place.[43] They deserve a better solution.

[1] Sources show a discrepancy in the percentage of Michigan's population who are veterans (5.5 percent, according to 2019 Census estimates, compared to 6.6 percent, according to the VA).

Alternative Futures: In-home Ambulatory Care

In 2016, Trinity Health developed the Whatever It Takes program, leveraging the 911 system—along with teams of community paramedics, nurses, and primary care physicians—to provide rapid, in-home medical, mental health, and social service triage to older adults in Michigan. Through this integrated, community-based delivery system, Trinity Health provided more timely care, prevented ER visits among 73 percent of participants, reduced ER and paramedic care costs by $500,000, and secured long-term support from payers. In addition, the Centers for Medicare and Medicaid Services Emergency Triage, Treat, and Transport (ET3) model embraced components of the program and is now implementing them nationwide.

Whatever It Takes Program

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Alternative Futures: University of Michigan Veterans Telehealth

Telehealth also has nearly limitless potential to support older adult patients' exercise and rehabilitation while reducing the institutional burden on the VA system. The University of Michigan partnered with the VA Ann Arbor Healthcare System to help older veterans improve their physical activity regimen after being discharged from the VA hospital. Access to

telehealth services and wearable sensor technology encouraged more than 70 percent of eligible veterans to take part in increasing their mobility. After participating six months in this initiative, the cohort's mean total steps increased by 1,892 and their average sedentary time decreased by two hours.[44]

Yet such solutions also require investment. Access to the minimum recommended 25M/3M broadband internet is spotty across Michigan.[45, 46] While fixed, non-mobile broadband service is widely available (80–100 percent) in 65 percent of Michigan's counties, rural areas struggle to meet those broadband availability rates.[47]

Michigan could develop competitive grant programs to provide faster internet speeds in targeted markets while ensuring greater accountability for managing public funds and encouraging matching funds and buy-in from local organizations and government units.[48] Such investment in public infrastructure meets older adult services agencies halfway, as many have already made private investments in their infrastructure to accommodate this need. The Silver Key Coalition, a collaborative of organizations advocating for an increase in state supported in-home services through the MDHHS Health and Aging Services Administration, found that 87 percent of older adult service agencies experienced increased costs to safely deliver services during the COVID-19 pandemic.[49] Of that total, 46 percent of agencies reported higher technology costs as people increasingly relied on online and telehealth services.[50]

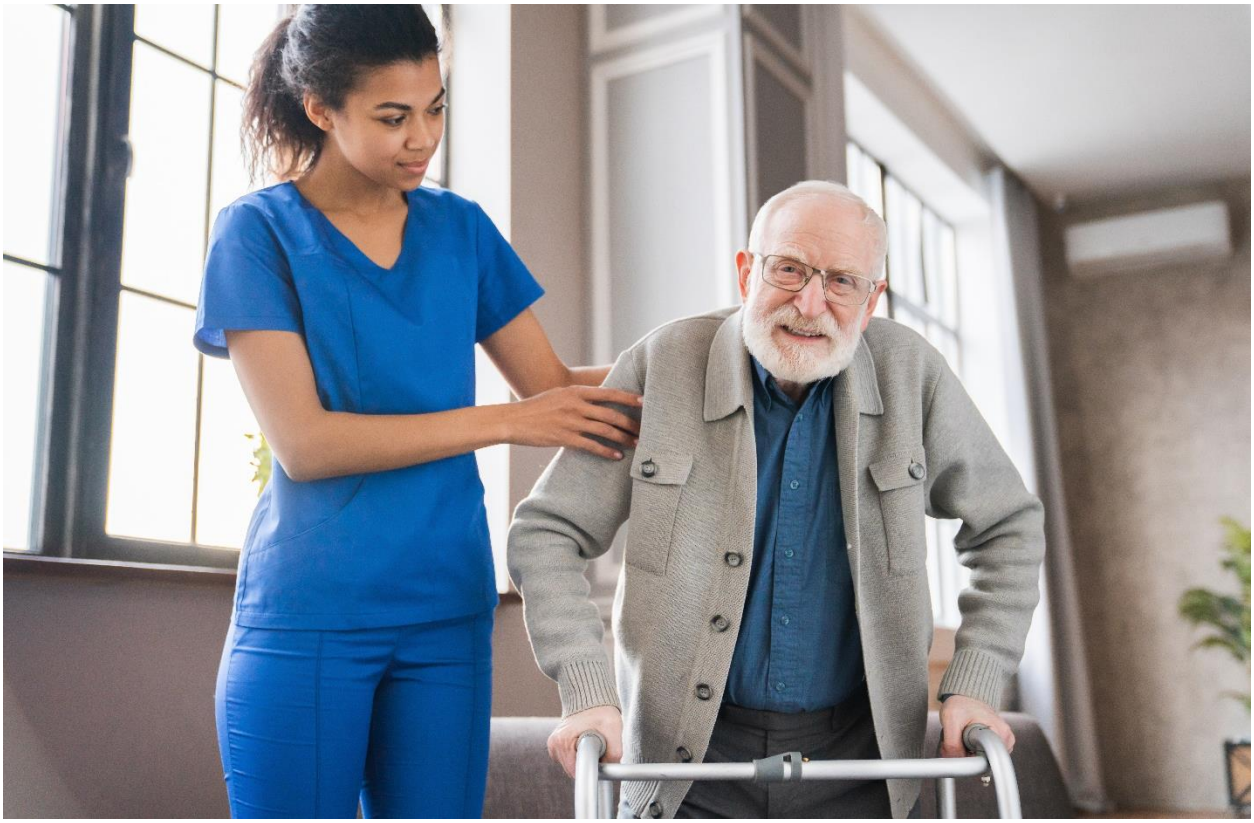
Direct Care Worker Shortage: Current Challenges with In-Home Care Availability

A disproportionate number of Michigan's direct care workforce are people of color when compared to their proportion of the state population.[51] On average, 33 percent of DCWs are Black and only 57 percent are white, compared to Michigan's total population (14 percent Black and 79 percent white, respectively).[52] Considered essential employees, DCWs experience significantly worse COVID-19 exposure risk as low-wage earners—low-wage earners are more likely to live with large groups of people, in multigenerational households, than their higher-paid counterparts.[53,54] DCWs face risks to their household health and financial security, given that frontline workers often have little financial cushion, potentially posing a challenge to take time off work.[55]

According to MDHHS, Michigan needed an additional 34,090 DCWs to meet anticipated demand for community-based care in 2020.[56] The pandemic has steadily increased this demand, even beyond the existing DCW shortage, and still more DCWs will be needed in the future to help care for a rapidly growing aging population.[57] Yet uncompetitive pay, low job satisfaction, and unpredictable, part-time schedules make attracting new DCWs and retaining existing DCWs a very tall order. If we do not find ways to address these trends, in-home care

services will only be available to those with resources. Not addressing these trends will cause lower-income populations to use more expensive and less independent tax-payer alternatives such as nursing homes, exacerbate the DCW shortage, and most importantly, prevent older adults from choosing how they age and the ability to age with dignity.

Such massive industry change will not occur overnight. Efforts to improve the paid direct care workforce must be augmented by strategies that expand support for unpaid family caregivers who represent a much larger share of older adult care providers statewide. Every year, nearly 1.3 million Michiganders shoulder considerable socioemotional, physical, and financial demands to help their older loved ones live independently at home and avoid being readmitted into hospitals or forced to move into nursing homes.[58] This invisible, unpaid workforce in Michigan's healthcare system provides voluntary care to their loved ones worth approximately $14.5 billion per year in aggregate.[59] Family caregivers also spend significant portions of their own income in the process. More than 78 percent of family caregivers incur out-of-pocket caregiving expenses–$7,000 per year on average–on home modifications, at-home care, transportation, equipment to help with daily living, and more.[60]



Alternative Futures: IMPART Alliance Direct Care Worker Talent Pipeline

Incentives such as stipends for workers' hazard costs—emotional and physical burden, or contracting and spreading COVID-19, for example—and unmet emergency needs such as childcare and transportation struggles could also stabilize Michigan's paid direct care workforce.[61] Another option to entice and retain new DCWs is to expand apprenticeships and career development programs in high schools.[62] One example is IMPART (Integrated Model for Personal Assistant Research and Training) Alliance, supported by the Michigan Health Endowment fund, one of the state's first personal care aide technical training programs for high-school students that uses the evidence-based *Building Training…Building Quality* curriculum.[63] IMPART could be expanded to other Michigan high schools, and sustained by public school funds would then pay for this high-school program.[64]

IMPART is one of the state's first evidence-based PCA training programs to encourage and sustain direct care workforce participation beginning in high-school.

Conclusion

Michigan residents of color died from COVID-19 at far higher age-adjusted rates than whites (controlling for other factors) and were also less likely to benefit from COVID-19 vaccination.[65,66,67,68] Yet COVID-19 simply exacerbated the shortcomings of institutions like traditional nursing homes, which fostered congregate settings that aggravated the spread of COVID-19 and overburdened VA hospitals, where survival rates declined during peak hospitalization, controlling for other factors.[69,70] Michigan can choose a brighter, more equitable future for all its older adults by ensuring greater access to smaller congregate settings, such as Green Houses®—in which Michigan has been a national pioneer—and improved access to home- and community-based services (HCBS), in which Michigan has lagged. However, Michigan must invest in remote access to telehealth providers, reliable, paid in-home care provision, and a strengthened direct care workforce on which this future depends.

A Call to Action

This report describes promising practices that Michigan could choose to adopt or expand by making use of federal funding available to the State of Michigan under the American Rescue Plan Act (ARPA) of 2021.

Promising and proven options exist, but access to them remains limited in Michigan due to a lack of HCBS providers in underserved areas, the continuing digital divide, and shortages of qualified, affordable direct care personnel.

AARP calls on policymakers to take steps to:

- Jumpstart efforts to rebalance Michigan's long term care system and increase residential care options for Michiganders by increasing access to MI Choice, PACE, and alternative residential care settings such as Green House small nursing homes.
- Expand access to affordable, reliable high-speed internet for Michigan residents in underserved areas, and support efforts to provide digital educational programs targeted at older adults.
- Support family caregivers, including by passing a state income tax credit for family caregivers who pay expenses out of their own pockets to help care for an older family member.
- Address critical shortages in Michigan's direct care workforce by advancing the recommendations of the Direct Care Workforce Advisory Committee, including efforts not just to increase wages, but to increase job satisfaction through improved staffing models and comprehensive training, credentialing, and career pathways.

Over the past decade, Michigan policymakers have pursued and achieved partial progress toward many of these goals, and AARP applauds those efforts. However, we know Michigan can do better. The above recommendations can improve quality of life for millions of Michiganders, for years to come.

AARP appreciates the opportunity to engage with policymakers and stands ready to assist in any way we can to help ensure the successful implementation of these goals.

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