Those Who Can Pay:
The Impact of Socioeconomic Status in Long Term Care

Desiree Schippers[1]

Lying on my cot in the darkness, I could see two sets of feet standing in front of my apartment door. My pulse was so loud in my ears that I could hardly make out what they were saying. But, I didn't need to hear to know what they were discussing. I knew they were gossiping about the chair.

An hour earlier, I had been sitting at Floor Supper surrounded by my fellow residents and a copious amount of lasagna and Valentine's decorations. I was chatting with my neighbor from a few doors down, a chemist, about his time as a professor and lab manager, when the tinkling of forks on glass interrupted our conversation. At the other end of the long white tablecloth, Dorothy straightened her sweater. Brushing a piece of loose hair from her eyes, she picked up the microphone and greeted us with a friendly smile. As her hand moved in a friendly wave, the diamond on her right hand caught my eye. It was bigger than I had ever seen before, similar in size to her polished pinkie fingernail. A few weeks prior, she had told me it was an investment diamond, that she and her husband had diversified their assets between her diamond, a mutual fund, and investing in the stock market. I had to ask what a mutual fund was.

She cleared her throat, preparing for announcements. She spoke in a dialect I couldn't quite place, but I imagined it was a dash of Southern mixed in with something more Katharine Hepburn-esque. After an off-pitch group round of Happy Birthday to the February birthdays and a few reminders about upcoming community events, the tone suddenly shifted.

"Now," Dorothy paused, shifting a disapproving gaze around the room. "I understand that we here are all from different backgrounds and have different tastes in decoration."

She paused again. I waited in anticipation, hoping she would spill the tea about some floor drama, which was actually more common around this place than I had originally thought.

"However, it is absolutely unacceptable to move or remove any furniture that you do not own."

I choked on a crouton.

Desiree Schippers is a graduate of Kansas State University with a B.A. in English Creative Writing and Secondary Major in Gerontology. She is currently pursuing her MFA in Documentary Film at Northwestern University.

“It has been brought to my attention that the chair near the North elevators has been...stolen!”

A cumulative gasp swept the room. A few women threw the back of their hands to their foreheads and I imagined some of them fainting into their chairs, like I had seen in old movies. I heard mutterings of “It was ugly anyway!” “Why?” and “Who would do such a thing?” Then came the accusations. “I bet it was that maintenance man!” “It could be the second floor! They were always jealous of our furniture anyway.”

I felt my face flush a deep crimson and sweat manifested on my face. Desperately, I tried to find my voice. I opened my mouth to tell them it was me; I borrowed the chair! It’s in my room, I’ll move it right back! I wanted to explain that I didn’t have any furniture in my room and that I’d needed the chair for a video project. However, my body had other ideas. Instead I sat frozen, pretending to be in just as much shock as everyone else, even shaking my head back and forth in disgust.

“Everyone, please.” Dorothy’s voice came through the uproar. “We will figure this out. But for now, we’ll just have to be vigilant.”

~~~~~~~~~~~~~~~~~

I used to think nursing homes were either good or bad; that it had to do with the effort of leadership and support staff, however, I’ve discovered the factors that influence a facility’s quality are complex, with many variables. The most important variable, I’ve learned, is financial, and that the socioeconomic status of residents has a major impact on their access to top tier facilities and their quality of care. I first came to understand these complexities during my sophomore year at Kansas State University.

From my first visit to Meadowlark Hills, I was in complete awe. Boasting around 370 residents and 400 employees, Meadowlark is on the forefront of modern long-term care facilities, and is known internationally for its integrated, person-centered care (Meadowlark, 2018). It seemed more like a small community than a nursing home, with a full restaurant, cafe, bar, movie theater, library, and fitness center complete with personal training and massage therapy. There was a chapel with stained glass windows, a coffee lounge, billiards room, and several gardens. The residents had access to group fitness classes, film showings, and several different clubs, all without having to leave the comfort of the building. The directory of specialized locations and scheduled activities was overwhelming. To be completely honest, I was ready to pack up my things and move into the facility myself.

So I did.
~~~~~~~~~~~~~~~~~

In the Spring of 2018 I lived in the nursing home for about four months as part of an immersive cultural anthropology course. But, as I said before, to me, it wasn't really a nursing home. It was a five-star resort compared to most of the facilities I had seen. Three hours and forty-five minutes away from Meadowlark was Buffalo Village Senior Living, nestled between cornfields and down the road from a Walmart. Buffalo Village had 54 residents and not many more employees. For four years, I ran between the long corridors, getting residents out of bed as early as 5:45 in the morning to try to get everyone to their dining room by 7:45. The facility had two small dining rooms, a central nurses' station where you could see down every hall, and a closed off dementia unit.

I loved Buffalo Village and still do, but the stark differences between the facilities shook me. Before moving into Meadowlark, I had taken a Gerontology course where we looked into the traditional models of long-term care versus the plan Meadowlark followed. We learned that in a traditional model or "old model" a nursing facility is set up much like a hospital. There is usually a central nursing station, long hallways with resident rooms, and a large dining room. Staff wear scrubs, float between halls, and get residents to wake up, eat, and perform daily activities at set times. Meals are served at set times and most residents receive the same meal, unless they have a special diet. In that class we watched a TEDxTalk by the CEO and founder of the person-centered philosophy and business model, Steve Shields. During his talk, he described with painful accuracy the everyday norms of traditional nursing homes: the closest thing people get to personhood are the 15 minutes in the morning when they are awakened, bathed, clothed, and taken to the breakfast table. He said nursing homes are one of the most heavily regulated industries in America, second to nuclear power plants. Residents are slumped in their wheelchairs, stripped of their ability to choose what to eat, what to wear, when to wake up in the morning, or even when to bathe (Untitled Speech, 2015). As the CEO of Meadowlark and the son of an ailing mother, Shields understood that things needed to change. He realized how inefficient traditional care facilities are, with different departments of people running past each other, doing nothing cooperative or productive. After careful planning and consideration, he introduced the household model of living (Untitled Speech, 2015).

The household model of living focuses on person centered care. Residents are divided into small households of around 20 people. The households have a front door, doorbell, a porch, living room, private bedroom halls, and a linen closet. Employees stay in one household, getting to know each resident and their individual routines. Care staff wear business casual clothing, so residents feel like they are in a home rather than a hospital. A full kitchen is

available for home cooked meals of the residents' choice and laundry is done in house. An emphasis is placed on the residents' personal choice and the residents set their own schedules and choose their own meals. This is significant because residents living in a facility that practices person centered care have a greater sense of comfort, feel empowered to make their own decisions, and have lower depression rates (PEAK 2.0, 2020). Walking into one of these households was like visiting a large family, in a natural, homey, setting. What's ironic about the household model is that it shouldn't have been considered groundbreaking, as it reproduces a "normal" living experience for those not in long-term care.

For a CNA and Gerontology student, the opportunity to live in Meadowlark was extraordinary. How many other people under the age of 70 can say they've lived in a nursing home? (A premier, virtually famous one at that!) Although I developed close bonds with the residents and enjoyed my evenings studying in their library or watching movies in the theater, I began to feel a creeping sense of guilt. While living there, I didn't come across a single resident of color or person who struggled with money. Just by looking around during coffee hour, I sensed that these people were affluent. In fact, while sitting with a resident at coffee one day, she started going through her mail, opening letters and tossing them to the side. A letter from an investment service slid my way, so naturally, I glanced at the page. I read that my friend had over $800,000 just in that account, and nearly spilled my coffee into my lap.

Perhaps I felt guilty because back at home, I had seen residents come through admissions with just the clothes on their back, having to wear hospital gowns until the social worker got them proper clothing. I watched my mom sell all of my grandfather's worldly possessions in order for Medicaid to pay for his stay in the nursing home. I had coaxed a crying resident who wasn't ready to get out of bed into the bath, because I couldn't fall behind schedule, we didn't have the staffing to be able to take our time. I had watched as bored residents stared blankly at a birdcage for hours on end while I was rushing to make sure their neighbors could get to the bathroom on time. I had hidden my tears when a woman pulled my head down toward her while tucking her into bed to tell me that she hated it here and that she wanted to go home. I wondered why these residents, these *people*, that I cared for, didn't deserve the same comforts and luxuries in late adulthood as the people who lived in places like Meadowlark. I laid in bed at night and tried not to think about how much my residents back home would enjoy watching a movie in the theater or having a meal in the restaurant. When I did, I felt overwhelming anger and jealousy, and I didn't know where to direct it. I didn't understand how there could be such a massive disparity between two not for profit nursing homes.

I wondered what life would be like for the residents of Buffalo Village if their facility had the same funding, staffing, and resources as Meadowlark Hills. I wanted to understand how one facility is able to offer such a higher quality of care. Where did the money come from? Why didn't Buffalo Village have access to those resources?

After discussing these questions with an expert in long term care I was able to piece together an overly simplified, basic rundown of how nursing homes operate financially:

- Nursing homes get their funding from three sources: Medicare and Medicaid, long term care insurance companies, and residents who privately pay. Private pay residents almost always pay more than the other two sources (Laci Cornelison, 2018).
- Nursing homes have to spend money to get money. Private pay and Medicare/Medicaid rates are based off of the cost of operating the facility over the course of the year. Therefore, if you have a new building and you pay your employees top dollar, your cost of operation will be higher and you will be able to charge more per person (Laci Cornelison, 2018).
- Nursing homes get penalized financially for deficiencies on state surveys. Deficiency penalties can cost facilities up to $10,000 per deficiency (Laci Cornelison 2018).

Under the Nursing Home Reform Law passed in 1987, nursing homes receiving Medicare and Medicaid cannot deny prospective residents unless they are unable to meet their needs (The 1987 Nursing Home Reform Act, 2001). The inability to meet resident needs can mean not having enough beds, staffing, or equipment to take care of a resident. Or, if the resident has a complicated condition, it could mean that the facility's employees do not have the certification or training to properly care for the resident. A resident can also be denied if they are violent or cause harm to other residents and employees. Barring these situations, homes are required to give low income residents the same quality of care as all other residents. Since it is illegal to deny care to low-income residents, it seemed strange to me that I did not see many low-income people living at Meadowlark. Curious, I spoke to the financial services director at Meadowlark and discovered that around 40% of their residents in the healthcare units (this data didn't include the independent living residents, who make up around half of the resident population) received Medicaid (Chris Nelson, 2018), whereas over 50% of the entire resident population receive Medicaid at Buffalo Village (Heather Sowers, 2019). The difference, when independent living residents were taken into account, was staggering, and I didn't understand how it was possible

for Meadowlark to have so many more residents who were able to afford private pay.

It turns out that high end care facilities like Meadowlark get around the admissions rule by prioritizing certain members and residents on the admissions list (Laci Cornelison, 2018). At Meadowlark, there is a program called the Passport Club, which allows members to jump ahead of non-members on the waiting list when the time comes for them to move into the facility. The membership fee is $1,000 and gives members access to amenities such as the fitness center and movie theater (Meadowlark, 2018). Thus, people who cannot pay to have priority are constantly bumped down on the list. In a lot of cases, people can't wait more than a few months, so they move on to a different facility. Poorer members of the community are also disadvantaged because residents living in Meadowlark's independent living apartments are guaranteed a top spot on the waiting list for the skilled care units as well, if needed. In order to live in an apartment, residents must purchase the apartment, then also pay a monthly fee, again excluding low-income people. I learned that the area where I lived and spent most of my time at Meadowlark was the independent living wing and that in Kansas, Medicaid doesn't help people with independent living costs, so nobody in my area was eligible for aid.

So why are Meadowlark's facilities better than those at Buffalo Village? It seems to me that it's because of the "spend money to make money" concept, along with the copious amount of private pay residents. Since Meadowlark has more private pay residents, they have more money in general. Their ability to spend this money allows them to expand their facilities, pay their employees better wages (and have more of them), and develop innovative programming for residents. Facilities like Buffalo Village, on the other hand, don't have a lot of money to begin with. On top of that, they could also be penalized by the state for performing poorly during state surveys.

This funding concept made absolutely no sense to me. Here's how I see it: you have a nursing home that's struggling to stay open, it doesn't have much funding to have new equipment, or a lot of equipment for that matter, and it can't pay its employees a living wage. Since it hardly has enough money to operate properly, it gets several deficiencies when the state walks through the door. In my experience, deficiencies on state surveys can be as extreme as elder abuse, use of chemical restraints (drugging someone up), or as small as an employee forgetting to wear their name tag. Other common types are poor charting, not having the correct nurse to resident ratio, infringement on resident rights, or residents not having access to their call bells at all times. But instead of state agencies stimulating growth and change with adequate funding, the

less-affluent facility gets penalized and has to lose $15,000. Now, I understand that facilities need to be held accountable to provide quality care for residents, but I just don't see how taking money from already-struggling facilities is beneficial for the residents who live there.

The director of nursing at Buffalo Village was so terrified of receiving a deficiency, that she implemented outrageous rules to eliminate any sort of risk. One day while the residents were eating lunch, a longtime employee came to me with tears in her eyes. When I asked her what was going on, she told me that she had been hugging a resident in the hallway and shortly after she was pulled into the director's office. She was scolded and told that she should not hug the residents while they were standing, as it was a fall risk. Frustrated and confused, I also shed a few tears. Oftentimes residents lack any sort of physical touch and affection, so to me, hugs are very important. I remember working the night shift, struggling to get a resident with dementia who hadn't slept in two nights, to fall asleep. Eventually, I helped her lay down, climbed into bed next to her and pretended to be asleep. Like magic, she drifted off within five minutes. I continued this sleep strategy with the resident but would watch the door in fear the whole time. I knew that if a supervisor saw this, I would get in trouble because unit policy stated that I shouldn't linger in residents' rooms, and that someone needed to be watching the hall at all times. Having a 24/7 hall monitor required several CNAs on the hall, which wasn't always an option. It hurt me that the fear of financial penalty was directly affecting the quality of resident care.

In the end, these inequalities boil down to more than just nicer facilities or access to restaurants, bars, and libraries. What matters here isn't necessarily about the luxuries. It's a resident's right to personhood. It's the fundamental need to feel valued; to feel like you are in control of your life and that your thoughts, opinions, and needs matter. Basic human dignities, like the right to make decisions, should not be doled out based on how much a person can pay. Unfortunately for most Kansas residents, this isn't the case, yet.

~~~~~~~~~~~~~~~~~

Back in my 3rd floor apartment, I panicked. I'd had no idea that the chair was such a big deal, and I had only planned on borrowing it for a short while. I continued staring at my neighbors' feet from under the door.

They had to know it was me. The chair had been ten steps away from my door and I was probably the only one on the floor who could lift the thing. I was also the only person on my floor who didn't have any furniture, just a cot and some blankets.
~~~~~~~~~~~~~~~~~

I glared at the chair in disgust. Its ugly floral upholstery stared back.

This was the end of the line for me. No more fieldwork, no more free chicken tenders and mashed potatoes from the restaurant. No more Bingo on Monday nights. I lamented the loss of coffee hour. There was no way they would allow a thief to continue living in their midst. If I wasn't evicted from the facility entirely, I would at least be ousted from the 3rd floor social circle, no longer invited to ice-cream socials and met with stink eyes anywhere else.

But I couldn't handle that. So I started to think.

I could plant the chair on the second floor! Some people already believed they were the culprits anyway. Maybe it would start a floor war and I would be able to study and document the aftermath.

But no. I couldn't do that.

I couldn't come clean either, because they would just ask why I didn't say anything during supper. I wouldn't be able to explain my silence. So, I did the only logical thing; I snuck out into the hall at 1:15 in the morning and dragged the dreadful chair out of my room and back into the hall where it belonged.

Bibliography

Castle, Nicholas G., Laura M. Wagner, Jamie C. Ferguson, and Steven M. Handler. "Nursing Home Deficiency Citations for Safety." *Journal of Aging & Social Policy*, no. 1 (2010): 34-57. doi:10.1080/08959420.2011.532011.

"Chris Nelson." Interview by author. November 23, 2018.

"Heather Sowers." Interview by author. January 14, 2019.

Hills, Meadowlark. "Meadowlark, Continuing Care Retirement Community, Manhattan KS". Accessed December 09, 2018. http://meadowlark.org/.

Klauber, Martin, Bernadette Wright, and AARP. "The 1987 Nursing Home Reform Act." AARP. February 01, 2001. Accessed December 09, 2018. http://www.aarp.org/home-garden/livable-communities/info-2001/the_1987_nursing_home_reform_act.html.

"Laci Cornelison." Interview by author. November 1, 2018.

"PEAK 2.0." Kansas State University. Accessed January 21, 2020.

https://www.hhs.k-state.edu/aging/outreach/peak20/.

Senior Living at Citizens Medical Center, Inc. Accessed December 09, 2018. https://www.cmciks.com/senior-living.

Shields, Steve. Speech, Hays, Kansas. May 26, 2015. Accessed November 8, 2018. https://www.youtube.com/watch?v=myQvl3ax-Jk&t=53s.