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Clinical Case Mix and other Challenges to Detroit's Medicaid-Dependent Nursing Homes[1]

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1. This paper is based on research conducted under Contract 2004-1005 with the Detroit Area Agency on Aging, 1333 Brewery Park Blvd., Suite 200, Detroit, Michigan. The work was conducted between May and September 2004 under institutional oversight of Eastern Michigan University's Human Subjects Review Committee.

Key words

nursing homes, Medicaid-dependent, long-term care, urban health care, nursing home administration, underserved minority aging, minority health care disparity

Abstract

Nursing homes that care for the poor in Detroit are frequently dependent upon Medicaid as their principal source of revenue. These facilities face numerous challenges because they face limited resources for maintenance of facilities, staff and administrative supports, and other normal costs. They lack the kinds of support that are provided in-kind, or by more generous sources of revenue and are often characterized as institutions of poor quality; yet nearly 70% of the nation's Medicaid-recipient elderly nursing home patients are in for-profit facilities that are sustained largely on Medicaid funding. These facilities are often sources of care for underserved minority populations, the adult mentally-ill, and others for whom alternative venues of care are no longer available. The case mix of aged, mentally ill, and numerous other chronic adult conditions is unlike any other health care environment in Michigan, yet the facilities that offer such care are poorly understood and insufficiently supported. The situation has established a health care disparity for the aged, urban poor.

INTRODUCTION

This project was undertaken in 2004 in order to understand the circumstances faced by Medicaid-dependent nursing homes in an environment that has witnessed several facility closures during the last five years and a shrinking of the aging population within the jurisdiction of the Detroit Area Agency on Aging. At the onset of the project the combination of a shrinking population of age-eligible, potential long-term care residents, the loss of facilities, widespread poverty, and economic decline in Detroit were recognized as likely to take a serious toll on this level of service availability for low income seniors in Detroit. Also, if the need for adequate nursing home care forced residents of Detroit, or their family members who make decisions on their behalf, to leave the City to find an appropriate nursing home placement, it would be unlikely that the patient would ever return to the City; this process was viewed as one that would contribute to the loss of population. This population loss would then be compounded by the loss of employment in a long-term care system for each lost patient, a loss of revenue to the DAAA-1-A associated with population shrinkage, and a ripple effect of other economic consequences to Detroit.

The exact proportion of Medicaid beds in PSA 1-A that is actually occupied by low income, elderly patients is not clear because eligibility and demonstration of need are not age dependent, but based on an inability to attend to activities of daily living and low income. Certainly the proportion that represent "traditional" frail elderly residents averages over time at less than 80% of the whole. In some facilities the proportion of traditional, elderly, frail is as low as 55% (Douglass, et al. 2004). If the demand for Medicaid nursing home beds in Detroit were based exclusively on the traditional elderly, frail (the traditional service population), then excess capacity and closures of beds and/or facilities would have accelerated in the last several years. Slack in the traditional demand has, however, been replaced by demand for beds from other populations, most principally the adult mentally ill for whom alternative placements are no longer available within the community. This has produced a new, non-traditional, clinical case mix in Medicaid-dependent nursing homes. The following discussion will include a review of the history of the nursing home industry in Detroit, the close historical relationship between this industry and the Medicaid program, and the methods and findings of the 2004 study regarding the emergence of a non-traditional clinical case mix that poses a serious challenge to Medicaiddependent facilities today.

BACKGROUND

Much of the following discussion should be considered in the context of an historically based, general dismissal of Medicaid-dependent nursing homes by many stakeholder communities, be those defined as academic gerontologists, social workers, nurses, advocates for the poor, health care managers and administrators, the business community, journalists, state or county civil servants, large health care systems, elected officials, or political entities. In light of the enormous technical and academic literatures dealing with geriatrics and gerontology, relatively few efforts have been launched with the goal of learning all that there is to know about Medicaid-dependent nursing homes or of the patients that they serve. Teaching, research, policyoriented and financial aspects of the larger health care system appear to us to have been unconcerned about Medicaid-dependent long-term care facilities. It is not much of an extension to realize that this also means that the larger health care system has been largely unconcerned about a large number of highly vulnerable and poor patients who are dependent upon these facilities. The conclusion applies even within the large literature in clinical gerontology and

geriatrics where most clinically oriented research takes place in environments with far more infrastructures and resources than the average Medicaid-dependent nursing home.

The majority of nursing home patients, however, live in Medicaid beds, and the majority of these are in largely Medicaid-dependent facilities for which Medicaid is the dominant source of revenue. It would appear then, that much of the literature and professional guidance is of little relevance to those who serve most of the elderly, frail and poor that live in Medicaid-dependent facilities. Upon assessing the extensive literatures from gerontology, nursing, health economics, public health, social work and geriatric medicine, we recognized that only a small portion of all studies on nursing homes, quality of care in long-term care, specialized care of Alzheimer's Disease, other dementias, regulation and management of nursing homes, and other related issues focus directly on Medicaid-dependent facilities or with Medicaid patients. Most research studies in the field focus on Medicare-based services and the vast majority of nursing home studies, independent of the discipline or perspective of the investigators, are relevant to issues such as improved quality of care that are feasible only in not-for-profit, charitable, hospital-affiliated, and other relatively affluent sectors (Douglass, et al., 2004). Because Medicaid-dependent facilities and their patients are rarely the subject of serious academic research and assessment, we are compelled to conclude that much of what we "think" we know about nursing homes fails to address important questions that apply to the majority of the patients who are poor and live in facilities where such research and teaching does not take place. Therefore, most gerontological and clinical, geriatric clinical educational material is drawn from studying institutions and patients in resource-rich environments where most of the nursing home patients in the United States do not live.

The literature reflects another observation. Most academic-nursing home partnerships are hosted in facilities that are eligible to receive gifts and grants and are places where academic research and teaching activities are generally conducted; places where students learn the state of the art. This observation was also noted by Mor, et al. (2004) who concluded that, "Those writing on the quality of nursing home care have, for the most part, framed the discussion in terms of its uniformly poor quality and have largely ignored the prospects and implications of a two-tiered system differentiated by quality." (2004, p. 227)

This widespread predisposition to provide guidance based on private pay and Medicare-supported patients, and most usually within the not-for profit sector, however, flies in the face of significant realities. Again, as summarized by Mor et al., "The Medicaid program is the United States' largest purchaser of nursing home services...Medicaid's *per diem* payment rates are usually lower than others and may even be below the actual cost of providing care...Those homes that are highly dependent on Medicaid as a source of revenue have the greatest difficulty securing the resources needed to provide good quality care."(2004 p. 228-229)

The basic facts of nursing home availability, inspection-based statistics of quality assurance, analyses of closures and terminations, or state-imposed temporary management, and additional relevant matters have been subjects of several recently publications. The information for most of these analyses is based on data required by Federal OBRA regulations (Harrington, et al, 2001; Harrington, O'Meara, Kitchener, Simon and Schnelle, 2002; O'Neill, Harrington, Kitchener, and Saliba, 2003; Harrington, Mullan, and Carillo, 2004). From these analyses urban, Medicaid-only or Medicaid-dependent facilities are more likely than others to serve African American and other minority populations (Douglass, et al., 1987; Gaugler, et al., 2004; Grabowski, 2004; Mor, et al., 2004). These facilities are reported to have higher than expected proportions of men than women (Davis and LaPane, 2004; Mor, et al. 2004), and substantial resident populations who are not aged, but younger populations who are mentally ill, disabled due to trauma or chronic

disease, or suffering from late stage HIV-AIDS (Harrington and Swan, 2003; Davis and LaPane, 2004). Poverty, racial separation such as in Detroit (in the context of S.E. Michigan), and issues of populations that are growing old, frail, and alone, are ubiquitous characteristics of residents in urban, Medicaid-dependent facilities (Pourat, Anderson, and Wallace, 2001; Davis and LaPane, 2004; Gaugler, Leach, Clay and Newcomer, 2004).

Nursing home facilities that depend on Medicaid and serve the poor are more likely than suburban facilities to be owned and/or managed by for-profit corporations, to be owned and operated as a component of a corporate chain franchise structure, and to have higher numbers and severity of deficiencies as determined by State surveyors and reported to the Center for Medicare and Medicaid Services (CMS) the Federal agency that oversees the Medicaid program. (O'Neill, et al., 2003; Wheeler and Benincasa, 2003; Mor, et al., 2004; Kinchelo, 2004; Harrington, et al. 2004, 2003; Grabowski, 2004a, 2004b; Ranz et al. 2004; Davis and LaPane, 2004;). Normally standards of care through state licensing regulations set the standard of care that is expected in Medicaid participating nursing homes. This level of quality is not to be considered a "gold standard" of care as much as a minimum expectation safety standard for the residents. More highly resourced facilities, however, especially those who also participate in Medicare with Skilled Care certification, do adhere to "gold standards" of care that are above and beyond the expectations of state licensing, alone. The expectation to apply such gold standards of care in Medicaid-dependent facilities is seldom reasonable, however, because the resources, intrinsic institutional supports, multi-institutional partnerships, or cross-subsidy financing that sustain such standards are not often available in Medicaid-only or highly Medicaid-dependent facilities. In such facilities and the communities that support them, poverty, combined with complex challenges common to urban settings and minority population status are also associated with slow nursing home placements (Stevens et al., 2004), predictably lower quality nursing care (Schulz, et al., 2002), and more likely than suburban or majority residents to face facility closures, terminations, or sudden transfers to other facilities.

THE HISTORY AND DEVELOPMENT OF MEDICAID-DEPENDENT NURSING HOMES

A brief review of nursing home evolution in Michigan and Detroit will help set the stage for the following discussion. The nursing home industry, as it has evolved over the last 40 years, has been nearly synonymous with the evolution of Medicaid in the United States. Prior to the implementation of Medicaid there were few true nursing homes. While some pioneering efforts in Detroit and the metropolitan area had been serving the needs of aged and isolated people for many years, such homes were few and tended to serve somewhat specific populations such as retired teachers; unmarried, aged women; indigent and aged veterans and other groups. Most frail elderly were cared-for in family homes. It was the overcrowding of State Mental Hospitals that moved State authorities in Michigan and throughout the United States to transfer the frail mentally ill from state institutions into the community. By moving these patients into the community, not because they were old and frail but because they were poor, the states could "split the cost" of continued care the mentally ill elderly with the Federal Government. With the new Medicaid Program the states set rules for eligibility and menus of service but the Federal Government put up half the money. This would relieve overcrowding and the burden on the state treasuries.

Nursing homes as we now recognize them, were often established expressly for the purpose of taking care of the aged, mentally-ill who were deinstitutionalized into the community.

Eligibility for basic 24 hour nursing care under Medicaid was based on these populations' indigence, a consequence of many years of institutionalization. Medicare was largely irrelevant because it was conceived in an acute care model and was focused on hospital care. The movement of tens of thousands of frail mental patients was below the radar screen of most Americans. The fact that large percentages of them died as a consequence of transfer trauma was also not noticed by most people. (Douglass, 1984; Wood, 2002). In part, however, due to the sorry state of affairs with this new industry the condition of nursing homes was given close examination by the U.S. Congress and found to be wanting, which came to public attention with the publication of Nursing Home Care in the United States: Failure in Public Policy in 1974 by the U.S. Senate Special Committee on Aging (U.S. Senate, 1974). With the completion of a series of Congressional inquiries, the passage of the Older Americans Act, as amended in 1974, and other sentinel events of relevance, the nursing home industry came away from the 1960's under a cloud of public dissatisfaction and suspicion. One of the underlying reasons for the passage of the Older Americans Act was explicitly to prevent nursing home placements.

The elderly, frail, and isolated, poor from throughout the Metropolitan Detroit urban area are at risk of nursing home placement as Medicaid dependents, if family members have left the community or died, and if their assets are insufficient to be converted into long-term care in a private-pay bed. Out-migration of middle-aged and middle class African American Detroiters has increased during the last 30 years while most often the elderly family members remain in the City until physical health, poverty, or a serious hospitalization require consideration of a nursing home placement. Adult children who usually include fully employed men and women, may want to place their parent in a facility closer to where they now live. This pattern is not apparent in reverse where adults who move into Detroit then could move their aged dependent closer to them. As noted by many authors referenced above, especially Angelleli and colleagues, when a cycle begins that forces facilities to admit larger numbers of mentally ill patients, the desirability of the facility as a place of choice and for private pay is greatly diminished. This makes the facility even more dependent on mentally ill placements to sustain occupancy.

The first generation of facilities from the late 1950's and 1960's now constitute the core of the physical plants of most urban nursing homes. This is clearly true in Detroit. Such aging facilities face the high costs of heating, cooling, cleaning, and other routine maintenance and operations expenses that are far more efficient in newer facilities. Costs exceed revenues from Medicaid, and there is increasing pressure to extend services well beyond the model of long-term geriatric care to caring for many kinds of adult disabilities, mental illness, and chronic conditions, including late-stage HIV disease.

Because nursing homes that are certified for Medicaid in Detroit often have empty beds in recent years, due to a shrinking population and alternatives to nursing home placements (as part of a national trend), when a Medicaid recipient becomes available it is not in the facility's best interests to decline the admission unless the patient poses a serious threat or a care-obligation that the facility cannot provide. As a result, hundreds of mentally ill adults, who have activity levels, behaviors and personal needs that do not fit the traditional "old folks home" paradigm, now share Detroit's Medicaid facilities with traditional, frail elderly residents. The growing burden of Medicaid's various dependent populations can present a clinical case-mix within a nursing home that is very challenging; ranging from very frail and old, bedfast, various types and stages of dementia, disabled and mentally ill younger adults. The Direct Care Alliance called attention to this challenge in February 2004 (Donar, et al. 2004).

The organizational distribution of nursing homes includes several distinct and significant categories: Not-for-Profit, charitable-affiliates; For-Profit franchise; For-Profit group managed;

For-Profit stand-alone. Not-for-profit facilities in Michigan and throughout the United States are less likely to have large numbers of governmental inspection deficiencies than for-profit facilities. However, the literature and public impression is that this is a causal relationship that stems from perceptions of greed and exploitation or diversion of resources to owners and stockholders. An alternative explanation is clearly that especially in urban centers like Detroit the degree of difficulty in all aspects of the operation is far greater for the for-profit, Medicaiddependent facilities than it is for the not-for-profits or the suburban facilities. This is especially true when it is recognized that multiple venues of care, and a financially healthy mixture of Medicare (skilled care) beds, and private pay beds with Medicaid beds permit the organization to provide care despite insufficient revenues from Medicaid. This set of circumstances is far more common in suburban areas of the Metropolitan Detroit market than in the City of Detroit.

As noted by Mor and colleagues (2004), there is a two tier system of nursing home care in the United States with the "haves" represented by both not-for -profit and for-profit facilities that have substantial proportions (or exclusively) private pay beds, Medicare-supported skilled care beds, multiple affiliated venues of care and basic beds that are resourced by both private pay and Medicaid. The "haves", in addition, serve a nearly homogeneous, traditional, elderly population that actually ranges from ambulatory and independent in terms of ADL to hospice. The "have nots", however, are nearly all predominantly Medicaid-dependent. The populations that they serve are predominantly poor. Populations served by the have-nots are far more likely to include large proportions of mentally ill, formerly institutionalized, and younger adults in a clinical case mix that is more challenging in many ways than a traditional, frail elderly population.

METHODS

A series of structured focus discussions was conducted during the summer, 2004 with samples of nursing home owners, administrators, and senior staff from facilities that are dependent on Medicaid for 85% or more of their residents as a source of revenue. This is our operating definition of "Medicaid-Dependent". Four group focus discussions were conducted between August and September 2004 that included 39 individuals from 11 independent facilities or nursing home chains. This represents approximately one third of the Medicaid-dependent facilities that serve the Detroit Area Agency on Aging's market. In addition, because several sampled individuals were not able to attend the group focus discussions, individual interviews were conducted with nine additional administrators, one owner and the corporate lawyer for one management firm. The focus discussions lasted approximately three hours while individual interviews lasted an average of two hours. Participants were afforded full human subjects informed consent protocol under the institutional supervision of the Human Subjects Review Committee (IRB) of Eastern Michigan University, from which permission to initiate field data collection was provided at the end of July 2004. All of these discussions and interviews were conducted under the same informed consent protocol. In addition, all participants were paid a small honorarium as compensation for their time. Focus discussions were tape-recorded, and reviewed for topic frequencies, technical substance, and sorted by subject area. These qualitative data were assembled and then paired to topic-specific conclusions from the published literature.

FINDINGS

Based on the very few relevant research reports in the published literature that deal exclusively with Medicaid-dependent facilities, the challenges faced by Detroit's nursing homes are similar to facilities in other major metropolitan areas. Participants reported that a majority of residents have few if any family members, close friends or others who visit on a regular basis. The majority of patients are African American, however very frail and isolated elderly residents are often White. These facilities, at the present time, are struggling to survive. Several

administrators told the groups that their facility was a major employer in the community. The owners and administrators indicated that their mission was not only to provide care for the patients, but also to continue to provide jobs and income to the communities in which they operate.

All but one of the facilities that were represented in the focus discussions were for-profit business. One was part of a chain of facilities; four were mutually owned and benefited from corporate and administrative assistance from a management company. The single owner/operator administrators frequently reported that their work was overwhelmed by interactions with families, government regulatory offices, the Medicaid authorities, and distractions from the "business of caring for people". It was noted that those facilities with "administrative depth" whose administrators could turn to specialists within their corporate system for financial, legal, or other support were more able to focus on management issues within the facility.

The Medicaid populations served in Detroit's nursing homes are highly case-mixed as a clinical distinction and rarely represent the traditional, homogeneously elderly patients with both Medicare and Medicaid clinical eligibility. Mentally-ill, developmentally disabled, or younger chronically ill adults with diagnoses such as Multiple Sclerosis, Parkinson's Disease, HIV-AIDS and other conditions that afflict a wide age-range of adults are often a large proportion of these nursing homes' resident populations. The focus discussion participants indicated that because of these clinical case-mixes the needs of residents are highly variable as well as the technical and training needs of the nursing staff. Staffs in such facilities are unable to focus on geriatric needs as they might have been trained to do in a nursing home because a large proportion of their patients do not have geriatric problems. The significant presence of ambulatory, mentally ill residents creates a number of problems and complications within the context of a nursing home.

Liability issues, too, increase when patients use or abuse alcohol or drugs. Visitors and family members supply some patients with alcohol and/or illicit drugs. This has been previously noted in S.E. Michigan (Douglass, 1980, 1981, Douglass, et al., 1982), however today the problem is exacerbated with substance abuse among younger and more ambulatory patients who share space with the frail elderly. When asked if family members brought alcoholic beverages into the facility covertly, an administrator responded, "How did you know?"

The clinical case-mix, alone, was reported to present significant challenges for nursing care planning, as well as all other services within such facilities. It is not unusual or uncommon for very frail elderly to share hall space, eating facilities, and recreational space with mentally ill adults. Recent management and psychological literature suggests that performance levels can be negatively affected with too much distraction beyond the "channel capacity". Minimally compensated nursing aides, who might be highly qualified for either geriatric care, or care of developmentally disabled adults, or for the younger adult mentally ill, or for persons with advanced HIV disease may not be able to handle the simultaneous complexity of having all of these conditions "on the floor" at the same time. Participants told us that finding appropriate training materials, avoiding staff burnout and recruiting new staff to work in a facility with this complex clinical case mix was very difficult. This case mix issue was raised by every participant (100%) and was always cast in the image of a degree of difficulty beyond the expectations of most people who work in long-term care. The administrators also indicated that with declining market demand from "traditional aged, frail patients", any empty beds needed to be filled or the financial crisis that most of these facilities would face would be overwhelming. One advocate also gave a prognosis of the situation by describing many facilities as being on "a slow slide to financial collapse, and dependent upon admissions of the mentally ill for short-term survival."

When asked about the problems that they face, and worry about, every day the participants were nearly of a single voice. A chronic shortage of registered nurses with appropriate training, qualified nurse aides, absenteeism and turnover of existing staff, and the need to, "begin the day by finding out how many staff 'called in' overnight" were issues that dominated the daily routine of these administrators, senior staff and owners. The participants also indicated that the local infrastructures were not helpful in staff retention because a shortage of safe and secure parking for staff's automobiles, lack of predictable mass transit for staff who could not afford to purchase their own vehicle, and other problems made the shortages of staff even more difficult to resolve.

The inadequacy of Medicaid reimbursement was the most frequently noted causal issue from all focus discussion participants. This is clearly a bottom-line issue that has precipitated many recent nursing home failures. Medicaid reimbursement rates are set annually, based on reports to the State every year. According to this study's respondents, however, increased reimbursement may not be implemented for as long as two years subsequent to reporting that costs have increased. Participants reported that it is very difficult to anticipate costs two years in advance and still be consistent with the requirement to report only true costs based on the most recent year's experience. Unanticipated expenses, which are common in older building stock, can wreck an administrator's budget and spending plan. Reliance on Medicaid revenues may offer little or no slack with which to initiate essential repairs and maintenance. Failure to initiate such repairs will lead to regulatory tickets and more unanticipated expenses. Facilities with little commercial credit, no profit centers beyond the Medicaid beds, and with ongoing debt, face a nearly impossible task to keep up with cost increases, competitive salaries for nursing staff, or even to respond to routine economic inflation with fixed Medicaid reimbursement rates.

When facilities have clinical case mixtures that include younger, mentally-ill residents; this may lead to lower Medicaid reimbursement rates. Although younger, active, mentally-ill residents have fewer or less costly medications and medical procedures, such patients are often more labor-intensive for the staff and, therefore, actually more expensive to care-for than many frail elderly patients. An administrator reported that, "...the need to accept younger patients has completely changed the job. What I really do is run a small mental hospital; I just happen to have a lot of needy old people too."

Medicaid applications on behalf of patients, even immediately after a hospitalization, can require months to process for approval. Facilities are expected to absorb the cost of care for such "pending" cases until the Medicaid approval is provided. For independent facilities with no corporate depth, this can be a major crisis.

DISCUSSION

The participants of focus discussions and those who were individually interviewed were highly motivated, experienced, and reflected a sense of near-desperation regarding the degree of difficulty that is present in the Medicaid-dependent nursing homes. In these discussions it was recognized that good management within the continuum of care for the most vulnerable people requires stability and continuity of staff and also administration. It was reported in every discussion that managerial turnover, dealing with the lack of qualified, licensed and willing replacement administrators, and then convincing them to take the job is as much of a challenge as is the widely recognized nursing shortages that all health care facilities face. The higher the dependence upon Medicaid and the greater the clinical case-mix of traditional, frail elderly with mentally ill and other categories of disabled adults, the greater the frequency of administrative (and ownership) turnover among nursing homes These findings are consistent with several studies of nursing home administrator work satisfaction and turnover (Murphy, 2004; Singh and Schwab, 1998).

Our thesis here is that Medicaid-dependent facilities are largely under-resourced and face a daunting task that would not be acceptable in more financially independent and well-resourced environments. Medicaid-dependent nursing homes have been financially distressed for over 30 years due to persistent increases in costs of facility management, staffing and building maintenance, medical care cost inflation, general inflation of salaries and minimum wage, and increased licensing expectations of the State. At the same time, the willingness or ability of the State of Michigan, along with most other states, to increase Medicaid reimbursement has suffered from legislative hesitation to sustain the Program in a way that counteracts these elements of normal and predictable cost increase.

Being financially dependent upon Medicaid has had many consequences for these facilities that are nearly all negative. These facilities serve populations defined by the patient's financial poverty instead of by the clinical presentation of the patient. Because of this and because of the closure of alternative institutions for the mentally ill, Medicaid-dependent nursing homes have become "dumping grounds" for the mentally ill who cannot manage their own affairs in more independent living circumstances. In addition, population losses in Detroit have reduced the demand for traditional nursing home care, leaving empty bed space that is available for patients other than the traditional, frail, elderly. In combination, such events have forced a clinical casemix within the facilities that is far from the traditional image of a nursing home. This has increased the degree of difficulty for the management and caregivers within these facilities. The age, gender, and diagnostic combinations of patients that are faced by Detroit's Medicaiddependent facilities present a degree of difficulty that is simply unacceptable if consistent, highly regulated, and high quality care is expected for any of these vulnerable populations.

One of the questions that initiated this project was that of how many nursing home beds does PSA1A need? If these facilities only served the elderly, frail, then Detroit and PSA 1A would have far more capacity than current demand requires. The clinical case mix, however, and the demands of a Medicaid Program that serves vulnerable adults on the basis of poverty status and not based on age, frailty, or other clinical determinants diminishes the ability of these facilities to consistently employ standards of care for age-segregated facilities as would be expected in a facility that only served the frail elderly. Nursing homes within PSA 1A that are largely Medicaid-dependent are needed because of a variety of human needs that greatly exceeds demands from the elderly market, alone. Statistical predictions of demand that are created on the basis of projections of aged population growth, without serious consideration to issues of poverty, out-migration of younger family members, urban development, transportation patterns for visitation as well as for employment, and other salient issues will give a false sense of expected demand in some areas.

We conclude from this that the stakeholders in public health, aging, mental illness, urban development, and health care are very reluctant to give the owners, administrators and staff of Medicaid-dependent nursing homes the credit they deserve, nor the financial resources that are needed, to do a job that the rest of us don't want to do ourselves. We as a larger society seem to punish this under recognized and poorly resourced enterprise for not doing a better job while simultaneously withholding the resources that we, ourselves, would probably require. Because of the situation with widespread poverty, deinstitutionalized mental patients, and unknown numbers of isolated elderly residents of PSA 1A (and elsewhere) who may soon be at risk of requiring some form or duration of nursing home care, the need for these facilities to succeed is in the best interests of the entire community, and the State of Michigan.

REFERENCES

Angelelli, J., Gifford, D., Shah, A., and Mor, V. (2001). External threats and nursing home administrator turnover. *Health Care Management Review. 26(3):* 52-62.

Angelelli, J., Mor, V., Intrator, O., et al. (2003). Oversight of nursing homes: pruning the tree or just spotting bad apples? *The Gerontologist. 43(Spec. No. 2):* 67-75.

Appelbaum, R.A., Medizadeh, S.A. and Straker, J.K. (2004). The changing world of long-term care: a state perspective. *Journal of Aging & Social Policy. 16(1):* 1-19.

Bonifazi, W.L. (1998). Who pays for long-term care? Form follows funding in long-term care as new payment systems emerge and old ones evolve. *Contemporary Long-Term Care. 21(10):* 76-8, 80, 82.

Brooks, S. (1996). Separate and unequal: Long-term care is failing to meet the needs of many black elderly. *Contemporary Long-Term Care . 19(6):* 40-1, 43-5, 47-9.

Castle, N.G. (2001). Administrator turnover and quality of care in nursing homes. *The Gerontologist. 41(6):* 757-767.

Castle, N.G. (1997). Replaced by fish: When a nursing home closes what happens to the residents? *Journal of Long-Term Care Administration.* (December): 10-11, 24-25.

Cohen JW. Dubay LC. (1990). The effects of Medicaid reimbursement method and ownership on nursing home costs, case mix, and staffing. *Inquiry. 27(2):* 183-200.

Davis, J.A. and K.L. LaPane. (2004). Do characteristics associated with nursing home residents vary by race/ethnicity? *Journal of Health Care for the Poor and Underserved. 1 5:* 251-266.

Douglass, R.L., et al. (2004). The Least Among Us: The Least Among Us: An Analysis of Medicaid-Intensive Nursing Homes in Detroit and the Patients That They Serve . Detroit, Michigan: Final Report to the Detroit Area Agency on Aging, PSA-1A.

Douglass, R.L., et al. (1987). Representation of the Black Elderly in Detroit Metropolitan Nursing Homes. *Journal of the National Medical Association. 80(3):* 3-7.

Douglass, R.L. (1984). A means of better care, or a fad of public policy? Deinstitutionalized elderly in nursing homes. *Contemporary Administrator for Long-Term Care. (March)*:32-34.

Douglass, R.L., Press, L. and Choi, W.S. (1982). Older alcoholics in long-term care. *Contemporary Administrator for Long-Term Care. (October):* 7-8, 10-11.

Douglass. R.L. (1981). Alcoholism within nursing homes in S.E. Michigan. Aging, U.S. Administration on Aging, USGPO. (September-October): 46.

Douglass, R.L. (1980). Aged alcoholic widows in the nursing home. *Focus on Women: Journal of Addictions and Health.1(4):* 258-265.

Donar, N., Jackson, J.D., Najar, F., et al. (2004). Factors Predicting Nursing Home Closure in Detroit and Its Impact on Residents. Detroit, MI: Citizens for Better Care [Report] provided by Detroit Area Agency on Aging PSA 1-A.

Fennell, M.L., Miller, S.C. and Mor, V. (2000). Facility effects on racial differences in nursing home quality of care. *American Journal of Medical Quality. 15(4):* 174-181.

Gaugler, J.E., Leach, C.R., Clay, T., and Newcomer, R.C. (2004). Predictors of Nursing Home Placement in African Americans with Dementia. *Journal of the American Geriatrics Society. 52(3):* 445-452.

Grabowski, D.C. and Castle, N.G. (2004a). Nursing homes with persistent high and low quality. *Medical Care Research & Review. 61(1):* 89-115.

Grabowski, D.C. (2004b). The admission of blacks to high-deficiency nursing homes. *Medical Care. 42(5):* 456-464.

Grabowski, D.C. (2001). Does an increase in the Medicaid reimbursement rate improve nursing home quality? *Journal of Gerontology: Social Sciences. 56(B):* S84-S93.

Harrington, C., Woolhandler, S., Milian, J., et al., (2001). Does investor ownership of nursing homes compromise the quality of care? *American Journal of Public Health . 91(9):* 1452-1455.

Harrington, C., O'Meara, J., Kitchener, M., et al. (2002). California Nursing Home Search: A Policy Paper. Oakland, California: HealthCare Foundation.

Harrington, C., Mullan, J.T., Carrillo, H. (2004). State nursing home enforcement systems. *Journal of Health Politics, Policy & Law. 29(1):* 43-73.

Harrington, C., and Swan, J.H. (2003). Nursing home staffing, turnover, and case mix. *Medical Care Research and Review. 60(3):* 366-392.

Hirschel, A. (2003). Predicting and Preventing Nursing Home "Performance Closures" in Michigan: Why Regulators May Not Have All the Tools They Need. Provided by Citizens for Better Care to the Detroit Area Agency on Aging PSA 1-A 2/26/2004.

Hirth, R.A., Manaszak-Holl, J.C., and McCarthy, J.F. (2000). Nursing home-to-nursing home transfers: Prevalence, time pattern, and resident correlates. *Medical Care. 38(6):* 660-69.

Howard, D.L., Sloane, P.D., Zimmerman, S.E., et al. (2002). Distribution of African Americans in residential care/assisted living and nursing homes: More evidence of racial disparity? *American Journal of Public Health. 92(8):* 1272-1277.

Kincheloe, J. (2004). Medicaid and long-term care: a recipe to mend a "safety net" full of holes. *Caring. 23(3):* 16-9.

MSA Bulletin. (2003). Nursing Facility Per Diem Rate Determination. Lansing, Michigan: Medical Services Administration, Michigan Department of Community Health. pp.1-16.

Mor, V., Zinn, J., Angelelli, J., et al. (2004). Driven to tiers: Socioeconomic and racial disparities in the quality of nursing home care. *The Millbank Quarterly. 82(2):* 227-256.

McKay, NL. (1991). The effect of chain ownership on nursing home costs. *Health Services Research. 26(1)* :109-24.

McMillan, A., Gornick, M., Howell, EM., et al. (1998). Nursing home costs for those dually entitled to Medicare and Medicaid. *Health Care Financing Review. 9(2)*:1-14.

Murphy, B. (2004). Nursing home administrators' level of job satisfaction. *Journal of Healthcare Management. 49 (5) :* 3 3 6-344.

O'Neill, C., Harrington, C., Kitchener, M. and Saliba, D. (2003). Quality of care in nursing homes: An analysis of relationships among profit, quality, and ownership. 41(12): 1318-1330.

Pourat, N., Anderson, R. and S. Wallace. (2001). Postadmission disparities in nursing home stays of whites and minority elderly. *Journal of Health Care for the Poor and Underserved. 12(3):* 352-366.

Ranz, M.J., Hicks, L., Grando, V., et al. (2004). Nursing home quality, cost, staffing, and staff mix. *The Gerontologist. 44(1):* 24-38.

Schulz, A.J., Williams, D.R., Israel, B.A. and Lempert, L.B. (2002). Racial and spatial relations as fundamental determinants of health in Detroit. *Milbank Quarterly. 80(4):* 677-707.

Singh, D.A. and R.C. Schwab. (1998) Retention of Administrators in Nursing Homes: What Can Management Do? *The Gerontologist. 38(3):* 362-369.

Stevens, Al, Owen, J., Roth, D., et al. (2004). Predictors of time to nursing home placement in white and African American individuals with dementia. *Journal of Aging and Health. 16(3):* 375-397.

U.S. Senate, Subcommittee on Long-Term Care. Senate Special Committee on Aging. (1974). Nursing home care in the United States: failure in public policy. Washington, DC: U.S. GPO.

Wheeler, L., and Benincasa, R. (2003). Location, owner tied to problems in nursing homes: Violations found more frequently at for-profit homes. Available at www.tennessean.com. Accessed May 19,2003.

Wood, E.F. (2002). Termination and closure of poor quality nursing homes: What are our options? Washington, D.C. AARP. Available at http://research.aarp.org.