Alex Spanko
Bob Kramer, always a pleasure to speak with you. Thank you for coming and joining us today.

Robert Kramer
Delighted to be with you, Alex. Thanks for inviting me to join you.

Spanko
Of course. You were really the first person that came to mind when we started this podcast project, when we were getting into the topics that we would drill down into. And this is an area that I've always found fascinating. It's kind of been my entry point into long-term care – the financial angle, the financing, the REITs, all that stuff.

If there's one thing that I wish policymakers, lawmakers, leaders, anyone who's really concerned about nursing home quality, long-term care quality – I wish they understood the financial system a little bit better, because I think we tend to have blinders on when it comes to how this care is financed, what are the levers that get pulled to create something new or to maintain the status quo.

So I thought this would be a perfect opportunity to get your insights, because as we're going through this podcast, the "Mission Possible" podcast, and as we're really thinking about the ways that we can operationalize the recommendations, it's going to take money, and it's going to take financing. It's going to probably take some shifts in the way we finance the care. So just to kick us off, and just to give our listeners sort of a background, can you walk us through the current landscape in terms of who is primarily funding nursing homes – whether that's new construction, which is not very common, or acquisitions – and assisted living facilities? Why do they see it as a good market to be in?

Kramer

Yeah, well, thanks, Alex. A couple of things. First of all, obviously, with skilled nursing, the daily operational costs – this is a government-reimbursed business from two sources: Medicare for short stay, post-acute care, and then Medicaid for long stay. Overwhelmingly, it's a government-reimbursed model of care.

In terms of the transactions, the buying/selling, let me say, the last 60 days have seen quite a shift. And so just the timing of this interview, even from when you first approached me, Alex, to today, the market has shifted. Transaction values are going down. When you've got double-digit, or close to it, inflation, you've got some enormous pressure there – and coupled with shortage of labor and soaring labor costs, and then coupled with interest rates that have more than doubled. So instead of thinking about refinancing or financing the debt on an acquisition at between three 3% and 4%, you now are liable to be financing at 7%, and with a much more cautious lender. Also the idea of bridge loans to HUD – that bridge loan financing is going to be much more expensive. And that bridge [lender] is going to be concerned whether or not they may get stuck with the bridge loan and ask for an extension. So I just want to point out that before I make some general comments, the last 60 to 90 days has seen a real change in the market conditions.

So prior to that, I would say for skilled nursing, unlike much of the public media discussion, it's not been institutional private equity. The Blackstones of the world, the Carlyles of the world, for the most part, they have all sold out and exited the skilled nursing sector [due to] the combination of regulation and reimbursement risk and so forth. That said, it is private money. And sometimes that private money may wrongly or rightly be termed "private equity." That's a subject for debate. But I want to distinguish between the very large national, international, what would be called institutional private equity players who invest in all kinds of property types, versus this private money that zeroes in on nursing homes.

Spanko
Not to interrupt, but that is such an important distinction that really does get lost. There has been a ton of lawmaker and policymaker interest on private equity. A lot of those articles will mention Carlyle and ManorCare, which was a huge, big deal. It's great hearing that point from you, because I think the Carlyle-ManorCare – I think everyone sort of learned their lesson [among] the big institutional [private equity players]. They just don't have the interest in it, they don't have the stomach for the headline risk, and really the increased attention. And so again, we're not trying to say that one type is better or worse in the end, but it's just to frame the conversation and really make sure we understand what we're talking about – and we're not sort of chasing the ghosts of the past.

Kramer
The key word is uncertainty. Because equity and debt players, when there's an uncertain environment, they are going to price in that risk, meaning that's a cost – they're taking a greater risk. The risk now is even greater because of the overall concerns about where financing is heading, and that has nothing to do with skilled nursing or assisted living [because of] the fear of a recession.

I have a talk where I talk about all the pluses to be optimistic about financing for long-term care, and then all the minuses to be pessimistic. They're each a pretty long list, and I'm not going to go through all the items. But for instance, there's the undeniable reality of the surge of the 75-plus population. And everyone talks about, "Well, the first Boomer will turn 80 in 2026."

And yes, that is significant. Remember, the average age in skilled nursing is lower, actually, than the average age in private-pay senior living, assisted living, memory care, independent living. Skilled nursing has the lowest average age. I think there are several reasons for that. One is on the post-acute side, you may have people who got a hip replaced – and it's not the hip replacement, but it's the fact that they live in apartment or walk-up, and they just simply can't get that care initially that they need at home. But then you also have this phenomenon we all often lose sight of.

The reality is that's a that's a tale of two cities. What do I mean by that? Private-pay senior living residents have the resources to afford assisted living, memory care, so forth. Those folks tend to be much more highly educated, which is the largest driver of greater longevity. Now, the folks in Medicaid skilled nursing, they tend to be poor; they're on Medicaid, and they tend to have less education. But what why is that significant? Because the private-pay group are not likely to be

customers for private-pay senior living for another 10 to 12 years, because their average age of entry is going to be late 80s to early 90s. The oldest Boomer right now is 76, and will turn 77 on January 1, [2023], so we're 10 to 12 years away from that surge for care-driven private-pay senior living.

Now let's switch to the nursing side. That's not true when you talk about a lower-income clientele that's had less health equity and health care access – and even the "forgotten middle," the sort of lower half of that. We know from research that they skimp on preventative care, and they don't do the things they should do for fear they'll run out of money. So by the time they qualify for Medicaid, they're sicker, frailer, and more likely to be institutionalized.

The surge of people coming into skilled nursing facilities in the future are going to be two very different populations, even more different than the past. One will be represented by an Ignite Medical Resort or other providers who just simply focus on post-acute care, and then the second group are going to be focusing on a Medicaid population, which is poor, sicker, and frailer. And those numbers are going to hit us sooner rather than later, because that population doesn't have that lifespan into the 90s. For many of them, they have a lifespan just into their 70s.

So what I'm saying is [there is] growing, escalating demand for long-term skilled nursing care, but I don't think the care-driven senior living growth isn't going to happen for another decade. And I think that's an important distinction. I think you see these two different worlds within skilled nursing … and often now working with providers or with insurers, with almost 50% of eligible seniors now in Medicare Advantage.

So it's a high-end facility really specialized on getting you home as quickly as possible, versus a Medicaid facility where you're moving there for and it's your last stay. So that gets me to my final point on this, which would be COVID revealed something we've known, Alex, to be true for a long time – and that is the implicit, not to say explicit, ageism in our country. On top of that, we don't really care for the most part – meaning we wouldn't want to fund care for poor elderly [people].

If you look at it – and I know I'm diverging a bit, but this is an important point – we've always had a virus that killed people in nursing homes in great numbers. It was called the flu, it happened every year, and we accept it. We so much accepted that it often was it was known as "the old man's friend," the flu, because it would end your life – so much so that many states didn't even distinguish, pre COVID, between 65-and-older deaths versus under 65 from the flu.

We just accepted that when you got to your 70s, you're going to die, and it was a question of what you're dying from. COVID all of a sudden shone a national spotlight on our skilled nursing and long-term care system. We didn't like it, but we're going to have to change that underlying ageism, and that underlying sense of who's going to advocate for the group that has the quietest voice and the most lack of a voice – and that's the poor elder who spends down onto Medicaid.

For all the lip service in public policy circles, nobody really wants to fund that, and that's our biggest problem. That's an issue that – as I say, to the students in many classes I teach at different universities – you actually have more at stake in this than I do, because you've got to change

these attitudes for your future and your children's future. But we're in a country where all of our social insurance programs, our whole system is set up for people to live and die in their 60s and 70s. But nobody got the newsflash that many people are living longer.

Spanko
That is such a great sort of setup, or context, of this whole landscape and where we're at. I want to drill down on your point about the bifurcation, because that's something that I've obviously seen in my time covering long-term care.

That's a big question that we get: Why aren't people building new Green House homes? Why aren't people even – if it's not Green House, small home models – why aren't people doing these novel, new ideas? Even though they're not all that new, but especially in the context of this – why aren't people building private-room homes for the Medicaid population? My answer is, well, the money is in Medicare, and that's why you see medical resorts opening up because if you focus on just that population, you only have the, what is it? $480-a-day Medicare rates, depending on where you are.

Kramer
Average is higher than that, yeah.

Spanko
Yeah. Whereas with Medicaid rates, you're talking about low $200s, mid-$200s – maybe high $200s in a state that's considered good for Medicaid rates. That has always been a concern of mine – you mentioned the folks who are not necessarily high-income or even middle-income, and they can't afford a long-term care solution if they're on Medicaid.

What do you see as the policy levers that can be pulled in order to make sure that we can build more alternatives like the Green House, or just even private room nursing homes? Because there's a lot of debate; critics of the industry will say that, oh, the Medicaid rates are more than enough. It's just that they're getting funneled out to the investors and those dollars aren't actually going to care.

So we tend to have, and I say this all the time, we tend to have a “fines-versus-funds” binary when we talk about: How are we going to improve care? Whereas it's definitely a combination of a lot of different factors, a lot of different carrots and sticks. So in your mind, when you say we’ve got to get people paying attention to the Medicaid problems, so to speak, what are the levers that you think policymakers could pull to encourage new development to really serve that [population]? They say “the forgotten middle,” but I don't like that term, because it's not as though the options for the lower end are really all that better – they just maybe have some coverage.

As I always say, I don't want to live in a three-bed-room nursing home, no matter how nice it is. So what are some ways to get that?

Kramer
[There's many] questions embedded in what you've just said. First of all, let's understand that today, investors for the most part are far more interested and want to see strategies – and operators want to have strategies – to move to more private rooms, or at least to move to semi-private. What you just mentioned, the three- or four-bed ward, that's seen as anachronism, I think, in a healthy way. All the issues about air quality and air flow, and just the danger of infection, were really highlighted by COVID. They were there all along, but they were highlighted by COVID. So first of all, there is a preference for buildings that have at least double occupancy and operators who have plans to move to single occupancy.

Having said that, within the post-acute world, it's a requirement. You're just not going to be able to get those customers if it's not a private room. So again, we're talking about the inequity of … what's available for the Medicaid recipient.

So let me make a couple of other statements. One, there are some bad-news owner-investors out there. They are not the majority; they are a minority. But that minority a continues to give a bad name to all operators and all owners – by the way, in an industry that still has many mom-and-pop, single-facility owner-operators. at times, they've had that property for years.

But they give a bad name to the owners and to the operators, and they basically are looking for end-arounds. They're building, for instance, their profitability model on ancillary businesses, and they're not investing in care. And I agree, those people should be kept out of the industry. That said, having regulations which have shown again and again – they haven't kept those people out, they failed, but they've added costs for all the good operators that want to provide good care. [It] doesn't make sense, and so we've got to think in a different way about this.

I'm all for greater transparency. Of course, the reason we got into these convoluted legal structures originally was because of liability risk – and, basically, the ambulance chasing that became the nursing home fall-chasing, or nursing home death-chasing, attorney.

But putting that aside for a moment. You know, I'm all for greater transparency of where the dollars go and of who really owns what. Frankly, I'll just put a number on it: Those 10% of owner-investors who give the industry a bad name, I'm all for things to get keep them out of the industry. If you don't bring your properties you run up to a certain standard, you cannot acquire another property, you can't invest in another property – and to end the Byzantine structures that hide that. So [I'm] absolutely in favor of transparency there though, of course, it will end up raising some further costs – because liability insurance that's already going up in double-digits will go up even more. But that said, we've got to have it.

But let's now talk about the 90% of investors and operators that want to have a good return but also realize that means having a good reputation and providing good care, versus that 10% that strip things to the bone, get all the dollars for the ancillary services, and don't seem to really give a damn about the quality of care. For that 90%, the issue is okay: How do we incentivize them?

Well, in the days of 3% [interest rates], HUD long term non-recourse loans. Now those days are behind us. HUD financing can still [go through], though difficult to get and long in the process.

HUD has never differentiated between the 45-year-old nursing home that's four beds to a room, and a much newer facility in with private rooms, or semi-privates. And it has never given any kinds of rewards or incentives for people to modernize technology, to go to single rooms. There are lots of ways they could do that. They could give additional loan discounts on rates – only available if you do the following things.

Or just as we do on affordable housing, they could give loans where a portion of the loan burns off over time, and does not have to be repaid if you show that you follow through on the following improvements to that home, which could include investments in technology, investments in air filtration systems, investments in moving to private rooms and having more private rooms – and also having more of a small-house or neighborhood model, where you have separate entrances, and you therefore don't have staff bringing into the entire population whatever infections they may have.

So I think one lever is HUD housing policy, and to get that in sync with CMS health care policy. It often hasn't been in sync; it's been like two silos doing their thing. I'm not knocking HUD. HUD has been a lifeline. But at the same time, that lifeline should prioritize things we want that we think contribute to quality care. Right now, I don't think it does enough of that.

Spanko

That is such a good point, because it's something that we talk about a lot at the Green House Project: How do we get HUD and CMS on the same page? Another frustration that I have when policymakers talk about "well, how do we fix this industry?" – they don't realize how much of this industry is real estate and housing policy, and how much nursing home quality is a housing quality issue for people who require additional services and supports.

I don't begrudge HUD for not really knowing what CMS is doing, because that's not HUD's job. HUD is housing; CMS is healthcare. But I don't think there's a better example of an industry that's probably 50-50 housing and health care the way specifically long-term nursing home care is.

I would question how many lawmakers out there really know the role that HUD and the 232 program play in maintaining the status quo for nursing homes or maintaining the market for nursing homes? And the Yeah, and the bandwidth? A few, a few tweaks the way you said – you know, we're not talking about a huge overhaul of the program, but just a few incentives. That could serve a dual purpose; the organizations that aren't willing to do that, the ones that really are just looking to strip them for parts, then they won't get that loan, and maybe they won't be able to continue in the sector.

Kramer

Yeah, and the cost of debt for everyone is going up, and the uncertainty about: Are we headed into a recession? The cost of food, obviously the cost of staffing. But yes, I think what I'm saying is, rather than seeking just to punish the bad guys – which hasn't worked so well, and secondly, which punishes everyone by seeking to punish the bad guys – let's create incentives for the good guys that want to do the right thing. I think that means HUD [saying] okay, if we've got the

following three or five things we think contribute to quality of life for residents in a skilled nursing setting, let's incentivize that. Let's give rewards, as I said, either in terms of a lower rate or in terms of a long-term loan, but which a portion of which burns off over time. This is a common principle in affordable housing if you do certain things. For instance, you must continue to serve, in this case, the Medicaid population, and you must do the things that got you the lower rate – you've got to show evidence you followed through on those, and that you've really done them.

So to my mind, there's an enormous opportunity there, because HUD, to a great extent, has kept these older – often 40, 50-year-old nursing homes – in business. And to a certain extent, it has artificially inflated their value, because of the opportunity to have fixed rate, non-recourse, long-term financing through HUD. So let's now turn that into a way to drive some of the very changes in quality of life and quality of care that we want to see happen. That's low hanging fruit that needs to happen.

Spanko
What I would say to the folks out there who maybe do believe in that more punitive, that more punishment-based approach, the story that I always tell about this is: Right before the pandemic, if you remember, there was that story in the New York Times about the Rosewood portfolio that defaulted on HUD [loans], and it generated a lot of negative press for the operator – and also for HUD, because here the New York Times was saying, "Well, how did you let this happen?"

I will say that at that last conference, late February, early March of 2020, no one was worried about increased regulations. No one was even worried about COVID. They were worried about: Is HUD going to tighten the screws on lending?

People don't realize that if you want to know what really keeps investors up at night, and really keep some of the worst guys up at night, maybe follow the trade press and follow what they're getting the most angry about, and what they're reacting the most to. That whole conference season, there was a lot of concern about is [HUD] going to start looking at star ratings more closely when it comes to lending? Is HUD going to really start to focus in on those things and make it more difficult? And then COVID happened and that kind of went to the wayside and everyone kind of forgot about it.

But I would say for the folks who maybe are more inclined still to prefer a punitive approach: This is a way that you can weed out folks that you don't want. They were very afraid of what might happen if HUD started to look at this stuff more closely – and for some, rightfully so, and for some, maybe they were worried about getting swept up with the crowd. But it's a way that you can pull that lever that already exists and hit at the heart of what really does matter for these organizations.

Kramer
I agree. it's important to realize at the same time that HUD has an enviable record. Not that Rosewood is, but an enviable record of a lack of defaults in its skilled nursing and assisted living loans. Very low rate. But that means they're focusing just on making sure that they, and therefore the taxpayer, aren't going to end up footing the bill – as they should, but what we're talking about

now is let's build in some incentives to encourage the behavior we want to see. For instance, if the standard rate is, let's just call it now is a standard rate is 5%. Do you get a half a point, if you do the following things, or as I said, do you get perhaps a portion of the loan burning off over time, as long as you show that you follow through on the following changes that you're going to do? So we need to create these incentives.

The 10% I just put in the bucket of basically bad investors that we need to get out of the industry – I'd love to see the industry be more proactive in identifying and getting [them] out. But outside of that, any operator would love to have a facility with all private rooms, because they know that both their private pay and their short stay market is going to go up because they're going to be more attractive to the customer. We know the customer wants that.

I think the Green House numbers have shown, Alex, as you know, well, it's not a matter of the operating model. It's not a matter of the operation cost. It's the cost to either do the renovation or to build new, and that's the issue that hangs up so many folks: How can you really scale this as a national model? Yes, maybe there are some states where Medicaid rates are favorable enough, and where you're in areas where it's a low cost of land. But the big challenge is alright, let's do this at scale in big cities, where you can't spread out, where the land is incredibly expensive.

You know how in those situations, and now with construction costs, let's face it – building new or substantial real renovation has gone up. … Within that situation, we're really going to have to create some incentives. And I think since we're talking financing, let's talk about better financing rates if you do the following things, and we only reserve our best rates for people that are doing things we think are most in the interest of the residents that are going to live in those buildings. That's what we need to be doing.

Spanko
We talk about incentives mattering all the time. I think a lot of times people forget that the industry, especially on the government-reimbursed nursing home side, they are simply responding to the incentives that are laid out to them. The example I always give is: Look at the way therapy rates, the usage of therapy has changed over the years. It's always just been in direct response to government incentives.

The old RUG system that got a lot of operators in hot water for providing unnecessary or worthless therapy minutes – well, that's because volume drove reimbursements, and so volume led to more dollars. So of course operators were going to play fast and loose, the ones who don't care about following the rules are going to try that.

And then when they switched to the new PDPM system, where it's more of a cost center and less of a revenue driver, then they substantially reduced therapy minutes in a lot of cases. So there's a whole new set of controversies about: Are they withholding therapy minutes, because it doesn't make them money anymore? It's a long way of saying that this is the way this industry is set up; they're always going to be responding to those incentives that are given to them.

To your point about the 45, 50-year-old buildings: If no one is incentivizing you to change, and you can still make money off those, why would you change? But the government at the same time is saying, “Hey, we fund you, and we want change.” So why not use these incentives?

The other one that I wanted to talk to you about – because we've seen it work for one of our partner operators in Arkansas – is targeted Medicaid rate increases, pay-for-performance Medicaid rate increases. I'm curious to get your take and where you think that plays into it. Is it a more powerful weapon than financing? Is it less powerful? Is it part of a quiver of different arrows that we should be using, and they're all kind of equal?

We've seen pay-for-performance in a variety of states. I did an interview with Lacy Cornelison, who has done the Kansas PEAK program, and she has some fascinating insights into how they're trying to diversify the metrics. But one thing that they never really do is physical design. On the federal Medicare level, it is various outcome metrics – rehospitalizations is the big one. What do you think about using Medicaid and having pay-for-conversion or pay-for-physical-improvement in addition to others to other metrics?

Kramer
Well, let me answer theoretically and then practically, because there's a difference. Theoretically, I think as one more arrow in the quiver, absolutely. For states that know how to do it, and know how to do it well, I think that can be a real plus. Again, it creates an incentive. That said, even compared to 90 days ago, with what's happened interest rates with the uncertainty about heading into a recession, I want to be practical now for the moment.

I think practically speaking, what's happened in the last 90 days in the broader finance world, internationally and in the U.S., is going to make it much tougher to get financing to do conversions or new builds that within the government reimbursement model. And why do I say that? Well, wages – depending upon what state you're in – have gone up by double digits across the board. That's including the cost of overtime, and the cost of agency health. And then on top of that, you have food costs that have been going up roughly 8%, 9%, 10%. If you have any gas fuel charges, particularly heating, expected to be through the roof and increases this winter.

Remember, unlike private pay senior living, you don't just pass those costs through to the customer – not that private pay senior living is going to be able to pass all those costs through. But in skilled nursing, you don't have that option. In other words, you whatever your costs are, your reimbursement rates are fixed, and that's all you're going to get. Between home health care and assisted living, you don't have many private-pay residents in your building, very few.

So you are totally dependent upon what that reimbursement rate is – the Medicare rate, the Medicare Advantage rate, which is about 20%, lower than the Medicare daily rate. So one’s $550, the other’s more like $440. And then, as you said, the Medicaid rate, which on average is going to be in the low $200s.

Knowing that, when prices are rising fast, you just put a huge risk factor in there for a skilled nursing investor. And now we've got construction costs, with natural disasters [that] just are going to drive up those costs even more, and the cost of labor. So I just want to be realistic. I

mean, conceptually, I completely agree with you, Alex. Practically, I think it's harder now that it's been a long time.

[In] private pay senior living, you can pass through an 8% [increase], and most are – for profit, not-for-profit, they're passing through. Many of them are doing now two rate increases a year, with the total often being a 10% to 12% rate increase. Now, in one sense, I'm really concerned about that, because all those rate increases just means the size of that forgotten middle is getting bigger, because more people won't be able to afford that.

Philosophically, theoretically, I just totally agree. Practically, we're in a very tough environment right now. So I think as we fight for changes, and we fight for incentives, we've got to be realistic about the situation and just understand that the operator and the owner-investor doesn't have a lot of levers available to them in government-reimbursed, long-term care, and government-reimbursed post-acute care, because they're at the mercy of the state legislature and CMS and Congress.

I just think that's an important context that we need, that there's flexibility in the senior living space that doesn't exist in the nursing care space. And that makes it, without question, tougher. We've got to be more creative with our incentives. People want private rooms, operators want them, consumers want them, family members want them. But the key thing is the capital costs and how you're going to finance those capital costs.

Spanko
That's a good point to bring up. The startup capital, again, is really where the cost comes in. Running a private-room nursing campus, the economics work out for a variety of reasons. On the Green House model side, there's a lot of cost shifting that occurs where there's less overhead, and there's more money [elsewhere]. Maybe you're spending the same amount on staffing, typically, but that money is going more toward the caregiver, and the direct care, versus overhead because it's more of a decentralized model.

But you're correct there that organizations, especially the non-profits that we generally work with, they're not sitting on a war chest of $50 million to redevelop their entire campus, especially if they're in a high-cost area.

One of the other areas where we've seen proposals, which we appreciate, is startup capital funds. There have been two bills on the federal level that have proposed structures like that. One of the reasons I'm a little concerned about that strategy is because asking Congress to set aside $30 billion for anything, especially infrastructure, really is a tough sell – especially as we go back to ageism. I think there is definitely a feeling that: “Well, you know, why are we investing this much money in the infrastructure?” We saw during COVID: “Oh, they're just old. That's why they die. That's why they get sick.”

Kramer
Yeah, let me put an exclamation on that. I've recently written about this. You have a very prominent biomedical ethicist, Zeke Emanuel, in 2014 wrote an article: “Why I Hope to Die at 75.” It was a catchy title … and he started quite a debate in the Atlantic, where he published it.

And you know, he was 57 at the time. Well, he now just turned 65. Many people wonder if his new 75 will be 85. But the point is, when you have a prominent article like that, that's ageism coming home to roost. What he's saying is: I will have no positive utility to society or myself after 75, so I hope I die. And then you look at the flus that sweep nursing homes that we've accepted for years, and you look at COVID.

Now COVID we got outraged about, but will we put our money where our mouth is if we devalue the very lives of the people that are there on two counts – one their age, and two in terms of health equity, often their race, their ethnicity, or their education level? That's a real issue, and if we don't acknowledge that issue and start explicitly addressing it, we're never ultimately going to get the changes you and I, the Green House model, want to see happen.

Spanko
There is that underlying ageism, and I think also our general bias against the poor in this country. I think in a perfect world, the Medicaid rates are enough to have a perfectly clean, perfectly nice two-bed nursing home room. I think if you got some transparency, and you got some of the older [buildings], some of the worst operators out of the system, and you really focused on making sure those Medicare and Medicaid dollars were spent correctly, I still think the best you could hope for is a very clean, very well-run two-bed nursing home ward.

And I think that really shows our ageism, and our bias against the poor, that that's all they deserve, right? You deserve to live in a clean medical facility. You don't deserve to have a full life where you have opportunities for enrichment and connections with the community, and the ability to determine when you wake up and what you want to eat, and how you want to define your own life.

I think that's a big barrier when we talk about financing, because there is a race to the bottom with Medicaid in terms of: What's the least we could get away with? And when you're talking about older folks, especially lower income older folks, why don't they deserve to have the same kind of enriching lives that people who live in private-pay nursing communities or elder care communities get to live in? I think that's a factor.

Kramer
There's another group that we have to recognize … and that's the people who are the caregivers in those settings. Whether it's home care or home health care, or skilled nursing, we've tolerated paying them less than a subsistence wage for years. Now, again, could homes be better run in some instances? I'm sure you're correct.

But when you just look right now at the realities, everyone's been had to pay a lot more for staff and they still can't get enough staff. You know, there's front page articles in the Washington Post and different major newspapers and online sources where hospitals are screaming because they can't get elderly patients out of the hospital. They can't get people who will take them. And as a result, it's the hospital's worst nightmare. They have an elderly patient who isn't scheduled for surgery. They can't do any more tests, they're just they're holding a bed. For a hospital, some people who are only paying room and board – it's a money-loser.

So they want them out of the hospital, but they can't find placements – both the home health care agencies, the home care agencies (private duty), and the nursing homes. But why are they when nursing home occupancy is as low as it is? Why, when there's so much on the home health care side, are they not able to discharge those folks? Why? Because they can't find staff.

Whether it's $25 an hour by ’25, or the drive to get to $20 an hour, something's got to give here. There's a lot to commend [about] the idea of having staffing minimums, but staffing minimums implemented now will mean, even more nursing home beds will sit empty. It's just going to be a reality. It'll exacerbate the present situation. I'm saying we've got to have a labor discussion here, too, because it factors into the very future of nursing homes and the cost of labor.

And on the one hand, yes, I definitely think those frontline staff and other hourly staff deserve to be paid more. But we don't value them because we don't value the work they do. For all the outcry after COVID, all the dollars that, for instance, were in the original Build Back Better and so forth for homecare – most all of it disappeared. We have a health care worker crisis; it's even worse in long-term care, and as a result, costs are exploding for labor. Until we address this issue, ultimately – you and I are talking about better quality experiences in nursing home settings, or in home settings, [but] we're not going to achieve that. So this is again, an area where I think ageism are willing to accept both their old and their poor. That's their problem, and ain't my problem.

Spanko
Yep. The workforce is considered to be “undereducated,” and frankly, they're mostly women, they're women of color, they're immigrants. So many groups that society, and our society in particular, devalues represented in one cohort of people.

I think sometimes the call comes from the inside of the house. How many times have you been at an industry conference where you heard somebody say, “Well, who would want to wipe butts when you can get paid $15 to work at Amazon?” And that's not what eldercare is. Sure, that's part of it, helping with activities of daily living, and that might include bathroom assistance. But you know, the people that I've encountered working at The Green House Project – they are passionate, they are intelligent, they have some of the best crisis management, some of the best time management [skills].

If you're looking for someone who could do the most with the least, I don't think you could find a better candidate than someone who has worked on the front lines in a nursing home or long-term care. We devalue this work so much, even sometimes from within the industry, putting it down [by] saying it's about wiping butts and changing diapers when it's not that at all. And then again, I think it just shows our internalized ageism whenever we frame it that way.

Kramer
I think you're onto something there, Alex, and I would agree. I come back our culture. As a culture, we have worshipped youth for years, and we've devalued age. Another thing as a culture, we for the most part have devalued people that serve in the sense of “wait on,” and meet the needs of other people. That's why so many immigrants make incredible long-term care workers, because they have two things which are key. One, they come from societies where there's a much

higher view of elders and their role. Two, they come from cultures where service and serving other people is seen as an enormous positive you can be proud of, rather than: Poor you, you haven't made enough money, you're still just serving other people. That pride in serving people, combined with that high view of an elder are two things.

When you have those two things, you have a great long-term care worker. Then it's a matter of: is the setting one that really sets them up, empowers them to do a great job and recognizes their value? I think one of the silver linings to the tragedy of COVID is that it's made senior care, both nursing home, private-pay senior living, and home care and home health care all realize that for the most part, our employees were only of concern to us from the time they clocked in on a shift to the time they clocked out. That view is a losing proposition to have a loyal workforce in the future.

You've got to show that you're aware, you have real empathy – and not that you're going to solve, but you're coming alongside to help your employees address the issues that they go through in their daily life prior to coming to work, or when they leave work. We became aware of that because of an infection risk. But it's much broader than that. The communities that are having far less staffing challenges are communities that have shown that sort of awareness, empathy, and engagement with the lives of their staff outside of their shifts.

I've written about many examples of that, where these communities, they've got people who want to work for them because the word gets out quickly: Wow, they do a lot of neat things for their employees. Before, we just always thought it was a matter of, you know, are the windows in the break room? Or is it buried in the basement? And how much do you pay? Yes, paying a fair and living wage is important. But it's about more than that.

And oftentimes today, as I've written about, the manager doesn't have a clue as to the world their hourly employee is dealing with, and what they return home to. As a result, even their efforts to come alongside that worker only reinforced the gap between the two of them in terms of the worlds they live in. So I just think these are big-picture issues. Yes. But COVID has forced us to [acknowledge] the workforce issue. Our workforce is key. They're the people that make the difference in what we do every day.

Look at the very phrase “essential worker.” You didn't hear that much before COVID. But essential workers, basically means hourly, people who are frontline in making us be able to live our daily lives. In our industry, frontline in terms of caregiving, and in particular, to see them get more of a spotlight as essential. And if they're essential, do we treat them as essential? And all too often in the past, the answer's no, we don't.

Spanko

That that gulf between what workers really need, or just their world, management is one thing that I appreciate you drilling down on. You see all these well-meaning attempts at self-care and things like that. [Management] comes from a world where people have a lot more time for meditation and yoga and things like that, because they come from more of a leisure class, versus

someone who's maybe working two, three jobs, someone who's sharing an apartment with another family. You're talking about a completely different world.

One of the things that I always say is: How did I get through the pandemic pretty intact and having healthy relationships and caring for myself? Part of it was I had time off. I had downtime, I had health benefits. I knew that the world wasn't going to end for me personally, and that went a long way for my mental health. I think sometimes we forget that we take that stuff for granted as people who have jobs where we don't have to worry about money as much. We don't have to worry about housing, and we don't have to worry where our next meal comes from. That's not always true – that's way, way too often true for a lot of the people who are working the majority of our direct care aides, our CNAs, our nurse aides and so forth.

Kramer
They're holding down multiple jobs, but they're either officially in poverty, or they're working as hard as they can to stay out of poverty. It's tough, and it's day-to-day, often, survival. Employers … can't solve all those issues. But whether the issue is daycare; an issue that that I've seen is really prevalent is domestic abuse for many of the majority women that are frontline caregivers. That doesn't mean necessarily that that's a new function of your HR, but it may mean: Do you have a relationship with a local domestic support center or domestic abuse center, where, with no information flowing back to the employer, people can go and get access to services and counsel on attorneys and so forth?

Or, as I've also written about, many times we have immigrants working in our direct care workforce, and they'd love to become citizens. How are we helping them both with the $10,000 costs to be able to afford the citizenship process, and with the studying for the exams that most most American citizens today couldn't pass? So it's exciting to see the examples that places like Goodwin Living in the greater D.C. area, and Ingleside, where the residents raise the money and the residents teach the classes so that the staff who are immigrants can get citizenship.

When that becomes a front-page story, as it did in the Washington Post, suddenly the word travels fast: This is a great place to work. Not just the management but the residents have your back. Well, those are people you'll take risks for, during a pandemic or a natural disaster, to be there because they're family, they treat me as family. So by golly, I'm committed to them as family.

There are wonderful stories like that out there. We don't hear very much about them. We've got to address how we view the staff, particularly the hourly staff, not just how we view the residents.

Spanko
Now, Bob, you and I can probably talk about this stuff for hours, but we've reached the end of our time. So I'd like to thank you again for participating in this, and I think that's a great place to end: It's the people who matter most. That's what this sector is. That's what the government is paying the sector to do, is to take care of people. And that's always important to remember. So again, thanks so much, Bob, and we'll talk to you soon.

Kramer
Alex, I enjoyed it. Thanks for having me on.