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The Longstanding Issues Within Long-Term Care

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ABSTRACT The COVID-19 pandemic unveiled frightening vulnerabilities within the long-term care system in the United States, as evidenced by disorganized management and high proportions of outbreaks within facilities. Systemic faults can be explained by the historical roots of nursing home facilities as poorhouses and the longstanding tug-and-pull conflict between prioritizing resident autonomy versus safety. Moreover, legal and financial conflicts of interest have interfered with the optimal implementation of ideal long-term care principles. Tracing flaws within the long-term care system is vital to prevent similar crises from unfolding in the future, as the aging population grows worldwide.

KEYWORDS: Long-term case, nursing home, assisted living, green house model, geriatrics, elderly

INTRODUCTION

The Life Center of Kirkland, Washington, was the first COVID-19 epicenter in the United States. In February 2020, staff began noticing the growing number of respiratory infections, but failures in communication and testing delayed the nursing home from confirming the coronavirus outbreak until early March. By then, the presence of disease had overwhelmed the facility's resources —ambulances arrived every few hours to transport gasping patients, nurses juggled surging cases while fielding frantic calls from families, and some residents were left in their beds, dirty and unattended, for days (1).

Less than three weeks into March, two-thirds of residents had fallen ill, and thirty-five people died (1). Despite the early warning signals highlighted by the tragedy at the Life Care Center, long-term care facilities nationwide would bear the brunt of the pandemic's devastation. A recent study found that 94% of more than 13,000 nursing homes experienced multiple outbreaks between May 2020 and January 2021 (2). COVID-19's catastrophic impact on residents and their families has thrust longstanding issues within the American long-term care system into the public spotlight: How have we arrived at this point, where the choices for aging appear divided between risking one's health for independence or surrendering autonomy for a restricted lifestyle in a nursing home?
The tragedy at the Life Care Center cannot be attributed solely to the actions of a single facility. Instead, it reflects the interplay of broader systemic forces, including unresolved historical inequities and economic pressures. In this paper, we will explore how the long-term care system is fundamentally unequipped to attend to the needs of America's older adults and how alternative care models have struggled to maintain accessibility and consistent quality.

We define long-term care as "care for chronic illness or disability rather than treatment of an acute illness," following University of Michigan professor Edward Norton in the *Handbook of Health Economics* (3). While long-term care encompasses a continuum of forms— from informal care provided by family members to institutional

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settings offering 24-hour supervision and medical services—we focus on institutional settings to examine structural differences. Specifically, we examine nursing homes and assisted living facilities as representations of two contrasting philosophies: one that prioritizes safety and clinical oversight, and another that emphasizes independence and a homelike environment. We also focus primarily on examining the needs of long-term care facilities with respect to older adults, who constitute the largest demographic in need of the services, though it is also important to note that services are extensively utilized by people across the age spectrum.

The aging population is growing at a rapid pace, with the World Health Organization estimating their share of the global population would nearly double from 12% to 22% between 2015 to 2060 (4). This demographic shift underscores the necessity of a responsive long-term care system that can provide care tailored to the needs of an evolving society. However, we contend that the long-term care system in the United States is misaligned with the needs of the population, a problem that is rooted in their foundations in 19th century "poorhouses" that emerged as a band-aid solution for unsheltered, marginalized populations. Despite the elimination of poorhouses in the 20th century following the expansion of social welfare, the emergence of nursing homes in their place has continued their legacy of congregate, depersonalized care, albeit with a greater emphasis on medicalized services (5).

While the culture change movement in the 1980s attempted to shift the focus of nursing homes from narrowly prioritizing "quality of care" to a broader emphasis on "quality of life," the goals have not been sufficiently realized to the present day (6). The original movement espoused necessary changes in nursing home practices and structures to create a more homelike environment. However, the actual execution of the assisted living model has been widely varied across the country, often hindered by staffing shortages, limited insurance coverage, and inconsistent regulatory enforcement (7). Despite such obstacles, some models, such as the Green House project, have achieved notable successes at a regional scale, excelling in quality-of-life metrics and demonstrating resilience during the COVID-19 pandemic.

By addressing the deficiencies of both traditional nursing homes and alternative models from a historical standpoint, alongside case studies of the assisted living facility Emeritus at Emerald Hills and Dr. Bill Thomas's Green House project, we aim to identify key parameters for evaluating the sustainability and quality of long-term care facilities. We will also explore strategies for improving elder care by analyzing facilities that have successfully navigated the challenges posed by the COVID-19 pandemic. Through this exploration of ongoing deficiencies and potential solutions, we seek to inform public policy and contribute to the reform of the long-term care industry in the years ahead.

LITERATURE REVIEW

Types of Long-Term Care Facilities

Long-term care institutional models, such as nursing homes and assisted living facilities, play a critical role in providing care for individuals with chronic illnesses, disabilities, and those who are aging. Among institutional models, nursing homes are among the most utilized, with the CDC estimating that 1.3 million individuals currently reside in such facilities (8). However, many patients express reluctance or fear about nursing home admission, even when they necessitate professional care due to functional limitations. For example, in a well-cited 1997 study involving interviews with 3,262 seriously ill hospitalized adults, 30% of respondents expressed that they would "rather die" than permanently live in a nursing home (9). Interviews with nursing home residents reveal common complaints about the impersonal delivery of care, including long wait times and the dismissal of personal preferences (10). Alternative care models aim to address these concerns by prioritizing residents' social and psychological needs but have faced criticism for potential shortcomings in maintaining high standards of clinical care.

A popular alternative model to the nursing homes is the assisted living facility, which was formally defined by the U.S. Senate Special Committee on Aging as residences that "provide or coordinate oversight and services to meet individualized scheduled needs, based on assessments and service plans, and unscheduled needs," as recorded by geriatric educator Thomas Boggatz (2019) (11). Emerging in the 1980s, assisted living prioritized patient autonomy through features such as private, lockable rooms; a focus on recreational programs; and communal areas designed to foster a sense of community.

Original tenants of this model also emphasized the presence of 24-hour awake staff to ensure constant care and responsiveness, alongside a flattened workplace hierarchy to promote collaboration across all levels. Today,

assisted living facilities are distinguished from nursing homes by the characteristics of their residents, who typically require moderate support for daily activities rather than intensive or personal care. Consequently, assisted living homes tend to have lower staff-to-resident ratios than nursing homes, often drawing criticism for having too few qualified healthcare staff to manage residents' unexpected or intensive health needs (7).

In a national survey of assisted living facilities by the US Department of Health in 2000, researchers found that most staff were "almost completely unaware of what constituted normal aging and what signs and symptoms warranted referral for evaluation and treatment," suggesting that some staff members may misinterpret treatable or reversible conditions as inevitable aspects of aging (7). Furthermore, personal care staff reported significant dissatisfaction with low pay—ranging from five to seven dollars per hour in 2020—and limited opportunities for advancement (12). Together, these findings indicate that insufficient training, inadequate compensation, and a lack of professional growth opportunities negatively affect staff morale and the quality of care provided.

More recent literature, such as the work of Thomas Boggatz, highlights how assisted living facilities vary widely in their implementation of originally intended services and support structures. This inconsistency is compounded by the absence of a universally accepted definition of the model, as federal committees never reached consensus. In his literature review, Boggatz noted that this lack of standardization has led to residents feeling conflicted about their autonomy. Some feel they must remain "independent against their will" due to the institution's philosophy "to provide care as minimal as possible," while others report feeling "incapacitated by security rules" to an extent similar to that experienced in nursing homes (11). Thus, the practical implementation of assisted living models reveals ongoing tensions, where a balance between autonomy and support remains elusive. These challenges are further exacerbated by difficulties in recruiting and retaining qualified staff, undermining the original vision of the assisted living framework.

Historical Roots of Long-Term Care Facilities

Understanding the conflicts surrounding long-term care facilities requires a historical grounding, as all models have faced pressures to address the shortcomings of their predecessors. In their paper, "*The Accumulated Challenges of Long-Term Care,*" Drexel University Professor David Smith and Brown University Assistant Professor Zhenlian Feng describe how the modern American long-term care system evolved from 19th-century municipal strategies aimed at managing impoverished populations (5). During this period, poorhouses were county-based institutions that provided shelter and basic sustenance to individuals who could not otherwise support themselves. The widespread construction of poorhouses across counties stemmed from resistance to taxpayer-funded "outdoor relief" programs, which provided ongoing cash assistance to those in need, and from prevailing negative perceptions of the moral character of people experiencing poverty. Poorhouses were built on a punitive philosophy designed to deter individuals from seeking aid and to rehabilitate them by instilling a strong work ethic. As a result, residents often endured conditions with inadequate sanitation, heating, and privacy while performing manual labor—such as industrial, domestic, or farm work—in exchange for their sustenance (13). One 1926 description of a Poor House in Prince William County, Virginia by a welfare reformer relates graphically:

"Poor farm located 13 miles south of Manassas, way back on poor, cutover land, off any traveled road, in the woods. Very few know that such a place exists. The poorhouse is an old frame shack, one story, about 14 x 84 with 6 rooms, some without doors, windows boarded up. Fertilizer sacks filled with straw and old buggy cushions for mattresses on broken-down beds. Bed covers are rags - parts of old blankets or quilts, and very filthy. An old man, clothes ragged and filthy, asleep on a pile of dirty rags, in a vile room swarming with flies and vermin" (14).

Such vivid accounts reveal the grim reality of poorhouses, which were commonly hidden away on the outskirts of society. Contrary to the expectations of their founders who saw poorhouses as a punitive but rehabilitative institution, poorhouses became a refuge not only for the impoverished, but also for disabled individuals, the mentally ill, widows, orphans, and older adults, who lacked the resources the resources to reintegrate into society solely through the application of work ethic. As the harsh conditions within poorhouses became more publicly known, early reform movements in the 20th century began advocating for changes, particularly emphasizing child welfare and mental health. These reforms gradually shifted the composition of poorhouse residents and led to a significant increase in the proportion of older residents from 23% to 67% by 1930 (5).

When the Great Depression plunged everyday Americans into financial uncertainty, nationwide protest movements emerged in response to the deplorable conditions of poorhouses. The implementation of Social

Security provided states with cash payments through the Old Age Assistance Program to support low-income older adults. However, because residents of public institutions were ineligible for federal aid, local governments transferred many older adults from poorhouses to private boarding homes for financial gain, while those who were sick or disabled were relocated to hospitals. This shift in policy marked the beginning of the industrialization and regulation of nursing homes. Despite these changes, neither private facilities nor hospitals were properly equipped to meet the growing medical needs of the influx of residents, leaving the aging population's needs largely unaddressed (5).

With the passage of the Hill-Burton Act in 1954, the Truman administration began providing grants and loans for hospital construction. However, hospitals' inability to address chronic disabilities associated with aging prompted the establishment of separate units for patients requiring long-term care, coined "nursing homes." The introduction of Medicaid and Medicare programs in 1965 further accelerated the growth of nursing homes, as federal funding made the industry increasingly profitable and attracted more providers to the sector (5).

In the 1980s, alternative models for long-term emerged following growing dissatisfaction with medical and institutionalized approaches of nursing homes. Assisted living pioneer Keren Brown Wilson, inspired by her mother's challenging experience as a nursing home resident and the work of developmental disability scholars, helped crystallize and later execute an alternate long-term care approach during her doctoral studies in 1979. In her thesis, Wilson proposed a new model focused on creating more homelike environments and fostering independence for elderly individuals. Reflecting on her mother's desire for autonomy, Wilson wrote, *"In spite of the assistance she routinely needed, her focus was always to get out of 'there.' She wanted her own place so she could have a life"* (7). This insight guided Wilson's model, which emphasized autonomy and aimed to create residential-style environments offering comprehensive services that empowered residents to control their daily lives. Her work led to the creation of the first licensed assisted living facility in the United States, which opened in Canby, Oregon (15).

The dissatisfaction with traditional nursing homes, coupled with the rise of new care philosophies, fueled the rapid expansion of assisted living throughout the 1990s and into the early 2000s. However, the growing profitability of the concept led to a rise in facilities marketed as "assisted living" that often deviated from its foundational principles. Many of these facilities prioritized catering to wealthier clientele, compromising the inclusive, autonomy-centered care that was at the heart of the original vision (7). These equity challenges were further compounded by the limited availability of long-term care insurance and inadequate funding from federal programs such as Medicare to cover service costs. As a result, the median monthly cost for assisted living services has steadily risen to about $4300 today, making it increasingly difficult for many to access this model of care (16).

By examining contrasting models of nursing homes and assisting living as facilities for long-term care, we continue to see a conflict between the medicalization of disabilities associated with aging and the treatment of disability as a product of the social environment. Nursing homes have been shown to cultivate unsatisfactory living conditions for residents, as staff focus on enforcing schedules and restrictions to preserve residents' physical health. While assisted living has attempted to establish communities that prioritizes residents' control over their lives, the successful implementation of the original underlying tenets has been mired by competitive corporate influences and incongruous interpretations of the original model. The conflict between long-term care models suggests that an area for future inquiry entails examining specific case studies of successful facilities on both sides and extracting the similarities.

Emeritus at Emerald Hills

Within the expanding, lucrative industry of assisted living in the 1990s to the initial 2000s, early entrant Emeritus emerged as a key player. Only two years following the opening of their first facility in 1993, the company began selling public shares at the New York Stock exchange, quickly gaining the funding needed to expand their reach to the nationwide scale. According to a report by Frontline and Propublica, Emeritus benefitted from two economic and demographic factors: the haphazard regulation of assisted living and the demographic shift toward an older population within the United States. As state governments were unprepared to develop regulations for the expanding industry in the 90s, the company employed an aggressive business strategy involving frequent real estate deals and acquisitions of smaller, financially distressed chains. Additionally, the fast-growing population of seniors aged 75 years and older allowed Emeritus to target private-pay clients, many of whom were willing to pay higher fees for the promise of an independent lifestyle. With the approval of Wall Street and a steady stream of

clients, Emeritus had opened 500 facilities across 45 states by 2008, solidifying its status as one of the nation's largest assisted living companies (17).

Thus, when the Boice family sought a homelike environment for their mother, 81-year-old Joan Boice, they turned to Emeritus at Emerald Hills, a three-story assisted living facility in Auburn, California. The apartment-style living appealed to the family more than the sterile conditions of a nursing home, and the salesperson convinced the family that the specialized staff was well-equipped to attend to Joan's advancing dementia. Despite the hefty price tag of $7,125 per month, the family was optimistic toward Joan's ability to lead a safe but stimulating lifestyle at the facility. However, governmental evaluations and testimonies from staff would later reveal that the facility was masking many shortcomings, such as inadequate staffing, lack of licensed healthcare providers, and misguided priorities from management, that actively threatened their residents' livelihoods (17).

The warning signs within the facility manifested far before the Boice family's introduction to assisted living, yet the Emeritus's prevailing corporate interests led to the suppression of residents' true living circumstances. Only a few months prior to Joan's arrival, the facility's single nurse, Mary Harris-Kasuba, authored a letter to Emeritus's top executives in Seattle, begging for the bare necessities to keep their "sinking ship" of a facility afloat. She was primarily concerned about the issues regarding the facilities' personnel, writing that there had "not been enough staff to cover any part of the day-to-day staffing needs" whether that concerned "the kitchen, housekeeping, resident assistants, or med teens [technicians]" (18). However, despite Harris-Kasuba's desperate plea for change, she was relieved of her position, and Emeritus progressed to refining their business strategy instead of addressing the unmet needs of residents. The corporate office's lack of care for the humanitarian tenants of assisted living was further exhibited through their deployment of the "Heads on the Beds" business model in 2008, which directed staff to "put as many people as possible in the beds and make as much money as possible" during the recession, according to a testimony by one former executive (19). The continued ignorance over the residents' needs follows the customary pattern of long-term care development, which decentered the quality of residents' experience in favor of perceived financial benefits over neglecting their care. In the case of Emeritus, the disparity between the avarice of the higher-level executives and the reality of overburdened facilities illustrates how alternate long-term care structures can be used to exploit the disabled, despite the well-intentioned propositions of scholars like Karen Brown Wilson.

Through Emeritus's failures, we can keenly see the incompatibility of the social model of disability and private corporations whose main priority aim is to generate a profit for their stakeholders. Joan would pass away from a combination of advancing Alzheimer's, a series of small strokes, and an accumulation of infected bed sores, much undetected during her weeks of residence within the facility. During a lawsuit instigated by the Boice family against Emeritus, lead lawyer Bryan Reid would argue that "Emerald Hills fulfilled its obligations" by "shepherding her [Boice] through her journey" (20). The company's ignorance toward the preventable aspects of Joan's rapid deterioration demonstrates their fundamental misunderstanding of assisted living. Rather than passively permit residents to endanger themselves in their mental or physical decline, the ideal facility should create an environment that enables residents to lead their most fulfilling lives, which necessitates sufficient expenditure on staffing, training, and accommodations. Emeritus's continued evasive statements throughout the trial convey their underlying assumption that the burden of disability should be entirely incumbent upon individuals to resolve, reflecting a mindset rooted in the medical model. The Emeritus case study clearly illustrates the dangers of an assisted living facility with conflicting priorities and the corporate subversion of theoretical models for long-term care.

The Green House Model

However, assisted living is not the only alternative to a nursing home. Among the calls to reform the nursing home industry in the 1980s came the idea of the Green House model, originating from geriatrician Bill Thomas. Like Wilson, the daughter of a nursing home resident, Thomas communicated with patients who suffered from the socially isolating effects of their facilities' sterile, institutional environments. He also had experience working within a nursing home facility, where he spearheaded a successful program to improve residents' well-being through the introduction of pets and plants into the facility. Channeling the lessons from his prior involvement in nursing home reform, he created the Green House, a small group home with more than twelve residents with private bedroom and bathroom spaces, complemented by shared communal areas such as kitchens and living areas. The workplace model revolves around the *Shabbazim*—certified nursing assistants who undergo comprehensive cross-training in caregiving, first aid, and household management. Operating in self-managed teams, these professionals deliver consistent, personalized care to residents while overseeing the home's daily

operations (21). This decentralized structure, coupled with high staff-to-resident ratios, has resulted in increased staff satisfaction and equal or improved resident outcomes when compared to traditional nursing homes.
According to Bill Thomas, as detailed in physician-writer Atul Gawande's book *Being Mortal*, the Green House model was deliberately designed to be "a sheep in wolf's clothing." It would present itself to government regulators as a traditional nursing home to meet stringent licensing and reimbursement requirements, thereby qualifying for Medicare and Medicaid payments. However, its structure, philosophy, and operations would deviate radically from conventional nursing home models, aiming to deliver a more humane and dignified living experience for residents without increasing costs for prospective occupants (22). Thomas envisioned these homes as fully equipped with "the technologies and capabilities to help people regardless of how severely disabled or impaired they might become" (22), ensuring they could accommodate even residents with complex medical needs while maintaining a non-institutional environment.

This vision required navigating significant logistical and financial hurdles, as the model had to comply with nursing home regulatory frameworks while simultaneously upending the traditional institutional model of care. Nevertheless, the plan proved feasible, largely due to strategic partnerships with nonprofit organizations and existing nursing homes seeking to innovate or expand their facilities. According to the Green House Project's *Business Case* report, major components of the success involved their consistently high occupancy rates, private-pay revenue, and reduced ancillary staffing costs due to the multifunctional role of the Shabhazim (21).

Numerous studies report that the Green House model leads to the improvement of facility quality measurements in categories such as the social engagement of residents, staff morale, rates of readmission than the traditional nursing homes facilities. Afendulis et. al. has hypothesized that the increased frequency of direct encounters between the caregivers and residents in the small home setting can result in greater likelihood of identification and intervention in the case of reversible medical conditions (23). Perhaps most strikingly, Green Houses have shown significantly reduced cases of COVID-19 during the ongoing pandemic. A 2021 study, conducted by University of North Carolina researchers, demonstrates the importance of the small resident population in affecting disease outcome: median mortality rates per 100 COVID-19 positive residents was 0 for Green Houses, 10 for nursing homes with a population of less than 50 beds, and 12.5 for homes with greater than 12.5 beds. The study further suggests that the lower admissions rates for residents, reduced ancillary staff, and the assignment of private bedrooms and bathrooms for residents led to increased ease in controlling potential outbreaks and creating spaces where residents could safely socially distance (24).

The Green House model's ability to provide an enhanced residential experience while effectively addressing the challenges posed by the pandemic suggests it could be a promising approach to long-term care in the post-COVID era. By prioritizing smaller, homelike environments, consistent caregiving teams, and a balance between clinical and emotional needs, the model addresses some shortcomings associated with traditional nursing homes and assisted living facilities. However, its widespread applicability hinges on overcoming logistical and regulatory hurdles, ensuring affordability for lower-income patients, and recruiting and retaining staff who embrace the caregiving philosophy. As state and federal policies often favor traditional nursing home setups, the adoption of smaller, decentralized care facilities will likely require evidence-based demonstrations of the model's cost effectiveness and superior outcomes. Additionally, creating sustainable funding mechanisms, such as increasing Medicaid reimbursements, public-private partnerships, or philanthropic support, will be essential to expand access for diverse socioeconomic groups that may not be able to afford out-of-pocket expenses. Finally, given the pitfalls in staffing that have previously been observed in assisted living facilities, Green House model will be challenged to address workforce shortages of qualified nursing staff and ensure resources exist to minimize burnout and turnover. By tackling these challenges head-on, the Green House model can better meet the growing demand for compassionate, equitable elder care while maintaining the integrity of its vision.

CONCLUSION

Through the historical and case study examination of long-term care facilities, it becomes apparent that both nursing home and assisted living models possess troubling failibilities. Nursing homes were not created to cater to the emotional and social needs for their residents due to their origins in poorhouses and adapt a heavily medicalized outlook on disability. Assisted living, which was devised as a radical alternative to nursing homes, does not consistently offer resources to assist residents in navigating their medical conditions, and they also deviate in quality. We see a cautionary tale embodied in the example of Emeritus at Emerald Hills, which demonstrates that the corporate temptations can lead the development of facilities away from their original priorities despite the intentions of alternative living pioneers. While the Green House model appears to offer a

potential solution for addressing both emotional and clinical needs, its ability to be scaled nationwide is still uncertain, and it remains to be seen whether it can overcome the systemic challenges of long-term care in a post-pandemic world.

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