

Assisted Living How To Make It Work In Rural Communities

"Assisted living," the current service of choice for people needing long term care, has been slow to come to rural areas because of the usual reasons: not enough people and not enough money. Many rural communities, however, are figuring out how to provide this popular housing option, in spite of barriers which appear insurmountable.

The idea is to provide housing for people who do not need all of the skilled care offered in nursing homes, but who may need a helping hand in some aspects of their daily lives.

Today "assisted living" is a rapidly growing industry, that includes a broad range of housing with services - from the original Oregon model with its emphasis on consumer choice and independence to traditional residential care, where people may share a room and a bath, have no private kitchen facilities, and receive a basic package of services. "The \$12.2 billion industry expects to more than double in size by the year 2000," says Karen Wayne, president of the Assisted Living Federation of America.

But housing with services becomes very expensive without economies of scale. Paying for an on-site staff presence 24 hours a day, for example, is much easier when 25 - 30 people are paying

rent than when you have only 10 - 15 units.

"Assisted living in rural areas is definitely doable, just not easily doable," says Sarah Carpenter, executive director of the Cathedral Square Corporation, a not-for-profit housing and community service provider in northwestern Vermont and chair of the Home and Community-Based Services committee of the American Association of Homes and Services for the Aging (AAHSA). "The trick is community interest and affiliation with others," she says.

"Recognize that you can't do it on your own. See where your possible partners' interests lie. It is often in the interests of rural hospitals and nursing homes to help develop assisted living facilities for people not eligible or appropriate for their in-patient services."

Condon, Oregon Wants Its Elders To "Age In Place"

By 1990, it was clear that the people in Condon, Oregon (pop. 650), 75 miles from the nearest hospital, were no longer willing to see their elderly family members and neighbors forced to leave the area when they needed some long term care. After discussions at a local church, a small group of people got together to explore the possibilities of creating a facility where people could "age in place." In 1994, Summit Springs Village opened for business. It is a two-part project: one building with 23 bedroom units and two other buildings with six cottage apartments.

"Summit Springs is a place where

people's needs can be met at any level until the end of life," says administrator Betty Lou Reed. "But it is not a skilled nursing facility." The cottages are independent apartments, rented at \$750/month, and you can receive housekeeping services and meals in the common dining room for an extra fee. If you live in a bedroom unit, ranging in cost from \$1365 - \$1680/month, you can receive the level of service you need - from personal care a few days a week to constant supervision - for additional fees.

After losing their staff nurse, says Reed, "we found it very difficult to attract another qualified RN to a community this size." The solution was to contract for nursing services 2 - 3 times a week through the home health agency in neighboring Heppner, 45 miles away. Two physician assistants, who staff Condon's town clinic, are on call 24 hours a day for emergencies.

"At first people told us it couldn't be done," says Reed. "But the state came through with a \$1.23 million low-interest loan when they saw our commitment." Condon raised \$240,000 from its own small community, including \$8000 from a church endowment and \$5000 from the telephone company. The County contributed \$6400.

Volunteers helped to prepare the site by demolishing an old gymnasium. Ranchers and farmers brought their trucks, and 4-H kids helped remove debris. "We would not be operating today without our community volunteers, who help with activities and maintain the grounds," says Reed. "And, of course, it's volunteer community board members who make policy and financial decisions."

Contact: Betty Lou Reed, administrator, Summit Springs Village, (541) 384-2101.

If You Can Create Assisted Living In Alaska, You Can Do It Anywhere

The state regional housing authority in Bethel, Alaska serves 20,000 people in 56 villages spread over an area the size of Ohio.

The villages are accessible only by airplane or boat. Most of the people live off the land and have some of the lowest incomes in the state. "If elders in our region need long term care," says Michael Moore, project accountant, "they have to travel to Anchorage, 400 miles away."

In the fall of 1998, they still will have to travel for services, but only to the regional center at Bethel - to a new 16-unit assisted living residence, the Lulu Heron Congregate Home. Lulu Heron, Moore explains, "was a wandering nurse on the tundra, a native elder who traveled from village to village in the 1920's."

Each 600 square foot unit will have a private bath and small kitchen, with a hot plate and refrigerator. At least one hot meal will be available in a central dining

room, and 24-hour staff will include a resident manager and a full-time nurse. Through the regional home care program, residents will be able to receive assistance with bathing, laundry, medical diagnosis, recreational activities, and financial counseling. The building will include "culturally significant amenities," such as a smokehouse for salmon, steam baths, and wild game preparation areas with cold storage.

"We are able to do this because everyone in the state, including the governor, is pushing for it," says Don Fancher, executive director of the housing authority. "It is such an obvious need. We were able to put together federal loans, state grants, and local contributions to come up with the \$2.8 million total cost, and the city of Bethel donated the land." The low-income residents will pay no more than 30 percent of their incomes for rent plus the services not covered by Medicaid.

"If we can do assisted living in Alaska, you can do it anywhere," says Kay Branch of the Bristol Bay Native Association.

Contact: Don Fancher or Michael Moore, (907) 543-3121.

Rural Iowa Nursing Home Adds Assisted Living

The Madrid Home for the Aging, a 172-bed nursing home in Madrid, Iowa (pop. 2400), which has served its community for 91 years, started twenty years ago "to change our image from warehouse to rehabilitation," says administrator William Thayer.

It is clear, Thayer says, that people

want choices in their care; and so the Madrid Home now offers to residents and non-residents a wide range of services co-located on its campus, including: physical, occupational, and speech therapy; home-delivered meals; and home health care. An on-site medical clinic leased by an independent physician's group, serves both nursing home residents and community members. A few years ago, says Thayer, we recognized that "the preferred method of people who need some help is assisted living. People like to live in their own homes."

During the past decade, the Madrid Home has developed 34 units of assisted living on its main campus, and 40 more units are being built on donated land in the neighboring town of Huxley (pop. 2300). Each is a small apartment with kitchen and bath. The Madrid units, built a few at a time, are 700 square feet. Rent is \$650/month, with a la carte services available from staff on campus. In Huxley, the units are smaller, with \$1600/month charges including 24 hour nursing supervision by dedicated staff. Affiliated with the Evangelical Lutheran Church of America,

which has 24 member churches, the Madrid Home was able to finance its on-site assisted living units with donations. "We were debt free until the Huxley project," says Thayer. "For that we borrowed \$3.8 million.

"What really makes the difference in assisted living is how people care about each other," says Thayer. "It doesn't have to take a lot of staff or cost a lot." The home can maintain people who have two or three deficits in activities of daily living at 60 - 70 percent of nursing home costs. Unlike a nursing home, he says, "the concept of assisted living involves risk sharing. Therefore the regulations can be less strict, and the costs can stay down."

Contact: William Thayer, (515) 795-3007.

Building Assisted Living Units One At A Time

Seven years ago, Stephen Menke went to a conference on health care and came away convinced that the future was care at home. He set to work creating a business that offers small modular homes for frail older people or people with disabilities, which could be attached or placed adjacent to a larger family home. This way family members who need some care, could have the advantages of living in their own homes with nearby help when they need it. Now his company, Life Designs of Lawrence, Kansas, designs modular cottages for rural nursing homes which want to add assisted living units.

"Usually, you must figure on about 25 units as a minimum for assisted living, the number needed to pay for the services," says Menke. "This is often too big for a rural area, but we can add as few as two at a time to an existing nursing home; and they can make it work because they are already providing many of the basic services and overhead. We can put the units in, depending on size and extras for \$25,000 - \$54,000."

Village Villa, a 50-bed for-profit nursing home in Nortonville, Kansas, has created Village East on its campus - six units of assisted living built by Menke around a central court with a gazebo. "They were filled almost immediately," says nursing home administrator Janet Blue. "And we're planning six more." Rents range from \$1200 - \$1400 for 600 -900 square foot cottages, including meals, personal care, laundry, and utilities.

Contact: Stephen Menke, Life Designs, (913) 838-3322; Janet Blue, Villa East, (913) 886-6400.

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"There should be at least one residential services option in every rural community, because many rural areas cannot support daily meals on wheels deliveries for frail people in their own homes. They cannot provide house-keeping help or companionship on a regular basis. Nor, because of the distances involved can they respond quickly when someone needs some personal assistance.

"A community that wants an

assisted living facility does not need to start from scratch. You can take an existing housing project or a hospital or nursing home wing and create supportive residential options. You may end up with something not quite as comprehensive as "assisted living," but it will be better than just shelter."

Sarah Carpenter, executive director of Cathedral Square Corporation in Burlington VT and chair of the Home and Community-Based Services committee of the American Association of Homes and Services for the Aging (AAHSA).

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The term "assisted living" was coined in Oregon less than a decade ago to identify a specific program and policy direction: self-contained living units with kitchen facilities, private bath, and lockable doors; and specific services financed and delivered in response to individual needs, not developed as a package.

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Once upon a time, frail older people or younger people with disabilities were cared for in multi-generational households. Then nursing homes or homes for the

aged were built in response to changes in family life styles and shifts in community needs. Currently, a growing elderly and disabled population is straining state Medicaid budgets with the burgeoning costs of medically oriented institutions and their strict and costly licensing requirements. And, when asked, people prefer housing with more privacy than that available in an institution, with greater choices in services, and more opportunity to be independent.

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"It's amazing to me that in three-quarters of all assisted living projects in rural areas, the seed idea comes from a community group, a church or city hall - not a provider or a developer," says Jeffrey Anderzhon, president of Anderzhon, Carlson Architects in Omaha NE, specialists in "life care," from independent life apartments to sub-acute units. "It's the immediate alliance between all the players that's most important in rural areas," he says. "If the community does not back the provider or developer, the project is bound to fail."

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What A Difference A Regulation Makes
"Policy, definitions, and regulations for assisted living vary dramatically across the states based on local history and traditions," says Elise Bolda Ph.D, of the Maine Rural Health Research Center. State regulators find different ways to balance people's desire for independence and

their need for protection.

Currently working on a study exploring the barriers to the development of non-medical residential care in rural areas, Bolda explains that the way a state writes its regulations can make a huge difference in the cost of assisted living units and their feasibility in rural areas.

When a state emphasizes "protection" and mandates strict building codes and fire safety standards, obviously costs go up

- sometimes without good reason. In Denmark, when firemen were asked

about the importance of requiring corridors wide enough to wheel beds out in case of a fire, says Bolda, they responded that they would never wheel residents out; they would simply carry them.

Instead of mandating certain numbers of staff in all facilities, Oregon encourages the development of assisted living by requiring "adequate staff to meet the needs of the residents."

"It all depends on state support," says Bolda. When long term care legislation is new and officials have little experience with it, they think assisted living cannot be done in rural areas, she says. In states which support assisted living and provide assistance for low-income tenants, affordable assisted living

is built - rural or not. "It is only in the most remote areas that such development appears to face barriers," says Bolda. "And even there, communities with strong wills and local leadership are surmounting the barriers." Contact: Elise Bolda, (207) 780-4430. "Development Of Non-Medical Residential Care In Rural Communities" will be available in the spring.

Side bar:

"It's not what can be done in a rural community; it's what a rural community can do." John Seavey, Ph.D., professor of Health Management and Policy at the University of New Hampshire.