Where Do We Go From Here?
Long-Term Care in the Age of the Baby Boomers

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I. Introduction

We have yet to meet a client who wants to spend his or her final years in a nursing home. Instead, aging in place has become the new meme of senior living. In a previous article in NAELA Journal,2 we explored this concept, highlighting residential models that promise to allow seniors to remain in the community. We described housing trends that incorporate amenities and services that seniors need in a more efficient and economical manner than traditional suburban neighborhoods. We also noted the proverbial elephant in the room: Aging in place cannot become a reality without integrating affordable long-term care services.3

The type of coordinated and focused effort being brought to bear to promote aging in place has not yet emerged for revamping the long-term care system. Although there is much discussion about the difficulties in financing long-term care, there is less focus on service delivery.4 We began to wonder, why has there been so little reform in the provision of long-

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1 In this article, we define baby boomers as those born between 1946 and 1964, which seems to be the most common definition
3 “Although the focus of this article is on the residential component, it is clear that one of the most significant measures of the success of any model for aging in place is the ability to provide home and community-based services and supports in a cost-effective manner.” Id. at 233.
4 See Howard Gleckman, Policy Experts Agree: The U.S. System for Financing Long-Term Care is Crumbling,
The number of individuals in nursing homes has stayed essentially constant during the past 30 years. During this period, the need for long-term care services has grown substantially. Nearly one-half of older adults, or 18 million people, have difficulty with or receive help with their daily activities. Over the past 15 years, we have seen major growth in the population over 80, the majority of whom need long-term care services; however, this has not resulted in the proliferation of new models of long-term care. Interestingly, the same population anomaly that has preserved the status quo now is likely to be the impetus for change: baby boomers.

During the past 20 years, large numbers of baby boomers have provided care to family members, thus mitigating the need for formal care. Approximately 90 to 95 percent of seniors rely on family members for some or all of their care needs. Nearly 3 million individuals who need assistance with three or more activities of daily living (i.e., who require nursing home level of care) do not live in nursing homes. Most of these individuals have at least one family caregiver. Unfortunately, this trend will not continue.

As boomers shift from caregivers to those in need of care over the next several decades, the strain on an already stressed long-term care system will be overwhelming. The demographic projections are stunning. Between 2010 and 2030, the population over age 80 will increase by 79 percent, while the population 45 to 64 will remain roughly the same. Between 2030 and 2040, the over-80 age group will continue to grow, increasing by an additional 44 percent.

The care needs of this population cannot be supported by a shrinking pool of informal caregivers, and our current paid care models are vastly insufficient. The cost of traditional long-term care is simply too expensive. A study by AARP found that long-term care services and supports are unaffordable for middle-class families in every state. Even home care costs consume approximately 84 percent of median income. Medicaid budgets are already overwhelmed with nearly half of Medicaid spending (more than $120 billion in fiscal year 2012).


6 Vicki Freedman & Brenda Spillman, Disability and Care Needs among Older Americans, 92 Milbank Q. 509 (Sept. 2014).


9 Freedman & Spillman, supra n. 6, at 509.

10 Redfoot et al., supra n. 7, at 5.

11 Id. at 6.

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Spring 2015

being consumed by long-term care. 13

These demographic and financial realities demand a policy response. There has been
much discussion about the challenges the above-described demographics will create for fund-
ing long-term care for the baby boomer generation. A number of studies have explored public
and private long-term care financing models. 14 Even though public policy must address and
expand financing options, it is just as essential to analyze how we provide long-term care
services and supports. Our current national approach to long-term care, which relies heavily
on unpaid family caregivers and Medicaid coverage for nursing home care, cannot meet the
needs of aging baby boomers.

Some progress has been made in recent years in developing better models for the provi-
sion of long-term care services and supports, overcoming the stereotypical model of the sterile
and uncaring nursing home. The Medicaid program has served as a laboratory for testing
and developing systems of providing a more diverse and appropriate range of long-term care
services to seniors in a cost-efficient manner. There have been some promising results, but
they have not led to widespread market reform. While federal law, including the Affordable
Care Act, 15 is slowly moving toward the goal of keeping seniors out of nursing homes, federal
efforts are centered on the means-tested Medicaid program, leaving it unable to spur the
private-sector changes that are necessary to address the long-term care needs of the middle
class. 16

This article discusses recent efforts in providing long-term care services and supports
and how they might be broadened and replicated. 17 We highlight examples of public-private
partnerships that maximize government services in conjunction with not-for-profit and pri-
ivate supports as a way to provide comprehensive long-term care services in a cost-effective
manner. We also touch on how technology can play a role in the continuing care of seniors
at a significantly reduced cost.

By reviewing some of the limited successes in the current delivery of long-term care, we
begin to formulate a vision of a long-term care system that combines government and private
resources to serve the anticipated long-term care needs of baby boomers. We also offer some first
steps state and federal government and other stakeholders might take to move this vision forward.

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13 Kaiser Fam. Found., Distribution of Medicaid Spending on Long Term Care, http://kff.org/medicaid/state-
indicator/spending-on-long-term-care (accessed Oct. 20, 2014)
14 Two such studies were published by The SCAN Foundation: Eileen J. Tell, Overview of Current Long-Term Care
www.thescanfoundation.org/sites/thescanfoundation.org/files/tsf_ltc-financing_private-options_frank_
15 Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010) as amended by the Health Care and
Education Reconciliation Act, Pub. L. 111-152 (2010). These two laws are collectively referred to as the Af-
fordable Care Act or ACA.
16 Ironically, the cost of these programs has exploded and is not sustainable, because many in the middle class,
who cannot afford the costs of long-term care, actively plan to access the Medicaid system.
17 We have provided references wherever possible, but note that the paucity of data and research on these issues
(beyond basic hand-wringing about how broken our long-term care system is) is one of our major points.
II. Family Caregivers Remain an Important Resource, but They Need Support

As highlighted above, informal care by family caregivers has always been an integral part of the long-term care system. The economic value of unpaid care was approximately $450 billion in 2009 — nearly four times the amount the Medicaid program spent on long-term care that year ($119 billion).18 Most Americans plan on relying on their families if and when they need long-term care.19 Unfortunately for most baby boomers, this may be an unrealistic assumption, because the number of potential caregivers for each older adult will plummet from seven today to less than three by 2050.20

We are starting to see greater recognition of the need for supporting family caregivers. This is perhaps the easiest and most cost-efficient action government can take to address the long-term care crisis. The recently published Centers for Medicare & Medicaid Services (CMS) rule on home and community-based services (discussed in detail below) requires Medicaid home and community-based services programs to conduct an assessment of caregivers’ needs when their assistance is part of the care plan for a person with a disability.21 This, it is hoped, will lead states to develop systems for providing caregivers with appropriate information, training, respite, and other services tailored to their individual needs and preferences.

One example of an evolving caregiver support system is nurse delegation. Family caregivers are increasingly finding themselves engaging in more complex nursing tasks.22 This is because most states allow nurses to train family members to perform many medical tasks, such as medication administration and tube feeding. However, nurses are generally prohibited from training paid direct care workers. This prevents families from relying on home health aides to provide services while they work or take respite time. Many states are beginning to address this issue by modifying their rules on nurse delegation to allow training of home health aides while incorporating guidelines for patient safety.

III. Home and Community-Based Care Is Preferable

Even when family care is not an option, policymakers and consumers agree that allowing seniors to age in place is preferable to placing them in nursing homes. Most older adults strongly prefer home and community-based care to nursing home care.23 Policymakers note that even when no informal caregivers are providing support, the average cost of care is substantially lower in a home setting than in a nursing home.24 Astonishingly, however, Medicaid has been slow to provide comprehensive home and community-based services. The majority of Medicaid dollars spent on long-term services and supports still go to nursing home care.

19 See Redfoot et al., supra n. 7, at 7.
20 Id. at 1.
22 Redfoot et al., supra n. 7, at 2.
This is particularly true for older adults, with an average of less than 30 percent of long-term services and supports expenditures going to home and community-based services.\textsuperscript{25} This is slowly changing as states try to stem Medicaid budget woes by shifting to more home and community-based services. Progress in this area is mixed. In the top three states, nearly 80 percent of Medicaid beneficiaries receive long-term care services and supports in the home and community compared with around 25 percent in the worst performing states.\textsuperscript{26}

Traditional single-family suburban housing can be a major barrier to seniors remaining in the community. As discussed in our previous article, residential models can be designed to encourage independence and facilitate aging in place.\textsuperscript{27} For instance, naturally occurring retirement communities (NORCs) and villages provide services to members of the community based on some basic concepts. These concepts include economies of scale, public-private partnerships, personal commitments, community and neighborhood commitments, in-kind contributions, philanthropic contributions, and resident fees.

Many NORCs contract with nonprofits or private agencies to provide health and social services to their residents.\textsuperscript{28} Villages provide their members with referrals to vetted providers who in turn offer discounted rates to those members. They also commonly offer limited support services such as transportation, companionship, housekeeping, home repair, yard care, and health care advocacy through volunteers and staff.\textsuperscript{29}

The provision of support services within senior or communal housing provides a number of efficiencies. It minimizes the need for offsite transportation and allows services to be delivered less expensively through economies of scale. A number of studies have found that these models of providing services can forestall the need for long-term care as well as increase social interaction and improve emotional well-being.\textsuperscript{30} However, these models do not currently provide sufficient services (nor are they widespread enough) to meet the needs of seniors most at risk for institutionalization (i.e., those with substantial long-term care needs).\textsuperscript{31}

If we really want seniors to be able to age in place, we must offer easy access to the services they need at affordable rates. Many seniors are forced to leave their homes when they need multiple types of services. Some senior housing programs offer service coordinators who provide information on the options, cost, and availability of needed support and health care services. Service coordinators in a federally subsidized housing program for seniors are also tasked with coordinating service delivery to maximize independent living and with monitoring the quality and quantity of services to fit needs of residents. This program has expanded

\begin{footnotes}
\footnotetext[25]{Reinhard et al., supra n. 8, at 33.}
\footnotetext[26]{Id.}
\footnotetext[27]{Siegel & Rimsky, supra n. 2.}
\footnotetext[28]{N.Y.C. Dept. for the Aging, NORC Concept Paper 2, www.nyc.gov/html/dfta/downloads/pdf/norc_concept_paper.pdf (accessed Oct. 20, 2014). In this paper, the department announced it was seeking proposals from qualified vendors to provide naturally occurring retirement community (NORC) supportive service programs.}
\footnotetext[30]{Id.; see also Lawler, supra n. 23, at 43 n. 18 (noting that state coffers have realized substantial savings in forestalling the need for more expensive care).}
\footnotetext[31]{See Graham et al., supra n. 29, at 96S.}
\end{footnotes}
since the 1990s, and now there are service coordinators at approximately half of the Section 202 communities across the country.\footnote{U.S. Dept. of Hous. & Urban Dev., Section 202 Supportive Housing for the Elderly: Program Status and Performance Measurement 55 (June 2008), http://www.huduser.org/Publications/pdf/sec_202_1.pdf (accessed Oct. 20, 2014).}

However, most baby boomers cannot or will not consider government-subsidized housing. Services need to be integrated into a variety of market-rate housing options in order to provide opportunities for sustainable long-term care.\footnote{LeadingAge has demonstrated the progress made: LeadingAge, Senior Housing in New York State (Feb. 2013), http://www.leadingagency.org/?LinkServID=1E3B04BD-C423-4037-8A4B9D30D753623 (accessed Oct. 20, 2014). In New Jersey, several nonprofits have banded together to provide “portable assisted living services” to residents in senior housing buildings. Colleen Diskin, Assisted Living at Your Doorstep: On-Site Senior Services in Westwood, NewJersey.com (updated Oct. 14, 2014), http://www.northjersey.com/news/assisted-living-at-your-doorstep-on-site-senior-services-in-westwood-1.1108652?page=all (accessed Nov. 14, 2014).} Again, we find the NORC serving as a model.

Although the earliest NORCs were in large buildings, a future goal is to apply the concept to community-based care while expanding the range of services offered. In 2005, the New York legislature dedicated funds to a new iteration, the Neighborhood NORC (NNORC). The NNORC applies the concepts that made the NORC successful to serve seniors in neighborhoods instead of only those in large housing developments.\footnote{Leading Age, supra n. 33, at 11.} It also substantially expands the services provided to facilitate aging in place with supportive services, such as service coordination, case assistance, case management, counseling, health assessment and monitoring, home-delivered meals, transportation, socialization activities, home care facilitation, and monitoring. The services are provided through an interfaith partnership that includes public, private, and nonprofit organizations.\footnote{See Jewish Fedn. of N.E. N.Y., Corporate Sponsorship Proposal – Neighborhood Naturally Occurring Retirement Community (NNORC), https://www.jewishfedny.org/give/corporate-sponsorship/nnorc (accessed Oct. 20, 2014).} Unfortunately, New York has invested only $2 million in the program; therefore, it is likely to remain limited in scope for the foreseeable future.\footnote{Leading, supra n. 33, at 11. Additional funding includes in-kind contributions, private housing partners, philanthropies, corporate sponsors, and community stakeholders.}

IV. Care Coordination Is a Necessity

For those not living in senior (or other congregate) housing, the provision of information about the numerous services available across the community is insufficient and services are provided in isolation. Any successful home and community-based long-term care model must include the provision of coordinated services. Although there have been demonstration programs such as the Programs of All-Inclusive Care for the Elderly (PACE) for many years, only recently are states and CMS moving toward a truly coordinated approach to home and community-based services.\footnote{The U.S. Department of Housing and Urban Development also is moving beyond offering service coordinators toward integrating health services with the Service Enriched Housing (SEH) program, which provides services to elderly residents who need assistance with activities of daily living in order to live independently.}
In 1990, the first PACE received Medicare and Medicaid waivers to operate. As of 2011, more than 80 programs existed in 30 states. PACEs provide a continuum of care and services to seniors with long-term care needs with the goals of controlling costs, delivering quality care, and allowing individuals to remain at home for as long as possible. PACE providers receive capitated fees for each participant, which rewards cost savings and encourages the efficient provision of services. Generally, the results have been positive. A number of studies have found that PACE participants have substantially lower rates of nursing home use and hospitalization and improved health outcomes. Studies have also shown that PACEs can result in cost savings to states compared with traditional Medicaid home and community-based services.

States and CMS have begun showing increased interest in managed long-term care services and supports (MLTSS) beyond PACE. Increasing numbers of states are turning to MLTSS — the number of states with MLTSS programs increased from 8 in 2004 to 26 in 2014. Medicaid MLTSS programs can be operated under multiple federal Medicaid managed care authorities at the discretion of the states and as approved by CMS, including sections 1915(a), 1915(b), and 1115. Section 1915(a) allows states to offer voluntary enrollment into capitated managed care otherwise unavailable to states providing home and community-based services on a fee-for-service basis. Section 1915(b) waivers allow services to be delivered through managed care organizations. These waivers can be combined with 1915(c) waivers, which allow states to provide long-term care services in home and community settings rather than in institutional settings. Section 1115 authorizes research and demonstration projects, allowing a state to apply for program flexibility to test approaches to financing and delivering services to Medicaid beneficiaries.

Recently, CMS took a major step in simplifying this piecemeal approach. It issued a rule in January 2014 that facilitates streamlined administration of home and community-based services waivers. The regulation also provides states with the option to combine coverage for multiple populations into one waiver under section 1915(c). In addition, it imposes a 5-year waiver approval and renewal cycle to simplify administration and allow states to align

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39 Id.
40 See Jody Beauchamp et al., The Effect of the Program of All-Inclusive Care for the Elderly (PACE) on Quality: Final Report, Mathematica Policy Research (Feb. 12, 2008); L.A. Meret-Hanke, Effects of the Program of All-Inclusive Care for the Elderly on Hospital Use, 51(6) Gerontologist 774 (2011).
42 Interestingly, Minnesota, which is the top-ranked state for long-term care services and supports, has enrolled its senior Medicaid beneficiaries in managed care since 1983 and incorporated long-term care services in 2005.
44 Social Security Act, 42 U.S.C., 1396n and 1315.
45 42 C.F.R. §§ 430, 431, et seq.
concurrent waivers with state plan amendments. This is significant, because the lack of a large-scale unified approach has undoubtedly limited the impact on the private marketplace up until now. Of course, as long-term care services largely remain uncovered by insurance, there has been little incentive for private providers to undergo systemic change.

**V. Seniors Who Cannot Remain at Home Can Receive Patient-Centered Care in a Home-Like Environment**

Some private providers have chosen to innovate and incorporate the principles of home-like environments and patient-centered care into their long-term care models. A growing number of facilities are promoting the Eden Alternative as the next best option for individuals who cannot remain at home. The Eden Alternative is a model that emerged in the 1990s, which focuses on providing holistic, patient-centered care in a pleasant, active setting. This approach aims to create an environment that fosters independence, actively engages seniors, and promotes strong interpersonal relationships. Hundreds of facilities and providers have embraced the Eden Alternative philosophy to varying degrees. Countless others promote patient-centered care and home-like environments without any affiliation with the Eden Alternative movement. Several studies have found that this approach can significantly impact patient well-being, resulting in a reduction in boredom, helplessness, and depression.46

Another model stemming from the Eden Alternative that is gaining in popularity is the Green House Project. This paradigm incorporates the Eden Alternative principles into building design, resulting in small communities of homes for 6 to ten seniors who require skilled nursing care. Green House facilities offer communal living in a home-like environment with direct caregivers who integrate personal care and management of the homes. The staffing of direct caregivers allows for more individual engagement and increased direct care time. Again, we see that residents living in Green House settings experience better quality of care and report better quality of life than traditional nursing home residents. Staff and families also reported higher rates of satisfaction.47

As the Green House model starts to reach some market saturation,48 consumers are starting to respond. A majority of consumers favor this model over other long-term care options. One survey found that 90 percent of consumers wish there were more Green House facilities available; 60 percent indicated that they would pay more for this type of offering.49

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This is important, because ultimately the market will be a key driver of culture changes for long-term care.

VI. Technology Will Play a More Important Role

Technology will undoubtedly play an important role in the provision of long-term care services in the future. It may reduce professional caregiver workloads; increase caregiver efficiency; provide coordination of care and longitudinal data; and provide peace of mind for family caregivers and reduce their burden. Technology can be used to provide access to resources and health information and reduce social isolation.

Remote sensor technology can be used to monitor the daily activities of vulnerable seniors. Sensors are placed unobtrusively around the home. Computer software learns to recognize daily routines. In the event of a change in routine, information is transferred to the call center, which can notify family members and social workers. Similar technology is being used at various NORCs.

To combat isolation, one nonprofit developed software in collaboration with Microsoft, the New York City Department of Aging, and the New York City Department of Technology and Telecommunications. The Virtual Senior Center allows homebound seniors to engage in activities such as discussion groups, video-based classes, face-to-face communication with peers, and wellness classes. Surveys show significant reduction in anxiety, depression, and loneliness. Other social connectedness technologies include senior-friendly social networking websites, easy-to-use email systems, email-to-paper communications systems, easy-to-use videophones, and video conferencing systems.

Telehealth promises to stretch limited resources, thus allowing providers to remain in contact with seniors in their homes. Devices that can use this technology include blood pressure cuffs, glucose meters, medication reminders, and weight scales. Another option is to locate telehealth kiosks in community centers or other buildings. Participants can activate

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51 See LeadingAge, supra n. 33, at 35. Innovations have been used by Selfhelp Community Servs., Inc., a not-for-profit organization dedicated to maintaining the independence and dignity of seniors and at-risk populations.
53 See LeadingAge, supra n. 33, at 35.
58 See LeadingAge, supra n. 33, at 36. Selfhelp has partnered with Jewish Home Lifecare; partial funding for the kiosks comes from Enterprise Community Partners.
a touch screen by swiping a card, which records and monitors vital statistics such as blood pressure and weight. Health care providers can then track the information.

Electronic documentation technologies are primarily aimed at health care professionals and professional caregivers. Technologies such as electronic health records, point-of-service systems, electronic prescribing, medication administration records, electronic charting, and electronic workflow and documentation systems can improve health care efficiency, ensure communication among providers, and allow for better performance and results measurement.59

VII. The Federal Government Must Play a More Proactive Role

With the looming demographic changes, none of the limited initiatives that are available now will be sufficient to address the tidal wave of baby boomers needing long-term care. Unfortunately, the federal government is only now studying new approaches. In 2013, the U.S. Senate Commission on Long-Term Care issued a report to Congress with detailed recommendations on rebalancing services, integrating care, performing uniform assessments, and improving access to care as well as recommendations on workforce and financing reforms.60

CMS recently took a major step forward in encouraging innovation and expansion of coordinated home and community-based services with the publishing of a new federal regulation.61 The rule implements the section 1915(i) home and community-based services state plan option,62 including new provisions under the Affordable Care Act that offer states the option to provide expanded home and community-based services. Under the new rule, CMS imposes new definitions of home and community-based settings to emphasize the importance of an individual’s independence and integration with the greater community.63 For instance, home and community-based settings must be integrated into and provide full access to the greater community and optimize an individual’s autonomy and independence in making life choices. Settings that are provider owned or controlled must allow for tenant protections, provide private units with lockable doors, provide access to food at any time, and have no limitations on visitor hours.64

The regulation includes provisions aimed at facilitating streamlined administration of home and community-based services waivers and provides states with the option to combine coverage for multiple populations into one waiver under section 1915(c).65

The new regulation also includes important provisions for person-centered planning, which require that a customized plan be developed to provide the health care and long-term services and supports an individual needs.66 The regulation requires the plan to incorporate

62 Social Security Act, 42 U.S.C., 1396n § 1915(i).
63 42 C.F.R. § 441.301(c)(4).
66 See 42 C.F.R. §§ 441.301, 441.530, 441.725.
an individual’s goals and preferences, including those related to community participation, employment, income and savings, health care and wellness, and education.67

Although it is too early to have gained any practical experience with these changes, they hold real promise as they normalize the concept of patient-centered care and coordination of services to meet the needs of individuals. The administrative provisions also are important, because they allow states to adopt a more comprehensive approach to long-term care instead of having to rely on a number of small, separate waivers.

VIII. States Need to Take the Lead in Engaging Private Providers and Nonprofit Agencies and Fostering Collaboration

Fortunately, some states have taken a more proactive approach by analyzing these long-term care issues and preparing for the upcoming demographic changes for some time. Minnesota’s Aging 2030 project was designed to help state agencies develop policy options to prepare for the demographic shifts that will peak in 2030 when baby boomers turn 85.68 Minnesota also evidenced a longstanding commitment to home and community-based services and managed care, innovative housing models, strong public-private collaboration, and a focus on quality improvement.69 Minnesota ranked first in its ability to serve new users of long-term care services and supports in home and community-based settings. At 83.3 percent, Minnesota’s effectiveness on this indicator is far above the national median of 49.9 percent. Minnesota also ranked first on the availability of assisted living and residential care alternatives.70 The AARP scorecard concludes that “a willingness to experiment, innovate, and challenge the status quo are the hallmarks of successful states.”71

Other states have actively engaged in developing public-private collaboration to provide long-term care services in the community. A common theme emerging from these programs is the importance of working together with existing community service providers, such as home care agencies, area agencies on aging, mental health providers, and adult day health centers.

New York has been active in promoting the integration of services in communities where seniors reside by collaborating with nonprofits and private providers. Besides the NORC and NNORC models, the Weinberg Campus, in Buffalo,72 combines market-rate independent housing with long-term care services. The Weinberg Campus is a not-for-profit community of modern buildings that offer an array of services for independent seniors.73 It also offers the Total Aging in Place Program, which is a managed long-term care health plan for those who need long-term care. Services covered by the program are provided by a coordinated team of nurses, rehabilitation specialists, and social workers who work with their clients’ physicians to develop a plan intended to meet the needs of each client.74 Services include day programs,

67 42 C.F.R. § 441.725.
68 Mollica & Hendrickson, supra n. 12, at 4, fn. 7.
69 Id. at 4.
70 Id. at 7.
71 Reinhard et al., supra n. 8, at 56.
73 Id.
care management, medical transportation, and home care and is available to persons who can pay privately as well as those covered through Medicaid.

Flushing House, in Queens County, is another example of a public-private partnership.\textsuperscript{75} Built in 1974 by the United Presbyterian and Reformed Adult Ministries, Flushing House provides independent housing and support services at more affordable middle-class rents.\textsuperscript{76} Practically nonexistent a few decades ago, retirement residences similar to Flushing House now number in the thousands across the United States. However, most of these independent living facilities are real estate developments owned by large, for-profit corporate chains, and many require large upfront buy-ins. The challenge is to capitalize on government and nonprofit involvement to allow this model to be more available and affordable for older Americans.

\section*{IX. Conclusion}

Although we have highlighted many hopeful signs that long-term care reform can occur, progress remains uneven across the country. The majority of individuals needing long-term care do not have access to the options highlighted here. Moreover, most of the innovation in the provision of integrated, patient-centered services has been directed at Medicaid recipients. Community-based long-term care options for the wealthy and the poor are beginning to expand, but for most middle-class Americans, the services they need to remain at home continue to be unaffordable and piecemeal. Unfortunately, the financing structure for long-term care has limited the impetus for private providers to innovate and collaborate. It is hoped that this will change as market demand increases.

We have approximately 20 years before large numbers of baby boomers need long-term care. Policymakers must engage now in systemic change to prepare. We are practicing Elder Law attorneys, not policy wonks. We do not claim to have all the answers and are not presumptuous enough to think we have the perfect model.\textsuperscript{77} However, our research has led us to reach certain conclusions that can form the basis for further study.

Coordinated, patient-centered long-term care services and supports must be integrated into communities to facilitate aging in place. We believe that communal living is necessary for cost-efficient service delivery. Although private companies may develop communal housing, not-for-profit agencies that serve seniors and people with disabilities may be the most well suited to provide these services. Models such as NNORCS, the Weinberg Campus, and Green Houses should be studied, because they hold promise for wider application.

Public financial support is also essential to the ultimate success of any program of long-term care. Government support should include direct financing, tax incentives, public grants, and knowledge sharing. States must also take the lead in supporting the most cost-effective means of providing care, such as providing additional support to family caregivers. This, along with maximizing technology, is key to reducing the cost of long-term care. Active engagement and collaboration among private providers, community agencies, and federal and state government is essential to bringing innovative patient-centered care to middle-class Americans.

\textsuperscript{75} Owned and operated by the United Presbyterian and Reformed Adult Ministries.
\textsuperscript{77} Of course, we realize that there is no one model that will solve our nation’s long-term care woes and therefore can only offer a series of recommendations for reform.