ADMINISTRATOR SURVEY, 47; AHCA CONVENTION PREVIEW, 50; MINIMIZING TURNOVER, 61

SEPTEMBER 1994 A BILL PUBLICATION $7.50

CONTEMPORARY LONG TERM CARE®

BETTER CARE THROUGH BETTER OPERATIONS

HONORING LONGTERM CARE'S ELITE

ORDER OF EXCELLENCE AWARDS

HONORING LONGTERM CARE'S ELITE

BY K.T. ANDERS

In nursing homes and retirement communities, as in all other areas of life, there are those who do things just a little bit better than everyone else. The Order of Excellence, awarded each year by *Contemporary Long Term Care*, with the support of a slate of prominent industry sponsors, was designed to recognize these outstanding facilities. Now in its fourth year, the Order of Excellence is becoming an elite fraternity whose members have been judged by their peers to be the nation's best.

Nominations submitted to *Contemporary Long Term Care* are divided into four classifications: nursing homes with 135 beds or less; nursing homes with more than 135 beds; retirement communities with 150 units or less; and retirement communities with more than 150 units. This year only three inductees were selected, as we received no nominations for retirement communities with under 150 units.

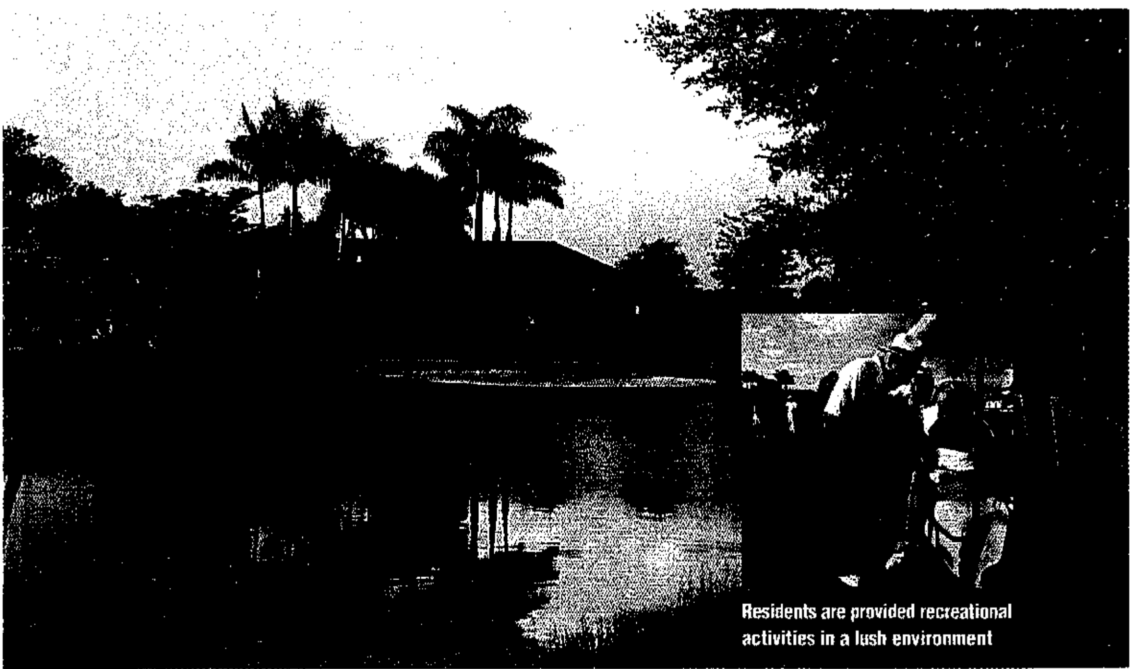
A distinguished panel of industry professionals—members of *CLTC's* advisory board made up of facility administrators and directors of nursing, as well as executives, consultants, and attorneys in the healthcare industry—sifted through all nominees to find those that excel in three categories: resident services, business management, and facility design.

Within each of these categories, facilities were judged on quality, innovation, and cost-effectiveness. Nominees were evaluated numerically, the totals computed by *CLTC*. The quality of the nominees was so high that often only a few points distinguished the winning facility.

CLTC publisher David A. Ellis extends his congratulations to the 1994 winners. "I am proud to be a part of the Order of Excellence program," says Ellis. "We are delighted once again to be able to recognize America's finest longterm-care facilities." *CLTC* would like to thank its industry sponsors for their support in recognizing the high quality of nursing and retirement homes, as evidenced not only by the winners but by all the nominees.

CLTC salutes the 1994 winners and all longterm-care facilities that strive for excellence in providing top quality healthcare services.

PHOTOGRAPH BY ADRIENNE HELE



Residents are provided recreational activities in a lush environment

Bentley Village, A Classic Residence by Hyatt

Naples, Fla.

RETIREMENT COMMUNITIES WITH MORE THAN 150 UNITS

EIGHTY-SIX LANDSCAPED ACRES SURROUND THIS year's inductee into the Order of Excellence in the category of retirement communities with more than 150 units. Residents of Bentley Village, a Classic Residence by Hyatt in Naples, Fla., enjoy all the amenities of apartment living in a country-club setting. In addition, they have the comfort of knowing their future healthcare needs will be met within the community.

Executive director Frank Mazziotta has been at the helm of the community since its opening nine years ago. "The people who come to live here have been used to the finer things in life—good dining, excellent service," he says. "So we cater to that."

The main village is comprised of twenty 18-unit complexes and one 12-unit complex, plus two villas. Apartment sizes range from one to three bedrooms (1000 to 2500 sq. ft.) and each has a patio, balcony, or screened lanai.

As part of the monthly fee, a variety of healthcare services are available for residents at Bentley Care Center. Each apartment is electronically linked to the Care Center nursing station. The skilled-nursing facility, with more than 70 healthcare professionals and 150 resident volunteers, has consistently been given the highest licensure rating awarded to care facilities in the state of Florida.

For those who need assistance in bathing and dressing but for whom a nursing home is inappropriate, the 18-bed Personal Care Center on the third floor is supervised by an LPN, with 24-hour care provided by nurse aides.

Bentley Home Care offers free, temporary follow-up care in residents' apartments during recuperation from illness or injury. A licensed home healthcare service is available on a fee-for-service basis.

Outpatient services include private doctors; physical, occupational, speech, and massage therapy; and specialties in family care, ophthalmology, podiatry, psychiatry, and dentistry.

Bentley's campus-like setting offers active residents a full range of activities. Tennis courts, a pool and cabana, and shuffleboard and croquet courts, along with a nine-hole golf course, provide ample outdoor recreation. A library, beauty shop, "village store," closed-circuit TV studio, billiards room, and pub are available, as well as card rooms, an exercise room, an arts and crafts room, a golf pro shop, and a spa. Tram service is provided within the village, and two vans and a Lincoln Town Car transport residents to cultural and sporting events.

One meal a day is included in the monthly fee, although all apartments have kitchens. While most residents opt for the four-course dinner, ordered from a varied menu that changes daily, breakfast and lunch are also available. Says administrator Mazziotta, "We're so non-institutional, we don't have a dining room; we have a clubhouse, where the restaurant is." Service is elegant, with flowers, table linens, and a staff dressed in black and white formal attire. Meals can also be delivered to apartments. Private parties from six to 500 can be accommodated in a private dining room, and the Zebra Lounge offers fine dining for 10 residents at a time.

Bentley's population is a contented lot. in 1993, 88.5% of sales generated were from referrals. Sales in '93-'94 exceeded projected revenue, and the waiting-list number has doubled. To ensure that the village is meeting residents' needs, a yearly survey is conducted to determine residents' level of satisfaction with all phases of life in the village. And residents are encouraged to become involved in a residents' council, which meets monthly.

Bentley's dual corporate structure divides operations and ownership to make residents feel comfortable with how their money is being spent. The operation corporation is not-for-profit, so residents are assured that 100% of their fees go for services. Hyatt, the ownership corporation, maintains the debt and manages apartment resale.

AS IN ALL BUSINESSES, EMPLOYEES AT BENTLEY help make the difference between success and failure. When Hyatt acquired the property a year and a half ago, it instituted several management systems that make Bentley employees feel appreciated and challenged. An operations audit allows supervisors to evaluate themselves according to how well they comply with specific standards. Positive performances as well as areas of vulnerability are highlighted. It's all part of the Classic Management System, a program that, according to Ben Pearce, vice president of operations, "identifies solutions to problems and charts our employees' successes, rather than documenting their failures. It creates an environment where employee performance and direction can be influenced by clearly defining employee goals and management expectations."

And to sweeten the pot, employees belong to an annual incentive plan in which selected managers can earn up to 10% of their gross income. In addition, employees fill out comprehensive yearly opinion surveys, rating their job satisfaction, supervisors, compensation, and benefits.

Not a dining room, but rather a restaurant with fine dining

"Our ultimate goal is to have employees who enjoy coming to work and who understand the importance of their role in running a quality operation," says administrator Mazziotta. "Employee longevity has a direct impact upon resident satisfaction. At a time in their lives when our residents are experiencing many losses, a stable staff provides the comfort of a family atmosphere."

And atmosphere is extremely important at Bentley Village. The decor of community rooms is primarily traditional, with photos, paintings, and sculpture by local artists. Furniture, fabric, and accessories were chosen to create the effect of a "collection" of pieces, rather than a professionally coordinated design statement.

But never are the physical limitations of an aging population forgotten. "Redundant cueing"—distinctive furniture groupings and variations in color, artwork, floor coverings, etc.—provides residents with a frame of reference as they move around the community. Multiple light sources and glass tinted to reduce glare compensate for vision deterioration. Furniture groupings are clustered together to facilitate face-to-face communication for those suffering from hearing loss. Chairs and sofas are designed for bodies that need extra support. Apartment appliances have easy-to-reach controls. "People who come to live at Bentley," Mazziotta says, "are moving their country-club membership." As residents' daily lifestyles become more challenged, Bentley provides a "cushion of care" so that they may continue to live independently for as long as possible. CLTC

THE WINNERS

Forestville Health and Rehabilitation Center

Forestville, Conn.

Linwood Convalescent Center

Linwood, N.J.

Bentley Village, A Classic Residence by Hyatt

Naples, Fla.

PREVIOUS ORDER OF EXCELLENCE INDUCTEES

1993

All About Life Rehabilitation Center
Fond du Lac, Wis.

The Pediatric Center at Plymouth House
Norristown, Pa.

Marshall Manor
Marshall, Va.

Mt. San Antonio Gardens
Pomona, Calif.

1992

Heartland of Boynton Beach
Boynton Beach, Fla.

The Jewish Home and Hospital For Aged
New York, N.Y.

Kachina Point Retirement Village
Sedona, Ariz.

The Fountains at La Cholla
Tucson, Ariz.

1991

Mary Conrad Center
Anchorage, Alaska

Miami Jewish Home For The Aged
Miami, Fla.

Villa Campana Retirement Residence
Tucson, Ariz.

The Renaissance
Olmstead Township, Ohio

1994 ORDER OF EXCELLENCE JUDGES

Martin Casper, administrator,
Greynolds Park Manor

Marie Fisher, R.N., M.S.,
director of professional regulatory services,
Maine Health Care Association

Sandra Grant, director of long term care,
Barnes Extended Care

Clare Hendrick, vice president of nursing,
Beverly Enterprises

Paul Klaassen, president, Sunrise Retirement
Homes and Communities

Karen Struve, president,
Walker Methodist, Inc.

1994 ORDER OF EXCELLENCE SPONSORS

HEATON PUBLICATIONS

HEALTHCARE SERVICES GROUP, INC.

PROFESSIONAL MEDICAL PRODUCTS, INC.

SCOTT HEALTH CARE

SODEXHO USA

Assisted-Living Design Considerations

Coalescing comfort and function from an operations perspective

By **Benjamin Pearce,** Genesis ElderCare, and **Thomas Grape,** Benchmark Assisted Living

Assisted living has been met with great enthusiasm by residents who find themselves having difficulty continuing to live at home but who do not yet need the full healthcare services provided in nursing homes. Typically, these residents seek out communities that "feel like home"; therefore, a predictor of success of assisted-living communities has been the degree to which they have been able to capture the most residential environment possible. An overview of some of the key planning principles are highlighted below.

The Residential Setting

Among other factors, layout of spaces is an important ingredient to accomplish this goal. For example, when one walks into a residential setting, it is more typical to have living spaces off the entry foyer, not a reception station with glass peering into an office space. Similarly, the selection of artwork and appointments for finishes should be as homespun as possible. Frequent examples include the elimination of fluorescent lights, the absence of institutional nursing stations, the design of public toilet rooms more resembling powder rooms and others. Also, the design of chair rails—as opposed to the institutional hand rails—serve the same function, but have a more residential feel. Most importantly, a residential environment can be achieved with the absolute commitment at the outset to not include anything in the community that would not be included in one's own home.

Keep the Scale Small

One of the characteristics of more institutional settings is a preponderance of large spaces (i.e., dining rooms, auditoriums, etc.). One of the ways in which assisted-living communities have been able to offer a more residential environment is by keeping their spaces on a smaller scale, for example, offering an entry foyer rather than a grand reception hall with large open space, chandelier, etc. Similarly, while assisted-living communities will include multiple large dining spaces, it is possible to break these down into smaller-scale spaces, which avoids the appearance of a "cafeteria" dining room. Finally, there have been some recent advances in moving away from traditional multifamily corridors with apartment entries on both sides into smaller clusters of apartments gathered around lounges. This reduces the feel of the long institutional corridor, as well as promotes more social interaction among the residents on a small-scale basis.

Design for the Frail Elderly

Consideration should be given to walking distances from the furthest apartment to the common areas. An opportunity to maximize spaces on the indoors to access the outdoors will make it easier for the frail population to enjoy patios and gardens. Layout considerations that allow residents to "preview" activities in a room without having to enter that room have proven to be popular. In addition, there are a host of considerations in the configuration of apartments appropriate for this population, most notably in the layout and design of bathrooms.

Customize to the Local Market

The local sponsorship of the proposed project should be able to provide some ideas on interior and exterior design that truly reflects the history, tradition and preference of the local community. Therefore, the development of an architectural program should incorporate spaces that are unique to the local area. In addition, the selection of regional artwork and crafts will further reinforce the feeling of familiarity.

What Are People Buying?

While the opportunity to develop a building design provides a long-term competitive advantage, it is also important to remember that, fundamentally, what people are buying is a solution to a problem, not real estate. Therefore, constant attention should be given to keeping the apartment sizes smaller than traditional multifamily housing and not overdoing the quality of finishes. Over-designing a building can be as much of a problem as under-designing a building. Here are some items to consider in the design of an assisted-living facility:

Building Layout

- Cluster-type rooms appear to get more use than the corridor-type rooms. An "L"-shaped or square building layout with a center courtyard and gathering rooms are less expensive to build and minimize travel distances for the residents.
- Groundfloor activities need to be spread out so that the residents do not congregate at the front door.
- Travel distances to elevators need to be minimized, and an elevator should be located adjacent to the main dining room for the most efficient transportation of residents during meal periods. In addition, public washrooms close to the dining room are essential, with raised toilets preferred.

Outdoor Spaces

- Adequate parking needs to be emphasized, recognizing the unique problems presented by the site limitations.
- Outdoor seating areas should take advantage of the "natural areas."
- Use blacktop or concrete for walking paths to prevent weed growth.
- Minimize the planted areas that require weeding and replace them with lawn areas that are easier to maintain. Mowing is always easier than weeding. These areas may also require an irrigation system.
- Water ponding can occur at the foundation of buildings due to the manner in which they were graded. This is a particular concern when the ground is frozen. Water should be channeled into proper drainage using the roof line and gutters, especially in areas where ice accumulates on eves and builds up at exit doors.
- Signs should be well-lighted and easy-to-read.
- Entrances need adequate clearance to accommodate a rescue van and ambulance.
- Greenhouses have a tremendous marketing appeal to seniors and their families. Consider adding one on the outside in a southwest-facing location convenient to the activity areas for supplies and clean-up.

Reception Area

- This area needs designated spaces for package deliveries and/or pickups, guest coats, wheelchairs and other storage.
- Security monitors and remote door openers should be installed.
- The reception desk should accommodate two computers recessed into a desktop designed to hide the institutional or business effect of this equipment.
- Incorporate a separate circuit for the emergency-call system computer to avoid interference from the other equipment that can produce false alarms.
- At the entry, consider recessing the ceiling and installing acoustical tile to dampen noise.

Country Kitchen

- This area is great to use as a waiting and gathering area for residents and staff. This can also be used for baking and cooking by residents and staff.
- Consider adding a reach-in refrigerator between the gift shop and country kitchen for sodas, milk, juice and other perishables that can be purchased by the residents. Also, consider installing a freezer to hold supplies for ice-cream socials.

Activities Room

- Install adequate seating, storage and upgraded lighting. Cabinetry should be lockable for storing supplies. A countertop with a sink is also helpful.
- The closets in the activity room should have floor-to-ceiling shelving with space for seasonal decorations. Both sides of the closet should be lockable.
- Glass display cases are useful for displaying residents' handiwork and provide evidence of an active lifestyle for your marketing staff to showcase.

Family Dining

- Family parties sometimes involve 20 people or more and often cannot be accommodated in the private dining room. These functions can be handled in a main dining room if it can be divided. This room can also double as a conference room.
- Provide a hutch for storage and a buffet server top with an outlet behind it for small functions and meetings.

Kitchen and Dining Area

- A well-designed kitchen will require a minimum of 1,200 square feet for an efficient operation.
- Incorporate two doors: one for entering, one for exiting the kitchen.
- Walk-off mats at kitchen exits can save wear and tear on dining-room carpets. Wait staff will pick-up anything spilled on the kitchen floor with their shoes and walk it into the dining-room carpet.
- Windows in the kitchen provide ventilation and promote a more enjoyable work environment.
- Dry storage areas should be lockable, and an area needs to be reserved for clean dish and linen storage.
- FRP/Plexiglass wall protection behind the dishwashing area and stainless steel behind the cooking line keeps walls cleaner.
- The dining room should be broken up into separate seating areas. Seating should be designed to accommodate approximately two-thirds of the population at a minimum.
- Consider adding a busing station with silver/glassware storage in the dining room. There should also be outlets to accommodate coffee warmers and soup kettles if desired.
- Adjacent to the kitchen and main dining room should be a community room that can be separated with air walls or French doors to provide flexibility in accommodating large functions.
- Kitchen equipment should include a tilt skillet, double convection oven, convection steamer, six-burner range, charbroiler and fryolater.
- Kitchen tile should have black grout to promote a consistent appearance over time.
- Dining-room chairs need casters on the front two legs. Chairs with arms are preferable to the elderly population.
- The dining-room design should minimize barriers to traffic flow in and out of the kitchen and allow easy access to all tables.
- Wood laminate tables can be used for breakfast and lunch if desired, saving on linen costs.

Residential Areas

- Laundry rooms should feature ironing boards, electrical outlets for irons and a countertop for folding laundry.
- Additional storage on each floor for residents, such as a trunk room, is desirable for storing residents' seasonal items.
- The installation of an emergency-call system in public bathrooms is a must. Avoid small tile floors as they are too hard to clean in high-traffic areas. These restrooms are best positioned by the dining room and near the elevator.
- Consider the inclusion of a trash chute near the stairwell, and run conduit along the shaft in buildings with more than four floors. Not only is it a more efficient way to dispose of trash, but it allows for the daily disposal of incontinent products by housekeeping or personal-care attendants and is necessary to eliminate odors. Also, at some point the community may be

required to recycle, and a trash chute with an alternating divider is a relatively simple method to accomplish this.
- Bench seating or chairs adjacent to the elevator on each floor are essential.
- Elevator cars must be large enough to accommodate a stretcher and two EMTs for emergency transport.

Apartments

- There needs to be a logical mix of apartment sizing (i.e., studios vs. one-bedrooms vs. two-bedrooms). A comparative analysis of apartment sizes currently in the marketplace needs to be conducted before construction. Studios may be easier to market in price-sensitive areas.
- Bedrooms need to accommodate a full-size bed and a night stand. One-bedroom apartments should be able to accommodate twin beds.
- In order to provide adequate closet and storage space, two-bedroom units need two closets in each bedroom (walk-in closets are best).
- In resident kitchenettes, be sure to check manufacturer's recommended wall clearances for hot tops. Single-burner stoves are adequate. The distance between the stovetop and the wall needs to accommodate a teapot. Separately circuit this appliance so that it can be disconnected if needed. Be sure to allow adequate space and ventilation for a microwave.
- The refrigerator needs to be raised and capable of storing a half-gallon of ice-cream.
- Pocket doors in the bathroom can help increase usable floor space and are preferred by residents in wheelchairs or with walkers. Grab bars by toilets that can double as a towel bar are preferred, and additional blocking should be installed behind the shower at the time of construction to allow for additional supports. The mixing valve should be firmly attached to the blocking upon installation as residents often depend on this fixture to support their weight.
- Surround the sink with countertop, providing room for medical supplies, shaver, hair brush, dentures, etc.
- Consider purchasing a shower with the mixing valve close to the outside edge of the shower. This allows the personal-care aide easy access without getting wet. It is much faster to shower someone if a shower chair can be rolled into the shower rather than requiring a transfer over a fiberglass lip. All shower stalls must have a seat—preferably molded, not hung. All showers should use a hand-held wand that can be turned on and off at the wand.

Administrative Areas

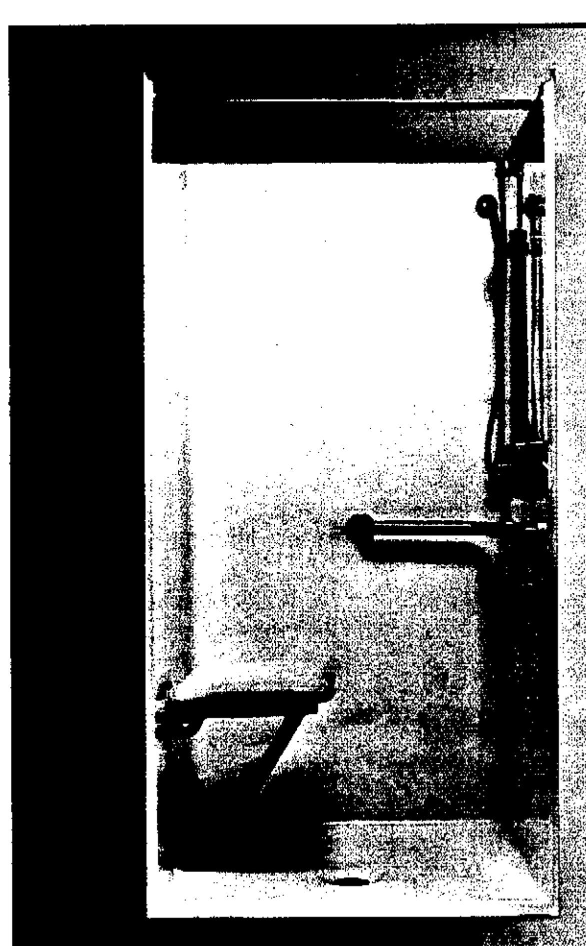
- Design the community to feature three lockable offices plus a copy/fax room equipped with lockable cabinets for supply storage.
- The marketing staff needs its own space, including storage.
- Employees need lockers in the lounge.

Emergency-Call Systems

- The E-call system should incorporate a "check-in" feature.
- The phone system should be set up with 10 to 12 lines (modem/fax lines included).

Building Components

- There needs to be good access to the HVAC units. There is also a need for thermostat covers in all common areas.
- Keying and lock systems must operate smoothly.
- Have the general contractor create a notebook with all cut sheets and equipment manuals. They should also provide two copies of the as-built drawings.



Clarion Bathware

Assisted Care Bathware

- ADA Compliant,
- Barrier Free, and Assisted Care Showers, and Tub/Shower Modules
- Fully Accessorized or, Accessorized per your spec.
- One-Piece Fiberglass
  Showers
  Tub/Showers
  Whirlpool Models
- Two-Piece Models
  Showers
  Tub/Showers
  Whirlpool Models
- Acrylic
  Showers
  Tub/Showers
  Whirlpool Models
- Custom Models Available

CLARION BATHWARE
205 Amsler Ave. • Shippenville, PA 16254
1-800-576-9228 Ext. 11

ADA COMPLIANT SHOWER

- It is helpful to create a video of maintenance and operational procedures on all physical plant systems and kitchen equipment using the manufacturer's representative or the mechanical engineer at the time of building turnover.

Interiors

- It would be helpful if all executive directors were furnished with cleaning specifications for all carpets and furnishings.
- Consider designing all public restrooms to be unisex. It is also more efficient to have multiple wheelchair-accessible bathrooms. All public restrooms should be equipped with an emergency-call button.

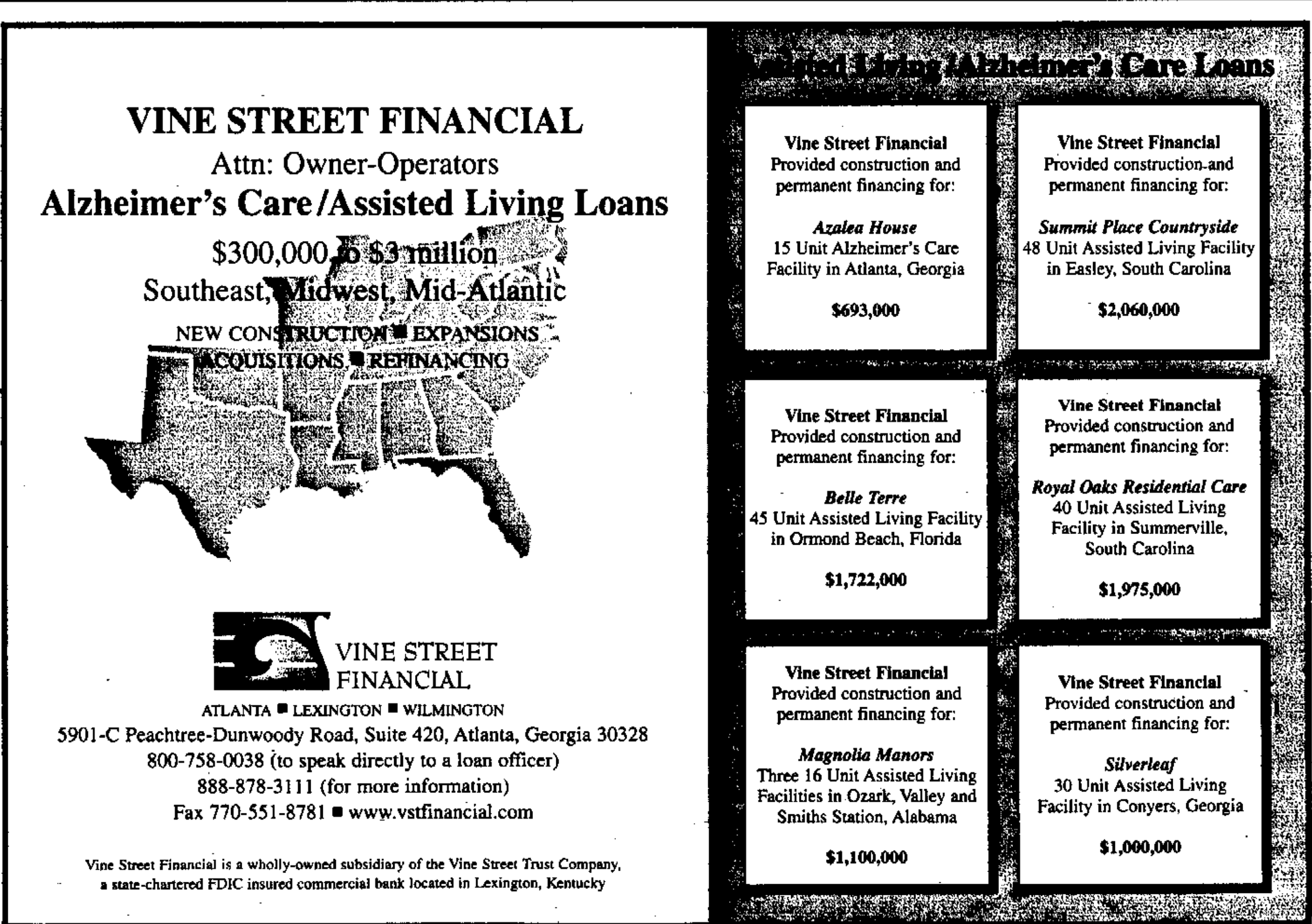
Dementia Units

- A plate rack in each room located just above eye level allows residents to display personal items for cueing, but keeps them out of reach of residents who may browse from room to room.
- Toilet tank covers need to be secured to prevent removal. This is needed for the safety of the resident and to prevent breakage. All toilets need to have arm rails to make the toilet more visible and facilitate seating. Toilet seats should be of a contrasting color for perception, which diminishes with Alzheimer's disease.
- Lighting needs to be non-glare, consistent and have the ability to simulate daylight. Decorative lighting should not be the main source of light.
- The delayed egress system is essential for providing safety and security to the residents in the unit. It controls resident access to outside areas, yet complies with building and fire codes.
- Adequate individual rooms are needed for activities, visiting, dining, preparing or distributing meals, snacks and laundry.
- Avoid coffee tables and end tables. They are too low and frequently not seen by the resident. Foot stools should be avoided.
- All wall decorations need to be touchable, and any pictures need to be cased in Plexiglass for safety. The colors need to contrast with the wall colors. Have contrasting colors where the walls meet the floor.
- Accessible bathrooms need to be provided in common areas. The visual cue is important to them to minimize accidents and clean-up.
- Lamps on bedside tables, even when attached to the table, can create shadows and present a hazard. Consider wall-mounted lamps.
- For outdoor areas, see-through fencing at least seven feet high is best. Also, consider outdoor benches and raised-bed garden areas.

By involving experienced operators in the design development stage of the new project, architects will treat themselves to a more user-friendly environment once it is built. Also, design teams that incorporate operational input during planning stages will provide a more efficient floor plan to operate at a lower cost once occupied. ❑

Benjamin Pearce is the senior vice president of network services for Genesis ElderCare and serves on the board of directors of the Assisted Living Federation of America, the Massachusetts Assisted Living Facilities Association and the National Association for Senior Living Industries. His book, **Senior Living Communities: Operations Management and Marketing for Assisted Living, Congregate and Continuing Care Retirement Communities,** *is currently being published by John Hopkins University Press and is due to be released Sept. 1, 1998.*

Thomas Grape is president of Benchmark Assisted Living in Wellesley Hills, Mass. He serves on the executive committee and board of directors of the Assisted Living Federation of America (ALFA) and was the founder and chairman of MassALFA.



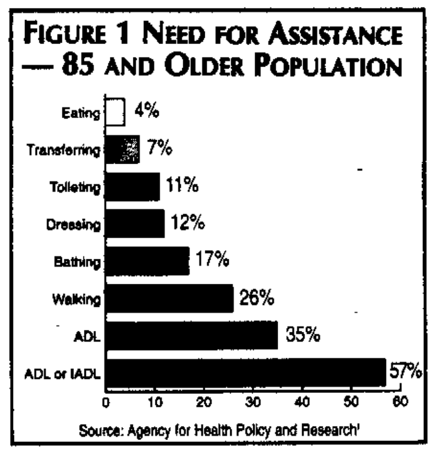
Acuity Based Delivery of Personal Care in Assisted Living Communities

As a rule of thumb, the cost of assisted living is only about two thirds of equivalent care in a skilled nursing facility. The cost of delivering personal care within a multi-family residential environment such as an assisted living community compared to purchasing home health services that are individually delivered to each resident's home is driving the current assisted living boom.

The typical assisted living community resident is an 83 year old female with 3.06 ADL deficiencies and some cognitive impairment. Residents stay an average of 2.38 years (28.5 months) and are discharged most commonly to a nursing home (46%), due to death (24%) or to a hospital (12%) which could involve a re-admission.[i]

As people live longer, their personal care needs increase. Figure 1 illustrates the average personal care needs for seniors 85 years of age and older from the general population. Fifty seven percent of the population will require some assistance with activities of daily living or instrumental activities of daily living. Thirty five percent need assistance with one or more ADL.

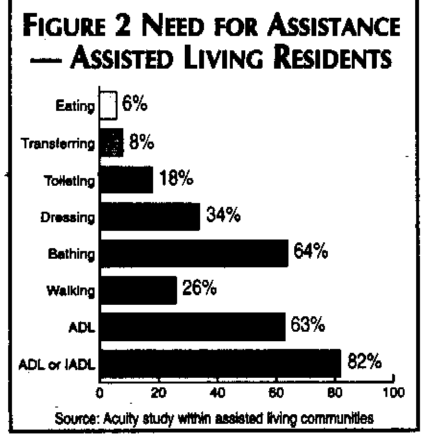
FIGURE 1 NEED FOR ASSISTANCE — 85 AND OLDER POPULATION



Source: Agency for Health Policy and Research[ii]

Acuity levels for residents in assisted living communities are considerably higher than the general population. Figure 2 illustrates actual residents living in assisted living communities in 1995. According to the figures, the highest assistance need is in bathing and medication reminders, followed by dressing and escort services.

FIGURE 2 NEED FOR ASSISTANCE — ASSISTED LIVING RESIDENTS



Source: Acuity study within assisted living communities

The most common disease states encountered in the assisted living setting are arthritis (42.6%), dementia / emotional illness (33%), hypertension (28.1%), asthma / pulmonary disease (11.5%), and diabetes (10.6%).[iii] The assisted living residents in the study averaged 2.9 diagnoses per resident. The percentage of residents suffering from incontinence has doubled from 15 percent in 1993 to 30.2 percent in 1996, indicating the effects of aging and increased acuity.[iv] The most common diagnoses are listed in Table 3. These residents are most often given cardiac drugs / diuretics (48.6%), CNS medications (46.3%), and laxatives / cathartics (17.2%). Thirty-five percent of residents had four to seven prescription records, and nineteen percent had eight or more. These residents have clearly identified the need for assisted living and will have higher personal care needs than those who may be living at home with family or other support.

By Benjamin Pearce

TABLE 3 COMMON DIAGNOSES IN ASSISTED LIVING RESIDENTS

Cardiac, Circulatory	44%
Arthritis, osteoporosis	42%
CVA, Stroke	28%
Dementia	26%
Depression	16%
Diabetes	11%
Chronic Obstructive Lung Disease	<10%
Thyroid irregularities	<10%
Cataracts and other eye disorders	<10%
Anemia	<10%
Hearing Impairments	<10%

The methods of delivery of the personal care component of assisted living vary greatly among providers, as does the staffing assignment. Typically, the equivalent monthly service package which includes 24 hour supervision and 45 minutes per day in personal care services will only purchase about 6 hours per day of home health services delivered to the home. Clearly, for those seniors who have extensive needs, and can afford it, assisted living can be very cost effective while providing the added benefit of companionship and twenty four hour emergency service.

The decision to move into an assisted living community is generally made by adult children seeking a more affordable alternative to nursing home placement. The advantages of a private residential unit and the non-institutional home-like environment can help to ease feelings of guilt often common to families considering institutionalization.

Alternative Service Delivery Methods

As the assisted living business has grown and matured, the complexity of service delivery and billing methods also has evolved. Assisted living originally developed as a concept in response to the preponderance of congregate or independent living communities looking for ways to maintain their occupancy and manage the aging-in-place of their existing residents. As residents' lifestyle challenges become increasingly complex, they require additional services. Some communities met this challenge through the introduction of home health agencies into their community, others discharged these residents to a "more appropriate level of care," while still others segregated their independent community by designating a separate floor or section of the property as personal care or assisted living. In the continuing care retirement community the progression is planned for in advance and a full continuum of care is offered including assisted living and skilled nursing.

Subsequently, developers recognized that prospects were becoming more aware of the limitations of traditional congregate communities and began developing properties with both independent living apartments and a separate assisted living component. This of course was more popular to many seniors who were interested in gaining access to services if they needed them, but did not want to live in an environment with other elderly who had become infirm over time. Ultimately free standing assisted living communities grew in popularity primarily designed for those seniors who have the financial resources to gain access to health care services in a residential setting while avoiding nursing home placement.

While there are a wide variety of service delivery methods employed by assisted living communities to deliver the care residents require, most are a derivative of one of four basic methods. The following discussion will describe each and itemize the advantages and disadvantages.

Home Health Option

This option segregates the basic service package from the personal care component. The developer or manager will provide the basic service package such as meal service, housekeeping, maintenance, laundry, activities, and transportation, and subcontract out the personal care component through a Medicare certified home health agency. This way, the residents of the community can have access to personal care services using their purchasing power as a community. This option is naturally attractive to home health agencies because they can deliver a wide array of services, many of which are Medicare reimbursable, to a captive audience without the expense and inconvenience of travel time.

The home health option enables the community to deliver a much higher level of care than would be possible under assisted living regulations in most states. The reason for this is that the residents are contracting with the home health agency for this care. It is not delivered by the

Continued on page 14

Fast-track access to the senior housing market.

ShoNet brings the world of senior housing to your desktop. A powerful marketing and networking tool, the Senior Housing Online Network gives you free access to:

- news, events, and industry databases
- new sources of funding
- e-mail and conferencing
- investors, vendors, and professionals
- national sales comparables
- exclusive investment opportunities

AZ	ALF	110 Beds	$6,600,000	MA	ALF	64 Beds	$4,250,000
CA	ILF	245 Units	$27,500,000	TX	ILF	90 Units	$6,200,000
FL	ALF	135 Units	$7,300,000	VA	ALF	62 Beds	$2,100,000

Call (800) 387-8988
or visit www.shonet.com
for free access today.

Lee D. Haris
Founder and President

2Be successful, you need 2Be informed . . .
You need 2BeMA Network Inc.

(415) 969-5372 e-mail: info@2bema.com

2BeMA Network Inc.

Acuity Based Delivery

Continued from page 13

management of the community directly as a component of the community service package included in the monthly service fee. The involvement of a Medicare certified home health agency can provide benefits for both residents and ownership. Residents can utilize Medicare benefits that they would perhaps otherwise be paying for separately. This arrangement can provide relief to those residents who may be experiencing financial pressure as their health care needs accelerate. The community can benefit from reduced turnover, stabilization of the assisted living population, avoidance of nursing care transfers, control of the continuity of care and differential billing structures.

This concept is very attractive to owners looking to defray expensive nursing costs particularly during the ramp-up period until stabilized occupancy is reached. During the start-up phase of the operation, occupancy is continually changing which makes it difficult for management to optimize staffing at the most efficient level. Also, by contracting with a single Medicare certified home health agency, ownership and management can have some influence and control over the personal care service delivery. Without this arrangement, an assisted living community will be subject to the risks of a wide array of different home health agencies delivering Medicare services to its residents with little or no control over the quality of these services or qualifications of its personnel. Should a medication error or resident abuse incident occur at the hands of a home health staff person, the community may be exposed to the resulting liability and bad public relations. In one East coast assisted living community, no less than fifteen different home health agencies were delivering services to its residents creating a real vulnerability for the community in terms of control and quality assurance.

The home health arrangement must be kept totally separate from ownership and management of the business. First, there can be no duplication of services that the facility is obligated to provide under the existing contract. The contract can, however, be modified to exclude those services so long as the home health agency provides for those residents who may not qualify for Medicare. Also, Medicare does not allow any inducement to residents for the provision of Medicare reimbursable services. Therefore, it is absolutely necessary for the community to not financially gain or receive any services in exchange for or as a condition of this subcontract. An arrangement where the community is delivering personal care services with its own staff in conjunction with a preferred home health agency that manages the program through nursing staff provided to the community at no cost may be in violation of Federal regulations by receiving services in exchange for access.

Providers can not legally deny any Medicare beneficiary the freedom to choose among health care providers. The agreement must be a non-exclusive arrangement in which the certified agency may engage other contractors to provide similar services or provide access to other certified home health agencies to provide its services. The provider must at all times refrain from recommending or referring patients (residents) to any single agency, but since the owner or manager is not providing personal care services, the residents are free to choose whom ever they choose, and most if not all will choose the main contracted agency out of convenience and because they may be already familiar with the home health agency staff that frequent the building delivering care to their fellow residents.

Finally, the ownership or management of the community can not receive any payments from the agency that takes into account the volume or value of any referrals or business generated between the parties for which the payment may be made in whole or in part by Medicare or a state funded health program. Also, ownership and management should avoid the creation of a supplemental staffing company and billing the home health agency for the nurse and home health aide who provide the Medicare services. This is also viewed by Medicare as an abuse of the system and considered an inducement for referrals. However, occasional use of specific subcontracting services can be allowable. The community can provide office space for a Medicare home health agency as long as it charges the agency a reasonable and customary rate per square foot.

By contracting out the personal care component of the service package, the community relinquishes any operating margins that could be reasonably expected through the delivery of these services with its own staff. Under most circumstances, the delivery of personal care services by a community's own employees is more efficient than if accomplished through a home health agency, producing a 70-80% margin in loaded costs. Another disadvantage of this home health option is realized after the community has been open and the resident acuity profile increases to become predominantly skilled. It then becomes difficult for the community to attract residents other than those who are nursing home candidates, thereby limiting its marketability.

Service Levels Option

Most assisted living communities include some level of personal care in their basic monthly service package. The amount of this service can range from 30 to 90 minutes per day of assistance with activities of daily living (ADL's) with the overall average for most communities about 45 minutes. For most residents this amount of service works well, and for those who need extra personal care, the community can provide it more economically than an outside agency. Be aware that some home health agencies will seek to provide private services which are not reimbursed by Medicare and bill the resident separately.

Personal care services normally include bathing, dressing, escort or tray delivery, medication reminders, additional housekeeping, personal laundry, dementia support, orientation and cueing, grooming, scheduled toileting, and safety checks. Upon admission residents are assessed of

their personal care needs and a personal care service plan is created. They are reevaluated periodically as their needs change and assigned to a service level. These are often referred to as level 1,2,3, etc. or basic, intermediate, enhanced, comprehensive or other such progressively higher level of care description. Most often premiums for each higher level of service are based upon additional personal care time required per day by the resident, translated to a monthly rate. For example, an assisted living community that includes 45 minutes per day of personal care in the basic monthly service package may charge an additional $120 per month for their intermediate level which provides up to 60 minutes per day ($16.00 per hour aide cost divided by 4 = $4.00 per 15 minute increment x 30 days per month = $120.00). This can continue for each 15 minute increment to $240 additional per month for 60 minutes, $360 additional for 75 minutes and so forth. Any significant change in a resident status which requires an increase in care on a long term basis, or significant increase in care on a short term basis triggers a service plan review with the resident and family.

While this system works fine for residents who normally utilize 45 minutes per day of personal care or less, some providers have found that it can be difficult to convince families and residents that they need to move up to the next service level and incur the additional expense. They will often attempt to convince you that the need for additional services is because they are suffering from a temporary set back and that there is no need to adjust the rate. Also, many residents will have a tendency to request escort service or demand to be catered to personally that never gets accounted for by management to trigger a service plan review. In addition, because the monthly service fee is adjusted with increasing levels of service, a service plan review that comes at the same time as a lease renewal and normal rent increase can be a tough sell to the resident and family.

Staffing the service level option can also bring challenges as it is difficult to quantify exactly the number of service hours per shift actually delivered to the residents. Personal care aides are constantly being pulled in many different directions to service residents on demand. Management will find that some basic level residents will require more care on an intermittent basis and higher service level residents are always demanding special attention because they are paying more.

POINT SYSTEM OPTION (ADL ACUITY GUIDE)

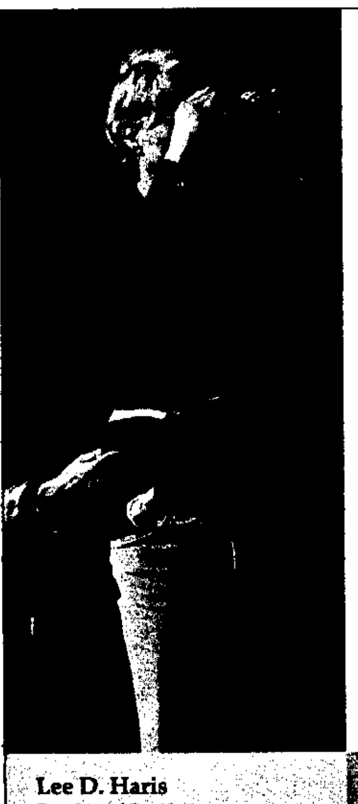
The point system is normally determined by a baseline assessment tool used to classify each resident's needs. A numerical score is determined based upon progressively higher levels of staff intervention each assigned a point value, usually 1-5. The higher the point value, the higher the acuity level. The final score is derived by adding the acuity points from each service category then dividing by the number of categories, usually ten. For example:

Category: Bathing and Dressing

1 Point: Independent in bathing and dressing.
2 Points: Requires assistance only in transferring into and out of bath, and can bathe self.
3 Points: Requires assistance in bathing and dressing but does most of the work.
4 Points: Requires considerable assistance with bathing and dressing.
5 Points: Completely dependent upon staff for bathing and dressing.

Resident acuity scores for all categories are added together and averaged. Each acuity level is generally assigned an additional monthly fee such as $200 or $300. Acuity levels of 4 or 5 can demonstrate a need for nursing home care and trigger discharge planning. Assessments are conducted upon admission and periodically thereafter on a scheduled basis. If the personal care director waits until an obvious reassessment is

Continued on page 18



Potential new residents are looking for you.

Over 40,000 families searched **LivOn** in just a few months, looking for senior housing like yours. We've built a powerful highway to new resident referrals so easy-to-use, you don't even need a computer. For $1.00* a month per facility, you'll receive:

- instant referrals by fax, mail, or e-mail
- features, photos, and floorplans online
- pre-screened, nationwide referrals
- no per-referral or hidden charges
- referrals direct to onsite managers
- summaries to operations directors and regional managers

*Good through August 31, 1998

Call (800) 525-6845 or visit www.livon.com
to sign up today.

Lee D. Haris
Founder and President

2Be discovered, you need 2Be accessible . . . You need 2BeMA Network Inc.

(415) 989-5372 e-mail: info@2bema.com

LivOn is a division of
2BeMA Network Inc.
Offices in San Francisco, Baltimore, Boise, Boston, Charleston, Chicago, Columbus, Dallas, Portland, Salt Lake City, Seattle, Tampa, Beijing, and London, plus over 40 state brokerage licenses nationwide.

ACUITY BASED DELIVERY
CONTINUED FROM PAGE 14

needed, chances are that the personal care aides are already providing the higher levels of service without recovery of additional costs. Consequently significant amounts of care are given away and the staffing of the unit is always short.

Like the service level option, the point system leaves significant room for interpretation. Residents and family will contend that the point system is based upon conjecture and can vary widely from one week to the next depending on how the resident may be feeling. Management needs to constantly stay on top of regularly scheduled assessments for every resident and resell the increase in fee structure many times throughout the lease term. In addition, the time to perform activities of daily living can vary widely between residents. One resident may require 20 minutes to bathe and get dressed for breakfast, while their neighbor will need 45 minutes to accomplish the same task with assistance. There is simply no way to directly correlate nursing time expended to each resident and fully recover the cost to deliver that care.

ACTUAL CARE OPTION

Under this system, residents are allocated a daily time limit such as 45 minutes included in their monthly service fee, and any additional care is billed in arrears for the actual care delivered. Upon admission, residents are assessed and a personal service (care) plan is developed. The service plan measures the amount of personal care the resident needs in a seven day period, normally Sunday through Saturday. The plan itemizes each daily assignment such as bathing, dressing, daily housekeeping, personal laundry, dementia support, daily orientation and cueing, grooming, and other recurrent activities such as scheduled toileting, breakfast, lunch, or dinner escort or tray, and morning, noon, or night medication reminders.

An initial seven day time study is performed by the personal care aides assigned to the resident which serves as the foundation of the service plan. The total number of minutes are added up for the week and if the total exceeds 315 minutes per week (45 minutes per day for seven days), the excess is billed to the resident's account each month separately in arrears for actual service delivered. The time study is only repeated for this resident if one or more of the following exist: 1) the resident returns back from the hospital after a short stay; 2) the resident's physician alters the resident's major medication or treatment regime; 3) the resident's overall personal care needs either increase or decrease; or 4) the resident experiences a cognitive decline. If any of these conditions exist, a care conference is called between the personal care director, personal care aides, family, and physician, if appropriate, to update the personal service plan. Normally personal care assistants account for every minute of their day during the time study as the tool can also be used to monitor performance. This way all possible interactions between personal care assistants and their residents are documented.

Another time study is completed on the revised service plan as the services are delivered the first week. The total time which exceeds the allotment in the monthly service fee is then billed separately, for example at 35 cents per minute ($21.00 per hour). This system is very beneficial to the resident and families because it allows for the fact that certain days a resident may need over 45 minutes of service (such as days when assistance in bathing is required) and on others the service needed is considerably less. This way, the resident is only charged for the care that exceeds 315 minutes per week even if they need one hour or more on any given day.

Delivery times for the same service will vary widely between residents. This system allows management to recover the actual cost for actual time of service delivered rather than a flat fee for bathing as in the service levels option discussed above. Also, upon completion of all time studies, management has a very accurate tally of the total staff hours actually required to deliver services to the resident so that the most efficient level of staffing can be scheduled or budgeted. Also, an accurate tally of the total service time by category can be an effective method to quantify the overall acuity of the resident population.

Each personal care assistant is assigned specific residents and has a daily schedule transposed from the weekly service plan. The daily schedule will include the time of delivery, apartment number, resident name, assignment detail with check-off boxes, and minutes allocated to perform the service. This way the personal care assistant's entire day is fully scheduled and they are expected to complete their assignments before clocking out. Under this system, it is not unusual to reach 90 percent efficiency in service delivery. Schedules do have some flexibility to allow for unscheduled service and personal attention, but overall, it is very efficient. Some companies have developed this system into a science using personal computers to develop the personal service plan, schedule each resident, assign a staff person to the residents, generate a billing statement, personal information sheet, medication record, and acuity report. Programs such as these can also be used to optimize staffing and manage the overall profitability of the ancillary care delivery system.

Upon completion of the time study, a daily schedule is completed for the week which documents the actual time needed to deliver each service that the resident requires. The actual service times and additional billing amount are discussed with the family or resident paving the way for consensus. By reviewing the service plan and approving it in advance, management can reach consensus before the billing statement is received. If the family feels that the additional billing amount is objectionable, then management can ask which services that they would like to be deleted from the plan and the implications of such actions. If the family has been involved in the care planning process from admission to discharge, they should be

Continued on page 19

Managing to Survive...
Continued from page 11

as a strong subacute rehab product with the goal of creating a more complete continuum and expanding our market. With respect to occupancy levels it appears that things are leveling off with occupancy of nursing beds stabilizing at 88% to 90% while converted, residential care bed occupancies exceed 95%. Those facilities that have converted some nursing beds to residential care are averaging overall occupancy levels of around 90% to 92%. Many facilities that have not converted beds are still experiencing average occupancy as low as 80% to 85%.

A challenge for Maine going forward is addressing the need for more affordable assisted living options for those who do not qualify for Medicaid, but also do not have the resources to afford the private pay assisted living and retirement communities in Maine.

SPECTRUM: So, "as Maine goes, so goes the Nation" is a saying that still has meaning for the senior living industry.

SRHS: No doubt. ■

David Wilderman is vice president at Love Funding Corporation's Jacksonville, Florida office and specializes in financing for senior housing and healthcare properties. He is also Chair of NASLIE's Editorial Board. He may be reached at 904-355-9697 or at DBWilde@aol.com.

[1]{source: 'Across the States 1996' by Public Policy Institute of AARP, originally from 'Nursing Home Yearbook, 1995' as extracted from HCFA's OSCAR database.}.
[2]Ibid.

Acuity Based Delivery
Continued from page 18

prepared to understand their options and the cost of alternatives rationally. ■

Benjamin Pearce is Senior Vice President of Genesis ElderCare Network Services. Over the past 15 years he has overseen the operations and marketing of 80 senior living communities in 23 states. His book, entitled Senior Living Communities: Operations Management and Marketing for Assisted Living, Congregate and Continuing Care Retirement Communities *currently being published by Johns Hopkins University Press, is due out this fall. Pearce may be reached at 610-444-6350.*

[i]The Assisted Living Marketplace. A Report to Ciba-Geigy Corporation. Marketing Solutions, March 22, 1995.
[ii]U.S. Department of Health and Human Services. "Functional Status of the Noninstitutionalized Elderly: Estimates of ADL and IADL Difficulties," J. Leon and T. Lair. Publication No. PHS-90-3462 (June 1990).
[iii]Clemmer, E. Assisted Living and its Implications for Long Term Care. AARP DEC 1994, pg. 1-15.
[iv]*Overview of the Assisted Living Industry*: 1996. Assisted Living Federation of America publication. Coopers & Lybrand L.L.P., 1996.

Just Because There's Snow On The Roof Doesn't Mean The Fire's Out In The Furnace.

It may be an old saying, but it's a new way of looking at assisted living. At Resources for Senior Living, we recognize that it's not the "same old business." Today's seniors are living longer, fuller, younger lives, and we're here to offer those in the Charlotte area a refreshing selection of assisted living and special care residences.

THE LAURELS is our assisted living residence with locations in The Village At Carolina Place and at Highland Creek. You'll find 98 one-bedroom, alcove and studio apartments arranged in individual "neighborhoods," each with its own parlor, laundry room and staff station. You'll also find all the amenities you would expect from a premier community. Such as a lovely dining room, glassed veranda and courtyard as well as a living room with fireplace and baby grand piano. An ice cream shoppe, hair salon and staffed activities room round out this wealth of features. An individual plan of care, based on a thorough assessment, is provided to each resident.

THE HAVEN, our special care residence, in The Village At Carolina Place, is designed specifically for those with Alzheimer's or dementia-related disorders. We haven't forgotten the details that best bring comfort and freedom to these residents. Thoughtfully designed neighborhoods, familiar sights, secured courtyards and walking paths stimulate memory. Each resident is individually assessed and receives a care plan specific to their needs. Our advanced approach truly marks a new era in helping those with dementia live more fully. We pledge that each and every resident will be cared for with the utmost dignity as an individual whose character and distinctive qualities have been forged over a lifetime.

Call us at 704-372-4228 for more information on any of our communities. We think you'll be glad you did. Because it's nice to have someone really care for you.

Developed and Managed by Resources for Senior Living.

ACCOUNTING FOR PERSONAL CARE

These needed services can make or break the assisted living community financially. A review of the options.

BY BENJAMIN PEARCE

As the assisted living business has grown and matured, the complexity of its service delivery and billing methods has also evolved. While there is a wide array of service delivery methods employed by assisted living communities, most derive from one of four basic methods, each with its own advantages and disadvantages:

1) Home Health Option

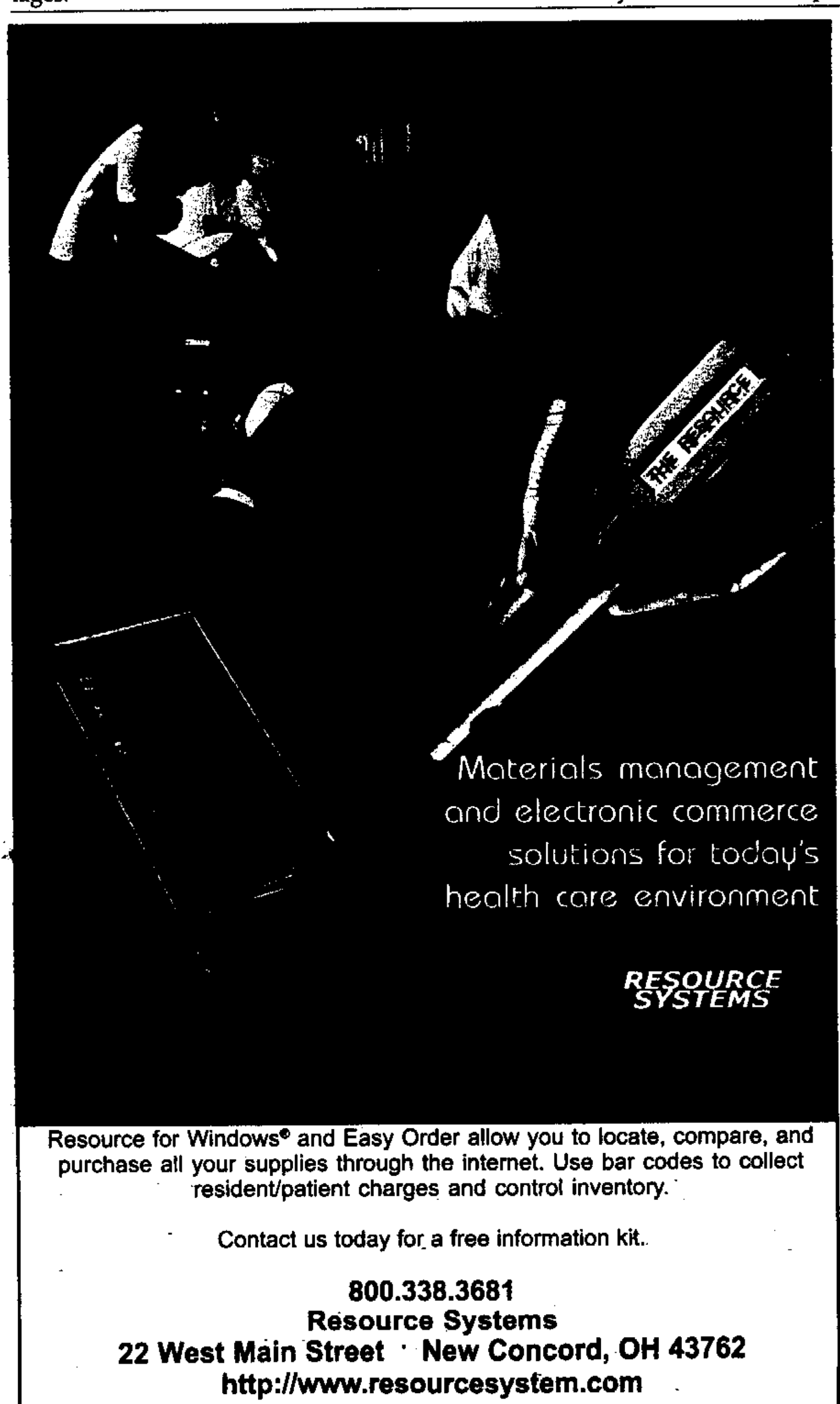
This segregates the basic service package from the personal care component. The developer or manager provides the basic service package, such as meal service, housekeeping, maintenance, laundry, activities and transportation, and subcontracts out the personal care component through a Medicare-certified home health agency. This allows the residents of the community to have access to personal care services and permits them to use their purchasing power as a community. This option is naturally attractive to home health agencies, because they can deliver a wide array of services, many of which are Medicare-reimbursable, to a captive audience, without the expense and inconvenience of travel time.

The home health option enables the community to deliver a much higher level of care than would be possible under assisted living regulations in most states. This is because the residents are contracting with the home health agency for this care. It is not delivered by the management of the community directly as a component of the community service package included in the monthly service fee.

The involvement of a Medicare-certified home health agency can benefit both residents and ownership. Residents can utilize Medicare benefits that they would perhaps otherwise be paying for separately, potentially relieving those residents who may be experiencing financial pressure as their healthcare needs accelerate. Meanwhile, the community can benefit from reduced turnover, stabilization of the assisted living population, avoidance of nursing care transfers, control of the continuity of care and differential billing structures.

This concept is very attractive to owners looking to defray expensive nursing costs, particularly during the ramp-up period, until stabilized occupancy is reached. During the start-up phase of the operation, occupancy is continually changing, which makes it difficult for management to optimize staffing at the most efficient level. Also, by contracting with a single Medicare-certified home health agency, owners and managers can have some influence and control over the personal care service delivery.

Without this arrangement, an assisted living community will be subject to the risks of having many different home health agencies delivering Medicare services to its residents with little or no control by management over the quality of these services or qualifications of personnel. This has medicolegal implications, as well, because if a medication error or resident abuse incident occurs at the hands of a home health staff person, the community may be exposed to the resulting liability and inevitable bad public relations. In one East Coast assisted living community, no less than 15 different home health agencies were delivering services to its residents, creating a real vulnerability for the community in terms of control



For more information Circle 15 on Reader Service Card

and quality assurance.

On the downside, by contracting out the personal care component of the service package, the community relinquishes any operating margins that could be reasonably expected through the delivery of these services with its own staff. Under most circumstances, the delivery of personal care services by a community's own employees is more efficient than if accomplished through a home health agency. Efficiently operated, a personal care delivery component offered by the assisted living community with its own staffing should produce a 70 to 80% margin in loaded costs. Obviously, state licensure requirements must be observed—they vary from state to state—and operators should take care not to exceed them.

Another disadvantage of this home health option is realized after the community has been open and the resident acuity profile increases to become predominantly skilled. It then becomes difficult for the community to attract residents other than nursing home candidates, thereby limiting its marketability.

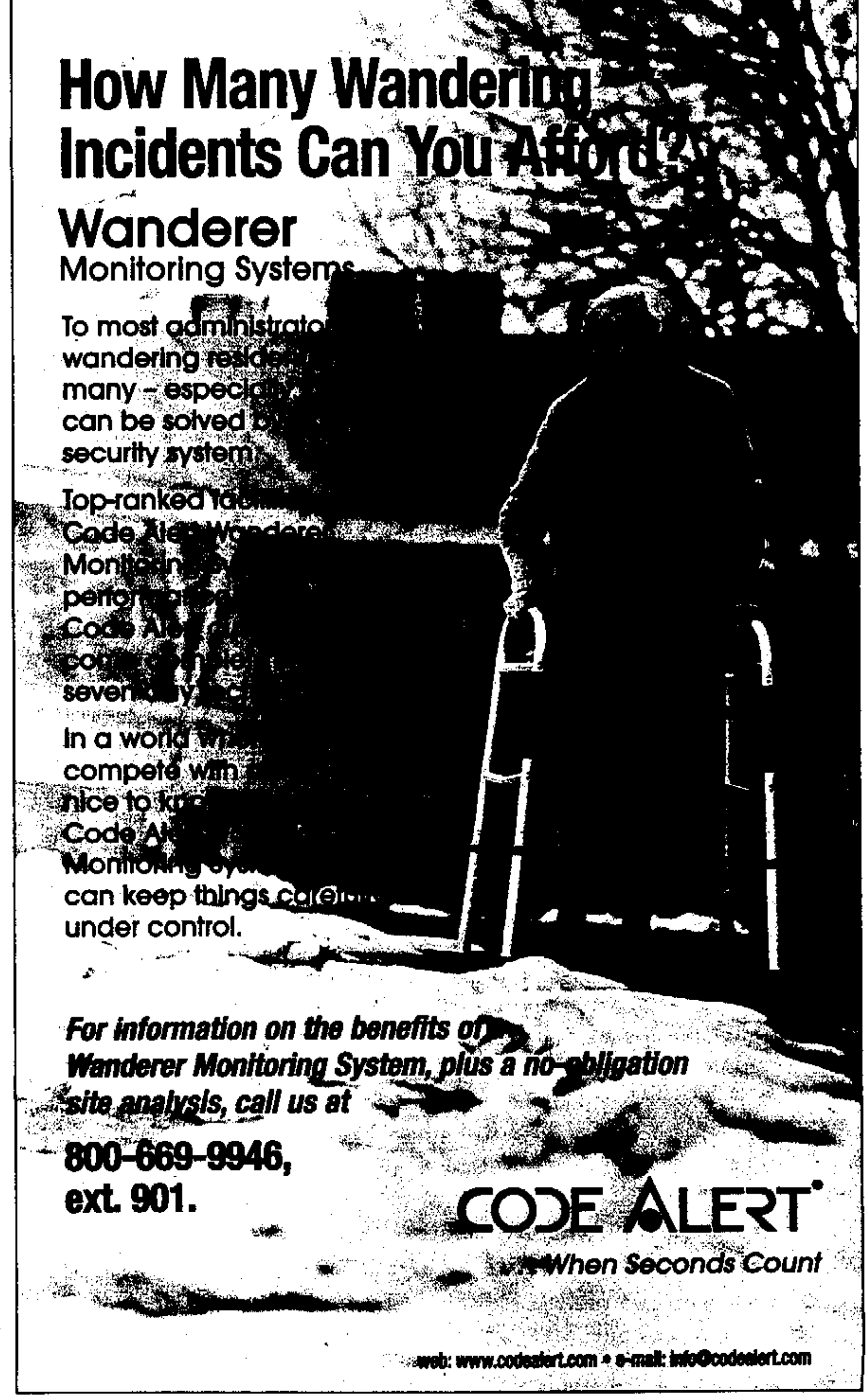
2) Service Levels Option

Most assisted living communities include some level of personal care in their basic monthly service package. The amount of this service can range from 30 to 90 minutes of assistance per day with activities of daily living (ADLs), with an overall average for most communities of about 45 minutes. For most residents, this amount of service works well, and for those who need extra personal care, the community can provide it more economically than an outside agency. Be aware, too, that some home health agencies will seek to provide private services that are not reimbursed by Medicare and bill the resident separately.

Personal care services normally include bathing, dressing, escort service, tray delivery, medication reminders, additional housekeeping, personal laundry, dementia support, orientation and cueing, grooming, scheduled toileting and safety checks. Upon admission, residents' personal care needs are assessed and a personal care service plan is created to deliver those services. Under the service level program, residents are reevaluated periodically as their needs change and assigned to a different service level if necessary. These levels are often referred to as level 1, 2, 3, etc., or by progressive terms such as basic, intermediate, enhanced and comprehensive.

Usually premiums for each higher level of service are based upon additional personal care time required per day by the resident, translated to a monthly rate. For example, an assisted living community that includes 45 minutes per day of personal care in the basic monthly service package may charge an additional $120 per month for their intermediate level, which provides up to 60 minutes per day ($16 per hour aide cost divided by 4 = $4 per 15-minute increment x 30 days per month = $120). This can continue for each 15-minute increment to $240 additional per month for 75 minutes, $360 additional for 90 minutes, and so forth. Any significant change in resident status that requires an increase in care on a long-term basis, or significant increase on a short-term basis, triggers a service plan review with the resident and family.

While this system works fine for residents who normally utilize 45 minutes



For more information Circle 17 on Reader Service Card

per day of personal care or less, some providers have found that it can be extremely difficult to convince families and residents that they need to move up to the next service level and incur the additional expense. Residents and families will often attempt to convince management that their need for additional services is due to a *temporary* setback and therefore no rate adjustment is justified. Many residents will have a tendency to request escort service or to be catered to personally in ways that never get accounted for to trigger a service plan review. As a final negative factor, because the monthly service fee is adjusted with increasing levels of service, a service plan review that comes at the same time as a lease renewal and normal rent increase can prove to be a very tough sell.

Staffing the service level option can also bring challenges, as it is difficult to quantify exactly the number of service hours per shift actually delivered. Personal care aides are constantly being pulled in many different directions to service residents on demand. Management will find that some basic level residents will require more care on an intermittent basis, while higher service level residents continually demand special attention because they are paying more.

The health care industry is subject to an extremely high rate of back and shoulder injuries - mostly caused by patient transfers.

We have the solution.

Our Back Injury Prevention Program

Incorporating in-service training and education, program support and follow-up, we help protect care givers and residents from injuries during lifting, transferring and repositioning.

FAABORG LIFTS

No-obligation trials/demonstrations

- Are state of the art, Danish-designed resident transfer systems
- Are CE certified and modular in design
- Provide safe, comfortable transfers for patients
- Are easy for care givers to use and maneuver
- Offer a wide selection of systems - including our AMERICAN Lift which can handle capacities to 550 lbs.
- Are the most reliable and come with the longest warranty in the business
- Are supported by a knowledgeable customer service and technical staff
- Are introduced with our ... T MOVE
- Are **guaranteed** to reduce injuries and claims
- Help ensure **OSHA** compliance

MOVING Solutions inc.

Patient Handling & Transfer Systems

Phone: 800-228-7980 Fax: 630-963-9588

For more information **Circle 18** on Reader Service Card

3) Point System Option (ADL Acuity Guide)

The point system is normally determined by a baseline assessment tool used to classify each resident's needs. A numerical score is determined based upon progressively higher levels of staff intervention, each assigned a point value, usually 1-5. The higher the point value, the higher the acuity level. The final score is derived by adding the acuity points from each service category, then dividing by the number of categories, usually 10. Thus:

Category: Bathing and Dressing

1 Point: Independent in bathing and dressing.

2 Points: Requires assistance only in transferring into and out of bath, and can bathe self.

3 Points: Requires assistance in bathing and dressing but does most of the work.

4 Points: Requires considerable assistance with bathing and dressing.

5 Points: Completely dependent upon staff for bathing and dressing.

Resident acuity scores for all categories are added together and averaged. Each acuity level is generally assigned an additional monthly fee, such as $200 or $300. Acuity levels of 4 or 5 can demonstrate a need for nursing home care and trigger discharge planning. Assessments are conducted upon admission and periodically thereafter on a *scheduled* basis. If the personal care director waits until an obvious reassessment is needed, chances are that the personal care aides are already providing the higher levels of service without recovery of the additional costs. Consequently, significant amounts of care are "given away," and the staffing of the unit is always short.

Like the service level option, the point system leaves significant room for interpretation. Residents and family will contend that the point system is based upon conjecture and can vary widely from week to week, depending on how the resident

may be feeling. Management needs to constantly stay on top of regularly scheduled assessments for *every* resident and resell the increase in fee structure many times throughout the lease term. In addition, the time needed for performing activities of daily living can vary widely among residents. One resident may require 20 minutes to bathe and get dressed for breakfast, while another will need 45 minutes to do all this with assistance. There is simply no way to directly correlate nursing time expended to each resident and fully recover the cost.

4) Actual Care Option

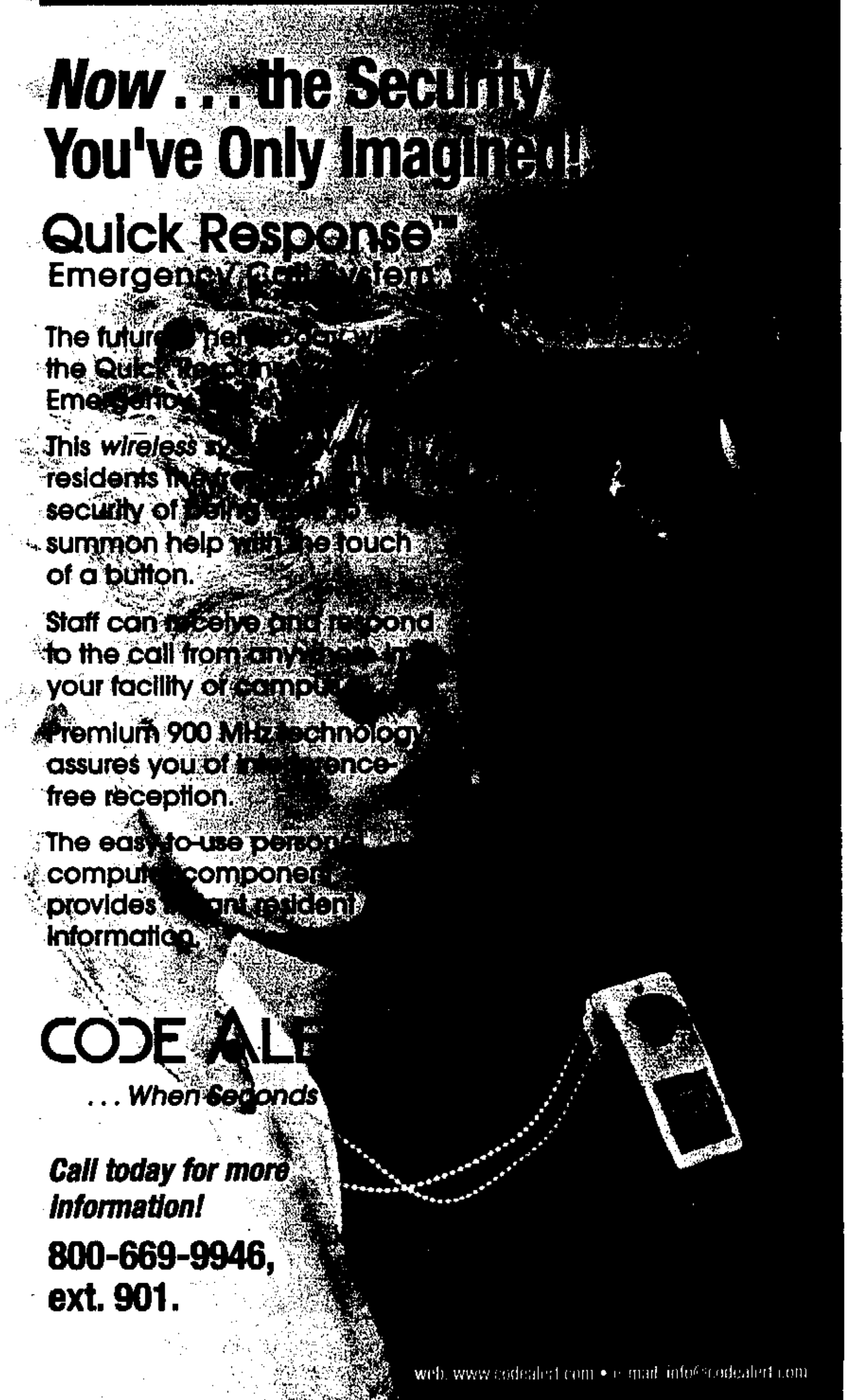
Under this system, residents are allocated a daily time limit for personal care, such as 45 minutes, included in their monthly service fee; any additional care is billed in arrears for the actual care delivered. Upon admission, residents are assessed and a personal service (care) plan is developed. The service plan measures the amount of personal care the resident needs during a seven-day period, normally Sunday through Saturday. The plan itemizes each daily assignment such as bathing, dressing, daily housekeeping, personal laundry, dementia support, daily orientation and cueing, and grooming; it also includes other recurrent activities such as scheduled toileting, escort or tray service for breakfast, lunch or dinner; and morning, noon or night medication reminders.

An initial seven-day time study is performed by the personal care aides assigned to the resident. The total number of minutes are added up for the week and, if the total exceeds 315 minutes per week (45 minutes per day for seven days), the excess is billed separately to the resident's account each month. The time study is repeated for this resident only if one or more of the following apply: 1) the resident returns from the hospital after a short stay; 2) the resident's physician alters the resident's major medication or treatment regimen; 3) the resident's overall personal care needs either increase or decrease; or 4) the resident experiences a cognitive decline. If any of these exists, a care conference occurs involving the personal care director, aides, family and physician to update the personal service plan, if appropriate.

Another advantage: Personal care assistants normally account for every minute of their day during the time study, allowing this to also be used to monitor performance. In sum, all possible interactions between personal care assistants and residents are documented.

For a revised service plan, another time study is completed as the services are delivered during the first week. The total time that exceeds the allotment in the monthly service fee is then billed separately—for example, at 35 cents per minute ($21 per hour). This approach is very beneficial to the resident and families, because it allows for the fact that on certain days a resident may need more than 45 minutes of service (e.g., when assistance in bathing is required), while on other days of the week, the service needed is considerably less. Residents are charged only for the care that exceeds 315 minutes per week, even if they need one hour or more on any given day.

Because delivery times for the same service will vary widely among residents, this system allows management to recover the actual cost for actual time of



For more information Circle 19 on Reader Service Card

service delivered rather than, say, a flat fee for bathing (as in the service levels option discussed above). Also, upon completion of all time studies, management has an accurate tally of the total staff hours actually required to deliver services so that the most efficient level of staffing can be scheduled or budgeted. An accurate tally of the total service time by category can also be an effective method to quantify the overall acuity of the community's resident population.

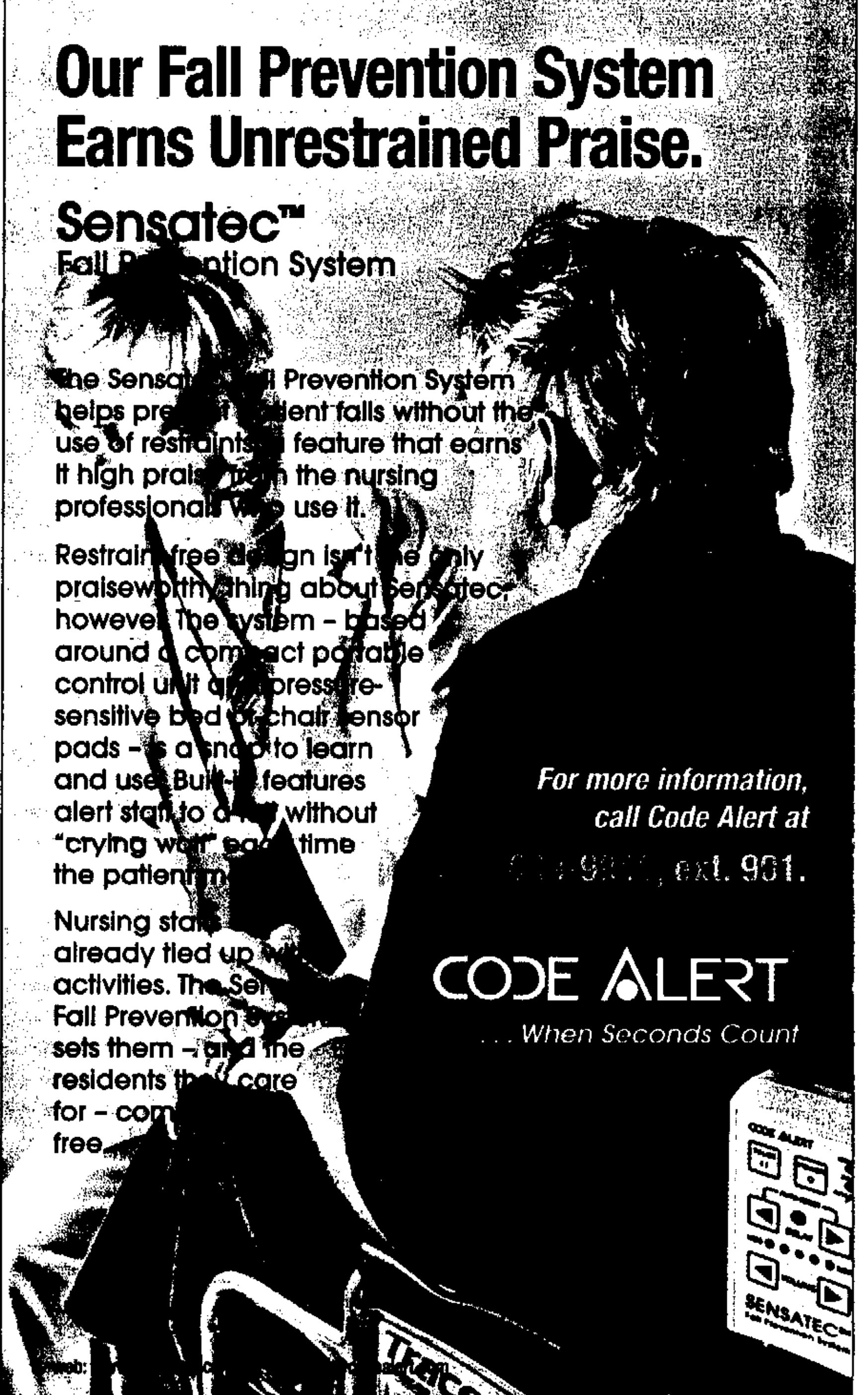
Under this approach, each personal care assistant is assigned specific residents and has a daily schedule transposed from the weekly service plan. This will include the time of delivery, apartment number, resident name, assignment detail with check-off boxes, and minutes allocated to perform the service. This way, the personal care assistant's entire day is scheduled, and the assistants are expected to complete their assignments before clocking out.

It is not unusual for this approach to reach 90% efficiency in service delivery. Some companies have developed this system into a science, using personal computers to develop the personal service plan, schedule each resident, assign a staff person to the residents and generate a billing statement, personal information sheet, medication record and acuity report. Programs such as these can also be used to optimize staffing and manage the overall profitability of the ancillary care delivery system.

Importantly, the actual service times and additional billing amount based on the time study are discussed with the family or resident, thus paving the way for consensus before the billing statement is received. If the resident or family feels that the additional billing amount is objectionable, then management can ask them which services they would like to be deleted from the plan and discuss the implications of this. If the family has been involved in the care planning process from admission to discharge, they should be prepared to understand their options and the cost of alternatives.

Management of staff cost is as important in assisted living as it is in home health care. A home health agency would not remain in business very long supporting staff that did not have billable hours. The personal care department must be operated as if it were a separate home health agency, so that all minutes of staff time scheduled are either billable or attributable to and covered by the monthly service fee. Whether the care delivered in the assisted living community is included in the monthly service fee or is billed additionally, it all counts and must be balanced against the total revenue recoverable from residents. Any margin of profitability can be very quickly erased with inefficient management and utilization of unaccounted-for in-house staff time. **NH**

Benjamin Pearce is the senior vice-president of operations for A•D•S Senior Housing, Newton, MA. He serves on the Board of Directors of the Assisted Living Federation of America, Massachusetts Assisted Living Facilities Association and the National Association for Senior Living Industries. Over the past 15 years, he has overseen operations and marketing for 69 senior living communities in 17 states. This article is adapted from his book *Operations Management and Marketing for Assisted Living, Congregate and Continuing Care Retirement Communities*, due shortly from Johns Hopkins University Press.



For more information **Circle 21** on Reader Service Card

Motivating Senior Living Employees

Motivation doesn't just happen because things are going well, it must be planned and managed. Motivated employees are more dependable, self confident, productive, satisfied, and team oriented. Most of all, the motivated employee stays in their job longer and ultimately delivers better care to the residents. Motivation is more than being nice to people, complementing them and creating a friendly work environment. Words of encouragement can stimulate employees to better performance, but never as much as responsibility and the opportunity to accomplish something personally. Motivation comes from giving employees continuing opportunities to learn more, to test their knowledge, and to gain a sense of achievement and recognition. In short, employees are motivated by responsibility, achievement, recognition, and opportunities for personal growth and advancement.

Dissatisfiers include money and benefits, working conditions, poor supervision, insecurity, policy and administration, lack of social relationships, and status. Financial compensation and benefits are expected, and while bonuses and commissions are effective for some, they do little to provide employees a sense of accomplishment and achievement. Also high performers may become dissatisfied and feel discriminated against as they compare their contributions to other less committed employees with similar compensation. Poor working conditions such as the physical environment or political climate of the work place can be a significant source of employee dissatisfaction. Adequate working conditions and user friendly "environmental" factors are basic expectations of most employees. Inadequate or incompetent supervision can also be a catalyst for employee dissatisfaction, as well as insecurity in the company or their position. In addition, managers who quote company policy or do not have a service orientated administration can frustrate and confuse employees looking for answers and reassurance. Employees don't want to be quoted the rule book, they want to be listened to and respected. Management that treats their employees with indifference and operates their community from behind closed office doors will create a sense of fear and intimidation. Further, employees are often dissatisfied when they are looked down upon by more senior level managers. It's hard to see things eye to eye when your looking down on someone. Finally, status and the use of power by management can be divisive, create dissension and break down the team.

By Benjamin W. Pearce

Employees who are rewarded for performance are more productive, more satisfied and more stable. Cash may be important, but cash has no memory element – it goes right into the bank or gets spent. Today's employees want more from their jobs. They want timely information, opportunities to solve problems and participate in decisions, and assurance that they will be recognized and rewarded for their contributions. Awards and recognition are something that they can share with their family, they will remember how they earned it, who sponsored it, and what business goal was met.

Employers should not overlook the many non-cash ways to motivate and reward their employees in addition to the job-based pay, job-evaluation systems. Most non-cash incentives fall into one or more of the following four categories: merchandise, travel, recognition and status. Merchandise and travel can fuel performance in the short term, but recognition and status builds an organization. The specific type of reward is less important to the employee than the significance employees place on management's interest in the recognition of its' employees. The focus should be in getting people energized and focused on what it takes to make the operation successful.

Non-cash rewards can be as powerful a motivator to increase performance levels as cash. Employee focus groups within retirement communities

across the country have confirmed this basic truth about staff motivation and retention. Provided salary ranges and benefits are competitive, the biggest motivator for employees is to be appreciated, recognized and treated with dignity. Categorically, employees are looking for management to do a better job of training first line supervisors to manage people, and the importance of management to set the right attitude towards staff from the top. Managers who recognize this teach their supervisors the lessons shown in the shaded box.

In his book entitled *1001 Ways to Reward Employees*, management specialist Bob Nelson explains that "employees find personal recognition more motivational than money. Yet, it is a rare manager who systematically makes the effort to simply thank employees for a job well done, let alone to do something more innovative to recognize accomplishments."[1] The primary reason why most managers do not more frequently reward and recognize employees is that they lack the time and creativity to come up with ways to do it.

Recognition flows down from the top of an organization and its source is self confidence. People feel empowered by recognition, it builds self esteem and confidence. Managers who look for opportunities to reward and recognize their staff will themselves be rewarded by employees who take pride in their work and believe that they have a stake in the operation's success. Equipped with this confidence managers will feel compelled to treat their employees similarly to the way they are treated by their supervisor. Empowering managers with confidence is like pouring water into a bucket from above. As the bucket fills it tends to overflow confidence down to waiting employees who also are seeking recognition. As their bucket fills, they become more confident and will start to take some ownership and assume some risk. This confidence in front line employees forms the very foundation for exceptional service to the residents. Confidence building is a continuous process. When the well runs dry up stream, blame often replaces recognition and mediocrity becomes the norm again.

Managers must be able to define what excellence looks like and communicate specific expectations to their staff designed to create it. Most employees want to do a good job and the better we can do as managers to show them what it looks like when it is well done, the better we equip them to work toward it. Walt Disney put it best when he said "You can dream, create, design and build the number one place in the world, but it takes people to make it happen." If there is not a big difference between what you offer and what your competition offers, there had better be a big difference in the way you treat people. ■

Motivating Employees

- Set-up a pro-active work environment and recognize employees for their strengths and have tolerance of their areas of vulnerability.
- Generate a sense of belonging and team spirit among the group to pull together and accomplish goals.
- Promote relationship building with residents and their families.
- Demonstrate that management is "hands-on" and not afraid to roll up their sleeves and participate in the work.
- Talk to employees, ask questions and listen.
- Discourage egos and turf building.
- Learn that everyone is responsible to make the operation run well. Managers who say "it's not my job"... might as well say "I quit."
- Keep their employees informed and involved in the overall operations of the community.
- Build self-esteem among their employees and empower them to step into "the decision making mode" to recognize problems and solve them as they arise on the spot. Create an atmosphere that encourages employees to take risks with little fear of retribution when mistakes are made.
- Respect employees' intelligence and opinions, and to seek out their ideas.
- Understand basic human problems and have a sensitivity towards all the emotional forces that motivate people.
- A common thread found among the most successful companies is laughter. Organizations which can create a level of urgency mixed with the right amount of humor learn to take themselves only seriously enough to get the job done. Companies which create an atmosphere where people enjoy their work and each other are far better positioned to be successful than their competitive task masters.

[1] Nelson, Bob. *1001 Ways to Reward Employees*. New York. Workman Publishing, 1994

Benjamin Pearce is the Senior Vice President of Operations for ADS Senior Housing. Mr. Pearce serves on the Board of Directors of the National Association for Senior Living Industries and the Assisted Living Federation of America. Over the past 15 years he has overseen the operations and marketing of 69 senior living communities in seventeen states. Pearce may be reached at (617) 332-5522

Reprinted from *Spectrum* Magazine
May / June 1997

The National Association for Senior Living Industries
4340 East West Highway, Suite 401
Bethesda, MD 20814-4411
(301) 718-6510 Fax: (301) 656-0989

Keeping

the Faith

When companies are in the midst of a merger, human resources may fall by the wayside. But keeping employees motivated during such times of transition is critical for optimal merger success.

By Benjamin W. Pearce and Farron D. Bernhardt

The effects of a merger go far beyond the details of the transaction, especially when it comes to human resources. During a merger, employee and resident anxiety are at an all-time high. Managing the inevitable changes associated with the merger should be as much a component of the deal as the transaction issues.

Keeping employees motivated and optimistic about the future is one of the biggest challenges organizations face as they merge. All employees at all levels should be kept informed about the transition, their new organization, and what they can expect. Senior management must embrace the new company and be agents of change, deliberately managing the change process as leaders in the organization.

Most of the merger details typically are closely held at the corporate office, which means employees get only sketchy information. This information vacuum creates a climate of fear, and the superficial information spread through the grapevine tends to be mostly negative in nature. It's normal for people on both sides of the merger to experience anxiety and speculation about changes in operation style or organization that may, in fact, be quite inaccurate.

Both companies should expect resistance from some employees. Encourage staff members to vent their concerns. This can open communication lines, dispel rumors, and actually build employee satisfaction and confidence in management. As retailer Marshall Field said: "Those who complain teach me how I may please others so that more will come. Only those hurt me who are displeased but do not complain. They refuse me permission to correct my errors and improve my service." Once you get issues out into the open, you're in a position to analyze them and work toward overcoming problems.

KEEP COMMUNICATION LINES OPEN

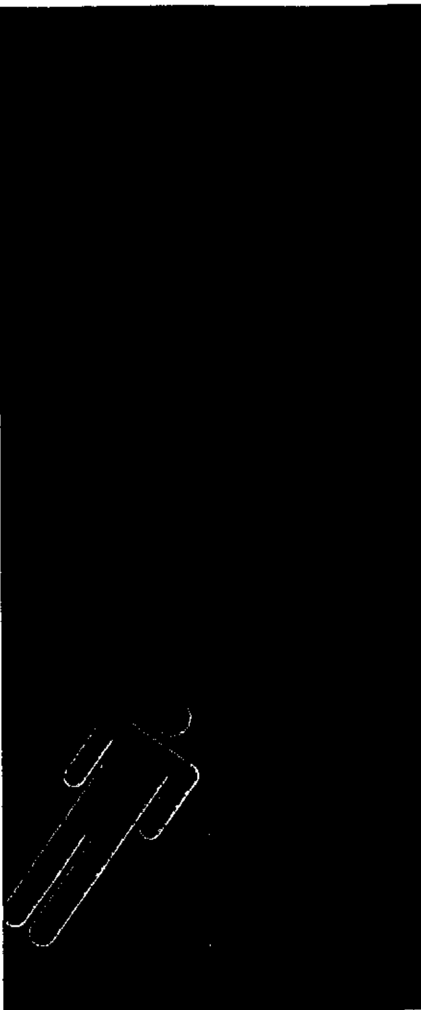
Before and during mergers, the rumor mill runs in high gear. Employees are hungrier than ever for answers and information, making them vulnerable to speculation and misinformation. This also is true of potential residents, referral sources in the community, and resident family members. Keep communication lines open, not only

ILLUSTRATION © 1999 DAVID WEISMAN/STOCK ILLUSTRATION SOURCE

with employees, but with residents and families as well. If people are equipped with accurate information, they are less likely to speculate and create false rumors.

By definition, a merger means to come together. To create consensus about any new idea, senior management must provide opportunities for employees to learn about the merger and communicate their concerns openly and honestly. Company leadership should make themselves available to listen to employee concerns and questions. It's easy to lose touch with employees during a transition stage when the focus is on the details of the transaction.

Hold monthly meetings with all executive directors and corporate management to provide managers the details they need to share with employees. In addition, a toll-free information line monitored by human resources professionals can help manage employees' expectatidns and fears, especially about their benefits.



Educate employees about the changes to be expected and the benefits of the transaction. By trusting your community-level management personnel with some of the details, you'll make them feel like a partner in the deal and position them to be agents of change. If the leaders at the community have signed on, the troops are sure to follow.

Be honest and communicate in words your service staff will understand, and don't underestimate their ability to influence the mood of the residents and their families. Caregivers and residents typically trust one another and confide their personal feelings with each other in real terms. Management should take advantage of these relationships and communicate with employees messages they want to send to the residents as well. Also, a question-and-answer flyer jointly distributed by the new company that addresses critical "me" issues, such as "Will I get to keep my job?" "How will my pay and benefits be affected?" and "Will we have new bosses?" can be helpful.

Managers will want some assurance of the parent organization's commitment to quality and protection of existing client relationships. The longer the company goes without closure on the "me" issues, the more likely its work groups will lose momentum. Focusing on what is best for the company is difficult when the "me" issues remain unresolved. Answer these questions expeditiously to avoid significant disruptions in operational performance.

To introduce the new company, its senior management, mission statement, achievements, and other successful acquisitions, consider publishing a transitional newsletter that can be distributed along with employee paychecks. Newsletter articles should serve to reassure all employees about the compatible philosophies of the two organizations, how the merger will strengthen both companies and improve their competitive position, and feature the new company's growth plans and success stories in the industry.

Bear in mind, employees will be suspicious of a sales pitch about the new company. Because they will expect some negatives, tell a balanced story. Employees deserve to know what they're getting into and it could help improve the credibility of management at a time when it is needed most.

RAISE THE BAR

In any transaction, people expect some change. They know life will be different, they anticipate it, and will more readily adapt than usual. Take advantage of this opportunity to identify changes already needed in the organization. Because they have a greater likelihood of successful implementation at this time, set aggressive short-term goals.

Staff members will reexamine their jobs, evaluate their careers, and be more open to changing their work habits. Grasp this opportunity to push employees harder and raise the bar. If everyone is busy reaching for new organizational goals, company operations and employee morale will improve. Employees will have less time on their hands to wait for change, speculating what it might bring and romanticizing about the past.

MOTIVATION MUST BE PLANNED

When they are motivated, people are better equipped to embrace change. Motivation doesn't just happen because things are going well; it must be planned and managed. Motivated employees are more dependable, self confident, productive, satisfied, and team oriented. Most of all, the motivated employee stays in the job longer and ultimately delivers better services to the residents.

But it's more than just being nice to employees, compli-

menting them, and creating a friendly work environment. Words of encouragement can stimulate employees to better performance but never as much as responsibility and the opportunity for personal accomplishment. Motivation comes from giving employees continuing opportunities to learn more, test their knowledge, and gain a sense of achievement and recognition. In short, employees are motivated by responsibility, achievement, recognition, and opportunities for personal growth and advancement.

The merger will shake people up; they will be looking for direction and will have new energy. Channel this energy into productive ways to improve performance and demonstrate to the new company owner the inherent value in what they have just purchased. Most companies that acquire others are so focused on the transaction, their due diligence activities, and the myriad details related to the closing that they spend little time strategically planning for how the combined resources of both companies will be organized and structured. Rather than worrying about the potential layoffs resulting from the consolidation and waiting for the boom to be lowered, management should actively focus attention on raising the bar.

Employees are a company's greatest asset. The front line is the bottom line. Any time a transaction is contemplated, an organization becomes vulnerable to approach by its competitors. Restless and jumpy, employees may be more willing than usual to consider job opportunities offered by other firms. The best employees will be the first to go, draining the organization of its best people at a time when it can least afford it.

The most capable people need to know where they stand and their own company should make the first move to re-recruit them. A merger is an opportunity for a company to express appreciation and loyalty to front-line employees. If done sincerely, the company will be rewarded with staff retention.

Mergers create two organizational groups: one ending and one beginning. It's a classic example of a group in transition, characterized by trust building, jockeying for position, resistance, conflict with leaders and others, feelings of anxiety and defensiveness, very little risk taking, suffering quality, clients and referral sources at risk, and increased job stress. All of these factors make a company vulnerable to losses in productivity and momentum. The more information managers can share with employees to help develop this new identity, the easier it will be to maintain group cohesion. The clearer the vision, the closer the goal.

Protecting human assets through motivation and communication is relatively simple. Most well-run companies enjoy employee loyalty, but lack of information about change makes everyone uneasy and unproductive.

Through careful planning, a merger can strengthen both organizations by capitalizing on the strengths of each when combining resources. By reducing the fear factor, both organizations ultimately will grow toward a common identity and remain productive throughout the transition.

Benjamin W. Pearce is senior vice president of senior living for Genesis Health Ventures and a faculty member of New York University Real Estate Institute. Pearce serves on the ALFA board of directors and is the author of Senior Living Communities: Operations Management and Marketing for Assisted Living, Congregate and Continuing Care Retirement Communities, *published by Johns Hopkins University Press. Farron D. Bernhardt is western divisional vice president of Atria Senior Quarters and a noted national speaker on operations management and marketing.*

Think Your Assisted Living Expertise Makes a Difference?

Prove It

The American College of Health Care Administrators knows that *management* makes the difference in resident care, quality outcomes and the bottomline. Consumers are more demanding and more knowledgable than ever before about the quality of care they should expect. They know that their safety, health and quality of life will be directly affected by the management of the assisted living facility they choose.

ACHCA has developed a certification program exclusively for experienced assisted living managers. The exam recognizes advanced knowledge and skill and has been developed by some of the most progressive leaders in assisted living — so they can prove to residents, employers and themselves that *they make the difference.*

Call ACHCA today and become a Certified Assisted Living Administrator (CALA).

Next Exam Dates:
February 21, 1998
20 locations nationwide

For more information call toll free 1 (888) 88-ACHCA

PREDICTIONS

From the Desk of Benjamin Pearce

The assisted-living industry continues to rapidly expand. This unbridled growth will continue as operators seek to capitalize on changes in the healthcare industry. The abundance of low-cost financing will continue to fuel this expansion. Wall Street has also discovered the assisted-living industry. With estimated annual revenues of $14 billion, the industry is expected to grow dramatically to $30 billion by the year 2000. Two years ago there was only one publicly traded assisted-living company; today there are 15. In 1996, assisted-living companies had raised 19 percent of the total amount of capital raised in the entire healthcare industry, compared to 6.9 percent in 1995 and less than 1 percent in 1994. The industry showed phenomenal growth in the past year with many top operators more than doubling their unit capacity. Companies that went public in 1996 generally used 1998 as their benchmark year for performance. During the next year—as actual results fall behind projections—the industry will experience considerable consolidation. This dramatic growth and development of the senior-housing business has introduced a number of participants who have learned the complicated task of delivering quality and consistent services to the elderly primarily by trial and error.

While many operators have successfully survived the learning curve, for others it has been an expensive and frequently disastrous attempt to capitalize on the growing demand for senior housing—notwithstanding the toll on seniors who bought into the dream and were later entangled in the developer's nightmare of financial difficulties.

As the number of assisted-living communities continues to expand, larger operators will find it very difficult to find experienced operators and managers to safely and efficiently deliver quality care to their residents. The industry is growing faster than managers can be trained to manage the new developments. At the same time, residents' healthcare needs will become increasingly complicated as they age in place. In the future, large companies—seeking to mitigate their healthcare risks and continue to develop communities in states where assisted-living licensing will become restricted—will develop strategic alliances with home-health providers. As the larger assisted-living companies continue to expand, they will see the profits on the delivery of the personal-care components erode as residents require more care. They will develop coordinated care agreements with home-health providers to subcontract the care component of the service package and also provide any Medicare home-health services to eligible residents. The home-health industry, still feeling the sting from federal Medicare cutbacks, will see the assisted-living community as a cost-effective base of operations.

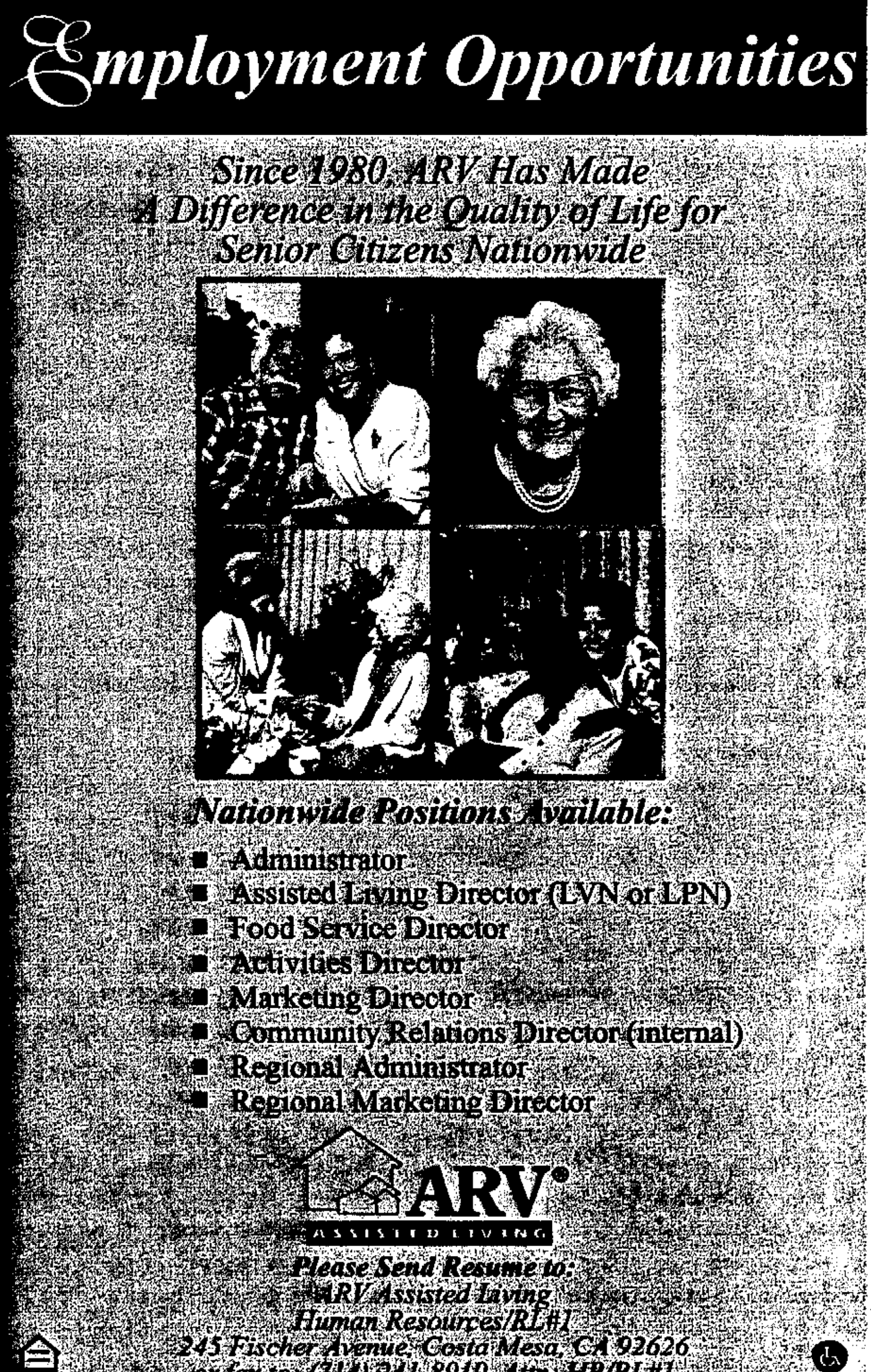
Controlling federal spending on Medicare's home-health benefit will require major changes in how home care is reimbursed. The home-health benefit is broadly defined, permitting large discretion in its interpretation.

Once approved, beneficiaries may receive an unlimited number of qualifying services so long as they are provided pursuant to the physician's plan of care. Physicians must review and re-sign the plan of care at least every 62 days. There are no limits on the number of days of care or visits, and beneficiaries currently pay no coinsurance or deductibles. Medicare pays home-health agencies the lower of their costs or a limit. The limits are established at 112 percent of the average cost per visit for fee-standing agencies. Some of the current initiatives that are being considered to control home-health costs include the introduction of beneficiary copayments, a case-mix adjusted prospective payment system (episodic rather than cost-based), and monthly limitations on per-visit payments. Each of these changes will, if implemented, place limits upon home-health utilization, and encourage seniors with chronic conditions to consider assisted living for these long-term needs. In addition, the use of personal-care services among the elderly tends to be intermittent in nature. They require the services at irregular intervals throughout their day. These services are more efficiently delivered in an assisted-living environment where staff is available when the services are required, rather than regularly scheduled through home-health care.

Strategic partnerships with hospital systems will play a critical role in fueling the continued expansion of assisted living. Medicare beneficiaries in managed-care plans will continue to grow at a rate of more than 30 percent per year. Medicare currently represents typically 40 percent or more of a hospital system's revenue base, and with this increasing penetration of Medicare-risk plans, hospitals will become more of a managing agent of low-cost healthcare through a continuum. Assisted living provides services in the middle of the continuum—between home care and acute-care settings—and can provide a cost-effective solution to reimbursement and utilization pressures within the managed-care continuum controlled by the hospital.

As managed care looks for high-quality, lower cost alternatives to home care and nursing-home care, the inclusion of assisted living within a hospital system's continuum will clearly enhance their attractiveness to managed-care payors. In addition, as assisted-living residents age-in-place, they will require an increasing amount of ancillary services such as therapies, pharmacy services and home care that will enable the hospital system to more fully utilize its affiliates and extend its services outside the acute care setting. This way, the system can maximize its revenue potential by controlling the market share across the continuum and retain its customer base as needs accelerate over time.

Joint ventures or other strategic alliances with existing private and public assisted-living providers can provide the management services while generating significant ancillary referrals to the hospital system. For the assisted-living provider, the affiliation with a local hospital system can significantly increase market acceptance within the community, while at the



same time take advantage of attractive financing options available to the hospital. For the hospital, this can be a very effective use of the hospital system's excess capital and property by completing the missing link in its healthcare continuum.

Development Opportunities

Future development of assisted living looks bright for a number of reasons:

1. Market-penetration rates required from age and income-qualified seniors for a typical project range from 1 percent to 4 percent. Demographic data should also be adjusted to include only single-occupant households, and exclude populations already institutionalized.

2. The assisted-living concept has been embraced by senior consumers and their families, as well as professional referral sources and legislators, as a cost-effective alternative for 15 percent to 20 percent of nursing-home residents who are primarily private-pay patients. It is estimated that 5.4 million people needed assisted living in 1995. Within a 10-year span, that number is expected to increase by 30 percent—to 7 million people—by the year 2005.

3. Assisted Living is a welcomed resource for adult children (ages 45-60) who are trying to deal with aging-parents needs. These people prefer the residential alternative of assisted living to skilled-nursing settings.

4. When adding to an existing campus, the concept draws upon many resources already in place and further amortizes existing fixed overhead. This revenue enhancer can add positive annual cash flow after debt service of $4,000-$7,000 per unit. It's also an effective response to aging in place to maintain the integrity of the independent section.

5. Assisted living can compete for the traditional private-pay nursing-home patients. The market is rapidly expanding as skilled-nursing facilities move toward sub-acute care and specialized care. The light-care private-pay segment will expand in the future, and well-positioned free-standing operators will take advantage of this. As a rule of thumb, the cost to provide assisted-living-care services to light-care patients is only about two-thirds of the cost of similar services provided in a skilled-nursing facility. In reality, assisted-living providers are delivering a need-driven product that can be adapted to the market. Nursing-home operators are confined by government mandates and higher costs.

6. The care of residents with dementia is growing and some providers may direct all of their resources into providing this care in the more cost-efficient setting of assisted living.

7. Current Medicaid funding is allocated 57 percent from the federal government and 43 percent from the states. This relationship could switch, which would force the states to enact legislation designed to expand the delivery of services to lower level of care arenas. Several states have already established moratoriums on the certificate of need process to halt the development of additional skilled-nursing beds.

8. As managed care becomes more wide spread, physician groups will increasingly control healthcare dollars. The Medicare risk programs will encourage physicians to look to assisted-living communities with respite or transitional care units for rehabilitative services.

9. Some community hospitals are paid a daily rate and an HMO controls the length of stay. Post surgery, the HMO encourages the physician to discharge the patient to a lower acuity setting for recovery and rehabilitation. Although there are significant variations in the spectrum of care provided in lower acuity settings, the common challenges of managing this care highlights the need for a "seamless delivery system."

10. Assisted living may provide opportunity for significant tax advantages if Internal Revenue Code Section 1034 Rollover and Section 121 Exclusion of Gain are amended to include these types of properties. In addition, the homebound elderly may also have financial incentives to move out of their homes due to changes in Medicare reimbursement and managed care. Currently 94 percent of America's elderly have their healthcare needs provided for at home.

Challenges and Risks

1. In most states, varying levels of assistance in daily living can currently be offered with limited levels of regulation. Projects likely to withstand the test of time include those that are well-conceived and backed by experienced "brand name" operators, those tightly integrated into continuum of care companies and those with a realistic exit strategy. Regulators do understand that the business is designed to promote cost containment and states are moving towards spending Medicaid dollars for the delivery of these services in the assisted-living arena. Therefore, they have a strong incentive to not overburden the industry with onerous regulations. However, as inexperienced operators make errors and expose their residents to serious risks, regulators may step in to define some minimum standard of care. Understanding these risks and responding responsibly through a process of trial and error may be a recipe for disaster.

2. Projects should be conceived and operated today in a manner that regulators might enforce in the future. It is likely that building codes will be adjusted to require steel construction on projects who expect to have non-ambulatory residents on second and third floors.

3. It will be risky to draw comparisons between the current demand for nursing-home beds and projected alternative demand for assisted living. This comparison will be misleading because as much as 50 percent to 70 percent of nursing care may involve Medicaid reimbursement. Assisted living is primarily a private-pay market. Many seniors in the service area may not be able to privately pay for assisted living.

4. New facilities always draw the most attention and even other residents of nursing homes and retirement communities. Reverse effects can also transpire with older developments. Also turn-over rates can be as high as 50 percent; marketing plans must be geared-up with this in mind.

5. The average price of assisted living is usually about 66 percent to 75 percent of prevailing nursing rates in the area. The maximum level of consumer affordability for private pay is typically 80 percent to 85 percent of cash flow disposable income applied to the monthly fee.

Financial Qualifications: Private Pay

Independent	$2,200 x 12 = $26,400
(@ 75%)	$26,400 x .75 = $35,200 per year
	or $2,933 per month
Assisted Living	$2,800 x 12 = $33,600
(@ 85%)	$33,600 x .85 = $39,529 per year
	or $3,294 per month

An independent resident leasing a unit for $2,200 per month would need to have an annual income of $35,000 to qualify. An assisted-living resident would need approximately $39,500 in annual income to qualify.

A long-term strategy in this business must be to keep development costs and overhead to a minimum and strike a balance between spending capital dollars and creating value perceived by the residents.

6. Concerns about the availability of funding for home care, which may ultimately act as a deterrent for people to leave their homes and move into a group residential setting. (Where costs can be more easily controlled with economics of scale.)

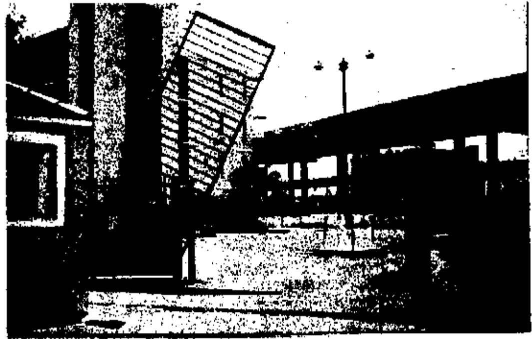
7. As competition increases in this rapid-growth environment, projects will find it difficult to maintain full occupancy. Profit margins that today average around 40 percent will be harder to achieve. Profit margins will parallel the downward trends already experienced by congregate operators. Steep price competition, the development of more affordable models, and the need to add more intensive services to serve residents will drive operating margins lower across the country. A report entitled *Selected Seniors Housing Transactions* recently published by the American Seniors Housing Association reports that average operating profit margins have generally decreased from a high of 55 percent in 1985 to 30 percent in 1993 with an overall average of 37 percent.

8. Nursing homes may bifarcate licenses to include assisted-living units within their skilled-nursing facilities, or convert partial or entire wings from level one to level five care.

Legislators, investors and lenders nationwide are headed in the most prudent and politically popular direction for elderly healthcare. We will clearly see a dramatic growth in the development of free-standing assisted-living facilities and home-health care over the next 10 years. Again, as inexperienced or under capitalized operators enter these developing arenas, future consolidation of this new wave of development can be predicted. While well-established, competent operators will surely benefit from this trend, lending institutions and investors have become more sophisticated in their underwriting criteria having already felt the sting of the consolidation in congregate developments during the 1980s. **RL**

Benjamin Pearce is the senior vice president of operations for A•D•S Senior Housing. He serves on the board of directors of the Assisted Living Federation of America, Massachusetts Assisted Living Facilities Association and the National Association for Senior Living Industries. Over the past 15 years, he has overseen the operations and marketing of 69 senior-living communities in 18 states. In addition, Mr. Pearce has authored a book, Senior Living Communities: Operations Management and Marketing for Assisted Living, Congregate and Continuing Care Retirement Communities, soon to be released by Johns Hopkins University Press.

Rising Above The Rest



The Vertical Lift Gate

Full operation during power outages

Opens and closes faster than traditional gates

Manufactured in any style

The Perfect Solution For Senior Housing Properties.

We invite you to call us for your nearest Dealer, and we also have a Video that demonstrates clearly the many advantages that a **Sun-Power Gate** has to offer.

Call us Today

Also see us on the internet at http://sun-power.com

(209) 722-3990

788 East Childs Avenue
Merced, CA 95340

Resident Satisfaction

by Ben Pearce

There are many ways to quantify the resident support of the management of the community. As with any business, word-of-mouth endorsements by your customers are your best advertisement. Residents will define quality as simply the difference between what they expect and what they get. If their expectations are exceeded (or even just met), they will represent your community as a quality operation. Conversely, if you are unable to meet their expectations, or under deliver on your promises, they will not recommend your community to friends and can even become hostile.

New residents will often walk into senior living communities with negative expectations. Those with little prior exposure to these communities will expect them to be restrictive, cold, and institutional. It is important for staff to be trained to recognize the forces that shape resident expectations. Some communities even go so far as to provide sensitivity training in gerontology to equip employees at all levels to understand the aging process and to develop a sensitivity towards the emotional forces at work in their residents.

Exceeding expectations is often simply a matter of doing little things properly. Communities who insure that all employees are service oriented and empower them to handle small problems for residents as they arise on the spot will often exceed the resident's expectations.

The average length of stay today in an assisted living community is about 2.2 years. During this time the average resident paying $3,000 in monthly service fees represents an asset to the community of approximately $80,000, not including a community fee. For an independent living community, whose average resident will stay 5.5 years, a $2,000 monthly fee represents a $132,000 asset. All of a sudden the value of rewarding the employee's initiative on the resident's behalf becomes crystal clear to management. To estimate your average length of stay, first calculate your number of move-outs for the year divided by the average number of occupied units to get a percentage turn over. Then divide this number into 1 for the average stay in years.

Exceeding expectations is often simply a matter of doing little things properly.

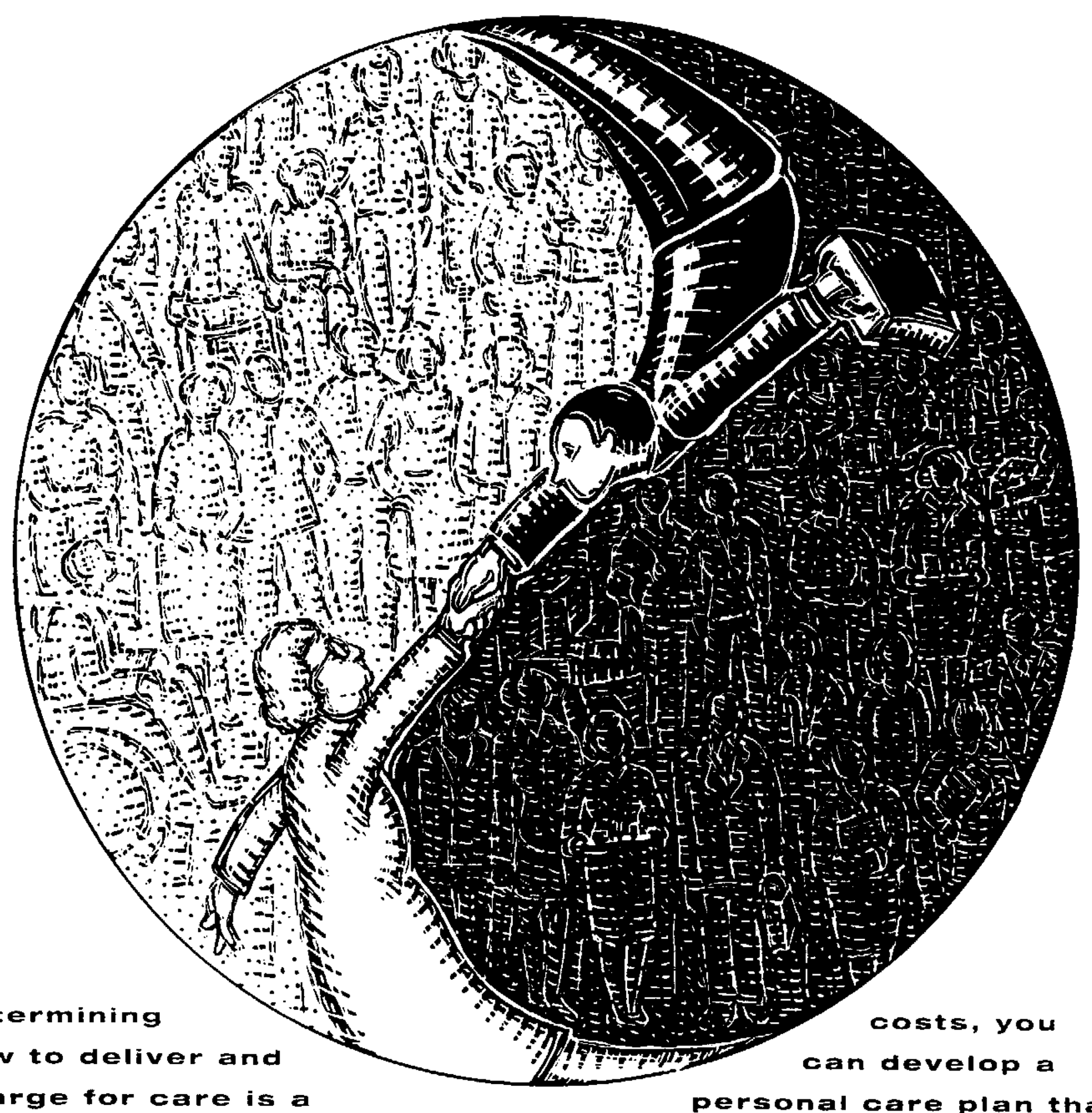
The characteristics which define high-quality service are personal attention, dependability, consistency, promptness, and employee competence. It is not as critical for residents to always get what they asked for as it is for them to receive a prompt, courteous, and competent response. Board rooms and executive offices are full of senior managers who are all for signing service proclamations and making speeches reminding "those people down in the trenches" how important residents are, but can't seem to find the time to actually "work" the problem of improving resident satisfaction. Resident satisfaction doesn't just happen because you have a beautiful building complemented by a high-quality service package. In fact, the nicer the property, the greater the resident expectation for service. I have often walked into a luxurious community only to be ignored by the receptionist. The combined effect leaves one with the impression that "something just isn't quite right". Resident satisfaction is an attitude that absolutely requires the commitment by employees at all levels with a dedication to making the dream a reality. It's the personal touch that brings the whole package to life. Resident satisfaction mirrors employee relations. Developing effective and proactive human resource practices builds an essential foundation for supporting your resident service package.

Resident satisfaction is the result of a dynamic, not static encounter. The resident evaluates both the process and outcome, and values both. For example, residents will accept a marginal food product temporarily if they receive consistently good service, or visa versa. However, poor product can not be overcome by a good relationship with the residents, at least not for long. Nor will good product overcome poor treatment. Fail at both and the residents will become part of the problem while concurrently turning off the tap on prospect referrals. The mandate is clear: To create a distinctive level of resident satisfaction necessary to earn their endorsements, management must understand and even shape the resident's expectations.

Benjamin W. Pearce is the Vice President of Operations for ADS Senior Housing

Checks and Balances

By Benjamin Pearce and Thomas Grape



Determining how to deliver and charge for care is a delicate equation. However, by managing services and staff costs, you can develop a personal care plan that meets the needs of residents, families, and owners.

ILLUSTRATION RUTH LOZNER © 1997

Assisted living communities employ a variety of methods to deliver the care residents require. However, most are derivatives of four basic methods: home health, service levels, point systems, and actual care options. Before deciding which method to support, management should consider these advantages and disadvantages.

Home health

The home health option segregates the basic service package from the personal care component.* Management provides the basic service package such as meal service, housekeeping, maintenance, laundry, activities, and transportation, but it subcontracts the personal care component through a Medicare-certified home health agency. This gives residents access to personal care services and allows them to use their purchasing power as a community. Home health agencies like this option because they can deliver a wide array of services, many of which are Medicare reimbursable, to a captive audience without the expense and inconvenience of travel time.

MORE CARE AVAILABLE

For the assisted living community, the home health option allows a much higher level of care than would be possible under assisted living regulations in most states. As a result, this arrangement provides benefits for both residents and owners. Residents can use Medicare benefits they might be paying for separately, offering relief to those experiencing financial pressure as their health care needs accelerate. The community enjoys reduced turnover; stabilization of the assisted living population; avoidance of nursing care transfers; control of the continuity of care; and differential billing structures.

QUALITY CONTROL POSSIBLE

This concept is very attractive to owners looking to defray expensive nursing costs, particularly during the rent-up period. The community must allow freedom of choice however, by contracting with a single Medicare-certified home health agency, it can have some influence and control over personal care service delivery. Without this arrangement, an assisted living community has almost no control over service quality or personnel qualifications. In one east coast community, at least 15 different home health agencies were delivering services to its residents, creating real vulnerability.

LOST INCOME, CHANGING DEMOGRAPHICS

Another factor to consider is that by contracting out the personal care component, the community relinquishes any operating margins it could expect if using its own staff. Under most circumstances, using a community's own employees is a more efficient option—one that produces a 70 to 80 percent margin on loaded costs.

The home health option allows a much higher level of care than would be possible under assisted living regulations in most states.

A possible disadvantage of this home health option is realized after the community has opened and the resident-acuity profile increases to become predominantly skilled. It then becomes difficult for the community to attract residents other than those who are nursing home candidates, thereby limiting its marketability.

Service levels

Most assisted living communities include some level of personal care in their basic monthly service package. This basic service can range from 30 to 90 minutes per day of assistance with activities of daily living (ADLs), with the average being 45 minutes. For most residents this amount works well, and for those who need extra personal care, the community can provide it more economically than an outside agency.

Upon admission, the community assesses resident needs and creates a personal care service plan. Under the service level program, residents are reevaluated periodically as their needs change and are assigned a service level. These are often called level one, two, and three, or basic, intermediate, enhanced, and comprehensive. Any significant change in a resident's status triggers a service plan review with the resident and family.

Normally, premiums for higher levels of service are based upon additional personal care time required per day and then translated to a monthly rate. For example, an assisted living community that includes 45 minutes per day of personal care in its basic monthly service package may charge an additional $120 per month for their intermediate level. This level might provide up to 60 minutes per day ($16 per hour caregiver cost or $4 per 15 minute increment x 30 days per month = $120).

ADJUSTING RATES

Overall, this system works well for residents who normally use 45 minutes per day of personal care or less. However, some communities find it extremely difficult to convince families and residents that they need to move up to the next service level and incur the additional expense. They will often attempt to convince the community that the need for additional services is due to a temporary set back. In addition, because the

* *Personal care services normally include bathing, dressing, escort or tray delivery, medication reminders, additional housekeeping, personal laundry, dementia support, orientation and cueing, grooming, scheduled toileting, and safety checks.*

> In staffing the service-level option... management will find that some basic-level residents require more care on an intermittent basis and higher-service level residents demand special attention because they are paying more.

monthly service fee is adjusted with higher levels of service, a service plan review that comes at the same time as a lease renewal and normal rent increase can be a tough sell to the resident and family.

Staffing the service-level option can also bring challenges. Most notably, quantifying exactly the number of service hours per shift delivered to residents is difficult. Personal care assistants are constantly being pulled in many different directions to serve residents on demand. Management will find that some basic-level residents require more care on an intermittent basis and higher-service level residents demand special attention because they are paying more.

Point system

The point system is normally determined by a baseline assessment tool used to classify each resident's needs. First, a numerical score is calculated based upon progressively higher levels of staff intervention. The community assigns each service category a point value, usually one to five. The higher the point value, the higher the acuity level. Adding the acuity points from each service category derives the final score, which is then divided by the number of categories. One category might be bathing and dressing:

CATEGORY: BATHING AND DRESSING

1 Point: Independent in bathing and dressing.
2 Points: Requires assistance only in transferring into and out of the bath. Can bathe self.
3 Points: Requires assistance in bathing and dressing but does most of the work.
4 Points: Requires considerable assistance with bathing and dressing.
5 Points: Completely dependent upon staff for bathing and dressing.

A resident's acuity scores for all categories are added and averaged. Generally, each level is assigned an additional monthly fee such as $200 or $300. Acuity levels of four or five can prove a need for nursing home care and trigger discharge planning. After the initial assessment, evaluations are on a *scheduled* basis. If the personal care director waits until a resident needs an obvious reassessment, chances are that assistants are already providing higher levels of service without recovering the associated costs. Consequently, owners give away significant amounts of care, and staffing is always short.

SCHEDULED REASSESSMENTS

Like the service level option, the point system leaves significant room for interpretation. Residents and families will contend that the point system is based upon conjecture and can vary widely from one week to the next depending on how the resident may be feeling. Management needs to stay on top of regularly scheduled assessments and resell the increase in fee structure often throughout the lease term.

Another potential difficulty is determining the time needed to perform ADLs. One resident may require 20 minutes to bathe and get dressed for breakfast, while her neighbor will need 45 minutes to accomplish the same task with assistance. There is simply no way to directly correlate nursing time expended to each resident and fully recover the cost to deliver that care.

Actual care

Under this system, a daily time limit, such as 45 minutes, is included in a resident's monthly service fee. Any additional care is billed in arrears for the actual care delivered. Upon admission, the community assesses a resident and develops a personal service plan. This plan measures the amount of personal care the resident needs in a seven-day period. It itemizes each daily task, such as bathing, dressing, daily housekeeping, and other recurrent activities such as scheduled toileting, meal escort or tray, and medication reminders.

NEED-BASED SERVICE PLANS

To develop the service plan, the caregiver assigned to the resident performs an initial seven-day time study. The total number of minutes is added up for the week and if that number exceeds 335 minutes, or 45 minutes per day for seven days, the excess is billed to the resident's account each month.

The time study is repeated for a resident if:

- The resident returns from the hospital after a short stay.
- A physician alters the resident's major medication or treatment regime.
- Overall personal care needs increase or decrease.
- The resident experiences a cognitive decline.

If any of these conditions exist, the community calls a care conference among the personal care director, personal care assistants, the family, and physician. The community discusses the actual service times and additional billing amount with the family or resident. If the family feels that the additional billing amount is objectionable, management can ask what services they would like deleted from the plan and explain the implications of such actions.

TIME AVERAGING

Another time study is completed the first week care is provided based on the revised service plan. Time that exceeds the allotment in the monthly service fee is then billed separately, for example, at 35 cents per minute, or $21 per hour. This system is beneficial to residents and families because it recognizes that certain days a resident may require more than 45 minutes of service, and on other days, much less. This way, the resident is only charged for care that exceeds 335 minutes per week, even if they need one hour or more on any given day.

Delivery times for the same service will vary widely between residents. The actual care system allows management to recover the actual cost for the actual time of service delivered. Also, upon completion of all time studies, management has a very accurate tally of the total staff hours required to deliver services. Therefore, the community can schedule and budget the most efficient level of staffing. This tally can also be an effective method to quantify the overall acuity of the resident population.

INCREASED STAFF PRODUCTIVITY

Each personal care assistant is assigned specific residents and has a daily schedule derived from the weekly service plan. The daily schedule includes the time of delivery, apartment number, resident name, assignment detail with checkoff boxes, and minutes allocated to perform the service. This way, the entire day is scheduled and the assistant is expected to complete her assignments before clocking out. Normally, personal care assistants account for every minute of their day during the time study. All possible interactions are documented, making this a useful tool to monitor overall performance. Under this system, reaching 90 percent or more efficiency in service delivery is usual.

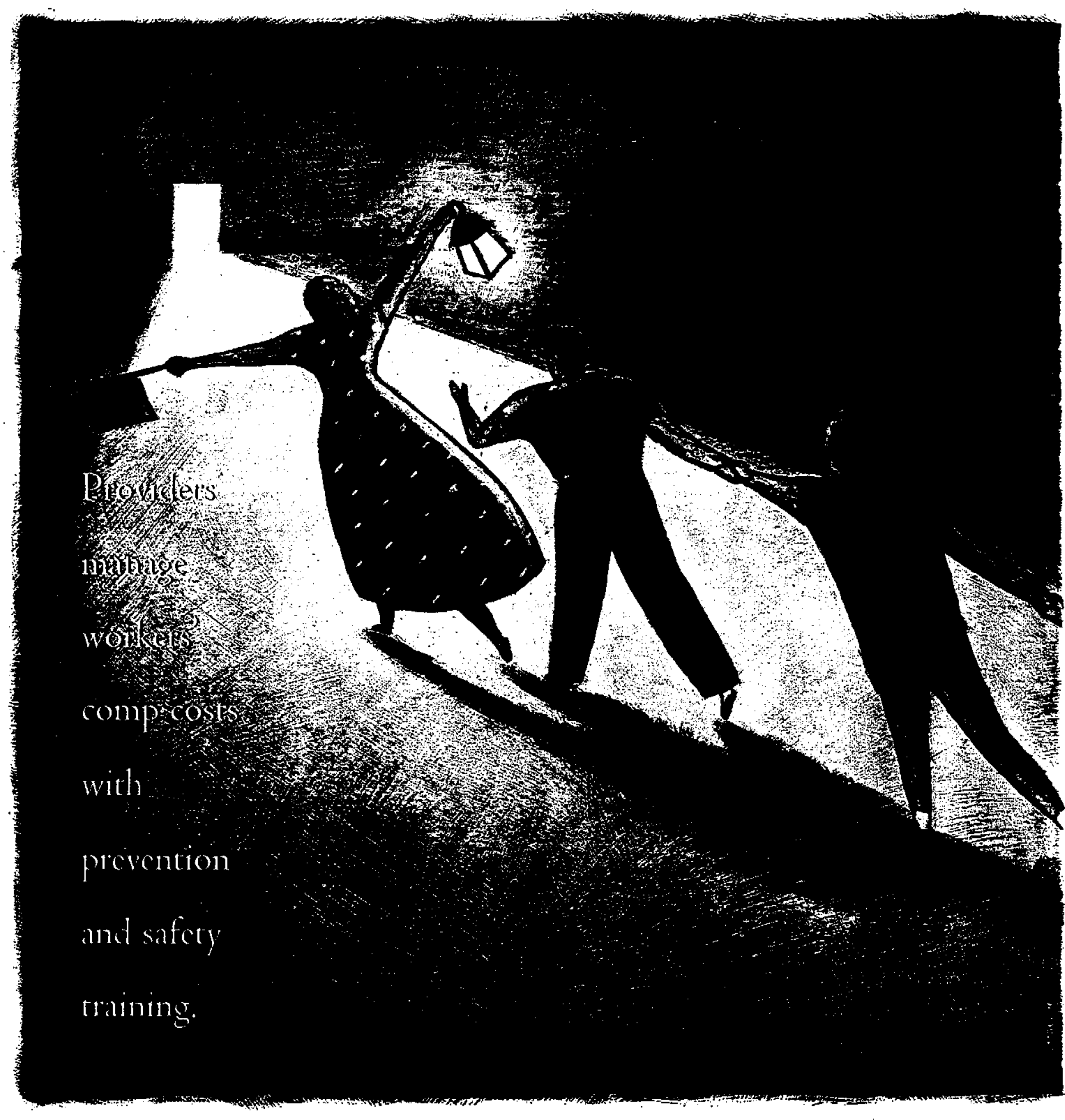
OVERSEEING STAFF COST

Assisted living communities must operate the personal care department as if it were a separate home health agency. All minutes of staff time must be either billable or attributable to and covered by the monthly service fee. Whether the care is included in the monthly service fee or is billed additionally, it must be balanced against the total recoverable revenue from residents. Otherwise, inefficient management and uncountable care will quickly erase the margin of profitability.

Benjamin Pearce is the senior vice president of operations for ADS Senior Housing, in Newton, MA. Over the past 15 years, he has overseen the operations and marketing of 69 senior living communities in 17 states.

Thomas Grape is the founder and managing director of ADS Senior Housing. He serves on the board of directors and executive committee of the Assisted Living Federation of America, and was the founder and chairman of MassALFA. ADS Senior Housing is the 26th largest provider of assisted living in the country.

> **If the personal care director [illegible] resident needs an obvious reassessment [illegible] are that assistants are already [illegible] levels of service without [illegible] costs.**



Lighting The Path To A Safe

When Jacklyn Friedman began managing a pair of continuing care retirement communities (CCRCs) in Colorado Springs, Colo., in 1989 she had her work cut out for her. The two facilities at Sunny Acres of Colorado had the highest employee turnover rate in the organization and together were paying $300,000 a year in workers' compensation claim payments.

By 1993 when Friedman moved east to take another job, Sunny Acres was spending $30,000 a year on workers' compensation, mostly for safety training and injury prevention. Today, the CCRCs have gone from being the worst performers in the organization in terms of workers' compensation trends to being the best. Since 1993, they haven't lost any time to worker injury. While management should get some of the credit for raising the profile of workplace safety, Friedman attributes most of the turnaround to employee involvement.

"We focused on the belief that we had the power to change behaviors," says Friedman, now managing director of elder care at Manchester, N.H.-based Optima Health Care. "If the right climate is set and culture is such that [safety] is a priority, then [employees] will take advantage."

Workplace

JANET FIRSHEIN

The Nuts And Bolts Of

In recent years, a growing number of long term care facility managers have taken similar steps to stem workers' compensation costs, compounded by worksite accidents and injuries linked to transferring residents, lifting hefty barrels of linen, or slipping on a wet floor. More and more facilities are devising strategies and incentives to keep workers injury-free. In truth, they have had little choice but to act.

Nursing and personal care facilities had the highest incidence rate of nonfatal occupational injuries for industries with 100,000 or more injury cases, according to a 1995 survey by the Bureau of Labor Statistics. Nursing and personal care facilities had an incidence rate of 17.8 injuries for every 100 full-time-equivalent workers in 1995, an increase from an incidence rate of 16.5 in 1994. Nursing and personal care facilities, however, ranked third in total injury cases—reporting 246,900 cases that resulted in either lost worktime, medical treatment other than first aid, loss of consciousness, restriction of work or motion, or transfer to another job. Eating and drinking establishments ranked first with 365,600 cases, and hospitals ranked second with 268,900 cases (see box, page 34).

The Occupational Safety and Health Administration (OSHA) has been attempting to create a national ergonomics protection standard to try to reduce the risk of worksite injuries. Last year, OSHA began an outreach-and-enforcement initiative aimed at reducing injuries and illnesses among nursing facility workers. It focused the initiative on seven states with more than 500 nursing facilities: Florida, Illinois, Massachusetts, Missouri, New York, Ohio, and Pennsylvania.

Industry representatives say nursing facilities are being unfairly targeted and that such claims are not reflective of the current environment. Nevertheless, they acknowledge the data are spurring nursing facility managers to address injury prevention in their facilities.

Workers' compensation is a state-mandated program. Employers are required to pay all the medical bills and a portion of lost wages to workers hurt on the job. Large employers that self-insure pay these claims as a direct expense, while smaller concerns typically purchase insurance, with premiums based in part on their claims experience and job classification.

It is important for providers to check with the Workers' Compensation Rating Bureau to determine the payroll classification for their employees. Slight classification differences can mean big savings on rates, especially for assisted living providers. For example, certain hotel class codes that might apply to assisted living—covering drivers, restaurant workers, salespersons, and others—carry a rate of $4.22 per $100 payroll. By comparison, the class code for home health employees is at the significantly higher rate of $4.49. Great care should be taken when selecting the class code to avoid being classified at a rate higher than necessary.

Experience rating is [illegible]

tors. Conversely, if the claim frequency is less than competitors, then the experience modifier can drop to less than 1.0, perhaps even as low as 0.8, which means that the company pays 20 percent less than its competitors. In a 100-unit community, this can translate to an annual savings of $6,000 in premiums alone, not to mention time loss, overtime coverage, and excess claims.

Experience-Rating Plan

The experience rating consists of a three-year rolling average, ending one year prior to the effective date of the policy period. This means that if claim experience is high, and management implements strategies to lower claims, the premium will not drop for two years.

The experience-rating plan is designed to give more weight to loss frequency than loss severity. For example, 15 $3,000 claims [illegible]

day after an injury occurs. Injured employees, therefore, must use up their bank of sick days to guarantee uninterrupted compensation (exceptions for severely injured workers are discussed below). Once benefits begin, the program pays only two-thirds of workers' normal hourly wages. Employees may be unaware of these drawbacks, and management should therefore make a point of educating workers about the realities of workers' compensation benefits.

The Workers' Compensation Act of 1991 has established new procedures for filing workers' compensation claims. The important distinction in this process is between time-loss cases and medical-only cases.

To qualify for determination as a time-loss case, an injured employee must [illegible]

employee initially sent to a clinic with whom management has previously made arrangements. The physician should be provided with a job description for the employee and advised whether the employer will allow a return to light-duty work.

Employees who are returned to light-duty work after an injury will feel useful and valued by their employer. Light-duty programs also allow people recovering from injuries to stay in touch and feel connected to the routine of working. Physicians will generally release patients to light duty if they know that such a program exists and is well managed.

In the meantime, a designated claims coordinator should act as the liaison to all injured employees. This coordinator [illegible]

Taking Control

The nursing facility industry spends about $1 billion a year in workers' compensation claims, according to the New Jersey-based Insurance Market Research Corp. Many argue the industry has not been as proactive as it could be to lower those costs.

Benjamin Pearce, senior vice president for ADS Senior Housing in Newton, Mass., agrees. "Workers' compensation costs can quickly get out of hand if they are not constantly and deliberately managed" as part of daily operations. Pearce says that developing safety programs to control the rate of injuries can save facilities thousands of dollars in claims payments and engender a stable, loyal workforce.

Michael Duffy, associate administrator for the Good Samaritan Home of Quincy, Ill., has heeded that advice. Seven years ago, workers' compensation costs at the 278-bed nursing facility were spiraling upward. Duffy estimates his facility was spending $300,000 a year in workers' compensation claims. The first thing management did, he says, was find an insurance carrier that would work with the facility and help them better manage costs.

Good Samaritan enlisted a risk-management association geared specifically to nursing facilities to help them address workers' compensation issues, including providing strategies and injury-prevention training when needed. In addition, Good Samaritan found an insurer that would investigate claims to make sure they were legitimate. Duffy also contracted with a physician group with a specialty in occupational medicine. Injured employees can visit their own physicians, but Good Samaritan strongly encourages them to also see the occupational group to ensure treatment consistency.

Enlisting Outside Help

Phylis Versteegh, executive director for the Illinois-based Nursing Homes Risk Management Association, says her orga-

Long Term Care Facilities Have High Injury, Illness Rate

Nursing and personal care facilities had an incidence rate of 18.2 injuries and illnesses per 100 full-time-equivalent (FTE) workers in 1995, up from 16.8 in 1994, the Bureau of Labor Statistics (BLS) says. In comparison, the national rate for nonfatal work-related injuries and illnesses in private industry was 8.1 per 100 FTE workers in 1995.

Injuries and illnesses in nursing and personal care facilities resulted in a lost-workday case rate of 8.8 per 100 FTEs. (Lost-workday cases are days away from work and days of restricted work.) The industry's lost-worktime rate, which counts days away from work, is 5.95 cases per 100 FTEs—about the same rate reported for trucking services and ship building and repairing, the BLS says. In comparison, private industry had a national average of 3.6 lost-workday cases and 2.5 lost-worktime cases per 100 FTE workers, the BLS says.

The BLS also performed a detailed analysis of the lost-worktime cases in nursing facilities for 1995 to get a better understanding of the demographics of the workers affected. With an estimated 1.5 million employees, the BLS estimates there were 82,411 lost-worktime cases in nursing and personal care facilities caused by injuries and illnesses on the job in 1995.

Nurse assistants, orderlies, and health aides accounted for [illegible] percent [illegible] cases, while workers who had been on the job one to five years made up 30 percent of lost-worktime cases. Workers who had been on the job five years or more accounted for 15 percent of lost-worktime cases. Ten percent did not report their employment tenure.

Overexertion, primarily while lifting and handling patients and residents, accounted for 54 percent of the lost-worktime cases in nursing and personal care facilities, the BLS says. Falls to the floor made up 12 percent of the lost-worktime cases, while 8 percent were classified as bodily reactions in bending, climbing, reaching, twisting, slipping, or tripping without a fall. Seven percent of lost-worktime cases were due to assaults by another person, and 10 percent were due to being struck by an object or against an object. Nine percent of lost-worktime cases were not classified.

Injured nursing facility employees typically return to work after four days, slightly quicker than the national median of five days, the BLS says. However, one-fourth of nursing facility lost-worktime cases had 11 or more missed workdays.

For nursing facilities, rates of lost-worktime injuries and illnesses have declined dramatically in recent years. For example, the rate of overexertion incidents in nursing facilities resulting in days away from work—3.2 cases per 100 FTEs—was 20 percent lower in 1995 than the [illegible] rate per 100 [illegible] a national [illegible] 1995 for overexertion [illegible] lost-work[illegible] nursing facilities [illegible] from work [illegible] FTE workers [illegible] FTE work[illegible]

—Christy Fisher

nization helps facilities like Duffy's get a handle on where their safety gaps are and how to fix them. Her staff enters facilities, sometimes as often as once a month, and conducts safety assessments to see where the potential for injury lies. Versteegh says they look at lifting patterns and how bloodborne pathogens are handled. The visits help provide perspective. Versteegh says she has seen instances where a facility will have a mechanical lift down the hall sitting unused because it's too much of hassle for an overburdened nurse assistant to employ. When a facility is short-staffed, she says, "sometimes it is easier to pick up a [resident] and put him in a wheelchair."

It is those behaviors that Duffy wants to change. At Good Samaritan, a safety committee composed of front-line supervisors meets monthly to evaluate all incidents in the facility. "What we are looking for are patterns," such as an excessive number of falls or back injuries, or burns or cuts among kitchen staff, Duffy says. When they identify problems, the committee devises solutions. These range from putting a mat in the kitchen to prevent slipping to buying a two-person lift to mitigate back injuries. Experts agree that employees are more inclined to avoid high-risk behaviors if they feel that their employer is committed to workplace safety.

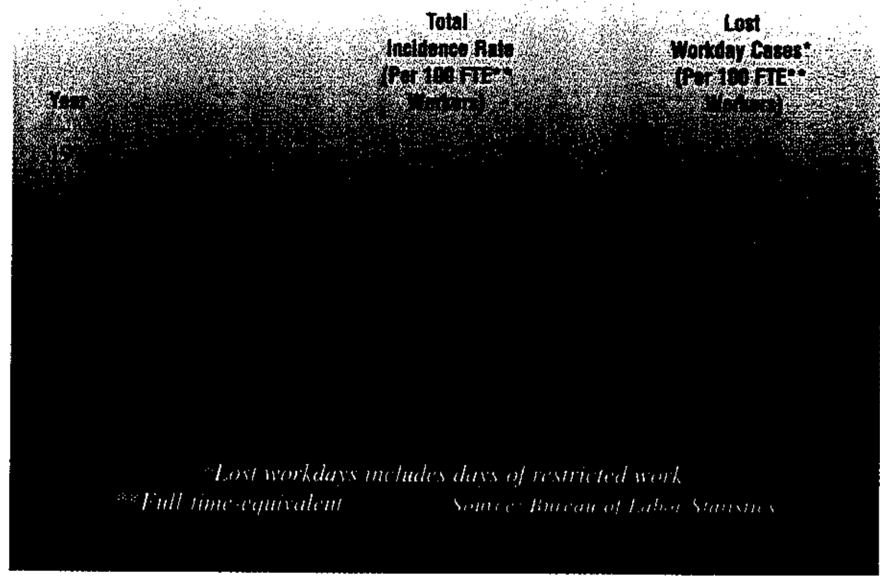
Duffy also has instituted an in-service education program that hones in on specific injuries and errant work patterns that could lead to accidents. Last year, Good Samaritan created an in-house safety video with real employees doing things right. The safety committee also conducts unannounced tours of each unit to seek out work behaviors that could lead to injuries. Safety committee members have observed such things as employees leaving bags of trash or electrical cords in the middle of the floor. They've also seen employees standing on a chair instead of a ladder. These kinds of observations are turned over to the unit, whose managers

talk to staff about safety tips. This year, the facility also began interviewing staff who have been injured and asking them what can be done to keep the worksite injury-free.

The initiatives have made a difference. The number of claims and lost hours and the severity of injuries has decreased in each of the past seven years, Duffy says. In 1996, the facility paid a total of $13,200 in workers' compensation claims. Duffy agrees that employees have to contribute to the solutions. "You can establish all of the programs you want, but if employees don't want to actively be a part of them, then [the programs] won't be useful."

The employees have benefited from that participation. Good Samaritan has used savings from lower injury rates to provide bonuses and build an employee fitness center, which has proved to be a win-win situation for the nursing facility. "Employees see this as something they have received for their own efforts," says Duffy. "And if employees are healthy, they are going to have fewer injuries."

Nursing Facility Injury And Illness Rates



"We spend a tremendous amount on back injuries; it is by far our biggest claim."

Gaithersburg, Md.-based Manor Care Health Services is aggressively dealing with its workers' compensation costs. Its main focus has been on back injuries, a particular problem for nursing facilities, which are handling sicker, more dependent residents. Overexertion, primarily while lifting and moving residents, accounted for 54 percent of lost-work-time cases in nursing and personal care facilities in 1995, the Bureau of Labor Statistics says.

"We spend a tremendous amount on back injuries; it is by far our biggest claim," says Chris Davis, manager for safety and loss prevention at Manor Care. Davis says the facility has attempted to apply a "common-sense approach" to ergonomics. The facility has tried to minimize bending, lifting, and resident-transferring responsibilities among its workers. "A lot of injuries are the result of lifts that are grossly unsafe," he says.

There also has been a renewed push for use of mechanical lifts and transfer equipment to move residents who present high risks for injury among caregivers. These include obese residents, residents with amputated limbs, and combative residents who are difficult to lift or move from their beds. Davis estimates that 20 percent of residents generate 80 to 90 percent of back injuries.

A full-sling lift costs about $5,000; a standup lift costs between $3,500 and $4,000. Davis says if a facility can prevent one back injury (which costs anywhere from $3,500 to $15,000) through use of this equipment, then it has made its return on the investment.

Equipment manufacturers have been more responsive to developing products such as lifts that help cut down on injuries. Facilities are eager to use lifts to prevent back injuries, but getting resident buy-in is part of the equation. Many family members resist having their loved one lifted because it is such an undignified process and often upsets the resident.

Davis says that when the facility spends time educating family members about the risks of injury for caregivers without use of the lift, usually family members relent. "We want to find a way to minimize the potential injury risk that high-need residents may inflict, but we also don't want to lose touch with the fact that these are human beings," Davis says.

Preventing and reducing employee injury is a goal of long term care facilities. Federal and state legislation and regulation mandates a safe workplace. Keeping up with injury statistics and pending standards is important. In addition, providers should develop [illegible]

maintains this site as a source of information on workplace repetitive-motion and stress injuries and illnesses, including carpal tunnel syndrome and lower-back pain. This newsletter includes a "what's new" section and sections on symptoms and prevention, standards and guidelines, and workplace interventions.

Bureau Of Labor Statistics Safety And Health Statistics
http://www.bls.gov/oshover.htm

The Bureau of Labor Statistics issues an annual report on the number of U.S. workplace injuries, illnesses, and fatalities. This site offers summary data as well as case and demo- [illegible]

Manor Care has been urging its employees to be more safety-conscious and carefully consider the height, weight, acuity level, and physical dependency of each resident they care for. The message to workers, says Davis, is "take a minute and some personal accountability to do the job as safely as possible. We can't account for every interaction you will have with a resident in our facility, but it is up to you to look at the situation and make a determination of the best way to approach a resident to ensure safety."

Letting Employees Know You Care

Jim Zoesch, director of safety and loss control at Beverly Enterprises in Fort Smith, Ark., says workers' compensation costs in his facility have been steadily decreasing in the past five years, and Beverly now has one of the lowest accident rates in the United States. The facility's lost workday case-incident rate is 42 percent below the national average for nursing facilities, he says. Back injuries stemming from transferring residents also have decreased. Back injuries used to account for 60 to 80 percent of workers' compensation costs; now they account for 40 to 60 percent, he says.

Zoesch attributes some of the facility's success to upper-management support. "I think everyone in our company realizes that workers' compensation costs are a controllable item, just like labor and food." In the past three years, Beverly has spent $5 million buying lifts, designing training programs, and putting in place safety-awareness programs for its workers.

Beverly and other facilities have been able to lower their lost-days-of-work rates after an incident through constant communication with injured workers. Beverly has hired a third-party administrator who not only calls the injured employee but also contacts the physician and nursing facility to make sure all communication lines are open. Beverly also has started sending get-well cards to injured workers to make them feel con-

nected to the workplace. "We let injured persons know we do care and value them as individuals and want them back to work as quickly as they can," adds Zoesch. Some other companies have a policy of sending flowers or delivering checks personally.

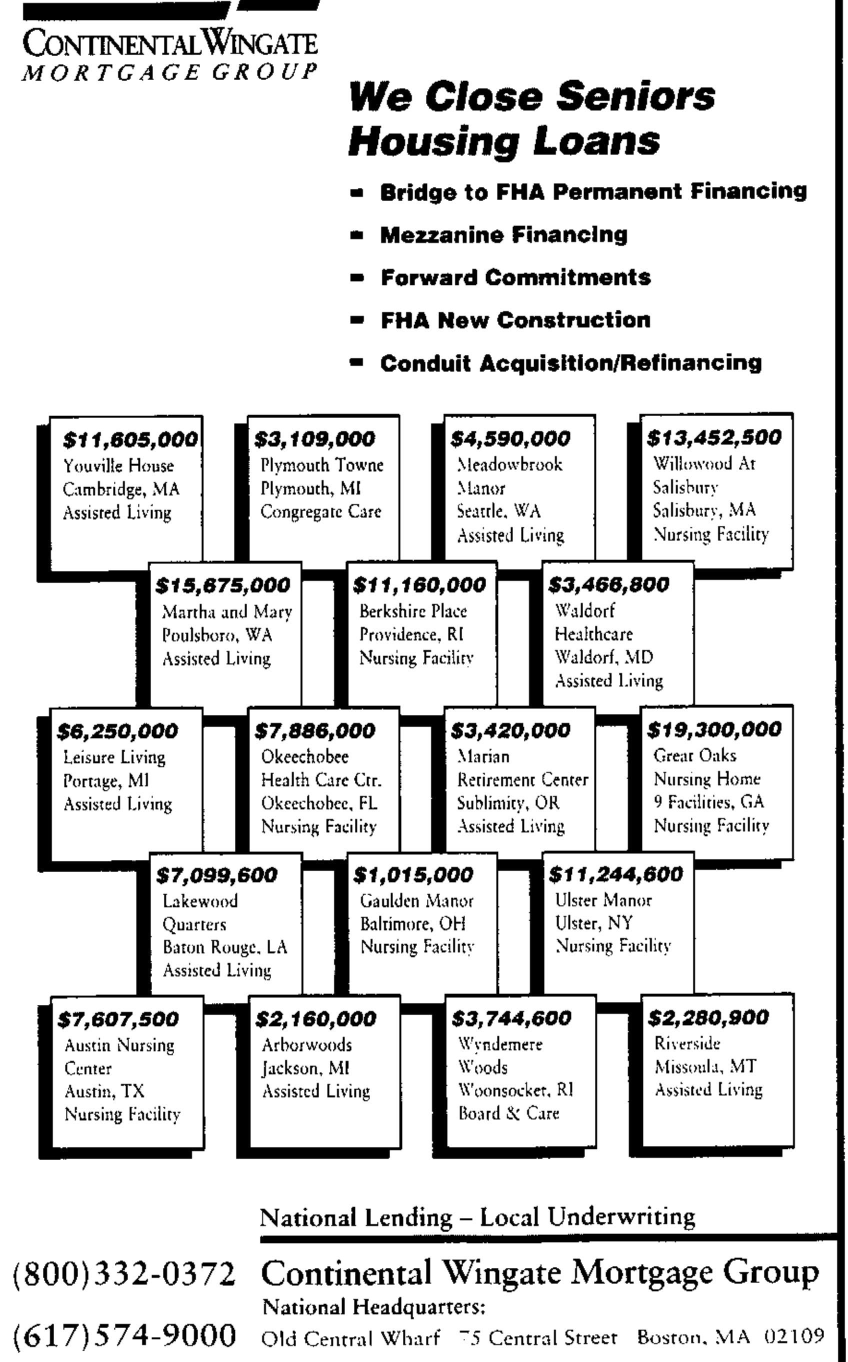
James Keeley, regional manager for the Pennsylvania-based Healthcare Services Group, which provides contract environmental and laundry services to nursing facilities, agrees that acting fast after an accident occurs and staying in touch with injured employees is a key strategy to keeping workers' compensation costs down and ensuring appropriate recuperation time.

Some facilities offer a light-duty program that gets people back into the workplace quickly after suffering an injury. Redesigning jobs to allow injured employees to return, in conjunction with the approval of the physician treating the employee, can get the injured worker back to work faster and lower the company's exposure to claims expenses, Keeley says. "If you don't get people back to work immediately, the likelihood of them returning is slim to nothing," adds Friedman of Optima Health Care.

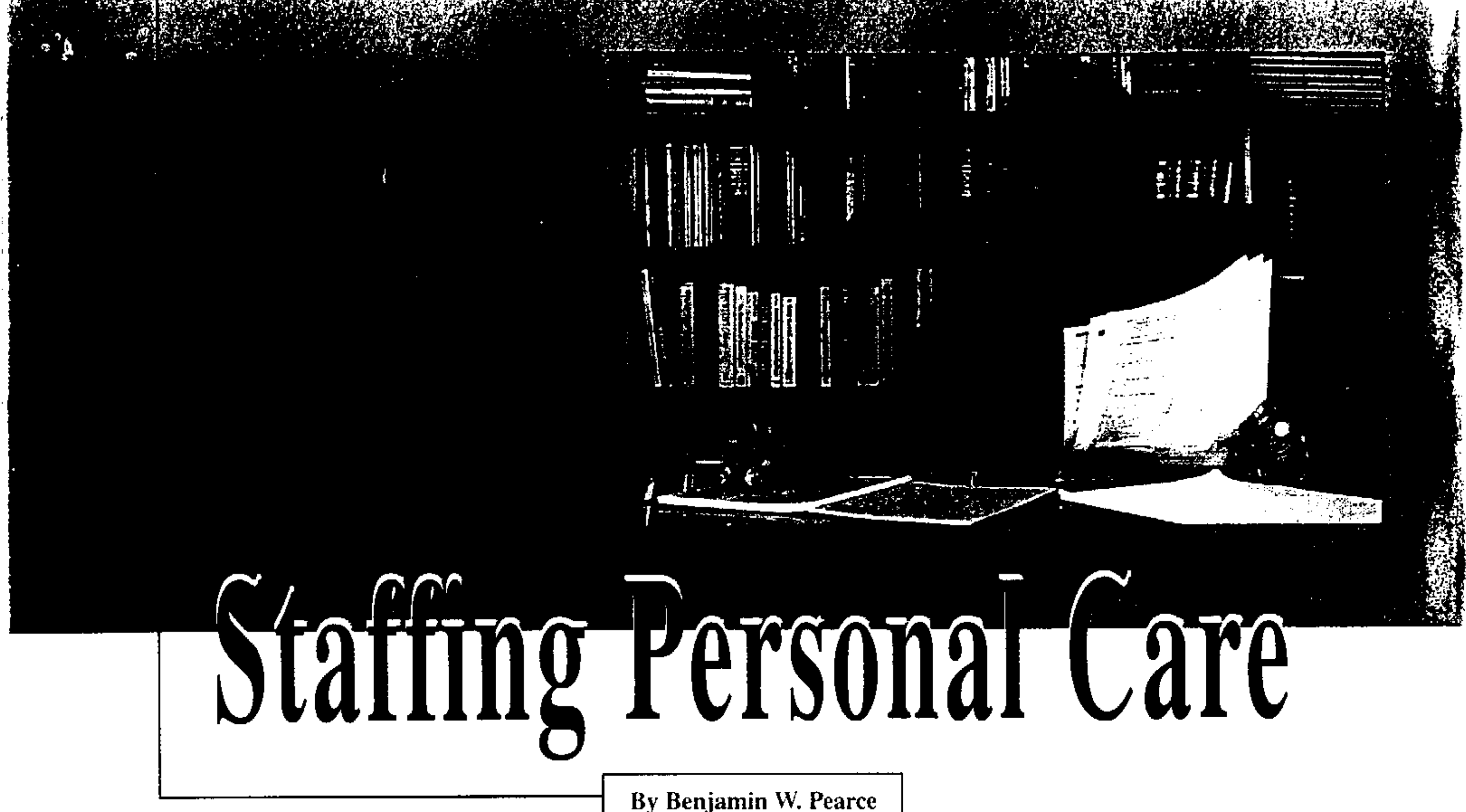
Pre-employment screening is another tool that Beverly uses to assess whether someone has the ability to handle the demands of the position for which they are applying. Beverly also conducts drug tests on its employees and background checks on prospective employees to find out if they were injury-prone and missed a lot of work in previous jobs. Zoesch says these efforts have had an effect on reducing turnover and the number of injuries.

Experts agree that a commitment to injury prevention can have a cumulative effect of helping facilities recruit the best employees. "People want to work in an organization that provides the best opportunity for growth, development, and safety," says Friedman. She says it makes business sense to provide a safe environment for employees who provide a service to residents. After all, if a facility takes care of its employees, Friedman adds, "they are going to give us all they have." ■

Janet Firshein is a freelance writer in Washington, D.C., who frequently writes about health care issues.



Circle No. 189 on Reader Service Card



Staffing Personal Care

By Benjamin W. Pearce

There are basically three schools of thought regarding staff assignments—universal worker, rotation and primary-care assignment. All three systems are commonly used within assisted-living communities, but rarely mixed under the same operation. We will first review what each assignment entails before determining methods of budgeting for staffing requirements.

Universal Worker

The universal worker concept has gained a lot of popularity among providers. In a typical assisted-living community, a variety of services—from bathing and grooming to meal service, to housekeeping and activity programs—need to be delivered every day. The traditional operation accomplishes these tasks through departmentalization. For example, the housekeeping department cleans the community, food and beverage prepares and serves the meals, the activity department organizes leisure interests and events, and nursing delivers personal care.

Each service is generally supervised by a separate department head and can become territorial and bureaucratic. As staff are only trained or experienced in one discipline, there is very little crossover from one department to the next. Consequently, the entire service package becomes compartmentalized and segregated. The more the residents' needs are passed from one department to the next, the more likely the risk of a communication breakdown resulting in a problem for the resident.

Under the universal worker concept, employees are hired as "care managers" and cross-trained in several departments. This way, they are conditioned to accept responsibility for the total care needs of the resident and there is little "buck passing" of service requests. An employee is hired as a care aide, for instance, then cross-trained as a housekeeper or wait person in the dining area. Employees are not expected to do all jobs at once. Rather, they can come to work and spend the first four hours of their shift bathing and dressing residents, then shift to cleaning apartments or working as an activities assistant.

In assisted-living based Alzheimer's or special-care units, the care manager normally handles all of the needs of the residents to whom they are assigned. Facility management or department heads can then act as facilitators and trainers, assisting the care managers in a "service rich" environment.

The system is designed to build accountability in meeting the residents' needs, whatever they may be, by each and every one in the operation. This effectively breaks down traditional hierarchy and bureaucracy, replacing it with an attitude of customer service. There are some technical skills, such as maintenance and cooking or bookkeeping, that are difficult to cross-train, but the majority of services that are delivered to the residents in a community can be performed by universal workers.

Clearly, it is easier to set up a new community under this structure than it is to break down the paradigm in an established community. Introduction of the idea is often met with resistance from the established employees who may feel that management wants them to work harder for the same pay. People are by nature resistant to change, because change itself forces them to step outside of their comfort zone.

Some operators have restructured their compensation plans to overcome this objection, hiring for attitude then training for skill. Employees are hired for one specialty and then, as they learn and pass competency tests on each new discipline, their base compensation is increased. For example, a personal-care assistant may be hired at $7 per hour, then cross-trained in housekeeping for an additional 25 cents per hour, then as a wait person for 25 cents more, or dishwasher for 15 cents more.

This way, as the employees learn and grow in their position, they become more flexible to management and consequently more valuable. As employees move up the learning curve, they are motivated by a sense of accomplishment and reward.

According to The State of Seniors Housing, 1994, the typical assisted-living community requires approximately .46 full-time equivalents per resident. Under the universal-worker concept, some operators are suggesting that this figure could be dropped to .356 direct-care FTEs providing care for residents who usually need help with activities of daily living.[1] One operator suggests that segregating job functions can result in a productivity loss of up to 40 percent. In the competitive assisted-living environment, it's no wonder that operators are embracing this concept on a grand scale.

The difficulty in managing the universal worker concept is in quality assurance and convincing employees to embrace the idea. Service to the residents can become inconsistent when employees skilled at performing one job are learning another skill. Staff can become frustrated that they are doing a lot of different tasks, but not any one particularly well. Management must respond to this frustration with continuing skill testing and retraining until proficiency is reached. Management must play an active role, continually reinforcing the merits of the concept to residents and family members throughout the start-up or transition period.

[1]Briefings on Assisted Living. Special Report: Flexible workers: A solution for assisted living; 1996: page 5.

Rotational System

The rotational system is designed to have staff assigned on a task basis, where personal-care assistants are rotated from one resident to the next. Many operators will rotate their personal-care assistants to prevent abuse of the assistant's time as bonds develop and to alleviate boredom among the staff. While this has been successful for some, aging residents experience a heightened sense of vulnerability and are very suspect of a new personal-care assistant.

Rotation does have a number of advantages. It allows for variety and can break the monotony of dealing with the same residents every day. To have all care assistants trained to the personal-care needs of all the residents makes rescheduling and call-in coverage easier. In addition, as residents become attached to a personal-care assistant and the employee leaves the community, separation anxiety may result.

The employee turnover rate does not become known to the residents with monthly rotation. Rotation also discourages favoritism on the part of the resident and the personal-care assistant. This allows for the workload to be equally shared among the personal-care assistants so that the same aides do not shoulder the burden of the more heavy-care residents, and it allows for the maximum scheduling flexibility.

Primary Care

Also known as modular nursing, the primary-care system assigns specific personal-care assistants to specific residents. The daily personal-care needs are scheduled for several residents, then assigned to one personal-care aide on each of three shifts. This way, accountability for service-plan delivery can be allocated to a minimal number of employees.

Residents always prefer this system. The delivery of personal-care services is a very intimate business. It requires a considerable amount of trust and is best accomplished through the development of personal relationships between the resident and the caregiver.

People who are attracted to the personal-care business are normally very compassionate human beings. They are motivated by their ability to influence the lives of the residents and often become quite attached to them. Over time, a symbiotic relationship will develop between patients and their CNAs. Patients will tell CNAs how much they appreciate them, comment on their appearance, help them through personal problems and even love them. Each becomes a support system for the other, and then it is in their best interest to care for their patients. In return, patients receive the best quality of care that the assistant is capable of giving. It is human nature for people (especially caregivers) to bond with each other. In the right environment, it happens naturally.

In many ways, the personal-care assistants will "mother" their residents and become acquainted with their most personal needs. Spending so much time with their residents, they become intimately aware of the resident's condition and overall health. Personal-care assistants who work with the same residents day in and day out will recognize minor changes in their resident's health, activity level and even bathroom habits, much the same as they would at home if they spot something irregular with their own children.

Spotting these changes as they occur allows the personal-care assistants to alert management and families so that problems can be diagnosed and treated immediately. This is the very essence of quality care. It's not about people delivering purchased services to residents in a consistent manner; it's about people caring about their residents personally and taking responsibility for their health and happiness because they want to. Also, families will feel more connected to the personal-care assistants whom they know and are better able to support them when residents exhibit behavior difficult to deal with. Families are always more comfortable with familiar employees and are generally suspicious of management when employees are constantly rotating or turning over.

When staff are rotated, even the best intentioned caregiver has no baseline to use in evaluating the present condition of residents. They can only go on what they see then and what their instincts, training and experience has taught them. It is nearly impossible for

them to recognize the often subtle changes that can lead to big problems. More importantly, it is not easy for the residents to have to remind their ever-changing caregivers about their specific inability to perform activities for which they are dependent upon for assistance. As soon as they become accustomed to one personal-care assistant and relaxed around them, the personal-care assistant is rotated onto a whole new set of residents. It's usually quite disturbing to the residents and their families.

Calculating Staffing Requirements

There are several ways to calculate staffing requirements in the personal-care department. Staffing can be figured based upon the number of minutes a day that are included in the residents' monthly fee and averaged; the coverage in the building throughout the day; actual care scheduled on each resident's care plan; or ratios of caregivers to residents.

Assuming a community that offers 45 minutes of personal care included in the monthly service fee, a fully occupied, 90-unit assisted-living community with four second residents should translate to 70.5 hours per day if everyone uses exactly 45 minutes and the night shift is completely utilized for care delivery. As a caregiver to resident ratio, it works out to about 1:23 on the day shift and 1:45 at night. The problem is, rarely does anyone ever use exactly any amount of care.

The best way to calculate staffing needs is to develop assignment sheets for each personal-care aide that match the needs and preferences specified in their care plan. These assignment sheets can then be translated into hours or minutes of service, and scheduled accordingly. For example, during an eight-hour shift, one personal-care aide can deliver approximately 400 minutes of care (480 minutes, less 60 for lunch and breaks, less 20 for transferring assignment documentation to the residents' files).

This 400 minutes can be perhaps delivered as 20 minutes for each of the 20 residents the caregiver may be assigned. Other personal-care aides will then pick up the care needs on the other shifts to complete the personal-care plan. With the exception of the night shift, when residents are mostly asleep but coverage is required, the personal-care aides should have this 400 minutes of care time fully scheduled.

At night, in smaller communities, one person may be adequate, provided there are no two-person transfer residents. If two people are required, one or both can be kept busy during slow periods with marketing or administrative projects, such as stuffing and labeling direct mailings or assisting with other office projects that are not of a proprietary nature. Some communities have one personal-care aide and one housekeeper scheduled during the night shift. The housekeeper can perform common-area housekeeping and do the entire day's laundry, as well as be available to assist with emergencies or transfers.

It should be understood that at times there will be distractions, refused care or care that takes longer or shorter, and is not generally predictable. This can be noted by the care aide, then the personal-care director will adjust the overall assignments accordingly in the future. It

Rx Your Prescription for a Successful Yellow Pages Program

American Ad Management

provides the following FREE services:

Specializing in regional and national discount Yellow Page advertising.

- Negotiates publisher discounts and special pricing programs to save you hard dollars on your yellow page expense.
- Buys the right types and sizes of ads, based on time proven competitive reviews.
- Utilizes computerized databases to target demographic data, allowing you to buy only in the books that pull response.
- Creates yellow page ads, applying time-tested, proven techniques that make the phone ring.
- Consolidates all directory billing into one manageable easy-to-read statement.

American Ad Management is a certified marketing representative in good standing for every directory in the United States.

For a FREE comprehensive account review call

is critical that all of their time be accounted for and allocated to a resident, including travel time between residents.

Efficient staffing is the resposibility of the personal-care director, who needs to recognize that residents will likely require more assistance/time as they continue the aging-in-place process. It is his duty to recognize these changes and ensure that proper staffing is scheduled to accommodate this promptly. When residents are transferred to the hospital, move out or require less care, staffing needs to be cut or aides reassigned to assist with other residents. It's a good idea to schedule some part-timers on the morning shift, when the care requirements are highest. Part-timers need to have flexible hours, which increase or decrease in accordance with the assignment requirements.

The management of staff cost is as important in assisted living as it is in home healthcare. A home-health agency would not remain in business very long supporting staff who do not have billable hours. Whether the care delivered in the assisted-living community is included in the monthly service fee or is billed additionally, it must be balanced against the total recoverable revenue from the residents. The margin of profitability can very quickly be erased with inefficient management and utilization of in-house staff not delivering countable care.

Scheduling residents for personal care is also an important consideration. In our example above, 94 residents requiring 45 minutes per day will need most of their service during the morning shift. At this time of day, residents require assistance with bathing and grooming prior to going to the dining room for breakfast. Those who are unable to accomplish this process during the breakfast hours will order a tray to be delivered. (They will, of course, blame management for not attending to them in time in an effort to have the tray-delivery charge waived.)

At the same time, personal-care aides can be found in the kitchen waiting for the trays that were already ordered. This creates a bottleneck in the kitchen and further delays service to residents who did manage to make it to the dining room and are now complaining about slow service. As the personal-care aides are forced to wait, still more residents waiting for help in their rooms will miss breakfast.

The entire cycle of poor service can be avoided or minimized by encouraging some residents to rise earlier for their bathing and dressing assistance and limiting the number of morning baths to a more manageable number. The expectations of residents must be managed so that everyone can be serviced without adding staff. Many of the residents can be scheduled for their bath after dinner and before they go to bed, so that they need only assistance with dressing the next morning.

Creative scheduling can often improve service to the residents and reduce cost to deliver that service. For most residents, you have 14 to 16 hours available to schedule their care. While some of it must be scheduled at certain times during the day, typically around meal times, some of the heavier care can be distributed throughout the day or evening.

If the resident was purchasing the supportive care from a home-health agency,

Clarion Bathware

Assisted Care Bathware

- ADA Compliant,
- Barrier Free, and Assisted Care Showers, and Tub/Shower Modules
- Fully Accessorized or, Accessorized per your spec.
- One-Piece Fiberglass
  - Showers
  - Tub/Showers
  - Whirlpool Models
- Two-Piece Models
  - Showers
  - Tub/Showers
  - Whirlpool Models
- Acrylic
  - Showers
  - Tub/Showers
  - Whirlpool Models
- Custom Models Available

CLARION BATHWARE
205 Amsler Ave. • Shippenville, PA 16254
1-800-576-9228 Ext. 11

ADA COMPLIANT SHOWER

it would be cost-prohibitive to have it delivered to them in small increments throughout the day. The personal-care department must be operated as if it were a separate home-health agency, so that all minutes of staff time scheduled are either billable or attributable to and covered by the monthly service fee.

The use of part-time personal-care aides during the busy morning rush between 6 a.m. and 10 a.m. can also help to defray care delivery costs. Some operators will run an 11 p.m. to 9 a.m. shift (10 hours per day, four days per week) to have two care aides helping with the morning rush. This will add four hours to the night shift, but will eliminate two four-hour morning shifts for a net savings of four hours per day.

Another important consideration should be to focus staff efforts on improving residents' self-care ability. There needs to be an acceptance of less-than-perfect performance from the residents who can learn to become more independent in some tasks and less dependent upon their personal-care assistant as a servant. Start or complete difficult tasks for the residents and encourage them to do the parts in between. This builds strength and self-confidence in the residents, while easing the burden for staff. Residents respond well to encouragement and recognition of small victories over the effects of aging.

Also, the resident's service plan should integrate some family involvement so that they can contribute to their parent's well-being. Families who are willing and interested can often be encouraged to perform small services on a routine basis. These tasks, once integrated into the service plan, can formalize the family's efforts to assist and generate some sense of teamwork between families and the staff. As problems arise or the care needs increase, the family is right there to observe the problems first hand and can be involved in the solution or more easily accept the cost of additional care.

When confronted by employees with personal scheduling problems, such as child care, transportation needs or other such issues, the personal-care director will normally accommodate these difficulties through creative scheduling. Creative scheduling almost always results in higher costs to the operation through less than efficient utilization of staff. It is crucial in this low margin operating environment to match the employees to the job requirements, not match the job to the employee's requirements. It is simply much easier for the sympathetic personal-care director to incur additional cost in the name of "better care" or to keep a good employee than it is to find a creative solution to the employee's schedule conflict or need for additional hours or overtime.

It is vital to make sure that the staff schedule has the same amount of hours scheduled as does the assignment sheet of personal care to the residents, which should also agree with the staffing budget for the department. If the level of care increases, the staffing level can also increase, provided the additional cost to deliver that care can be recovered from the resident through additional billing. The executive director should do a weekly or bimonthly audit of the time cards against the schedule, assignment

What Pharmacy Provider Can Already Treat You to 21st Century Services?

Omnicare welcomes you to the future of long term care pharmacy services, systems and support.

No other institutional pharmacy provider has taken such a dramatic leadership role in assuring its customers access to the most sophisticated, comprehensive array of pharmacy programs available on the planet.

- **Disease State Management ...** our unique programs target diseases common in the elderly where specific drug therapy interventions have been proven to promote positive resident outcomes. Current programs include Heart Failure, Flu Vaccine Immunizations, Depression, Atrial Fibrillation / Warfarin / Stroke Prevention and Osteoporosis.
- **Geriatric Pharmaceutical Care Guidelines...** the only geriatric-specific, referenced document of its kind, ranks drugs first by their clinical effectiveness and second by their cost-effectiveness.
- **Computerized MDS Care Planning...** our exclusive Accu-Care, IMPACT and Nursing Solutions technologies are nationally recognized for their thorough, easy-to-use performance
- **Integrated Clinical Research Capability...** superior expertise helps us provide our customers with exclusive cutting edge information to improve the quality of their care delivery. Omnicare Pharmacies can help you succeed into the 21st Century with stellar performance and a fail-safe commitment to your absolute satisfaction. Contact us today and meet the future ahead of time.

Omnicare, Inc.

6457 Wheatstone Court Maumee, OH 43537

sheets and budget for the department to keep a handle on this inevitable cost creep. Teach staff to be flexible so that the community can deliver the best care that it can with the resources it has available. Often, it is simply a matter of learning to adapt an old routine to a new one. In the long run, residents will receive better care and be more satisfied.

There has been much study about the most efficient number of units in assisted living. Too few units, and the overhead in supervision cannot be fully amortized by the resident monthly service fees; too many, and the complexity of supervision to maintain quality control becomes prohibitive. As described earlier, quality is difficult to monitor in the private apartment setting of an assisted-living environment. In sharp contrast to a skilled-nursing facility, where patients are available throughout the day, the assisted-living residents are more secluded in the privacy of their own apartment. Therefore, as the number of units increases, it becomes more difficult to keep track of their individual care needs.

A nurse supervisor (RN or LPN) can reasonably cover approximately 60 residents. This includes care planning, supervision, scheduling assignments, medication monitoring, dealing with families and physicians, emergency response and some direct care. Larger units will require additional supervision depending upon the overall level of acuity and cognitive impairment. Communities with more than 100 units will also tend to develop higher acuity among the residents as they age in place and management holds onto residents longer to maintain higher occupancy.

The problem then builds upon itself. As acuity increases so does the need for additional supervision. The turnover rate increases as the average length of stay decreases, costing more marketing dollars to refill the units. In a competitive environment, this trend can lead to financial difficulty. A stand-alone assisted-living community should not exceed 60 to 80 units for maximum efficiency, unless there is a special-care unit associated with it on the same site, such as an Alzheimer's or memory-impaired unit. This way, nursing supervision and other staffing can be shared for both units. *RL*

Benjamin W. Pearce is the senior vice president of operations for ADS Senior Housing, based in Newton, Mass. He manages all development, operational and marketing activities for the company's assisted-living and Alzheimer's communities located primarily in New England. During his 15 years in the senior-housing industry, Mr. Pearce has served as vice president of operations for Classic Residence by Hyatt, regional director of operations for the Hillhaven Corp., vice president of operations for International Care Centers, and he has managed 10 skilled-nursing facilities with the Careage Corp. Retirement communities under his management have been awarded the prestigious Contemporary Long Term Care Order of Excellence Award on three occasions.

In addition, Mr. Pearce is a director of the National Association of Senior Living Industries, the Assisted Living Federation of America, and the Massachusetts Assisted Living Facilities Association, and he has been widely published in trade journals.

This article is excerpted from Mr. Pearce's book, Managing Retirement Communities, *which is due out in October.*

Attn: Owner-Operators

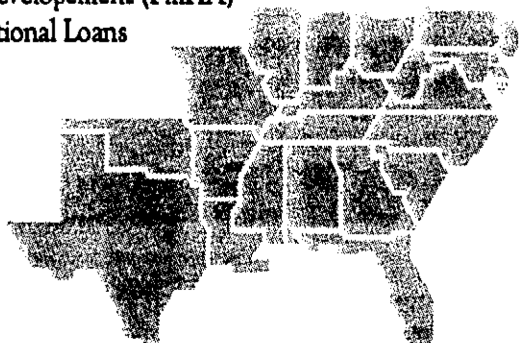
Alzheimer's Care / Assisted Living Loans

$300,000 to $3 million

Southeast, Midwest, Mid-Atlantic

VST FINANCIAL

- SBA 504 and 7(a) Loans
- Rural Developement (FmHA)
- Conventional Loans



Please call Andrew Logan at (800) 758-0038 for details.

Atlanta Lexington Tampa Wilmington

VST Financial is a wholly-owned subsidary of the Vine Street Trust Company, a state-chartered FDIC insured commercial bank located in Lexington, Kentucky.

Guide your organization into the next century with

The Next Generation of Senior Services

Development · Marketing
Management · Strategic Planning

To learn how Walker Management & Development can provide a single service or the entire spectrum of senior service consulting, call

Ken Ward, Senior Vice President,
Walker Management

1-800-735-3048 or
(612) 827-8369

3737 Bryant Avenue So. • Minneapolis, MN 55409

Calculating Assisted Living Unit Absorption and Financial Performance

by Benjamin Pearce

There is a direct relationship between the fill-up rate of a senior housing community and its financial performance. Generally speaking, the quicker the fill-up, the better the return on invested capital.

For example, an $11 million, 100-unit community with a 20-year mortgage at 9 percent will require approximately $98,000 per month in amortizing payments. Let us assume that operational cash flow requires 50 percent occupancy and servicing the debt requires 86 percent occupancy (86 units). At a net absorption rate of eight units per month, it will take 11 months to reach cash flow. This means that the project will need to borrow working capital for 11 months to meet operational shortfalls. Interest will also accumulate on the working capital funds during this period.

After cash flow is reached, the surplus balance is normally used to pay down the more expensive working-capital loan. Only after this is completed will the project be able to realize any return on invested capital. If the net absorption rate is only four units per month, then it will take approximately 21 months to reach cash flow after debt service.

To calculate the financial impact of the slower fill-up rate, consider the $100,000 per month in debt service payments that will be required each and every month from month 11 to month 21, or $1 million plus interest that will need to be financed if the fill-up rate is four units per month rather than eight This additional financing requirement will add at least $100,000 per year to the amortizing payment based only on our 9 percent initial interest rate and not including additional operational shortfalls incurred during the slower fill-up period. These operational shortfalls could easily total $500,000 or more.

The addition of $100,000 per year in debt service translates to $8,333 per month. At an average rent of $3,000 per month, it will require three more occupied units to reach cash flow after debt service, or 89 percent occupancy, not including the additional cost per month to service these additional residents. Add in the debt service of $4,500 per month ($500,000 / 9 percent/ 20 years) on the additional operational shortfalls, and 1.5 more units to cover this, and we're up to 90 percent occupancy before the investor will see any return. This leaves only 4.5 units at 95 percent stabilized occupancy for return on investment, capital improvements, principal reduction, and coverage for unexpected contingencies, underscoring the importance of running the buildings at 100 percent occupancy. At this point, it all drops to the bottom line. This small margin is further eroded if the inflated cost of operations each year cannot be passed on to the residents, who are normally on fixed incomes.

Larger Projects Must Fill Up Fast

The larger the project, the faster it will need to fill up in order to achieve the same result. A 200-unit project may, for example, have $7 million more in debt service (100 additional units x $70,000 per-unit project cost) than its 100-unit competitor. This project will need to fill at eight net units per month in 20 months to reach the same 80 percent operations-plus-debt-service cash-flow threshold. The financial implications and risks of a slow fill-up are significantly amplified in larger projects.

Another factor affecting the project's financial feasibility is the impact of absorption on project financing. Construction loans normally bear a higher interest rate than do the permanent loans that will replace them. The longer the construction loan remains outstanding, the greater the interest expense carried by the project. Normally, permanent mortgage financing will replace the construction financing after certain specified operating net income thresholds have been met. Therefore, for each month that occupancy fails to reach the required threshold and the construction loan remains in place, the project incurs a higher interest expense than was projected in the financial proforma. In essence, this higher interest expense becomes a construction-cost overrun.

Absorption and continued occupancy are clearly the most critical factors affecting the financial feasibility of senior living (as well as other multi-family real estate) projects. The combined effect of the costs associated with a slower-than-projected fill-up or absorption rate of the project can quickly wipe out any contingency funds built into the proforma by the developer and can turn an otherwise well-conceived project into a financial disaster. The inability of developers to meet their projections has been the single greatest factor contributing to the preponderance of failed

projects that ultimately were sold at a loss, foreclosed upon, or filed bankruptcy.

A break-even point analysis on operating expenses only and on operating expenses plus debt service (principal + interest)—not including depreciation—can be very useful in determining the number of occupied units needed to reach investment performance thresholds. It is important to note that the loan-to-value ratios will impact the break-even point analysis relative to the level of leverage and debt service on the properties. The first break-even point will be reached when revenues cover operating expenses. Industry averages range from 49 percent to 67 percent occupancy. Property taxes, location, and type of community will also affect this margin.

Secondary Break-Even Point Is Significant

The second and more important break-even point is reached when operating revenues equal operating expenses plus debt service. This point is generally lower for congregate communities, increasing with the relative level of care provided. This factor will vary according to the relationship of debt service to the number of units and the revenue generated from the unit mix. For a 100-unit assisted living community, this break-even point with debt service should be reached at approximately 80 percent occupancy. Projects with higher break-even points are either operated inefficiently or carry too much debt service. For example, projects that are overburdened with debt may be highly leveraged or expensively built.

As a general rule, a community operating at stabilized occupancy should have a capitalized value that is at least equal to or greater than its debt-service balance. Projects that fall short of this target are probably not worth their debt-service balance and will require equity to liquidate.

Benjamin Pearce is the senior vice president of operations for ADS Senior Housing, *Newton, Massachusetts. Over the past 15 years, he has overseen the operations and marketing of 69 senior living communities in 17 states.* ■

Copy Right 1997 by Thompson Publishing Group
New York, NY 1-800-934-1610

Recognizing The Need

Assistance for Assisted Living

by Myrna Chandler Goldstein
Senior Contributing Editor

When assisted living becomes a choice of residency, affordability is a key concern to both elders and their caretakers. Most elders are paying with their own financial resources. However, as more and more need financial assistance, and with very few places to find it, assisted living residences are trying to keep the monthly rents affordable. Heritage at Cleveland Circle (above) has developed methods to offer more affordable rates.

Everyone dreams of an old age that is filled with vim and vigor. You want to be the elder who wins the five mile senior's swim or runs in the Boston Marathon. We all wish for a long, healthy, active and productive life.

Some seniors are so blessed. They remain in remarkably good health well into their 80s and 90s. However, most older Americans develop physical and/or memory limitations. As they age, these may become more pronounced. Many will require assistance with some of the tasks of daily living.

The National Institute on Aging (NIA) notes that, "Increasing age heightens the probability of functional limitations.

"In one survey, 9 percent of people age 64 through 69 required day-to-day assistance, including help with bathing, dressing and eating, compared with 50 percent for those 85 and older," NIA said. "One-third of elderly women age 75 and older are functionally dependent and in need of considerable assistance."

As a result, large numbers of people turn to home health agencies and family members to complete these tasks. Often, that assistance is sufficient.

But there is another side to the story. Sometimes, even with aid, seniors are no longer able to remain at home. In the past, seniors had only one option—a skilled nursing facility.

Thankfully, recent decades have witnessed the emergence of a whole new type of housing option—assisted living. Seniors live in their own or shared apartment units and receive help with specific tasks of daily living such as bathing, dressing, meal preparation and the supervision of medications. According to the Assisted Living Federation of America (ALFA), "currently, up to 1.5 million Americans are living in an estimated 30,000 to 40,000 assisted living communities. The vast majority of residents nationwide are frail elderly."

ALLOWS ELDERS TO "AGE IN PLACE"

Assisted living enables seniors to age in place—to remain in their own units while receiving only the services they need. It is what most seniors prefer, and it is far more cost efficient than a skilled nursing facility. Citing statistics from the Marion Merrell Dow and Healthcare Financial Management Association, ALFA notes that the average per diem rate in the U.S. for a skilled nursing home is $111; the rate for assisted living is $72. In the Northeast, those figures are generally higher.

Without a doubt, there is a need for such housing. According to the Bureau of the Census, the oldest old, those 85 years and older, "are the most rapidly growing elderly age group."

"Between 1960 and 1994, their numbers rose 274 percent," according to the Bureau of the Census. "While the elderly population in general rose 100 percent, the entire U.S. population grew only 45 percent. The oldest-old numbered 3 million in 1994, making then 10 percent of the elderly, just over one percent of the total population. Thanks to the arrival of the survivors of the baby boom generation, it is expected the oldest old will number 19 million in 2050. That would make them 24 percent of the elderly Americans and five percent of all Americans."

Using Census data, ALFA said that, "the population of people 85 and older is expected to increase 39.3 percent by the year 2000 and 33.2 percent between the years 2000 and 2010." The Commonwealth of Massachusetts Executive Office of Elder Affairs said that 819,284 of the state's residents were 65 years of age and older in 1990. By the year 2000 this number should grow to 855,000.

Traditionally, the vast majority of assisted living has been privately paid. Those who did not have the resources to pay simply did not apply. Often, they would enter a skilled nursing facility, even when they were sufficiently well for assisted living.

ELDERS NO LONGER THE POOREST

But seniors are no longer the poorest segment of U.S. society. Their financial net worth has grown. It has become a true

Recognizing The Need:

misnomer to think of all elderly as destitute.

"According to Claritas, Inc., a nationally recognized demographics firm, (by the turn of the century) 53 percent of those individuals 80-years-of-age and older will have incomes of $15,000 and above, and nearly 35 percent will have incomes of $25,000 and above," ALFA said. Further, according to the NIA, "The median income for the elderly (in constant 1992 dollars) has more than doubled since 1957."

Moreover, a 1996 survey conducted by ALFA and Coopers and Lybrand L.L.P. found that assisted living residents in the Northeast have an average annual income of $34,200—higher than any other section of the U.S. On the average, they have financial resources of $280,400—also the highest in the U.S.

Because of this, many seniors are increasingly able to pay for assisted housing, for a while at least. In addition, in recent years, as federal and state governments have searched for ways to control the escalating costs of health care, they have begun to realize that it never made sense to place people in skilled nursing facilities when they could live in a type of assisted living. With ever tightening budgets, it is foolhardy.

"Although I have seen statistics that indicate that about 8 percent is publicly paid through SSI or Medicaid waivers, today, assisted living is primarily private pay (90-92 percent)," said Suzanne Perney, associate publisher of *Briefings on Assisted Living*. "But a recent American Health Care Association study says 42 percent of the 352 facilities that answered its survey have at least some residents whose care is supported by a state program."

Yet, a few states have assumed a leadership role in this area and are directing Medicaid resources to assisted living.

MEDICAID IN SOME STATES

"In some states, such as Oregon and Texas, a significant amount of state Medicaid money is used for assisted living," Perney said. "And those states have been successful in transferring people from skilled nursing to assisted living."

"Typically, we require that they use no more than 85 percent of their income for housing.

—Benjamin Pearce
Senior Vice President
ADS Senior Housing in Newton

Tom Grape, president of Benchmark Assisted Living in Wellesley and a foremost national authority on assisted living, said that the only assisted living Medicaid subsidy program in Massachusetts is Group Adult Foster Care.

"It is for people with limited means," said Grape, who serves on the board of ALFA as well as the board of the Massachusetts Assisted Living Facilities Association and the board of the Connecticut Assisted Living Association. "At the moment, it is virtually the only government subsidy."

A Fact Sheet from the Division of Medical Assistance of the Massachusetts Executive Office of Health and Human Services states that Group Adult Foster Care is available for those who meet the standards of financial and clinical eligibility: "Financial categories of assistance are determined either in the MassHealth Enrollment Centers, or in the local Social Security Administration office which determines financial eligibility for Supplemental Security Income (SSI). Physician authorization must confirm that an individual may be at risk of institutional placement and that Group Adult Foster Care services are appropriate to meet the physical and psychosocial needs of the participant. The individual must have a medical diagnosis and a daily need for assistance with at least one activity of daily living (ADL)."

The Fact Sheet also states, "The Division reimburses the provider $15.70 per participant per day for personal care services." Administrative services are reimbursed at the rate of "$18.00 average per participant per day."

In other words, Medicaid will reimburse for personal care and administrative services but not for room and board. According to Carolyn Blanks, associate director of government relations for Massachusetts Extended Care Federation, "the Division of Medical Assistance (DMA) and the Department of Transitional Assistance (DTA) are currently working on a plan for a new Supplemental Security Income program that would help pay the cost of living expenses for low income elderly in certified Group Adult Foster Care residences."

"While the legislature last year authorized the creation of the program, the language stipulated that DMA and DTA must first submit a plan for legislative approval," Blanks said. "It is expected that (re)implementation of the program would not begin before July 1, 1997."

WHAT ABOUT MASSACHUSETTS?

And what is available in Massachusetts for people with a little more money?

"With the exception of a few assisted living residences that have private trusts, there is not much available for lower/lower-middle income elders looking for

Assistance for Assisted Living

affordable assisted living," Blanks said. "I encourage people to investigate public or private elderly housing that may provide or arrange for assisted living-like services."

Nancy Shapiro, executive director of the Heritage at Cleveland Circle, an assisted living facility, said that twenty percent of her facility's residents receive one of two types of financial assistance. Those found eligible for Group Adult Foster Care pay a maximum rent of $498 per month. For each of these residents, Medicaid pays almost $1100 per month.

Sister Mary Sears and Sister Lena Breton (left to right) giving their green thumbs a workout at the Provincial House of Sisters of Charity of Montreal, "Gray Nuns," which is being converted to Youville Place Assisted Living Residence in Lexington. Phase 1 will open in late April.

AFFORDABLE PROGRAMS AVAILABLE

The Heritage at Cleveland Circle also offers an Affordable Resident Program. Those residents who meet the Massachusetts low-income guidelines—for a single person that is $19,800—pay a rent of $498 and $1100 for the package of assisted living services.

"The reason we are able to do this is that we received financing from the Massachusetts Housing Finance Agency," Shapiro said. On the other hand, eighty percent of the residents pay the full rent, which ranges from $2500 to $4000 a month.

Benjamin Pearce, senior vice president of ADS Senior Housing in Newton, explained that when potential residents apply they complete a financial application.

"We ask them to disclose information on assets and income," Pearce said. "Typically, we require that they use no more than 85 percent of their income for housing. Most of resident have assets such as proceeds from the sale of their homes, pensions or investment income."

His company owns or manages eight existing assisted living communities including Heritage at Cleveland Circle, with three currently under construction.

Pearce said that the average ADS Senior Housing resident stays about 30 months. "We evaluate the income based on that," Pearce said. "If we feel at the time of admission that the resident may be short of the amount of the funds they will require, we ask the family to sign a responsible party agreement. This is an agreement with the children that they will provide financial assistance if required. Some residents may be able to go on Group Adult Foster Care. But that has a component requiring assistance with the tasks of daily living. And not all our residents require such assistance."

On the rare occasion that a financial problem does emerge, it is important that it be addressed as soon as possible. "We counsel families to work out a reasonable solution and not wait until the situation becomes a crisis," Pearce said.

Affordable housing is also available from facilities owned or managed by religious organizations. One example is Youville Place Assisted Living Residence in Lexington, which is opening in late April.

According to Susan McDonough, vice president, Elder Services, Covenant Health Systems, which is marketing and managing Youville Place, "Affordability is being addressed in two ways.

"First, donations of land and a convent building by the Sisters of Charity of Montreal significantly reduced development costs for this project. This savings is being passed on to all future residents in the form of lower monthly fees, which average $3,100 a month.

"Second, as a condition of its granting zoning approval for Youville Place, the town of Lexington required that 25 percent of all units (up to 23 apartments) be set aside as moderately priced housing for frail elders who qualify under the Mass. Group Adult Foster Care Program."

Tom Lucas, CEO, Mary Immaculate Health Care Services in Lawrence, another Covenant Health Systems, said that his 304-unit community was developed in the 1980s with federal funding for low-income elderly. "They then received subsidies after paying 30 percent of their monthly income as rent."

Covenant then developed a "Supportive Housing Program," which he said provides a package of assisted living-type services to qualifying seniors for a fixed monthly fee of $1,050. "Sixteen seniors are currently enrolled in this program," he said.

Another helpful assist for elders in need, Perney pointed out, is that "even when there is no Medicaid reimbursement, residents are rarely forced to leave assisted living programs.

She added, "Often facilities [as Benjamin Pearce noted] require adult children to guarantee financing in the eventthat mom or dad runs out of money.

"By and large," she noted, "people don't move into assisted living unless they think they can afford it. Also, most

Assistance for Assisted Living

come from their own homes, and when they sell the home they generally have the cash. Remember, most people don't go into assisted living until their mid-80s, and the average length of stay is 2.8 years. Also, many companies and facilities have one or two residents that they partially subsidize, although they don't advertise the fact. In some instances, people have bequeathed funds to help residents who run out of money."

In the future, Perney anticipated that private insurance will direct more resources to assisted living. "The new Kennedy/Kassebaum law makes long-term care insurance tax deductible as a medical expense, and this coverage can include assisted living," she said. "In the future, it is expected that this insurance, which employers can deduct, will impact the field."

ASSISTED LIVING BEING CONSIDERED BY MANAGED CARE AND HOSPITALS

She added that managed care is "eyeing assisted living as a lower cost venue than skilled nursing. I've heard of different types of agreements and networks where elderly or chronically ill people will go to assisted living for a short term stay if there is no one at home to care for them." Perney said. "Assisted living is also a venue for some chronic care needs, such as diabetes, stroke victims, Alzheimer's, who don't require more skilled nursing. I believe we will see more of this as Medicare HMO's develop and more networks form."

"Many hospitals are also interested in adding assisted living to their continuum of services," Grape added. "I've worked with approximately 10 hospitals in New England that are adding assisted living to their campuses, building assisted living residences off site or are forming strategic alliances with assisted living residences developed by others in their market area. They clearly recognize the demographic and public policy changes promoting the growth of assisted living and the significant opportunities for hospitals to benefit from this trend."

MODEL PROJECTS SHOWING BENEFITS

The benefits of the managed care approach have already been demonstrated in a number of model projects. One of the better known examples is the Program for All Inclusive Care of Elderly (PACE), a demonstration program funded by Health Care Financing Administration (HCFA).

According to Jerry Reardon, Ph.D., one of the directors of the health care consulting practice of Arthur Anderson, Eastern Region, instead of having separate Medicare and Medicaid revenue streams for each of its members, PACE, which has 17 sites throughout the country, receives a certain amount of money, from both federal and state funds, per member per month.

With that money, PACE provides each of its members with the most appropriate services. If a member should need assisted housing, PACE will pay for it; if a subacute or rehabilitation nursing facility is a better alternative, then that is chosen.

"By putting all the dollars together, it gives whoever is responsible for a covered life the most efficient, least restrictive, approach," Reardon said. "It makes sense. Why hasn't it been done? Because of regulation against mixing revenue streams. In PACE projects, elderly people agree to use only providers and services provided by PACE. Like any HMO, there are some limitations. But in the long run, they get what is best for them. Managed care allows you to use money in a cost efficient way—based upon need and limited by boundaries between federal and state regulations."

In Massachusetts, PACE is known as the Elder Service Plan (ESP). According to Pamela Gossman, the ESP Replication coordinator, all PACE plans, "provide a complete range of health and health-related services designed to improve or maintain the functional status of frail elders and to keep them living in their community as long as possible.

"A multidisciplinary team of providers including a primary care physician, nurse practitioner, nurses, social worker, nutritionist, physical therapist, occupational therapist, recreational therapists, and health aides plans and provides the care," Gossman said. "A central feature of PACE is the community-based center where participants receive services and enjoy activities and the company of others. Home health services, meals and transportation are other critical components of the PACE model. Transitional housing staffed by qualified caregivers is available at some sites.

"Funding for PACE services is made through capitated Medicare and Medicaid payments. This payment method gives providers flexibility in designing services and care plans that fit the unique needs of each participant without fee-for-service restrictions. In addition to medical, restorative, social and supportive services, PACE is responsible for acute and long-term care costs which it has controlled successfully through substitution of community and home-based services for institutional care."

Assisted living in Massachusetts continues to grow at an incredibly rapid pace. The options are many, but mainly for those with financial resources. For those without sufficient resources, there appears to be some hope as the state is slowly beginning to address their plight of being able to afford housing with assisted living.

Hopefully, *Hospital News* will have a very different story to tell within the next few years. ❒

Reprinted from Hospital News, Massachusetts • April 1997
PO Box 8015 • Westborough MA 01581

REACTIVATING Appetite

NATURAL FLAVOR ENHANCERS TEMPT AGING TASTE BUDS

EVEN IF THEY EXISTED only to allow us to savor the pure pleasure of a ripe peach in August or a well-seasoned bowl of soup in December, our senses of taste and smell would be miracles of engineering. But these artfully crafted digestive aids serve another vital purpose: they help the body absorb nutrients. When people taste or smell appetizing food, saliva builds up in the mouth, gastrointestinal juices are released into the stomach, plasma insulin is released into the bloodstream, and the pancreatic system is engaged, all combining to aid digestion.

As people age, however, their senses of taste and smell generally atrophy. This causes them to enjoy food less and absorb it less efficiently, which in turn puts them at risk for malnutrition. These losses tend to begin around age 60, and become more severe in people over 70 years of age. Until recently, not much was known or

PHOTOGRAPH BY STEVEN MARK NEEDHAM

By Cheryl Lucas, Benjamin Pearce, and Susan Schiffman

FLAVOR-ENHANCED FOODS

	FOOD TYPE	FLAVOR USED	PREFERRED BY
VEGETABLES	Carrots	Carrot	75%
	Green Beans	Bacon	83%
	Green Peas	Pea, Bacon	94%
	Potatoes	Potato, Bacon	81%
MEATS	Beef (ground)	Bacon, Beef	94%
	Beef (casserole)	Bacon, Tomato	83%
	Chicken	Bacon, Chicken	80%
SOUPS	Chicken	Chicken, Bacon	78%
	Tomato	Bacon, Tomato	84%
	Vegetable	Bacon, Tomato, Pea	83%

done about this phenomenon. But a recently published study, conducted by Susan Schiffman and Zoe Warwick at the Duke University Medical Center, demonstrates a way of using natural flavor enhancers to boost impaired senses and restore seniors' appetites.

Taste is mediated through taste buds located on the top of the tongue and on the epiglottis, larynx, and the first third of the esophagus, which deteriorate with age. A study published in issue 308 of the *New England Journal of Medicine* found that subjects between the ages of 20 and 70 had an average of 206 taste buds each, while people between ages 74 and 88 averaged only 88. Smells are processed by bulb-shaped bipolar neurons in the upper part of the nasal cavity. Cross-sections of this bulb taken from elderly people often shows a "motheaten" look due to a loss of neuron cells. These losses are especially profound in Alzheimer's patients.

Taste and smell can also be dulled by certain types of surgery, by radiation, and by exposure to smoke or other airborne contaminants. Many medical conditions, including head traumas, multiple sclerosis, hypothyroidism, diabetes mellitus, and hypertension, may deaden these senses as well.

A number of drugs that are commonly taken by the elderly can have the same effect. These include anti-rheumatic, anti-inflammatory, diuretic, and antihypertensive drugs, as well as several vasodilators and drugs for the treatment of Parkinson's disease. These affect the senses only as long as they remain in the system, but elderly people often take such medications with their meals.

AS A RESULT, FOOD SERVED AT LONGTERM CARE facilities often tastes bland to the residents, who may inadvertently harm themselves by using too much salt at the table to add flavor. Many residents also skimp on meals and eat too much dessert, which they can still enjoy because the ability to taste sweet things is one of the hardiest parts of the sense of taste.

The Duke University study suggests that adding certain naturally produced flavors to foods can enhance their flavors for elderly people with chemosensory losses. The chart on this page shows the percentage of elderly subjects who preferred flavor-enhanced foods in the study.

The flavor enhancements used are commercially produced, inexpensive (costing less than a penny a meal), and readily available from major food suppliers. They are made by reducing down food such as chicken, capturing and concentrating natural flavor and odor molecules in the process. These molecules, which include only the essence of the flavor, are then attached to a carrier such as water, oil, or flour.

Fresh herbs, spices, and marinades can also enhance flavors, but too many herbs and spices can overpower a dish. Besides, many residents' delicate digestive systems may become agitated by an excess of herbs and spices. Concentrated natural flavors such as chicken, bacon, and peas cause no digestive problems—and they contain none of the fat, salt, or other harmful products associated with artificial flavoring. Even bacon flavoring should be acceptable to people on restrictive diets, as it contains only chemical essences extracted from pork products, not the products themselves.

In the study, residents and employees of Classic Residence by Hyatt in Chevy Chase, Maryland, were randomly selected as subjects. Their mean ages were 82.6 years for the residents and 40.4 years for the employees. The subjects rated three flavor levels each for chicken consommé; herb-marinated, seared chicken breast; and beef tenderloin with brown sauce. They then ranked the samples in order of preference and explained why they chose that order.

For all the foods tested, the young subjects like the mildest flavors better than the elderly subjects, which suggested that the taste and smell functions of the young subjects remained intact while those of the elderly had decreased. Both groups, however, liked the mildest flavor of chicken consommé least and the medium flavor best. (The medium consommé was flavored with one tablespoon of chicken stock per pint.) The elderly subjects' preference for the medium level of flavoring may be explained by their comments, which indicated that the highest level was too salty, although absolutely no salt was used in the cooking process. This suggests that residents associate more flavor with more salt and may avoid more flavorful foods even if they prefer them because they are following low-sodium diets.

Residents ate more of the flavor-enhanced versions of 22 of the foods tested. These were beef barley soup, cauliflower, succotash, eggs, English peas, French-cut green beans, grits, macacroni and cheese, maple syrup, mushroom gravy, mustard greens, peas and carrots, roast beef, brown gravy, kale, spinach, stewed tomatoes, tomato gravy, veal, paprika stew, vegetable gravy, and waxed beans.

Reactions to the study indicated that communicating with the participants about the new diet was key. They were fintersted to learn that taste and smell deprivation is a normal part of the aging process and that changes can be made to compensate for it. And they were gratified to see management using this knowledge to make their meals more pleasurable—and, ultimately, more nutritious. CLTC

Offensive Versus Defensive Marketing:

Marketing Stabilized Communities In The Nineties

By Mary G. Leary and Benjamin W. Pearce.

As more and more senior living communities approach stabilized occupancy, the following issues are being raised:

▲ What are appropriate marketing expenditure levels at stabilized occupancy?

▲ What are adequate staffing levels?

▲ How should sales compensation programs be structured?

Traditional marketing approaches have employed "defensive" marketing tactics to sustain stabilized occupancy. "Defensive" marketing is a reactive marketing strategy for managing ongoing turnover. Defensive marketing assumes a small marketing budget, minimal staffing and minimal sales compensation levels. The advantage of defensive marketing is marketing expenditure savings. The potential disadvantages of defensive marketing can however significantly outweigh this cost savings advantage.

How many communities do you know that have lost occupancy after reaching stabilization? Have some independent living communities retained frail residents longer than they really should? Have certain established communities offered price concessions to obtain sales? Have others lost top sales producers to the competition? These situations may be indicative of a defensive marketing strategy gone awry.

Lower marketing expenditures mean fewer leads generated for a community. If leads are insufficient to cover turnover, several problems can result.

■ Insufficient leads may result in longer time frames to obtain sales and move-ins, thus reducing anticipated apartment revenue. Difficulty in obtaining sales breeds potential for price concessions, which is a further drain on revenue. And, last but not least, vacancies reduce a community's ability to command premium rate increases due to high demand.

■ Some communities may try to retain failing residents longer than is appropriate, raising ethical concerns regarding provision of care in the most appropriate setting. Frailer residents will also erode the active image of a community and will attract frailer new prospects.

■ A smaller marketing budget may find marketing staff working harder with fewer resources and lower compensation levels. Staff may find that the "grass is greener" at another community and move to a competitor. The time, energy and money invested in training this staff is wasted, requiring unexpected expenditures to train new staff.

There Is A Better Way

An alternative to succumbing to the pitfalls of defensive marketing is that of "offensive" marketing. Whereas defensive marketing manages turnover, offensive marketing proactively manages the profitability of a community. The disadvantage of offensive marketing is a larger marketing budget than may be traditionally assumed for stabilized communities. The advantages can contribute much more to the bottom line than could any defensive marketing budget savings.

Offensive marketing tactics seek to minimize marketing expenditures without compromising a community's ability to maintain stabilized occupancy and maximize revenue. Offensive marketing provides the following assurances:

▲ Sufficient leads are generated to keep pace with turnover.

▲ Sale and move-in time frames are minimized, thus achieving or exceeding apartment revenue projections.

▲ Resident acuity levels are optimized, so that failing residents are placed in the most appropriate care settings. By retaining the integrity of a community's active image, a community is better positioned to compete against new communities. This is particularly important for congregate rental communities which do not have the internal transfer option which continuing care retirement communities (CCRCs) have with their ability to transfer from independent living to assisted living or nursing care.

▲ Monthly fee increases on turnover units are maximized. Monthly fee increases on renewals can also be aggressively managed, since turnovers can be filled quickly.

▲ Price concessions are minimized because lead generation efforts generate sufficient demand to build a strong waiting list.

Continued on page 12 ...

Offensive Versus Defensive Marketing:

Marketing Stabilized Communities In The Nineties

... Continued from page 10

▲ Top sales producers are retained because they have the resources to generate sufficient new leads to fill turnover, have the necessary support staff to facilitate the sales process, and receive compensation which is competitive.

▲ Staff recruitment and training costs are minimized.

Offensive Marketing Can Reduce Your Financial Exposure

Specific examples of offensive marketing strategies include:

▲ Maintaining a higher staffing complement to better work existing leads and minimize staff "burn-out".

▲ Providing a competitive sales compensation program that rewards staff for reaching goals in excess of budget.

▲ Conducting ongoing sales training to reduce sale and move-in time frames and to keep staff motivated and challenged.

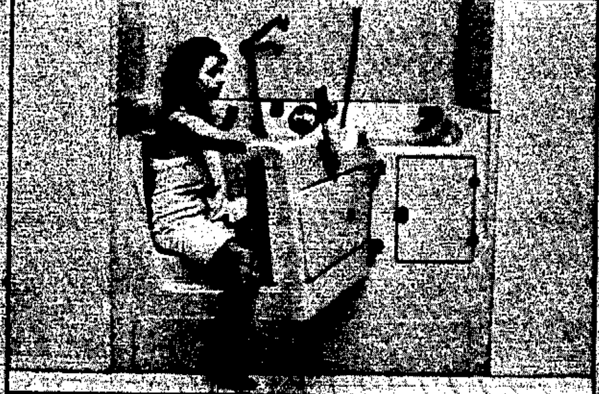
▲ Keeping a "baseline" presence in the media to avoid starting from scratch to re-build awareness, should lead generation efforts fall off.

Offensive marketing reduces a community's financial exposure by proactively managing turnover and its impact on revenue. An example of the impact of **not** following an offensive marketing approach is as follows:

DEFENSIVE MARKETING PITFALLS	ANNUAL LOSS
✦ 2 less units occupied in a month (eg., $2,000 lost revenue x 2 units x 12 months)	($ 48,000)
✦ 2 slower move-ins (eg., $2,000 lost revenue x 2 units x 12 months)	($ 48,000)
✦ 2 leases lost because existing residents "too old" (eg., $2,000 lost revenue x 2 units x 12 months)	($ 48,000)
✦ No increase in turnover unit rent versus 5% increase (eg., $2,000 x 5% = $100 per month x 12 months x 36 turnover units per year)	($ 43,200)
✦ 1% less on renewal rents because not full building (eg., $2,000 x 1% = $20 per month x 12 months x 200 units)	($ 48,000)
✦ Concessions equivalent to 1-month's rent (eg., $2,000 x 36 units per year)	($ 72,000)
✦ Cost of recruiting/training new marketing staff (eg., $10,000 recruitment/training costs)	($ 10,000)
TOTAL	($317,200)

Continued on page 20 ...

Side Entry Tubs & Barrier Free Showers



Access Tubs
The Access Tubs are personal size spas, tubs and whirlpools designed to fit in the same space as a standard tub. The Access series tubs allow the user to enter and exit the tub easily. The comfortable seat and contoured interior provide a luxurious, convenient, and safe environment. A variety of optional plumbing and installation packages are available.

Barrier Free Showers
Designed and built for the home, Silcraft Showers feature roll-in access, non-skid floor, grab bars, controls, shower wand, and waist high shower curtain. A molded or fold-down seat is optional. Knock-down versions allow easy renovation of tub or shower enclosures in existing structures. ADA compliant models are available.

SILCRAFT CORPORATION
528 Hughes Drive, Traverse City, MI 49684 (800) 678-7100

circle reader #116

Offensive Versus Defensive Marketing:

Marketing Stabilized Communities In The Nineties

... Continued from page 12

Offensive marketing offers the opportunity to add significant value to a senior living investment. Through offensive marketing, the above defensive marketing pitfalls could be avoided and $317,200 more in revenue/expenditure savings could result. At a 12 percent "cap" or investment interest rate (cap rates are an indicator commonly used to determine asset value based on cash flow), approximately $2,643,000 in increased property value could result. Increases in the marketing budget to achieve these offensive marketing results are clearly justified.

An alternative way of examining this issue is to analyze the "opportunity" cost related to marketing defensively. Vacant units will result in lost investment value for a community. For example, if 75 percent of the monthly fee is typically needed to cover fixed operating expenses and debt service, then each vacant unit reduces the contribution to fixed operating expenses and debt service. A 200-unit community that stabilizes at 94 percent versus 99 percent, represents an opportunity cost of $180,000 in lost revenue or $1,500,000 in lost value for the community at a 12 percent capitalization rate (200 units x 99 percent = 198 units) - (200 units x 94 percent = 188 units) = 10 units x $2,000 per month x 12 months = $240,000 x 75 percent contribution to fixed operating expenses and debt service = $180,000/.12 = $1,500,000.

Communities have traditionally focused on reducing expenses as buildings mature. However, only so much value can be added to an investment by cutting expenses. Communities which focus on a defensive, expense management strategy **as well as** an offensive, revenue enhancement strategy, will be better able to provide additional value beyond expected returns on investment. Clearly, communities which focus on efficiency **and** revenue enhancement will be positioned for strategic advantage in the marketplace.

In summary, offensive marketing is a revenue enhancement strategy, whereas defensive marketing is an expense management strategy. While both elements are important, potential revenue generation opportunities can significantly outweigh marketing budget savings for a stabilized community. "Judicious" offensive marketing budgeting can bring untold financial benefits to stabilized communities during the nineties.

"DEFENSIVE MARKETING"

A REACTIVE, EXPENSE MANAGEMENT STRATEGY FOR MANAGING TURNOVER

DEFENSIVE MARKETING ASSUMES:

Small marketing budget
Minimal staffing
Minimal compensation

DEFENSIVE MARKETING ADVANTAGES:

Marketing expenditure savings

POTENTIAL DEFENSIVE MARKETING PITFALLS:

Can't keep pace with turnover
Resident care needs increase
(raises ethical concerns)
(erodes active image)
(attracts frailer new prospects)
Turnover time frames increase
Can't maximize rental rates
Rental allowances increase
Can't retain top producers
Training costs increase

"OFFENSIVE MARKETING"

A PROACTIVE, REVENUE ENHANCEMENT STRATEGY FOR MANAGING PROFITABILITY

OFFENSIVE MARKETING ASSUMES:

Larger* marketing budget
Larger* staff
Higher* compensation

POTENTIAL OFFENSIVE MARKETING PITFALLS:

Higher marketing expenditures

OFFENSIVE MARKETING ADVANTAGES:

Keep pace with turnover
Minimize turnover time frames
Optimize acuity levels
Generate active new prospects
Build waiting list
Maximize rental rates
Minimize rental allowances
Retain top producers
Minimize training costs

* In comparison with Defensive Marketing Strategy ❑

Mary G. Leary is vice president of sales and marketing and Benjamin W. Pearce is vice president of Operations for Classic Residence by Hyatt of Chicago, Illinois.

THE HIDDEN LIABILITIES OF HOME COMPANIONS

by Benjamin W. Pearce, President, Potomac Homes

At-home care using home companions or home health aides is the single largest, yet informal system for the delivery of healthcare services in this country today. Families that hire caregivers or outside contractors may unknowingly be exposing themselves to a variety of financial risks and tax consequences.

The IRS requires payroll tax filings by a domestic employer who pays a caregiver more than $1,200 cash wages in a calendar year. These payroll tax obligations may include: Social Security and Medicare Taxes, Federal Unemployment Tax (FUTA), State unemployment and disability insurance taxes levied on the employer, and advance payment of earned income credit for eligible employees. The employer is required to collect the employee's social security and Medicare taxes. Should the employer fail to collect, they still remain responsible for remitting these taxes for the employee. Congress revised the "Nanny Tax" legislation in October 1994, offering employers alternative means to remit the federal payroll taxes for wages paid. This legislation requires employers to disclose the wages paid to household staff on the employer's personal income tax return. When a former employee files for unemployment, disability or social security benefits, the state then realizes that the person was receiving unreported compensation. Employers are required to give their employee a wage and tax statement (Form W-2) no later than January 31.

Domestic employees must be paid at least the Federal minimum wage, currently $5.15 (9/1/97). Live-in employees must be paid for every hour worked; all employees must be paid overtime for any hours exceeding 40 hours per week. If the person lives on site, then the Department of Labor assumes 8 hours sleeping or 16 hours working per day, or 112 hours per week. Since anything in excess of 40 hours per week is required to be paid at time and one half, this situation would result in 72 weekly hours of overtime. This translates to $2,600 per month for 24-hour coverage, not including loading for payroll taxes, which is comparable to the cost of assisted living. For a live-in, fair value of room and board can be deducted from straight pay. Also, you are legally required to verify your candidate's employment eligibility under immigration laws using Form I-9.

Unlike most home health agencies, most independent home companions do not carry comprehensive general liablility insurance. Therefore if a home companion is injured on the job while providing care for your family member you may be liable personally for their injury. New Jersey is one of several states that mandates coverage. Prices vary, but a typical policy costs around $400 for employees making at least $15,000 annually. Typical homeowners policies will not cover any injury to an employee.

Understanding your liability exposure when employing independent home care companions can be a complex task. While the access to this apparently inexpensive pool of help for an aging parent may at first glance be an attractive option for many families seeking to help their aging parents remain at home, the risks to the family need to be considered. Further, as the level of care increases over time, it is often much less expensive and more advantageous to seek healthcare professionals to deliver this care in a safe, homelike environment where the quality of life can be very high.

There are so many different reasons for having a wig:

- for Fun
- for a Bad Hair Day
- for a Different Look
- for Vacation
- for Thinning Hair
- for Complete Hair Loss

Sunshine Beauty Supplies

Servicing the wig and hairpiece needs of Sussex and Morris Counties & Eastern Pennsylvania for over 14 years.

At Sunshine Beauty supplies, the needs and concerns of each client are treated with care, consideration and confidentiality.

We have a fully trained and certified staff.

Styling personalized to you.

153-C Woodport Road
Sparta, NJ 07871

973-729-4991

FAMILIARITY IS THE KEY TO SUCCESS

by Ben Pearce, President, Potomac Homes

People with Alzheimer's disease can retain certain living skills that they would normally lose if caregivers let them perform those skills regularly. This conclusion is the result of a recent study by researchers of the Occupational Therapy Department at the University of Pittsburgh. The researchers found that guiding people with AD to perform certain activities of daily living (ADL's) rather than performing the tasks for them allows them to hang onto those skills they might otherwise lose as a result of the progressively degenerative brain disorder. "Typically, individuals with Alzheimer's disease have not been able to gain access to a great deal of rehabilitative care because it was felt that the disease is a progressively degenerative disease, and they would not benefit from the care," explains Joan Rodgers, leader of the study. "What our study demonstrated is that when people with Alzheimer's are provided with the appropriate support they can improve their ability to participate in ADL's." The appropriate support involves "behavioral intervention", cueing or providing a hint meant to guide behavior.

Rodgers explains "If nursing staff or an in-home caregiver does things for people that they can do for themselves, a condition can occur called 'access disability', which is the inability to perform activities and is caused by the caregiver, not necessarily the disease." Caregivers need to resist the temptation to perform these tasks for people simply because it is often easier and quicker. If caregivers provide cueing to start and finish some challenging tasks, such as dressing, and encourage people with Alzheimer's disease to attempt to complete some portion of the task themselves, they will help their patients to build confidence and ultimately, maintain independence longer.

This type of intervention puts demands on patients and could possibly create an increase in disruptive behavior. The caregiver must assess whether a particular activity can be completed successfully by the patient in order to avoid a negative response.

When living at home is no longer feasible, a residential arrangement as close to home as possible can provide many advantages. Familiarity with their environment can encourage patients to accomplish tasks like helping out in the kitchen, folding laundry, etc. which can keep them independent longer.

While providing comfort and assistance for a loved one afflicted with Alzheimer's, caregivers should challenge them to hold onto skills that they still may possess.

No wonder it's called a Reverse Mortgage.

Increase your income, make home repairs, pay off medical bills, or take a vacation using a Reverse Mortgage. Best of all - there are no income or credit requirements.

So, if you are over the age of 62 and want extra income without mortgage payments,* pick up the phone and contact us.

Roslyn McGriff - Smith
(800) 228-1136
(973) 357-7982

BNY MORTGAGE℠
A BANK OF NEW YORK COMPANY

*Repayment of mortgage is due upon sale of the dwelling or when it passes into borrower's estate.

2003 BNY Mortgage Company LLC, a Bank of New York Company. An Equal Opportunity Lender. Licensed Mortgage Banker - New York State Banking Department, 440 Mamaroneck Ave, 2nd Floor, Harrison, NY 10528. Licensed Mortgage Banker - NJ Department of Banking and Insurance, 385 Rifle Camp Road, West Paterson, NJ 07424.(973) 247-4900. BNY Mortgage Company is a service mark of The Bank of New York.

Is Alzheimer's care a tax deductible expense?

Over the years I have been asked countless times by residents and families "Are the costs associated with the care they receive tax deductible?" While much of the tax code is subject to varied interpretations, and each individual should seek competent advice from their own professionals, it appears that the answer to this question is "likely."

Section #213 of the publication *Selected Federal Taxation Statutes and Regulations – 2000 Edition* states *"There shall be allowed as a deduction the expenses paid during the taxable year not compensated for by insurance or otherwise for medical care of the taxpayer, his spouse or a dependent to the extent where that expense exceed 7.5 percent of adjusted gross income."* The exact definition of medical care has been further explained in Section 1016 *"If an individual in a nursing home or a home for the aged because of his physical condition and the availability of medical care is a principal reason for his presence there, the entire cost of maintenance, including meals and lodging is deductible."* The key distinction is the purpose of living there. If it is for personal or family reasons, then only the portion of the cost attributable to medical or nursing cost is deductible. The reason that the deductibility becomes cloudy is that service fees in assisted living facilities bundle the medical care component with room and board, making it difficult to determine or justify what portion of the rent covers the care of the resident. Further, most assisted living facilities go out of their way to advertise that they are not a medical care facility. Officially it is defined as: *"Assisted living facilities are a type of living arrangement which combines shelter with various personal support services, such as meals, housekeeping, laundry, and maintenance. Assisted living is designed for seniors who need regular help with activities of daily living (ADLs), but do not need nursing home care."* Under this definition the deductibility of costs associated with these facilities may be hard to justify.

> In homes specifically designed for the care of those with Alzheimer's disease and related dementia, the care, meals and lodging are an integral part of the complete service plan to constitute "medical care."

Publication 502 by the Department of the Treasury, Internal Revenue Service entitled *Medical and Dental Expenses* helps to clarify the question. *"You can include in medical expenses the cost of medical care in a nursing home or home for the aged for yourself, your spouse, or your dependents. This includes the cost of meals and lodging in the home if the main reason for being there is to get medical care. Do not include the cost of meals and lodging* supervision of the individual may be tax deductible subject to the 7.5 percent adjustment. Chronically ill is defined in Publication 502: *"A chronically ill individual is one who has been certified by a licensed health care practitioner within the previous 12 months as: 1) Being unable for at least 90 days, to perform at least two activities of daily living without substantial assistance from another individual, due to the loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence **or** 2) Requiring substantial supervision to be protected from threats to health and safety due to severe cognitive impairment."* With the enactment of the Kennedy-Kassebaum bill, the law is now clear. Congress stated clearly that the tax code should provide equal consideration for persons with Alzheimer's disease or other irreversible dementia. The only cloudy area remaining is the fee structure of the facility in which they reside.

Homes, which are dedicated to caring for people with Alzheimer's disease and related dementia rendering substantial supervision to protect residents from threats to health and safety due to severe cognitive impairment, meet the test. Residents who fall under the care of board-certified geriatricians and licensed health care practitioners who certify their status should qualify. In homes specifically designed for the care of those with Alzheimer's disease and related dementia, the care, meals and lodging are an integral part of the complete service plan to constitute "medical care." Entrance fees that are intended to cover the cost of the initial assessment, and development of the plan of care for the resident relates completely to medical care, qualifying it as tax deductible under the definition.

What does all this mean? Well, depending upon your personal income, the deductibility of your monthly fees in a home properly qualified can result in an annual after tax savings of between 15 and 20 percent. So it might be more than worth your while to check this out with your accountant or financial advisor prior to making your decision on where to place your loved one.

For more than a decade, Potomac Homes has made it possible for those with Alzheimer's disease or dementia-related illnesses to enjoy the benefits of full-time professional care in a comfortable residential setting. To learn more about Potomac Homes call us at (800) 935-9898 to arrange a private tour or visit us on our website at www.potomacgrouphomes.com. (To order free IRS publications call 1-800-TAX-FORM).

Benjamin W. Pearce is the president of Potomac Group Home Corporation a pioneer in residential living for those with Alzheimer's and related dementia illness. He has served on the board of directors of the Assisted Living Federation of America, Massachusetts Assisted Living Facilities Association and the National Association for Senior Living Industries. Over the past 24 years, he has overseen the operations and

Last
Don't ju
person w
experie

(845
• Phys
121 Dunnin
Middletown

"We he
P
(E
NO

Local News
Weather &
Community
Oriented T
Shows!

Isolation can lead to health complications

By Ben Pearce

Many inquires and subsequent admissions to assisted living communities are often triggered by an event in one's life. Many seniors and/or their families often investigate lifestyle changes as a result of some type of loss in their life. They may have lost their spouse, their ability to drive, to take care of themselves independently, or perhaps some other traumatic event. During times like these it is human nature to bereave one's loses, and through this process people have a tendency to re-evaluate their lives. It is natural to compare personal accomplishments and position in life to a mental image of what they thought it might be at this stage when they were younger. At forty, when one comes to the conclusion that their life has not met their expectations, there is ample time to adjust one's priorities and get back on track. At eighty, however, the opportunity for change becomes more limited. John Barrymore, Sr. once said "A man is never old till regrets take the place of dreams." Research into seniors' attitudes and behavior suggests that anxieties related to future adverse health conditions can actually *cause* those conditions to arise. This is the time in life when the physical world may be perceived to be continually shrinking. Many face this time and the bereavement process quite alone, as they re-evaluate their lives and are confronted with their own mortality. There is a natural tendency to focus on the limitations of one's life and all of the obstacles that aging presents. When sadness turns to depression, they are headed for trouble.

Much of the stress of this process becomes internalized which can make the elderly very vulnerable to depression. Suspect depression if they spend an inordinate amount of time sleeping or sitting in front of a television. There has been ample research to demonstrate the mind's capacity to influence one's health - both positively and negatively. If left unchecked, depression and despair can inhibit recovery from illness, lead to hopelessness and even ultimately premature death. Researcher Ken Wells in the landmark Rand study at UCLA found that 50 percent of all depressed people are over the age of 65. He studied depressed vs. non-depressed people and found that depressed elderly use 4 times the amount of health care dollars than non-depressed and had a 58 percent greater mortality rate within the first year of admittance to a skilled nursing facility than their non-depressed counter parts.[1] For example, depressed people tend to lie around all day and don't get up. This inactivity makes them susceptible to urinary tract infections and pneumonia, which if left untreated can lead to kidney failure and death.

Living well in our later years is all about *quality* of life. People who are active and social generally avoid depression that can lead to health complications and dramatically affect the quality of one's life. People who spend their time isolated from others their own age can become depressed and find that they are continually facing one health crisis after another.

The reluctant admission to an assisted living community is for many yet another reminder of their inability to live at home independently. Americans of this age group who struggled through the depression years to ultimately achieve the American dream of home ownership derive much of their identity from their living environment. It is indeed a significant challenge for many to give up a home in which they have lived for many years and now identify with the new retirement "home", not to mention learning to function in a communal environment and lifestyle. However, we humans are social creatures, we crave companionship, it keeps us more alert and fulfilled. In the past twenty years that I have been working with the elderly, I have seen that the people who are in daily contact with other people their own age and with similar lifestyle issues seem to gain strength from each other. They are more aware of their appearance, and hold onto their lifestyle skills longer. Those people who stay home too long because of promises their children were forced to make to keep them out of a "home" do not receive the social stimulation they absolutely require to remain healthy. By the time they are forced to investigate other supportive environments, their health has deteriorated so far that few will consider them appropriate, leaving the adult child or home care giver exhausted, frustrated and run down and at risk for their own health. In many cases it may be actually more cost effective to consider assisted living earlier, than wait until the extremely expensive nursing home is your only choice.

For more than a decade, Potomac Homes has made it possible for those with Alzheimer's disease or dementia-related illnesses to enjoy the benefits of full-time professional care in a comfortable residential setting. To learn more about Potomac Homes call us at (800) 935-9898 to arrange a private tour or visit us on our website at www.potomacgrouphomes.com .

[1] W.G. Manning and K.B. Wells, "Use of Outpatient Mental Health Care" (Rand report R-3277-NIMH) (Los Angeles: Rand Corporation, August 1986).

M
ser
O
CH
Sc
To
$48.
A Sen
• F
Plea:
Offic
55 Fu

Feeling a little guilty?

By Ben Pearce

There are few people on earth better equipped with the natural innate ability to make us feel guilty than our own mothers. In our culture guilt has been instinctively crafted to an art form designed to influence our behavior. It is a learned behavior passed on from generation to generation. Feelings of guilt can be self-inflicted or can be imposed upon us by other people. When guilt is legitimate, it spurs us to do better. When it is unwarranted, it only causes anxiety and hinders our ability to make sound decisions and provide quality care.[1]

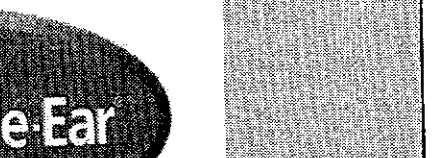
As a parent's care needs increase while they undergo the natural aging process, the amount of time and energy required of the caregiver increases exponentially. It is very normal to have feelings of resentment as demands on our time begin to radically change our daily routines. Often adult children already have their hands full caring for the needs of their own children. The average woman in America today will spend more time caring for her parents than for her children. She is typically 45 to 65-year-old married female with children at home, in college, or with families of their own and thus can feel herself sandwiched between two generations. As her parents' needs for assistance increase over time, she often feels as though she simply cannot do enough for them. Often she will become frustrated when her efforts to try to "fix" things that go wrong in her parents life begin to create conflicts in her own life, and the fixes never seem to last. Ultimately she begins to feel that she is losing control of her life and realizes that things that were once routine for her and easily manageable are quickly becoming more than she can handle. Conflicting priorities can often lead to feelings of helplessness and guilt that she is not doing anything well. This self-imposed guilt then becomes her constant companion.

Others can also impose guilt upon us. Failures in our elder caring duties, and obligations to our own families can lead to criticism from those whose opinions we value most. One is never really prepared to accept responsibilities thrust upon them by their aging parents. Few people understand the complexities of health problems, insurance coverage, assisted living and nursing homes, drug plans, Medicare, legal obligations and other senior-related issues. Caregivers continuously bombarded by limitations. What is important is ensuring the quality of life and meeting the realistic needs of the elderly. It is not your role to insure everyone's happiness, only your own. Perhaps much of the guilt comes from thinking that yon have more influence than you really do.

Often as the caregiver is pulled in conflicting directions, she may invite her aging parent to come live with them. Caring for a loved one at home may not be the best solution for either. Many people have made promises to each other about their elder care when they are young thinking the day will never come, but *it always does*. Often the caregiver struggles to meet the ever-increasing needs of their loved one at great personal sacrifice. Be realistic about what level of care that you can safely provide. Financial resources should be applied before the caregiver herself begins to weaken. Often the decision to move out of the home is delayed until a nursing home is the only option. Consider using the financial resources while she can still gain some benefit from them in a more social environment. Once the funds are exhausted, the Medicaid alternative is always available in the nursing home setting. Many senior living environments can provide the additional cushion of care for your parent when they really need it. This way professionals can deal with the issues that may be unfamiliar to you and when you visit your parent, your time with them can be spent more relaxed. This will help to relieve the stress that may be building in your relationship, and help to quiet the guilt.

For more than a decade, Potomac Homes has made it possible for those with Alzheimer's disease or dementia-related illnesses to enjoy the benefits of full-time professional care in a comfortable residential setting. To learn more about Potomac Homes call us at (800) 935-9898 to arrange a private tour or visit us on our website at www.potomacgrouphomes.com .

[1]Rogers, L, et.al. *Fourteen Friends' Guide to Elder Caring.* Broadway Books, New York, 1999: 59-70.



constant companion.

Others can also impose guilt upon us. Failures in our elder caring duties, and obligations to our own families can lead to criticism from those whose opinions we value most. One is never really prepared to accept responsibilities thrust upon them by their aging parents. Few people understand the complexities of health problems, insurance coverage, assisted living and nursing homes, drug plans, Medicare, legal obligations and other senior-related issues. Caregivers continuously bombarded by these issues are bound to make mistakes, which will frustrate them even further. Uninformed family members, and siblings seeking to offer help, often only serve to highlight the primary caregiver's shortcomings. Just remember, there is nothing out there that you can't learn, seek out the advice of professionals such as Geriatric Care Managers, Eldercare Attorneys, local support groups, and use the local library. Information brings control.

Feelings of responsibility set us up for the probability of occasional feelings of guilt. We must be able to distinguish between legitimate guilt that motivates us to do better and harmful guilt that might be undeserved and leave us dispirited.

Sometimes it might be helpful to write down the things that make you feel guilty. Examine the underlying reasons and determine if a solution is within your power. Sometimes compartmentalizing a large problem into several smaller issues can make things more manageable. Constantly fretting over what seems to be an insurmountable responsibility can only lead to more anguish and more guilt. Tackling and completing a few problems can give you a sense of accomplishment and build your confidence to handle those never-ending new surprises as they arise. Consider that your parent may be feeling guilty because they are imposing on you, while you are feeling guilty that you don't have the time to do more.[1] Also, it is never helpful to anguish about the past, concentrate on what can be done now and resist the temptation to allow old conflicts to create guilt today.

To determine if the guilt you are feeling is warranted, ask yourself if you have done everything that is practical and necessary within your own

visit us on our website at www.potomacgrouphomes.com .

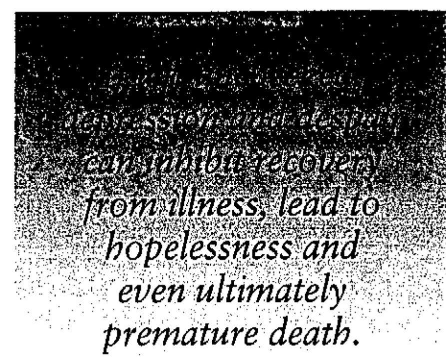
[1]Rogers, L, et.al. *Fourteen Friends' Guide to Elder Caring*. Broadway Books, New York, 1999: 59-70.

A Disguise for Depression

by Benjamin W. Pearce

Many inquiries and subsequent admissions to assisted living communities are often triggered by an event in one's life such as a loss. They may have lost their spouse, their ability to drive, or to take care of themselves independently. During times like these it is human nature to bereave one's losses, and through this process people have a tendency to re-evaluate their lives. At forty, when one comes to the conclusion that their life has not met their expectations, there is ample time to adjust one's priorities and get back on track. At eighty, however, the opportunity for change becomes more limited. John Barrymore, Sr., once said "A man is never old till regrets take the place of dreams." Research into seniors' attitudes and behavior suggests that anxieties related to future adverse health conditions can actually cause those conditions to arise. This is the time in life when the physical world may be perceived to be continually shrinking. Many face this time and the bereavement process quite alone, as they re-evaluate their lives and are confronted with their own mortality. There is a natural tendency to focus on the limitations of one's life and all of the obstacles that aging presents.

Much of the stress of this process becomes internalized which can make the elderly very vulnerable to depression. There has been ample research to demonstrate the mind's capacity to influence one's health – both positively and negatively. If left unchecked, depression and despair can inhibit recovery from illness, lead to hopelessness and even ultimately premature death. Researcher Ken Wells in the landmark Rand study at UCLA found that 50 percent of all depressed people are over the age of 65. He studied depressed vs. non-depressed people and found that depressed elderly use four times the amount of health care dollars than non-depressed and had a 58 percent greater mortality rate within the first year of admittance to a skilled nursing facility than their non-depressed counter parts.[1] Living well in our later years is all about quality of life.



People who are active and social generally avoid depression that can lead to health complications and dramatically affect the quality of one's life. People who spend their time isolated from others their own age can become depressed and find that they are continually facing one health crisis after another.

The reluctant admission to an assisted living community is for many yet another reminder of their inability to live at home independently. Americans of this age group who struggled through the depression years to ultimately achieve the American dream of home ownership derive much of their identity from their living environment. It is indeed a significant challenge for many to give up a home in which they have lived for many years and now identify with the new retirement "home," not to mention learning to function in a communal environment and lifestyle. However, we humans are social creatures, we crave companionship, it keeps us more alert and fulfilled. Those people who stay home too long because of promises their children were forced to make to keep them out of a "home" do not receive the social stimulation they absolutely require to remain healthy. By the time they are forced to investigate other supportive environments, their health has deteriorated so far that few will consider them appropriate, leaving the adult child or home care giver exhausted, frustrated and run down and at risk for their own health. In many cases it may be actually more cost effective to consider assisted living earlier, than wait until the extremely expensive nursing home is your only choice.

Benjamin W. Pearce is the President and Chief Executive Officer of Potomac Homes. Mr. Pearce has authored numerous publications including: "The Management Curriculum, Assisted Living Training System," "Accounting Systems and Risk Management for Assisted Living," Senior Living Communities: Operations Management and Marketing for Assisted Living, Congregate, and Continuing-Care Retirement Communities. To learn more about Potomac Homes call (800) 935-9898 or visit www.potomacgrouphomes.com.

1. W.G. Manning and K.B. Wells, "Use of Outpatient Mental Health Care" (Rand report R-3277-NIMH) (Los Angeles: Rand Corporation, August 1986).

Visit our website at:

www.sanjonline.org

Get clear and concise information about SANJ on our Home Page.

Use the sidebar to link quickly to information about SANJ activities.

I'm afraid I'm giving up my independence.

Mom Doesn't Want to Move...

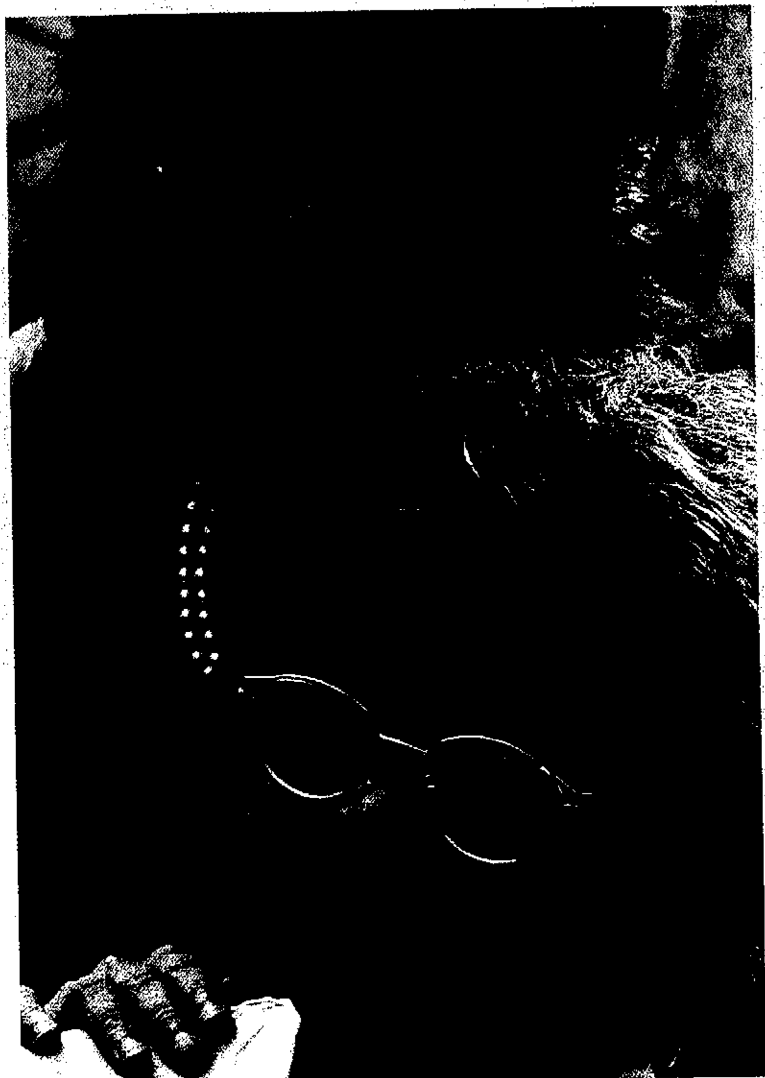
It's one of the most common difficulties families face...knowing their loved one is not safe at home but getting resistance or an unwillingness to consider moving to a senior housing community from the person who needs it. We hear it every day in our work helping families..."My Mom will never move" or, "I haven't spoken to her about it yet because I know she doesn't want to leave her home," or "I'm so concerned about his safety and health but he doesn't think he's ready."

What does it mean when a loved one, who clearly needs to move, says, "I'm not ready yet?" In most cases its fear of change. Moving is a tough decision for anyone but even tougher for someone who has lived happily in their home for over 30 years. All of the following thoughts and fears are real to seniors: I'm afraid I'm giving up my independence. I'm afraid of giving up my privacy. I'm afraid this means I'm going to die soon. I'm afraid of leaving my home which I've lived in for years. I'm afraid of the unknown. I'm afraid it will be an awful place with people I don't like or won't like me. I'm afraid it's too expensive...what if they raise the rents and I can't afford to live there anymore? When someone says they are not ready yet, what it really means is that they are having one or more of these fearful feelings. It also means they do not understand the benefits that the "new" senior living communities can offer them.

I'm afraid of leaving my home.

A tremendous amount of research has been done on the lifestyles and values of older adults. While opinions differ, some general conclusions can be drawn. Seniors are interested in being active and involved. They see themselves as at least ten years younger then their true chronological age. Seniors' anxiety about their age often is associated with an aversion to the health complications that will eventually place restrictions on their personal freedom. They are looking for empowerment so that they can live fuller lives and stay in control

continued on page 26



I'm afraid of the unknown.

continued from page 24

longer. They are generally private people, especially about their finances and are comfortable with themselves. They are family oriented, proud and independent.

So how do you approach this proud and "independent" person who you believe is not safe living alone? How do you answer them when they say they are not ready? It never easy but here are some practical suggestions from a few of the Family Advisors at A Place for Mom.

Focus on Quality of Life. Point out the improved quality of life they will gain by having someone to prepare meals, assist with laundry, housecleaning, transportation and other "chores." Allow them to see and experience an activity schedule. Focus on the freedom all this allows them and how they will have more time to spend doing the things they really like to do.

Tim Burris, Family Advisor, Raleigh, NC
A Place for Mom

Know their passions and hobbies. Find a community that can cater to their needs as this can make the difference in their feelings about the move. This made a big difference with my mom too! She was a college librarian for many years and we found an Assisted Living that had a library. On the tour, the director asked her if she could be in charge of organizing it. My mom was so proud. This helped change her mind about moving and gave her a great way to help others.

Ellen Murphy, Family Advisor, Rhode Island
A Place for Mom

I'm afraid I'm giving up my privacy.

Meet others who have done it. Ask the director to set up a time for your parent to have coffee with other residents who live at the community. They are often happy to tell their story and the positive results of the move. This can help ease the fear.

Teresa Kirwan, Family Advisor, New Jersey
A Place for Mom

Ask their personal physician to get involved in recommending a move for safety and health reasons. This can take the pressure of being the "bad guy" off of you.

Jerry Graham, Family Advisor, Tacoma, WA
A Place for Mom

Research home care options as an alternative while you are doing your search. This way, you'll know she is safe and being taken care of. This may also help her recognize how much better it feels to have a little assistance every now and then.

Sarah Mitchell, Family Advisor, Alaska
A Place for Mom

Stay positive! When you discuss the options with your parent, have a positive attitude, a calm demeanor and a smile on your face.

Patricia Grace, Family Advisor, Philadelphia, PA
A Place for Mom

Discuss what will happen in a crisis. Tell your loved one you don't want to have to select a community for them if a crisis should occur. If mom or dad go out and tour communities now, the decision can be theirs rather than having the children select for them.

Linda Temple, Family Advisor, Portland, OR
A Place for Mom

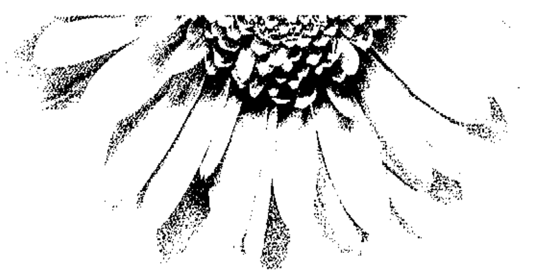
It takes a village. As adult children, we are looking for three things; safety, security and peace of mind. If we cannot be at work or home without worrying about whether mom has fallen, forgotten to take her medications, or isn't eating well…it is time to make the move. Seek out the support of clergy, physicians and close friends that mom trusts, and essentially conduct an intervention of sorts so that mom is hearing the same concerns from everyone in her life. It is very important that everyone is on the same page and agrees that the move is necessary.

Toby Mullenger, Family Advisor, Minneapolis, MN
A Place for Mom

Ask Questions! Find out WHY mom doesn't want to move. What are her fears and her wishes? Ask her if she had to move out of her current home for any reason, what would be important to her in her new home. Matching her needs with the new home will lessen the separation loss and minimize the transition time.

Cheryl Fleming, Family Advisor, Fullerton, CA
A Place for Mom

of leaving my home.



Try a short-term stay (respite care). Many communities offer a "trial stay" program which can help your parent experience the benefits of a senior living home. Many times caregivers need a break and this is a good way to have a person experience many of the uplifting activities that happen in senior housing.

Carrie Kirkpatrick, Family Advisor, Madison, WI
A Place for Mom

Enthusiasm sells! Tour the communities first and find the ones that you see your loved one fitting in best. This gives you a chance to get enthusiastic and helps when trying to get your parents to tour.

Rita Files, Family Advisor, New Jersey
A Place for Mom

Don't Give Up. I can't tell you the number of times that families have told me their mom or dad is not willing to move. Just know that you will get through this resistance if you are caring and persistent. Soon they will be taking advantage of the many great things that are offered and will be healthier, happier and safe. Many times the most resistant seniors are the ones that end up being on the welcoming committee or chairman of the bridge club!

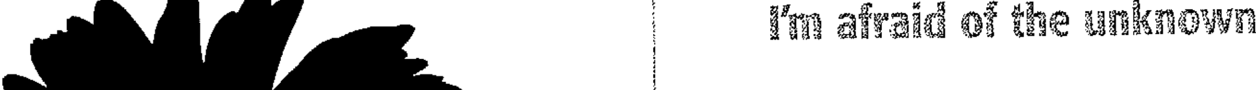
Denise Salabarria, Family Advisor, Atlanta, GA
A Place for Mom

Sometimes love gets tough. People who are isolated can become depressed and depression leads to health failure, which puts them at risk. When they were the parent they would not even think of allowing you as a child to be exposed to a potentially dangerous situation regardless of what you wanted. As an adult child, you may have the same decision to make for your parents.

In the end, overcoming objections is a process of developing a comfort level with the decision. Be patient with your loved one. Listen for other hidden meanings in their concerns. Repeat the objection to clarify your understanding. Sometimes when people hear their objection repeated back to them, it sounds worse than they really intended it to be. Seniors like to have their objections acknowledged and affirmed. Question their real intent behind the objection and look for common ground. Answer their concerns as best you can without being smart or glib. Confirm the answer by relating the experience to others in their situation that may have had the same objection but ultimately found that it might have been overstated. Finally, close on neutral ground and leave the discussion with something that you both agree on about the situation.

Thousands of families deal with these tough decisions. Know that its the process they fear rather than the end result. Once they move to a senior living community they readily adapt and start to eat right, take their medications on time and find new friends and activities. In no time, their quality of life will improve and everyone can focus on enjoying time together.

This article was provided by A Place for Mom and Benjamin W. Pearce, President, Potomac Homes, the pioneer in residential living for those with Alzheimer's and other forms of dementia-related illnesses. Locations throughout New Jersey. www.potomacgrouphomes.com. Telephone 201-368-7070.



I'm afraid of the unknown.

Pre-registration is required for all programs. See page 18.

Signing Primates – Communicating with Chimpanzees

Most people believe that language is unique only to humans. About 35 years ago, Washoe was the first chimpanzee to learn American Sign Language and then teach it to her adopted infant chimp Loulis. Join us for the fascinating stories about four chimpanzees who know sign language and use it to communicate with each other and with humans.

Presenter: Joan Thuebel, Earthwatch volunteer
1:30 p.m.
Thursday, November 1
The Collins Pavilion at Chilton Memorial Hospital Conference Center

Discovering the Writer Within

During this four-week journal-writing course, allow the creative process to work its magic as we talk, write and reflect together. Journal books will be supplied. **Course limited to 10 participants.**

Presenter: Dianne Herald DiMella
1:00 p.m.
Tuesdays, November 6 to 27
Location: Chilton Health Network, 242 West Parkway, Pompton Plains
Second Floor, Community Outreach Conference Room

Healthy Holiday Meals

It's that time of year when our healthy eating habits are often forgotten. Learn how to create healthy holiday dishes, which are also festive and delicious. Recipes and tasty samples of all dishes will be provided. **Register early, seating is limited.**

Presenter: Deidra Baker, Culinary Director, Bloomingdale's
1:00 p.m.
Thursday, November 8
Location: Deidra's Kitchen, Bloomingdale's Level 3, Willowbrook Mall, Wayne

South Africa

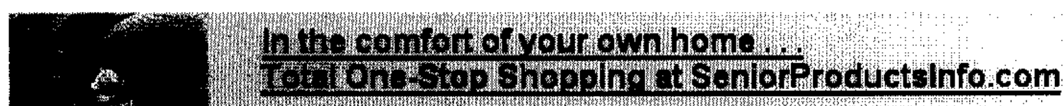
South Africa is home to spectacular wildlife on a level with the Serengeti. Both Mala Mala and Londolozi offer an upscale safari experience and hold the unrivalled positions of the top Safari Lodges in the world. Only at these premier camps is one guaranteed to see leopards. Alan will entertain and dazzle us with his breathtaking photography of the diverse landscape and wildlife of South Africa. Wildlife includes lions, elephants, white rhinos, specific antelopes not found in Kenya, a wide variety of birds and the elusive leopard. Don't miss this one!

Presenter: Alan Levin, Professor, County College of Morris
10:00 a.m.
Friday, November 9
The Collins Pavilion of Chilton Memorial Hospital Conference Center

Alzheimer's and Dementia: A Changing Lifestyle

Information on Alzheimer's disease is detailed including mild cognitive impairment, vascular dementia, Lewy Body disease, Frontotemporal Dementia and Pick's disease, Hunningtons, Parkinson's and Creutzfeldt-Jakob disease. Learn about treatable causes of dementia and current research into probable causes and genetic links. Finally attendees will learn how to recognize early stage symptoms and how to respond to their loved one's issues relating to short-term memory loss, word-finding problems, asking the same question repeatedly, denial, decision making and paranoia.
Refreshments will be provided, compliments of Potomac Homes.

Presenter: Benjamin Pearce, President of Potomac Homes
10:00 a.m.
Friday, November 16
The Collins Pavilion of Chilton Memorial Hospital Conference Center



SeniorsResourceGuide Morris-Somerset

SRG Directory
www.SeniorsResourceGuide.com/Morris-Somerset

Isolation Can Lead to Health Complications

Article submitted by Ben Pearce, President of Potomac Homes.
He can be reached at 800-935-9898 or bwpearce@ix.netcom.com

Many inquires and subsequent admissions to assisted living communities are often triggered by an event in one's life. Many seniors and/or their families often investigate lifestyle changes as a result of some type of loss in their life. They may have lost their spouse, their ability to drive, to take care of themselves independently, or perhaps some other traumatic event. During times like these it is human nature to bereave one's loses, and through this process people have a tendency to re-evaluate their lives. Its natural to compare personal accomplishments and position in life to a mental image of what they thought it might be at this stage when they were younger. At forty, when one comes to the conclusion that their life has not met their expectations, there is ample time to adjust one's priorities and get back on track. At eighty, however, the opportunity for change becomes more limited. John Barrymore, Sr. once said "A man is never old till regrets take the place of dreams." Research into seniors' attitudes and behavior suggests that anxieties related to future adverse health conditions can actually cause those conditions to arise. This is the time in life when the physical world may be perceived to be continually shrinking. Many face this time and the bereavement process quite alone, as they re-evaluate their lives and are confronted with their own mortality. There is a natural tendency to focus on the limitations of one's life and all of the obstacles that aging presents. When sadness turns to depression, they are headed for trouble.

Much of the stress of this process becomes internalized which can make the elderly very vulnerable to depression. Suspect depression if they spend an inordinate amount of time sleeping or sitting in front of a television. There has been ample research to demonstrate the mind's capacity to influence one's health - both positively and negatively. If left unchecked, depression and despair can inhibit recovery from illness, lead to hopelessness and even ultimately premature death. Researcher Ken Wells in the landmark Rand study at UCLA found that 50 percent of all depressed people are over the age of 65. He studied depressed vs. non-depressed people and found that depressed elderly use 4 times the amount of health care dollars than non-depressed and had a 58 percent greater mortality rate within the first year of admittance to a skilled nursing facility than their non-depressed counter parts[1] For example, depressed people tend to lie around all day and don't get up. This inactivity makes them susceptible to urinary tract infections and pneumonia, which if left untreated can lead to kidney failure and death.

Living well in our later years is all about quality of life. People who are active and social generally avoid depression that can lead to health complications and dramatically affect the quality of one's life. People who spend their time isolated from others their own age can become depressed and find that they are continually facing one health crisis after another.

The reluctant admission to an assisted living community is for many yet another reminder of their inability to live at home independently. Americans of this age group who struggled through the depression years to ultimately achieve the American dream of home ownership derive much of their identity from their living environment. It is indeed a significant challenge for many to give up a home in which they have lived for many years and now identify with the new retirement "home", not to mention learning to function in a communal environment and lifestyle. However, we humans are social creatures, we crave

environment and lifestyle. However, we humans are social creatures, we crave companionship, it keeps us more alert and fulfilled. In the past twenty years that I have been working with the elderly, I have seen that the people who are in daily contact with other people their own age and with similar lifestyle issues seem to gain strength from each other. They are more aware of their appearance, and hold onto their lifestyle skills longer. Those people who stay home too long because of promises their children were forced to make to keep them out of a "home" do not receive the social stimulation they absolutely require to remain healthy. By the time they are forced to investigate other supportive environments, their health has deteriorated so far that few will consider them appropriate, leaving the adult child or home care giver exhausted, frustrated and run down and at risk for their own health. In many cases it may be actually more cost effective to consider assisted living earlier, than wait until the extremely expensive nursing home is your only choice.

[1] W.G. Manning and K.B. Wells, "Use of Outpatient Mental Health Care" (Rand report R-3277-NIMH) (Los Angeles: Rand Corporation, August 1986).

Copyright April 2004 Benjamin W. Pearce

Back

© Copyright 2000-2004 Seniors Resource Guide. All Rights Reserved.
Site designed and maintained by Web Publishing and Services, Inc.

Choose an Assisted-Living Facility

HOW TO

Choosing an assisted-living facility can be a difficult but important decision, one often complicated by emergency situations that rush decision-making. However, all it takes is some time and research to find the right facility for a loved one.

The main goals of assisted living are to aid residents – often the elderly – in tasks, and provide a living experience where the mind and body are kept active. Assisted-living facilities generally provide housing, group meals, personal care and support services, and social activities in a residential setting.

"The most common services provided by an assisted-living facility are shelter, room and board, and assistance with activities of daily living, including bathing, dressing, grooming, eating, and ambulating. Assisted living is really designed for seniors who need regular help with activities of daily living but do not need nursing home care," said Benjamin Pearce, president of Potomac Homes, which has 11 locations in northern New Jersey.

TAKE THE FIRST STEP

The first step is to determine the facility characteristics you or your loved one may benefit from. According to AARP, formerly known as the American Association of Retired Persons, assisted-living facilities best serve those who don't require skilled nursing or long-term assistance. Would your loved one enjoy a larger facility with many new people or a more intimate setting? Do you have any specific medical needs? Some facilities include special programs and facilities to aid residents with dementia or Alzheimer's, for example.

Once you've determined your needs, compile a list of facilities to visit. AARP recommends a number of sources, including the local yellow pages; the state licensing agency; and your local area Agency on Aging. Make sure to ask friends or relatives for advice as well.

LOOK AROUND

Visit several facilities. Pearce recommends visiting as many facilities until you find the right one.

"An individual should visit as many facilities as they can until they find a comfort level, and that comfort level revolves around whether they would live there or not," he said.

When visiting, make careful observations. As Pearce suggests, check for cleanliness.

"The place needs to be clean, kept up, to reflect pride of ownership," Pearce said.

Also check if the atmosphere is friendly. How does the facility assess and meet residents' needs? Does the staff seem attentive and polite? Observe and talk to the residents. Do they seem well cared for?

Another quality to look for Pearce said is staff members that have been with the facility for some time.

"I want a place that has a stable staff, because they recognize subtle changes in [residents'] condition, which translates into quality of care" Pearce said.

He also said caregivers should be on duty 24 hours a day and the owners of the facility should have experience in the business.

In addition, check for safety measures. As the American Association of Homes and Services for the Aging suggests, look for well-lit stairs and halls, handrails in bathrooms and ways for residents to summon help if needed. Check to see if smoke alarms are installed in each room and hallway, that halls and passageways are clear, and that exit doors are clearly marked, not locked and operate freely – especially disabled-assist doors. Facility staff should know evacuation procedures, and emergency numbers should be prominently posted.

CHECK CREDENTIALS

Find out if the facility is licensed. Pearce recommends contacting the state's Department of Health and Human Services for a list of licensed facilities. Pearce said under state-licensing requirements, facilities must undergo annual license renewals, and periodic inspections, which are done more or less depending on the number of problems discovered.

"If there are many problems, they [the state] will place a hold on new admissions and all of this is a matter of public record," Pearce said.

He also advised calling discharge planners at local hospitals, who may recommend facilities. Another source Pearce cited is A place for Mom, a company that provides free advice and information to consumers. For more information, visit the company's Web site at www.aplaceformom.com.

CONSIDER COSTS

Pearce cautions families thoroughly examine all the costs involved.

"Costs will vary depending on level of care," he said.

Find out if costs are itemized or is there a flat fee?

"When you inquire about rates, you need to ask: 'What are the extras? What else will appear on the bill?,'" he said.

Ask for all charges up front and in writing to avoid surprises.

EASE THE TRANSITION

If looking for a loved one, involve him or her in your search process. Once you decide on the facility, bring your loved one for a visit. Keep lines of communication open to ease the transition. Find out what customizations you can make to the new space to make it feel more like home.

Find out about social activities. Activities are essential for preventing boredom, loneliness or depression. Pearce advised a good facility will have activities geared to people of all levels, not just a one-size-fits-all approach.

"It needs to have an activity program that is designed to be therapeutic for people with different functioning levels. That helps to build an individual's confidence and independence," he said.

Quick Tips:

PLANNING

- Begin discussion and research early. Don't wait for an emergency.
- Determine the type of care needed. Is specialized care needed?
- Look for facilities in your area. To contact the nearest Agency on Aging and other services for older adults, call Eldercare Locator at 1-800-677-1116 or check its Web site: www.eldercare.gov.

RESEARCH

- Contact the state's Division of Health and Human Services to see if the facility is licensed.
- Examine the facility's features: Is it clean? What facilities are available?
- Examine the staff: Do they greet residents? Are they attentive? Do they treat residents well?
- Examine the residents: Are they well cared for and active? Do they seem happy?
- Talk to residents: Do they like the facility? What are their likes, dislikes?
- What costs can you expect?
- Find out how much input and flexibility your loved one will have in his or her daily life and care. For example, if assistance is needed with bathing, will your loved one be able to choose when and how often?

Additional Press on Potomac

How To Choose An Alzheimer's Care Facility

Selecting an Assisted Care Facility for you or for a loved one involves many choices and decisions, but especially difficult are those decisions involving a loved one who has Alzheimer's. Yet, planning ahead is a good idea. Evaluating your options before things become unmanageable can allow you to make informed choices--rather than allowing a crisis to dictate your actions.

While there is no one way to care for a loved one with Alzheimer's, the good news is that there is care available at every level and budget.

When it comes to housing options there are several that work for those in various stages of Alzheimer's:

- Assisted Living: This is a good option for those in the middle stages because it allows more independence and for couples to remain together. Facilities offer personal care services, support services such as housekeeping and transportation. Many Assisted Living providers have a separate locked section where their dementia residents reside apart from the main community. There are also providers who specialize in Alzheimer care in specialty designed residential environments where residents can receive more individualized care. These homes may feature as few as 15 units rather than 25 or even up to 60 units and typically have an all inclusive rate structure.

- Skilled Care or Nursing Homes are needed when your loved one is dependent on 24 hour care.

- Hospice Care is an alternative to nursing home care that is often overlooked for those in late stages of this disease. These patients typically access this care from their own home or within a skill nursing setting. Hospice care emphasizes dignity and comfort measures while providing necessary skilled care.

- Continuing Care Retirement Communities (CCRCs) offer a range of options in housing and skilled care services from independent to assisted living to 24 hour skilled care. The drawback here, is the expense.

What To Look For:
While you are at any facility, observe the appearance of it. Is it inviting and well kept? Are special needs like those of the physically challenged met at the front of the building? It's also important to find out who owns the community, whether it's a national corporation or a smaller, family-owned operation. Both types have their unique features, and many people are more comfortable with one than the other. Another important question is whether the community is strictly a senior apartment complex, or an organization with individual support services providing specialized dementia care.

Interview the staff
Once you've selected a potential Alzheimer's care facility, call and arrange for an appointment to meet the marketing manager to tour the community. The marketing manager will answer many of your questions related to services, apartment layout and rates. You should also be able to get price lists and brochures during the interview that will help you select the right community for your needs. You may also want meet with the Executive Director or General Manager.

Tour the facility
During the tour, ask about the experience of the staff members, what kinds of educational credentials they have, etc. A tour of each facility you're considering will reveal the types and sizes of the living quarters, whether they be studios, or apartments. Look for safety features, emergency response equipment and handicap accessibility. Consider the space needed for you or your loved ones' furnishings, closet space and storage space when looking at community's residences. The upkeep, cleanliness, and maintenance of the property should be noted during the tour. Talk to the employees. Is the atmosphere friendly and relaxed? How long have the caregivers been in their jobs? Staff longevity translates directly to management effectiveness and ultimately to quality of care. Facilities with frequent staff turnover do not allow employees to become familiar with the residents. Conversely, long-term employees who know the residents well can recognize small but important changes in residents' condition, much the same way a mother recognizes when her own child may not be feeling well. Sometimes even subtle changes can lead to something more serious if they are not caught in time.

Services, amenities and levels of care
When selecting an Alzheimer's Care Facility, it is important to inquire about services, amenities and levels of care. What services are included in the basic rental agreement, and do some services add an additional cost? Also ask about amenities such as meals, housekeeping, telephone, cable television, transportation, social activities and laundry/linen service. Are these amenities included in basic costs? Many families are surprised when they see their monthly bills increase dramatically due to add-ins for additional services.

The community's recreational and social activity program should be considered when making a choice of senior living communities. There should be a social or activities calendar available for you to look over. A well-rounded activity schedule should include cultural entertainment, physical activities and mentally stimulating activities. Activities should be presented in a manner, which allows a resident to be as active or inactive as he or she wishes. Residents should be assessed upon admission to determine what leisure interests they have and can still do. Quality programs for Alzheimer residents feature both group and individual activities that are "failure-free" and build confidence. Avoid facilities that seem crowded and force all residents into a unilateral program.

For more than a decade, Potomac Homes has made it possible for those with Alzheimer's disease or dementia-related illness to enjoy the benefits of full-time, professional care in a comfortable residential setting. The Potomac Home concept is expanding into Mercer, and Monmouth counties in the near future.

For more information or to schedule a private tour contact Andrea Stone at (800) 935-9898.

For more information about Alzheimer's, or for a virtual tour of one of our residences, please visit our website: www.potomacgrouphomes.com

Affordable Dementia Care at up to 40% Less

Potomac Homes provides professional, 24 hour dementia care, in a cozy,

QUICK TIPS

- Speaking with the marketing manager may be extremely beneficial for gathering information about the

Focusing on Alzheimer's research, care

Potomac Group Homes Corp.

PARAMUS—Last month the Alzheimer's Association hosted World Alzheimer Congress 2000, the world's largest international conference on Alzheimer's disease and related dementias. World leaders in Alzheimer's research and care converged on Washington, D.C., marking the first time specialists have come together to share information on research and care to improve the lives of people affected by the disease.

If the increase in the disease is left unchecked, the number of patients is expected to increase to epidemic proportions. There is no known cure, and little is understood definitively about the cause of Alzheimer's disease, which afflicts about 4 million Americans. This number is expected to increase significantly, to 14 million people in the next 50 years.

With the average global population aging, "we have an imminent worldwide epidemic," warns Edward Truschke, president of The Alzheimer's Association. By 2050, 45 million people worldwide may have Alzheimer's, a toll rivaling cancer, said Robert Katzman of the University of California at San Diego.

Battling Alzheimer's disease will involve identifying symptoms early, before the disease can gain a foothold in the brain. Scientists' recent, successful mapping and identification of human DNA may facilitate the identification of those who may be more susceptible to the disease

heimer's disease and related dementias. Recognizing this fact, the federal government will spend half a billion dollars on Alzheimer's research this year.

Better treatments may be coming, but considering the disease's immense complexity and the difficulty of diagnosis, improvements may not materialize quickly enough for millions of Americans and their families.

Potomac Group Homes Corp. is dedicated to caring for people with Alzheimer's disease and related dementias in a secure, safe home setting. The corporation's philosophy is, and research and experience support, the notion that a small, intimate home setting is the best environment to provide a supportive milieu.

Potomac Group Homes' high ratio of specially trained staff creates a warm, family environment that is focused on retaining each person's uniqueness and independence. ◆

You don't have to suffer from unwanted birthmarks, spider veins, wrinkles or age spots anymore.

The Skin Laser Center at Pascack Valley Hospital

In the entire country, no community hospital treats more skin problems than the The Skin Laser Center at Pascack Valley Hospital. Recognized internationally as a leader in laser research, directed by world renowned Dr. David Goldberg, staffed with nearly a dozen board-certified specialists, and armed with the widest variety of lasers, the Center is uniquely qualified to help. It is also why we are one of the

later in life.

Elan Pharmaceuticals has been experimenting with a new vaccine that may be able to delay Alzheimer's disease. In clinical trials, the vaccine, which is a synthetic version of a protein called beta amyloid, appears to hold some promise. In Alzheimer's patients, plaques containing beta amyloid build up in the brain, leading some scientists to believe that these plaques contribute to the loss of memory and personality associated with the disease.

The vaccine triggers an immune response which, when tested on mice, cleared the amyloid plaques from their brains. Scientists caution, however, that what may work on mice may not necessarily be effective on humans, and since there has been no definitive cause established for Alzheimer's disease, the efficacy of this treatment may be to only delay progression of the disease. But for many Americans and their families, even a partial benefit would create a longer period of independence.

Other Alzheimer's disease researchers believe that tangled fibers inside nerve cells are the disease's cause.

The disease is becoming so widespread and costly that the research attention is well-deserved. According to the Alzheimer's Association, the disease will cost the nation at least $100 billion a year, including $26 billion in workplace productivity loss associated with caregiver duties. Half of all nursing home residents suffer from Alz-

DAVID J. GOLDBERG, M.D.

Director of The Skin Laser Center at Pascack Valley Hospital

One of the Top 10 Laser Surgeons in the U.S., Self Magazine

One of the Best Doctors in America, Woodward/White, Inc.

Chief of Dermatological and MOHS Surgery, UMDNJ

Graduate, Yale University School of Medicine

studies and research protocols. To learn more about the Center or to schedule an appointment, call (201) 594-9901.

For more information about our integrated network of services or a physician referral call us at (201) 358-6000 or (914) 426-5505. Or visit us at www.pvhospital.org.

The Skin Laser Center at

Pascack Valley Hospital

201-594-9901

The miracle of medicine. The power of people.
Westwood, New Jersey

A MEMBER OF DIRECTCARE MEDICAL SERVICES, L.L.C., AFFILIATED WITH NEW YORK MEDICAL COLLEGE, HACKENSACK UNIVERSITY MEDICAL CENTER AND WESTCHESTER MEDICAL CENTER. ACCREDITED WITH COMMENDATION BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS.

Pascack Press
North Jersey Newspapers
Rockland Journal News
4 col x 10.75"

100 line screen

SONNENBERG HAVILAND PARTNERS, INC.
a marketing group

The Old Post Office
30-38 Oak Street
Ridgewood, NJ 07450
Tel: 201-670-7600
Fax: 201-670-6570
Email: SHPINC@aol.com

THE HIDDEN LIABILITIES OF HOME COMPANIONS

by Benjamin W. Pearce, President, Potomac Homes

At-home care using home companions or home health aides is the single largest, yet informal system for the delivery of healthcare services in this country today. Families that hire caregivers or outside contractors may unknowingly be exposing themselves to a variety of financial risks and tax consequences.

The IRS requires payroll tax filings by a domestic employer who pays a caregiver more than $1,200 cash wages in a calendar year. These payroll tax obligations may include: Social Security and Medicare Taxes, Federal Unemployment Tax (FUTA), State unemployment and disability insurance taxes levied on the employer, and advance payment of earned income credit for eligible employees. The employer is required to collect the employee's social security and Medicare taxes. Should the employer fail to collect, they still remain responsible for remitting these taxes for the employee. Congress revised the "Nanny Tax" legislation in October 1994, offering employers alternative means to remit the federal payroll taxes for wages paid. This legislation requires employers to disclose the wages paid to household staff on the employer's personal income tax return. When a former employee files for unemployment, disability or social security benefits, the state then realizes that the person was receiving unreported compensation. Employers are required to give their employee a wage and tax statement (Form W-2) no later than January 31.

Domestic employees must be paid at least the Federal minimum wage, currently $5.15 (9/1/97). Live-in employees must be paid for every hour worked; all employees must be paid overtime for any hours exceeding 40 hours per week. If the person lives on site, then the Department of Labor assumes 8 hours sleeping or 16 hours working per day, or 112 hours per week. Since anything in excess of 40 hours per week is required to be paid at time and one half, this situation would result in 72 weekly hours of overtime. This translates to $2,600 per month for 24-hour coverage, not including loading for payroll taxes, which is comparable to the cost of assisted living. For a live-in, fair value of room and board can be deducted from straight pay. Also, you are legally required to verify your candidate's employment eligibility under immigration laws using Form I-9.

Unlike most home health agencies, most independent home companions do not carry comprehensive general liablility insurance. Therefore if a home companion is injured on the job while providing care for your family member you may be liable personally for their injury. New Jersey is one of several states that mandates coverage. Prices vary, but a typical policy costs around $400 for employees making at least $15,000 annually. Typical homeowners policies will not cover any injury to an employee.

Understanding your liability exposure when employing independent home care companions can be a complex task. While the access to this apparently inexpensive pool of help for an aging parent may at first glance be an attractive option for many families seeking to help their aging parents remain at home, the risks to the family need to be considered. Further, as the level of care increases over time, it is often much less expensive and more advantageous to seek healthcare professionals to deliver this care in a safe, homelike environment where the quality of life can be very high.

There are so many different reasons for having a wig:

- for Fun
- for a Bad Hair Day
- for a Different Look
- for Vacation
- for Thinning Hair
- for Complete Hair Loss

Sunshine Beauty Supplies

Servicing the wig and hairpiece needs of Sussex and Morris Counties & Eastern Pennsylvania for over 14 years.

At Sunshine Beauty supplies, the needs and concerns of each client are treated with care, consideration and confidentiality.

We have a fully trained and certified staff.

Styling personalized to you.

153-C Woodport Road
Sparta, NJ 07871

973-729-4991

Advertisement Advertisement Advertisement

When caring for a loved one with Alzheimer's, studies show that

Familiarity is the Key to Success

People with Alzheimer's disease can retain certain living skills that they would normally lose if care givers let them perform those skills regularly. This conclusion is the result of a recent study by researchers of the Occupational Therapy Department at the University of Pittsburgh, who found that guiding people with AD to perform certain activities of daily living (ADLs) rather than performing the tasks for them allows them to hang onto those skills they might otherwise lose as a result of the progressively degenerative brain disorder. "Typically, individuals with Alzheimer's disease have not been able to gain access to a great deal of rehabilitative care because it was felt that the disease is a progressively degenerative disease, and they would not benefit from the care," explains Joan Rodgers, leader of the study. "What our study demonstrated is that when people with Alzheimer's disease are provided with the appropriate support they can improve their ability to participate in ADLs. The appropriate support described by Rodgers and her team involves 'behavioral intervention', a research term for cueing. At Potomac Homes, we have recognized the many advantages inherent in our home-like setting. Our homes seek to imitate the environment that our residents have been accustomed to in living in their own private homes so that the connection to familiar things like their kitchen can keep them as independent as possible. Many of our residents can be seen helping in the kitchen or setting the tables, folding laundry, even helping other residents.

The environment is so natural, that many of these tasks that would be impossible for them in other large assisted living environments are encouraged here in our Potomac homes. Rogers goes on to explain "If nursing staff or an in-home caregiver does things for people that they can do for themselves, you run into a condition called 'access disability' which is an inability to do things that's caused by the caregiver, not necessarily the disease." Caregivers need to resist the temptation to simply perform these tasks for them because it is often easier and quicker. However, if we can provide cueing to start and finish some challenging tasks, such as dressing, while encouraging them to attempt to complete some portion of the task themselves, it can help build confidence and maintain independence longer. But this type of intervention puts demands on people and could possibly create an increase in disruptive behavior. The key here is when we ask them to do something, we must be careful to gauge the activity as to determine if they could do it successfully, so we do not get a negative response. This philosophy fits in well with our attempt to enter our resident's reality and create a failure free environment, rather than force them into ours. We are encouraged by this research and applaud our employees for not only providing the care our residents require, but also recognizing the value of their involvement in the process to improve the quality of their lives. Our residential setting is fostering more independence as an outcome, and make coping with the disease more manageable for our residents.

For more information, please call 1-800-935-9898.

by Ben Pearce
President, Potomac Homes

M169688-7

Talk more.

By Sherry Karasik
Special to The Star-Ledger

The staff at continuing care facilities play a crucial role in the psychological well-being and safety of their residents. Personnel range from nurses, assistants and activity directors to chefs, dietitians, social workers, physical plant managers and the housekeeping staff.

Psychologically, the attendants, certified nurses' aids and certified geriatric aids may have the most profound impact upon the well-being of the residents, say the experts. After all, these personnel are engaging in the most one-on-one interaction with the residents.

"Their job is one that requires a special person, with compassion and caring. They truly affect the residents' daily lives, and ensure that residents' personal care needs are met," says Pattie Oliver of Castle Senior Living. Castle Senior Living operates The Chelsea Senior Residences at East Brunswick, Fanwood, Florham Park, Montville, Warren and Monroe Township (called The Chelsea at Forsgate), all of which offer assisted care living.

These workers really are on the front line of care, agrees Timothy Doyle, administrator of Tally Ho Manor in Boonton Township in Morris County. Tally Ho Manor is a licensed residential and long-term care facility which has almost a one-to-one ratio of staff to residents, according to Doyle. While the nursing staff, consisting of R.N.s, sistant staff r tivities in bot physic

"Th vates recrea as to other the sa

The sponsi tural a and o Finn, Spring Summ comm that t and (get in our in joint Meado says F

Bot quick the un ties scenes

Every (right at Dau

ADVERTORIAL

Is Alzheimer's Care a Tax Deductible Expense?

Over the years I have been asked countless times by residents and families "Are the costs associated with the care they receive tax deductible?" While much of the tax code is subject to varied interpretations, and each individual should seek competent advice from their own professionals, it appears that the answer to this question is "likely."

Section #213 of the publication Selected Federal Taxation Statutes and Regulations - 2000 Edition states "There shall be allowed as a deduction the expenses paid during the taxable year not compensated for by insurance or otherwise for medical care of the taxpayer, his spouse or a dependent to the extent where that expense exceed 7.5 percent of adjusted gross income." The exact definition of medical care has been further explained in Section 1016 "If an individual in a nursing home or a home for the aged because of his physical condition and the availability of medical care is a principal reason for his presence there, the entire cost of maintenance, including meals and lodging is deductible." The key distinction is the purpose of living there. If it is for personal or family reasons, then only the portion of the cost attributable to medical or nursing cost is deductible. The reason that the deductibility becomes cloudy is that service fees in assisted living facilities bundle the medical care component with room and board, making it difficult to determine or justify what portion of the rent covers the care of the resident. Further, most assisted living facilities go out of their way to advertise that they are not a medical care facility. Officially it is defined as: "Assisted living facilities are a type of living arrangement which combines shelter with various personal support services, such as meals, housekeeping, laundry, and maintenance. Assisted living is designed for seniors who need regular help with activities of daily living (ADLs), but do not need nursing home care." Under this definition the deductibility of costs associated with these facilities may be hard to justify.

Publication 502 by the Department of the Treasury, Internal Revenue Service entitled Medical and Dental Expenses helps to clarify the question. "You can include in medical expenses the cost of medical care in a nursing home or home for the aged for yourself, your spouse, or your dependents. This includes the cost of meals and lodging in the home if the main reason for being there is to get medical care. Do not include the cost of meals and lodging if the reason for being in the home is personal. You can however, include in medical expenses the part of the cost that is for medical or nursing care." This means that in an assisted living facility, unless the purpose of the stay is to receive medical care, the cost of lodging and meals may not be deductible.

However, if the individual is chronically ill, as defined under the section entitled Qualified long-term care services all costs associated with the care and supervision of the individual may be tax deductible subject to the 7.5 percent adjustment. Chronically ill is defined in Publication 502: "A chronically ill individual is one who has been certified by a licensed health care practitioner within the previous 12 months as: 1) Being unable for at least 90 days, to perform at least two activities of daily living without substantial assistance from another individual, due to the loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence and 2) Requiring substantial supervision to be protected from threats to health and safety due to severe cognitive impairment." With the enactment of the Kennedy-Kassebaum bill, the law is now clear. Congress stated clearly that the tax code should provide equal consideration for persons with Alzheimer's disease or other irreversible dementia. The only cloudy area remaining is the fee structure of the facility in which they reside.

Another important consideration is the entrance fee, lifecare fee or 'founder's fee'. "You can include in medical expenses a part of the lifecare fee or 'founder's fee you pay either monthly or as a lump sum under an agreement with a retirement home. The part of the payment you include is the amount properly allocable to medical care." Many of today's assisted living communities charge an entrance or maintenance fee. This fee is intended to cover administrative processing and maintenance of the property, rendering it a non-tax deductible expense according to the Internal Revenue Service.

Homes, which are dedicated to caring for people with Alzheimer's disease and related dementia rendering substantial supervision to protect residents from threats to health and safety due to severe cognitive impairment, meet the test. Residents at Potomac Homes fall under the care of board-certified geriatricians and our own licensed health care practitioners who certify their status. In homes specifically designed for the care of those with Alzheimer's disease and related dementia, the care, meals and lodging are in integral part of the complete service plan to constitute "medical care." Our modest entrance fee is intended to cover the cost of our initial assessment, and development of the plan of care for the resident, therefore it relates completely to medical care, qualifying it as tax deductible under the definition.

What does all this mean? Well, depending upon your personal income, the deductibility of your monthly fees in a home properly qualified can result in an annual after tax savings of between 15 and 20 percent. So it might be more than worth your while to check this out with your accountant or financial advisor prior to making your decision on where to place your loved one.

For more than a decade, Potomac Homes has made it possible for those with Alzheimer's disease or dementia-related illnesses to enjoy the benefits of full-time professional care in a comfortable residential setting. To learn more about Potomac Homes call us at (800) 935-9898 to arrange a private tour or visit us on our website at www.potomacgrouphomes.com. (To order free IRS publications call 1-800-TAX-FORM).

by Ben Pearce
President, Potomac Homes

ditches are numbered like [illegible]. The smaller ditches [illegible] fields are like town and county roads.

This is where maintenance becomes very important. Orange County and the four towns involved need to keep the Wallkill and other creeks clear. It is then the responsibility of all the farmers and other landowners to keep the commissioner's and field ditches clear and free flowing. Cheryl Rogowski is a firm believer that each group needs to take care of the ditches in their geographic area or area of responsibility. This is especially important since some land is owned by people who are not living in the area and actively farming. They still have a responsibility to see to it that ditches near their property do not have a negative impact upon anyone else.

Rock Ledges and Development

Several rock ledges in the Black Dirt Region need modification. These ledges need to be lowered so water flows more freely. Although some farmers believe that this will not help when the Wallkill and other creeks are already at flood stage, removing them as an working on crop insurance issues to be brought up to the Department of Agriculture. Remember, crop insurance is an important issue to farmers because it should help to counterbalance losses caused by not only floods, but also other disasters. Hall toured the Pine Island area on Saturday, April 21 to view the flooding. The Congressman can be pivotal in helping to solve the flooding issues. The farmers are looking to him for assistance.

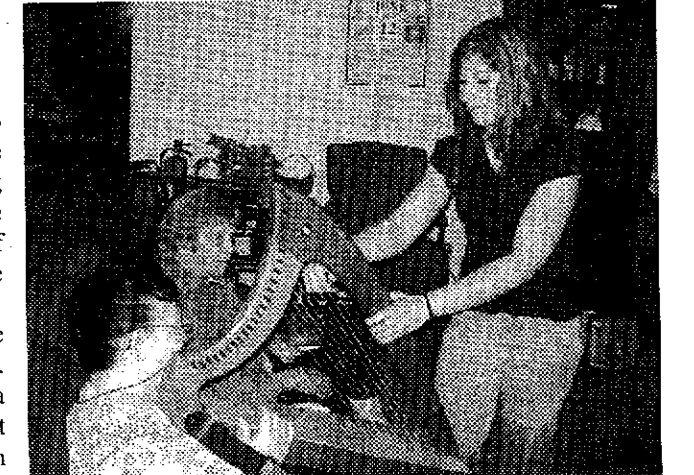
Public Education

Finally, there needs to be more public education about the needs of farmers and the importance of agriculture in all of our lives. What happens to farmers will eventually affect every one of us. There are some very important questions that need to be asked. Chris Pawelski and Tom Sobiech both touch upon this. Chris asks, "Do we want to have a domestic food supply or not?" and Tom adds, "America has to determine where our food is going to come from – domestically or foreign." We all need to learn more about our farmers and what they do – all of us will be better off for it. •

Music Therapy Reaches Dementia Patients

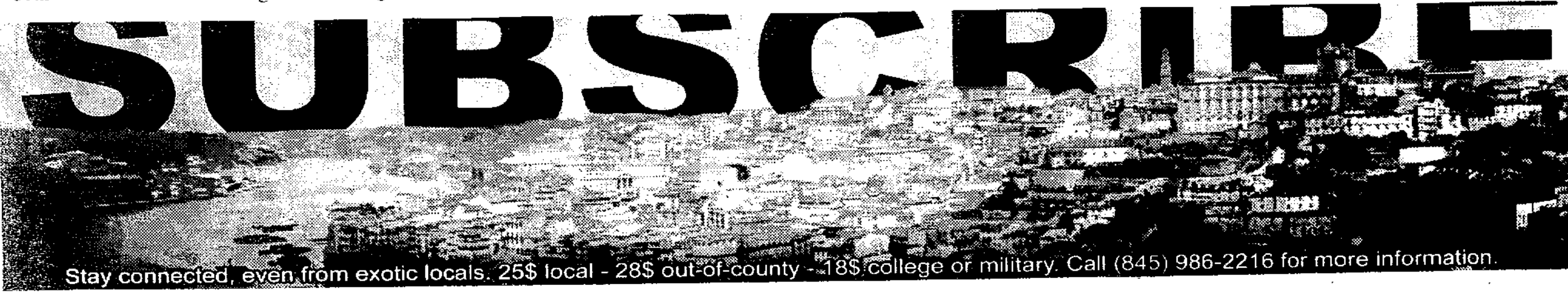
Potomac Homes Alzheimer's residents are feeling the good vibrations of music in a very therapeutic way. Alyssa Martini, a gifted musician from Warwick, NY, plays her harp for and with the residents, helping them to ease the stress associated with Alzheimer's disease. Since ancient times, music has been recognized as a calming agent and an antidote to stress and tension. Studies have shown that listening to music affects the release of powerful brain chemicals that can regulate mood, improve sleep, and reduce aggression, as well as depression.

"Many people with Alzheimer's disease have behavior problems of aggression and agitation," said Ms. Martini. "A structured music therapy program has a calming effect, and agitated or aggressive patients might benefit from this natural therapy." Ms. Martini will soon complete her training for certification as a Harp Therapist through a program called Bedside Harp. Harp therapy has both the benefits of relaxing and calming sounds of the harp, but also impacts listeners by the vibration of the instrument's tone. Vibrations from a harp produce similar frequencies in lower octaves (25 to 50 Hz) as a cat's purr, which can produce healing effects in humans including increases in bone density and pain relief.



Musician Alyssa Martini giving off good vibrations to those suffering from Alzheimer's.

People who suffer brain damage from Alzheimer's can still respond to music. "It touches those parts of the brain that are uninjured and can help Alzheimer's patients communicate with others and lead a more social life." Martini says. "People who can't put two words together may be able to sing songs associated with birthdays, weddings, and other important events from their past." While Alyssa plays, residents of Potomac Homes relax and hum along, tap their toes, and attentively watch her fingers strum the strings to renditions such as "America the Beautiful" and "Somewhere Over the Rainbow."



When caring for a loved one with Alzheimer's, studies show that

Familiarity is the Key to Success

People with Alzheimer's disease can retain certain living skills that they would normally lose if care givers let them perform those skills regularly. This conclusion is the result of a recent study by researchers of the Occupational Therapy Department at the University of Pittsburgh, who found that guiding people with AD to perform certain activities of daily living (ADLs) rather than performing the tasks for them allows them to hang onto those skills they might otherwise lose as a result of the progressively degenerative brain disorder. "Typically, individuals with Alzheimer's disease have not been able to gain access to a great deal of rehabilitative care because it was felt that the disease is a progressively degenerative disease, and they would not benefit from the care," explains Joan Rodgers, leader of the study. "What our study demonstrated is that when people with Alzheimer's disease are provided with the appropriate support they can improve their ability to participate in ADLs. The appropriate support described by Rodgers and her team involves 'behavioral intervention', a research term for cueing. At Potomac Homes, we have recognized the many advantages inherent in our home-like setting. Our homes seek to imitate the environment that our residents have been accustomed to in living in their own private homes so that the connection to familiar things like their kitchen can keep them as independent as possible. Many of our residents can be seen helping in the kitchen or setting the tables, folding laundry, even helping other residents.

The environment is so natural, that many of these tasks that would be impossible for them in other large assisted living environments are encouraged here in our Potomac homes. Rogers goes on to explain "If nursing staff or an in-home caregiver does things for people that they can do for themselves, you run into a condition called 'access disability' which is an inability to do things that's caused by the caregiver, not necessarily the disease." Caregivers need to resist the temptation to simply perform these tasks for them because it is often easier and quicker. However, if we can provide cueing to start and finish some challenging tasks, such as dressing, while encouraging them to attempt to complete some portion of the task themselves, it can help build confidence and maintain independence longer. But this type of intervention puts demands on people and could possibly create an increase in disruptive behavior. The key here is when we ask them to do something, we must be careful to gauge the activity as to determine if they could do it successfully, so we do not get a negative response. This philosophy fits in well with our attempt to enter our resident's reality and create a failure free environment, rather than force them into ours. We are encouraged by this research and applaud our employees for not only providing the care our residents require, but also recognizing the value of their involvement in the process to improve the quality of their lives. Our residential setting is fostering more independence as an outcome, and make coping with the disease more manageable for our residents.

For more information, please call 1-800-935-9898

by Ben Pearce
President, Potomac Homes

POT EDITORIAL 6.4375X8 pg 3