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## *An Historical Overview*



**EVOLUTION OF THE INDUSTRY  
THE CONTINUUM OF CARE  
THE SERVICE DISTINCTIONS  
OWNERSHIP AND PAYMENT**

1/3/02

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This module provides a brief history of seniors’ housing and care, including several topics that affect and will continue to affect the business:

- The early days of the industry and (by today’s standards) the less institutional, less regulated approach to supporting seniors in need.
- The dramatic influence of Medicare and Medicaid and the degree to which financing often structures product.

- The ongoing question: who determines the options—the consumer or the payer?
- Increasing options for senior care, including the changing role of funding.
- Changes in the marketplace, both customer-related and project-related.

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### NOTES:

The Johns Hopkins Bloomberg School of Public Health  
“Managing Long-Term Care Services for Aging Populations”

*In the Beginning...*



- Medicare
- Medicaid
- Their Strengths
- Their Weaknesses
- Perversion of the Continuum

1/3/02

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Passage of Medicare and Medicaid (1965) has been the most significant influence on the senior-care industry to date. In addition to providing the main source of funding for facility care, the programs influenced operations by requiring them to meet specific regulations to become certified. Regulatory compliance, therefore, has become necessary for virtually any government-funded care facility to stay in business.

### Medicare

Medicare provides acute care, so is less of a factor in supporting housing.

- Universal eligibility (all who receive social security)
- Acute care orientation that results, for the elderly, in a *perversion of the continuum*: an inverse correlation between coverage and chronicity
- Co-payment for treatment (other than in-hospital) of about 20%
- Early 80’s: Introduction of diagnostically related groups (DRGs) encouraging shorter hospital stays, less extensive services, earlier transfer to nursing facilities
- Expanded home health-care benefits in 1990’s

### Medicaid

Medicaid provides chronic care, largely in nursing homes.

- State-administered, means-tested.
- Option to provide services to “medically needy” led to Medicaid becoming primary funding mechanism for facility-based long-term care.
- Coverage and eligibility create a bias towards nursing homes and against home and community based services

## *Funding Propels Growth*

- Facilities
- Residents
- Program \$\$\$
- Tied to Demographics
- And Continued Frailty

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Before 1950, seniors who couldn't stay at home were either placed in boarding homes or in mental institutions (in fact, up to 23% of such institutions' population was comprised of these seniors.) Alternatives became available in the 1950s, when government policies encouraged the building of more nursing homes.

Both nursing homes and their population increased steadily from 1965 to 1985; they have continued to increase since then, but at a slower rate. This slow-down may have resulted from

expanded options for seniors needing housing, decreases in disability levels, and state budget constraints.

As seniors become older, they are more likely to be in a nursing home:

65 yrs old	1%
75	5%
85	20%

The level of disability among nursing home residents has increased dramatically. In 1977, 10% had 0 dependencies in activities of daily living (ADL), 40% had 5 or more. In 1995, more than 5% had 0, 60% had 5 or more.

Assisted living has grown steadily and should continue growing. According to the “NIC National Supply Estimate of Seniors Housing & Care Properties,”

“In the eight years since 1991, the number of properties providing assisted living services has increased by 49.4% and the number of beds of assisted living has increased 114.8 percent. In contrast, the number of properties offering skilled nursing services has grown by only 22.2% and the number of beds increased by only 19.4%.”

The Johns Hopkins Bloomberg School of Public Health  
“Managing Long-Term Care Services for Aging Populations”

*The Golden Rule*

- He Who Has the Gold...
- Regulation As a Function of Payment
  - Safety
  - Product Specification
- The Nature of the Product
- The Impact of Customer Choice
- The Role of the Market

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Medicare and Medicaid established minimum rules that nursing homes had to follow to be able to receive payment for patients. Kane et al identify three primary federal objectives:

- Purchase care only for those who truly need it
- Establish minimum standards of institutional safety (such as fire prevention) and quality of care
- Get the best possible results for funding

The results for the long-term housing care industry:

- Facilities that could not meet the safety or building standards went out of business.

- New facilities (nursing homes) that met regulations rather than customer desires often had an institutional, hospital-like atmosphere.

Regulations expanded with provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1987:

- Increased federal involvement
- Mandated new standards
- Installed new review process
- Expanded remedies (“penalties”) for non-compliance

What happens now? A common view is that the major determinant of care has been the funding source, such as Medicare, Medicaid, and comparable state programs.

Investors and administrators have sought to meet the market-driven requirements of those programs and other funding agencies. Will the advent of new funding sources such as managed care, private pay and long-term care insurance (and new investors following those funding sources) change the nature of the product?

## *Government-Friendly vs. Customer Friendly*



- Cookie-Cuter Approach
- Ossification of Care
- Institutional Environment
- Loss of Customer Focus

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Established nursing homes (the large majority of senior care facilities) made necessary changes to meet government regulations. Newly built homes were specifically designed to do so--a requirement for being in the business.

While the general effect was to enhance the residents' medical care, safety, and basic services, another result occurred: the institutions started to “look alike,” with little differentiation of atmosphere, personal services, quality of life, and other key factors.

Facilities sought to please the government, perceived as the *customer* because of its role as primary funding source. With few options, most residents took what they could get: an often unpleasant, highly institutionalized environment. Fairly in some cases, unfairly in most, nursing homes came to be seen as unpleasant places where you went to die.

Simply, nursing homes' tending to confuse payers and customers often led to a “take-it-or-leave-it” attitude, since the government made its Medicaid payments regardless of the residents' satisfaction.

Still, residents are the ones who decide which facilities to go to. Their broadened funding options and the types of facilities available to them have already affected the nursing home monopoly of the industry.

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### **NOTES:**

### *But Markets Aren't Static*



- Increasing Affluence of Elderly
- Willingness of Elderly to “Spend Down”
- Willingness of Children to Subsidize
- Growth in Alternative Funding Sources
- Availability of Alternative Products

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A decreasing number of seniors depend on government funding for their care. Several changes in seniors' financial condition and the industry itself have resulted in greater options.

As expected, seniors' income is significantly lower than that of other age groups. For example, households whose residents are over 75 average \$23K per year; those from 48 to 54 years old average \$54K. These figures are misleading,

however; for example, seniors usually do not have major expenses, such as college tuition or large mortgages.

Further, seniors have a high level of assets, reflected in the fact that those from 70 to 74 have a higher net worth than any other age group (largely home equity).

As their affluence has increased, seniors have become increasingly able to cover all or most of their housing costs. For example, a major NIC study and follow-up found that two-thirds of the seniors in assisted living facilities have incomes less than \$25K. That amount had previously been considered to be the minimum income to cover expenses. Two factors enabled seniors to afford assisted living even with relatively low incomes: their “children” are increasingly willing and able to subsidize care; and seniors are showing a greater willingness to liquidate assets (most notably, their homes) to fund housing and care.

Additional funding sources, such as long-term care insurance, may also enable seniors' to choose the facility they want-which, in turn, will lead to a broader range of options, some considerably more affordable than traditional nursing homes.

## *New Product Types*



- Housing
- Home Care
- Adult Day Care
- Congregate Care
- CCRC's
- PACE
- Etc., Etc., Etc.

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Nursing care is being replaced or supplemented (depending on one's perspective) by products that give seniors additional choices. While definitions can vary and several of the products overlap, we ordinarily describe them as follows:

**Seniors' housing:** Communities that provide housing for seniors, often in a condominium or rental-type environment. Such facilities provide no social, medical, or other services (other than amenities).

**Home care:** Support from a visiting health care professionals or paraprofessionals who help the senior take prescribed medication, assist with bathing or dressing, provide basic nursing services, etc.

**Adult day care:** The senior can participate in activities, socialize, eat one or more meals, etc. at a community facility. Ongoing contact enables staff to recognize and respond to changes in mental acuity or physical health.

**Congregate care:** These facilities are designed for seniors who require little, if any, assistance with ADLs. Such facilities provide at least one (usually three or more) congregate services, which may include meals, housing, transportation, and social/recreational activities.

**Continuing care retirement communities (CCRC):** Settings combining the entire continuum of services (housing, assisted living and nursing care).

**Program for All-Inclusive Care of the Elderly (PACE):** A new, somewhat experimental approach to keeping the frail elderly out of nursing homes by integrating services (usually in adult day care settings) and funding (Medicare and Medicaid).

The Johns Hopkins Bloomberg School of Public Health  
“Managing Long-Term Care Services for Aging Populations”

## *Seniors Housing and Care*



- Independent Living
- Congregate Care
- Assisted Living
- Skilled Nursing

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In the area of seniors’ housing and care, The National Investment Center for the Seniors Housing and Care Industries (NIC) offers (on the next page) a categorization focused on the kind of services provided in addition to “real estate” (housing):

Category A: Real estate with no additional services  
(other than amenities)

Category B: Real estate with convenience services

Category C: Real estate with services and ADL care

Category D: Real estate with services, ADL care, and  
medical care

Essentially, definitions are important only as a function of services provided. Services, in turn, are a function of need, and needs are a function of customer condition.

The chart on the following page (based on work by Glenn Mueller and Steven Laposa) details the four types of residential facilities and the relative mix of real estate and service components.

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### NOTES:


The Johns Hopkins Bloomberg School of Public Health  
 “Managing Long-Term Care Services for Aging Populations”

Senior Living Categories

<b>A</b> <b>\$600 - \$1,200</b> <b>Monthly Fee</b>	<b>B</b> <b>\$1,400 - \$2,000</b> <b>Monthly Fee</b>	<b>C</b> <b>\$2,400 - \$3,000</b> <b>Monthly Fee</b>	<b>D</b> <b>\$2,800 - \$4,000</b> <b>Monthly Fee</b>
<div data-bbox="247 1300 569 1442" style="border: 1px solid black; padding: 5px; text-align: center;">                     100% for Housing                 </div>	<div data-bbox="604 1138 995 1442" style="border: 1px solid black; padding: 5px; text-align: center;">                     45% for Services  <hr style="border: 0; border-top: 1px solid black;"/>                     55% for Housing                 </div>	<div data-bbox="1031 1008 1451 1442" style="border: 1px solid black; padding: 5px; text-align: center;">                     65% for Services &amp; ADL Care  <hr style="border: 0; border-top: 1px solid black;"/>                     35% for Housing                 </div>	<div data-bbox="1486 894 1843 1442" style="border: 1px solid black; padding: 5px; text-align: center;">                     75% for Services, ADL Care, &amp; Medical Care  <hr style="border: 0; border-top: 1px solid black;"/>                     25% for Housing                 </div>

source: The Investment Case for Senior Living and Long Term Care Properties

*Categorized By The  
Continuum of Service*



- Convenience Services
- IADL Services
- ADL Services
- Nursing Services
- Therapy Services
- Medical Services

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**Convenience Services:** May include convenient, helpful services, such as housecleaning, transportation, and dining facilities. The seniors may be able to provide these services for themselves (such as preparing meals), but prefer the greater convenience of the services being provided for them (such as in a dining facility).

**IADL Services:** These services support daily tasks that do not involve assistance with personal functions, including shopping, picking up medication, bringing meals, providing transporta-

tion, etc. IADL services are *provided on behalf of* the individual.

**ADL Services,** *performed on* the individual, include assistance with bathing, dressing, administering medications, eating, and similar functions.

**Nursing Services:** A function of the individual’s *medical* condition. Are self-descriptive in that licensed personnel provide them.

**Therapy Services:** Oriented toward an individual’s functional impairments. Include such services as physical, occupational and inhalation therapy.

**Medical Services:** Care for an illness, either chronic or acute.

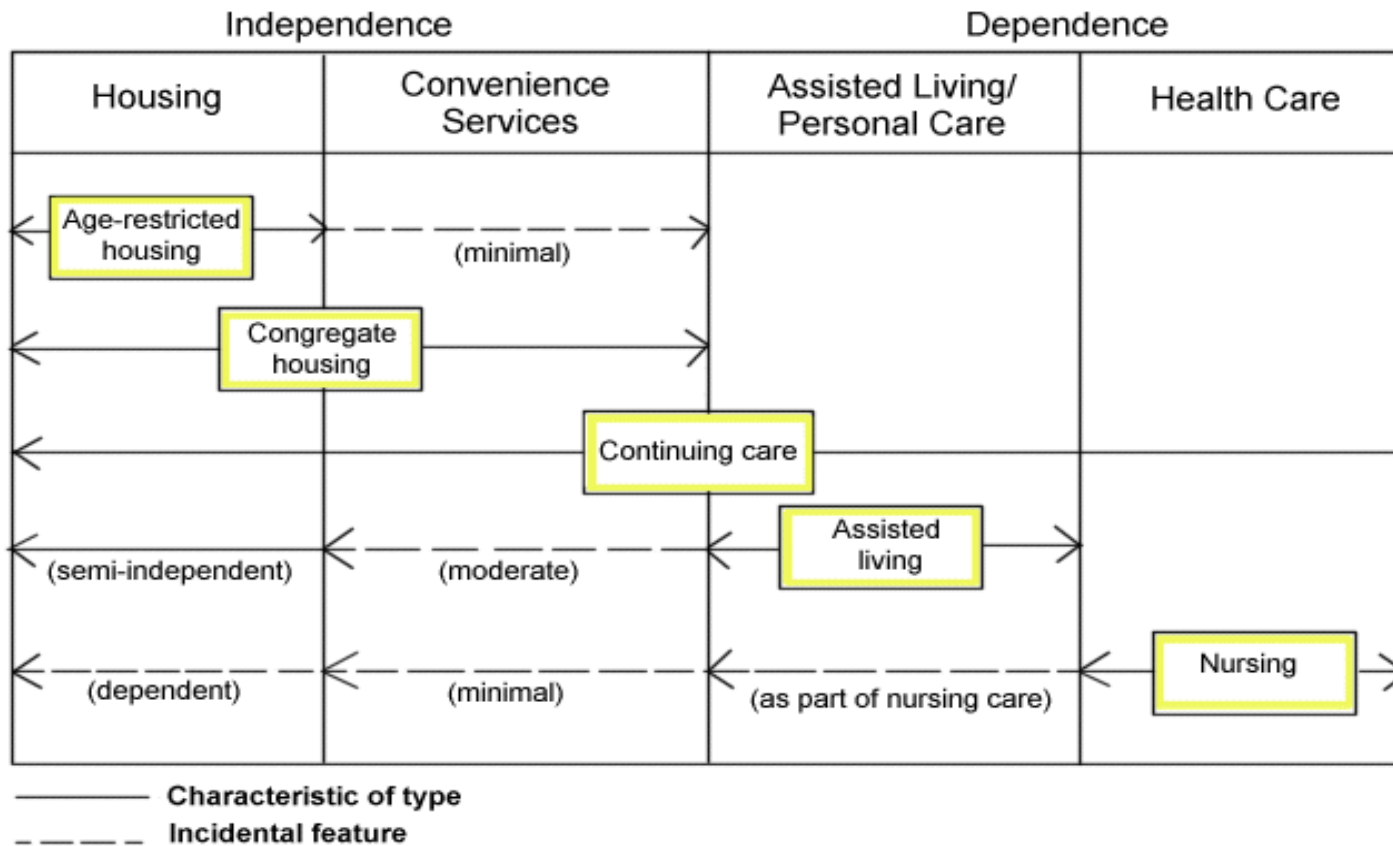
The chart on the following page, developed by Paul Gordon, shows the types of facilities categorized by service.

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**NOTES:**

The Johns Hopkins Bloomberg School of Public Health  
 “Managing Long-Term Care Services for Aging Populations”

Figure 2.4 From Paul Gordon (Seniors' Housing and Care Facilities)  
**Typical Seniors' Community Models**



The Johns Hopkins Bloomberg School of Public Health  
“Managing Long-Term Care Services for Aging Populations”

## *Independent Living*

- Oriented Toward Active Adults
- \$600 - \$1,200 Monthly Fee
- Costs All Housing-Related
- Focus On Real Estate
- Includes
  - Seniors Apartments
  - Active Adult Communities
  - Owner Occupied Single Family and Mobile Homes

1/3/02

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Independent living facilities, which may be known as “retirement communities,” “senior housing,” etc. are essentially a place for seniors to live with other seniors. There may be a number of attractions: recreational opportunities, a built-in opportunity to socialize with others of the same age, less (or no) responsibility for yard work, etc.

The individuals living in independent living facilities are usually “young seniors,” healthy and with an interest in such activities as golf, cultural events, hobbies, etc.

The distinguishing characteristic is that (other than amenities, such as golf course or swimming pool) there are essentially no services. Unlike nursing homes and, usually, other care facilities, the residents choose independent living as almost exclusively a social alternative. When health care is needed, it is arranged for privately, with no involvement by the community itself. Consequently, the costs involved in independent living are almost all real estate related.

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### NOTES:

## *Congregate Care*

- Active Adults Desiring Conveniences
- \$1,400 - \$2,000 Monthly Fee
- Costs Still 55% Housing-Related
- Can Include Meals/Transport/Housekeeping
- Includes
  - Congregate Care Facilities
  - Independent Living in CCRC’s
  - Board and Care Facilities (w/o Services)

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In the continuum from housing without services to nursing homes, congregate care is the first step from independent living. The emphasis is still on housing, but the level of services increases.

The housing itself is more likely to be “apartment-style,” unlike the more individualized housing of independent living. Another difference is that congregate care provides a level of convenience services to the residents, such as community transportation and housekeeping. In congregate care, the residents are more likely to eat one or more of their meals in a

common facility. Still, seniors in such facilities are likely to have essentially the same self-sufficiency as those in independent living, with the added convenience of congregate services.

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### NOTES:

## *Assisted Living*

- Oriented Toward ADL/IADL Needs
- \$1,500 - \$3,000 Monthly Fee
- Costs 35% Housing-Related
- Focus Mostly on Services
- Includes
  - AL Facilities
  - AL Units in CCRCs and Congregate Care
  - Board and Care (with Services)

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As noted, assisted living is the next step in that it provides for needs that most adults don't have. Seniors in these facilities have conditions that would make living alone very difficult, if not impossible.

The residences may still be like apartments, but could also be single rooms (studios). They definitely have features not found in most homes, such as bars in the shower, wheelchair-accessible doorways, and elevator access to all floors.

The level of assistance may vary considerably, even within the same facility. “Marginal” residents may only require support in IADLs, such as financial management, reminders to take medication as scheduled, meals, and housecleaning. Other residents may have more involved needs in ADLs, including bathing, meals, dressing, and toilet use.

Assisted living residents need support with day-to-day life, but do not have the kinds of medical conditions that might warrant more extensive care, such as that provided by a nursing home.

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## NOTES:

The Johns Hopkins Bloomberg School of Public Health  
“Managing Long-Term Care Services for Aging Populations”

*Skilled Nursing*

- Oriented Toward Nursing/Medical Needs
- \$3,000 - \$5,000 Monthly Fee
- Costs 25% Housing-Related
- Focus On Medical and Nursing Care
- Includes
  - Nursing Facilities
  - Skilled Nursing Units in Congregate Care Facilities, CCRCs and Hospitals

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Nursing homes are at the end of the continuum, characterized by a shift in emphasis from housing to medical care. These are the traditional facilities, most viable in the past because of their eligibility for Medicaid funding.

The role of nursing homes is to provide medical care to individuals who are essentially unable to live on their own or with family members. Typically, these are people with serious physical ailments, such as severe heart disease and/or such mental conditions as Alzheimer’s disease.

Largely because of government funding practices, however, many seniors have been placed in nursing homes when they could have been served at least as well in a less medically oriented facility—often at lower cost.

While there will always be a need for nursing homes, many residents who would have been in a home in the past now have options—particularly as their income and assets have increased. Nursing homes therefore may be in a position in which they must adapt to a changing niche in the market place or disappear.

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**NOTES:**

The Johns Hopkins Bloomberg School of Public Health  
“Managing Long-Term Care Services for Aging Populations”



*Hybrid*

Continuing Care Retirement Communities

- Offers the Entire Continuum within One Community
- May Add a Financing Component
- Focuses on Aging in “Place”
- Avoids Transfer Difficulties

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Continuing care retirement communities (CCRC) provide a complete range of services within one facility or community. An individual who requires additional services can “graduate” from independent living to congregate care to assisted living to nursing care. CCRCs were originally run by church and social groups, but for-profit organizations now operate 2% of the facilities.

Three differentiating service characteristics:

- Nursing care is available under contract.

- The facility guarantees availability of the next level of care.
- The facility promises to care for residents for a more extended period of time than is common in independent, congregate or assisted living.

Different CCRCs offer multiple financing options. The individual’s financial situation may play a large role in determining the financing approach. In some cases, residents’ fees cover all services, so payment of the fee ensures they will obtain needed care as long as they live. In other cases, residents pay a monthly fee that increases as more intensive care is required. Many CCRC’s provide a combination of these options, giving potential residents a wide range of choice regarding the payment plans and services they want.

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**NOTES:**

**The Johns Hopkins Bloomberg School of Public Health  
 “Managing Long-Term Care Services for Aging Populations”**

*You’ve Seen One CCRC,  
 You’ve Seen One CCRC*



- Increasing Popularity
- Changing Nature of Pricing Structures
- Movement from Non-Profit to Proprietary

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<u>Period</u>	<u>Population in CCRCs</u>	<u>% of Market</u>
1986-1990	339,000	3.21%
2000-2005	2,044,000	11.66%
2016-2020	3,607,000	18.24%

CCRCs can attribute their increasing popularity to the fact that they are more capable of dealing with customer’s desire to “age in place.”

Factors affecting the cost of a CCRC may include level of care, location, and overall quality of the community. Payment usually involves a blend of an initial fee upon entry and a


monthly fee; the monthly fee may increase as more extensive service becomes available. The following table shows representative payments.

Type	Description	Initial Fee	Monthly Fee
A	<b>Extensive:</b> Unlimited long-term care at no additional cost	\$59K	\$874
B	<b>Modified:</b> Special nursing care with nominal fee increases	\$42K	\$721
C	<b>Fee for Service:</b> Costs to customer based on services received.	\$35K	\$583
D	<b>Month-to-month</b> contract	N/A	Varies

Determining the fee schedule that is best for a given individual therefore requires an assessment of likely longevity, health, and level of services needed.

**NOTES:**

## *Handwriting on the Wall*



- Increasing Skepticism About Nursing Facilities
- Growing Scrutiny of Assisted Living
- Problems of Affordable Housing
- Continued Demographic Pressures
- Struggle to Maintain Customer Focus

1/3/02

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Nursing facilities are falling into disfavor. Their poor reputation is based, in part, on some facilities that have been truly abusive to residents and/or fraudulent in managing funds. However, many well-run facilities have unfairly been stigmatized in the same manner.

However, growing concerns about facility-based long-term care are not limited to nursing facilities. In April 1999, the General Accounting Office identified the following problems regarding assisted living:

- Inadequate or insufficient care
- Inadequate medical attention
- Insufficient and unqualified staff
- Inappropriate medication
- Improper admission and discharge

As seniors' housing begins to expand beyond the traditional nursing-home-as-the-only-option perspective, many issues regarding care remain. They cross the entire continuum of seniors housing and care and include questions regarding the availability, quality, and cost of service. Seniors' housing and care is increasingly caught in a squeeze between price and promise. Can the field address these concerns (many of which raise the specter of government involvement) while maintaining a focus on the real customers--residents and their families?

The next module will address the importance of services to residents.