In Florida the Future is Now: Aging Issues and Policies in the 1990s

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THE average age of the American population is increasing steadily as the number of people over sixty-five grows. Florida has been the leader of this trend for several years. In 1984, persons over age sixty-five constituted a greater percentage (17.6%) of the total Florida population than any other state.1 The rest of the country will not reach this level until the year 2020.2 This means that Florida's response to one of the most important demographic trends of the next century will probably define the parameters of the nation's aging policy for the next thirty to forty years.3

Florida has made great progress over the last twenty years in responding to the opportunities and challenges created by an aging population. For example, the Community Care for the Elderly (CCE) Program provided a cost-effective alternative to nursing home placement for almost 40,000 elderly people in 1989.4 The Better Living for Seniors public education campaign launched by the Department of Health and Rehabilitative Services (HRS) in 1988 educated elderly Floridians about services available to them; it also deployed a new information system enabling the elderly to access the system more readily.5 Because of these improvements, HRS projects that it will handle 452,000 inquiries from seniors in need of community services during fiscal year 1990-91—an increase of 175,000 service calls from just two years ago.6 In the area of services provided to the elderly with Alzheimer's disease, there are now respite care programs for Alzheimer's Disease victims and their families in

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2. Id. at 31-32.
3. See id. at 31.
4. FLORIDA HRS, PERFORMANCE INDICATIONS, FISCAL YEAR 1986-87 THROUGH FISCAL YEAR 1989-90, at 60 (Aug. 15, 1990) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.). Approximately 1/3 of all CCE clients would be placed in nursing homes if not for the services provided by the CCE Program. Id.
5. Id.
6. Id.
twenty-nine Florida counties, and funding for Alzheimer's research and treatment programs has doubled to $4 million over the past three years. A nursing home pre-admission screening program diverted 4,800 people from nursing homes to community residential alternatives in fiscal year 1989-90. This is an increase of 186% since fiscal year 1986-87, when 1,700 elderly people were diverted through the program. Also, by increasing the income eligibility level to 100% of the poverty level, the number of elderly people covered by Medicaid in Florida has increased from about 2,400 three years ago to more than 34,000 today. A Medicaid supported hospice program served 15,000 people in fiscal year 1989-90—an increase of 70% since the program’s inception. Furthermore, Florida has made outstanding progress in the “untying” of the elderly who live in Florida nursing homes. Between June 1989 and March 1990, the number of elderly persons restrained in nursing homes declined from 24,000 to 13,000—a reduction of 45%.

Challenges to the state’s ability to meet the needs of its older residents will increase as the older population expands during the 1990’s. For example, the over seventy-five population will grow from 945,000 in 1990 to 1.4 million in the year 2000, and the over eighty-five population will increase from 196,000 to 347,000 over the same period. Although most of Florida’s older population will remain very healthy and active, the growth in these older segments of the aging population will greatly increase the demand on all of the state’s programs for older people. For instance, Alzheimer’s disease affects 1% of those aged sixty-five to seventy-four, 7% of those aged seventy-five to eighty-four, and between 25% and 50% of those over the age of eighty-five. Furthermore, almost 20% of the over eighty-five population is below the poverty level.

14. FLORIDA PEPPER COMMISION ON AGING, MASTER PLAN ON AGING FOR FLORIDA, VOLUME I, PART A 6 (Sept. 1990) [hereinafter PEPPER COMMISSION PART A] (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.). The Florida Pepper Commission on Aging was created by the 1989 Florida Legislature to help state leaders understand the many issues affecting the elderly population, to propose recommendations for dealing with those issues, and to provide a framework for implementation. Ch. 89-294, § 1, 1989 Fla. Laws 1819.

15. ALZHEIMER’S DISEASE ADVISORY COMMITTEE, ALZHEIMER’S DISEASE INITIATIVE PLAN 1 (Apr. 1990) (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.).

16. THE VILERS FOUNDATION, ON THE OTHER SIDE OF EASY STREET 16 (1987) (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.).
and 23% of this group suffers from limitations in four or more activities of daily living.\textsuperscript{17}

For the over age sixty population, the aging network\textsuperscript{18} now serves over 300,000 clients annually in its four major community based programs; 40,000 in the Community Care for the Elderly program (CCE), 275,000 in federally funded Older Americans Act programs, 11,000 in the Home Care for the Elderly program, and about 2,500 in the Alzheimer's disease day care and respite care programs.\textsuperscript{19} Latest estimates indicate, however, that only one-third of the older population in need of community services received them,\textsuperscript{20} and the waiting list for CCE services in 1989 exceeded 9,000 persons.\textsuperscript{21} Approximately 63,000 elderly persons reside in community residential programs (congregate living facilities) in Florida.\textsuperscript{22} Of this number, about 6,500 receive public assistance.\textsuperscript{23} In 1990, Florida had almost 64,000 nursing home beds occupied by the elderly;\textsuperscript{24} 40,000 of these are supported by the Medicaid program,\textsuperscript{25} which receives 55% federal funding and 45% state funding.\textsuperscript{26}

In a recent report entitled \textit{The Needs of the Elderly in the 21st Century}, the Urban Institute in Washington, D.C. documented three major needs among the elderly that will become urgent by the year 2020.\textsuperscript{27} The study was national in scope and did not reflect the fact that the identified need trends are likely to emerge in Florida twenty

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\item \textsuperscript{17} \textit{Pepper Commission Part A}, supra note 14, at 6. Activities of daily living include bathing, toileting, walking, and eating. \textit{Id.}
\item \textsuperscript{18} The aging network in Florida presently consists of the HRS Aging and Adult Services program, area agencies on aging, community care for the elderly lead agencies, and a large number of direct service providers. See \textit{Florida Pepper Commission on Aging, Master Plan on Aging for Florida, Volume I, Part B 8-16} (Sept. 1990) [hereinafter \textit{Pepper Commission Part B}] (available at Fla. Dept't of State, Div. of Archives, Tallahassee, Fla.).\textsuperscript{19}
\item \textsuperscript{19} \textit{Id.} at 26.
\item \textsuperscript{20} Letter from Larry Polivka, Assistant Secretary, HRS Aging and Adult Services to June Noel, Executive Director, Florida Pepper Commission on Aging, attached graph (May 23, 1990) (available at Fla. Dept't of State, Div. of Archives, Tallahassee, Fla.).\textsuperscript{21}
\item \textsuperscript{21} \textit{HRS Aging and Adult Services, Community Care For the Elderly Nursing Home Diversification Program Implementation Report 7} (Mar. 1990) [hereinafter CCE Elderly Diversification Program Report] (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).\textsuperscript{22}
\item \textsuperscript{22} \textit{HRS Aging and Adult Services, Exhibit D-3A, Budget Request Printout for Period 1991-93}, at 2464 (Sept. 26, 1990) [hereinafter \textit{Budget Requests for 1991-93}] (available at Fla. Dept't of State, Div. of Archives, Tallahassee, Fla.).\textsuperscript{23}
\item \textsuperscript{23} \textit{Id.}
\item \textsuperscript{24} \textit{Pepper Commission Part A}, supra note 14, at 10.
\item \textsuperscript{25} \textit{Pepper Commission Part B}, supra note 18, at 28.
\item \textsuperscript{26} Office of Program Analysis, Medicaid Statistics, Feb. 1990, at 52 (Apr. 2, 1990) [hereinafter Medicaid Statistics] (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).\textsuperscript{27}
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years before they appear in other states because of Florida’s unique demographic composition.

The three major needs identified by the Urban Institute report were the need to reduce incidence of disability among those over sixty-five;\(^{28}\) the need to complete the construction of a fully developed, fully coordinated service delivery system from senior center activities to community based, in-home services to nursing home placement;\(^ {29}\) and, the need to develop financing mechanisms to fund fully developed services systems that will make them affordable to all older Americans.\(^ {30}\)

Florida International University, under contract with the HRS Aging and Adult Services Program Office, is completing a study designed to project needs among the over sixty-five population through the year 2000.\(^ {31}\) The report will not be ready until after this Article’s publication date, but some of the early findings shed light on many of the issues addressed in this Article and provide a specific perspective on the major issues raised in the Urban Institute Report. Fourteen percent of the population over the age of sixty receive or need help with one or more activities of daily living (ADL).\(^ {32}\) Only 56% of that figure actually receive daily assistance,\(^ {33}\) and only 16% report obtaining such help from a public agency.\(^ {34}\) Twenty-seven percent report receiving help from family members,\(^ {35}\) and 20% report serving as a caregiver for another in the last five years.\(^ {36}\) According to National Institute of Health projections, the number of Floridians over the age of sixty-five with a major ADL deficiency will grow from 530,000 in 1990 to 688,000 in the year 2000.\(^ {37}\) In addition, the number of disabled elderly over the age of seventy-five will grow from 318,000 in 1990 to 481,000 in the year 2000—a 50% increase.\(^ {38}\)

\(^{28}\) Id. at IV-18 to IV-20.

\(^{29}\) Id. at IV-20 to IV-36.

\(^{30}\) Id. at IV-37 to IV-50.

\(^{31}\) Southeast Florida Center on Aging at Florida International University, Aging 2000: Interim Report on the General Population—Survey of Older Floridians (June 1990) [hereinafter Aging 2000 Survey] (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.). An addendum of graphs and demographic statistics was compiled and is referenced hereinafter as Aging 2000 Survey Graphs (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.).

\(^{32}\) Aging 2000 Survey, supra note 31, at 12. For a list of some common activities of daily living, see supra note 17.

\(^{33}\) Aging 2000 Survey Graphs, supra note 31, Caregiving Graph.

\(^{34}\) Id.

\(^{35}\) Id. Of the help received from family members, 43% is received from daughters, 24% from spouses, and 23% from other relatives. Id.

\(^{36}\) Id.


\(^{38}\) Id. at 24.
The three general needs identified in the Urban Institute Report and supported by the findings from the Aging 2000 project and the current HRS Better Living for Seniors Initiative provide the fundamental framework for the major policy and budgeting priorities of the HRS Aging and Adult Services Program Office for the 1990’s. In preparing for the impact of previously mentioned demographic trends over the course of the next decade, Florida’s public and private sectors must be prepared to undertake efficient initiatives to protect the quality of life of its older citizens. Florida benefits enormously from the economic, social, and spiritual resources of persons over sixty-five as this group pumps over $25 billion annually into our economy. They deserve our best efforts to increase opportunities for their active participation in community life and to ensure the provision of effective services when they are needed.

The policy framework described in this Article does not address all of the issues arising from the demographic trends confronting Florida in the 1990’s. This Article focuses only on the role of the public sector. The private sector, however, also has a major role to play even within the limited framework developed here. A clear delineation of governmental priorities should clarify opportunities for the private sector and help provide the foundation for joint initiatives.

The motivating goals of the public sector are based on the values expressed in the sections of the Florida Statutes governing the provision of state supported services for older people. The fundamental mission of the aging services network and the HRS Aging and Adult Services Program Office is to ensure that people aged sixty and over receive the services of their choice in the least restrictive environment. The principal goals of these services is to maintain the self-sufficiency and autonomy of older people as long as possible and to ensure the safety and security of vulnerable and frail older people without unduly limiting their autonomy.

More specifically, the aging services network has designed and implemented programs to protect the physical and mental self-sufficiency of all older Floridians and to meet the needs of those who become dependent on social and medical services as their health and

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39. HRS AGING AND ADULT SERVICES, COMPREHENSIVE PLAN FOR BETTER LIVING FOR SENIORS (Mar. 1989) [hereinafter BETTER LIVING FOR SENIORS] (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.).

40. A lengthy discussion of the potential for private sector initiatives on aging issues is presented in L. POLIVKA, SPOTLIGHT ON AGING AND BUSINESS (Oct. 1989) (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.).

41. BETTER LIVING FOR SENIORS, supra note 39, at 4.

42. See id. at 6.
financial conditions decline. In accordance with this design, the programmatic focus of the public sector moves from general needs such as preventive health care, emergency services, and mental health services, to more narrowly defined issues affecting the special needs of the older population needing some form of long-term care. The last section of this Article briefly addresses a wide range of institutional issues affecting all older people.

I. Health Promotion and Preventive Care

The effectiveness of health promotion and preventive services is becoming increasingly apparent. One of the major reasons for the increasing longevity of the population is the 40% decrease in the number of deaths from cardiovascular diseases.\(^4\) This decrease is at least partially the result of improved health practices, including a decrease in the number of people who smoke.\(^4\) Virtually all of the health promotion and preventive care strategies that are effective for younger adults work at least as well, and frequently better, for people over sixty. Recent research has shown, for instance, that the beneficial effects of smoking cessation after the age of sixty are about as extensive as those associated with smoking cessation prior to that age.\(^5\)

Preventive care programs in Florida are currently a patchwork affair with some communities offering extensive services and others offering little. The state is now providing model services through county public health units in Hernando and Citrus counties.\(^6\) These are comprehensive programs whose clients benefit from a wide range of screening and educational services offered in a variety of conveniently accessible sites, including senior centers.\(^7\) The state also supports, with generous private sector contributions, volunteer physician programs in Broward County and southwest Florida that have become very proficient providers of preventive services and primary health care.\(^8\) Preventive care not only improves the quality of life of older people, it also delays the onset or progression of chronic and disabling conditions and the attendant need for continuous long-term care.\(^9\) This is one of the major ways in which prevention helps reduce the costs of health care.

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43. PEPPER COMMISSION PART A, supra note 14, at 20.
44. See Omenn, Prevention and the Elderly: Appropriate Policies, 9 Health Affairs 80, 83 (Summer 1990).
45. Id.
46. PEPPER COMMISSION PART A, supra note 14, at 21.
47. Id.
48. Id. at 21-22.
49. See Omenn, supra note 44, at 82.
The HRS Aging and Adult Services Program Office and the Pepper Commission have adopted the development of a comprehensive preventive health care program as a top policy priority.\textsuperscript{50} Aging and Adult Services has developed a health promotion and prevention care plan with a three-year implementation time frame.\textsuperscript{51}

II. ABUSE AND NEGLECT EMERGENCY SERVICES

As the population of older Floridians grows, the number of reported cases of elderly abuse and neglect will also increase. Efforts to educate the public about ways of preventing elderly abuse and neglect will help reduce the rate of increase, but the sheer increase in the number of older people, the increasing sensitivity of the public to the problem, and improved reporting mechanisms will produce a continuing increase in reports.

In particular, the greater than 70\% increase in the over eighty-five population during the 1990's\textsuperscript{52} will lead to large increases in the number of reported cases of self-neglect. This relationship is a function of the increased frailty and economic hardship of this group and the relative decline in support group resources. These increases are already evident in the number of cases reported in 1988 and 1989. Reported abuse and neglect cases jumped from 9,213 in fiscal year 1986-87 to 19,788 in fiscal year 1988-89.\textsuperscript{53} This trend will continue and will put increasing pressure on the state's ability to provide adequate emergency relief to abused or neglected older people. With the implementation of the automated abuse registry for children and adults in 1988,\textsuperscript{54} the state's ability to detect and investigate cases of abuse and neglect has greatly improved. However, the state does not yet have sufficient emergency services to meet the frequently temporary but urgent needs of this client group. This means that in some cases the opportunity to intervene early is lost, resulting in the increased costs of more extensive services provided later.


\textsuperscript{51}. See State Agency on Aging, supra note 50.

\textsuperscript{52}. See Pepper Commission Part A, supra note 14, at 6.


\textsuperscript{54}. Ch. 88-337, 1988 Fla. Laws 1774 (codified at Fla. Stat. § 415.504(4)(a) (1989)).
The HRS Aging and Adult Services Program is using $500,000 this year in CCE funds to increase the availability of emergency services. Much more than this amount will be needed to meet the immediate demand caused by the increasing number of abuse and neglect referrals.

III. Mental Health Services

The mental health needs of older persons have historically been neglected. Most assessments of the need for mental health services in the general population have noted that persons over fifty-five suffer from the greatest disparity between the need for services and their availability. There are admittedly not enough mental health resources to adequately meet the needs of any population group, and older people are also more reluctant than younger people to seek out professional help for mental health problems.

Basic misconceptions about need may account for much of the disparity. Too many mental health professionals believe that the majority of mental health problems among older people are a function of organic conditions, usually Alzheimer's disease or some other form of dementia, that are not responsive to conventional mental health interventions. In fact, the most prevalent mental health problem among older people is depression, which is arguably one of the most treatable of mental health disorders. Depression is a frequently predictable reaction to the losses that accompany aging, particularly the death of spouses, siblings, and other loved ones. Depression, if left untreated, can become a major precipitating cause of institutionalization of older people with deficiencies in the activities of daily living. Clearly, any effort to create a comprehensive array of community alternatives to institutional care must include increased access to mental health services.

In the past ten years, Florida has developed a number of effective mental health programs designed specifically for the older client. The

55. Fla. Stat. § 216.292(2)(a) (1989) permits the head of each department to transfer up to 5% of the originally approved budget when the circumstances are determined to be in the best interest of the state. Under this statutory authority, the Secretary of HRS Aging and Adult Services authorized the transfer of $500,000 of the fiscal year 1990-91 CCE budget for emergency services. See also Memorandum from Larry Polivka, Assistant Secretary, HRS Aging and Adult Services to 1-11 District Administrators (July 3, 1990) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).

56. See generally Shapiro, Are Elders Underserved?, 10 Generations 14, 14-17 (Spring 1986).

57. See id. at 16.

58. See generally Blue Ribbon Task Force on the Mental Health Needs of the Elderly, A Model Continuum of Mental Health Treatment For Older Floridians, at Executive Summary (Aug. 1989) [hereinafter Blue Ribbon Task Force] (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).
Geriatric Residential Treatment program is a community-based psychosocial, residential, and treatment program designed in 1980 to respond to the deinstitutionalization of geriatric clients. As cost-effective alternatives to mental hospital, these facilities serve persons over age fifty-five with the most serious mental health problems, frequently some form of dementia. Therapeutic foster homes are now available in many parts of the state and provide a wide range of services to older clients with a variety of mental health needs. Many community mental health centers now offer geriatric clinical mental health overlay services to older people in nursing homes and congregate living facilities. The 1990 Florida Legislature added counseling as a Community Care for the Elderly (CCE) service. These services, plus case management, constitute the foundation for a community-based continuum of mental health services for older people. The essential issue is to fund these services collectively at a level that will support their concentration in geographical areas small enough to allow inter-program coordination. The HRS Mental Health Program has developed and proposed a budget that would fund the development of a complete continuum in two of the eleven HRS districts in 1991 and 1992.

IV. TOWARD A COMMUNITY ORIENTED LONG-TERM CARE SYSTEM

As noted earlier, the percentage of Floridians over the age of sixty-five was at a level in 1984 that the rest of the country would not achieve until the year 2020. This statistic means that Florida will have to develop a far more extensive and varied array of long-term services than other states over the next ten years. Florida will also need to create more rigorous and integrated methods of managing and funding these services. A brief description of current community programs reveals that much of the framework for developing and managing the required array of services is now in place.

The federally funded Older Americans Act (OAA) provides funding under Title III for supportive services for those aged sixty and older and their spouses; it also funds state and area agency administration.
Among the goals of the Older Americans Act is the development of comprehensive and coordinated community-based systems of services for persons aged sixty and older in every community. 68 Area agencies use the resources available under the Older Americans Act to fill gaps in the local service systems as well as to coordinate and develop private and public resources. 69 Area agencies also act in their planning and service areas as the principal advocates and focal points for issues affecting the elderly. 70

The CCE Program offers an array of ten services to clients in their own homes, including homemaker services, personal care services, respite and chore services, medical transportation, adult day care, and health care. 71 In fiscal year 1990-91, the program will serve over 40,000 clients at a cost of $49 million. 72

The CCE Diversion Program is an intensive version of regular CCE designed to serve only clients who are eligible for nursing home placement. 73 This program allows more clients to receive multiple services than the regular CCE client services package. 74 The program has a current budget of $3 million, 75 and projects to serve over 700 elderly people in fiscal year 1990-91. 76

The Home Care for the Elderly (HCE) Program provides monthly subsidies to caregivers. 77 The regular HCE subsidy averages about $50.00 per month. 78 This program presently serves about 11,000 caregivers/clients for $11 million annually. 79

The Alzheimer’s Disease Initiative provides funding for research activities through memory disorder clinics at four university-related
sites, and it provides day care and respite services for eligible clients. The program receives about $4 million annually.

The Adult Congregate Living Facility Program and the Foster Home Program are the major community residential resources available to older people and disabled adults who require housing and some occasional limited assistance in their activities of daily living.

The State Nursing Home Program is funded through the Medicaid Program and provided for 17.8 million days of client care in 1988. In fiscal year 1990-91, the program will receive state and federal funds in excess of $838 million.

These programs provide a solid foundation for the development of a comprehensive long-term care system. The principal tasks required in this development are to expand existing community programs and create new programs to fill crucial gaps in the currently incomplete array of community services, to implement management techniques that ensure the efficient use of all long-term care resources, and to develop funding strategies to support the growth of community programs by reducing the fiscal imbalance between community and institutional care.

All of these tasks must be pursued simultaneously if Florida is to provide the kinds of services that older people and their families prefer. A recent national poll by the American Association for Retired Persons (AARP), and a similar study in Florida, found that older people vastly prefer in-home services or other community-based alternatives to institutional care.

The AARP survey was based on a random national sample of 1,500 adults age fifty-five and older. Eighty-six percent of those polled indicated a preference to remain in their homes, compared with 78% who expressed this preference three years ago. The most vulnerable segments of the older population were most likely to want to age at

80. STATE AGENCY ON AGING, supra note 50, at III-17.
81. ALZHEIMER'S DISEASE ADVISORY COMMITTEE, supra note 15, at vi.
82. STATE AGENCY ON AGING, supra note 50, at III-17 to III-18.
83. HRS OFFICE OF REGULATION AND HEALTH FACILITIES, FLORIDA HEALTH CARE ATLAS 120 (J. Barry Mittan ed. 1990) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).
84. APPROPRIATIONS 1990-91, supra note 75, at 354.
85. AMERICAN ASSOCIATION OF RETIRED PERSONS, AARP'S 1990 HOUSING SURVEY SHOWS MORE OLDER PEOPLE WANT TO AGE IN PLACE (Spring 1990) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).
86. See Aging 2000 Survey, supra note 31.
87. AMERICAN ASSOCIATION OF RETIRED PERSONS, supra note 85, at 1.
88. Id.
89. Id.
home.\textsuperscript{90} Leah Dobkin, AARP Housing Specialist, expressed her opinion about the results:

Determining how to maintain these people in their homes will be the greatest challenge to public policy makers and nonprofit housing, health, and social service providers . . . . Intensifying this challenge is the fact that these same subgroups are also most likely to live alone and to prefer living alone. Many lack a support system that could provide or monitor critical services.

. . . .

It seems to me that older people are now seriously committing themselves to staying where they are and are willing to accept help to reach that goal . . . . As a result, . . . there could be an increased demand for affordable and reliable home and outdoor maintenance and repair services, the availability of which could very well influence an older person’s decision to stay at home.\textsuperscript{91}

Naturally Occurring Retirement Communities (NORC’s) are neighborhoods or apartment buildings where 50\% of the residents are age sixty or older.\textsuperscript{92} The AARP survey indicated that these other types of communities are the most dominant and overlooked form of senior housing.\textsuperscript{93} Twenty-seven percent of those surveyed responded that they live in NORC’s, compared to only 5\% who responded that they live in retirement communities planned specifically for older adults.\textsuperscript{94} The survey also indicated that older people living in NORC’s were less dissatisfied about their housing than those elderly living in retirement communities.\textsuperscript{95} Similarly, a Florida survey of 1,950 people over age sixty\textsuperscript{96} found that 70\% preferred to stay in their own homes and receive help rather than move to another location, and 76\% preferred an apartment with a kitchen if they had to move.\textsuperscript{97}

It is clearly the task of the public and private sectors to cooperate in providing long-term care services in the least restrictive settings compatible with an individual’s needs, and to provide these services in the most efficient manner achievable.

\textsuperscript{90} Id. People 75 years of age or older, those with incomes of less than $12,000 a year, and widowed persons have been identified as those most vulnerable. Id.

\textsuperscript{91} Id. at 1-2.

\textsuperscript{92} Id. at 2.

\textsuperscript{93} Id.

\textsuperscript{94} Id.

\textsuperscript{95} Id.

\textsuperscript{96} See Aging 2000 Survey, supra note 31.

\textsuperscript{97} Aging 2000 Survey Graphs, supra note 31, Alternative Living Arrangements Graph.
A. Community In-Home Services

Several years of experience with programs like CCE demonstrate that elderly people with deficiencies in their activities of daily living who do not need intensive nursing care can be effectively served at home, particularly if a caregiver is available.98 A 1985 Inspector General evaluation of the CCE program found that most of the program’s participants were seriously disabled, and many were eligible for nursing home placement.99 Nursing home costs average $18,000 per client per year compared to an average cost of $1,200 per CCE client per year.100 Many of the others in the CCE program may have their need for nursing home care delayed by receiving CCE services.101 The amount of dollars saved through this program could be effectively increased by raising the average annual per client cost to the $1,800-$2,000 range and increasing the number of services provided.

Not everyone at risk of institutional placement, however, can be adequately served in an in-home setting through the regular CCE program. For instance, instead of homemaker or personal care services once a week, a person may need these services three or more times a week. The 1989 Legislature established the CCE Diversion Program to meet the needs of this rapidly growing sub-population of CCE clients.102 The CCE Diversion Program clients are funded at $4,200 a year, and each client receives an intensive array of services.103 Prospective clients must be eligible for nursing home services, and they must meet certain financial need criteria.104 An initial assessment of the program indicates that all clients meet the criteria and that the program has generated a broad base of support.105 The program has also demonstrated substantial potential for reducing long-term care costs through institutional avoidance.106 This potential would be enhanced by increasing the allowable annual general revenue expenditure cap for CCE Diversion Program clients who are at the greatest risk of institutionalization to $9,000 and the average annual client expenditure to $6,000. The general revenue contribution to nursing home

98. CCE Elderly Diversion Program Report, supra note 21, at 2-3.
100. FLORIDA HRS, supra note 4, at 61.
101. CCE Elderly Diversion Program Report, supra note 21, at 2.
102. Ch. 89-294, § 39, 1989 Fla. LAWS 1851-53 (codified at FLA. STAT. § 400.702 (1989)).
103. CCE Elderly Diversion Program Report, supra note 21, at ii.
104. See id. at 16.
105. See id. at 19-23.
106. See id. at 35-42.
Medicaid clients is now $9,000 annually. Therefore, even at the $9,000 cap and $6,000 average, the CCE Diversion Program would cost less than institutional placement. The Channeling Project, operated by the Miami Jewish Home and Hospital, is similar in design and administration to the CCE Diversion Program. The Channeling Project serves a population of seriously disabled older clients and is a compelling model for the future development of the CCE Diversion Program.

Another very promising nursing home diversion option is the Social/Health Maintenance Organization. This is, in effect, an insurance plan designed to provide complete inpatient, outpatient, and preventive care for a group of plan participants at a cost below the standard market rate for each of the services provided separately. The ElderCare Program, operated by the Mt. Sinai Hospital in Miami since 1988, is based on the Social/Health Maintenance Organization model. A recent evaluation by Mathematica Policy Research, Inc. revealed that the ElderCare Program provides cost-effective alternative care to nursing home placement. The clients meet nursing home level of care requirements, but are maintained in the community with services that cost an average of $1,000 a month, compared to...

107. In fiscal year 1988-89, the cost of nursing home care for a seven month stay was $12,304; thus, for a twelve month stay, the cost would be approximately $20,000. See Transmission from Charlie Liem, Administrator, HRS Medicaid Waiver Section to Larry Polivka, Assistant Secretary, HRS Aging and Adult Services (Oct. 19, 1990) (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.). Thus, $9,000 is the 45% (of the total twelve month stay) contributed by the State of Florida from its general revenue. Medicaid Statistics, supra note 26, at 52.

108. For a description of the Channeling Project, see HRS Office of Evaluation and Management Review, Interim Evaluation of the District XI Channeling Demonstration Project (May 6, 1984) [hereinafter Channeling Project] (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.). A description of the CCE Diversion Program can be found in CCE Elderly Diversion Program Report, supra note 21, at 9-18. While similar to the Channeling Project, the Community Care for the Elderly Diversion Program is integrated with all programs administered by the HRS Aging and Adult Services Program. Id. at 10. The CCE Diversion Program also operates in all HRS districts, rather than at selected sites in the state, and has the potential to utilize a broader array of community services. Id.


111. Id. at 31.


113. Id. at 171-81.

114. Id. at 49.

115. Id. at 107.
nursing home costs of $2,000 a month.\textsuperscript{116} These results indicate that the state should encourage more hospitals and large health care providers to implement Social/Health Maintenance Organizations.

Elderly persons with Alzheimer's disease present another group that could be more cost-effectively cared for in the home. The Florida Legislature established the Alzheimer's Disease Initiative in 1985.\textsuperscript{117} The initiative was funded to provide diagnostic, day care, and respite care services to Alzheimer's victims, and to support university-based research activities.\textsuperscript{118} The program now receives $5 million and serves about 1,500 clients,\textsuperscript{119} which is about 1% of all Alzheimer's sufferers in Florida in 1990.\textsuperscript{120}

Recent estimates of the prevalence of Alzheimer's disease indicate that the percentage of the over eighty-five population with Alzheimer's may be between 40% and 50%.\textsuperscript{121} If this estimate is accurate, the number of Floridians over the age of eighty-five suffering from Alzheimer's disease will exceed 150,000 by the year 2000.\textsuperscript{122} The growing number of Alzheimer's victims will greatly increase the demand for community services, and in the absence of these services, institutional costs will escalate.

If the full potential of the regular CCE, CCE Diversion Program, and Alzheimer's programs for meeting the long-term care needs of an increasingly older population are to be realized, substantial funding increases will be required over the next several years. The regular CCE program, which served 39,000 clients in fiscal year 1989-90,\textsuperscript{123} is currently meeting only one-third of the estimated need for CCE services among elderly over the age of sixty.\textsuperscript{124}

The number of frail elderly in greatest need of services will increase steadily through the 1990's. Thus, any cost-effective strategy for responding to the long-term care needs of this population must include large and continuing investments in community in-home and residential care. This approach could strengthen the provision of informal

\textsuperscript{116} Id. at 116.
\textsuperscript{117} Ch. 85-145, 1985 Fla. Laws 1035-37 (codified at Fla. Stat. § 410.401 (1989)).
\textsuperscript{118} Id.
\textsuperscript{119} See Alzheimer's Disease Advisory Committee, supra note 15, at 1.
\textsuperscript{120} See Budget Requests for 1991-93, supra note 22, at 2530.
\textsuperscript{122} This number is based upon a prediction that 347,000 persons over the age of 85 will be living in Florida by the year 2000. See Pepper Commission Part A, supra note 14, at 7. Forty-five percent of this population would be approximately 150,000 persons.
\textsuperscript{123} Letter from Larry Polivka, supra note 20, at attached graph.
\textsuperscript{124} Id.
care by family members, friends, and private sector organizations by building formal support systems in the community. Nationally, over 80% of long-term care services are now provided by family members.\textsuperscript{125} It is essential that this level of care be maintained or increased by adding the kinds of services provided through CCE, HCE, and CCE Diversion Program to the care offered by families and others in the informal system.

\textbf{B. Community Residential Programs}

One of the greatest challenges in building a full array of community long-term services is filling the current gap in community residential care. The two major community residential programs now available are the Adult Congregate Living Facility (ACLF) and the Foster Home programs.\textsuperscript{126} There are about 5,500 state supported clients in the ACLF programs, and approximately 450 state supported clients in foster homes.\textsuperscript{127} The Foster Home Program had 945 state supported clients five years ago.\textsuperscript{128} Both of these programs will need to be expanded substantially over the next several years, and enhancements need to be made in the kind and amounts of services provided if the state is to have a full array of cost-effective alternatives to institutional care.

The state currently pays $542.00 a month for room, board, and a limited range of services for eligible clients in ACLF's.\textsuperscript{129} A 1988 cost report found that the payment level should be $711 per month just to cover the costs of operating an ACLF at an acceptable level.\textsuperscript{130} Adult Congregate Living Facility providers are not likely to take many more state supported clients until the payment level is increased substantially.

The state must also address the need to allow ACLF's and Foster Homes to provide a wider range of services and to pay for them. The current gap between nursing homes and ACLF services should be filled through the development of an assisted living program which would provide a wide range of services, including ready access to

\begin{flushright}
\textsuperscript{125.} PEPPER COMMISSION PART A, supra note 14, at 9.
\textsuperscript{126.} See STATE AGENCY ON AGING, supra note 50, at III-17 to III-18.
\textsuperscript{127.} PEPPER COMMISSION PART B, supra note 18, at 27.
\textsuperscript{128.} Budget Requests for 1991-93, supra note 22, at 2464.
\textsuperscript{129.} Letter from Karen Wilson, President of Concepts in Community Living, Inc. to Larry Polivka, Assistant Secretary, HRS Aging and Adult Services (Feb. 26, 1990) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).
\textsuperscript{130.} HRS OFFICE OF EVALUATION AND MANAGEMENT REVIEW, ADULT CONGREGATE LIVING FACILITIES RATE STUDY 40-41 (1988) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).
\end{flushright}
nursing care for individuals living in apartment settings. Assisted living would represent a significantly enhanced form of the ACLF program, but those elderly in an assisted living program would be less dependent on nursing services than those in nursing homes. Clients also would have greater privacy and freedom of movement than is usually allowed in nursing homes.

The current reimbursement system does not allow for variations in the payment structure and prohibits facilities from providing different packages of services to meet different resident needs. There is no reimbursement mechanism to allow for the changes in residents' needs as they become more frail. The assisted living program outlined above would be funded by a system of reimbursement which ties a complete service package to the level of payment. The cost ceiling would be set at the Medicaid nursing home cost level. The total program funding would be pegged to an average annual per client expenditure of 80% of the average Medicaid nursing home cost. The program would then be a cost effective alternative to nursing homes.

The state must also be prepared to expand and improve foster home care. The decline in the availability of foster homes should be reversed and, like ACLF's, they should be funded to provide a wider range of services. A Foster Care Program developed in Oregon provides services to 6,000 elderly clients with disability levels similar to many nursing home clients, and the program ties reimbursement to service packages. In Oregon, the average Medicaid nursing home rate is $1,615 per month and the average expenditure under the Foster Care Program is $800 per month per client, with some homes receiving as much as $1,600 monthly for severely dependent clients with intensive services needs. It is unlikely that Florida will develop a foster care program as extensive as the one currently functioning in Oregon, but major increases in the number of foster care beds and in the provision of services to foster care clients are essential objectives for the development of a full array of community programs.

131. For a detailed proposal of such an assisted living program, see K. Wilson, Assisted Living: The Merger of Housing and Long-Term Care Services (unpublished paper) (available at Fla. Dept' of State, Div. of Archives, Tallahassee, Fla.).
132. Id. at 3.
133. Id.
134. See Letter from Karen Wilson, supra note 129.
135. Id.
137. Id. at 139, 139A. Intensive services needs are required by clients who are incontinent or wheelchair dependent. Id.
V. Management Strategies

As the number of state supported community programs has grown since the late 1970's, the state's capacity to manage these programs effectively and in a client-responsive manner has paradoxically increased and diminished. The nursing home pre-admission screening program (CARES) has become a very effective mechanism for identifying and diverting Medicaid eligible clients from unnecessary nursing home placement to alternative community programs. The percentage of clients screened and diverted continues to increase each year. This is a result of several factors including improved screening, increased availability of community resources like those provided in the CCE Diversion Program, and more targeting of services to clients based on need. There are, however, several deficiencies in the current management of community programs which are likely to become more evident as the demand for services increases. Without major increases in the number of staff needed to operate the CARES and financial eligibility (SSI-related program) processes, the delivery of services to clients will become increasingly inefficient and the cost-effectiveness of community care will be diminished. This staff is necessary to manage the provision of services to clients through case management, and to handle the growing burden of administrative and financial management tasks.

The overall administrative capacity of aging programs has failed to keep pace with the growth of services for several years. The CARES Program was designed to conduct comprehensive evaluations of 50% of all applicants for nursing home placement. Workload increases, however, have reduced the percentage of evaluations to 40% of all applicants. Case managers in the CCE Program have caseloads of over one hundred clients. In order to provide effective service in this area, most experts think that caseloads should not exceed sixty.

Increased productivity must be a constant concern in both the public and private sectors. Productivity enhancements, however, should not come at the expense of meeting the minimal requirement for doing effective work. A consensus should be reached in staffing standards at all organizational levels and these standards should be adhered to rou-

138. For a further description of the CARES Program, see Budget Requests for 1991-93, supra note 22, at 2625-26.
139. Id. at 2627.
140. Id. at 2626.
141. Id.
142. Id. at 2513.
143. See id.
tinely as programs are expanded to meet service needs. The standards should be adjusted as proven productivity enhancements are developed.

One of the major sources of increased productivity is computerized information systems. The computer technology is now available to develop a comprehensive information system that will generate detailed, timely, and accurate client and financial data. Successful development of a long-term care system with an extensive array of community services depends on the ability of case managers, service providers, and HRS managers to assess client needs accurately. They can then match the clients with assessed needs to specific programs, track and monitor their progress, and conduct complete and timely financial audits. Only a fully computerized and integrated information system will provide these capabilities. With the current array of fragmented and partial systems, it is difficult to document who is receiving services, what kinds of services they are receiving, and what the effects of these services are. A comprehensive information system is now being developed as a pilot project in the Orlando area. Such a system will need to be implemented statewide before its full benefits can be realized.

Finally, the organizational structure of the HRS Aging and Adult Services Program in Florida must be assessed in terms of its readiness to support the development and efficient management of services needed by the rapidly increasing number of older people. The current structure was largely created in the 1970's and early 1980's. The major modification in the last five years was the integration of the CARES Program and the SSI and Medicaid eligibility determination programs with the HRS Aging and Adult Services Program in 1988. This integration improved the administration of all aging services and created the framework for new programs like the CCE Diversion Program. Increased accountability and service delivery efficiency, however, may require more extensive restructuring at the state and local levels.

VI. FUNDING STRATEGIES

Florida cannot depend on increases in state general revenue alone to build the array of services recommended here to meet the needs of the

144. See Memorandum from Kerry Schoolfield, Medical Health Care Program Analyst, HRS Aging and Adult Services to Larry Polivka, Assistant Secretary, HRS Aging and Adult Services, attachment (Sept. 28, 1990) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).

145. See Response to the Executive Office of the Governor, Cares Transition (June 15, 1988) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.); Memorandum from Margaret Duggar, Assistant Secretary, HRS Aging and Adult Services and Don Winstead, Assistant Secretary, HRS Economic Services to 1-11 District Administrators (Dec. 5, 1988) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).

146. PEPPER COMMISSION PART A, supra note 14, at 2.
state's older population over the next ten years. The total expenditures for Medicaid nursing home care increased four-fold during the 1980's. In comparison, the state is now spending about $66 million for the CCE, HCE, and the Alzheimer's Initiative programs. The community programs receive relatively small incremental increases annually. The Medicaid supported nursing program, however, has been increasing at a rate of 20% for several years. If these patterns hold over the next ten years, the Medicaid nursing home budget will exceed $3 billion in the year 2000, but the budget for community programs will barely reach $100 million.

These figures demonstrate the clear need to adjust the fiscal relationship between community and institutional programs by funding a shift from institutional to community-based long-term care programs. This should not occur at the expense of providing for an acceptable quality of nursing home care. Instead, it should be achieved by reducing the need for institutional care through the diversion of long-term care clients to a greatly expanded series of community programs. There are several ways to fund such a shift in emphasis, including, for those who can afford them, an expansion of long-term care insurance policies that cover community services, and an increase in the number of individuals receiving elder-care services from private and public employers.

Most experts predict that only a modest number of those needing long-term care in the future will be able to pay premiums for long-term care insurance. The state and federal governments will remain the principal payer for those who cannot afford private insurance. A greater effort should be made, however, to create public and private partnerships designed to promote private insurance. A leading so-

147. Memorandum from Mike Urban, Bureau Chief, Administrative Services, HRS Aging and Adult Services to Larry Polivka, Assistant Secretary, HRS Aging and Adult Services, at attached graph, Comparative Funding—AAS & Medicaid NH (Apr. 9, 1990) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.). In fiscal year 1990-91, Florida will spend $838 million on nursing home care. APPROPRIATIONS 1990-91, supra note 75, at 354.

148. Id. Forty-five percent of these amounts is state general revenue and 55% is federal funding. Medicaid Statistics, supra note 26, at 52.

149. Memorandum from Mike Urban to Larry Polivka, supra note 147, at attached graph, Comparative Funding—AAS and CYF Total Funding. See also PEPPER COMMISSION PART B, supra note 18, at 29.

150. See Memorandum from Mike Urban to Larry Polivka, supra note 147, at attached graph, Comparative Funding—AAS & Medicaid NH.

151. See Wiener, Which Way For Long-Term-Care Financing?, 14 GENERATIONS 5, 7-8 (Spring 1990).

152. Id. at 7-8.
ciologist has pointed out that a majority of those requiring extended or long-term care will probably be dependent on public sector support. For this group, the major method of shifting the focus of long-term care is to redirect a significant percentage of the projected Medicaid budget from institutional to community programs. Several states are beginning to move in this direction, including Oregon, which has stabilized nursing home admissions since 1980 by greatly increasing community programs. Approximately 70% of the funding for Oregon's community programs comes from the Medicaid budget. It is not unreasonable to set a goal of increasing the percentage of Medicaid funding for Florida's community programs from 8% to between 35% and 40% and using the increase to fund a major expansion of the community portion of the long-term care system.

The state Medicaid program and the HRS Aging and Adult Services Program are now actively pursuing several avenues for achieving these goals. Methods of expanding the Medicaid support for community programs include the following:

A) The program should expand and improve screening of potential nursing home clients. The current CARES program has increased the number of potential clients diverted to nursing home alternatives. The program should be expanded to screen all HRS Aging and Adult Services clients.

B) The program should increase the service packages for all aging services programs, both in-home and community residential, in order to enhance their capacity to serve clients who are eligible for nursing home care and who may be served under a Medicaid waiver.

C) The program should provide more services to clients that are now reimbursable under the Medicaid waiver, thus expanding services with federal financial assistance. Such services would include speech, physical and occupational therapies, home repair, adaptive equipment, medical supplies, and case management.

D) The program should develop pilot projects designed to greatly increase community program alternatives that would delay signifi-

153. Id. at 5.
156. The Medicaid budget for the community services provided in the State of Florida was $4.6 million for fiscal year 1989-90. HRS, Medicaid Waiver Earnings, July 1989-June 1990 (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.). This figure represents approximately 8% of the total community services budget for fiscal year 1989-90 of $66 million. Pepper Commission Part B, supra note 18, at 29.
cantly the projected growth in nursing home growth over a three-year period. The community initiative would focus on expansions of the CCE Diversion Program and community residential programs (ACLF, Foster Homes) offering enriched service packages. As many clients as possible would be included under the Medicaid waiver. If successful, these pilot projects could become the model for a statewide program in 1994-95 based on a capitated Medicaid waiver, rather than a waiver capped by the current formula which allows waiver services for only 9,400 clients in 1990.\textsuperscript{158} Part of the funding for the pilot projects should be provided from the projected nursing home expenditures that would not be spent as the community alternatives are increased.

E) The program should include the CCE Diversion Program in the State Estimating Conference that projects the number of people who will be eligible for Medicaid nursing home services each fiscal year, beginning with the 1991-92 fiscal year. By adding the diversion program now and the ACLF and foster home programs with enriched services packages later, the nursing home Medicaid budget could be reduced by serving some conference-determined percentage of the projected Medicaid nursing home caseload in the less expensive community programs. The pilot projects described above would provide the conference the opportunity to assess the impact of a full array of community programs on nursing home growth and expenditures.

VII. INSTITUTIONAL ISSUES

The previous sections of this Article generally describe a policy framework for responding primarily to the serious needs experienced by a minority of the elderly population. Most older people will never need nursing home care or an extensive array of community services. All older people and their families, however, can certainly benefit from the peace of mind arising from the knowledge that these services will be available if necessary. Assuring this availability is the major objective of the policy initiatives outlined in the earlier sections. There are, additionally, several other areas that must be addressed in a comprehensive effort to meet the needs likely to be experienced by the majority of the elderly population.

\textsuperscript{158} A description of the current formula is found in HRS REGULATION AND HEALTH FACILITIES, OFFICE OF COMPREHENSIVE HEALTH PLANNING, HEALTHY FLORIDIANS: THE 1989 FLORIDA STATE HEALTH PLAN 132 (July 1989).
A. Images of Aging and The Media

America is a youth-oriented society. As the median age increases, however, an awareness of aging as an opportunity for positive change and increased community involvement is emerging. These contrary perceptions produce confused and often contradictory attitudes about aging. The need for public awareness about a variety of topics concerning older persons represents an opportunity for the media to play a major role in preparing society for a constructive adjustment to future demographic changes.

Partnerships need to be developed between the media and aging network organizations to address both public awareness and public attitudes regarding issues affecting older persons. The media must be prepared to promote increased understanding of aging issues, for it has great potential to change attitudes about older people and create opportunities that will improve the quality of life for people of all ages.

B. Employment of Older Workers

The average retirement age among men nationally has gradually fallen from the mid-sixties in the late 1960’s, to the mid-fifties in 1983. This steady withdrawal of older workers from the labor force is a function of several factors including attractive early retirement packages, and management misconceptions of the productivity of older workers. In its monthly periodical, the Employee Benefit Research Institute noted the following trends and important issues in early retirement:

The labor force participation rate for men aged 55-64 has fallen since 1970 from 83 percent to 67.2 percent in 1989.

Nearly one-half of all male workers and nearly 60 percent of female workers begin receiving Social Security at age 62, the earliest age possible.

In 1988 almost three-fifths of participants in defined benefit pension plans sponsored by medium-sized and large establishments could receive normal retirement benefits before age 65, although they often had to meet minimum service requirements.

Less-than-full actuarial reductions and other subsidies in employer-sponsored pension plans may cause a peak in pension accruals and thus may encourage retirement at a particular age. One

159. L. Polivka, supra note 40, at 1.
160. Id.
161. See id. at 2-3.
study examined characteristics of about 1,500 defined benefit pension plans and found that benefit accruals generally peaked at the age of early retirement eligibility.

Employers may offer enhanced early retirement benefits to reduce their work force in lieu of layoffs. Such incentives may persist because both employers and employees may prefer earlier retirement. In one survey, nearly two-thirds of employers offering incentives found that more employees accepted the early retirement incentive plan than the employer anticipated.

Fifty-seven percent of retirees aged 55-64 and 67 percent of nonretirees aged 55-64 had employer-based health insurance in 1987. Both retirees and nonretirees were about equally as likely to have coverage from some source.

The Labor Department estimates that the labor force as a whole will grow more slowly, increasing 1.2 percent annually between 1988 and the year 2000, compared to an annual growth rate of 2.0 percent in the previous 12 years. Slower growth in labor supply may require older workers to remain employed longer.162

This trend toward early retirement may be reversed over the next decade as the number of younger workers fails to keep up with the growing demand for labor. This will be a particularly beneficial development for poorer older persons who need continued employment to remain self-sufficient. A large portion of this category includes minority women163 who, because of the nature of their work histories, do not have adequate social security benefits.164 Any effort to create more employment opportunities for older workers must include initiatives designed to educate employers about the economic advantages of hiring older workers. Research has shown that older workers are at least as productive as younger workers in most jobs,165 and are reliable and loyal employees capable of learning new tasks.166

C. Housing

Another critical issue for the maintenance of a self-sufficient older population is accessibility to appropriate housing. Accessible housing refers both to the accessibility of the building in terms of its design,
and the accessibility of the location in terms of proximity to shopping and health care.  

Older persons have been characterized in recent research as having diverse needs for products and services. This diversity is reflected in the demand by the elderly for different housing products.

Florida’s rapid land development causes inflated property values in areas in or near major metropolitan areas. Price scales for new homes in these areas, therefore, attract only the most affluent buyer. Land values are lower in rural areas, thus the development of affordable new homes and condominiums concentrates in these communities. Increasing land values also cause conversions of affordable mobile home park housing to higher scale developments. These conversions are occurring in South Florida markets where mobile home developments have been annexed by municipalities and where zoning changes tracts of land from agricultural to residential zoning. These conversions result in a dramatic increase in the value of a rented mobile home plot, and the eventual eviction of the retired person on a fixed income who cannot afford the property’s new value.

Such mobile home park conversions are evidence of the limitations of mobile home ownership as a viable retirement plan. Ten years after purchase, a mobile home is often in disrepair and unable to be moved without prohibitive cost. Thus, elderly and physically limited owners may lose the equity value of the mobile home as well as the independence and self-sufficiency of home ownership. These situations shift the burden onto publicly funded emergency shelter programs and municipal governments who then must deal with the problems of the elderly homeless. The Florida Legislature should create alternative housing programs which include housing subsidies, home sharing, housing counseling, home renovation, and home equity conversions.

### D. Transportation

Meeting the transportation needs of older persons is a prerequisite to their independence and to their achieving access to health and so-

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167. See PATHWAYS 2000, supra note 1, at 68.
168. Id.
169. Id.
170. Id.
171. Id.
172. Id.
173. Id.
174. Id.
175. Id.
176. Id.
177. Id.
178. Id.
Many elderly persons maintain full and active lives because their access to transportation provides them with a certain level of independence. Public transportation services for the elderly are essential because many elderly passengers are not able to or should not drive an automobile. Those who can drive may not be able to afford the operating expenses and insurance cost of owning an automobile. Also, many of the elderly would be less dependent on others if transportation services were more readily available.

Florida is one of the ten more populous states which does not provide operating assistance to local transit systems. The historical absence of state provided assistance is a major reason Florida has relatively few buses operating at “peak” hours. Since 1980, the number of operating buses in Florida has decreased in relationship to need due to decreases in the federal operating funds and local resources. Only through greater local and state effort can Florida obtain the transit system it needs to meet the transportation needs of the elderly.

E. The Special Needs of the Minority Elderly

The 1984 amendments to the Older Americans Act authorized that preference be given to older persons who were in the greatest economic or social need, giving particular attention to low income minority individuals. The minority elderly generally experience more complicated health problems and other needs because of their generally lower socioeconomic status. In Florida, the minority elderly are more likely than non-minority elderly to be widowed, living alone, living in rental units, living without air conditioning, and living with incomplete plumbing. Furthermore, many minority elderly in Florida are also linguistically and culturally disadvantaged. About 66% of the elderly Hispanics, 40% of the elderly Asians, 33% of the elderly American Indians, and 10% of the elderly African-Americans cannot speak English. This frequently discourages the minority elderly

179. Id. at 96.
180. Id.
181. Id. at 58.
182. Id. at 57.
183. Id.
184. Id.
186. PATHWAYS 2000, supra note 1, at 60.
187. Id.
188. Id.
189. Id.
from using supportive services available to them in their communities.\textsuperscript{190}

Economically, the minority elderly often have a lower income than non-minority elderly.\textsuperscript{191} According to a 1985 report on social security: "Nonwhite elderly individuals have substantially lower money incomes than white elderly. In 1984, the median income of white males aged 65-69 was $12,749 compared to a median of $7,545 for black men, and $8,778 for hispanic men. Income differences between minority women and white women were not as pronounced."\textsuperscript{192}

It appears that, for various reasons, minority elderly nationwide are not utilizing Older Americans Act Programs. One reason is a perception among the minority elderly that these programs are unresponsive to their needs and priorities. Also, the programs suffer from ineffective outreach systems, and unsuccessful monitoring and evaluation programs. Finally, the programs lack the basic necessities of a bilingual staff and written materials in languages other than English.\textsuperscript{193}

United States census reports, statewide survey findings, and minority aging studies all indicate that minority elderly are among the most disadvantaged groups in Florida and in the United States.\textsuperscript{194} In response, state and area agencies on aging should develop aggressive state policies to improve utilization of all aging services by our most disadvantaged and vulnerable Floridians: older minority persons.

\section*{F. Gender and Aging}

During their working lives, women have historically earned less than men. The concentration of women in relatively low wage jobs, the assumption of the family caregiver role which removes many women from the labor market for long periods of time, and labor market discrimination, among other factors, all contribute to this disparity.\textsuperscript{195} As women get older, this difference becomes more onerous. Although 63\% of the elderly are women, 73\% of the elderly poor are women, and 82\% of the elderly poor who live alone are women.\textsuperscript{196}

A review of the data on the income gender gap indicates that differences in longevity and income levels between men and women largely

\begin{footnotes}
\item 190. Id.
\item 191. Id. at 61.
\item 192. Id.
\item 193. Id.
\item 194. Id.
\item 196. Davis, Grant & Rowland, Alone & Poor: The Plight of Elderly Women, 14 GENERATIONS 43, 43 (Summer 1990).
\end{footnotes}
shape the experience of growing older.\textsuperscript{197} Women live longer and are poorer than men,\textsuperscript{198} which means they are less secure and more vulnerable than men. In addressing policy options designed to reduce gender income differences, researchers note:

Guaranteeing women equality of opportunity in the labor market may eliminate some of the disparity in old-age security, but such a solution will not eliminate the gender gap. Pension structures penalize women in invisible ways by not granting credit for family time. One political possibility, negotiated in the public sector, is to provide women full credit for their nonmarket labor in pension schemes; the second, which involves intervention into the private lives of individuals, requires equalizing non-market work between men and women, so that the losses associated with caring for the family are redistributed between men and women.\textsuperscript{199}

Another researcher has recommended Social Security reform to reduce the poverty level among older women.\textsuperscript{200} Specifically, Social Security credits should be given for caregiving, and the total combined social security credits earned by the husband and wife during the marriage should be shared equally.\textsuperscript{201}

Further suggestions identify other reforms that would reduce poverty among all elderly, although elderly women would benefit most since they comprise a higher percentage of the impoverished.\textsuperscript{202} For instance, if the Social Security benefit level to the poverty threshold were raised, the poverty rate among the elderly would immediately be reduced from 12\% to less than 8\%, and among those elderly persons living alone the poverty rate would be reduced from 19\% to 12\%.\textsuperscript{203} Thus, about 600,000 poor elderly persons living alone would be raised out of poverty.\textsuperscript{204} Also, if poor elderly people received full Medicaid coverage, and if the near-poor were allowed to purchase Medicaid benefits on a sliding scale basis, then financial protection against the

\textsuperscript{197} See Quadagno & Meyer, Gender & Public Policy, 14 Generations 64, 64-66 (Summer 1990).

\textsuperscript{198} Davis, Grant & Rowland, \textit{supra} note 196, at 43.

\textsuperscript{199} Quadagno & Meyer, \textit{supra} note 197, at 66.

\textsuperscript{200} Glasse, Growing Old: It's Different for Men and Women, 14 Generations 73, 75 (Summer 1990).

\textsuperscript{201} \textit{Id}.

\textsuperscript{202} Davis, Grant & Rowland, \textit{supra} note 196, at 43-47.

\textsuperscript{203} \textit{Id} at 45 (citation omitted).

\textsuperscript{204} \textit{Id}. Of the 600,000 impoverished elderly who are living alone, 400,000 are widows. \textit{Id}. Furthermore, poverty among elderly widows living alone in the year 2020 would be reduced by up to 30\% if the Social Security benefits were increased now. \textit{Id}. (citation omitted).
cost of medical bills could be enhanced.\textsuperscript{205} It would cost less than $2 billion in federal and state funds to provide this protection.\textsuperscript{206}

These changes would ensure that impoverished elderly women who live alone would have access to appropriate care to treat their failing health. "[A] relatively small investment to supplement improvements to the Medicaid and SSI programs . . . would go far in assuring that no elderly person lives in poverty . . . and would reduce the risk of institutionalization faced by severely impaired elderly people of all incomes."\textsuperscript{207}

\section{G. Geriatric Training and Medication}

As the population over sixty-five grows, the demand for geriatric oriented care will increase. This trend will magnify the need for geriatric training of physicians, nurses, and other health care professionals. The Pepper Commission has noted that there is now relatively little funding for geriatric training in Florida's health care training programs.\textsuperscript{208} The Pepper Commission recommendations to increase funding for geriatric training must be implemented immediately to ensure the availability of future services for the elderly.\textsuperscript{209}

One of the benefits of increased geriatric training would be a reduction in the over-medication of elderly patients. It is important to note that physicians, not pharmacists, are the health care providers involved in prescribing decisions.\textsuperscript{210} In order to make decisions that are more clinically intelligent or cost-effective, physicians need programs to teach them how to use and prescribe drugs more precisely.\textsuperscript{211} The economic effects of such programs has been shown to far exceed the cost of their implementation and administration.\textsuperscript{212} These types of programs improve the quality of clinical decision making, therefore, the quality of care will also be improved. Researchers also document

\begin{itemize}
\item \textsuperscript{205} Id.
\item \textsuperscript{206} Id. (citation omitted).
\item \textsuperscript{207} Id. at 47.
\item \textsuperscript{208} PEPPER COMMISSION PART A, supra note 14, at 34.
\item \textsuperscript{209} Id. at 34-35. The increased funding would provide for programs to encourage retired physicians to become active part-time providers to offset the primary care shortage areas. Id. at 35. These physicians would also be requested to incorporate the study of the aging process in the medical school curricula, to encourage and develop internships in aged care settings, to create residencies in geriatric medicine, to encourage and support medical, public health, and social science research into the health care issues of the aged, and to encourage the role of rural hospitals in providing care to elderly persons. Id.
\item \textsuperscript{210} Avorn, The Elderly and Drug Policy: Coming of Age, 9 HEALTH AFFAIRS 6, 13 (Fall 1990).
\item \textsuperscript{211} Id.
\item \textsuperscript{212} Id. (footnote omitted).
\end{itemize}
that physicians, nurses, and aides modify their use of psychoactive drugs in a nursing home setting when educated in geriatric pharmacology.213

More research on the effects of medication among the elderly is also needed. As with geriatric education, however, relatively few resources are currently available for this task. It would require only "small sums of research money intelligently spent [to] save their cost several times over in directly related public and private expenditure."214

H. Senior Volunteers

Since the early 1980's, Florida has created several volunteer programs for older people. The Retired Seniors Volunteer Program (RSVP) and Senior Companion Program (SCP) are outstanding examples of what can be achieved by providing older people with well organized and managed opportunities for volunteer services.215 These programs are not large enough to take full advantage of all the potential for volunteer activity that exists among Florida's elderly; in fact, Florida has just barely begun to take advantage of this large and growing resource.

Many older people would be delighted to volunteer their experience and energy in service to children in schools, day care centers, group homes, hospitals, and to adults in programs like community care for the elderly and halfway houses for the developmentally disabled. The ability of programs to increase the volunteer activities of the elderly hinges on an expansion of management capabilities at the state and local levels. Volunteers are a very cost effective resource, but they are not free. Their time and efforts need to be properly managed if they are not to be wasted or overlooked.

I. Consumer Protection

As the number of people over the age of seventy-five grows, the number vulnerable to unscrupulous and fraudulent consumer practices will increase. The current concern over medigap insurance and the emerging concern about long-term care insurance demonstrates the kind of consumer worries that accompany the aging of the population. The HRS Aging and Adult Services Program Office is now developing a collaborative initiative with the Florida Department of Insurance and the American Association of Retired Persons to pro-

213. Id. at 16 (footnote omitted).
214. Id. at 17.
vide insurance counseling services throughout Florida by the end of 1990.216

There are many areas in addition to insurance, however, where the potential for fraudulent practices is substantial. The public and private sectors should cooperate in developing an expanded capacity at the state and local levels to protect the interests of older consumers. The state aging office should have a senior consumer protection unit which could provide guidance and support for similar units at the district level, probably in area agencies on aging or through senior centers. These units could also serve as a focal point for crime prevention and victim support services targeted to the elderly.

J. Intergenerational Initiative

The public and private sectors have just begun to take advantage of the opportunities for intergenerational programs offered by Florida's large population of active, service oriented elderly. Communities can certainly benefit from intergenerational day care centers and the use of elderly volunteers or part-time elderly workers in children's day care centers. The Foster Grandparent program is just one example of an effective and popular federal program that has brought joy and fulfillment into the lives of many children and older people.217 These trends will continue to grow as the number of day care centers and children in need of special attention increase over the next several years.

The belief that the elderly are exceptionally affluent has been used by a few public policy analysts to claim that the elderly receive too much of the public dollar.218 The fact is, however, that the elderly are the only adult group to experience significant increases in the number of people each year who become impoverished.219 Furthermore, recent data indicate that fewer older people are receiving pensions. According to a recent article in the New York Times:

The company-financed pension, once envisioned as a principal source of retirement income for millions of Americans, is instead an

216. See Pepper Commission Part A, supra note 14, at 32.
217. For a detailed description of the Foster Grandparent Program and some project examples in Florida, see Action, Action Annual Report 6-7 (1989) (available at Fla. Dep't of State, Div. of Archives, Tallahassee, Fla.).
218. See The Villers Foundation, supra note 16, at 5.
219. See id. at 11. "According to the Census Bureau, some 3,456 million elderly Americans (men and women aged sixty-five or older) were poor in 1985. This was an increase of 126,000 from the year before, and the elderly were the only age group to experience such an increase." Id. (citation omitted).
ever-shrinking portion of the money they receive in later years. The trend could force today’s generation of wage earners to rely heavily on Social Security and savings.

Among the roughly six million people getting pension checks from former employers, only 7 percent depend on them for half their income, Government surveys show. In fact, a growing number of these people have told the Government that their company pensions have shrunk to less than a fifth of their retirement income.

"The hope was that Social Security for the baby-boom generation would be more of a supplement to retirement income and less of the mainstay that it is today," said Prof. Olivia Mitchell, a pension specialist at Cornell University. "Now that hope is fading."220

There is no denying the need to expand efforts to reduce poverty among children and improve the quality of education they receive, but these must not be achieved at the cost of undoing one of the greatest social policy achievements since the Depression: the reduction of the poverty level among older persons. We cannot allow the needs of our children to be pitted against the needs of our parents and grandparents. We must confront these issues from the perspective of the intergenerational family, and recognize the fact that the elderly migrants and retirees bring billions of dollars into the state each year and traditionally use less of the public services than younger migrants.221

A major new area for intergenerational activity is the labor force for in-home and residential services to older people in need of assistance. Service providers are beginning to encounter serious difficulties in recruiting and retaining capable employees to provide homemaker, choreworker, personal care, respite, and other services.222 The turnover and absentee rate in some programs is generally very high,223 and in light of the projected labor shortages through the year 2000, these problems are not likely to be solved soon. An intergenerational initiative, however, may provide a partial solution.

The HRS Aging and Adult Services Program is seeking start-up funds for a Youth Services for Aging Corps in southeast Florida, where the labor force issues are most acute.224 To implement the pro-

220. N.Y. Times, May 29, 1990, at 1, col. 5.
221. See Longino & Crown, Retirement Migration and Interstate Income Transfers (accepted for publication in GERONTOLOGIST, Dec. 1990) (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.).
223. Id.
224. Memorandum from Mike Urban, Bureau Chief, Administrative Services, HRS Aging & Adult Services to Greg Keller, Chief, Interprogram Coordination, HRS Deputy Secretary for Programs (Aug. 6, 1990) (available at Fla. Dep’t of State, Div. of Archives, Tallahassee, Fla.).
gram, up to one-hundred fifty high school graduates ages seventeen to twenty-four living in Dade, Broward, or Palm Beach Counties would be paid the minimum wage to work twenty to forty hours a week providing in-home and residential aging services. Those working part-time would be required to attend, on at least a half-time basis, post secondary school, and the program would pay for their tuition and books. Those working full-time would receive a $4,000 grant for tuition, books, and supplies for each year of full-time employment.

Funding the Youth Services for Aging Corps would achieve several service and intergenerational objectives, including an improved labor force for aging services, a new source of financial assistance for young people who want to pursue a post secondary education, a new incentive for young people who may not have considered post secondary schooling or even finishing high school, and a promising opportunity to join the generations in a common pursuit.

VIII. CONCLUSION: POLICY PRIORITIES FOR THE 1990's

The major conclusions to be drawn from the demographic trends, service needs, cost projections, and program descriptions and analyses presented in this paper may be summarized as follows:

A) The number of people in Florida over the age of seventy-five will increase faster than any other age group during the next decade. These are the age groups at greatest risk of becoming disabled and being placed in nursing homes. The number of disabled persons over the age of seventy-five is projected to increase from 318,000 persons to 481,000 persons in the next decade.

B) In fiscal year 1990-91, Florida will spend $838 million on nursing home care and about $66 million on community long-term care programs. Older people vastly prefer community care to institutional care. The $66 million has been enough to fund a foundation for the required community care, but not enough to ensure adequate availability of programs.

C) The state will need to build an extensive array of community in-home and residential programs over the next several years if it is to

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225. Id.
226. Id.
227. Id.
228. PEPPER COMMISSION PART A, supra note 14, at 7.
229. Aging Survey 2000 Graphs, supra note 31, at Figure 2: The Disabled Elderly in Florida by Age: 1990-2000.
230. APPROPRIATIONS 1990-91, supra note 75, at 354.
231. Memorandum from Mike Urban to Larry Polivka, supra note 147, attached graph, Comparative Funding.
avoid huge increases in an already expensive institutional program. The quality of nursing home care should be ensured by adequate funding. One way of ensuring appropriate funding is to limit placement to only those who require it.

These general conclusions provide the rationale for the following policy priorities which will guide the Aging and Adult Services budget requests, and the legislative package which will be presented to the 1991 Legislature:

1) The Legislature should develop a statewide, comprehensive preventive health care and health promotion program based in county health units with linkages to senior centers, congregate meal sites, churches, and other locations where large numbers of older people gather. The program should be designed to provide health screening and follow-up services, nutrition education, counseling, and other necessary health education programs. The program should be closely integrated with the primary care program and include a provision for sliding scale fees for people above 125% of the federal poverty level.

2) The Legislature should expand and add emergency services necessary to meet the needs of protective services clients. This should include a purchase of services component managed by protective services staff which should be available on a twenty-four hour basis.

3) The Legislature should expand information and referral client screening, assessment, and program placement functions through expansion of the Better Living for Seniors hot line and short-term case management programs, through expansion of the CARES program, and through the development of other systematic mechanisms designed to ensure appropriate services and program placement for all clients.

4) The Legislature should increase mental health care by expanding mental health overlay services for nursing home, ACLF, and foster care residents, and by providing counseling and mental health support services to CCE and HCE clients. Part of the funding for the counseling services should be provided through the CCE program.

5) The Legislature should develop a complete continuum of non-residential and residential care programs which will ensure appropriate, cost-effective services and program placement for all clients. The continuum should be designed to integrate all community programs and increase their accessibility to clients.

To provide better non-residential programs, the Legislature should increase the allowable annual expenditure cap for CCE Diversion Pro-
gram clients to $9,000 and increase the average annual expenditure to $6,000. These increased resources should be used to create a flexible, client oriented continuum governed by rigorous case management, client tracking, and outcome monitoring capabilities. The CCE Diver-

sion Program should be enhanced through the development of a client sponsored fund (donations for specific clients) and increased purchase of service capability. The placement of high expenditure clients through the CCE Diversion Program under the Medicaid waiver cap should be prioritized and efforts should be made to actively pursue all cost-effective options. Furthermore, the Legislature should increase the allowable monthly Home Care for Elderly expenditure for clients to $300 and include the program under a comprehensive case management system. It should also increase the Alzheimer’s Disease diagnostic, respite, and day care services by expanding services to all counties and increasing the percentage of need met by 5% annually.

To provide better community residential programs, the Legislature should increase residential program reimbursement rates and eligibility levels. It should enhance the capacities of adult foster homes and adult congregate living facilities to provide a wide range of services to clients through budgetary and regulatory changes, and it should pursue Medicaid waiver funding for services to community residential clients. The Legislature should develop an assisted living program to provide services to clients who need more than an adult foster home or adult congregate living facility can provide and less than nursing homes are designed to deliver. The assisted living program should be based on an “apartment with common living area and comprehensive services package” model. The average annual expenditure for these clients should not exceed 80% of nursing home per client expenditures, and funding levels for each client should be tied to individual service plans. Clients in this program should also be included under the Medicaid waiver.

6) The Legislature should develop a comprehensive program to manage the emerging system of community residential and non-residential care and to ensure accountability at the appropriate organizational level. In order to achieve this objective, the Legislature should support an automated, statewide information system which will provide for information and referral service, client assessment, fiscal accounting, and client tracking at every point in the service system. It must also develop a comprehensive, clearly defined, rigorously administered, and properly staffed case management system with adequate provisions for staff training and development.

7) The State should develop and implement a fee collection system for all community programs based on an ability to pay sliding scale. Fees will be used to expand services.
8) The State should develop a caregiver's initiative designed to increase the caregiver's knowledge of effective caregiving practices, and to increase support resources available to the caregiver.

9) The State should support expansion of medical research on diseases of the elderly in both public and private institutions, and it should expand geriatric training in Florida's medical and nursing schools.

Much has been done in the last thirty years to improve the self-sufficiency of older people and to accommodate the changes in society and the family structure. These changes and the public policy responses to them now allow many older persons to live without fear of poverty. On the whole, their lives are now longer and healthier than they would have been thirty years ago. At the same time, society, for the sake of the young and the old, must take steps to ensure that older people can experience their longer, healthier lives as socially engaged and self-sufficient individuals. It is this perspective that has shaped the policy priorities of the Florida Aging Network and the HRS Aging and Adult Services Program.