



Geriatric Care Management Journal

VOLUME 16

NUMBER 3

**FALL
2006**

*Published by the
National
Association of
Professional
Geriatric Care
Managers*

1604 North Country
Club Road

Tucson, Arizona
85716-3102

520.881.8008 / phone

520.325.7925 / fax

www.caremanager.org

Alternative Housing Issues

Beyond Independence: Designing Care Settings for Community <i>Stefani Danes, AIA</i>	2
Community for the Second 50 Years <i>Joy Silver, MA</i>	8
Future Models and Responses for a Changing Global Community <i>Maria B. Dwight, MA</i>	11
Assisted Living: Good News, Bad News <i>Keren Brown Wilson, Ph.D.</i>	16



Beyond Independence: Designing Care Settings for Community

Stefani Danes, AIA

Abstract

For frail, ill, or cognitively impaired elderly, the physical environment can create serious obstacles to well-being. It can also be an important therapeutic tool. A well-designed care facility, for example, can play a significant role in a resident-centered program by supporting personal dignity and a sense of belonging. This article will discuss ways that the environment reflects evolving models of care delivery. As these models have progressed from the institutional to the residential, and the role of the resident has evolved toward greater independence, the design of the environment has focused on supporting personal autonomy, privacy, and identity. In the near future, as more baby boomers seek not just to “age in place” but to “age in community”, they will look for environments that foster social engagement and sustain an authentic sense of community. Care settings can support a richer and more rewarding community life by offering ample privacy, clear boundaries, pleasant common spaces, and an inviting array of informal connective spaces.

“Dependent people need others to get what they want. Independent people can get what they want through their own effort. Interdependent people combine their own efforts with the efforts of others to achieve their greatest success.”¹

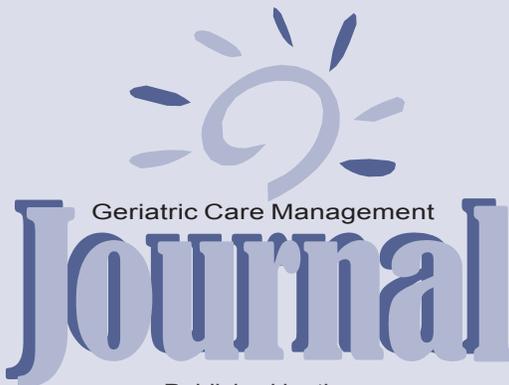
In the last thirty years we have seen an evolution in the philosophy of care for the elderly. By rethinking fundamental assumptions about aging and care, a “culture change” is transforming the values and methods of the gerontological care profession. Institutionalizing people is giving way to providing respectful support. Residential care settings enable people

to live longer and healthier lives. However, despite this transformation in standards of care, many elders have not experienced a high quality of life. In particular, a high proportion of the elderly suffer from chronic depression, a condition most often attributable to a sense of meaninglessness or isolation. The older people are, the more likely they are to have depression. Nearly half of the population over 80 years old is afflicted with chronic depression. Even in congregate housing, loneliness can be a serious problem. We have enabled people to become more independent, but as essential as autonomy is to a good life, it cannot overcome social isolation. On the other hand, there is

evidence that social engagement can add a sense of purpose and longevity to people’s lives.²

From Dependence to Independence

In the last thirty years we have seen a fundamental transformation in the philosophy of care for the elderly. It is premised on our evolving understanding of the process of healthy aging and the role of caregiving in that process. We have developed a better understanding of the aging process and the potential for healthy aging. When aging was defined primarily in terms of physical disabilities, care was defined as providing medical services, and it was not very different from



Published by the:
National Association of Professional Geriatric Care Managers
1604 North Country Club Road
Tucson, Arizona 85716-3102
www.caremanager.org
Published quarterly for members of GCM
Non-member subscriptions: \$95.00 per year
© Copyright 2006

The *GCM Journal* is published as a membership benefit to members of the National Association of Professional Geriatric Care Managers. Non-members may subscribe to *GCM Journal* for \$95.00 per year. Send a check for your one-year subscription to: Subscription Department, GCM, 1604 N. Country Club Road, Tucson, AZ 85716-3102.

EDITORIAL BOARD

Rona Bartelstone, MSW
Fort Lauderdale, FL

Lenard W. Kaye, Ph.D.
Orono, ME

Carmen Morano Ph.D.
Baltimore, MD

Monika White, Ph.D.
Santa Monica, CA

EDITOR-IN-CHIEF
Karen Knutson
MSN, MBA, RN
Charlotte, NC

PUBLICATIONS COORDINATOR
Jonathan Boyle
Tucson, AZ

GRAPHIC DESIGNER
Kristin L. Hager
Tokyo, Japan

hospital care. Still today, many aspects of the institutional environment are regulated by public licensure agencies, which mandate hospital-like conditions. When people are seriously ill or injured, the traditional institutional model of care is entirely appropriate. However, nursing homes have been housing many people without medical needs only because they had no other option. It has become clear that elderly people who are not in need of medical intervention or supervision need an alternative to institutional care. Even more imperative has been the need to find a suitable care setting for the increasing number of cognitively impaired residents, who require assistance and security but not medical care.

Dissatisfaction with the institutional model of care has arisen, in part, from the success of medical treatment. Medical and technological advances have enabled elderly people to survive catastrophic events and manage chronic illnesses. As people live longer in better health, we have learned that the disabilities of aging are not the same as illnesses or injuries, and we've realized that the traditional medical model is too narrowly focused on the physical deficiencies that people experience. It is also clear that even the best-run institutional setting has undesirable effects on people. Most fundamental is its tendency to erode independence, to promote an increasingly passive attitude and behaviors. The more effectively services are provided, the greater is the tendency to become dependent on those services. Ironically, by focusing on satisfying people's needs, the institutional model encouraged those needs to grow.

The movement to reform elderly care that began in the 1970s asserted a new model of aging: healthy aging was seen as the capacity for self-care and the maintenance of functional abilities for as long as possible. It was the beginning of a larger societal trend that shifted responsibility for health from medical professionals back to the individual. With this shift, the role of care was redefined as supportive, and its therapeutic goals were refocused on supporting personal autonomy. Quality of life was redefined in terms

of the capacity to sustain one's autonomy and dignity. This new model of caregiving was based on the premise that everyone has some capacity for self-care, and that this asset is essential to a healthy life.

The Residential Care Model: Settings Designed for Independence

Aging in Place

The institutional model was therefore expanded to the concept of a continuum of care that encompassed a much broader view of aging. The continuum introduced a "home-like" or residential model of care, which is becoming more prevalent today. This model tries to provide greater continuity in life by enabling people to maintain as much as they can of the autonomy they had at home. This is the basis for the concept of "aging-in-place". Known as either a residential (vs institutional) or a social (vs medical) model of care, it aims to assist people in living as independently as they can, enabling a person to stay at whatever point on the care continuum he or she is for as long as possible. Today, providers of housing and services for the elderly are committed to supporting the strengths of residents, as well as fulfilling their needs. These goals are reflected in the standards of practice that have been developed by professional and industry organizations. For instance, the Assisted Living Federation of America has established a philosophy of care to which its members subscribe. The ten points of the philosophy emphasize meeting individual needs, fostering independence, promoting residents' individuality, allowing choices, protecting their privacy, and creating a resident-focused environment.³

Just as our model of aging affects our model of care, so the model of care affects our model of the environment. This can be seen by comparing the institutional environment with the residential environment.

Just as our model of aging affects our model of care, so the model of care affects our model of the environment. This can be seen by comparing the institutional environment with the residential environment. The nursing home, which is designed and operated in accordance with healthcare regulations, reflects a medical model of care. Its physical form is derived

from the hospital: rooms on long double-loaded eight-foot wide corridors, nurses' stations controlling intersections, central staff facilities, and hard surfaces for durability and cleanliness. Control over behavior is the responsibility of the institution's staff, as is the control over the environment itself. Patients occupy beds, but their access to any other space in the facility is strictly regulated. By contrast, a facility based on a residential model of care derives its form from residential building types, such as houses, inns, or apartment buildings: private rooms or apartments, access to welcoming common rooms, such as living rooms or kitchens, staff workspaces integrated into resident spaces, and soft finishes and lighting.

The contrast between these two types of settings is not just a matter of aesthetic appeal. A mismatch between the philosophy of care and the design of the environment inevitably leads to frustration, dissatisfaction, and wasted resources. Long corridors, complicated floor plans, and sterile spaces are constant obstacles to carrying out a resident-oriented model of care. The physical facility is one of the most powerful and expensive therapeutic tools that an organization has, and so it should be carefully designed. There is now ample evidence in the

(continued on page 4)

Beyond Independence: Designing Care Settings for Community

(continued from page 3)

resident and family satisfaction and behavioral studies that the physical environment can make significant difference in the quality of care experienced. Elders in a residential care environment are more active and satisfied with their care than in an institutional setting.⁴ A post-occupancy study of five residential facilities for Alzheimer's residents showed that residents retained their functional capacities significantly better than a comparable nursing home population.⁵ A facility can contribute to the overall therapeutic goal of promoting independence by supporting personal autonomy, privacy, and identity.

Personal Autonomy

Personal autonomy is the opportunity to make choices or decisions for oneself. To permit residents to make choices in a care facility, caregivers need to know that the options are not going to endanger the resident or others. Impairment of balance, strength, or vision all affect residents' mobility and vulnerability to falls. Residents who are cognitively impaired may not be able to make decisions or to take responsibility for decisions, and caregivers must understand the capacity of individual residents to anticipate the consequences of their decisions. A facility supports autonomy by providing security without constant staff surveillance, so that residents are free to move as they please without jeopardizing their safety. A building that is clearly organized with distinct places and simple connections allows residents to find their own way around. Eliminating barriers to mobility and daily function enables residents to maintain their daily habits as well as their independence. Kitchens that give residents an opportunity to prepare food provide flexibility in personal tastes and routines. Along

with the design of hardware, railings, finishes, and furniture, many other features, such as thermostats with large numbers, windows that open easily, and shelves within reach, can make a meaningful difference.

Privacy

One of the ways we use the built environment is to help control the information about ourselves that we share with others. For residents, having privacy is not just the ability to be alone, but the ability to make choices about what kinds of social

A facility can be designed to promote independence by supporting personal autonomy, privacy, and identity.

interaction they want. Private space is where they can choose to be alone or with someone else. The ability to choose to be with others willingly is as important as the ability to choose to be alone, and each person finds his or her own balance. Committing space to private bedrooms and bathrooms represents the most significant dedication to privacy in a care facility. The expense of building private rooms with private bathrooms can add ten to fifteen percent over the cost of double rooms, but even modest private accommodations are significantly better than shared personal spaces.

Identity

The environment provides opportunities to reflect ourselves and reinforce our identity in our surroundings. Enabling residents to personalize their space communicates the importance of their individuality and helps connect them with their past. In addition to providing enough space to allow residents to bring some of their own furniture, shelves and deep window sills invite them to display personal possessions. In some facilities, residents have contributed

items to the common areas. For instance, residents in an assisted living facility assembled collections of their books and displayed framed pictures of grandchildren in the common living room.

Today, when older people need assistance in their daily lives, they often (though certainly not always) have better choices than they had thirty years ago. Outreach services and building adaptations enable people to stay in their own homes much longer, delaying the average age for entry into assisted living to their mid-eighties.

Moreover, once they make the decision to move to a care setting, they are likely to find it far more resident-friendly than ever before. The care industry has embraced the idea of "aging-in-place". The overall standard for care settings for older adults has been raised from the institutional environ-

ments of nursing homes to the home-like settings of congregate care facilities. The primary accomplishment has been to increase individual autonomy. Elderly people and their families today can expect to find the option of a private apartment or a private room with bath. They can bring their own furniture and other personal possessions they value. It is not unusual to find settings where they can have breakfast on their own schedule in a small kitchen setting, rather than having to attend a meal served to perhaps sixty people in a large dining room. There is generally more opportunity to enjoy the traditional amenities of a residential environment with more personal space, greater personal identity, and more personal freedom.

An Emerging Model: Designing Settings for Interdependence

Ageing-in-Community

In the next ten years, we will undoubtedly see a continuing evolution in the philosophy of care and environments designed to

support it. In fact, we may be on the brink of a revolution. The emerging generation of baby boomer elders is bringing new expectations and a desire for better options than their parents have. Many baby boomers want a new type of living that reflects their intention to stay fully engaged with life and with other people in their life. They embrace the value of interdependence as well as continued independence. While “aging-in-place” is about elders taking responsibility and caring for themselves, interdependence means expanding that sense of responsibility to include others: caring for others as well as caring for oneself.

Community, in its truest sense, is founded on interdependence. This is a more exact use of the word “community” than its common meaning, which is often merely a population living in any single area—ie, continuing care retirement community. “Living in community” refers to more than sharing the same spaces or participating in the same activities. A community is a network of relationships. Authentic community is not managed or imposed on people. Aging-in-community means residing in proximity to neighbors who are known personally, with opportunities for mutual support and caring, sharing work and enjoyment, and respecting individual interests and privacy.⁶

In planning facilities that will support aging-in-community, we need to look beyond simplistic design concepts. Creating the appearance of “streets” with a theatrical set-like design does not enliven it if it doesn’t connect the places people go every day. Nor will benches along a dull corridor attract people to sit and converse. Instead of applying simplistic or sentimental ideas, we should be looking more closely at the specific behaviors that build community and the characteristics of the physical settings in which they take place.

How is the sense of community fostered? Residents who are moved to a long term care setting are taken out of their social context. They no longer have the social roles or

network of relationships they have created over time. In a new context, they may have privacy and autonomy, but may not feel a sense of belonging or purpose. Relationships and social roles develop through social engagement. Some people, depending on their personalities, interests, and capacities, are better at getting socially engaged than others. However, aging-in-community does not mean living in a constant stream of social activity. The purpose of encouraging social interaction is only to create the building blocks from which community develops. It would be neither respectful nor effective to impose a “social program” on every resident. Social engagement works only if it is authentic, which means it has to grow naturally. More specifically, the ways in which community develops naturally are through direct personal interaction, common goals and experiences, a sense of common ownership or claim, and affiliation or group identity.

Social interaction that contributes to community formation consists of three different types of behaviors, which occur in different physical and social settings. They represent an increasing intensity of involvement. The first is observing, simply being present with others and being aware of what’s going on. This is a passive activity, quite prevalent, sometimes as a precondition to active involvement and other times as a preferred state of social reserve. The second is neighboring, which is a limited social interaction based on proximity and familiarity over time. It can occur in any common or public place. It is a more active engagement than observing, but relatively impersonal. The third behavior is cooperation or collaboration, in which two or more people work together to plan or carry out an activity or solve a problem. This behavior is motivated more by people’s personal interest in an activity, and less affected by the happenstance of proximity.

There are many ways that the environment can facilitate these community supporting behaviors. Some involve general principles of

good design, such as providing ample daylight, access to outdoors, good air quality and acoustics, accessibility, and security. Other strategies focus on creating either formal or informal gathering spaces. As important as these are, they will not be discussed here. Instead, this article will focus on three often overlooked types of space that contribute to a sense of community: private space, connective space, and in-between space.

Private Space as a Community-Building Tool

It may seem strange to talk about private rooms as part of a community-building strategy, but it’s one of the most important ways to encourage social behavior. Social relationships cannot be forced, and people need to be able to make the choice to be with others rather than feel they cannot help but be with them. The option to be alone allows a resident to choose to be with others. In fact, where residents have private rooms, they tend to spend most of their time in common spaces with other people. At Woodside Place, for example, residents with private rooms spent only about ten percent of the day in their room. Besides providing a place of retreat, private rooms provide the place for personal preparation that enables residents to engage with others. Private bathrooms are not only convenient, but afford the personal dignity that is most appreciated by residents, their families, and care staff.

Since “good fences make good neighbors”, boundaries are an integral, but sometimes disregarded, part of community building. Boundaries allow people to observe others at a social distance. They also define the social protocols for neighboring. Social interaction is deterred by confusion over whether someone belongs in a space. The transition from private to public space should be well-defined, with definite boundaries between. A small-group living room should not be a space totally open to a more

(continued on page 6)

Beyond Independence: Designing Care Settings for Community

(continued from page 5)

public corridor, but should have an entry, even if only between half-walls. It is also important, however, that there is a gradual and well-defined transition from public to private space in the building. Unlike an institutional environment, residential space is especially sensitive to this transition. For the same reason that houses in the city don't open their front doors directly onto a big city plaza, neither is it appropriate to open residents' bedroom doors directly onto a common living or dining room. Just as a neighborhood is a community built of private dwellings, a good community environment in a care facility depends on first getting the private spaces right.

The Connective Tissue of Community: Circulation Spaces

The connections throughout a facility are the lifelines of the community. Their importance as social spaces is sometimes neglected. Traveling from place to place is one of the ways people encounter each other on a daily basis. These connecting spaces can discourage residents' use if they are overly long and oppressive. But if they are comprised of relatively short segments and appropriately proportioned and finished, they can play a positive role in community building. Two types of connections should be considered, links between major destinations and loops that allow people to circulate the facility without dead ends. Links work best if the destinations they connect are part of everyday life for many people. For example, a hallway that links the main elevator lobby with the dining room is a great opportunity for both neighboring and observing. With windows and space for comfortable chairs along one side, it can be an enjoyable place to meet someone for dinner or have a casual conversation afterwards. With other functions, such as offices, shops, or a library, opening onto that space, it is even more enlivened. By combining circulation, observing, and

interaction space, these links become the community's true "main street"—and without any lamp posts or artificial brick.

Loops provide an easy-to-understand path through a facility that connects everything along it on one circular route. Besides providing access, it serves as an opportunity for walking as a recreational and physical activity. An increasing number of residents walk regularly to improve or maintain their fitness. Circulation loops, whether hallways or a running track or a shopping mall, are a natural walking path. Walking is a great social activity, and one of the best forms of neighboring. At Woodside Place, we observed residents walking with other residents, with a family visitor or a care attendant. People in pairs walking arm-in-arm were not uncommon. Most often people walked with one other person, and occasionally in groups of three or four. In fact, walking in groups was such a prevalent activity that it became known as "social walking". The popularity of walking is increasing as a new fitness-oriented generation ages, and they will be reluctant to give up this beneficial practice. As baby boomers have found out, fitness and social activities tend to be highly inter-related. Companions are the best way to get motivated to exercise. Walking companions not only share time together, but they also share the cooperative experience and reward of meeting a common goal. Spaces that are an integral part of daily activities are the natural settings for social interaction and shared experiences. These are the spaces that connect people to each other and thereby strengthen the fabric of a community.

The Social Life of In- Between Spaces

Just as connecting spaces in a building are overlooked as social opportunities, so are the "in-between" spaces. These are the places where people pause just outside a room, or where two people stop to talk at an intersection, or where someone about to enter a room full of people can stop to watch. These transitional spaces are where social interaction tends to be the most dense and consists of all

three types of community-building behaviors: observing, neighboring, and cooperating. Conversations are typically spontaneous or a continuation of something that started elsewhere. In programmed activity spaces, when a large group of people gathers, the socializing tends to happen before and after the event, in doorways, lobbies, and hallways. In general, social interaction is related more to informal and spontaneous activities, such as taking a coffee break or checking the mailbox, than to formal scheduled activities.

Ironically these in-between and connective spaces, which are the locus of so much social interaction, are the areas of the building that are not "programmed", that is, they are without any stated functional purpose. However, if they are recognized as social settings, they can be designed to make more of a contribution to the community life of the facility. By setting a doorway of an activity room a few feet in from the hallway, a transitional space is created that makes the before-or-after conversation a little easier. A line of columns to the side of a room or a hallway provides a good way for residents to enjoy the activity without feeling it necessary to participate directly. This social behavior has been referred to as "porch sitting" and it is related to social walking. Along a loop path frequented by social walkers, other residents sit and chat in comfortable chairs as they watch people walk by.⁷

In general most people observed in residential care facilities choose to spend time where they can see or engage with other people. These are the connective or in-between spaces, the non-programmed circulation spaces that link other spaces. They are not, however, isolated corridors. Rather they are more "street-like" spaces, well-populated spaces with good views of people in adjoining spaces.

In summary

In care settings that are designed to encourage community life, it is not uncommon to see a plentiful variety of common spaces, the subdivision of large group spaces into small group settings, and an emphasis on visual detail. Sometimes these features facilitate the formation of community,

but often they are only representations of a social cohesion that doesn't exist. Here we have looked at ways the care setting environment supports community-building behaviors by providing privacy for residents and by creating informal common spaces that support social interaction. We noted three aspects of the common space that seem to contribute to its capacity to support a sense of community.

First, it is connected to other spaces: if it is a common room, it is important to be connected to a well-traveled path; conversely, if it is a link between destinations or part of a continuous loop, it needs to connect directly to everyday activity spaces.

Second, it is a pleasant space to be in. People respond to what they consider attractive space. This seems to mean that the space is naturally lit in the daytime and lit with soft, indirect light at other times. It is well-proportioned and carefully detailed, and the palette of materials and colors gives it a "fine residential" image.⁸

Third, it is open to other spaces, both interior and exterior, offering views in several directions of other activities and movement. It is an interesting place. The in-between spaces, in particular, allow a person to be aware of social activity without making a commitment to participate. It creates a "fringe zone" where a resident can participate vicariously or passively, and stay connected with others.

Today, as we see a new generation looking for the engagement and vitality of living in community, we are challenged to design environments that enable them to initiate and sustain meaningful relationships. New residential alternatives, such as the Green House model advanced by Dr. Bill Thomas and the concept of senior cohousing communities introduced by Charles Durrett, are responding to these changing expectations. Care facilities that create a thoughtfully-designed environment can help foster a sociable setting and an authentic sense of community. What we hopefully will see is a new kind of care setting, a setting that will support a richer and more rewarding community life by offering ample privacy, clear boundaries, pleasant common spaces, and an inviting complexity of informal connective spaces.

Bibliography

Brawley, Elizabeth C. *Design Innovations for Aging and Alzheimer's: Creating Caring Environments*. New York: John Wiley & Sons. 2006.

Durrett, Charles. *Senior Cohousing: A Community Approach to Independent Living*. Berkeley, CA: Habitat Press. 2005.

Marsden, John P. *Humanistic Design of Assisted Living*. Baltimore: The Johns Hopkins University Press. 2005.

⁹ Milke, Doris L, Charles H.M.Beck, Stefani Danes. "Meeting the Needs in Continuing Care of Facility-Based Residents Diagnosed with Dementia", *Journal of Applied Gerontology* 25, no. 2, (2006): 103-119.

Regnier, Victor. *Design for Assisted Living: Guidelines for Housing the Physically and Mentally Frail*. New York: John Wiley & Sons. 2002.

Schwarz, Benjamin and Ruth Brent, eds. *Aging, Autonomy, and Architecture: Advances in Assisted Living*. Baltimore: The Johns Hopkins University Press. 1999.

Silverman, Myrna, Edmund Ricci, Judith Saxton, Stefani Danes (Ledewitz), Carol McAllister, Christopher Keane. "Woodside Place, the First Three Years of a Residential Facility", Pittsburgh, PA: Presbyterian SeniorCare, 1995

Ms. Danes is a registered architect and principal in the firm of Perkins Eastman Architects, where she is responsible for designing and managing projects in senior housing and long term care. Her experience includes facilities for dementia care, independent and assisted living, skilled care, and retirement communities. She has extensive experience in the design of housing and facilities for older persons and people with special needs. Her recent work includes the direction of the Perkins Eastman Research Initiative, which focuses on the experience of residents and staff members in facilities designed by the firm. The Initiative seeks to build a more comprehensive knowledge base within the firm and to share that knowledge with the professions serving the elderly.

Footnotes

- 1 Covey, Stephen R. *The Seven Habits of Highly Effective People*. New York: Simon and Schuster, 1990, p 49.
- 2 Glass, Thomas A, Carlos Mendes de Leon, Richard A Marottoli, and Lisa F Berkman. "Population based study of social and productive activities as predictors of survival among elderly Americans", *British Medical Journal* 319 (Aug 1999): 478-483 Assisted Living Federation of America. "Guide to Choosing an Assisted Living Residence". Fairfax, VA: Assisted Living Federation of America", p. 3.
- 4 Hoglund, David and Stefani Danes (Ledewitz). "Designing to Meet the Needs of People with Alzheimer's Disease". In *Aging, Autonomy, and Architecture*, edited by Benjamin Schwarz and Ruth Brent, 229-261. Baltimore: The Johns Hopkins University Press. 1999
- 5 Milke, Doris L, Charles H.M.Beck, Stefani Danes. "Meeting the Needs in Continuing Care of Facility-Based Residents Diagnosed with Dementia", *Journal of Applied Gerontology* 25, no. 2, (2006): 103-119.
- 6 Unpublished correspondence by Ruven Liebhaber, Co-Director, Aging in Community Network. www.pentaview.com.
- 7 Silverman, Myrna, Edmund Ricci, Judith Saxton, Stefani Danes (Ledewitz), Carol McAllister, Christopher Keane. "Woodside Place, The First Three Years of a Residential Facility", Pittsburgh, PA: Presbyterian SeniorCare, 1995, pp. 39-89.
- 8 Marsden, John. *Humanistic Design of Assisted Living*. Baltimore: The Johns Hopkins University Press. 2005. pp. 63-85.

Community for the Second 50 Years

Joy Silver, MA

RainbowVision Properties, Inc., headquartered in Santa Fe, New Mexico has created and opened the doors to RainbowVision Santa Fe, a community designed for the over- 50 GLBT (gay, lesbian, bisexual, transgendered) population and their friends. The property sits on approximately 13 acres directly in the city of Santa Fe at 500 Rodeo Rd. As of this writing, RainbowVision is the first to develop, own, operate and manage (RainbowVision Management Group) a hybrid community for this population. The following options are available at RainbowVision: 60 condominiums, with residential maintenance, dining and fitness center/spa membership included (similar to amenities found in “Active Adult” communities in the industry), 60 Chelsea Village leased units (following the residential and maintenance services of Independent Living models), and 26 units in the Castro (Assisted Living services, providing five ADL’s). Our amenities, services and Assisted Living residences are housed in our 45,000 sq ft El Centro building. We became fully operational June 10th, 2006, and celebrated our Grand Opening Ribbon Cutting with the Governor of New Mexico as well as with the Mayor of Santa Fe.

Our second community, RainbowVision Palm Springs, Palm Springs, California, is in pre-development and design, on 13 acres, with similar programming to Santa Fe for approximately 200+ residential units, and a Grand Central building for amenities and services. We look to a late spring-early summer of 2007 for start of construction.

Current Status

Communities for this population have been envisioned for more than

35 years. Most are still in the planning stage, few have become operational. We find that the differences occur in the provision of housing, residential services, and assisted living services in the planning and projected operation of each project. To discuss the available options we start from an historical perspective, beginning with, The “Mother of Them All” located in Apache Junction, at Superstition Mountain, Arizona. The concept originated with the nucleus for this community, RV’ing Women, who decided that retirement was travel in recreational vehicles. Two women, no longer connected to this project, took on the responsibility to create a community where RV’s could be docked or modular homes could be placed. They built a community center in this park-like atmosphere and expanded to an additional site directly across from the original site.

Building on this concept, two women developed “Resort on Carefree Blvd”, with Private Women’s Club, in Ft Myers, Florida for 278 modular homes and a clubhouse. They have since opened “Carefree Cove”, a second property

close to Blowing Rock, North Carolina for men and women. The community offers home sites to be built by individual builders as desired and clubhouse amenities. Carefree will be developing the infrastructure for the property. Similar to this concept, without an identified construction date for the clubhouse, is “Birds of Feather Resort Community”, in Pecos, New Mexico, primarily designed for women. Lots are available for pre-

designed homes, and construction is proposed to begin summer of 2006. All these projects are for-profit ventures

GAYCARE, a Residential Care Facility specializing in the care of Gay males over sixty and those under sixty with like needs has been in existence since 1981 in Daley City, California. It is the oldest residential facility that exists for the care of the elder gay population and is run by a non-profit organization. The staff to client ratio is more than double that of most facilities.

They have a wireless call system for each client that operates anywhere on the grounds with a licensing capacity of five. Licensure is for both ambulatory and non-ambulatory clients.

To discuss the available options we start from an historical perspective, beginning with, The “Mother of Them All” located in Apache Junction, at Superstition Mountain, Arizona.

Both Administrators live in the facility and actively participate in the daily care of clients.

The Palms of Manasota, Palmetto, Florida, a for-profit company, bills itself as “America’s first gay and lesbian retirement community”. POMCA consists of 21 homes in the Phase I section, completed in 1999, with Phase II villas now in construction. Currently, residents are living there and there is talk that the community has plans for Assisted Living and a clubhouse.

GLEH (Gay Lesbian Elder Housing), West Hollywood, CA is the acronym for Gay & Lesbian Elder Housing, a non-profit organization that has broken ground and expects project completion winter/spring 2007. The project is a housing development, containing 104 housing units, with a public community center and retail shops. Health services are to be separately contracted out.

Stonewall Communities has purchased the properties at 23 and 9 Miner Street in the Fenway/Audubon Circle neighborhood of Boston, Massachusetts. It is expected to be a residential community of 66 homes targeted to older lesbians, gay men, their friends, and families with common dining room, communal library fitness and wellness center. Stonewall also expects to contract out for health and social services.

Aegis, Fountaingrove Lodge, outside Santa Rosa, CA, follows the traditional CCRC (Continuing Care Retirement Community) model of senior residential services and, although not owned by the population it intends to serve, is designed to provide LGBT people with traditional retirement community services, following a mainstream model.

There are a number of others with plans in various stages of conceptual design, land acquisition and fund raising, some in major cities like San Francisco, others in small towns like Rehoboth Beach, Delaware. The ones mentioned here are

either currently open (Apache Junction, Gaycare, Carefree, Palms of Manasota and RainbowVision) or have acquired property and are close to construction. To fully understand the challenges of developing and operating communities of this kind, it helps to have an historical context.

“RainbowVision” gets its name from the shared “vision” of the diverse people, now known as the lesbian, gay, bisexual, transgender population, who have come to identify with the rainbow as a symbol for this diversity.

Envisioning Our Future, Ourselves:

“RainbowVision” gets its name from the shared “vision” of the diverse people, now known as the lesbian, gay, bisexual, transgender population, who have come to identify with the rainbow as a symbol for this diversity. The history of the “Rainbow Vision” is one that dates back to the Gay Civil Rights Movement. In the 60’s, a time when Civil Rights were taking a leap forward for all minorities, June 27th, 1969 saw the advance of Gay Civil Rights with the event of what is now called “The Stonewall Riots”, in New York City. Fueled by the funeral of Judy Garland on this same day, she had died a week earlier. Her death, as her life, had great meaning for the gay and lesbian population. Garland served this population as a great icon for many reasons. The straw that broke the camel’s back arrived when the New York City vice squad raided Stonewall, a gay bar in Sheridan Square NYC whose patrons included a large percentage of drag queens (men who dress as glamorous women). Heartbroken, and emotionally distraught over Judy’s death, the queens stood up to the police and

forever changed gay and lesbian history.

During this historical time period, and as it remains severely so in many places in the United States today, gays and lesbians could not live without fear of losing jobs, housing, family, beatings, even murder if discovered. To survive, it was critical that GLBT’s kept the past hidden and present lives protected. To think of having a future was difficult since so much energy had been devoted towards everyday survival. Stonewall marked the change of all this, and having a future was within the realm of possibility.

On the West Coast, the advance was further marked by Armistead Maupin’s “Tales of A City”, stories about GLBT life in San Francisco, debuting in the San Francisco Chronicle on Monday May 24, 1976. In these stories, the idea of a nursing home was discussed among the characters in Maupin’s story, showing that this conversation was gaining momentum among gays. With the advance in civil rights for minorities, the GLBT population, on a whole, began Envisioning Our Future, Ourselves.

Who We Are

So now that a Future has been Envisioned, and in the case of RainbowVision, manifested, lets look at some of the experiences that are taking in place, even in this short time. The experience of living in a community designed to meet the needs of the GLBT population and their friends is relatively new. In doing so within RainbowVision, the stories of shared experience are already beginning to surface. In RainbowVision Santa Fe’s SilverLight Lounge, two male residents sat together at the end of the bar and discussed the concept of never moving again. One said to the other that he wasn’t moving again

(continued on page 10)

Community for the Second 50 Years

(continued from page 9)

until they shipped him out in a box, and the other remarked how being in the Lounge was like sitting in a gay bar. At lunch and dinner, the residents continue to bring tears into the eyes of the employees as they speak of being a family, all of which illustrates the joy at this place where the GLBT population is in the majority. Some residents have moved in from mainstream senior communities and are having the time of their lives. The oldest lesbian resident, 94 years old, has said that these are the best years of her life, and she never had so much fun, nor felt so close to people. Two other residents, in their early 70's, have discovered that they were in the first grade to together in a small town in Pennsylvania. Stories of the residents being in the same place at the same time, but never meeting until

this moment continue to surprise and delight us. And last weekend, the residents and the employees participated together in Santa Fe's Gay Pride March.

Is It A Panacea? Options Welcome!

Much is left to unfold before we know how this experiment will fully evolve. We are currently into our leasing program, and as residents move in we will observe the way in which community issues are handled.

Much is left to unfold before we know how this experiment will fully evolve. We are currently into our leasing program, and as residents move in we will observe the way in which community issues are handled.

The fact remains- Americans are not brought up to function in community.

Rather, we have been brought up to value individuality over group good, and in a community where the population has lived and continues to live through repression and denial of civil rights in the larger sense, there is much work and learning to arrive at a place of total harmony. The residents are very aware of being pioneers, and it is to their credit they

work with the evolving policies and programs by contributing to them directly. Our heterosexual residents also weigh in, and seem happy with all the possibilities in their future. As a 90 year old female resident says, she may meet a man here at RainbowVision yet- everything is possible!

I have been asked, do I see this as a beginning to more communities designed with the GLBT population and their friends in mind? No doubt we will see a number of projects move forward from the idea stage to next steps. The projects themselves are fairly complex, and we will most likely see more co-venturing or merging take place as challenges are encountered by various groups attempting to create similar communities. It is still too early to predict a trend as to outcomes on experimental communities of this kind. We, at RainbowVision look forward to documenting the information on a social, political, cultural and economic scale.

Joy Silver, President for RainbowVision Properties, Inc. is responsible for the creation of the RainbowVision. Creating GLBT communities has been a goal of hers for 27 years- and this year marks the company's success. Ms. Silver holds an MA in Women's Studies, and a BA in Political Science.

Future Models and Responses for a Changing Global Community

Maria B. Dwight, MA

Introduction

Every society in every locality of this diverse country has its own special considerations and will seek its own appropriate and local solutions to improve and maintain the quality of life for its older citizens. Every individual has a personal set of values and expectations. But people everywhere are seeking a quality of life that transcends the basic need for medical care and shelter. There is no best or correct model, but rather a multiplicity of appropriate responses which, when thoughtfully combined, will make the most appropriate model for that specific time, in that specific place.

As populations continue to expand and new generations of people enter late life in an increasingly technological and global community, the options and models will need to be flexible to respond to market factors. The demands for less costly, less institutional responses will continue to drive the private and public sectors toward consumer driven innovation.

The Traditional Housing Models

Since the years after World War II, the major providers of housing care for the elderly have focused their

SPECTRUM OF SERVICES INHERENT IN EACH SHELTER ENVIRONMENT

● Continuous ■ Intermittent	Independent	Congregate	Assisted Living	Nursing Care		
				Intermediate	Skilled	Sub-Acute
RECREATION	●	●	●	●	●	●
TRANSPORTATION	■	■	●	●	●	●
HOUSEKEEPING	■	■	●	●	●	●
EMERGENCY CALL	(Varies)	■	●	●	●	●
MEALS		■	●	●	●	●
MONITORING	■	■	●	●	●	●
PERSONAL CARE		■	●	●	●	●
REHABILITATION			■	■	●	●
SKILLED NURSING				■	●	●

energies on emulating two diverse and equally inappropriate models. The “retirement housing” segment looked for cues within the collegiate model of campus and dormitory. The healthcare component, driven by the advent of Medicare and Medicaid, followed the medical model as exemplified by the acute care hospital. Within the rigid boundaries of such diverse environments, we have tried to develop continua of care, which have historically required that consumers physically move from living space to health care space, depending upon their level of frailty.

It is within this context that we now have “Communities for 55+” which are usually high-density condos (high rise or village plans) with minimal services, including building and ground maintenance and a social center. Many are advertised

as “Gated Communities”, to appeal to the demand for security (and perhaps exclusiveness) that middle and upper income older households are seeking. At least 80% of the residents must have a household member over 55.

The 55+ communities that are sprouting up in suburbs all over the country are smaller versions of the retirement villages and cities that have

proliferated in California, Arizona and Florida since the 1950s, with the advent of Leisure Worlds, Rossmoors, and Sun Cities. These are mega-sized communities with extensive recreational and social facilities, and were originally located in the Sun Belt and marketed to the snowbird market. The new communities are located throughout the United States and are responding to the desires of older families to remain in the area where they have existing social and support networks, or where their adult children and grandchildren reside.

It has been interesting to follow the “maturing” of some of these 50 year old “retirement communities” as they have “aged in place” along with their residents. New generations of households are demanding different amenities, and the older residents are seeking supportive services rather than

(continued on page 12)

Future Models and Responses for a Changing Global Community

(continued from page 11)

recreational opportunities. The emphasis on fitness in later life and healthy aging, however, may have found its genesis in these planned communities. Ad hoc and institutional responses to the increasing needs for assistance have created a broad array of new business in the communities that are adjacent to these large retirement campuses including hospitals and nursing homes, assisted living facilities, travel agencies, funeral homes, and personal services, filling the gap created by these retirement communities that do not have an enriched service program or a continuum of care.

There are also “**Independent Living Communities**” (ILUs or apartments) which, because of Fair Housing Laws, are limited to adults

over age 65. This category includes both subsidized and market rate housing with few services other than maintenance. The development of housing for low and moderate income people has been restricted by the lack of Federal and/or State funds and programs (in spite of the dramatic demographic data) that previously provided options for housing that were specifically designed and managed to support elderly residents. The demand for low and moderate income housing far outstrips the supply, and waiting lists are long for people whose time is often short.

Independent living is in theory a

“static model”, which means that it is incumbent upon the resident to relocate when no longer “independent” and in need of additional services. This model, sometimes reinforced by local codes and regulations, is intended to maintain the vitality of the community and to serve as one discrete part of a continuum. However, the residents often subvert this intention, by privately bringing in the services necessary to remain in their apartment or home. The Americans with Disabilities Act (1990) and

The Fair Housing Act (1968) support the residents in their desire to stay in their residential setting.

A variation on the theme of the morphing of independent housing is the emergence of “**NORCs**”, or **Naturally Occurring Retirement Communities**”. These are usually apartment buildings, often in urban centers or older suburban centers, whose residents have aged over time. Informal support systems have developed and

mutual assistance networks are part of the fabric of the building. The doorman becomes the security system along with “dial a neighbor” for a morning telephone call. Food and meals are delivered through the phone or the net. Neighbors, family, friends or agencies provide assistance with ADLs. The lack of case management and professional coordination of services are the major weak links in this mutual support system. Early intervention and therapeutic responses are not initiated, organized, or professionally managed.

Congregate housing (CHU or **congregate care)** is usually a licensed

facility, although each state has its own set of regulations and acronyms. The concept is basically an “accommodating model” that provides services to allow the resident to “age in place”. These services typically include an emergency call system, transportation and meal programs, but options for services and amenities can be far more intensive (and expensive). Congregate housing may consist of cottages, duplexes and/or apartments. It may be a single building (autonomous or on a campus) or an entire retirement community.

There are community or public spaces to accommodate the service program and compliment the housing. This can be as basic as a multipurpose room with a serving kitchen, to as comprehensive as cultural centers with theaters, fitness centers with exercise equipment and pools, dining rooms, cafes, convenience stores, libraries, ATMs, art studios, etc. The concept of congregate housing is to provide a flexible menu of services that will support residents as they age in place. The importance of socialization in maintaining emotional and physical health is a basic tenet of congregate housing.

Higher levels of congregate care are often difficult to distinguish from **Assisted Living (ALF)**. Some assisted living programs are designed to replace nursing homes and others are designed on a more social and residential model. The dwelling units were historically very small, and often shared, but in response to market demand, the suites are now usually a studio or one bedroom unit with an emergency call, a bathroom with a roll in shower, and a “tea kitchen” that can be disconnected, if necessary. There is usually a whirlpool bath to compliment the bathing program. An increasing number of couples are seeking assisted living so there are increasing numbers of two bedroom suites being developed.

The basic service package of assisted living includes three meals a day and snacks, daily bed making and housekeeping, recreational activities and assistance with (not the adminis-

The development of housing for low and moderate income people has been restricted by the lack of Federal and/or State funds and programs that previously provided options for housing that were specifically designed and managed to support elderly residents.

tration of) medicines. Often additional services are charged for on an as-used basis, and include incontinent care, bathing, dressing, ambulation and companion services.

Throughout the long-term care system we are seeing higher dependency factors and acuity among applicants to, and residents in, residential settings. This is certainly true in assisted living. The level of ADLs and IADLs vary widely from community to community, from sponsor/developer to sponsor/developer and from state to state. In some states, the level of service and support can span the whole late life cycle, until hospice and death. In others, the level of services is limited

form and function. The culture change is becoming resident/patient –centric with on-line caregivers assuming more responsibility for patient care. The Pioneer approach de-centralizes care functions from the traditional “top-down management model” to a “neighborhood model” of mutual respect and decision-making at the CNA and aide level. The Eden Alternative’s goal is to “Teach ourselves to see the environments as habitats for human beings rather than facilities for the frail and elderly.” These combined forces have changed the physical design of nursing centers as well as their culture. The country kitchen has replaced the back of the house kitchen, with its rigid menu and

needs of middle-income older people and the 1960s saw a spurt of development, The early CCRC typically consisted of independent living units, (cottages and/or apartments, with an emphasis on studio, alcove and one-bedroom units) perhaps a small transitional unit (called personal care) and an infirmary. As residents became frailer they were physically relocated from one level of care to the next. There was communal dining (usually three times a day), communal laundry rooms, and communal worship and activity spaces.

The contracts were based on a one-time entry fee, whose value was amortized down over several years, and was not refundable, even in the case of premature death. An additional monthly fee supported the administration and operating costs.

Over time the infirmary became a nursing center, often adding Medicare-certified rehabilitation beds. The personal care expanded and the small dwelling units became unattractive to younger/older people.

A new generation of CCRCs began to emerge in the 1980s and 1990s. In response to the market demand of the retired World War II generation, dwelling units became bigger, with dens, multiple bedrooms and bathrooms, full kitchens with dishwashers, with washer and dryers in the apartment. The amenity space multiplied to include fitness centers and pools, exercise equipment, and classrooms. The demand for the return of all or some portion of the entry fee upon leaving the CCRC became popular in the 1980s. The basic concept of socializing costs eroded and the demand for pay-as-you-go models replaced them.

Recently, residents have strongly resisted the physical displacement from their home, and are demanding that services be brought to them rather than moving to receive the services. This has exacerbated the aging in place dilemma for management. The next generation of potential residents is resistant to moving to a community with a plethora of walkers

(continued on page 14)

Throughout the long-term care system we are seeing higher dependency factors and acuity among applicants to, and residents in, residential settings. This is certainly true in assisted living.

and assisted living becomes a “static model”. Often the payment type (private or public) determines when a person is relocated to a higher level of care, rather than the social, emotional and physical needs of the older resident.

Research and empirical evidence have demonstrated that people with various types and stages of dementia can be cared for and, in fact, can thrive in the residential setting of assisted living rather than in the institutional model of nursing homes. Unfortunately, dementia care is expensive and Medicaid reimbursement in a nursing facility is the only, even if inappropriate, option for people of modest and low incomes.

However, with the advent of The Pioneer Network in 1990, (<http://www.pioneernetwork.net/>) and the Eden Alternative (www.ednaalt.com) nursing centers are slowly becoming more residential and less medical in

time schedules. The nurse’s station has been incorporated into the country kitchen, thereby removing the barrier between caregivers and care receivers. Technology supports the caregivers and frees them to participate in high touch interaction that is often impossible in other models. There is a profusion of plants, animals, and other activities within the nursing unit. Many of the Pioneer nursing homes have preschools as a part of their facilities, and children and their parents regularly participate in the programs and activities.

There are also **Continuing Care Retirement Communities (CCRC)**, which bring together several levels of housing and care to a single campus or within a single building. CCRCs are licensed by each state and come under various jurisdictions. It is a highly regulated product. Initially developed by fraternal or faith based groups, CCRCs were intended to meet the

Future Models and Responses for a Changing Global Community

(continued from page 13)

and wheelchairs in the dining room. Assisted living in CCRCs is slowly replacing the custodial care aspects of the nursing center, as well as the care for residents with dementia.

The cost of developing CCRCs has greatly escalated over time. The model has also attracted the for-profit development sector, and the primary consumer is no longer middle class but rather upper middle class to affluent. The forty-year-old buildings, with their small dwelling units, are no longer attractive to those of lower incomes, although they may be more affordable.

The next generation (the Parents of Boomers) that represents the new consumer of the CCRC model is not even as accepting of the traditional ways of living as were the preceding generations. They may well be the bell cows for the future, as everyone is in a tizzy about “The boomers are getting old(er)”!

The New Forces

Within the last decade we are seeing the unraveling of these models. There has been a dramatic change in expectations and demands among older people. They refute the concept that old age is a disease and they are aware that their lifestyles do and will play an important role in their health and in the quality of life in their later years. They are looking for the services that will help them to stay mentally and physically active, and not simply for services to care for them when they are ill.

There is power in information. Older people are finding access to information through new and varied

conduits. The Net and the Web have opened up new avenues (half of people over 65 are online and it is the fastest growing segment of the computer literate population). In 1995, only 9% of adults in the US were computer users and eleven years later, 77% report being on line.¹ Alternative and/or complimentary medicine has augmented or sometimes replaced traditional medicine. The doctor is no longer “God in a white coat.” The use of vitamins, herbs, and hormonal

The cost of developing CCRCs has greatly escalated over time. The model has also attracted the for-profit development sector, and the primary consumer is no longer middle class but rather upper middle class to affluent.

supplements is commonplace among the older population; as is the demand for therapeutic massage, stress reducing exercise, and meditation. The concept of healing has taken on new dimensions, which include spiritual as well as physical manifestations. According to a study in 2000 by Dr. Gong-Soog Hong of Ohio State University, some 70% of older adults use some form of Complimentary and Alternative Medicine (CAM).

There is accessible information about all facets of life besides health care. The knowledge of how and where to access reliable and valued services is available, as well as cost, quality measures, and consumer satisfaction levels. Our research shows that older people are primarily seeking accessibility to, and quality of, services. The old constituent loyalties are gone, having been replaced by the pursuit of quality.

This bursting forth of technol-

ogy has had another profound effect on the future of service delivery among the elderly. Most older people prefer to remain in their own homes until they die. It is not an unreasonable expectation, which is now made more possible with the plethora of medical procedures that can be delivered in the home setting. Tele-medicine (or rather Tele-health) has not yet come of age in the US, but its advent will allow people far more latitude in living arrangements.

Adaptive and new technologies are being beta-site tested now, to make the homes of the future into intelligent environments, providing unobtrusive security, health monitoring and safety features.

This combination of forces; a new consumer cohort with new demands and new technologies with innovative applications, is creating cracks of

significant proportion in the traditional models of care and service for older people. To exacerbate the situation, the third party payers (public and private insurance programs) have one agenda, which is to reduce costs through reduced utilization. If all of these forces were to come together in a reasoned fashion, we might construct a new policy and an intelligent approach to serving the elders of this country.

Some New Trends and Models

If the providers of housing for the elderly are to succeed in the future, they must reinvent themselves out of the past. The college model has some attributes that can be salvaged. The concept of collegiality and “environment matching” is sound. People like to live with people who share their values and ethics. The most intriguing part (and its raison

d'être) of the "college" model that was omitted is now being reintroduced. This is the concept of the campus as a learning center. We are working with colleges and universities to create life-long learning centers because many people are enjoying a longer span of healthy late life and are seeking opportunities to continue to grow intellectually. Many institutions of higher learning are seeing increasing numbers of non-traditional students flock to their classes, and Elderhostel has become successful by providing inexpensive opportunities for older people to participate in educational programs overseas as well as in the US.

In recognizing this trend, and the increasing demand for "healthy bodies and healthy minds," we have had the opportunity to design an integrated university and retirement campus. The interplay between the two student populations is self selected, and does not impinge on the privacy of either. It is anticipated that many retired faculty will welcome retirement in this academic setting, as will many who simply seek an intellectually stimulating

environment. However, with the advent of the "Virtual University" and distance learning centers, this model could be initiated in free-standing retirement communities or in the community at large.

Other models have developed around college and university campuses. These include Co-housing (both age specific and age integrated) that offer a more innovative opportunity for intergenerational living and also makes efficient use of human and financial resources, which in turn keep costs competitive. Princeton University and University of California, Davis are two models that have recently received national press.

Sunrise, the largest private developer of retirement facilities, is initiating a "Condo-for-Life" product, which will provide the resident with on ownership contract and offer home delivered care. This is based on a fee-for-service model.

Co-op housing has been successful in many parts of the country, and is often an approach to more affordable housing.

Managerial styles are also

changing to accommodate these new expectations. With more men surviving to late life and selecting retirement communities, and with more self-assured women with business and professional experience, there are more questions about management direction, and resident participation on all levels of decision-making becoming more prevalent.

Conclusion

The evolution in the United States from a post industrial, post technological society into the information age is having a profound effect on how we meet the housing and service demands of the elderly. Simultaneously, we are experiencing the influences of the largest, mostly highly educated, geographically mobile, affluent cohort of older people that we have ever had in our society. The gap between rich and poor, however, continues to grow.

Maria Dwight, president and founder of Gerontological Services, has over 40 years' experience in programming and planning facilities and services for older people with emphasis on the inter-relationship of housing, health and social services. Maria received her undergraduate degree from Hampshire College and her master's degree from the Leonard Davis School of Gerontology, University of Southern California.

With more men surviving to late life and selecting retirement communities, and with more self-assured women with business and professional experience, there are more questions about management direction, and resident participation on all levels of decision-making becoming more prevalent.

Footnotes

- 1 Harris Interactive Poll, April 2006

Assisted Living: Good News, Bad News

Keren Brown Wilson, Ph.D.

One of the most interesting changes that has occurred in the field of aging is the emergence of “choices.” Major initiatives such as consumer directed care and negotiated risk in a more complex service environment has made case management both easier and more difficult. That is true for those serving clients in all income and care levels. But it seems nowhere more difficult than in serving frail individuals in need of support that is both hard to schedule and uncertain in duration. Most of this care still takes place in the older person’s “home” with the assistance of a spouse, adult children, and intermittent paid caregivers such as home health nurses. For some, time and continually increasing needs lead to discussion about moving to a more supportive environment. This is usually in some form of “senior housing.”

Senior housing is a broad term, often used to describe an array of options ranging from some form of independent living to a variety of board and care options.

In this article, I attempt to provide an organizing scheme for housing as a setting or location where “mostly” seniors live, and where some or all need supportive services. The goal is to help the client or the support system to realistically evaluate the choices available to them as their needs change. Recognizing that everyone craves clarity, it is important to remember that individual clients thrive or fail in different settings for reasons not at all related to the setting or its characteristics. In particular, personal characteristics such as income, need for supportive services, and individual character traits impact the accessibility, affordability, and acceptability of the

housing choices for older adults and subsequently the “goodness of fit” for the client and the support system. It is with this in mind that I have attempted to sort through major types of settings and speculate on the accessibility, affordability and the acceptability of these settings for various type of clients.

The Accidental Senior Housing Site

For at least 25 years, a distinct pattern of housing involving the “naturally occurring” graying of neighborhoods has emerged as a phenomenon with which support systems of elders and case managers must contend. While this might be a short lived issue, given the behavior of younger homeowners, it will likely pose a serious challenge.

This challenge is to get services to individual households in suburban areas with little in the way of support systems. Transportation and provider networks are often remote and older adults who lose their “wheels” are at serious risk of having limited access to preventative interventions. For many, moving is not a viable option,

given the high cost of newer settings with or without services.

Clients themselves are often committed to staying in their environment regardless of resources. Thus, for case managers, perhaps the most crucial question is: Why does the

person want to stay in the face of daunting problems securing services? They could then tackle interventions around those issues: services to help clients pare down possessions; encouraging development of neighborhood based service co-ops; identifying potential sources for reverse mortgage or other financial planning resources and the like. And this is definitely an issue that case managers, financial planners and others would be telling “boomers” about in order to help them think about being more playful about their own future.

*For at least
25 years, a distinct
pattern of housing
involving the
“naturally
occurring” graying
of neighborhoods
has emerged as
a phenomenon with
which support
systems of elders
and case managers
must contend.*

The Planned Senior Housing Site

In addition to graying neighborhoods, in the past 25-30 years age segregated senior housing has emerged as a distinct market niche. As mobility dwindles, some older people prefer to live and socialize with those

with similar interests, abilities and concerns. Thus, the number of age-segregated housing options continues to grow. Be it gated communities, planned unit development for 55 plus, low-income public housing, snow-bird mobile home parks, or various other versions of retirement communities, significant numbers of older adults select some form of senior housing that brings them in close physical proximity with each other. They are likely to continue to make this choice. As the populations in these settings age, some want or need varying amounts of support services. In some settings these services are largely arranged by the individual client. In these cases the case managers must think of strategies similar to those used for accidental senior housing clients. Even the clustering of those who need services is likely not to be an advantage, since those older adults living in such settings typically are the client, not the setting as an organizational entity. While these settings may arrange for the provision of services particularly as related to maintenance of grounds and structures, they seldom get involved in IADL or ADL service provision beyond provision of a community bulletin board where the availability of such services may be posted to be utilized at the discretion of the individual.

Some age segregated settings such as congregate housing, continuing care retirement communities, and co-housing offer a venue for the introduction of some supportive service arrangements where the individual clients know prior to making the selection of the setting what service is typically included as part of a monthly charge, what service might be arranged and purchased from the managers of the setting, and importantly, any restrictions that might be imposed on those living there since individuals have moved from a straight housing rental or lease arrangement to somewhat of a hybrid rental-service agreement that is binding on

both the setting and the individual client. The case manager in these situations is often called upon when there is a question about the need for services beyond those routinely offered and what plans must be put in place for the individual to retain residency.

Supportive Housing Models

At the most elementary level supportive housing simply means services consistently offered and managed at a specific housing location. Some settings might be characterized as housing with services. Such services might be the result of personal preference such as having a housekeeper to change the bed, clean the bathroom, or vacuum floors. For others the use of services might be the result of an inability to perform everyday tasks such as securing groceries and preparing meals. In these settings the line is often blurred between desire and need for service, with older adults responding mostly positively to approaches that emphasize lifestyle choice. As long as an individual is paying privately, the case manager can take this approach. But if other payers are involved, receiving such services is typically defined as need driven and involve some form of licensure and external oversight to assure both the delivery of and conformance to established standards for "needed" services. This distinction is important to case managers because if no external oversight is in place, the case manager must assume more of the quality assurance role for privately paying clients. If deficiencies are discovered, the case manager typically must use market forces, contract law, or abuse statutes to as they apply to an individual. If public funds are involved, discovery of a problem for an individual client can lead to a larger review of the setting or the licensed provider and the case manager's role may be supplanted by the regulatory agency's authority.

Some older individuals seek options of housing with service arrangements sooner than others. Whether this is a function of personal character traits or a function of access related to personal resources is a topic of debate. Case managers might find it useful to help individuals examine their penchant for delaying decisions regarding living situations until forced to do so by a precipitating crisis. Separating out factors related to personal characteristics and financial concerns earlier might make it easier to address changing conditions in a more planful way. This is another way of suggesting that acceptability and affordability have more impact on planning for changing needs than currently thought and is something about which case managers should be mindful.

Regardless of whether planning for changing needs occurs or not, for some clients a time comes when the regular use of services is not optional. At this point discussions typically are focused on finding an acceptable setting that offers housing and services at a price that can be met. The acceptability of such an option may be embraced with the greatest of reluctance and it is left to the individual client, the family, the case manager, and the provider to make lemonade out of lemons. "Nice and clean," "very handy for me to stop by on my way from work," "a good reputation with the state," and "a great activity program" are examples of the types of things people say when talking about housing and service settings.

These settings come in many sizes, levels of care, and are known by many names: adult homes, board and care homes, domiciliary care, residential care, and, of course, assisted living communities. Housing and service options typically come as a package deal. These settings include a minimum set of basic services such as a meal plan, housekeeping and laundry; many include extensive personal and health related services that vary

(continued on page 18)

Assisted Living: Good News, Bad News

(continued from page 17)

according to individual need.

These settings are almost always licensed and monitored by state regulatory agencies. In housing and service settings where subsidies are provided, the shelter component is often pegged to SSI shelter rates, regardless of amenity level. Some subsidy systems pay a fixed flat rate for both housing and services based upon SSI and, possibly a state supplement. Others, particularly when Medicaid waiver funds are utilized, allow the service portion to vary by level of required care. This approach has led, for the most part, to a limited supply of housing and service settings that have both shelter and care capacity at desired levels. This shortage of affordable housing and service

options affects the private pay market as well. Case managers may find options that are acceptable to clients either too expensive for clients not eligible for subsidies or offering too little care.

When money is not a problem, most clients can readily be helped to find an acceptable setting where the service level is rich enough or can be added onto through the use of supplemental options such as home health. In these situations the case manager's concern is often more about value and quality.

That is, is the price properly set for services sought and is the quality of services provided adequate for the price paid. Some private pay settings use a Club Med approach, with all inclusive rates that vary.

These settings typically have services available at any time, including nights, weekends and holidays. Staff is always on the premises. Staff availability results in more available unscheduled care capacity. Some offer special services such as a secure setting, responding to unscheduled care needs such as night-time toileting, routine and skilled nursing services, therapies, respite and end-of-life care. Of course one might argue that nursing facilities are a very specialized housing and services option.

The case manager often has the most difficult time assisting the

The case manager often has the most difficult time assisting the client who does not qualify for assistance, financially or medically. This client falls financially into an ever widening gap between private rates and Medicaid or state eligibility rates.

client who does not qualify for assistance, financially or medically. This client falls financially into an ever widening gap between private rates and Medicaid or state eligibility rates. Indeed, even the most generous of state plans, at 300 percent of SSI, can often leave a wide gap in many markets for settings that offer higher levels of care. Those clients who have a dual diagnosis or behavioral issues may not qualify at all because of the nature of their disease. Or payment may be so low as to suppress the supply of barely adequate settings.

Thus in many ways these are the most difficult, and most prevalent type, of clients to serve.

It is easy to understand why case managers may feel let down or left out of one of the most remarkable changes in the field of aging in the past decade. They hear about all of the great new places older adults who need care can go, but the odds of securing a place for the client with modest resources are about the same as winning the lotto. Their clients would benefit from significant improvements in the physical environment, including life safety features, access for those with mobility problems, control over private living space, and common space to encourage community building. A more normal environment for those living in housing and service settings should not be a novel concept, but rather the norm. Yet this outcome is not as likely as it once was hoped by many, including myself. Why? The answer is simple: we lack the will to address fundamental flaws in our approach to long-term care and the willingness to address serious innate differences in opinion about individual v. societal responsibility to address a variety of issues around education, housing, income security, and health care. Unluckily, case managers come up against this conflict more frequently than others in their day to day work.

Dr. Wilson teaches courses in political and administrative issues in aging and international aging. She has worked in community-based care since 1976. She was an owner and the operator of the nation's first assisted living facility in Oregon (1981-1986). Dr. Wilson has 25 years of experience in aging services delivery systems and has, for the past 20 years, focused primarily on assisted living. She is President of the Jessie F. Richardson Foundation, a not-for-profit organization advocating innovation and quality in housing and long-term care.



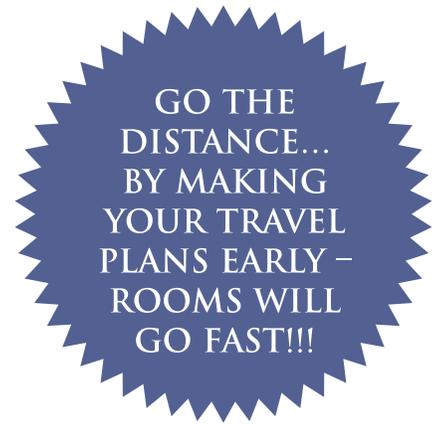
GCMs GO THE DISTANCE

BOSTON 2007

APRIL 12-15

PRE-SESSION APRIL 11

23RD ANNUAL CONFERENCE



SAVE THE DATE!

2007 NATIONAL ASSOCIATION OF PROFESSIONAL GERIATRIC CARE MANAGERS 23RD ANNUAL CONFERENCE
APRIL 12-15, 2007 / PRE-SESSION APRIL 11 / INTERCONTINENTAL BOSTON HOTEL / BOSTON, MASSACHUSETTS

HOTEL INFORMATION

InterContinental Boston Hotel
500 Atlantic Avenue
Boston, MA 02210
Hotel Phone: (617) 747-1000
Reservations: (888) 424-6835
Hotel Rate: \$175 single/double, plus tax

Exceptionally convenient, InterContinental Boston Hotel is surrounded by the Boston Harbor on one side and just steps away from renowned Boston attractions such as the North End, Boston Tea Party Ship Site, Filene's Bargain Basement and Logan International Airport. The InterContinental Boston offers luxurious guest rooms with stunning views, a bevy of exciting cocktail and dining options, I-Spa and 24-hour, state of the art health club. For more information on the

InterContinental Boston Hotel and its surrounding area, including its location to the shopping/dining options, please visit www.intercontinentalboston.com.

For reservations, call 888-424-6835 and be sure to mention you are with National Association of Professional Geriatric Care Managers (GCM) to receive this special rate. Reservations are on a first-come, first served basis and cannot be guaranteed after March 2, 2007.

Navigant International is available to assist you with any of your travel arrangements. (Service fees will apply). For more information, call (800) 229-8731.

A complete registration brochure will be available in January 2007. For more information, visit our website at www.caremanager.org.

A complete registration brochure will be available in January 2007. For more information, visit our website at www.caremanager.org



NATIONAL ASSOCIATION OF PROFESSIONAL GERIATRIC CARE MANAGERS

1604 N. Country Club Road
Tucson, Arizona 85716
(520) 881-8008 Phone
(520) 325-7925 Fax
www.caremanager.org



**National Association of Professional
Geriatric Care Managers**

*1604 North Country Club Road
Tucson, AZ 85716-3102*

PRESORTED
STANDARD
US POSTAGE
PAID
Tucson AZ
Permit No 3178