Assisted Living for Changing Needs

Strategies and Working Examples Clarify Challenges In Mission-Driven Senior Housing

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"Assisted living," meaning special residential facilities by that name, for the elderly began to develop in the United States in the 1980s as a reaction against premature institutionalization. Too many seniors who needed just a little help were reluctantly going to nursing homes because there were few alternatives, especially for the poor and middle classes. "Nursing homes," by then called "skilled or intermediate care *facilities*" were said to be too medical, too regulated, too stifling to the human spirit of those who worked and lived in them.

Assisted living today, whether it is a special residential facility or a service provided by Catholic and other organizations to those living in low-income housing, is addressing the need for alternatives. It is instructive to understand how we got where we are today.

A Brief History of Long-Term Care

As a young researcher working in the early 1970s on a national study of "homes for the aged," I interviewed staff and the people living there, carefully recording observations in notebooks that I still have.

Many of the places I visited in Virginia were comfortable, converted boarding houses, but many of the people looked unkempt, although they were dressed in street clothes. Most appeared to have nothing to do. We researchers joked that "room and board" really meant "room and *bored*." Some places, which looked like hospitals, had nurses in uniforms, and the people who lived there were in their pajamas in the middle of the day.

Massachusetts was more advanced. The state even had an Office of Aging. It had the issues about levels of care all worked out officially, with rules for staffing and the types of places that could admit people with various service needs.

One of the best homes I visited then has subsequently evolved into a highly regarded not-for-profit research and care organization in Boston. Administrators explained new concepts—the need for "a continuum of care," the benefits of "multi-level facilities," and the relationship between what things are called and "reimbursement." I asked, "Why is the room where the ladies are talking and sewing called the 'Occupational Therapy Room'?" The administrator replied, "No one pays for 'sewing,' but a good son will always pay for Mama's 'therapy.' Maybe the state will too."

The years from 1970 to 1980 revealed serious quality problems. The comfy old wooden houses were fire traps; nursing staffs were inadequate in many places; there were scandals about public monies. New legislation tightened standards, especially where public money was involved, but new standards brought new problems.

In 1980 the Task Force on Long-term Care, convened by the secretary of the U.S. Department of Health and Human Services (HHS) concluded:

> The Congress, government officials at all levels, consumers, and providers generally agree that the present [long-term care] programs often fail to promote desired objectives:
>
> • the maximum feasible independence of the individual in making decisions and in performing everyday activities;
>
> • the provision of services in the least restrictive environment, preferably at home or in other community settings;
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> • the provision of appropriate, cost-effective, accessible, and humane care to all individuals who need it; and

• the encouragement and support of the care provided by family and friends.

The Challenge Today

To create a long-term care system that supports these objectives requires new approaches. Last year, Catholic Charities USA and the Catholic Health Association joined in an effort to promote mission-driven assisted living: a concept that blurs the boundaries between housing and healthcare. The two organizations published *Ministry Partners in Senior Housing* (see p. 28). This publication's "Shared Vision for Service" and "Principles for Catholic-Sponsored Assisted Living and Senior Housing" embody many of the same goals—and use many of the same words to describe long-term care problems—that the nation (according to the HHS report) agreed on nearly two decades ago.

Today's assisted living reaches back to the past for the comfort of the old boarding houses. We want to avoid past mistakes of creating overmedicalized facilities, even as assisted living residences care for sicker and older people.

Today's new models of assisted living are being built in the midst of a dramatic restructuring of health and long-term care systems. There is a new emphasis on harnessing market forces to promote efficiencies and high quality of care. Serving the poor today, as in the past, often means reaching out for public funds. Our public healthcare financing programs are in transition—moving,

SOME ONGOING HOUSING PROGRAMS

Covenant Health Systems, Lexington, MA

Covenant manages congregate services for the Grey Nuns at Youville Place and an array of programs, including the Assisted Living Program of Mary Immaculate Residential Communities (a multilevel campus).

Contact: Susan McDonough, vice president, Elder Services, 781-862-1634

Sisters of Providence Health System, Seattle

The system sponsors assisted living programs and residences in multiple settings, including nine HUD projects and three licensed "board and care" facilities. It also participates in two joint ventures with other organizations.

Contact: Charles Hawley, vice president, continuum development and long-term care, 206-464-4237

In the Portland area, the system manages the care at Providence House, a special HUD program; sponsors Emilie House, HUD-sponsored independent housing for low-income seniors; and sponsors Elder Place, an apartment building with 42 residential units and a day health center serving seniors in the PACE (Program of All-Inclusive Care for the Elderly) program.

Contact: Nancy Erckenbrack, director of long-term care operations and housing for the Portland area, 503-215-2650

Catholic Charities Housing Services, Baltimore

The agency owns and operates nine rent-assisted senior housing facilities in the Baltimore area.

Contact: Carolyn Peoples, director of quality assurance and community relations, 410-547-5508

Christopher Homes, Inc., New Orleans

About 6,000 elderly people are served in 30 HUD-subsidized locations owned by the Archdiocese of New Orleans and managed by Christopher Homes, Inc.

Contact: Thomas Perkins, executive director, 504-596-3460

Cardinal Ritter Institute, St. Louis

The institute sponsors adult day care services, homemaker services in low-income housing, three assisted living residences, and other programs for seniors.

Contact: Carole DiSanza, director of residential care facilities, 314-652-2662

Loretto, Syracuse, NY

Loretto offers a full continuum of integrated care, including assisted living facilities for a range of income levels and assisted living services in HUD housing.

Contact: Kathryn Ruscitto, senior vice president, 315-469-5274

St. Anthony Village, Portland, OR

This housing project consists of 17 independent living apartments, 24 Alzheimer's units, and 86 assisted living units in five levels of frailty. Eighty percent of the units are reserved for seniors with fixed, low incomes. The housing units are part of an integrated complex that includes a church, a parish center, a child development and day care center (aimed at low-income and/or single-parent families), and a community park. St. Anthony Village recently won a silver medal for its design from the National Council on Senior Housing.

Contact: Rev. Michael Maslowsky, director of pastoral services, Archdiocese of Portland, and chairman of St. Anthony Village board, 503-233-8385

Catholic Charities, Baltimore

Catholic Charities sponsors a hotline to help seniors find suitable services and a continuum of care from services in two small converted convents to the Jenkins Community—a campus that includes two HUD-assisted residences with congregate services.

Contact: Answers for the Aging, 410-646-0100

some lament, farther away from a national social insurance model.

Creating Mission-Driven Assisted Living

For this article, I interviewed a small set of innovative people who are developing Catholic-sponsored assisted living. They included system leaders and program managers struggling to make practical decisions for the 21st century. They describe the creative ways in which their organizations are doing what many others—large, publicly traded corporations and small nonprofit groups—are doing. I also heard something different—some difference that the Catholic mission makes. The people I interviewed agreed on several concepts.

Assisted Living Is Not a "Nursing Facility" There is some debate about whether assisted living is a place (a special residence), a service, any combination of housing and services for elderly people who need help, or only certain combinations of housing and services for people with specific types of need. But nearly everyone agrees that assisted living is not a *nursing facility*, as defined and (many say) overregulated by federal and state laws.

Special Philosophy There is widespread agreement on the following fundamental equation: *Assisted Living = Housing + Services + A Special Philosophy of Care.* The Assisted Living Federation of America (ALFA) has itemized a 10-point philosophy of care to which members subscribe (see **Box**, p. 32, for ALFA's website). The list addresses many of the problems I observed as I toured facilities in the 1970s. ALFA members (including a number of Catholic-sponsored organizations and assisted living residences) agree that assisted living is about fostering residents' independence, promoting their individuality, and protecting their right to privacy. Many items on ALFA's list are nearly identical to those in *Ministry Partners in Senior Housing.*

Overregulation Must Be Avoided "If it is sufficient to have just Ten Commandments, we surely don't need 10,000 pages of regulations for assisted living," I was recently told. The American Association of Homes and Services for the Aging, the American Association of Retired Persons, the American Health Care Association, the American Senior Housing Association, and ALFA have joined forces as the Assisted Living Quality Coalition in an effort to find new ways to preserve flexibility for assisted living, while promoting continuous quality improvement throughout the industry.

The People Are Not "Patients" Nearly everyone also agrees that people in assisted living are not to be called "patients." But are they "residents," "customers," "clients," "consumers," or "tenants"? Discussions about terminology appear trivial, but names are important.

In the 1980s, we learned to use the term "residents" rather than "patients" for people living in places licensed as "nursing facilities" in order to emphasize that such places were actually home. That transition reflected efforts to provide a social model, not a medical model, of care.

The latest term ("tenant") for those living in the latest model of care ("assisted living") is strongly advocated by Keren Brown-Wilson. She is widely respected as a pioneer and innovator, continuing to focus on *affordable* assisted living and refining a model she built from scratch in Oregon as a university professor and daughter dissatisfied with her mother's care in a nursing home. She built a home and then a company, took that company public, and became part of an even larger corporation in a recent move that was hot news on Wall Street. Brown-Wilson's assisted living residences served the poor at a time when private enterprise focused primarily on the high-end market. Thus, mission-driven and not-for-profit-organizations look to her for inspiration and practical ideas.

How Mission-Driven Assisted Living "Works"

Charles Hawley, vice president, continuum development and long-term care, calls the people served by the Sisters of Providence Heath System, Seattle, "customers," reflecting the new emphasis on serving people in a way that treats them with consideration and responds to their needs. When I asked him for details regarding how they really made things work, he said: "The primary focus at every step of the process—from the partners you choose for the initial development to cleaning the bathrooms later—must be on the values that underlie the management and delivery of services. The values and mission are both the 'why' and 'how' we do things. Everything else is 'what we do.'"

Well, I thought, how does that work? Below I consider some complex issues, setting them out as three questions each posed as a dichotomy. The difference that mission makes is in how you strike the balance.

Am I My Brother's Keeper or Is He My Tenant? In civil parlance, to be someone's "keeper" can mean to be one's "jailer." Brown-Wilson's term "tenant" is used to distance the concept of assisted living from institutional nursing facilities, emphasizing that those who live in assisted living are autonomous adults, not inmates in a jail.

"Tenant" also implies a civil, legal relationship between the people who own and run an establishment and those who work or live in it. Terms

of agreement are specified in contracts, enforceable in public courts. A tenant who fails to pay rent is evicted according to civil law and regulations.

Mission-driven assisted living residences do have written contracts and sometimes do evict residents who fail to live up to their end of the bargain—including failing to pay the rent.

But a commitment that begins with an underlying belief that "I am my brother's keeper" is a contract of a different sort—one that many struggle to fulfill in daily life and business dealings. Such a commitment makes decisions more difficult. If the higher commitments are not fulfilled, however, some see the mission as failed.

This tension was exemplified in my interview with Susan McDonough, vice president, elder services, Covenant Health Systems, Lexington, MA. She calls the people "tenants." When I asked her why, she explained that her system is trying to keep people out of nursing homes. Later in the interview I asked, "What do you do if a person runs out of money? What if everyone projected that Mrs. Jones would live for two more years...." McDonough interrupted me, "And then she lived for four and ran out of money? It happens. But, look, we are a Catholic organization; we are not going to put anyone on the street. We will find a way." But she hastened to add, "We can't take everyone; we have to run like a business; we don't just give stuff away."

What does this tension mean to not-for-profit, mission-driven organizations, such as CHA and its members and Catholic Charities, in national debates about financing and quality assurance in assisted living? Seeking new ways to promote high quality by harnessing market forces, many have joined the Assisted Living Quality Coalition. And the vision and principles for senior housing jointly prepared by CHA and Catholic Charities specify a need for "efficiency" and "cost-effectiveness," but those concepts are under the heading "stewardship," not "markets." I searched the vision and principles and found much about independence, but nothing about promoting competition. Instead, I saw statements, echoed by those I interviewed, about "the common good" and "justice."

Is It about Independence or Interdependence? Everyone's notion of assisted living includes an emphasis on independence. Brochures prepared by Catholic Charities from Baltimore to Portland all say that their assisted living programs help seniors "maintain independence." Three of the 10 ALFA philosophy points speak directly about independence. Independence is an American value.

> Everyone's notion of assisted living includes an emphasis on independence.

In truth, of course, no one is really independent. At any age, we all need help from other people to negotiate everyday tasks and manage our lives—plumbers, electricians, hired staff, and family and friends. Assisted living promises similar help.

I asked program directors for details about the services they did and did not offer, pressing for *information about how things really worked.* What if people sign up for one thing, but then don't want it, or they want it but don't really need it? In response, I heard little about contracts; I most frequently heard, "We are a family."

The central idea of family is *interdependence.* In families, decisions about who does what, where, to whom, for whom are often contentious. Frequently, families have rules specifying who takes out the trash, who cooks dinner. But exceptions are accommodated, trade-offs occur, negotiations are fluid.

In families, something is given to and something is expected of everyone, regardless of age. This familial reciprocity is lived out, for example, when some roles of children and aging parents are reversed, but the elders continue to lead by setting the tone. My family, like most, has many stories about reciprocity.

In 1929, my grandmother, Puffy, her husband, and their four active kids were living with my great-grandparents, Gom and Biz, in New Roads, LA. Biz supervised the family garden; Gom was the beloved head of household affairs. As Puffy managed her roles as both mother and daughter, her responsibilities included helping her mother with her bath. "What about the issue of 'role reversal' and personal services?" I recently asked my mother, a researcher and archivist whom I frequently consult. She explained that "Gom wore her batiste nightgown in the bathtub; all of the ladies, I think, did that at the time."

Puffy's niece, Boots, was a teenager being

schooled during the week in a nearby convent. My mother (then one of the younger kids) remembers walking into town to pick up some extra household supplies when Boots brought a friend to spend the weekend.

Seventy years after later, I was sick at home in Chevy Chase, MD. My cousin—daughter of the 1929 teenager—called from her cell phone. "Hi, I'm heading back from work. Can I pick up some groceries for you?" Families work like that.

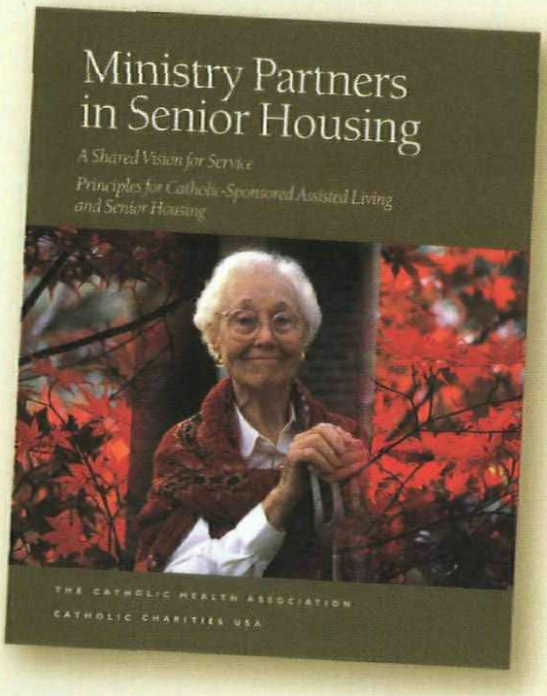
As my stories show, in families reciprocal obligations are balanced over generations. Mission-

MINISTRY PARTNERS IN SENIOR HOUSING

As the number of aging persons, many of whom are frail and vulnerable, increases, the need for affordable assisted living and senior housing services is growing. The Catholic Health Association and Catholic Charities USA are working together to respond to this need, combining their strengths to promote quality, access, and affordability in housing for older persons.

As part of their efforts, the two organizations have developed a booklet, *Ministry Partners in Senior Housing*. The first part of the document, "A Shared Vision for Service," describes how Catholic healthcare providers and Catholic Charities agencies can together carry out an effective housing ministry. Reflecting this vision, the second part of the booklet provides principles for Catholic-sponsored assisted living and senior housing. The principles will be useful to organizations embarking on senior housing programs, as well as to the general public and benefactors who want to know what values distinguish Catholic-sponsored housing.

Following is an excerpt from "A Shared Vision for Service."



The focus of Catholic healthcare is changing because of a combination of factors, including the aging of the population, an increase in the incidence of chronic illness, and the growth of managed care. The Catholic health ministry is moving beyond acute care into the full continuum of care, serving persons throughout their lives and illnesses.

Similarly, the focus of Catholic Charities agencies' work is evolving. In addition to their work with families and children, many Catholic Charities agencies are responding to the needs of the aging population and pressures from managed care organizations by forming partnerships with private and public organizations to better serve individuals through a continuum of care.

[The] forces impacting health, social, and housing services for aging persons encourage a renewed expression of this shared ministry of Jesus. Through housing services, Catholic health and charities organizations and other church providers can respond to emerging community needs, contributing to the development of comprehensive, integrated continuum of care.

Some housing initiatives Catholic Charities and Catholic health organizations may be involved in include:

Creating affordable housing services for low- and moderate-income aging persons with integrated health and social services to promote health, autonomy, and well-being of residents

Developing innovative social and health services in housing programs, such as the Program of All-Inclusive Care for the Elderly, adult day care, mental health services, and nutrition programs

Leveraging fiscal and human resources from within their own and other Church ministries to bring new capital and other assets to senior housing programs

Building on the strengths of the broader Church to help frail and chronically ill aging persons

To order copies of Ministry Partners in Senior Housing, *contact the Catholic Health Association at 314-253-3458.* Ministry Partners in Senior Housing *is also available on CHA's website: www.chausa.org.*

driven organizations should strive for the same long-term balance, expecting more than payment from residents and more than task completion from staff. People who live or work in assisted living should understand that unless everyone contributes and reciprocates, the collective enterprise suffers.

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Striking the right balance between independence and interdependence in assisted living for mission-driven organizations means solving the tensions inherent in the Pledge of Allegiance: "One nation, under God, indivisible, with liberty and justice for all."

Does "Least Restrictive Setting" Refer to Licensure Status or the Human Spirit? The CHA–Catholic Charities vision includes supporting services for "aging persons living in the least restrictive setting practical in light of their changing needs and wishes." In 1980, HHS reported that the nation's long-term care programs failed to promote "services in the least restrictive environment." Those of us drafting the report meant that Grandmother should be helped to stay in her own house, or possibly in a friendly boarding house; she should not have to go to a nursing facility. We borrowed the term "least restrictive environment" from earlier reformers, who had been closing down other institutions (mental hospitals and state institutions for "the mentally retarded," as they were called) which restricted choices.

Restricted choices, however, can mean freedom. Mental hospitals built as part of 19th century reforms were conceived as asylums, where simplified routines would help residents. Just recently, specialists in Alzheimer's disease at the Mayo Clinic reported in their on-line newsletter "Health Oasis" that "wandering [may be precipitated] when there's too much stimulation, such as multiple conversations in the background or even the noise of pots and pans in the kitchen....By reducing the number of stimuli, [caregivers] can help reduce the likelihood of wandering."

Mission-driven organizations have opportunities to signify their mission in how they help people adjust to more simplified surroundings—how they build, manage, and orient people to different "levels of care."

Visitors to multilevel residences and campuses see generously appointed independent living quarters, filled with personal possessions. The assisted living area has smaller spaces and fewer personal things. The healthcare center, generally a nursing facility to licensing agencies, has two beds in each hospital-like room and nothing more than a bedside table for personal mementos.

Those in the independent living units rarely visit the assisted living area, avoiding the thought of "stepping down" themselves, averting their eyes from those with fewer choices, fewer things, fewer physical faculties. Staff and residents alike, however well intentioned, often emphasize differences between those in independent living and the "poor dears" in assisted living. A mission-driven organization can and should change that attitude, teaching a consistent, different lesson about what things, and the lack of things, signify.

Some Practical Approaches to Program Issues

I personally hope to die like my Grandmother Puffy did—in some place that I call "home." I expect to move from the place where I live now. The places and programs available to me then will be descendants of those being built today. These innovative, experimental programs provide help for people who fought in two world wars and lived through the Great Depression, and the strategies developed today may provide responses to the national challenge posed by the far larger, more demanding generation of Baby Boomers.

Cost-Effective, Personalized Services Meeting the challenge to develop "cost-effective and efficient services that meet the needs of individuals" (see *Ministry Partners in Senior Housing*) is a serious challenge when the needs of each individual change with age and personal circumstances and internal program operations are constrained by external forces. Some services are especially problematic. Following are examples of approaches to these issues.

- *Health promotion.* Carolyn Peoples is director of quality assurance and community relations, Catholic Charities Housing Services, Baltimore, which owns and operates nine rent-assisted senior housing facilities in the Baltimore area. "Our mission is to improve the residents' quality of life," she said. Her organization is taking a proactive approach to prevent health problems, rather than

just reacting when a resident has a health crisis. One effort is an ongoing study with the University of Maryland Division of Gerontology on the link between health status and exercise. The program includes health education and a treadmill program.

Another effort addresses the mental area of wellness. HUD provided funding for computers in eight community computer centers in the housing facilities, which enhance residents' mental stimulation and memory and provide them the opportunity to contribute to their building. They will sell products they have created on the computer, such as cards and stationery, at computer fairs in each building. The proceeds will be used to support the apartments.

• *Adapting the physical environment.* Kathryn Ruscitto, senior vice president, programs and policy, Loretto, Syracuse, NY, manages congregate services "layered," as she puts it, on HUD housing and also creates assisted living for seniors living in old apartment buildings. When Loretto took on the task of serving seniors living in a 13-story building on top of a mountain, respiratory distress was a serious problem. Adding air-conditioners was a cost-effective solution.

• *Help with unscheduled needs.* To some seniors, "maintaining independence" means services brought to the house or apartment where they have always lived. That model adds substantial transportation costs where people are widely dispersed. It can work efficiently when people need a defined set of predictable services—for example, a licensed nurse to periodically check a homebound patient's course of IV antibiotics. Ruscitto and others provide more complex medical care to some people at home than do some neighborhood nursing facilities.

But caring well for seniors who need help available for unscheduled needs, can be a problem when there is no one else at home. Ruscitto says "it's not medical issues; it's confusion" that determines the need for help *available* around the clock. But actual hands-on help is generally needed only intermittently. Assisted living residences and multilevel campuses are efficient solutions, where appropriate staff are there if needed, but do not sit idle when residents do not require their services.

> There are multiple models between "everything separate" and "all-inclusive."

Ruscitto and similar managers working with low-income elders living in senior housing have created an efficient service model referred to as "the shared aide." Various programs (including Medicare and Medicaid) pay for home health aides and personal care services. An individual can qualify for a specific block of scheduled services if he or she meets conditions that vary among programs and states. For example, an individual may qualify for one hour of help, three times a week. With a sufficient volume of people in one location such as an apartment building, managers can arrange services so that the equivalent of a full-time aide is available on-site 24 hours a day.

Pricing for People with Different and Changing Needs

Packaging and pricing assisted living appropriately involves financial risk, sophisticated management, and moral choices. The two ends of the pricing spectrum are "everything separate" and "all-inclusive" prices. There are multiple models in between.

Rebecca Galloway, division director, Senior*Life* Services, Catholic Charities, Baltimore, now provides a package of services to those who choose to participate in the Congregate Care Program, but she wants to move toward an à la carte menu. "People want only what they want," she says, adding that the total package provides more services than some need and is "stigmatized" as a downward step.

Ruscitto has found that an à la carte structure "works best where we can control the admissions to a building." Menus of services are tailored to the general level of care and needs in each building.

McDonough points out that in some à la carte structures, "some providers are building facilities where the price really just covers the basics and everything else is extra." She worries about people skipping meals and skimping on needed help to save money. At Youville, MA, where Covenant Health Systems manages services for the Grey Nuns, the price is nearly "all inclusive"; a small set of services (guest meals, for example) is available at extra cost.

Covenant's newest model involves choices that are attractive but simplified. Rather than offering a full menu at lunch and dinner, the model offers a main dish and an alternative.

Sisters of Providence Health System primarily uses all-inclusive prices. The system has a sophisticated assessment team; an individually tailored service package is negotiated with residents at the outset. Families are encouraged to continue to help. But regardless of what each resident needs at the outset or later, the service price is the same for all.

Molly K. Miceli, writing in *Provider* journal (February 1999) notes that managing financial risk is a critical aspect of pricing strategies and that in an all-inclusive pricing package there is no room for "outliers," individuals who use far more services than anticipated. Even so, mission-driven organizations can use all-inclusive pricing without excluding any residents if they spread the risk among a large enough number of people. This may mean more partnering and bigger systems. Sophisticated information systems are essential.

Making Decisions about Moving Must Grandmother move from independent to assisted living? Should Grandpa go to the health center on the campus or to the hospital down the road? Decisions about moving are intimate choices, made in environments shaped by individual entrepreneurs and public laws.

Nearly two decades ago, Paul Klaassen was inspired to begin Sunrise Assisted Living, which today is part of a national chain, when he and his wife sang in local nursing homes with their church group. They were appalled by the difference between those places and the ones available to their grandparents in Scandinavia.

The Klaasens bought an old nursing facility and lived with the residents during renovations. Turning a nursing facility into their concept of assisted living meant reconfiguring the space and social relations within. The Sunrise residences they subsequently built had wide porches to sit on. The front door opened not to a uniformed receptionist behind a glass partition, but into an entry hall with a grand staircase. A Sunrise resident could be proud to invite her family to dine; she might also get exercise going up and down the stairs. She also might fall.

Klaassen speaks passionately about "the dignity of risk." Locking people up or dispensing pills at six o'clock from a cart might be safer, but most people do not want that. He supports appropriate safety standards, but urges us to "let customers choose."

But choosing the right place is difficult for seniors. The first move to a retirement setting is hard; subsequent moves are harder. When choosing is complicated by cognitive changes, which may require multiple moves among places on the same campus, decisions are especially difficult for families.

The options are governed in substantial part by public choices: how We The People strike a balance between free choice and concerns in common. Local zoning laws dictate where assisted living places may be built. Fire and construction codes—varying from place to place—specify details designed to enhance safety. State legislators grapple with complex licensure issues: Should assisted living be licensed as a separate type of place? How should it be defined? Should there be standards defining who is permitted to reside in assisted living? Should staffing patterns be prescribed?

Bob Mollica, an expert at the National Academy for State Health Policy, has studied policies regarding assisted living and how they vary among the 50 states. In 1997, he found three models:

- New Jersey specified the people whom assisted living may serve. The state included those who were bedridden more than 14 days, those who were a danger to themselves and/or others, and those with medically unstable conditions.
- Florida specified the people whom assisted living may *not* serve, *excluding* people with the conditions listed above.
- Oregon implemented less restrictive requirements than either of the other two states. In 1997, an Oregon assisted living residence could ask a client to leave if the client became an imminent danger to self or others, if a residence could not meet needs, if needed services were not available, or if the client exhibited a "pattern of noncompliance."

Mollica told me that the trend is toward state rules that allow people with greater care needs to live in assisted living. There has been overbuilding in some areas, he says, leading to occupancy problems. Some states are concerned about quality of care for those who chose assisted living, now that owners are forced to cut costs more. "The greatest need," says Mollica, "is for assisted living built from the start to be affordable."

Affordable Assisted Living

The number-one call (and 20 percent of all calls) to Catholic Charities' Senior Answer Line in Baltimore comes from people looking for affordable assisted living. In much of the country, there are many choices for people who can afford to pay $3,600 per month (the market rate in the Lexington, MA, area), but few options for those with moderate or low incomes.

"The challenge," says Charles Hawley, "is to drive down the out-of-pocket costs to the low-income customer by creatively combining a variety of financing and funding sources—philanthropy, state and federal housing subsidies,

Medicaid—whatever works."

For a project to work in bankers' terms, there must first be sufficient money ("sources of funds") to match the project development costs ("uses of funds"). In addition, a workable project operation requires sufficient revenues from rent and service payments to meet ongoing operational expenses. Keeping development costs low involves minimizing the cost of land, construction or renovation, and fees for the development team (architects, consultants, bankers). Keeping operating costs low after the project has been developed involves great care and creativity in putting together the initial financing package ("sources of funds"). Minimizing ongoing debt payments is crucial; tax-exempt bonds and other publicly sponsored low-interest loan programs are options.

Strategies for operating a project with out-of-pocket rent and service payments low enough for people with little money include (1) a so-called Robin Hood approach, in which revenues from the poor are explicitly subsidized by revenues from other residents, and (2) finding public programs that will pay at least part of rates for the poor.

The Grey Nuns use both approaches at Youville. The core approach is a Robin Hood strategy. Rates for 20 low-income units are subsidized by those for 90 other units. In 10 of the low-come units, rates are partly paid by a state program (Group Adult Foster Care). In the 10 other units, Youville charges substantially reduced rates, pegged to the same formula used by HUD for calculating low-income status in the community. The difference between the cost of operating the low-income units and the revenues received from their residents is subsidized by above-cost rates paid by residents of the other 90 units.

Medicaid Questions Should Medicaid be one of the sources of public funds paying for assisted living for the poor? Policymakers at the state and national level hotly debate this issue. Medicaid, designed as a healthcare insurance program for the poor and jointly paid by state and federal funds, is subject to federal rules, such as the general prohibition on use of Medicaid funds for housing, and state rules, such as the standards for how poor a person must be to qualify for Medicaid. States may or may not choose to cover many of the services that assisted living frequently entails, and they have different options for covering services.

One option, used by most of the states that pay for assisted living under Medicaid, requires a special "home and community services" waiver from the federal government. The waiver provides Medicaid reimbursement for an array of personal and healthcare services for people poor enough to meet Medicaid income standards and frail enough to be deemed "nursing home eligible." Conditions vary from state to state. Need varies. Those interviewed for this project have different opinions regarding Medicaid and assisted living; they reflect the national debate and

ON THE WEB

American Association of Homes and Services for the Aging

www.aahsa.org

Click on the home page search button; then type "assisted living." You will find more than 100 documents: press releases that describe current issues, updates on legislative actions, tips for consumers, and numerous useful technical assistance guides on matters from staffing to finance.

American Health Care Association

www.ahca.org

Click on the search button on the home page. On the screen that appears, indicate that you are looking for "words describing a concept." Type "Assisted Living" in the space provided. Then click on "Excite Search" for a list of articles and issue briefs. The article "Assisted Living: Meeting The Needs of A Growing Elderly Population" includes under the heading "The Assisted Living Philosophy" the eight "resident rights" advocated by ACHA's National Center for Assisted Living.

Assisted Living Federation of America

www.alfa.org

Click on any of the topics on the left side of the home page for additional information, including lists of state affiliates and how to get in touch with them. The topic "What Is Assisted Living?" leads to a brief description of the industry and the 10-point philosophy of care to which ALFA members subscribe.

Catholic Health Association

www.chausa.org

On the home page, click on the "Long-Term Care" button. On the Long-Term Care screen, click on the "Housing" button. For related resources, click on the "Search" button on the home page and type "assisted living."

U.S. Department of Health and Human Services; Office of Disability, Aging and Long-Term Care Policy

(A Division of the Office of the Assistant Secretary for Planning and Evaluation)

http://aspe.os.dhhs.gov/daltcp/home.htm

Click on the "Topic List" and select "Residential Care Settings." You will find interim reports from The National Study of Assisted Living for the Frail Elderly, a summary of assisted living regulations for every state (last updated June 1998), and reports from other federally sponsored major studies on quality of care, options for consumer-directed personal care services, and related issues. Abstracts and shorter documents can be viewed on your screen; large reports can be downloaded directly from the site.

offer some innovative ideas.

Rebecca Galloway is a strong advocate of Medicaid for assisted living, driven by her concern that "without affordable assisted living, we force the poor into nursing homes or leave them alone and unable to care for themselves." She is not gravely concerned about the regulations and paperwork that come with payments from Medicaid, noting that "We don't like the hoops, but the people need the care." As she sees it, Medicaid is the only feasible approach in Maryland because the federal government picks up nearly half the costs. The state has applied for a federal Medicaid waiver, which had not yet been approved at the time of this writing.

State officials face tough choices about Medicaid and assisted living.

One problem in Maryland, according to Galloway, is that the state restricts "nursing home eligible" status to only poor people sick enough to need a great amount of nursing and personal care. She believes that some government officials are reluctant to change the rules because they are "stymied by the fear of too many seniors rushing forward to claim services."

State officials across the nation face tough choices in debates about Medicaid and assisted living. It is not clear that diverting Medicaid recipients from nursing homes to assisted living will save money; it may cost the state more in the aggregate. Regardless of costs, state officials must also consider potentially adverse social consequences. Following are three major concerns.

• *Increased total use.* One concern, described by Galloway, is that Medicaid-eligible people who try to stay out of nursing facilities will be attracted to assisted living. In general, a single day of care in an assisted living facility costs less than a single day in a nursing facility. But the aggregate cost to Medicaid could rise if total use increases as people who would not otherwise enter a facility opt to go into assisted living if it is available. Similarly, the number of Medicaid recipients (and aggregate Medicaid spending) can increase if those with moderate incomes exhaust their resources on *costly* assisted living and then become Medicaid recipients.

• *Medicaid nursing home rates.* Second, officials worry about what will happen to Medicaid nursing home rates as poor people with the least needs ("low case mix") are diverted or transferred from nursing facilities to assisted living. More than half the states now pay nursing facilities Medicaid rates that are tied to resident acuity. In these states, as average case mix in nursing facilities increases (i.e., as residents have greater needs), Medicaid costs rise. This concern will soon affect all states. The federal government has just implemented a national payment system for Medicare skilled nursing facilities that will, among other things, drive virtually all states to pay case mix-based Medicaid rates.

Although Medicaid will pay more to nursing facilities as case mix rises, Medicaid pays less to assisted living facilities, which have lower case mixes. Assuming that the total number of care days paid for by Medicaid stays the same, total Medicaid costs could, in theory, be held constant. But Medicaid officials find it difficult (because of factors such as capital and fixed rates, and declining occupancy) to make the trade-offs work in such a way that the state can save money or just hold payments constant.

• *Adverse social consequences.* Finally, many are concerned that growth of assisted living will lead to the oldest, sickest, poorest people being concentrated in nursing facilities while younger, more affluent seniors elect assisted living. Without help from more able residents, the most vulnerable may not be able to advocate for their own quality of care.

St. Anthony Village in Portland, OR—slated for official dedication in June—has made an explicit commitment to serve both the very poor and those who are better off. "It took the creative vision of Card. Francis George (then head of the Portland archdiocese), close collaboration with a host of state and local officials, and endless hours of work by parishioners to bring the project together," according to a close observer of the process.

The project was built on the grounds of St. Anthony Catholic Church—a five-acre site. In that neighborhood, half the elderly needing assisted living are "officially poor," according to state definitions. The challenge was to serve them and others together in affordable assisted living. Creating affordable assisted living requires close attention to development costs. Constructing the

building and paying other development costs required borrowing money. Not-for-profit organizations frequently and appropriately turn to state and federal low-interest loan programs. While valuable, many of these programs come with restrictions that limit an organization's ability to serve people with the desired range of incomes in the same place. The St. Anthony Village board creatively structured the financing to keep interest costs low and to fulfill the church's commitment to keeping people of varying incomes together in a parochial setting. "Among the unique aspects of St. Anthony Village is the integration of senior housing and care into a parish setting complete with church, day care, and a neighborhood park," says Rev. Michael Maslowsky, pastor of St. Anthony Catholic Church and chairman of the St. Anthony Village board.

Oregon has been a pioneer in developing nursing home alternatives, using Medicaid and state funds to support access for the poor, and was thus willing to help St. Anthony's in a project that promises to both help the poor and keep Medicaid costs low. The state has invited research study and continues to refine its model, especially with regard to regulations, quality, and cost.

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Lessons from a Long Experience

In Louisiana, a New Orleans project, somewhat ahead of its time, has struggled with most of the issues discussed above. The experience of Christopher Homes is an instructive example for Catholic organizations confronting the varied challenges involved in providing housing for frail, poor elderly persons.

In 1966, the year that Medicaid was established nationally, Abp. Philip Hannan of the Archdiocese of New Orleans, spearheaded an effort to provide safe, decent housing to people with low and moderate incomes, including all races, creeds, and colors. Thomas Perkins, executive director, Christopher Homes, Inc., New Orleans, was charged with implementing the program, including working out agreements with HUD. Today Christopher Homes provides thousands of apartments, primarily for poor and moderate-income persons.

Providing More Services Perkins is especially concerned about the increasingly frail residents. A resident's annual income, according to Perkins, is typically $4,800-$7,200, of which one-third goes for rent alone. By the time residents are 80 to 85 years old, many have outlived family and friends, he says, estimating that at least 2,000 of the residents need assisted living services—meals, housekeeping, and help with personal care and activities of daily living.

Christopher Homes owns a space for congregate dining and a large kitchen, built in the early days. HUD legislation, passed in 1970, provided funds for dining facilities and equipment in low-rent public housing projects. But it provided no money to cover meals or other services. Over the years, Christopher Homes found it increasingly difficult to provide affordable meals from its own kitchen to residents. Inconsistent attendance eventually made the meal program financially infeasible. But now the number of people in Christopher Homes has increased, giving Perkins a new opportunity to provide meals and offer other services.

Creative Approach His new program was in the number-crunching, planning stage at the time of this writing. For low-cost meals, Perkins plans to work with a local establishment—a nursing home, hospital, or caterer—for cooking. Christopher Homes will pick up the meals or arrange for them to be delivered.

Residents' need for personal care services at low cost, will draw on the community's ample supply of caring, semiretired, persons—many with training and experience in health and social services. These Christopher Home neighbors, notes Perkins, want opportunities to serve. Some need the "probably minimum wage" jobs he will be able to provide, and they prefer part-time work.

Advice Some advocates of the poor in Louisiana strongly favor Medicaid-funded assisted living. Perkins, a fan of public investment in the poor, cautions that "Medicaid waivers can bring uncertainty." He advises, based on 30 years' experience and his bishop's original charge: "Don't take on something if you don't plan for a long-term commitment; keep a close watch from the outset on finances; be mindful that the true long-range financial feasibility of projects cannot solely depend on programs you cannot control." □