

# **MDS** Moore Diversified Services, Inc.

*Serving Senior Living Clients For Over 37 Years  
There Is No Substitute For Experience*

*“You’ve Got Questions . . . We’ve Got Answers”*

*March, 2009*

## **PROVIDING INCREASED ASSISTANCE TO INDEPENDENT LIVING RESIDENTS**

*Responding to a Resident’s Increasing Needs Presents a  
Huge Sponsor and Owner/Operator Dilemma*

Many sponsors and owner/operators are involved in both assisted living and independent living. These living arrangements are typically separated.

But now a human drama is unfolding in independent living communities across the United States. It’s one that can have an enormous impact on the future of your CCRC or independent living community. That’s because your existing independent living residents have aging-in-place needs – and at the same time your community must remain fully market-responsive to new residents. This is often viewed as a no-win situation.

In my work with senior living clients, I’ve lived briefly in over 130 communities. I do this to witness the actual senior living environment up close and personal. I dine with the residents whenever possible. One night at dinner, Mary, an 85-year-old widow said, “***Jim, I really don’t want to go the Big House!***” She went on to describe the prison that was referred to in that famous old James Cagney movie. Fred, also 85, chimed in, “***Jim, I’m not concerned about death or dying, what troubles me is the path I’ll have to take to get there.***” Another resident said, “***I really love Mary, but it troubles me to see her every day in her current state . . . I know but for the grace of God go I.***”

These statements reflect both concern and reality for many seniors.

### **The Dilemma Defined**

Aging-in-place describes the gradual deterioration of the health of residents in senior living communities. It is one of the most predictable trends in senior housing today. Aging-in-place is also one of the most difficult trends to manage effectively *and* compassionately.

Average annual resident turnover rates range from:

- 24 to 40 percent for independent living.
- 50 percent or higher for many assisted living communities.
- 18 to 22 percent for CCRCs – lower off-the-campus turnover because residents are typically transferring within the comprehensive continuum.

Sponsors and owner/operators have a natural tendency to increase the level of services to reduce turnover. But as aging-in-place becomes an increasingly dominant trend within independent living, practical, effective and consistent responses to this dilemma often elude even the most experienced and innovative sponsors and owner/operators. The issue is easily defined, but difficult to address. Here is the issue: ***To what degree are you willing to deliver health-related assistance to your residents who live in independent living?***

Don't answer this question quickly. First, consider two other key questions:

1. ***How and when specifically should you facilitate a resident's move to a higher level of care?***

***and . . .***

2. ***Should you embrace or avoid a naturally occurring assisted living community?***

Sponsors and owner/operators are also realizing this is not an autonomous internal decision.

## **The Assistance in Living Concept**

Dealing with aging-in-place in independent living is, at best, extremely complex. There is a strong temptation to procrastinate or make shortsighted, short-term operational decisions. Many astute operators create distinct living and care continuums that include active adult housing, independent living, assisted living, special Alzheimer/dementia units, and nursing. But others offer assistance in living (AIL) services, which offer as-needed assistance with the residents' activities of daily living (ADLs) to independent living residents. The theory is that care is portable and we can do great things with technology. But are these AIL decisions *strategically correct?*

## **Short-Run Tactics – The Quick Fix**

The quick fix sounds good because in the short run, providing assistance in living services is good for the residents being served. It also appears to solve immediate aging-in-place problems, and slows down turnover. If properly priced, the AIL concept can also provide the sponsor with ancillary income and a hedge against operating expense cost creep. But this short-run solution can frequently trigger serious long-term problems.

Some sponsors are using licensed, third-party home health agencies to deliver the “*medical component*” of service delivery, while they continue to focus on the “*shelter component*.” Properly executed, this can appear to be a viable, reasonably seamless concept. However, the strategy is frequently not truly market-driven or resident-centered. Home health or assisted living charges are frequently billed separately from the monthly service fee and often appear fragmented, excessive, inequitable, and confusing to the resident.

### **Long-Run Impacts – The Self Selection Process**

If you deliver AIL services to your *independent* living residents long enough, a large percentage of seniors will become *assisted living* residents. Many will experience various stages of cognitive impairment. To compound this challenge, the profile of new residents moving in will likely change. New prospects visiting communities that offer extensive AIL services to independent living residents increasingly judge all residents there as “older, frailer people.” Many prospects and their families tend to make move-in decisions based on how they perceive the existing resident population. In this scenario, older, frailer seniors may be the ones to feel that the particular community is right for them. Thus, new move-ins tend to be the result of a *self-selective process*. By appealing to an older, frailer population, you compound and accelerate the cumulative aging-in-place process of the community’s resident population.

### **You Must Respond – Two Types of Conditions**

Assistance in Living (AIL) for seniors can involve one or both of the following conditions:

- ***Chronic Condition*** is the natural changing health status of seniors as they age. The need for assistance with the Activities of Daily Living (ADLs) gradually increases with time – including addressing the special needs of those seniors experiencing various levels of Alzheimer’s or other related dementia. The *process* is generally predictable. What’s more difficult is being certain of the most appropriate ways for care providers to *respond*.
- ***Episodic Condition*** is a sudden change in health status due to an “episode” such as a hip fracture or stroke. This usually triggers an abrupt increase in ADL needs, and sometimes a permanent change in the need for sheltered living arrangements. Here, treatment and procedures are well defined, with recovery outcomes that are reasonably predictable.

Regardless of their initial conditions, most seniors age in place and eventually develop chronic health conditions.

### **Four Stakeholder Groups Are Involved in the Process**

Let’s take a look at the implications of aging-in-place from the real world perspective of four very involved groups:

1. ***Existing residents.*** Existing residents experience the growing complications of aging, and are obviously trying to cope with their physical afflictions. They frequently experience fear, confusion, frustration and insecurity. Many either refuse to understand – or fail to recognize – the real implications of their changing health conditions. In other words, they’re acting human.
2. ***Family members.*** Family members generally fall into one of two broad categories. They either deny that changes are occurring in their loved one’s condition, or they hope their loved one (and your staff) will miraculously cope with the situation. Some family members, but not enough, also recognize it’s time to make some very difficult decisions.
3. ***Peers and neighbors.*** Peers and neighbors of ailing senior living residents who have not yet experienced serious aging complications don’t want to be constantly reminded of the inevitable.
4. ***Professional staff.*** These professionals frequently find themselves facing three aging-in-place challenges:
  - Providing love, patience, and compassion while addressing the changing needs of the residents.
  - Working effectively with family members who simply refuse to deal objectively with bad news.
  - The balancing act: upper management works to strike a delicate balance between delivering increasing levels of care into independent living, while facing complex and costly operations and marketing issues.

Complicating this balancing act is the sometimes conflicting compliance requirements between the national Fair Housing Act and unique state regulations. Some state regulations might require the movement of a particular resident to a higher level of care. On the other hand, Fair Housing may impose fines for moving the resident prematurely!

There are alternative approaches to delivering assistance in living to seniors. Meeting this enormous challenge is more than many owner/operators bargained for when they initially planned their high ambience, independent living community.

The chronic aging process of seniors has caused many older, conventional apartment buildings and condominiums to gradually transition into what is called a “NORC” – a Naturally Occurring Retirement Community. Meanwhile, *independent* living retirement communities are evolving into marginally efficient, less attractive, *Naturally Occurring Assisted Living Communities*.

### **Six Tough Questions to Address**

The first step in attacking this aging-in-place dilemma is to address the six tough questions outlined in Figure 1. If you objectively respond to these six questions, you will probably recognize some potential problems.

**FIGURE 1  
YOU MUST ASK AND ANSWER  
SIX TOUGH AIL QUESTIONS**

**To avoid getting into trouble down the line as a result of delivering AIL services to existing independent living residents, ask yourself six tough questions now. Answer the following questions from the perspective of the years 2009 through 2014:**

1. What is your optimum resident profile, for both your existing independent residents and new move-ins?
2. What will your future business model and market positioning look like? Will residents be independent with moderate needs? Or high acuity assisted living residents? Or a combination of both?
3. Will you have the capability to accurately measure levels of care, those actually delivered to each resident, in order to recover your increasing AIL costs?
4. Will your community be fully market-responsive if residents are charged for incremental increases in assistance with ADLs as they age in place?
5. As resident care needs intensify, can you deliver ADL assistance cost-effectively to randomly distributed independent living units throughout your community?
6. Are all of your care level policies in independent living consistent so that you do not “cannibalize” the other senior living options on your campus?

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### **There Are Some Viable AIL Strategies**

Your long-term prospects may seem dim after answering the questions in Figure 1. However, there is some light at the end of that long, dark tunnel. In next month’s newsletter we will address seven practical strategies will help you learn how to manage the aging-in-place dilemma. This includes more information on the option of creating an integrated, yet separate area to provide increased assistance in living within your independent living community.

### **Call to Action**

Consider the challenges and opportunities of offering increasing levels of assistance in living for your residents in independent living. What are your biggest concerns? How will you address these concerns? Do you need to implement some new policies? When? Are you really comfortable with your answers to the questions posed in Figure 1?

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