Keiro Senior HealthCare

Presented by The Institute for Healthy Aging at Keiro and USC Davis School of Gerontology with the support of the Consulate General of Japan in Los Angeles

The Institute for Healthy Aging at Keiro

USC DAVIS SCHOOL OF GERONTOLOGY

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The Institute for Healthy Aging at Keiro, the Consulate General of Japan, and the USC Davis School of Gerontology presented this half-day summit to facilitate international policy discussion and shape the debate addressing global aging. The Summit highlighted best practices and policy solutions to create a sustainable health and long-term care system for older adults.

Welcome: Dean Gerald C. Davison

The USC Davis School of Gerontology has been in existence since 1975, making it the largest and oldest gerontology school in the world. We have been a leader in research and education in the field of gerontology and indeed in helping to define the very field itself. Today's event represents the launching of a partnership with The Institute for Healthy Aging at Keiro and underscores the interest that our school has had for many years in global aging issues, including those that affect Japan and the many Japanese Americans who live and work in our city. For the University as a whole, the Pacific Rim has been the focus of research and teaching for over 25 years and several members of our faculty have been collaborating with colleagues in Japan, Taiwan, Hong Kong, and in China for many years. As it will become clear to you this morning, the challenges and opportunities of an increasingly older population in many countries, and especially in Japan, demand our attention and concern. As the Dean of this school, I welcome you; I look forward to an informative discussion with the experts that we will all be privileged to hear from today and I wish you a productive conference.

Welcome: The Honorable Junichi Ihara – Consul General of Japan in Los Angeles

Good morning. Thank you for this opportunity to speak. I'll first congratulate Keiro Senior HealthCare and its members and particularly, President and CEO Shawn Miyake on the institution's 50th anniversary. I think it is very appropriate and meaningful for Keiro Senior HealthCare to celebrate this milestone by organizing this Healthy Aging Summit. I also appreciate the leadership role played by the USC Davis School of Gerontology and its Dean, Gerald Davison. This is a wonderful building and I learned that this school of gerontology has the longest history of its discipline in the United States. I thank the panelists today for taking time out of your very busy schedule, in particular Professor Ono, who came from Japan and who generously agreed to replace the original speaker who is from the Ministry of Health, Labour and Welfare in Japan. The original speaker had to remain in Japan due to the recent terrible earthquake and tsunami.

As aging is something inevitable to each individual, our society ages with its members. Japan is the frontrunner of these aging societies. People's reaction to aging varies. Some try to resist it, others simply resign to it, but probably the best approach to aging both individually and socially will be embracing it by making aging as healthy and vigorous as possible. Japan faces daunting problems of rapid aging. We are worried about whether our social welfare system can be sustainable in the future, whether we need serious tax increases to finance social welfare policy, or whether we have to lower the level of service to patients and the elderly. I think, however, that healthy aging will resolve or at least delay many of these problems. First of all, we can change the definition of "elderly." Statistically we categorize people over 65 years old as senior citizens and consider them a non-productive population. Following this classification, 23% of Japanese, almost 1 in 4, are active

recipients of social welfare services. We can change this definition of elderly through healthy aging. If we consider the population between 65 and 75 as being active adults, this number of 23% drops down to 11%, only 1 out of 10 people. After meeting so many active older adults, my sense now is that the 60s and even the 70s are still too young to be called elderly. The people over 90 years old finally attract my attention as those that should be called "elderly." I hope that in today's seminar we will reveal some key elements of healthy aging and contribute to the attendees' daily work in your respective fields and professions.

Welcome: Shawn Miyake – President and CEO, Keiro Senior HealthCare
Keiro has been serving the Japanese community here in Los Angeles since 1961 when we operated a small Japanese hospital in Lincoln Heights. Since then, Keiro has grown to include Keiro Nursing Home in Lincoln Park, Keiro Retirement Home and Keiro Intermediate Care Facility in Boyle Heights, South Bay Keiro Nursing Home in Gardena, and The Institute for Healthy Aging at Keiro. I welcome anyone that is interested in healthy aging to visit any of our facilities and alternately to take time to visit us on our website at www.keiro.org to check out our healthy aging resources. Once again, thank you for attending today and we hope that you will enjoy the rest of the program.

Dr. Eileen M. Crimmins – AARP Professor of Gerontology, University of Southern California
POPULATION AGING IN THE WORLD

I want to talk about population aging today and will spend my time comparing the United States and Japan in many ways. Aging is a trend that is going on all over the world. We are going to age and that is the bottom line. We are never going to be young populations again. We know why, we know how it happened, and this is the future so we might as well get used to it. This is a graph that shows two lines in world population. One is the number of people over age 65 and one is the proportion of the population less than age 5. These lines are going in opposite directions. It's not only that we are getting older, this is the increase in the global population at the older ages and you see that the 65+ population is growing, the 85+ population is really growing fast, and the 100+ population is growing extremely fast. (refer to slide: Projected Increases in Global Population by Age). A lot of the work on the 100+ population has come out of Japan because they have had good records for a long time and we understand that people who are 100 years old are not uncommon anymore, whereas they were a century ago.

As the Consul General said, these are the 15 oldest countries (refer to slide: The World's 15 Oldest Countries). Japan and Italy are tied for first, as the oldest countries in the world. The United States is at number 15, making it a relatively young country compared to Japan. Most of the older countries are in Europe. If you are referring to the slide, the oldest part of the world is the darkest part of the world. The somewhat dark areas are moderately aged, that's the United States, Australia, Russia, Canada, and South America. The youngest part of the world is Africa, but everyone is aging. The Japanese have been through the aging process, although the process still

continues. The United States still has to age and in the next 20 or 30 years as the baby boom passes through, it will reach the levels that the Japanese population now has.
(Population Aging Represents the Greatest Triumph of Science in the 20th Century)

Aging is really a positive thing. It represents the greatest triumph of science and perhaps of choice in the 20th century. We couldn't have lived to be an old population before the middle of the 20th century. The triumphs of science have extremely increased life expectancy. In Japan, life expectancy changed from just over 60 years old in women to well above 80 from 1950 to 2008. If we look back to 1900, life expectancy was 40 years. Life expectancy has doubled in Japan in the 100 years from 1900 to 2000. That is a remarkable triumph. We wanted to help people live long by curing diseases and improving health and that's what we did. (Trend in Total Fertility Rate in Japan: 1950-2007)

As life expectancy rose, people decided not to have as many children because children were surviving after birth. This is why I say that aging populations are attributed to both science and choice. The real reason Japan and other countries are aging rapidly is because the number of children they have has decreased. The total fertility rate, or the average number of children in a family was almost 4 in 1950 and it decreased to 1.2 in the early 2000s. That is extremely low fertility. Fertility rates dropped in the 1960s and continue to steadily decline. Other Asian countries have low fertility rates as well. Korea's fertility rate is about 1.2, Thailand is 1.6, China's is low due to the emphasis on a 1 child family. The European country that has the lowest fertility rate is Italy, and that is the country that is the oldest along with Japan. Advances in medical science and public health have made it so that most children who are born live into old age. In Japan the normal age of death is about 90. This is a massive change that took place over a 100 year period.

Japan has been the world leader in life expectancy and in many other ways. In Japan, life expectancy at age 50 is over 34 years. Other countries have higher life expectancy at age 50 compared to the U.S., including France, Spain, and Italy. The United States' life expectancy at age 50 is 31 years. We have a relatively poor life expectancy which is a concern to the U.S. Government. Trends in life expectancy from 1950 – 2010 show Japan lagging behind other European countries in the 1950s, but it becomes the absolute leader around the 1980s – 1990s. On the other hand, the United States was among the pack of leaders in 1950 and now we have fallen far behind, indicating that we have done quite poorly relative to the other countries in the last 30-40 years.

There is something quite interesting and special about aging in Japan. With any number of health indicators, the U.S. is among the highest as compared to Japan, which tends to be very low. Rates of diabetes are very high in the United States and low in Japan. Stroke is the one indicator where the Japanese are not the best in the world. Males and females in Japan have a relatively high prevalence of stroke. In contrast to the United States where stroke mortality rates have leveled off and not fallen much, Japan's rates have decreased rapidly. Other indicators such as prostate cancer and breast cancer incidence and mortality are very low in Japan, whereas the U.S. has high incidence and low mortality rates from these cancers. This means that there is a lot more treatment

of cancer occurring in the United States. Colorectal cancer is the one cancer that is relatively high in Japan.

One of the main reasons for the differences between the United States and Japan is the high obesity rates in the U.S. The U.S. has the highest obesity rates in the world and these rates continue to increase. Conversely, in Japan obesity is almost unknown. We know that to be one of the reasons that the health of the Japanese population is better than the health of the American population. In America, we are living with obesity longer, we are heavier, we are more obese than we were in the past and we are approaching old age with obesity. The Japanese have higher measured blood pressure rates than the United States, yet they live longer. This is because of the high use of anti hypertensive drugs in the U.S. Americans are the highest users of blood pressure medication. The U.S. also takes the most lipid lowering medications.

One of the big explanations for the difference in life expectancy between the U.S. and other countries are current and past smoking rates. Although Japan currently has high smoking rates, this was not true in the past. The United States is now paying for its past smoking history in ways that may not be expected. Life expectancy in the U.S. would be more than 2 years longer if the older population had not smoked. Japan would gain half of a year. Today, daily smoking rates in the U.S. are quite low whereas Japan is quite high. Our finding is that in countries where there is very high life expectancy, there were very low smoking rates historically. Countries that have a history of smoking tend to have a shorter life expectancy, since that history continues to affect the older population.

There are clearly other differences between the U.S. and Japan that contribute to Japan's better health. Equality is greater in Japan, meaning that the different social classes behave more similarly. People have access to healthcare, healthcare is provided for all people, there is emphasis on routine health care, all of which contribute to better health.

Aging is not a problem, but rather a measure of success. However, with such massive changes in a country, large families to small families, short life to long life, adaptations must be made to accommodate the population changes.

Cultural values may have helped Japan adapt to becoming an older population. Japan has always been the longest working population in the world, as indicated by labor force participation at older ages. It becomes easier to support an older population if much of that population supports itself. The proportion of people working at older ages is starting to fall in Japan, so one needs to develop ways to keep people in the labor force for as long as possible. In a country like Japan where a lot of people are still in the labor force at older ages, you need to work on it before it changes. In the United States, the discussion about cutting deficits in the next few years will mean that we will need to work longer, retirement age will get older, and we will have to become more like the Japanese. Another cultural attribute is the strong family and social networks that the Japanese have. Much of the care for older people comes from their families in Japan. Japan has been able to age with a strong family system and with families living close to each other, if not in the same household. However, that dynamic will change with a modern society and in a society where

families are getting smaller. The United States will need to provide support for aging adults at a social level when it cannot be done at a familial level.

Japan has benefited from their long working careers, good family and social structure, and good health. Our investigation of health in the United States and in Japan shows that it is not the health care system that helped Japan and caused problems for the United States, but rather health itself. Clearly there are secrets of health that we are yet to figure out from the Japanese population but it is what all the world is striving to learn.

Dr. Kate Wilber, PhD, Davis School of Gerontology, University of Southern California
U.S. HEALTH POLICY FOR AN AGING POPULATION

I am going to talk about the problems in the U.S. health system, the needs and unmet needs, and some of the research that is being developed to address these problems. Finally I will talk about health reform and what the promise is for health reform for an aging society.

Does having Medicare mean that you receive free care? The answer is no. Medicare has high deductibles and cost sharing requirements. Median out-of-pocket costs are 16.2% of income and 1 in 4 Americans spend more than a third of their income on healthcare even with Medicare. One in 10 people spends more than half. Total out-of-pocket spending was almost $200 Billion in 2006, partly because 1 in 5 people purchase additional Medigap insurance. The average out-of-picket expense per person was $4,241 in 2006. That's hardly free healthcare even for people who have their well-financed Medicare system.

Medicare is one of the largest health care programs in the world and benefits almost 50 million people. Medicare covers 99% of people 65 and older and people with permanent disabilities in this country. Expenditures were $524 billion in 2010. The focus of the Medicare system is on acute care, not chronic care, which has created some problems in the 21st century. Medicare has several parts, Part A is hospital; Part B is supplemental physician care; Part C combines part A and B with preferred provider service, health management organization, and options for choices; and Part D covers prescription drugs. There are a number of things that Medicare does not cover, including long-term custodial care, most home and community-based care, dentures, dental care, eyeglasses, and hearing aids. Looking at the long-term care side, the Medicaid system pays for half of those costs; 18% is paid out of pocket. Medicaid is a health care system for people of all ages who are low income. Income eligibility is very low for Medicaid; a single person's assets must be under $2000 or $3000 for a couple. About 1 out of 5 people that have Medicare also have Medicaid.

Almost all of Medicare is spent treating chronic conditions, including diabetes, hypertension, and congestive heart failure. As you age, you are more likely to have chronic conditions that you have to learn to live with and manage. 90% of Americans 65+ have at least one chronic condition and 77% have two or more chronic conditions. The majority of Medicare spending is on those with

five or more chronic conditions. 10% of Medicare enrollees account for more than 60% of Medicare costs; these represent the people with the multiple chronic conditions. The system is not set up to address these chronic conditions because it was originally created for acute care expenditures. The key problem area in health care for older adults is that the acute care system is being used for a chronic care population. There is difficulty transitioning among settings, there are gaps and duplications in care, often there is no primary care manager which makes care difficult to track.

Mrs. Consumer, or Mrs. C is a recent widow whose husband provided much of her care, was diagnosed a year ago with uncontrolled diabetes and congestive heart failure. Since the death of her husband, Mrs. C has been unable to pay her bills, keep her apartment clean, or adequately prepare food. She has not paid the rent and the landlord is trying to evict her. Mrs. C does not have a working phone, her refrigerator has been disconnected, there is no food in her house, and she remembers eating little in recent days. She lives with two uncaged birds and a dog.

What services does Mrs. C need? Perhaps transportation, housekeeping, medication monitoring, personal assistance, home maintenance, money management, shopping help, pharmacy, and diagnostic services. Many of the things Mrs. C needs cannot be provided by her doctor. When someone like Mrs. C needs services, she is navigating a fragmented system that requires various methods of payment and has different regulations. She may or may not qualify for all of the services she needs. Her primary care provider most likely does not know about all of the services Mrs. C is utilizing. Many times, patients like Mrs. C are asked about what medications they are on, what kind of help they need with activities of daily living, but the information is not shared between service providers. This causes assessments to be repeated numerous times by many different people. Like Mrs. C, 87% of adults who need help and support with functioning receive it from unpaid caregivers. These unpaid caregivers average 21 hours per week in caregiving. The typical caregiver is a 46 year old woman who works outside the home. AARP estimates $364 billion per year would be the cost at $9.70 per hour for this service. When thinking about how to construct a more coherent system, we have to keep these unpaid caregivers in mind and consider the support that these people also need.

A more coherent system should have the ability to link information so that information can follow the patient. It needs to be able to make effective referrals, and it should have aligned incentives. At USC we asked graduate students to identify various assessment tools and track all of the questions asked in each assessment. These were then compared to see who is asking what questions, who duplicates services, and then used to try to develop an integrated data warehouse in California. We also evaluated the relationship of process of care and subsequent function and survival among people over age 75. Findings showed that those who received quality care had smaller declines in functioning, therefore there is potential for these large linked data sets to help track quality outcomes. The study also included a component for assessing care of vulnerable elders, looking at elders who are most at risk and what types of care they get. Preventive care was received the least and diagnostic care and treatment were received the most. Care for geriatric conditions such as falls and incontinence were not often part of the care, although they are common problems in this age group and important components of comprehensive care for this group.

In summary, services are fragmented, disjointed, and duplicative. There are inefficiencies and gaps and it is difficult to negotiate and transition between services. There are multiple funding streams, incompatible regulatory requirements, lack of integrated information, duplicative assessments, different providers and many different consumer needs. Consumers need more flexible care. This can be done through care management, provided by a social worker or a nurse. When care managers looked at people dually eligible for Medicare and Medicaid, they found that 26% of dully eligible elders had a confirmed medication management problem. Through this care management program and working with a pharmacist, these medication management problems were able to be corrected. Another simple intervention involved care managers making monthly telephone calls and asking clients how they could help. The care managers were able to help people set up appointments and access services and this intervention not only reduced incidences of hospitalization, it also reduced mortality.

Almost half of adults 65 and older will spend some time in a nursing facility; however, the majority of them leave within three months. This is why accessing and utilizing services is so important to help with a smooth transition between the nursing facility and home. The focus used to be on keeping people out of nursing homes, but findings show that many people enter nursing homes for rehabilitation purposes and transition back to their homes, if that is what they desire. Most people who leave nursing facilities come out quickly, comprised of short-stay and rehab residents; whereas the emphasis has been on long-stay residents. Most of the residents that are able to transition back to their houses have a positive support person or a caregiver, they are married, and they utilize in-home services. Those that tend not to go home have trouble completing activities of daily living, have had a recent fall, have severe cognitive impairment, bounce between the nursing home and the hospital, lived in another facility, and are incontinent.

About one in five Medicare beneficiaries discharged from the hospital is readmitted within 30 days and one in three is readmitted within 90 days. Some of this is medically necessary, but research shows that some of this is also due to poor transitions and this bounce-back could be improved.

There is currently about one geriatrician for every 4,000 older Americans. People aren't going into primary care, they aren't becoming geriatricians, and reimbursement rates are not an incentive to go into primary care or to become a geriatrician. Our medical system is unprepared for the aging of the baby boomers. The good news is that wellness programs do work for people aged 65 and older with disabilities or who are sedentary or obese. Improvements were seen in groups that underwent behavioral change training and exercise.

Health Reform is moving this acute care system toward a chronic care delivery system. It provides incentives for primary care doctors, improved coordination through the use of an interdisciplinary team, aligning cost incentives with outcomes such as penalizing poor transitions, and implementing the CLASS Act (Community Living Assistance Services and Supports Act) which will provide some long-term care insurance to people. It's a voluntary, public insurance, with no tax dollars associated with it, and has no exclusion for preexisting conditions. The program promotes choice and access with opportunities to choose what types of programs and services they want. I think that time will tell whether these reforms will work but the take-home message is that

this is a complicated system with many moving parts that is difficult for frail older adults to navigate. These innovations are exciting and it is exciting to be part of an aging society that indicates the success that we have had.

Taichi Ono, Professor, Graduate School of Public Policy, University of Tokyo
AGING IN JAPAN – FOCUSING ON LONG-TERM CARE INSURANCE

As Dr. Crimmins' presentation indicated, Japan is the front runner of aging populations. Life expectancy at birth is 79.59 for males and 86.44 for females. The speed of aging is another concern for Japanese policy making. Japan is aging at a faster rate than the United States, so we have to modify the system to catch up with the rapid change in demography, which means a rapid change in society as well. Japan's population is already starting to decrease. At its peak in 2005, Japan's population was 127 million people, but has since decreased continuously. The ratio between people of productive age (15-64) and those over 65 will change from about 2 in 3 people to 1 in 2. The aged population will double to 40% in 40 years. Those aged 65 and older become eligible for Japan's long-term care insurance.

At about age 80, the ratio of males to females is 10:7. At 85, it is 1:2. Therefore, we must think about restructuring services and tailoring them to meet the needs of these proportions. The number of elderly people living alone is increasing, meaning that familial support is becoming weakened. It was not uncommon for three generations of a Japanese family to live in one house. Now, households with a single person or a couple are becoming more common. Still, family members are the main caregivers in Japan. Therefore, supporting the caregiver is also a concern in Japan as people in their 80s will be caring for their spouses and people in their 60s will be caring for their parents.

Average per capita income of the elderly is not so different compared to the younger generation. Japan's long-term care insurance system is another social insurance program that has been added to the public pension and public health care. Before long-term care insurance, the Gold Plan was initiated in 1989. This was a 10-year strategy to promote the health and welfare of the elderly. The main aim of the long-term care insurance program is to break down the barriers between medical care services and welfare services. In the Gold Plan era, medical services and welfare services were different systems. It was segregated and not well-coordinated which caused many problems including the unnecessary hospitalization or stigmatization of those who receive necessary welfare services.

The long-term care insurance program also aims to reduce the burden on family caregivers, especially women, who take care of their family members. This system was invented to secure a stable flow of resources to support long-term care for the future. The law was established in 1997 and began in April 2000. The first major reform was introduced in 2005 to stress prevention within this system. The second major reform for long-term care insurance was scheduled to take place in the fall of 2011, but due to the disaster, Japan's political situation is unknown.

The long-term care insurance system covers in-home services to facility services. In-home services include home help, visiting nurses, home bathing help, and care management. Community services include day care and day rehabilitation, short stay services, collective living services such as private nursing homes, care houses, group homes, and facility services like nursing homes, and health services facilities. In Japan, insurance providers give the same amount of payment to service providers and service users pay different amounts based upon the level of care needed. Fees increase as levels of service needed increase.

An overview of the 2005 long-term care insurance reform highlights five issues that caused the reform. Conversion to a prevention-oriented system, review of facility benefits, establishment of a new service system, securing and improving service quality, and reviews of cost-bearing and system operations. In order to move to a prevention-oriented system, the program will need to create new care prevention benefits and create community support programs so that people will stay healthy and as a result, require fewer services. Establishing a new service system will allow the creation of community-based services, community-based comprehensive support centers, and improve resident services. This would include providing coverage for smaller day care centers and enrichment.

A regional comprehensive support center is similar to a public office established in each municipal government around the country. Staffing includes representatives from three disciplines of care management support: counseling; rights advocacy; and preventive care planning with a care manager, health nurse, and certified social worker. Care managers will coordinate with other service providers and will create a network of services including local dental care associations, medical care associations, and other services. Preventive care plan health nurses will establish preventive care plans to incorporate public health into the care plan and not only focus on life support services but more health enhancement services by helping users to socialize more or participate in physical exercise or community groups. The target goal is to establish a regional comprehensive support center in each junior-high school district. This will become a center of long-term care in each district of Japan.

Comprehensive community care is the focus of the 2011 reform. Comprehensive community care refers to a regionally-organized system that provides various life-support services, not only medical care or long-term care but welfare services located within daily living zones to secure safety, peace of mind, and health in daily life. The reform will implement measures to promote a comprehensive community care system that provides medical services, long-term care services, preventive services, residential arrangements, and life-support services in a seamless manner in order for the elderly to live independent lives in the community.

The concept of a comprehensive community care system includes five types of services: long-term care, medical care, preventive services, residential arrangements, and life support services. These five services are provided to the elderly within their daily living zone which is made up of the area within 30 minutes from a person's home. The reform will strengthen cooperation between medical care services, provide enrichment of 24-hour home medicine, visiting nurse and rehabilitation, and allow several medical practices to care workers. Enriched and strengthened long-term care services will include enhanced promotion of the long-term care insurance infrastructure such as specialized

nursing homes and strengthening in-home services. Promotion of preventive services will include promoting services that enhance health so as not to become in need of care, as well as care services that enhance the independence of the elderly. Securing various life-support services and rights advocacy will promote services such as guardianship or meal delivery, property management, and other services that accommodate the increasing numbers of seniors living alone. Enhancing the provision of services for residents in nursing homes will amend the elderly residence law to include the for-profit nursing homes that meet standard for proper regulation.

Part of the 2001 long-term care insurance reform was to assemble a service plan that takes into account regional needs and issues in each daily living zone. This service plan is revised every three years to re-estimate the needs of the elderly and the amount of services provided. Needs are based upon data collected in each municipality including household composition, issues related to dementia, income level, housing, health conditions, ability to perform activities of daily living, and degree of socializing. This data is compared with other districts, making the unique needs of the elderly in each municipality evident so that the local government can plan service provisions in an efficient manner.

Premiums vary in each municipality and the number of service users is increasing for in-home services because facility services are limited to the amount of beds available. The total amount reimbursed to institutions and service providers doubled between 2000 and 2008. Half of this is financed by tax money and half is provided by the long-term care insurance premiums paid by enrollees. The two key concepts for long-term care insurance are comprehensive community care and accountability. All of the long-term care insurance features that promote accountability also help enhance the financial stability of the system. In order to keep the total cost of the system from skyrocketing, a 10% fixed rate copayment was introduced, rather than having copayments at fixed amounts. Also, a maximum amount of use for each care level was introduced along with a care management component that aims to provide only services that are necessary. The reform that took place in 2005 changed the system to be more prevention-oriented so that the long-term care insurance system will be sustainable in the future; however the natural increase of the elderly population has raised concerns for the fiscal soundness of the system.

Throughout the 2011 reform debate, additional measures to promote financial sustainability were on the table. Among these were options to promote fiscal sustainability under the “pay as you go” principle. This would eliminate services for the elderly with less care needs, increase the rate of copayment for the elderly with less care needs, increase the rate of copayment for elderly with higher income levels, introduce copayments for care management services which are currently paid for out-of-pocket, and restrict subsidies to the poor for room and board copayments. All of these options are not employed because they are unpopular. The only employed measure to reduce the premium increase was dilution by further cashing out of the reserve fund.

The current cabinet and the party in power agreed that the issues of funding for long-term financial stability should be discussed as a whole with other social security expenditures such as public pension or health care. In the debate, the increase of the consumption tax rate is the alternative. At first, the discussion about the comprehensive reform of the tax and social security

system was supposed to be concluded in June this year. However, due to the disaster, the political schedule is unclear at this moment. Also, tremendous public finance needs for recovery and rebuilding have changed the premise of the discussion about tax and social security reform. Debate on fiscal sustainability is still ongoing in Japan. Currently, one-third of the national expenditure is spent on social security. Long-term care insurance has been modified rapidly so as to catch up with the changes of society. Possible options are limited, due to the constraints given by the population change, economic situation, and fiscal condition.

Japan has learned a lot from the United States in many aspects of society. One of these things was the system for elderly care. The PACE program in the U.S. provided Japan with the model to establish a service system under long-term care insurance. Specifically, the community-based care and services, the flexibility to meet health care needs, helping elders to continue living in the community, and the use of interdisciplinary teams of professionals working with you and your family to develop the most effective plan of care. These were incorporated into Japan's long-term care insurance system.

As countries with an aging population, both the U.S. and Japan have enforced various policies for the elderly. With such experiences and our shared value of freedom and friendship in mind, the U.S. and Japan could and should lead the world together to provide safe, healthy, and content lives for the elderly around the world, who have enabled us to live in the world as it is today.

Shawn Miyake, President & CEO, Keiro Senior HealthCare

KEIRO SENIOR HEALTHCARE'S MODEL OF CARE FOR A HEALTHY COMMUNITY

As I walked into the local community center, I was confronted by a sea of gray-haired people sitting in the room having a discussion about how to sustain the community center going forward. The center's board of directors was mainly comprised of people in their early 80s. Some were dozing and later complained that they could not hear what was being discussed. The volunteers at the community center were as old as the board members. Many talked about people they knew who were no longer able to attend events or activities at the center and they wondered out loud who would replace them in the future. The discussion swung around to the declining membership of the center and was the center still relevant after all of these years especially in light of the evolving diversity in the community.

This scene gets played out time and time again in many of the churches, temples, community centers, and service organizations in the Japanese American community. This is the oldest ethnic community in the United States with close to 21% of the population being over the age of 65 years old, compared to the general population of the United States at roughly 12%. Many Americans are not aware of this fact and the experience of the Japanese Americans goes largely unnoticed.

By all measurements, the Japanese American community appears to be coping well enough. Many assume that respected elders live with their families in traditional family structures and little is made know through the media about the community's plight. A closer look reveals a community

that is challenged with the demands of a large aging population which is attempting to utilize community resources to support their desire to age in place.

The Japanese American community's experience is significant because it foreshadows what the rest of America will experience in 2050 when it too will have the same proportion of older adults. The Japanese American community represents a microcosm for how a community with one-fifth of its residents over the age of 65 reacts and copes and how well current systems of support and care work for such an aged population. Such challenges threaten the very social fabric of the community and call into question the reasons for the existence for many traditional and time worn institutions and practices.

The high proportion of aging in the Japanese American community puts a strain on health care organizations like Keiro Senior HealthCare. Despite having the largest service capacity of any senior health care organization serving Japanese in the United States (over 640 older adults), we still find ourselves overwhelmed with the demand for services. All of our facilities are typically full with waiting lists. At our retirement home, the waiting list is two years for a studio apartment and five to six years for a one-bedroom apartment. In Keiro's nursing homes, we have about a 500-bed capacity in three facilities and the waiting lists can vary anywhere from a couple of weeks to over a year if you are a man with dementia.

While Keiro offers a complete continuum of senior care services with a consistent philosophy of culturally sensitive care, it is interesting to look at the utilization within our system. Over 70% of our resident care capacity is dedicated to skilled nursing care. We often serve the frailest and most chronically disabled portion of our community. This is consistent with many families' desire to provide caregiving at home, often with the help of in-home supportive services. Early on, we made an assumption that families could benefit from respite from their caregiving duties and we opened two adult day care facilities. Over time, we learned that early in the caregiving cycle, many families who had been caring for family members at home did not wholeheartedly embrace adult day care as a care option, which resulted in the eventual closing of the two programs.

The cultural value of caring and respect for the elderly is still important in the Japanese American community today as many families voice a preference to be responsible for the care of older family members while often still caring for younger children. In the Japanese American community the issue of filial piety, or as we call it, *oyakoko*, is still a strong value, even if family members do not know what drives them to do things and feel the things they do. As such, feelings of obligation and guilt often inhabit the care coordinating experience.

Added to the caregiving challenge is the effort to understand the types of senior services available, how to access them, and how reimbursement works. Many of our callers requesting help often describe a system they have tried to engage as "fragmented and confusing to work through" despite the wealth of information currently available on numerous websites and in published materials like brochures. As Dr. Wilbur so convincingly presented earlier, it is quite confusing, and if anyone has ever tried to get their family member into a skilled nursing facility or day care, it is not simple. It is not simple to understand the levels of care and it is not simple to understand who

pays for them. Although the Japanese community is well into its fourth and fifth generations, a considerable portion of the community still relies on the Japanese language as the primary avenue of communication for their complicated matters.

It may seem odd that the Japanese American community offers such an opportunity to learn about how society will cope with the wage of the aged in our nation as America is so diverse, made up of many wonderful cultures and backgrounds. But it is not so much what makes Japanese Americans different than it is a study of what makes us so alike, so as to warrant a comparison. While much of what we have learned about cultural sensitivity in our history is unique to Japanese Americans, the process of cultural sensitivity can be applied to the wider community of older adults.

Our nation will soon become very familiar with being more culturally sensitive as we will all experience a culture of aging. While we have our individual and collective differences, we are essentially the same human beings with time-limited warranties in our bodies. We share the same biology after all. We are all going to age, parts will wear out, and chronic conditions set in. It's a fact of life. Just as we at Keiro have come to understand and appreciate the finer points of our culture, so will the rest of the world have to come to grips with a culture of aging surrounding them. There will be so many older adults in the community in 2050 that the aged will become their own subculture defined by their shared experience of aging. Younger Americans will have to deal with this subculture as it will become so prevalent.

The aging subculture will define what is important to society, how resources are allocated and how life is lived. Believe me, that is how it is in our community today. We structure so much of our social life in the Japanese American community around the knowledge of how many older adults we expect to participate in the activities we plan. This impacts decisions about the venue, the time of day as many older adults do not want to drive at night, if valet service is needed because entry at curbside is a lot easier for people that have mobility issues, the type of food served, and the number of volunteers required to assist people. Sometimes our functions need to provide one-to-one assistance, and we often have as many volunteers as we have residents attending programs. We consider the types of chairs used, and we have to be really careful about how people are checked in. Japanese people in general seem to arrive early. They always want a cup of coffee or tea and they want to be able to sit someplace. One of the things that amazes me so much about different activities is that at cocktail hours, which are about an hour before the event, we expect 80 and 90 year old people to stand and mingle, and it does not really work. I shop with my wife quite often, and I am always amazed at the lack of seating for men, particularly in areas where women shop. Likewise, if you want older adults to enjoy themselves, you have to provide seating for them.

Our assumptions based on best-practice white papers are not necessarily meaningful to the older adults that we interact with. We have to take additional time to try to understand the experience of the aging, the changes that we will all someday share in, and the generational and individual differences that form the foundation for their behavior to really understand ourselves and be successful in what we do.

Aging in place is quite often mentioned as a solution for a rapidly aging community. This answer seems to resonate with many people that are doing so. The reality is that it is a very difficult objective to accomplish. A recent panel sponsored by the Washington Grants Makers agreed that without a strong infrastructure of community, family, and public support, it is often not possible for people to live at home and it might even be considered dangerous. Some departments of health find it increasingly difficult for governments to deliver needed services to support people living at home. In Montgomery Maryland, it costs five times as much to deliver a meal than it does to buy it. It appears that we are creating expectations that people should age in place, but in reality the government does not have the resources necessary to meet those expectations.

Someone once said, "It takes a community to care for an older adult." Our conclusion over the past 50 years is that this statement is truer than more people realize. If not for a community's efforts to provide culturally-sensitive care facilities staffed with a number of volunteers and an extremely supportive donor base, Keiro would not have been able to succeed in accomplishing our mission. Our experience is that it takes a single-minded focus that taking care of our elders is an important value that we all must share.

Keiro has also learned over the years that we are not the care providers in a traditional medical model sense where someone is dropped off at the front door and leaves the care to facility staff. We define our role as being an extension of family. This extension of family is meant in the truest sense of community, being part of a village, if you will. This is a sense of being interdependent on one another. What it means to us is that we regard the resident and family as the one in charge and we view ourselves as coming alongside them to provide a measure of support. Families can rest easy knowing that the daily living and care functions are handled; they can go home and return the next day to visit the resident and enjoy spending time with them knowing that the heavier care responsibilities such as bathing, grooming, dressing, cooking and serving food, and making sure that their medications are delivered as required are all taken care of.

This approach is evident in something as mundane as establishing visiting hours. At Keiro, visiting hours are any time a family member has an opportunity to visit their loved one. While at other facilities, this may seem like an unnecessary intrusion in the workplace, we view it as a common activity in the resident's home. This partnership with families is at the core of Keiro's care approach and builds an authentic sense of community.

Because we understand families are really on the frontlines of caregiving in our community, we invest heavily in supporting their success as caregivers. We have provided a dozen caregiver conferences over the past few years, attracting anywhere from 250-300 caregivers each time. This is the scale of demand we have come to expect in our significantly aged community. If 29% of the U.S. population, or 65 million people, today are providing care to family members, we can expect that this need will be doubled by the year 2050. Family caregivers are indeed the foundation of the long-term care system and we acknowledge this by providing culturally sensitive referrals, support, education, and resources to them.

For the first time in its history, the American Heart Association has identified better health as a principle goal, as opposed to only reducing disease. This is a dramatic change in institutional thinking. Keiro has been pushing this idea for the past seven years. Seven years ago, we were challenged by our board of directors to think outside the box for a new approach to providing care for our community. We were beginning to conclude that the senior care industry as we know it today is unsustainable. We did not believe that there would be enough beds for everyone when the general population reached 21% over 65 in the year 2050. As a matter of fact, as care providers and those of you in long-term care and skilled nursing know, the occupancy rate is upwards of 90% in nursing homes today. When that demand doubles by 2040 and 2050, there are definitely not going to be enough beds (not that anyone wants to be in a nursing home). We could see that happening in our own organization with long waiting lists in all of our facilities. Also facility-based care beds were too expensive to build and maintain with unpredictable reimbursement rates. Added to all these issues was the idea that the consumer did not want what we had to offer. They wanted to stay in their own homes for as long as possible.

As the recent economic recession is beginning to show us, there will not be enough money to fund all of the care that we desire to provide. Our current medical infrastructure is not set up to handle the needs of our current baby boomers and their multiple chronic conditions. The bottom line is that there is no government bail-out for our health. An important point for consumers to realize is that we are responsible for our own health.

The American Heart Association has recently called self management of health the cornerstone of any health reform effort the government takes on. Research increasingly shows that incremental lifestyle changes produce amazing results, preventing and even reversing chronic illnesses. Although something so simple as making a few lifestyle changes is so accessible, fewer than 1% are able to follow the seven simple steps to heart health that are outlined by the American Heart Association. As the saying goes, an ounce of prevention is sometimes a ton of work.

So many baby boomers live with their unhealthy lifestyles because many believe that modern medicine has a cure in the form of a medical procedure or a medication to undo the problems we have caused by our lifestyle choices. We are, in fact, the first generation that will use medications widely as a preventive measure. Medical interventions like medications and stents can delay death but they do not instill health. True health is the result of lifestyle improvements.

Many of the chronic conditions we have or will have started well before we were adults. Just look at obesity in older adults. Many chronic conditions like obesity and the illnesses related to it are problems of older adulthood which have had their genesis in childhood. In a recent journal of circulation, research concluded that the risk of heart disease can appear as early as age 9. Fortunately we are not held hostage to our genes as research has shown that through lifestyle changes, even the predisposition of our genes can be altered. As Dr. Crimmins noted, it is not so much about the system as it is about how we manage our own health that is important.

To that end, Keiro created The Institute for Healthy Aging and has been on a crusade to think beyond the original charge of our founders to provide a safety net of facility-based care. We know

that the current rate of utilization of nursing homes is about 5% of those 65 and older and the other 95% of older adults living in the community for the most part want to stay at home. This was a major paradigm shift for our organization from focusing on the direct care of chronic disabled persons to promoting the health of our community.

I would like to share with you what our model looks like. As our 50th anniversary approached, we began to really think about our organization's legacy, which has been based on an institutional model and voiced as "offering peace-of-mind to our community through a tradition of caring." As we looked ahead, we strongly felt that our future was in large part based on a model of healthy living or aging and could be simply stated as "supporting our community to age with confidence." We see this as a major paradigm shift for our organization and one that could actually be our mission in the future. We believe that at some point, probably 20-30 years from now, we will not even have facilities and we will spend all of our effort and time promoting healthy aging in our community and beyond.

Our mission to create healthy communities is actualized through a focus on four population segments in our community: adults that are 50 years and older, especially women; employees within our organization; volunteers who support our programs; and our residents and their families. We support their health by offering programs in the eight dimensions of wellness we have identified: physical, occupational, financial, emotional, social, spiritual, and environmental. We feel that losses in one dimension can be offset by strength in other dimensions. For instance, if someone has recently had a stroke and becomes limited in the physical dimension, strength in the social dimension can make up for these limitations by having friends provide them with assistance. If all of these dimensions are in balance, we feel it represents *genki*, or healthy living.

We believe that health is a result of personal responsibility, which can be increased through awareness, information, practical lifestyle management tools, and access to culturally sensitive resources. Our efforts are targeted at 50+ older adults, employees in our organization, volunteers, and residents who live in our facilities and their families who are the backbone of the caregiving network.

The programs we offer are selected from evidence-based programs currently available. We hope to develop our own research-based programs through our collaboration with university students who have been doing research at our facilities, but until then, we have been adopting and promoting available programs from schools like Boston University and Stanford University, to name a few. There are a lot of evidence-based programs available and many are free to the public. We select the programs based on the relevant needs in our community, revealed through needs-assessment research.

A critical component in our model is volunteerism, which we believe to be essential to its long-term success and sustainability. We believe that our efforts will be sustainable only with the support of volunteers who lead the evidence-based programs, engage in fundraising activities, and provide socialization and activities for residents in our facilities. Research indicates that volunteerism and social connectedness are essential to a *genki* lifestyle.

We took on this challenge of supporting healthy aging and aging in place in our community at a time when these issues were on the distant horizon for most Americans but on the doorstep of the Japanese American community. Reimbursement for these types of activities was often talked about in hypothetical terms and largely unavailable. Nonetheless, our organization committed its resources to invest in the health of our community. Our greatest triumph will be to see the health status of our community improve to the point where we see the utilization of facility-based care drop dramatically and people achieve their goal of remaining in their homes and enjoying as independently lived, the highest quality of life possible.

We recognize the need to partner with others in these new and developing approaches. We currently work with AARP and the Partners in Care Foundation to make progress in this area. We are also making available evidence-based programs for fall prevention, which is the fifth most common cause of death in the Japanese community; diabetes management, the seventh most common cause of death in our community; and a chronic disease management program that will provide support for all the other chronic conditions that afflict our community. In addition, since memory loss is often cited as one problem of most concern for baby boomers, we provide an evidence-based memory enhancement program called Memory *Kai* (*kai* means meeting, association in Japanese), which was developed at the UCLA Longevity Center (formerly UCLA Center on Aging).

Further, we have been trying to develop better measures to track the health of our community and the impact of our evidence-based best practices approach to health promotion and wellness. We take what we have learned in the community and reinvest that knowledge back into our facility-based care. We have come to understand that home is wherever someone calls home and are prepared to offer support for older adults and their families to achieve their goals as they age. We are also making these programs available for our employees and volunteers. We believe that all of our experience to this point has yielded a model for healthy aging that can be replicated in other communities.