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ASSISTED LIVING IN THE 21ST CENTURY: EXAMINING ITS ROLE IN THE CONTINUUM OF CARE

HEARING

BEFORE THE

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UNITED STATES SENATE

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ASSISTED LIVING IN THE 21ST CENTURY: EXAMINING ITS ROLE IN THE CONTINUUM OF CARE

THURSDAY, APRIL 26, 2001

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 9:06 a.m., in room SD–562, Dirksen Senate Office Building, Hon. Larry E. Craig (chairman of the committee) presiding.

Present: Senators Craig, Breaux, Carnahan, and Wyden.

OPENING STATEMENT OF SENATOR LARRY E. CRAIG, CHAIRMAN

The CHAIRMAN. Good morning, everyone. Thank you for attending our Senate Special Committee on Aging hearing this morning. I would like to thank our witnesses for agreeing to testify before the committee on "Assisted Living in the 21st Century."

Two years ago, this committee held a hearing to gain a better understanding of the emerging industry of assisted living. This emerging industry has now over 30,000 facilities in the United States, housing approximately one million citizens. Since such large numbers of seniors are choosing assisted living facilities, I feel compelled as the new chairman of the Special Committee on Aging to take a second look at this industry and evaluate efforts to provide quality care to consumers.

Senator Breaux, my ranking colleague here, who has also seen this as an important priority, has been involved in this and monitored it closely over the last several years. I also have a personal reason for wanting to examine this issue. My in-laws are currently living in a retirement community with an assisted living facility, and I am grateful that they are in a good environment receiving quality care. The goal of this hearing is to make sure that all residents receive high levels of care.

Two years ago, GAO issued a report to Congress that indicated assisted living facilities did not consistently provide consumers sufficient information to determine whether a particular facility meet their needs. Because of these results, this committee has asked the assisted living industry to come up with solutions to provide consumers with the best information and care possible.

We are here today to evaluate progress that has been made. Currently, assisted living facilities are not regulated at the Federal level. Instead, States are responsible for oversight. I believe in

most cases States should be permitted to govern without Federal mandates. In this case, we must ask whether the States and the industry are doing enough to protect the elderly who rely on assisted living facilities.

Today, we will hear from both industry and consumer groups who will discuss the current status of assisted living facilities. I'd like to thank the witnesses for agreeing to testify, and I want to especially thank Senator Breaux for his interest in this area. As I said, he has been involved with this issue and continues to work on addressing its concerns.

Very early on in this hearing, I am going to need to step away to attend another hearing, so I want to also recognize Bill Southerland from Eagle, ID, who is on our third panel, who is providing assisted living in more rural settings, which I think is a uniqueness of the diversity of this kind of a facility and caregiving.

With that, let me turn to our ranking member, Senator John Breaux. John.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Good morning, Mr. Chairman, and thank you for participating and working with us on this hearing and to show the continued interest of the Aging Committee in this particular area. It was almost 2 years ago, I think, to this month that this committee under Chairman Grassley had a hearing on assisted living, and we are continuing the effort to try to monitor what is happening in this industry.

As the 77 million baby boomers out there look forward to their golden years, we are trying to make sure that what we do as a nation is not just extend the life of our citizens, but also improve the quality of their lives, and, of course, assisted living facilities is part of that mix. No longer is the only option as you grow older a life relegated to a nursing home. There are other options now and assisted living facilities are one of those options with 33,000 facilities, almost 800,000 units.

This is a growing industry out there, and the question is do we just sit back and sort of ignore it or do we help participate with this industry and try to provide the quality of assisted living that is so important at this particular time in the lives of so many of our citizens?

I think information is important. I think that it is unfortunate that in many areas of health care, we find out more information about the quality of the toasters and the washing machines that we have in society through looking at consumer reports and finding out which ones work, which ones don't work, how much it costs to fix them, and we give guidance to consumers in so many different areas with regard to the quality of products that they receive.

Certainly having the best information on the quality of assisted living facilities is extremely important to know which ones are good, which ones are not so good, and which ones, in fact, do not meet the standards that we all want to have in this country.

It is interesting that about 38 States, I think, now are operating with waivers to use the Medicaid program, which is a Federal-state partnership, to help pay for this. This is an extremely expensive product. And I really think it is incumbent for us in Congress not

just to look at how they are being run, but also try to find ways in which we can help in providing financial assistance to cover the very expensive costs at assisted living facilities as well as what nursing homes charge for their services, which are very valuable services and also very expensive services.

So we are delighted that we got a good group, delighted that Senator Clinton is our lead-off witness and will talk about the New York experience and their involvement in this area. And I look forward to this hearing.

The CHAIRMAN. John, thank you very much. Now let me turn to Senator Jean Carnahan.

STATEMENT OF SENATOR JEAN CARNAHAN

Senator CARNAHAN. Thank you, Mr. Chairman. I want to thank Senator Breaux, too, for calling this hearing on assisted living and its role in continuum of care. Senator Breaux called for the first hearing on this subject some 2 years ago. And he has remained a strong champion of senior citizens ever since, and I commend him for that.

Caring for our loved ones as they grow older is an issue that hits close to home for many in Missouri. A few years ago, I cared for my father in my home, the last 7½ years of his life, and so I understand how important it is that our senior citizens have the care and the dignity and even the love that they deserve in their later years.

I believe we have a moral obligation to empower our senior citizens to keep their independence and their dignity as they age. It is the wish we all have for our own parents and for them to live in an environment where they can maintain a high quality of life for as long as possible.

I look forward to the opportunity to examine long-term care options to allow seniors to accomplish this goal. Assisted living is one of those options. Assisted living strikes a balance. They offer independent living with some support services. Assisted living is a growing phenomenon. To date, there are more than 100 such facilities in Missouri alone, and although I see assisted living as a positive long-term care option for seniors, I am troubled by recent news reports about the lack of oversight of assisted living centers.

What concerns me most is that the health and safety of some assisted living residents may be at risk. When someone puts a family member in an assisted living center, they should know with confidence that their loved ones will be cared for. The importance of this issue will only increase as our country's population ages, and with assisted living becoming more and more prevalent, now is the time to ask ourselves whether we are doing everything possible to ensure quality care.

I am pleased that this committee is calling attention to assisted living in this country today, and I hope the committee will continue to monitor the quality of care that residents receive in these centers. We owe our loved ones no less. Thank you.

The CHAIRMAN. Senator, thank you very much. Now, let me turn to Senator Ron Wyden of Oregon. Ron, in his private life before he came to Congress was actively involved with seniors and has re-

mained certainly a stalwart spokesperson for them while he has served both in the House and the Senate. Ron.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman. After 20 years of friendship with you, it is very good to see you chairing this committee and working with Senator Breaux, who has done so much work in this area. I appreciate both of you convening this hearing.

I have had an interest in this subject, as you mentioned, Mr. Chairman, since my days as co-director of the Gray Panthers. It was over 3 years ago when Senator Breaux and I along with Senator Grassley asked for the first set of definitions about what assisted living was in this country. What we found is that in some States, assisted living is sort of a sponge bath. It is very modest health care by any analysis, and in other States it is extraordinarily sophisticated health care.

When I was visiting my mother in her assisted living facility this weekend, I thought about how far we have come on a bipartisan basis in this committee over the last 3 years. We now have seen the industry, for example, set up a web site and consumer protection checklists, a variety of steps that can assist families. I think it is very appropriate that we look today at what the next steps ought to be, and that is why it is so good to have our friend and colleague, Senator Clinton, here because New York, of course, as in so many areas, has been on the front lines in terms of looking at new approaches.

I would like to ask, Mr. Chairman and colleagues, that we think about two particular areas this morning. One is I think that it is time to look at a model state statute in order to try to lay out a set of baseline consumer protections for older people and at the same time encourage the kind of flexibility that the industry needs in order to be creative and innovative.

I do not think we need to set up some sort of one-size-fits-all Federal program. What I am talking about is not all that different, with some of the steps that we have taken in areas like Medigap, where there has been a modest Federal role, but insurers have worked with the States and the insurance area with the National Association of Insurance Commissioners. Here it would be with the health departments, the consumer advocates, and industry. I think it is time for us to look, and it is again an ideal opportunity for bipartisanship, with the idea of a model state statute for assisted living so we deal with this crazy quilt of statutes around the country. I look forward to examining that issue.

The other area that I would hope that we would look at is that we have a dire shortage of qualified workers to do the critical services for older people in these facilities. By the way, I think we all understand we have got a dire shortage of qualified workers across the board in the health care area. My sense is it is particularly acute in the assisted living facility, and I hope that we could examine that issue as well.

As Senator Carnahan has said, and she has had a family experience with Assisted Living, three of the four of us so far have touched on our family experience, and Senator Breaux, of course, is a long-time expert in this field. So I think it is clear that we can

go at this issue as we have done on so many in a bipartisan way. I look forward to working with you, Mr. Chairman, Senator Breaux and Senator Carnahan to do that.

The CHAIRMAN. Ron, thank you for expression of your thoughts and ideas in this area. I would also like to make part of the record a written statement from Pete Stark, a congressman from the State of California.

[The prepared statement of Mr. Stark follows:]

TESTIMONY OF REP. PETE STARK

I am pleased to participate in today's hearing on how assisted living fits into the continuum of care for senior citizens. More and more seniors are choosing to live in assisted living facilities (ALFs). Until something happens to a loved one, however, few people recognize that there are no national quality standards for these facilities. In fact, regulation varies widely from state-to-state with some States having virtually no regulation at all.

Furthermore, although originally developed as an alternative to nursing homes, recent news coverage by the *Washington Post, New York Times,* and *Wall Street Journal* points toward a growing industry trend to recruit the same frail seniors that might otherwise be served by nursing homes. The simple truth is that frail elderly have significant medical needs no matter where they live.

Until recently, the industry has been almost entirely private-pay. But times are changing and ALFs increasingly seek and receive federal funding through Medicaid's Home and Community-Based Services waiver. In fact, overall spending for this waiver swelled 29 percent between 1988–1999, due in part to growing numbers of ALF placements.

In many States, industry expansion has not been accompanied by a tightening of quality standards or accountability measures. Instead, the definition and philosophy across ALFs varies from state-to-state and there is little consistency in state regulatory efforts. Furthermore, a 1999 General Accounting Office report found that 25 percent of surveyed facilities were cited for five or more quality of care violations between 1996–1997 and 11 percent were cited for 10 or more problems. Frequently cited problems ranged from providing inadequate care, particularly around medication issues, to having insufficient and unqualified staff.

I believe that it is our responsibility to take action before widespread problems are reported. For that reason, I recently took the first step of introducing H.J. Res. 13. This resolution calls for a White House conference to pull together consumers, industry, State officials, and other interested parties in order to develop consensus around quality standards for ALFs. It has been endorsed by several organization active in protecting consumer interests in assisted living and other settings, including the Consumer Consortium on Assisted Living, American Medical Directors Association, California Advocates for Nursing Home Reform, National Association for HomeCare, and Elder Care America.

Beyond H.J. Res. 13, I am actively exploring other legislative solutions to quality concerns within the assisted living industry. ALFs that receive federal funding should be required to meet reasonable, commonsense quality standards to protect residents. Frail, elderly ALF residents must be protected and sub-par facilities must face real consequences. I look forward to working with my colleagues on both sides of the aisle to protect frail seniors in ALFs throughout our country.

Thank you for holding a hearing on this important topic.

The CHAIRMAN. Now, we have the opportunity to hear from Senator Clinton, who is with us today to talk about the New York experience on assisted living. I am sure you are all aware that earlier this year, The New York Times released an article on assisted living, and undoubtedly the senator, I'm sure, has heard from a good many of her constituents on the issues that were raised in the article.

So we are pleased you are with us this morning to share your experience and the experience of your constituents as it relates to assisted living in New York. Welcome to the committee.

STATEMENT OF SENATOR HILLARY RODHAM CLINTON

Senator CLINTON. Thank you so much, Mr. Chairman. I am very pleased to be here, and I thank you and I thank Senator Breaux as well as Senators Carnahan and Wyden for holding this very important hearing and building on the work that you began 2 years ago. It is very encouraging to see how we are looking at a problem ahead of the curve, because although there are lots of issues to be raised, I think this is one that we can address in a bipartisan way, as Senator Wyden has just pointed out, and do some very constructive work, but as we all know, that is work that needs to be undertaken in an expeditious manner because we have to begin planning for the continuing needs of our seniors.

Now, I want at the very beginning to say I am not an expert. You will have some excellent witnesses today who are experts in this area, who have been on the front lines of providing the care that is needed and have been the recipients of such care.

But I have heard, as the chairman just referred to, from many New Yorkers about their experiences with assisted living facilities and with some of the questions that they have because New York has made some very important efforts in trying to deal with and define assisted living programs. So perhaps our experiences will be helpful to the committee and to the rest of the country.

The popularity of assisted living speaks to the autonomy and homelike setting that it can offer, which is, you know, very welcoming to many of our seniors and particularly to the growing population of frail elderly who need some assistance with the activities of daily living but may not need the level of care provided in a nursing home.

According to the New York State Department of Health in a recent report, 10 to 15 percent of the 114,000 nursing home residents in our State could probably live more independently and sometimes less expensively in assisted living facilities. But as we have heard from newspaper reports, assisted living is governed by a myriad of different state-based regulations, often with multiple regulatory frameworks coexisting uneasily even within a single State.

Now, New York's experience really highlights what happens when an emerging long-term care option like assisted living outgrows the patchwork regulatory structure that has evolved over time, and I would very much endorse Senator Wyden's proposal for a model statute. I think that could be an extraordinarily helpful development.

In New York, for example, there are at least, and I say at least because we are not quite sure, but we think there are at least three different kinds of assisted living programs in New York. Now, to the consumer, each of these types of facilities can look remarkably similar, offering housing with personal care services and the ability to provide a range for nursing services and home health care.

And yet consumers are often now aware that these facilities are held to very different standards, which is the point Senator Breaux made. But one thing we have to do is provide information in usable form to consumers.

In the first category, we think adult care facilities. Now they represent the modern-day evolution of the traditional board and care homes which combine residential settings with supportive services.

The second category is called assisted living programs, through which the State gives special certification to roughly 4,000 beds to help make assisted living affordable for those who are eligible for Medicaid and SSI.

New York sets a number of standards for both of these first two categories on subjects ranging from services provided to staff training.

Now, however, in New York as in many other States, there is also a third category of facilities. They are called assisted living, "look alikes" or, "non-licensed" assisted living. These facilities offer housing and may either own or contract with a separately licensed home health care agency. However, they do not have a license to offer the two together in an assisted living arrangement.

Now, if you are confused already, so are many consumers in New York, because trying to sort out the adult care facilities, the so-called ACFs, from the assisted living programs from the non-licensed look-alike assisted living programs causes a lot of confusion. And it is not anyone's, you know, fault. It is just that this is how this has developed and evolved over time, which is why this hearing is so important.

The category of so-called "non-licensed assisted living" is an interesting example of how state specific issues affect assisted living consumers. Now, New York has historically held licensed health care facilities such as hospitals, nursing homes and adult care facilities accountable for quote "character and competence." As a result, our State has a long-standing prohibition preventing publicly traded business corporations from operating licensed health care facilities. Now, that means that some of the larger assisted living chains, which are often subject to licensing in other States, operate under this unlicensed category in New York.

Now, that is something that has caused a lot of confusion among consumers and even among some of the businesses, you know, because they are used to operating under licensing standards in one State, then they come to New York, and they are no longer under licensing standards, which is why having some kind of national model statute which sets a framework, which, you know, all of the good, competent facilities will want to abide by, will be a great first step to sort out this confusion.

Now, we know that many of the providers in New York of all of these different kinds of facilities offer very good environments for our older citizens who appreciate the greater independence and the individually tailored care. But consumers have no guarantee of that and no easy way to compare facilities. So they have to operate basically blindly when it comes to making a decision and that falls usually on family members themselves who are trying to help with determining what is best for their loved ones.

Now, a story I heard recently illustrates this point. A daughter came to New York to select what she thought was the best assisted living facility to care for her mother who has dementia and heart problems. The agency was an unlicensed facility with a licensed home care agency that it owned onsite. But the daughter was not aware of the implications of that confusing licensing structure until it was too late.

At the beginning she instructed the facility that her mother would get agitated and not take her heart medications unless they were crushed. You know sometimes older people have difficulty swallowing; trying to get the pills down is a problem, so, you know, it is a rather common occurrence to crush that medication. Yet within a mere 6 weeks, the mother was hospitalized with a diagnosis of rapid atrial fibrillation and sadly she died.

Later, the daughter found out that her mother had missed one of her medications 15 times and another one five times. Interviews with the nurse from the home care agency revealed that the woman was agitated and did not cooperate with taking her medications. There was no record whether or not they had crushed the medications. And so although the daughter had clearly instructed the facility about this need for her mother, she did not anticipate she might have to also separately instruct the home care agency as well.

In the end, the home care agency was fined $3,000, but the daughter was shocked to learn that the facility itself was not cited for this oversight, because the State lacks oversight over the facility as a service provider. This is a typical example of how when you have a licensed situation and an unlicensed situation, and unclear differences as to what is expected by consumers, tragedy can sometimes ensure.

For those of us who would like to make the experience of assisted living available to the many people who could benefit from its advantages over nursing home care, stories like this raise important questions. And I think this committee already knows that we have to provide answers to these questions:

Do consumers receive enough information to make wise choices? I think we all understand that we don't. What assurances do consumers have that the care will be adequate? That is where a model statute/more information can make a very big difference. Does the licensing and oversight structure as it currently exists in States exacerbate an already difficult decision? And ultimately how can we assure access to quality assisted living facilities at an affordable price?

I would also echo another point that Senator Wyden made, and that is our worker shortage in health care in general—I serve on the Health Committee. A subcommittee has recently held a hearing on our nursing shortage. We know that that is becoming a very serious problem. Well, the shortage of workers in our assisted living programs, our adult care facilities, and our nursing homes is reaching an acute stage of crisis. And it is not even so much as the lack of workers and the expense of training them and keeping them, because we know that the compensation is often very low, it is also creating that extra sense of care and love that Senator Carnahan referred to.

I spoke recently with the directors of some of our adult facilities in New York, and they said that they want to make sure that the emotional component is present, and they are having a hard enough time just finding the bodies to do the work. And then you layer that with the need to find people who will care for our elderly, which is what everyone of us hope for. They have gone so far in some instances to suggest that maybe we should have an option

for facilities and for States to provide a requirement that there be video cameras in the rooms of our elderly so that families could monitor from their own homes what is happening because we do not have the staff on hand to take account of it.

I would hate to see us move toward that, but there are a lot of worried families who don't know what it is they are buying, don't know whether they have got the right information to make a good decision, and perhaps there is something even as extreme as that sort of monitoring that would have to be considered as an interim measure until we take appropriate steps.

Now, as the AARP has said, and I could not agree more, there should be no confusion about what is considered assisted living and what it can and cannot offer older New Yorkers. I would only amend by saying that should cover older Americans everywhere, and I thank you for calling this hearing about an issue that is important today, but will only grow in importance in the next years, and I appreciate the opportunity to testify before you today.

[The prepared statement of Senator Clinton follows:]

PREPARED STATEMENT OF SENATOR HILLARY RODMAN CLINTON

Thank you so much Mr. Chairman and Senator Breaux. I am so pleased to be invited here today to talk with you very briefly about assisted living. I'm not an expert—you have some excellent witnesses today who are—but I have heard from people in New York about their experiences with assisted living facilities and I'm pleased to have this opportunity to share some of their views and concerns with you.

The popularity of assisted living speaks to the autonomy and home-like setting it can offer to the growing population of frail elderly who need some assistance with the activities of daily living, but may not need the level of care provided in a nursing home. According to a New York State Department of Health report, 10 to 15 percent of the 114,000 nursing home residents in New York could probably live more independently—and sometimes less expensively—in assisted living facilities.

As we have all heard from newspapers and from our States, assisted living is governed by a myriad of different state-based regulations, often with multiple regulatory frameworks coexisting uneasily even within a single State. And New York's experience really highlights what happens when an emerging long-term care option outgrows the patchwork regulatory structure that has evolved over time.

There are at least three different kinds of assisted living in New York. To the consumer, each of these types of facilities can look remarkably similar, offering housing with personal care services, and the ability to provide or arrange for nursing services and home health care. And yet, consumers are not aware that these facilities are held to widely different standards.

In the first category we see adult care facilities. They represent the modern day evolution of the traditional board-and-care homes, which combine residential setting with supportive services. The second category is called the Assisted Living Program, through which the State gives special certification to roughly 4,000 beds to help make assisted living affordable for those who are eligible for Medicaid and SSI. New York sets a number of standards for both of these first two categories on subjects ranging from services provided to staff training.

However, in New York, there is also a third category of facilities. They are called assisted living "look-a-likes," a "non-licensed" assisted living. These facilities are licensed to offer housing and may either own or contract with a separately licensed home health care agency. However, they do not have a license to offer the two together in an "assisted living" arrangement.

In fact, this category of so-called non-licensed assisted living is an interesting example of how state-specific issues affect assisted living consumers. New York has historically held licensed health care facilities, such as hospitals, nursing homes and adult care facilities, accountable for "character and competence." As a result our State has a long-standing prohibition preventing publicly-traded business corporations from operating licensed health care facilities. Thus some of the larger assisted living chains, which are often subject to licensing in other States, operate under this unlicensed category in New York.

If what I have just described sounds confusing . . . it is. And imagine how difficult it is for families to navigate this complex terrain and decide what kind of facility is best for their family members.

Certainly, many of the providers in New York offer wonderful living environments for our older citizens, who appreciate the greater independence and the individually-tailored care. But consumers have no guarantee of that, and no easy way to compare different facilities. In short, they have to operate on a good deal of faith. But when it comes to protecting our elderly family members, I don't think that kind of "faith-based program is what families need.

One story I heard recently illustrates this point. A daughter came to New York to select what she thought was the best assisted living facility to care for her mother who had dementia and heart problems. The agency was an unlicensed facility with a licensed home care agency that it owns on site, but the daughter was not aware of the implications of that licensing structure until it was too late. At the beginning, she instructed the facility that her mother would get agitated and not take her medications unless they were crushed.

Yet, within a mere 6 weeks, the mother was hospitalized with a diagnosis of rapid atrial fibrillation, and, sadly, she died. Later the daughter found out that her mother missed one of her medications 15 times and another one 5 times. Interviews with the nurse from the home care agency revealed that the woman was agitated and did not cooperate with taking her medications. But there was no mention of whether they had crushed the medication or not.

The daughter had clearly instructed the facility about her mother's medications, but did not anticipate that she might have to separately instruct the home care agency as well. In the end the home care agency was fined $3000, but the daughter was shocked to learn that the facility itself was not cited, because the State lacks oversight over the facility as a service provider.

For those of us who would like to make the experience of assisted living available to the many people who could benefit from its advantages over nursing home care, stories like this raise important questions. Do consumers receive enough information to make wise choices? What assurances do consumers have that the care will be adequate? Does the licensing and oversight structure exacerbate an already difficult decision? And, ultimately, how can we assure access to quality assisted living facilities at an affordable price?

I applaud those in my State who have and will continue to work hard on addressing these fundamental, but difficult questions.

As the AARP has said, and I couldn't agree more: "There should be no confusion about what is considered assisted living and what it can and cannot offer older New Yorkers."

Thank you so much for calling this hearing so that the expert witnesses here today can help lend insight to the questions that many of my constituents, along with many of yours, are asking.

The CHAIRMAN. Senator, thank you. You have obviously related to us some of the experiences that you have heard about and the frustrations that New York is going through and its citizens are going through.

Two years ago, Governor Pataki recommended consumer protection for residents of assisted living facilities within the State, but I am told these proposals didn't make it into law. How is New York now working to give clarity and direction to the very frustration you spoke to?

Senator CLINTON. Well, Senator Craig, I commend our Governor who came forward with consumer protections, additional disclosure and information provisions, but I think that the fact is that in the absence of a broader awareness of what the Governor was attempting to accomplish, there were a lot of questions raised, and a lot of confusion about what should or shouldn't be covered and who should or shouldn't be licensed, and New York does have this traditional provision which I think is causing us some challenges, and that is that publicly traded companies cannot offer these services in our State under a license.

That doesn't mean they can't do business, but it just means the State can't license them. In effect, the State historically has not wanted to give the seal of approval to a publicly traded for-profit company offering such programs, and of course we have them in New York, but they are not under aegis of the State.

So we have some particular issues we have to deal with, but the Governor was on the right track, and I am hoping that in a bipartisan way in our State bringing together the interested parties, the Governors' proposals, and others who have worked on this will come together, and we will be able to come up with some of the statutory changes that would address the disclosure issues, the information issues, some of the licensing issues.

But I think we would be greatly aided by the kind of model statute and the work that could be done here out of this committee.

The CHAIRMAN. Well, thank you very much. I am going to turn to our ranking member. I am also going to hand him the gavel. I will need to step out.

Senator CLINTON. That is dangerous, Mr. Chairman, you know. [Laughter.]

The CHAIRMAN. All I can say is don't you wish? [Laughter.]

Only for the day. Only for the day, John Breaux. Only for the day.

Senator BREAUX. Time will cure everything.

The CHAIRMAN. Oh, it will. Again, thank you.

Senator BREAUX. [presiding.] Let me thank also the chairman, but also thank Senator Clinton. I think that you point out something that is confusing to you and it is confusing to us. You can imagine how confusing it is to the average citizen who is sometimes desperately looking for some facility to take care of a mother or a father or a relative. As to whether it is a licensed facility, whether it is not, you really can't tell.

I am wondering—and Senator Wyden spoke to this, the difficulty that New York is having in licensing these facilities I am sure is repeated in almost every other State—if there is not some Federal role that we can do without being too intrusive to set up some national standards and national guidelines and somehow encourage the States to have a unified system throughout the system? You know, if we have 50 different sets of rules and regulations for assisted living facilities, it seems like we are not really solving the problem. Do you think that is something we can pursue here?

Senator CLINTON. Well, I would certainly encourage you to do that, senator, because one of the underlying issues here is that because we are a very mobile country, oftentimes parents and children live in different States. You know, as I referred to in the example I gave, a daughter came from out of State, her mother did not want to leave New York, and so her mother wanted to stay there, the daughter came to try to make arrangements. The rules are different from state to state, and it is a patchwork, and so I think anything we can do to set some kind of model statute, maybe to set some national standards and some additional recommended voluntary provisions to encourage all of the players to come to the table, I think from my discussions with the providers in New York, they would welcome that, because, you know, the ones who are

doing a good job, they want to be recognized for the good job they are doing and they deserve to be.

They want to be separated out from, you know, those few bad apples that don't do what should be done in taking care of our seniors. So anything we could do to set up a framework that would enable that to occur, I would be very much in favor of.

Senator BREAUX. That is an excellent point. Thank you very much for being with us. Senator Carnahan, any questions?

Senator CARNAHAN. No.

Senator BREAUX. And Senator Wyden.

Senator WYDEN. Thank you, Senator Breaux and Senator Clinton. Excellent presentation and you know one of the reasons that I argued for it now being the time to look at a model state statute is what you have experienced in New York. I think it is sort of a microcosm of this crazy quilt that we are seeing around the country that GAO told us about more than 3 years ago when they gave us this sort of report on the hodgepodge of definitions. I thank you for an excellent presentation.

I hope that this committee, on a bipartisan basis, will with Senator Breaux and Chairman Craig, pull together an effort to look at a model state statute involving consumer groups, State regulators, the industry, and we would very much like to have you involved in that issue.

Let me ask you about one other question—and I think New York may have a unique ability to contribute. We all know we are having this demographic tsunami in this country with so many older people. New York has a very high percentage of seniors already, and I have noted over the years in my work with Gray Panther advocates up there that you have a lot of low income senior citizens.

Senator CLINTON. Right.

Senator WYDEN. There has been a debate among senior advocates with respect to how to integrate low income seniors into the assisted living model. There has been discussion by both the advocates and the industry of using essentially the housing arm of the government, the various housing programs, in order to stimulate some additional services for low income seniors. Has New York looked at that? And if so, I gather you could conceivably involve State housing programs, HUD, conceivably even some of the government, you know, backed-up programs. I would be interested in what New York has found with respect to housing and low income older people.

Senator CLINTON. Well, senator, I think that you have put your finger on one of the potential areas for exploration in the next few years. We do do some of that in New York. Other States do as well. Trying to provide supplemental housing for low income seniors, but we have by no means done enough nor have we come up with a kind of a priority list of how we proceed to provide affordable housing as people get older.

You know this is not an issue that is on the front page of the newspaper, but everywhere I go in New York from western New York where the aging of the population is particularly acute, because we have lost too many of our young people so our aged citizens are disproportionate in the population, to Long Island, which is thriving economically and can't figure out how it is going to af-

ford to keep their elderly and their young people on the island because affordable housing is so scarce.

We need a housing policy in our country, as you know so well, and one of the elements of it should be low income affordable housing for seniors, and anything we can do to try to bring that into the debate, I would certainly favor, and I would be happy to have my staff, working with your staff, put together the range of options that we do in New York so that you can see what is available. I am not so sure it is different from other places, but I think we perhaps have more State money and maybe in some areas more local money and even some private-public partnerships that we are trying to develop.

But I am very pleased you raised that because when you look at the reimbursement level, even in New York where the cost of living is high, yet the State has made a great effort over the years to provide additional funding for our seniors—you know, we have got under assisted living the permission to use combined Medicaid-SSI financing at roughly $94 a day—that does not go very far if you have got somebody in an unstable medical condition, chronically bedfast or chair-fast, or who requires two people lifting, and equipment, you know, but at least we are making that effort.

And so we have got to bring more resources in, and I think the housing sector, both the public and the private, could make a real contribution.

Senator WYDEN. Thank you for a very good presentation.

Senator BREAUX. One of our witnesses, I would point out, a lady from Louisiana, is going to talk about using HUD funding to build assisted living. That will be really interesting.

Senator CLINTON. Good.

Senator BREAUX. Senator Clinton, thank you so very much.

Senator CLINTON. Thank you.

Senator BREAUX. Delighted to have you.

Senator CLINTON. Thank you very much.

Senator BREAUX. Let us welcome up our next witnesses, and what I would like to do is to bring them all up, and we will have them at one panel rather than divided up, and we would like to welcome Dr. Emelia-Louise Kilby from Arlington, VA, and Ms. Esther Gallow from Monroe, LA; Mr. Bill Southerland who is managing partner of the Southerland Residential Care Homes; Ms. Karen Love from Falls Church, VA; and Ms. Margaret Thompson. I think we can fit in all the panel at the table.

Our first witness will be Dr. Kilby. We are delighted to have you. I understand you have been living in an assisted living facility for some time. And we are delighted to have your comments.

STATEMENT OF EMELIA-LOUISE KILBY, PH.D., ASSISTED LIVING RESIDENT, ARLINGTON, VA

Ms. KILBY. Thank you. Senator Breaux and members of the committee, I am called Lou Kilby. I am a resident of an assisted living facility. It is my pleasure to testify today and provide a resident-centered perspective of what it is like to live in assisted living.

I am a paraplegic and assisted living has been an ideal solution to my problems. I had not expected to spend my golden years in a wheelchair without long-term care insurance. In assisted living, I have had a chance to be fairly independent, to be up and about most of the day, to order and take my own medications, and to continue in a leadership capacity serving on committees. A worrisome thing for me is that costs go up yearly and I fear that I will outlive my money.

Most of the 50 residents live in private apartments, complete with their own bathroom, shower and small refrigerator. Despite the positive aspects of an attractive home, the environment tends to be depressing with some residents unable to communicate, uninterested in taking part in activities, and sleeping much of the day in the common areas.

It is sad, too, when a resident dies or leaves for a nursing home for more care. The activity program is outstanding with various opportunities for the active-minded resident. The program has consistently been an important part of my life and was of great help in my transition from independence to assisted living.

More effort could be made by the staff to encourage attendance of the 30 assisted living residents. Barely a third participate regularly in any activity. I am pleased to say that a number of residents regularly report for morning stretch, which I lead. My star pupils are a 99-year-old woman and a 98-year-old man. The woman has expressed her philosophy by saying she participates not to live longer, but to make her days better.

The wellness nurse supervises the administration of medications and the monthly check on weight and vital signs. Both the nurse and the weekend LPNs only work the daytime hours. During evening hours, the supervisors and the medication technicians, called med techs, make decisions about 911 calls and consult with the resident's doctor.

There is no doctor on the premises. A well-trained med tech delivers pills and other medications such as atomizers. A resident may receive as many as a dozen pills with a small glass of water despite the fact that most pills say to take with eight ounces of water. Sometimes pills are given out before the resident has had breakfast. I wonder about the advisability of such practices.

I have concerns about the protocol practiced when a resident falls. The resident should be carefully helped up once a determination has been made that it is safe to move them. The staff should first check the resident's vital signs and range of motion. This is not always done.

Resident assistants, or RAs, provide the personal care for residents such as giving showers and baths, changing diapers, dressing, seeing that the residents get to meals and so forth. They also do the laundry and make the beds on the assigned floor. In addition, they work in the dining room waiting on tables and doing

dishes. All this for $7 or $7.50 an hour depending upon their experience.

For many, English is a second language and misunderstandings do occur. Presently, since the house is not full, the RA work hours are being cut by one full day a week. This represents a loss of approximately $56 a week. Of great concern is the unrecognized deterioration of some residents, particularly the more independent residents who do not receive daily assistance from the staff. Problems such as depression, confusion, unsteadiness, and weight loss are not always brought to the attention of the nurse or the executive director.

Alert residents are frequently more aware of these resident changes than the senior staff. The turnover in staff at all levels is truly appalling. In my 6½ years, for example, we have had seven executive directors, six activity coordinators, and countless RAs. The turnover is disruptive. Just as you get used to someone, she is gone or he is gone. The work pressures, low pay, amount of work are surely factors.

To make ends meet, some of the staff take on second jobs, and just cutting each RA's time not only discourages loyalty but also sends a message that they are not important to the home.

I appreciate this opportunity to express my views about assisted living. It has made my life, which is difficult at best, much more pleasant. Thank you.

[The prepared statement of Ms. Kilby follows:]

"Assisted Living from a Resident's Perspective"

Hearing of
The U.S. Senate Special Committee on Aging

Testimony of
Emelia-Louise Kilby, PhD
Arlington, VA

Washington, DC: April 26, 2001

Chairman Craig, Senator Breaux, and members of the Committee, my name is Lou Kilby. I am a resident of an assisted living facility. It is my pleasure to testify today, and provide a resident-centered perspective of what it is like to live in assisted living.

Assisted living provides comfortable living for thousands of seniors with physical and mental disabilities and a retirement home for independent persons not wishing to continue maintaining a separate dwelling. In my case, as a paraplegic, it was an ideal solution to my problems, as I had not expected to spend my golden years in a wheelchair without long term care insurance. Residing in assisted living has given me a chance to be fairly independent, to be up and around most of the day, to order and take my own medications (avoiding the $7 a day charge for administration), and to continue in a leadership capacity serving on committees. A worrisome thing for me is that costs go up yearly, and I fear I will outlive my money.

The setting where I have lived for six and one half years is a large, attractive home. There are currently 50 residents - 30 in assisted living and 20 in the Alzheimer's special care section. The grounds are equally attractive and well maintained. Most of the residents live in private apartments complete with their own bathroom, shower, and a small refrigerator. Despite the positive aspects of this lovely setting, the environment tends to be depressing with some residents unable to communicate, uninterested in taking part in activities, and sleeping in the common areas. It is sad when a resident dies or leaves for a nursing home for more care.

Meals are served in an airy, spacious dining room with lace tablecloths and flowers on the table. Flowers are arranged by residents in the floral club. There is a salad bar and a dessert table, and ever popular ice cream. Emphasis is on choice with 2 entrees for dinner and supper or sandwiches if preferred. I am happy to report that fresh fruit was available all winter long. The chef is responsive to residents' concerns and his menu committee meets twice a month to discuss likes, dislikes and special functions. The private dining room, seating 8 comfortably, is available for special parties like a birthday celebration. This space is also used for meetings with family members to discuss a resident's care plan.

The activity program is outstanding with varied programs for the active-minded resident. The program has consistently been an important part of my life and was of great help in my transition from independence to assisted living. More effort could be made by the staff to encourage attendance of the 30 assisted living residents. Barely a third regularly participate in any activity. Activities frequently fall through the cracks during the weekends. Videos are organized to be shown, but that does not always happen.

I actually wrote some of my testimony while sitting on the sun porch listening to a sing-a-long. Other musical programs include a swing band, a classical pianist, guitarists, and others too numerous to mention. There are regular opportunities to do some food preparation to make one feel at home. Residents mix ingredients to make cookie dough,

for example, and spoon the dough onto trays to be baked later. Bingo is popular with 7 residents in our facility. I am pleased to say that a number of residents regularly report for morning stretch which I lead utilizing my background in health and physical education. My star pupils are a 99-year old woman and a 98-year old man. The woman has expressed her exercise philosophy by saying she participates not to live longer, but to make her days better. Seasonal activities such as the 4th of July barbecue and the Winter holiday party bring family and residents together for wonderful food and musical fun.

Pets are allowed and this is really a plus. Some residents keep a cat in their room. My facility has a dog, cat, and a bird. Our facility pets are not properly cared for though causing me and other residents to worry about them. They are often fed and hydrated irregularly and not regularly groomed.

The wellness nurse supervises the administration of mediations and sees that an updated list for each resident is computerized. A copy of this list accompanies a resident to a doctor visit or to the hospital. The nurse also supervises the monthly check on weight and vital signs. We have a LPN during the weekends. Both the nurse and LPN only work daytime hours. During evening hours, the supervisors and medication technicians make decisions about 911 calls and consult with the resident's doctor. There is no doctor on the premises.

A medication technician delivers pills and other medications such as atomizers. A resident may receive as many as a dozen pills with a small glass of water despite the fact that most pills say to take with 8 ounces of water. Sometimes pills are given out before the resident has had breakfast. I wonder about the advisability of such practices. The medication technician does not wait to see if the resident actually downs the pills. Occasionally a resident refuses even to take the pills, and little is actually done about that.

I have concern about the protocol practiced when a resident falls. The resident should be carefully helped up once a determination has been made that it is safe to move them. The staff should check the resident's vital signs and range of motion. This is not always done. Also, an accident report is supposed to be written up.

A care plan is developed for each resident following a conference with the executive director, wellness nurse, a supervisor, a family member, and if possible, the resident. Per state regulation, the care plan is to be updated yearly. Mine has not been reviewed in over a year, so I guess I am all right.

The resident assistants (RAs) are the workhorses (for lack of a better word) of the house. . An effort is made to hire RAs with some experience. New staff participate in a rigorous training program conducted by a senior staff member. Fortunately our home currently has an excellent trainer, but this has not always been the case. The RAs provide the personal care for the residents such as giving showers and baths, changing diapers, dressing, seeing that residents get to meals, etc. They also do the laundry and make the beds on their assigned floor. In addition, they work in the dining room waiting on tables and doing the dishes. All this for $7.00 or $7.50 an hour depending on their experience.

For many, English is a second language and misunderstandings do occur. Presently, since the house is not full, the RA's work hours are being cut by one full day a week. This represents a loss of wages of approximately $56 a week. When this happened once before, I asked - not too innocently - if the wellness nurse's hours were also being cut. There was no response to my query.

A continuing staff problem is absenteeism. Holidays are particularly difficult. This past Easter Sunday, there were only two staff members for the 3-11 shift. They delivered medications, served dinner, put residents to bed, and cleaned dishes. Fortunately for us, these two staff were old-timers and very capable. I doubt they received any extra pay for their hard efforts.

Of great concern is the unrecognized deterioration of some residents, particularly the more independent residents who do not receive daily assistance from staff. Problems such as depression, confusion, unsteadiness, and weight loss are not always brought to the attention of the nurse or the executive director. The dining room hostess does not appear to follow up if a resident does not come for meals. Alert residents are frequently more aware of these resident changes than the facility staff.

The turnover in staff at all levels is truly appalling. In my 6 1/2 years, for example, we have had 7 executive directors, 5 activity coordinators, and countless RAs. The turnover is disruptive. Just as you get used to the RA, she is gone. The work pressures, low pay, and amount of work are surely factors. To make ends meet, some of the staff take on second jobs. Cutting each RAs time by one day per week not only discourages loyalty, but also sends a message that they are not important to the home. Our chef told me he works 3 jobs.

The marketing person, called Director of Community Relations, is under pressure to fill the house and keep it filled. You get the impression that the home will take anybody. I doubt this is completely true, but this is how it feels. Admission mistakes are made. Sometimes a new resident arrives directly from the hospital, but does not seem well enough to handle assisted living. This puts a burden on the RA who must handle the difficult situation. Sometimes residents are admitted to assisted living, but it becomes apparent after a few days that the person is not appropriate for assisted living and they are moved to the Alzheimer's section.

There does seem to be an attempt to keep people here when they begin to need more care. This is more the case of individuals living in the Alzheimer's section as their families want them to stay. For those residents not residing in the Alzheimer's section, family members seem to recognize when assisted living is no longer appropriate for their loved ones, and they make arrangements for a change to a nursing home. Two of my friends left recently.

I appreciate this opportunity to express my views about assisted living. Assisted living has made my life, which is difficult at best, much more pleasant. Thank you.

Senator BREAUX. Dr. Kilby, thank you very much for sharing your thoughts with us, and we are delighted to welcome now Ms. Esther Gallow from Louisiana. Delighted to have you with us.

STATEMENT OF ESTHER GALLOW, PRESIDENT AND CEO, BOOKER T. COMMUNITY OUTREACH, INC., MONROE, LA

Ms. GALLOW. Good morning. I bring you greetings from the State of Louisiana. I am Esther Gallow, president of the Booker T. Community Outreach, Incorporation, in Monroe, LA. Our goal is to improve the living conditions of the poor and elderly residents of the Booker T. Community by producing affordable, safe, and decent housing, and creating vehicles to improve the social and economic conditions of the residents in the Booker T. area.

Booker T. is the oldest and largest neighborhood in Monroe, where the greatest concentration of very low and low income elderly live. It has the highest concentration of deteriorated houses and structures in Monroe. The average income of our seniors is between $3,200 and $5,361 per year.

My organization is proud of the fact that through our efforts for the first time in 20 years, reinvestment and revitalization is occurring. When the long-time low-income elderly in our community can no longer live in their own homes, they literally have no place to go, and nursing homes come into play. They have no choice about life.

My organization believes it is important for elderly persons to have the opportunity to stay in their communities where they can continue to play a vital role and stay connected with their families and friends. To address this most critical need, Booker T. has embarked on this largest project, the development of a Senior Village, a $5.5 million project consisting of 28 units of independent rental units and 40 units of assisted living and adult day care, all on 7.2 acres in our community.

I believe the Senior Village will serve as a national model where no such facility has provided for low income in our State. The State of Louisiana does not presently have a Medicaid waiver. To accomplish our goal thus far and make the dream of the Senior Village a reality, many partnerships are involved.

First, Booker T. enjoyed a strong, positive and supportive relationship with the residents of the Booker T. community. Family and community members will play a critical role in the ongoing management of their family members by providing such things as housekeeping, bathing, involvement in activities. In other words, this is our village, these are our seniors, and we plan to take care of them.

Booker T. is grateful to Senator Breaux, Senator Mary Landrieu and their staffs, also Richelle from the McAuley Institute, who were instrumental in getting Booker T. a $498,900 EDI special project grant through HUD's 2001 appropriations bill.

We were able to leverage this, bring in the public and private together. The Sisters of Charity of the Incarnate Word, who was one of our major sponsors, also is one of the largest providers of health care in the State of Louisiana and Texas, has joined forces with us. Not only did they purchase the land for us, they have put up mone-

tary donations and will also manage the assisted living which they currently do anyway.

The Christus Help Foundation has also put up monetary of $150,000 toward this project. The city of Monroe, I just was informed last night, has agreed to do all the infrastructure on the 7.2 acres and also a commitment of $250,000 toward this project. AmSouth will do the gap financing, if necessary, and has also cosponsored a loan application to the Federal Home Loan Bank to support the assisted living facility.

We have applied for a 202 HUD that will support the independent facility, and through the Louisiana tax credit program, we have applied for a loan that will take care of all of the construction costs for the assisted living facility.

AARP is instrumental in our project also. We have opened up a local office in our community. All of these people are coming together to help and we are not at this point through with begging and asking for assistance. Our main concern is to get as much money as we can into the assisted living part so that it will not be looked upon as a profit-making but a way of helping our people.

I would like to urge the committee, No. 1, to investigate ways to encourage States that have not yet granted Medicaid waivers to do so.

No. 2, to promote the use of project-based Section 8 for low incomes in non–202 projects.

No. 3, to encourage HHS and HUD and other entities to work closer together to resolve this problem.

Finally, I would like to urge this committee to press more for Federal resources to produce these type of facilities. Our elderly should have a choice. I thank you and welcome questions or comments.

[The prepared statement of Ms. Gallow follows:]

Testimony of Esther Gallow
Chief Executive Officer (CEO) of Booker T Community Outreach, Inc.
Before
Senate Special Committee on Aging
April 26, 2001

Good morning, I am Esther Gallow, chief executive officer of Booker T Community Outreach, Inc. in Monroe, Louisiana. Booker T. Community Outreach, Inc. (Booker T.) is a nonprofit organization founded in 1996. Our goal is to improve the living conditions of the poor elderly residents of the Booker T. community of Monroe by producing affordable, safe and decent housing and creating vehicles to improve the social and economic conditions of the residents in the Booker T. Community.

Monroe is located in northeast Louisiana, approximately 100 miles east of Shreveport and 100 miles north of Alexandria. Among cities with a population over 50,000, it is the third poorest in the nation. Of the 54,909 residents in Monroe, 37.8 percent live below the poverty line and 65 percent are over 60 years in age. Of the elderly minority, 70 percent have housing problems.

Booker T. is the oldest and largest neighborhood in Monroe where the greatest concentration of very low-income elderly African-Americans resides. It has the highest number of deteriorated and dilapidated structures in the Monroe. The median family income (MFI) of the 5,336 residents of the Booker T. community is $10,723. Of those, 671 are extremely low-income, between 0 to 30 percent of MFI, which is an annual income of $3,216 or less a year, and 447 are very low income, between 31 to 50 percent of MFI, which is an annual income range of $3,324 to $5,361 per year. The elderly rental population in Booker T. is 3,201 households. An alarming 71 percent of African American households are extremely low-income renters and 29 percent have incomes below 50 percent of the median family income.[1]

My organization, Booker T. Community Outreach Inc., is proud of the fact that through our efforts for the first time in 20 years reinvestment and revitalization is occurring in the Booker T. community. Thus far we have produced 33 units of affordable rental housing for extremely low income elderly residents in the Booker T neighborhood. Just last week we had the grand opening for 15 units for the elderly. We have produced economic development opportunities by creating a business incubator which houses four small businesses; a tax service, a florist, a taxicab service, and an emergency medical clinic. All of the employees live in the Booker T. community. We recently reopened a neighborhood convenience store staffed by Booker T. residents that had been closed for 10 ten years. We just received funding to provide day care services for young, single, working mothers, that will assist with safe and healthy child care needs for residents of Booker T.

When the long-time, low-income elderly in our community can no longer live in their own home they literally have no place where they can afford to go. My organization believes that it is

[1] Consolidated Plan 2000 for the City of Monroe, LA , Department of Housing and Community Development, Melvin Rambley, Mayor

important for these elderly residents to have the opportunity to stay in their community where they can continue to play a vital role and stay connected with their families. To address that critical need, Booker T. Community Outreach, Inc. has embarked on it's largest project, the production Booker T. Washington Senior Village (Senior Village). This $5 million dollar project consists of 28 units of independent living rental housing for low-income residents, 40 units of assisted living, and an adult day care on a 7.2-acre site.

I believe The Booker T. Washington Senior Village can serve as a national model. This project is the first of its kind ever attempted in Louisiana, where assisted facilities for low-income elderly African-Americans are non-existent. It addresses the three key dimensions of elderly housing conditions: adequacy, affordability, and accessibility. The project will add jobs to the community and become a resource for youth to interact with elderly members of the community.

To accomplish our goals thus far and to make the dream of Senior Village a reality, many partnerships are involved. First, Booker T. Community Outreach, Inc. enjoys a strong, positive and supportive relationship with the residents of the Booker T. community. Family and community members will play a critical role in the ongoing management of their family member by providing housekeeping, bathing and etc.

Present at this hearing are staff members from McAuley Institute. McAuley was founded by the Sisters of Mercy in 1983 and is the only national faith-based housing organization that focuses its resources on low-income women and their families. Seventy percent of the Booker T. community is made of women-headed households. McAuley's mission is to support the work of community-based organizations and their partners to create affordable and decent housing and strengthen communities. McAuley Institute has worked closely with Booker T. Community Outreach, Inc. since 1998, in providing both technical and financial services.

Along with McAuley, the Sisters of Charity of the Incarnate Word in Houston, Texas, have continued to support us from the beginning, providing crucial operating support and housing development funding for rental housing units. Through the Sisters in Houston, Booker T. was able to cultivate a relationship with the Sisters of Charity in Monroe. This congregation of women religious has provided Booker T. with the land for Senior Village through a $1 a year lease agreement for 99 years. The Sisters, who operate St. Joseph's Nursing and Assisted Living Facility for moderate and upper income in Monroe, will be Booker T.'s mentor in managing the assisted living portion of Senior Village.

Booker T. is grateful to Senator John Breaux and staff members, Fred Hatfield and Jennifer Guste, who were instrumental in gaining statewide support for the development of Senior Village. Along with Senator Landrieu, they also provided the key support that led to Booker T.'s receiving a $498,900 Economic Development Initiative (EDI) special project grant in the FY 2001 HUD appropriations bill.

Many other present and potential state and local partners are involved in the Senior Village project. Booker T. has submitted an application for tax credits through the Louisiana Housing Finance Agency (HFA). This relationship was developed in 1998, when McAuley began holding statewide training sessions that were co-sponsored by the HFA. The city of Monroe will

provide the infrastructure of streets, water/sewage and drainage on the 7.2 acres site. This work will be paid for from Community Development Block Grant (CDBG) funds. The city has previously awarded Booker T. HOME Investment Partnership Program funds for other rental housing projects. Gregory Hamilton, Community Development Director (CPD) of the New Orleans regional HUD office, has been very helpful in assisting Booker T. in processing the necessary paperwork in order to receive our EDI grant. Hibernia Bank has made a commitment to Booker T to provide construction or bridge financing for the project, if necessary. Booker T. also hopes to receive a grant from the Federal Home Loan Bank of Atlanta through their Affordable Housing Program. Finally, Booker T. has submitted a $1.9 million Section 202 proposal to HUD. This funding will be used to assist in the construction and operation of the assisted living units in Senior Village.

Booker T. is grateful for the support it has received thus far for the production of Senior Village. In order to serve the extremely low-income elderly population of Monroe more is needed. I would urge this Committee: 1) to investigate ways to encourage states that have not yet granted Medicaid waivers for assisted living facilities to do so, and 2) to promote the use of project-based Section 8 certificates for extremely low and very low-income elderly in assisted non-Section 202 rental projects.

Louisiana has not granted needed Medicaid waivers. A strong coalition opposing Medicaid waivers for assistance living facilities has been able to keep those funds directed only to nursing homes. Many seniors who for various reasons need to leave their own home are better served in assisted living facilities. It is nearly impossible to sustain the operation such facilities over time without Medicaid funds. Perhaps states could be given an enhanced federal match for covering assisted living facilities that serve extremely low and very low-income elderly. I would draw to the Committee's attention the fact that Life Care Insurance policies which will pay for assisted living expenses are very good vehicles for moderate income elderly persons, but they are out of the reach for the low income elderly population in the Booker T. community.

When HUD contracts directly with private landlords so that they can make apartments available to low-income tenants at rates they can afford, it is called "project-based" assistance. Public Housing Authorities (PHAs) can project-base 20 percent of their total Section 8 vouchers and certificates. The Monroe PHA has not done any project-basing thus far. It has 583 vouchers and 564 certificates available and 1,522 units of public housing. It has a waiting list of over 1,634 families of which 932 are elderly.[2] The Senior Village independent living rental units would help meet the needs of these elderly households. Receiving Section 8 project-based rental assistance would greatly assist in meeting the on-going operating costs of the facility.

Finally, I would urge this Committee to press for directing more federal resources to producing assisted living facilities that serve low and very low-income elderly. There is an urgent need to address the comprehensive housing and health care needs of low-income elderly persons in our nation. As the elderly population grows, the need for low-income assisted living options will become even more pressing.

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[2] Consolidated Plan 2000 for the City of Monroe, LA , Department of Housing and Community Development, Melvin Rambley, Mayor, p. 45

How far you go in life depends on your being tender with the young, compassionate with the aged, sympathetic with the weak and the strong, because someday in life you will have been all of these. [3]

I thank you for this opportunity to present my views and would be pleased to answer any questions the committee members may have.

[3] Slvia's Book of Poetry, Washington, DC 1995

Senator BREAUX. Thank you very much, Ms. Gallow, for an excellent presentation. Mr. Southerland.

STATEMENT OF BILL SOUTHERLAND, MANAGING PARTNER, BILL SOUTHERLAND'S RESIDENTIAL CARE HOMES, EAGLE, ID

Mr. SOUTHERLAND. Good morning, Senator Breaux and Senator Wyden. I am Bill Southerland, managing partner with Southerland's Residential Care in Boise and Cascade, ID. I serve as president of the Idaho Assisted Living Association, an affiliate of the Assisted Living Federation of America, and also am on the board of directors for the Greater Idaho Chapter of the Alzheimer's Association.

I am honored to be here this morning to speak about some of the issues relating to rural areas providing quality assisted living in those areas. I have been a resident of Idaho for 40 years. I started my business 16 years ago with my father-in-law Emerson Smock. We currently operate four facilities in Boise, and one in Cascade, Idaho has a population of 1,000.

I researched the area, Cascade, and found that there was an aging population there, and if assisted living services were available, there would be enough clients to make it worthwhile. With the help of the SBA and a local lending institution in Boise, the project was started and completed in 1995. We opened up with five full-time residents and it continues to operate at full capacity.

The average assisted living resident in Idaho usually needs a minimum or stand-by assistance with ambulation and requires help or verbal cuing with activities of daily living, and help with bathing, dressing, and some degree of incontinence. Medication management, housekeeping and nutritional needs are also common. Usually most residents suffer some form of memory loss.

Assisted living in Idaho also takes care of folks that have mentally ill diseases and developmentally disabled problems. They are all under the assisted living rules and regulations. Assisted living communities provide services to meet the needs of all of these clients, particularly elderly.

The assisted living service is greatly needed in rural communities. A lot of times the smaller communities are overlooked for several different reasons: the ability to operate efficiently in a small rural area; having the choice of staffing and qualified staffing; and the ability to educate the staff to provide the services long-term basis.

Assisted living provides choices for people requiring 24-hour basic care and supervision. Elderly residents in rural areas sometimes have to leave their homes and move to larger areas to seek these services. Families are faced with additional hardships having to travel longer distances to see their relatives, and also it makes the resident that has to travel to get the services feel isolated and a lot of times depressed.

Some of the challenges facing development in assisted living in rural areas include financing and finding and retaining qualified staffing, educating the local agencies of laws governing assisted living. Medicaid reimbursement is very critical. A lot of times in the rural areas a lot of folks have to depend on Medicaid reimbursement for their care in assisted living. The ability to provide training for caregivers on a continuing basis is very, very critical also.

Assisted living communities in Idaho must be licensed. Idaho was the first State to require licensed administrators for assisted living communities. Regulations have been a significant tool to help improve quality of care and assisted living. We have worked with our association and State regulators to provide regulation from the State level to make sure that assisted living is a safe and secure environment for our seniors.

The Idaho Assisted Living Association worked closely this year with the House Health and Welfare Committee in Idaho that was formed to take a look at the existing survey process. The subcommittee's recommendations have been passed on to the Residential Care Council for Elderly for further review and implementation. The objective of the recommendations was to make the survey process less adversarial and more constructive. That subcommittee was a very successful venture and we are really proud of that.

Consumer rights are very important in assisted living and are mandated by Idaho state law. These rights are posted in each licensed assisted living residence. Included in the consumer rights is the right to access advocates and adult protection services. Informing residents and family members of these rights is a mandatory part of the admission process.

Medication management regulations are the responsibility of the Idaho Board of Nursing. Rules in place now allow caregivers in assisted living to attend comprehensive medication management courses, be tested, and following, if the caregiver or attendant passes the test, an RN still has to give the delegation to that person in order to be able to manage the medications.

Access to current information in rural areas is critical for caregivers and administrators. Utilization of the internet to provide education and information on a regular basis is needed.

Another challenge facing rural assisted living providers is obtaining Medicaid reimbursement levels for clients in rural areas.

Finally, rural areas could benefit greatly from a bona fide wellness program on a consistent basis. I initially got into assisted living for one reason: to make a living. However, I learned very quickly that assisted living is more than just making a living. I can make a difference in someone's life. I can provide a home-like environment for someone who has had to move from their own home. I can make a difference by just spending a little time to give to a resident who is lonely and does not want to bother anyone.

I can listen to a resident explain about their past and what significance he or she played in history. I can give a person choices when they think that no choices are left. I can give them personal care with dignity. I got into assisted living to make a living, but it is so much more. Thank you.

[The prepared statement of Mr. Southerland follows:]

STATEMENT OF BILL SOUTHERLAND

MANAGING PARTNER OF
BILL SOUTHERLAND'S RESIDENTIAL CARE HOMES
EAGLE, IDAHO

BEFORE THE
UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

APRIL 26, 2001

Statement of Bill Southerland
Managing Partner of
Bill Southerland's Residential Care Homes

Providing Quality Care in Rural Areas

Good morning Mr. Chairman and members of the Committee. I am Bill Southerland, managing partner in Bill Southerland's Residential Care Homes in Boise and Cascade, Idaho. I serve as the President of the Idaho Assisted Living Association (IDALA), which is an affiliate of the Assisted Living Federation of America, and on the board of directors for the Greater Idaho Chapter of the Alzheimer's Association. I am honored to be here today to speak about my experience as an assisted living provider serving a rural community. I will be focusing on the value of assisted living in rural settings, the challenges facing development of assisted living in rural areas, regulatory issues, and what can be done to ensure quality of care in rural areas.

Personal and Business Background

I have been a resident of Idaho for over 40 years. I founded Bill Southerland's Residential Care 16 years ago with the help of my father in law, Emerson Smock. We operate five assisted living communities ranging from 8-10 beds. I am currently providing consultation for the city of Challis, Idaho, population just over 1,000, which is planning to build an assisted living community in 2002.

I built my first assisted living community outside of Boise in Cascade, Idaho. I was attracted to that area because of the fishing and recreation in the area. I became interested in finding out if Cascade needed assisted living services when my wife and I were researching the history on an old school house that we had remodeled for a vacation cabin. We found that many families had chosen to stay in Cascade and a lot of elderly folks resided there. I researched the demographics and found that there was an aging population in Cascade and surrounding areas that would use assisted living services if they were available. With the help of the Small Business Administration and a lender in Boise, the project was started.

Benefits and Challenges of Assisted Living in Rural Idaho

Most residents seek out an assisted living community following an emergency. The average assisted living resident in Idaho usually needs minimum or standby assistance with ambulating, requires help or verbal cueing with activities of daily living such as bathing, dressing, and help with some degree of incontinence. Medication management, housekeeping, and nutritional needs are also common with the average assisted living resident. Usually, residents must be encouraged to participate in social activities and some form of memory loss is also common. And finally, the family members are usually concerned about the ability of the resident to make proper decisions about everyday tasks.

Assisted living communities provide services to meet the needs of residents in a home-like environment. This assisted living service is greatly needed in rural communities. Often in a rural setting a local clinic is the only health care option available, and the clinic is usually not operated full time. Home health care can be accessed, but not on a continual basis. Assisted living provides choices for the person requiring 24-hour basic care and supervision. The residence is also an economic source for the community, by providing jobs and purchasing goods and services locally.

Elderly residents in rural areas sometimes have to leave their homes and move to another city to access assisted living services. Families are faced with additional hardships by having to travel long distances to see their relatives. The assisted living resident is left feeling very isolated. In Challis, the only options are to stay at home and not receive services, or move to a larger city to get the needed services. In the past few months, several Challis residents have had to move away and leave their friends and family to access assisted living services.

The practical aspects of serving several people in one assisted living residence makes good fiscal sense. Most basic care can be coordinated and delivered in one location, making better use of quality caregivers and home health nurses. Assisted living communities are also licensed and inspected by the Department of Health and Welfare, Bureau of Facility Standards. State oversight is in place to ensure quality of care in the assisted living environment. The assisted living model offers flexible care for seniors with changing needs, so people do have more choices for their care. Assisted living also is usually less costly than skilled nursing facilities.

Some of the challenges facing development of assisted living in rural areas are: Financing the residence; finding and retaining qualified staff; educating local agencies on the specifics of laws governing assisted living; Medicaid reimbursement rates that may not be enough to entice development of a community in rural areas; the lack of availability of acute health care services in rural areas because clinics may not get enough revenues to operate properly; communications; and the ability to provide training for caregivers on a continuing basis.

State and Provider Collaboration

All assisted living communities in Idaho must be licensed. Idaho was the first state to require licensed administrators for assisted living communities. Regulations have been a significant tool to help improve quality of care in assisted living. I have always supported the state's role in regulating assisted living communities. It has been a very positive experience for me to work together with consumers and state officials to make assisted living a safe and secure environment for seniors. Our state association and the Bureau of Facility Standards are planning to meet once a month to discuss issues concerning assisted living.

The Idaho Assisted Living Association worked closely this year with a House Health and Welfare Subcommittee that was formed to take a look at the existing survey process and find ways to improve it. The Subcommittee's recommendations have been passed on to the Residential Care Council for Elderly and the Board and Care Council for

further review and implementation. The objective of the recommendations is to make the survey process less adversarial and more constructive. The Board and Care Council and the Residential Care Council for Elderly meet at least two times a year and more if needed. The Councils are made up of providers, residents, advocates and regulatory agency personnel from the state. This is an excellent forum to discuss issues relating to assisted living and to deal with them effectively.

Consumer rights are very important in assisted living and are mandated by Idaho state law. These rights are posted in each licensed assisted living residence. Included in the consumer rights is the right to access advocates and adult protection services. Informing residents and family members of these rights is a mandatory part of the admission process.

Medication management regulations are the responsibility of the Idaho Board of Nursing. The rules in place now allow caregivers in assisted living to attend a comprehensive medication management course. A test is given based on the materials presented. After the caregiver passes the test, an RN still must give their delegation to the caregiver in order for them to be able to manage medications for the residence. The classes and nurse delegation have helped the process of managing medications. It is less costly and there is oversight from an RN. This procedure also helps providers in rural areas since an RN is not always available, and is too costly to have a full time nurse in small rural communities.

What is Needed in Rural Areas to Help Ensure Quality of Care?

Access to current information and education is critical for caregivers and administrators in rural areas. Utilization of the Internet to provide education and information on a regular basis is needed. ALFA's educational and training arm, ALFA University, has made available to providers an on-line training system that includes many important topics including training for caregivers and administrators.

I have worked on utilization of the Internet for two years because of the need to monitor our assisted living residence in Cascade. We have developed an Internet-based program for management that allows us to communicate with the caregivers at the residence on day-to-day issues. Since the system is web based, I can monitor resident issues and look at a daily log on each resident by logging onto our web site from any location where I have access to the Internet. I can be informed of any concerns or incidents that occur during the day through the system. Input by caregivers and administrators into the system is simple and less time consuming. Caregivers and administrators have online access to their work schedules, and administrators can update these schedules when needed from anywhere they have access to the web. Educational courses for caregivers can be taken by using the Internet and course tests can also be given over the web. A passing test grade will generate a certificate for the caregiver. This procedure allows us to know if the caregiver has absorbed the educational content. Privacy and levels of security are built into the system and are managed by one designated person in the company--usually the owner or administrator. The Internet program will be utilized in Challis when that community is completed.

Another challenge facing rural assisted living providers is obtaining adequate Medicaid reimbursement levels for clients in rural areas. In Challis, fifty percent of the eligible residents for assisted living services will have to access Medicaid funding. Idaho has a Medicaid waiver in place to help provide funding for Medicaid recipients in assisted living. The waiver program has been in place for almost two years and has worked well especially in rural areas. The reimbursement levels must keep up with rising costs and rising acuity levels of assisted living residents. Medicaid funding in Idaho is always under close scrutiny by the legislature. The waiver process for assisted living can be used only when the cost of care under a waiver does not exceed the cost of care in a skilled setting. This results in a cost savings for the state.

Finally, a consistent wellness program will help the general health of assisted living residents. A study completed several years ago by Dr. Michael Pollyck from the University of Florida confirmed the benefits of a consistent wellness program. The 15-year study followed age groups from 20 years old to over 100. Groups of people with similar conditions were studied. Some groups had congestive heart failure diagnosis, others included people with severe depression. The basis for the program was to see if the overall health of residents could be improved by utilizing strength training to increase muscle mass. In each group, the muscle mass was increased. By increasing muscle mass, better overall physical condition was achieved, appetites improved, digestive problems decreased, and some medications could be discontinued. The overall study was the first to track a strength training program. The length of the study produced valuable data. Rural areas could greatly benefit from a wellness program on a consistent basis.

I initially got into the assisted living business for one reason--to make a living. However, I learned very quickly that assisted living is more than just making a living, I can make a difference in someone's life. I can provide a home-like environment for someone who has had to move from their own home. I can make a difference by just spending a little time talking to a resident who is very lonely and doesn't want to be a bother to anyone. I can listen to a resident explain about their past and what significance he or she played in history. I can give a person choices when they think that no choices are left. I can give them personal care with dignity. I got into assisted living to make a living, but it is so much more!

Thank you, Mr. Chairman, for the opportunity to appear before the Committee today. I would be pleased to answer any questions.

Senator WYDEN. Thank you. The chairman is back and why don't we just move to Ms. Love.

STATEMENT OF KAREN LOVE, EXECUTIVE DIRECTOR, CONSUMER CONSORTIUM ON ASSISTED LIVING, WASHINGTON, DC

Ms. LOVE. Good morning. Thank you, Senator Breaux and Senator Wyden, for the opportunity to address this committee this morning. I am here today on behalf of the Consumer Consortium of Assisted Living, an organization I co-founded in 1995. We commend you for taking up this timely topic again.

I have been an administrator of an assisted living facility, two different types, one ranging in size 60 beds, the other a 220 bed campus. I am also a consumer. My father has Alzheimer's disease and resides in an assisted living facility and has for over 2 years.

According to Dr. Catherine Hawes, the author of the National Assisted Living Study, one in four assisted living residents currently need as much help as a typical nursing home resident. One recent caller to our CCAL helpline described the situation in which her father had lived in an assisted living facility for over 3 years. The father needs daily assistance with activities of daily living such as bathing and dressing. He often goes without assistance because there is not enough staff. As a long-time resident, he has bonded with staff and residents and is willing to accept poor care in lieu of moving out of the facility and somewhere else where he does not know anyone.

This creates serious conflicts for the daughter because she hates to see her father poorly cared for, yet she understands his need to fit in, as well as his ability to make his own decisions. Unfortunately, this is not an isolated situation. CCAL hears all too frequently about care problems. To operate a facility without sufficient trained staff to care for the contractual needs of its residents is corporate negligence. The industry has allowed an unacceptable margin of error for itself.

Assisted living has experienced explosive growth. At times, this rapid growth has occurred at the cost of resident care as quality resident services have not kept pace with brick and mortar construction.

The Census Bureau projects that the population of individuals 85 years and older will be the fastest growing part of the elderly population throughout the rest of this century and will more than double by the year 2030. This enormous growth has significant implications for assisted living as individuals 85 years and older are those most likely to become assisted living residents.

Yet, despite the tremendous growth of the industry, frailty of the residents and the demographic trends, as has been discussed earlier this morning, we know that there are no uniform standards or Federal regulations to protect residents and ensure that their needs are met.

According to a statement Dr. Hawes made last year, the combination of sicker people and low caregiver-to-resident ratios is dangerous. These two things are on a collision course. It is just a time bomb waiting to go off she says.

This time bomb may have already gone off. Recent front-page stories in *The New York Times, Wall Street Journal* and the *Washington Post* abound with stories of problems in assisted living. A dearth of workers which we have also heard about this morning in the long-term care industry and low occupancy rates pressuring the need for providers to fill beds has further heightened the concerns about quality care.

The Washington Post recently reported about a situation in which an 83-year-old frail female resident residing in a facility of one of the industry's largest providers was assaulted in the day room by a 55-year-old male resident. This vulnerable female resident died 2 days later in a hospital from injuries sustained in the assault. Was this male resident an appropriate admission to a facility caring for vulnerable individuals or was the company simply filling beds?

These significant problems are compounded by the uneven and patchwork approach to State regulations and oversight producing an increasingly alarming picture of the industry. The industry is regulated, as has been mentioned earlier, individually by States, but there is such a variability, even in what we call assisted living. There are over two dozen names. For example, adult residential services, home for the aged, domiciliary care. It is very confusing. Senator Clinton beautifully described the confusing array of licensing options when she described what New York state alone has.

One of the problems with nursing home oversight and national standards is that advocates have spent decades trying to catch up to an industry that got off to a freewheeling and virtually unrestrained start. Our nation's nursing home residents and their loved ones have paid and continue to pay a high price for that.

The assisted living industry has been given—we are into the second decade of an unrestrained start. We believe that no further time should pass before we really begin appropriately addressing and responsively answering these important needs. I am so glad to hear, Senator Wyden, this morning your suggestion about national standards.

CCAL has begun the effort to develop what we have called model standards, model resident-centered standards, in a process to enlarge the national dialog on assisted living and the action. This should be encompassing of all of the stakeholders and we hope that the industry will join us as well. Thank you.

[The prepared statement of Ms. Love follows:]

CONSUMER CONSORTIUM ON ASSISTED LIVING

STATEMENT OF

KAREN LOVE
Co-Chair, Board of Directors
Consumer Consortium on
Assisted Living

BEFORE THE
UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

Washington, DC: April 26, 2001

P. O. Box 3375 Arlington, Virginia 22203 (703) 533- 8121

Chairman Craig, Senator Breaux, and members of the Committee, thank you for the opportunity to speak with you today about what I believe is one of our nation's most important long term care concerns. I am here today on behalf of the Consumer Consortium on Assisted Living (CCAL). We commend you for taking up this timely topic again following this Committee's important hearing on assisted living in 1999.

BACKGROUND

CCAL, established in 1995, is the only national, consumer-focused organization dedicated solely to the needs and rights of assisted living residents. I have been an administrator of several assisted living facilities ranging in size from 60-beds to a 220-bed campus. I co-founded CCAL and currently serve as Co-Chair of the Board of Directors. I am a consumer. My father has Alzheimer's disease and has resided in an assisted living facility for over two years.

CCAL heartily supports assisted living as a vital option for long term care services. However, **CCAL does not support caring for America's frail elderly in assisted living without defining and specifying what appropriate care is and without assuring its provision through national standards.** Our country, perhaps inadvertently, is placing a very vulnerable population at an extraordinary risk. The tremendous growth of this industry runs the risk of overriding our commitment to the care and protection of this vulnerable population.

An estimated 1.0 million elderly currently reside in assisted living. Compare this to the estimated 1.5 million residents of nursing homes, an industry that has been around significantly longer than assisted living, and one understands the explosive growth occurring in this relatively new long term care option. The U.S. Bureau of the Census projects that the population of individuals 85 years and older will be the fastest growing part of the elderly population throughout the rest of this century, and will more than double by 2030. This enormous growth has significant implications for the assisted living industry as individuals 85 years and older are those most likely to become assisted living residents.

At times, the rapid growth of the industry has occurred at the cost of resident care as quality resident services have not kept pace with "bricks and mortar" construction. The average assisted living resident is an 84-year old frail female. Catherine Hawes, PhD, author of the U.S. DHHS funded National Assisted Living Study, found that one in four assisted living residents needs as much help as a typical nursing home resident. Yet despite the tremendous growth of the industry and the frailty of its residents, there are **no uniform standards or federal regulations** to protect residents.

FACTS

In a sobering report to this Committee two years ago, the General Accounting Office (GAO) noted that the lack of uniform standards forces consumers to rely primarily on providers for information about assisted living. The GAO found that providers do not routinely provide consumers with the information necessary to select the setting most appropriate to meet their needs. CCAL has found that some marketing literature continues to be misleading (such as showing pictures of staff in lab coats with stethoscopes when, in fact, the facility

does not provide healthcare), or incomplete, (such as not fully describing costs and eligibility, requirements for different levels of care, or what happens when a resident's finances are exhausted or when he or she becomes seriously ill or disabled).

Other frequently cited problems identified in the GAO report include: **inadequate or insufficient resident care; insufficient, unqualified, and untrained staff; and inappropriate medication administration.** One recent caller to our Helpline described a situation in which her father has lived in an assisted living facility for over three years. This caller described her father as needing assistance daily with basic care needs such as bathing and dressing. Her father often goes without assistance because there are not enough staff. As a long time resident, he has bonded with the staff and residents and is willing to accept poor care in lieu of moving somewhere else where he does not know the staff or residents. This creates serious conflicts for the daughter because she hates to see her father poorly care for, yet she understands his need to fit in as well as his ability to make his own decisions. Dr. Hawes recently found that 25% of the more than 300 assisted living facilities she studied had only one caregiver for every 20 residents in the 3-11 shift and one for every 34 at night. According to a statement Dr. Hawes made last year, the combination of sicker people and low caregiver-to-resident ratios is dangerous. "These two things are on a collision course - it's just a time bomb waiting to go off."

We fear that in the two years since the Committee's last hearing the time bomb may have already gone off. Recent front-page articles in *The New York Times, The Washington Post,* and *Wall Street Journal* abound with stories of problems in assisted living facilities. *The Washington Post* reported that an 83-year old frail female resident residing in a facility of one of the industry's largest providers was assaulted in a day room by a male resident with a psychiatric history. This vulnerable resident died two days later in a hospital from injuries sustained in the assault. Was this male resident an appropriate admission to a facility caring for vulnerable individuals?

Not only are catastrophic events for some residents and their families continuing, but in the last two years, a dearth of workers in the long term care industry and low occupancy rates pressuring the need for providers to fill beds have further heightened concerns about quality care for the vulnerable consumers of assisted living.

STATE REGULATION

These significant problems are compounded by an uneven and patchwork approach to state regulation and oversight thus producing an increasingly alarming picture of the assisted living industry. The assisted living industry is regulated individually by states and predominantly funded by private resources. **State standards are highly variable, and the variability begins with the very designation of the name 'assisted living'.** Broadly defined, assisted living can be described as a residential care alternative to nursing homes that allows people to "age in place" while receiving services to help them retain their dignity and preserve and enhance their autonomy. States, however, use over two dozen designations even to refer to what is commonly known as assisted living, for example: California - residential care facilities; New Mexico - adult residential shelter

care facility; New York - assisted living program, adult care facility, adult home, and enriched housing program; and Michigan - home for the aged and adult foster care.

This lack of any consistency or uniformity in definitions can create great confusion and poor outcomes. For example, both New York and Michigan have many facilities that fall into none of the categories in existing law, meaning they do not have to be licensed. These unlicensed facilities include some that are owned by some of the nation's biggest assisted living operators. Alterra Healthcare Corporation, the nation's largest operator of assisted living facilities, for example, has 19 homes in New York State. Half of these facilities are unlicensed despite a claim by their President and CEO, who is quoted in the November 26, 2000 edition of *The New York Times* as stating "I am proud of the fact that all of our residences are licensed and that we have done that voluntarily". That is simply not true.

The regulatory variances among states are vast. In California, for example, residents may be required to leave a residential care facility if they become incontinent. New Mexico statute has no provisions for a resident bill of rights, admission criteria, contracts, or grievance procedures. In New York there are no specific guidelines for care of individuals with dementia. In Kentucky, new regulations exempt all facilities that already existed when the new law took effect in July 2000. A Michigan task force on assisted living rejected the idea of stronger state oversight, recommending instead, that the state simply require facilities to sign a clear contract with each person who moves in. Even this poorly conceived proposal has languished.

The processes by which states develop their assisted living regulations also leave much to be desired. For example, the Tennessee Department of Health recently determined that the most expedient way to develop assisted living regulations for their state was to invite leaders from the nursing home and assisted living trade associations together to form consensus on new assisted living regulations. The groups were given the state's nursing home regulations to use as the basis for developing assisted living regulations. Consumers and other advocates were excluded from the process. The state's Commission on Aging was invited to participate, but declined. Unfortunately, this approach is not unique to this state.

The patchwork state regulatory approach is extremely confusing to those with expertise in the assisted living field. Imagine the difficulty faced by consumers who typically must make their placement decisions in the midst of personal crisis.

Is there any industry that would not love the opportunity to police itself? By default in some states, and by a patchwork of regulations in other states, this is in effect happening all too often in the assisted living industry. According to a founder of Kapson Senior Quarters, a chain of assisted living facilities that is now part of Atria Inc., "the industry is doing one hell of a good job of policing itself". Many consumers, long term care ombudsmen, state regulators, geriatric care managers, elderlaw attorneys and other advocates would beg to differ not to mention the abundance of front-page newspaper stories describing egregious incidents.

"If a consumer does not like a certain facility, they can let their feet vote", is a statement oft heard from leaders in the industry such as two past presidents of the Assisted Living Federation of America. This statement is demeaning to consumers, and does not reflect market or personal realities for consumers. Making a decision to leave a facility that is not providing appropriate care for a resident's needs is not the same as deciding not to return to a certain restaurant because service was poor, or to take your drycleaning elsewhere if prices are increased. The decision to move out of a facility is a last resort decision fraught with emotional, psychological, and financial complications.

MYTHS

Many myths immediately surface whenever there is any discussion about the need for federal regulation or oversight of assisted living facilities. One myth is that there are very few federal dollars spent on assisted living, and therefore the federal government should not be involved in regulating this industry. We all know what would have happened had the tire industry not been subject to any federal scrutiny over tire standards for SUVs. The federal government does not directly subsidize the tire or auto manufacturers, yet they oversee and protect consumer safety needs for both of these industries. Nor has the federal government delegated this important function to individual states. It can be argued that increasing amounts of federal dollars are in fact going to assisted living. More and more states are allowing the use of Medicaid waiver dollars for residents of assisted living. Medicaid is a shared federal-state responsibility with the federal government paying fifty percent of the cost.

Another myth is that federal regulations have not worked to provide quality care for nursing home residents, therefore, this same approach should not be replicated for the assisted living industry. Research has demonstrated that improved quality of care has occurred as a result of OBRA 1987 - the landmark Nursing Home Reform Law. For example, the use of physical and chemical restraints in nursing homes has dropped dramatically as a result of OBRA 1987. A closer look at nursing home regulations, however, finds that it is not federal regulations that have not supported quality resident care, but rather, too often, the quality of the management and operators of individual nursing homes, as well as uneven oversight by state regulators. Often, when nursing home providers speak of overburdensome regulations, closer inspection reveals that they are speaking of important standards relating to fire safety or sanitation, or outdated state-specific regulations, not standards or requirements in federal law or regulations. Furthermore, when nursing home providers malign the regulatory system, they are often referring to the enforcement process - not the regulations. Good, caring providers and health care professionals working in nursing homes are generally in tune with the national standards for quality of life, quality of care, and resident's rights. In fact, the national nursing home trade associations came to consensus with consumers and advocates on the standards in current law, with the exception of the enforcement provisions and the need for stronger nurse staffing requirements.

Another frequently heard myth is that consumers in each state have their own specific needs and therefore the standards and regulations need to be uniquely tailored to

individual states. Through the CCAL Helpline, we hear from consumers and advocates from across the country. It is CCAL's belief, based upon our personal experience with consumers and their families, that consumers, regardless of where they live, have the same concerns about receiving good quality and appropriate care. We live in a highly mobile society where family members and special friends are often scattered throughout the country. It is natural and practical that we want consistency in how our loved ones are cared for.

One last myth - that regulation stifles innovation. Many other industries have been successfully regulated without adversely affecting innovation such as the building industry, auto manufacturers, and pharmaceuticals to name a few. It is the individuals who design and create products and services that affect or limit innovation - not the standards themselves.

ACCREDITATION

ALFA, the largest trade organization of assisted living providers, indicates that it is eager to improve quality, but prefers a new private system of voluntary accreditation that is beginning to inspect facilities and grant a seal of approval. In 2000, both the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission of Accreditation of Rehabilitation Facilities (CARF) began accrediting assisted living facilities. The accreditation criteria are very broad and non-specific. Several examples of criteria include: "The assisted living facility provides safety and security measures to meet the needs of residents"; and "The assisted living community provides services for each resident according to accepted standards of practice and law and regulation." Both organizations refer to their accreditation criteria as 'standards'. Rather than setting definite requirements, these 'standards' set out general objectives that are meant to focus on continual quality improvement. **These 'accreditation standards' would more accurately be defined as quality improvement tools.** They cannot be equated with or considered to be specific, uniform and measurable standards. In effect, they can only be measured with a "yes" or "no" response. Can any of us imagine a facility answering "no" to the sample criteria noted above? Unfortunately, in the absence of any consistency in assisted living standards, these new accrediting programs can serve to further confuse assisted living consumers about what defines and connotes appropriate resident care.

CONCLUSION

As the aging of America continues to spiral upward, so will the number of individuals residing in assisted living. One of the problems with nursing home oversight and national standards is that advocates have spent decades trying to catch up to an industry that got off to a free-wheeling and virtually unrestrained start. Our nation's nursing home residents and their loved ones have paid and continue to pay a high price for that. The assisted living industry has been given a virtually unrestrained start as well. CCAL believes no further time should pass before our nation begins to appropriately and responsibly address the serious conditions that have developed in assisted living. **From urban to rural locale, from coast to coast, from provider to provider, our nation's frail elderly need uniform standards that define and provide guidance and protections to consumers.**

We at CCAL feel so strongly about this that we have initiated an effort to develop model standards for assisted living. I am delighted to say that the American Bar Association's Commission on Legal Problems of the Elderly has agreed to join us in this effort. The National Citizen's Coalition on Nursing Home Reform also supports this initiative. While we believe there should be national standards -- and that in time there will be national standards -- we can help now by offering a set of model standards. Our hope is that at minimum, individual states will agree to adopt our model standards, and that progressive industry leaders would adopt them for their own facilities. We hope that the industry will join us along with many others who are stakeholders in assisted living in developing these standards.

Thank you again for the opportunity to appear before the committee today.

Senator BREAUX. Thank you, Ms. Love. Next we will hear from Ms. Thompson. Ms. Thompson.

STATEMENT OF MARGARET THOMPSON, BOARD OF DIRECTORS, ASSISTED LIVING FEDERATION OF AMERICA, WASHINGTON, DC.

Ms. THOMPSON. Good morning, Mr. Chairman and Senator Wyden. Thank you very much for this opportunity. My name is Peg Thompson. I am from Huntsville, AL. My family owns and operates nine assisted living residences in small communities in Alabama, Pennsylvania, Mississippi and Tennessee.

I am also a founding member of ALFA, the Assisted Living Federation of America, and it is in that capacity as a representative of ALFA's 7,000 members and 41 State affiliates that I am privileged to be here today.

This is an extraordinary opportunity, and as a provider in those small States, I cannot tell you how heartened I am to hear the support of the committee members in making sure that assisted living is a vital part of the continuum of care in this country.

Since ALFA's founding in 1990, we have been committed to enhancing consumer choices in long-term care and championing quality of life issues for older people and particularly our residents. Our assisted living communities, as you all have said, offer a needed residential alternative for the elderly and others who need help with the daily activities that many of us take for granted and do without any care at all.

Mr. Chairman—excuse me—Senator Breaux and Senator Wyden, there are three points that we as an industry think are essential that we focus our discussions on today. First, a cherished value in this country is independence, and independence, as Senator Carnahan mentioned earlier, means freedom of choice. Older Americans want to choose where they live and what their daily activities consist of and how they do those activities.

All of us as Americans have an obligation to respect and protect their freedom to choose, even those people who need help in those choices everyday. Assisted living offers one of those choices and for many people it offers the choice that has advantages over living at home. It offers the advantage of security and services and a social life that sometimes is missing for older people in their own homes.

Second, we wholeheartedly unequivocally as an industry support regulation. We support regulation at the State level, which is the level that is closest to the consumer. We are heartened by Senator Wyden's suggestion that we look at a model statute to bring some language consistency across the country and provide States with some needed, not necessarily guidance, but to take the things that really do join us together and move on from that point.

All 50 States regulate assisted living. All 50 States and the District of Columbia regulate assisted living today. We are diligently working in the States to clarify the understanding of assisted living, to bring more consistency, particularly in disclosure, because that is an issue, and to make improvements in staff training and availability of staff across the country. Those are huge priorities for us.

But those regulations must be done in a context where they do not restrict seniors' choices.

Third, since we met 2 years ago, ALFA and its Informed Choice campaign has made real progress in the areas of disclosure, staff training, and our most serious concern which is availability of staff. And with your permission, I would like to give you a couple of examples in each one of those areas that might amplify what really is happening in assisted living today.

Regarding the imperative to protect older people's right to choose, I think I need not do anything other than point to Dr. Kilby's examples of the choices that she has made to make her life dealing with chronic disabilities more possible for her. She is an example of the reason that most of us in this industry are assisted living providers and feel privileged to provide those services everyday.

Last week, one of my residents in a community in Pennsylvania said it this way: you know, I have never eaten breakfast at 6:30 in the morning; I don't want to eat breakfast at 6:30 in the morning. Why can't I choose to eat it at ten o'clock? And by the way, someone said that in the nursing home I would have to have my bath at ten o'clock in the evening. I don't stay up until ten o'clock in the evening. I have always had my bath at seven o'clock in the morning.

Those seem like little choices, but those are choices that are very important to our residents and we want to protect those choices. Being at home means these things and being at home is assisted living.

A move from a beloved home to assisted living is a huge family choice. And that is why we are such proponents of full disclosure before, during and at the end of someone's residence, and I will discuss those things in just a minute.

Regarding regulation, I can't emphasize how supportive we are of States providing a good regulatory structure in which we can function. We are caring for the frail of this country. We take that responsibility seriously, and our collaborations with States have been very successful in creating regulation at the level that impacts consumers the most, the closest level to the consumer, so that local consumer groups, local chapters of AARP and the Alzheimer's Association can contribute to that process.

In my home State of Alabama, a very good example is in place today. Over the last 8 months, we have created all kinds of regulatory structures brand new for the industry, and all people involved are now stakeholders in the success of those regulations.

In regard to staffing, ALFA has an array of programs that are in place today including certification for administrators, which is the biggest example, that 750 of our administrators have already participated in. It is an example of a program that works not only to improve the quality of the ability of our administrators but also improves the quality of service for our residents, and ALFA has instituted ten other such programs that are being very widely accepted in the industry.

Those three points, Senators, the importance of protecting choice, the cornerstone of state regulation in the process of maintaining quality of care in our industry across the country, and the indus-

try's continued desire to work with regulatory agencies, with consumer groups, to make sure we are creating an option that is a true choice of quality in this country, are critical to all of us, and I thank you very much for the opportunity of speaking this morning.

[The prepared statement of Ms. Thompson follows:]

STATEMENT OF MARGARET THOMPSON

EXECUTIVE VICE PRESIDENT, THOMPSON WHITE & ASSOCIATES

FOR THE

ASSISTED LIVING FEDERATION OF AMERICA

BEFORE THE

UNITED STATES SENATE SPECIAL COMMITTEE ON AGING

April 26, 2001

I. Introduction

Good afternoon, Mr. Chairman and members of the Committee. I am Peg Thompson, Executive Vice President of Thompson White & Associates Inc. We are based in Huntsville, Alabama and operate nine assisted living communities in Alabama, Tennessee, Pennsylvania and Mississippi. I also am a founding member of the not-for-profit Assisted Living Federation of America (ALFA), the largest assisted living trade association, and it is in that capacity that I have the honor to address you today. On behalf of ALFA's 41 state affiliates and 7,000 members, including the majority of assisted living providers in the U.S., I want to thank you for this opportunity.

Since its founding in 1990, ALFA has been committed to enhancing consumer choice and championing quality of life for assisted living residents. Our members range from small family-owned businesses like mine to large national operators, both for-profit and not-for-profit, who specialize in assisted living or offer it in combination with other forms of senior housing and healthcare.

Assisted living offers a residential alternative to the elderly and others who need assistance with activities of daily living. Through our onsite staff as well as visiting health professionals who contract directly with residents, assisted living offers a blend of hospitality and access to health services that can be enhanced as a person ages and their needs change. In that way, residents can access the same health services in their assisted living residence that they would be able to access in their own home. Indeed, 80 percent of surveyed members report that home health agencies visit their premises to serve individual residents, and contract directly with residents for such services.

As diverse as ALFA's membership is, we are united by our shared commitment to ALFA's 10-point assisted living philosophy of care, which includes such core goals as offering cost-effective, quality care personalized for each individual resident's needs, in a safe environment that is the resident's home, legally and otherwise, rather than in an institution (see Appendix A).

— Because they can exercise choice, residents feel that assisted living truly is their home.
— Because assisted living provides security, services and social life, residents can remain independent.
— And because they can add services as they age, residents can move on with their life, without moving out.

Two years ago, we were privileged to address the committee for the first time and to offer our view on the findings of the April,1999 U.S. General Accounting Office (GAO) report on assisted living. At that time, the committee challenged us, as representatives of the industry, to help clear up consumer confusion about the growing and diverse assisted living model, and to pursue industry initiatives to safeguard quality of care. **My purpose today is to update you on the progress that ALFA and its members have been making to ensure quality care for assisted living residents and to improve disclosure of provider information to consumers.**

First, I want to mention some examples of state and industry partnerships to illustrate our strong belief that the state regulatory system is working and is continuously enhancing quality of care and consumer protection. Secondly, I want to share what ALFA has done to help address the concerns raised by this committee two years ago. Lastly, I want to introduce ALFA's new ***Informed Choice*** campaign to bring more consistent disclosure requirements to all states while maintaining the consumer's right to choice.

II. ALFA Partners with States for Quality

ALFA's state affiliates have worked closely with policymakers in 41 states over the past two years on a wide range of quality initiatives. Compared to 10 years ago, when assisted living tended to be regulated under pre-existing housing categories such as "adult homes," assisted living regulations have come a long, long way, with the help and input of providers and consumers. **Today, not only is assisted living regulated in all 50 states and the District of Columbia, but 30 states now use the specific licensing term "assisted living," with four more states pending.**

Much of the progress that has been accomplished is directly attributable to the collaborative efforts among industry leaders, state policy makers, and consumer groups to develop a consumer-driven model of long-term care. Other changes have been initiated by states, themselves, as our industry has grown and evolved in their state. Indeed, regulations have grown and evolved right alongside the model, itself.

As a direct result of collaborative efforts between industry providers and state regulators, quality assurance has been enhanced through increased monitoring, improved staff training and a commitment to preserving consumer choice. Consider these examples of recent regulatory innovations at the state level involving ALFA and its state affiliates.

Let's look at examples of monitoring for **quality assurance** first.

- *Meeting consumer expectations.* Iowa is experimenting with a state survey approach that challenges providers to meet residents' expectations as expressed in a state-approved customer satisfaction survey process, rather than simply settle for "minimum standards." They are using a survey instrument adapted from one that was originally developed for ALFA members.

- *Community certification.* After more than 15 months of collaboration between the Kentucky Assisted Living Facilities Association, AARP and other consumer groups, Kentucky enacted new certification requirements for assisted living communities last March. This new consumer-driven law also includes numerous disclosure requirements and is a model for the whole country.

- *Emphasis on prevention.* ALFA's Washington State affiliate is working on legislation that would establish a Quality Improvement Consultation Program to augment the

state licensing inspection and complaint investigation process through proactive self-monitoring and quality improvement by the provider.

- *Outcome-based regulations*. The Wisconsin Assisted Living Association is engaged in overhauling state regulations to shift the regulatory focus from prescriptive regulations to resident outcomes. The collaborative effort also would update training standards, introduce the concept of competency-based training for administrators and staff and emphasize the resident's control of medications.

Staffing is clearly a critical element of quality care. While the entire health care industry is experiencing severe staffing shortages, several states have partnered with the assisted living industry to improve training and encourage certification:

- *Increased training on Alzheimer's*. The California Assisted Living Facilities Association (CALFA) partnered with the Alzheimer's Association to pass a bill that specified additional staff training requirements for assisted living residences that provide Alzheimer's and dementia care. The new law requires increased resident care orientation and in-service training as well as administrator certification and continuing education for those who provide care to residents with dementia.

- *More training and less turnover*. To address high staff turnover, the North Carolina Assisted Living Association (NCALA) has recommended the state enact a "labor enhancement" program to improve staff recruitment and retention. NCALA also is working closely with regulators and legislators to enhance and implement training initiatives such as a Medication Technician Training Program. Recently, the state Department of Health and Human Services approved ALFA's Administrator Certification Program as one of only three approved courses in the state. In addition, the state is using ALFA's Alzheimer's curriculum to train staff on caring for residents with dementia.

- *Focus on frontline caregivers*. Washington State lawmakers, with support from ALFA's Northwest Assisted Living Facilities Association, passed a more comprehensive caregiver training program last year covering orientation, basic training, continuing education and competency testing. Additional training for staff who provide care for residents with special needs, such as dementia, also will be integrated.

- *Raising standards where necessary*. Alabama's ALFA affiliate is sponsoring legislation that would hold assisted living residence managers to a higher knowledge base, and is developing Alzheimer's-specific training standards for managers and caregivers.

Numerous states are stepping up **disclosure** requirements, particularly for Alzheimer's facilities:

- The Oklahoma Assisted Living Association helped enact legislation requiring a consumer disclosure statement for assisted living communities that offer services for residents with Alzheimer's disease and other dementia-related illnesses. A Senate bill from the last session of the North Carolina General Assembly mandates full disclosure in the area of dementia-specific services and creates a separate licensure category for units or buildings dedicated to Alzheimer's care. States such as Texas, Oklahoma and California have adopted regulations requiring uniform Alzheimer's disclosure requirements and/or standardized disclosure forms that all providers in that state must complete and make available to prospective residents.

These improvements are considerable, but they would fall short of fully satisfying customers without **protection of choice** for our residents. On this front, some progress is being made:

- The state of Michigan, with support from the Michigan Assisted Living Association, has approved legislation emphasizing the importance of case-by-case decision-making by a team of caregivers and doctors when it comes to deciding whether a resident can adequately be cared for in an assisted living residence, rather than leaving it up to the state regulatory agency. This places Michigan in good company with states such as Oregon, New Jersey, Maine, Kansas and Arizona, which also allow residents to choose to remain in their assisted living home despite functional decline as long as their needs can be met.

These examples of state actions offer just a snapshot of advances over the past two years that clearly illustrate the progress of a state-by-state regulatory approach. According to the National Conference for State Legislatures, over 450 assisted living bills currently are under consideration in the states and state lawmakers appear eager to determine the best approach to regulate an industry that may increasingly shoulder the nation's long-term burden. Nine states already have enacted new assisted living laws this year, including Arkansas, Colorado, Kentucky, Nebraska, South Carolina, South Dakota, Utah, Virginia and Wyoming.

ALFA's goal on behalf of the assisted living industry is to build on these regulatory successes. To that end, ALFA is taking the lead to develop "Best Practices" guidelines for assisted living regulations that will build on the advances already made by the states to provide policy makers, consumers and providers with a framework that states can adapt to meet their own state culture and needs. ALFA will introduce these Best Practices Guidelines at a summit of state regulators to be convened this fall, which will bring together top licensing officials and industry leaders for the first forum of this kind.

III. The Doorway to Quality Care: Industry Disclosure & Training Initiatives

As we have learned from the long history of traditional nursing home regulations, regulations are useful for setting minimum standards, but cannot alone guarantee quality or excellence. The industry, too, has a vital role. Choice, competition, information,

innovation, and a focus on customer service are all critical to achieving high customer satisfaction.

Provider Disclosure to Consumers. During the April,1999 Senate Special Committee on Aging hearing on assisted living, Committee members voiced concern that consumers may not always be receiving adequate information to make wise decisions when shopping for an assisted living residence. The committee challenged ALFA to address these concerns.

ALFA is committed to educating consumers to be smart shoppers, while guiding providers to offer quality services and disclose all policies, services and fees clearly and consistently. ALFA took the committee's "wake-up call" seriously. In the area of improving disclosure, we:

1) Provided consumers with up-front information to make wise long-term care decisions. ALFA provided every one of our members with a "Consumer Information Statement" and a sample "Resident Admission Agreement" to use with new and prospective residents. In addition, we updated and revised our 15-page "Assisted Living Guide & Checklist,"

The "Consumer Information Statement" is for providers to give to a potential resident and their family during the initial interview to help them navigate the choices available. It discloses key information about services, fee structure, policies and staffing in an up-front, consistent way. Some states have used this statement as a reference when revising their disclosure requirements. Many other states have strengthened or already have strong consumer disclosure requirements. ALFA will continue to pursue all remaining states to likewise adopt such disclosure requirements through our ***Informed Choice*** campaign.

ALFA's sample "Resident Admission Agreement" was created to serve as a guide for assisted living communities when creating their own agreements. Adaptable for use in any state, it calls for clearly communicating services, fees, admission and discharge criteria, and house rules in understandable language.

The 15-page "Assisted Living Guide and Checklist" is provided to consumers free of charge by ALFA and our members. The guide has been updated to emphasize the importance of resident admission agreements, of being an informed consumer, and former Special Committee on Aging Chairman Senator Charles Grassley's own "Tips for Assisted Living Consumers." In the past 12 months, alone, more than 150,000 brochures have made their way into the hands of consumers across the U.S. I, for one, require my own communities to use this excellent guide with every inquiry.

2) Provided more information about specific residences on the Internet. ALFA initiated an effort to expand the consumer section of our web site (www.alfa.org) and enhance residence profile information in our online directory. Each month tens of thousands of visitors search our online directory for assisted living communities or access

our "consumer information statement" and checklist online. With the additional information that has been added about each community, consumers are better able to select a setting that meets their individual needs.

3) Adopted a disclosure pledge for all ALFA members: ALFA's Board of Directors recently approved a pledge to fully disclose to consumers all terms and conditions of residency in an assisted living community. The pledge must be signed and committed to by all ALFA provider members as a condition of association membership. *We will not cash a membership dues check unless that member commits to our full and clear consumer disclosure standards.*

Staff Training and Certification. In addition to disclosure initiatives, ALFA also has focused on staff training and certification. ALFA's national administrator certification has hit a responsive chord as more providers participate in staff training and certification opportunities. In addition, ALFA has partnered with several states to adopt ALFA's certification as standard.

Since its introduction last year, more than 750 assisted living administrators nationally have applied to complete the coursework necessary to receive ALFA's national administrator certification, a two-year certification renewable through additional study. Nevada was the first state to recognize ALFA's administrator certification and now six additional states have moved quickly to endorse the program as the benchmark for administrator training. For myself, I can attest to the value of this training to my company, as it is something that the managing directors of all my facilities have completed and are anxious to continue with.

In addition, we offer 10 certificate of study programs for frontline caregivers that build on their skills in a wide range of care aspects.

Accreditation. In 1999, ALFA endorsed the development of a voluntary, independent accreditation process for assisted living by CARF (the Rehabilitation Accreditation Commission). A National Advisory Committee of consumers, surveyors, advocates, providers, and state regulators then drafted a set of assisted living accreditation standards. The first Assisted Living Standards Manual was released in January 2000, and the standard went into effect in July, 2000.

While the accreditation process is very new, six assisted living communities in California, North Carolina, Michigan and Colorado have completed the process and have been accredited. ALFA continues to educate our members about the importance and benefits of accreditation and urge them to begin the process. As the industry continues to evolve and learns more about the advantages of accreditation, we are certain that the numbers of providers going through the accreditation process will increase.

Doubtless, more providers would feel the incentive to become accredited if states were to embrace and recognize the accreditation process, as they do with hospitals. CARF and assisted living providers are currently in discussions with regulators in Idaho,

Rhode Island, Washington, Kentucky, New York, Iowa and Alaska. The idea behind accreditation is to create a public-private partnership that adds a new dimension of continuous quality improvement not usually found in the state regulatory structure.

Affordability Initiatives. Seniors who are at highest risk of receiving inadequate care include those who have the least ability to pay for the services they need. In addition to individual state initiatives, ALFA has been working with both the federal and state governments through its year-old program, ALFA*cares*, to make assisted living more accessible to low- to moderate-income seniors nationwide.

The solution to making assisted living more affordable is challenging and complex. ALFA*cares* provides a forum for providers, lenders, developers and state agencies to share information and form collaborations to make assisted living more accessible and available to lower-income seniors. ALFA*cares*' priorities include:

- Promoting state reimbursement policies, such as Medicaid waivers
- Working at the state level to eliminate regulatory barriers that affect affordability
- Enhancing and influencing federal and state funding programs that promote affordable housing, such as the Low-Income Housing-Tax-Credit Program, HOME and HOPE VI programs, Section 7 and 202 HUD programs and federal loan guarantees that reduce the cost of the shelter component of assisted living.

For more information on ALFA's affordability initiative, see Appendix B.

IV. Where from Here? New Industry Initiatives

As you can see, we've made progress on a number of fronts and we're proud of it, but we're still a young industry and there's more work to do. To further our two-year efforts, ALFA is initiating a new campaign called ***Informed Choice***. The purpose of the campaign is twofold:

1. Improve consistency of disclosure regulation at the state level and educate the public about what assisted living is, how to be a smart consumer shopper and how it differs from other senior living options ("Informed")

2. Ensure that assisted living residents and their families retain the right to self-determination and the right to choose where they want to receive services ("Choice")

As part of the overall campaign, ALFA is rolling out the following initiatives:

- ***"Best Practice" Guidelines for State Assisted Living Regulations***. As mentioned earlier in my testimony, ALFA is developing "best practice" guidelines for state regulation of assisted living by taking the best of what states are doing to regulate the industry and offering it as a guide to states as they develop and revise their own

regulations. State regulators from across the country will be involved in this effort and will convene at the ALFA Regulator Summit to be held this fall.

- ***Model "Informed Choice" disclosure act.*** This model disclosure act for states emphasizes the consumer's right to have full disclosure of all the terms and conditions of residency in an assisted living community ("informed") while supporting the right of seniors to determine where they want to live ("choice"). For more information, see Appendix C.

- ***Medication Management.*** ALFA and the American Society of Consultant Pharmacists (ASCP) are working on best practices for medication management in assisted living which will be unveiled at the upcoming ALFA Regulator Summit.

- ***Public Education.*** As part of the Informed Choice initiative, ALFA is committed to stepping up public education and communication efforts to educate the public about the variety of assisted living choices and what they need to know in order to make an informed decision.

- ***Addressing Staffing Shortages.*** ALFA is pursuing solutions to staffing shortages in assisted living communities through possible legislation, and collaboration with other organizations to resolve this nationwide problem.

In addition to the Informed Choice campaign, ALFA and its members also are pursuing:

- ***New Staff Training Initiatives.*** ALFA has taken a leadership role in developing traditional and online training programs such as ALFA's aforementioned Administrator's Certification Program. In addition to providing ongoing staff training, ALFA also is continually developing new programs to meet member's needs:
  - "Advanced Sensitivity Training," which ALFA is offering free to our members, teaches staff who care for residents with Alzheimer's disease to understand their special needs;
  - "Incontinence Management" provides useful tips to family members and physicians as well as practical ideas for caregivers on how to help residents self-manage incontinence, and is free to ALFA members;
  - "Risk Reduction Program" helps frontline caregivers minimize the risks to residents that might result from falls and wanderings. In addition, this program will train staff to recognize and document significant changes in a resident's condition.

- ***Quality Indicators Project.*** ALFA expects all assisted living communities to consistently provide high quality of life and care as well as respect for individual choice for all residents. To meet that goal, ALFA has developed a list of quality indicators that ALFA considers essential to ensuring quality. Included among the indicators are: quality in organization, financial viability, physical environment,

personal support, social group support, caregiver/staff systems and administrative systems.

A Cautionary Note...

Quality of care is our top priority. But in order to assure quality, all parties need to understand what "quality" means not only to regulators and providers and advocates, but also to residents and family members. We must learn from the shortcomings of past long-term care regulatory approaches and address quality of care issues while protecting and nurturing residents' quality of life.

ALFA recently asked a small group of residents in Florida about what assisted living means to them, and the features they find most important. The answers of the 70 to 90 year old residents are revealing in their subtle reinforcement of the value of self-determination in the day-to-day aspects of residents' lives:

"I do my own laundry. I make my own bed. They'll give you extra care if you need it – some days you do, some days you don't, but it's there."

"We don't ask them when we can come and go. You just sign your name when you go out the door."

"You can lock your door."

"Rather than living alone, [you get] the security. You get your three meals if you want them, and you can do what you want to, when you want to. You can be your own boss."

There is no question that offering a safe environment and access to nursing services or health care to those assisted living residents who need it is a primary ingredient of "quality care." But as these residents' comments suggest, "quality care" also refers to intangibles that have little to do with regulations or medical procedures, and more to do with values like choice, privacy, independence, security and autonomy. Industry studies show that residents want us to offer them a true home, where they can maintain independence and direct decisions as much as possible while also having access to extra care and services as needed. **We feel that no discussion of quality care is complete without taking into account residents' own values and considering how each resident personally prioritizes and balances these values**.

How we as a nation address quality questions today will affect millions of Americans, including each of us here today. We at ALFA support the states continuing on the path toward innovative regulatory strategies. We support full disclosure. We support more consistency. But we also know that there are no two consumers whose needs are exactly alike, and preferences vary all over the map. That's why there are such a variety of assisted living choices. Assisted living is a market-driven response to consumers' diverse, expressed needs and preferences. After years of limited options, seniors today finally have some additional choices – home health care, hospice, nursing homes, adult day services, and assisted living – and the ability to exercise choices within each of these options. Some observers claim choices are confusing, but we have seen that

the American consumer ultimately likes choices and proven they particularly like the choices which assisted living provides. **To create care systems that will pass the test of time, we must be able to address areas that have caused consumer confusion without stifling the variety of assisted living options now available to them. We must continue to innovate ways to improve quality of care while allowing consumers optimal flexibility in their day-to-day personal choices. That is the promise that we've made to consumers, and the balance I try to strike every day.**

Thank you for the opportunity to appear before the committee today. I will be happy to answer any questions you might have.

Appendix A

About ALFA

The Assisted Living Federation of America (ALFA) represents over 7,000 for-profit and not-for-profit providers of assisted living, continuing care retirement communities, independent living and other forms of housing and services. ALFA was founded in 1990 to advance the assisted living industry and enhance the quality of life for residents. ALFA broadened its membership in 1999 to embrace the full range of housing and care providers who share ALFA's consumer-focused philosophy of care. The federation includes 40 state associations representing 41 states and Puerto Rico.

ALFA's Philosophy of Assisted Living Care

- Offer cost effective quality care personalized for the individual's needs
- Foster independence for each resident
- Treat each resident with dignity and respect
- Promote the individuality of each resident
- Allow each resident choice of care and lifestyle
- Protect each resident's right to privacy
- Nurture the spirit of each resident
- Involve family and friends in care planning and implementation
- Provide a safe, residential environment
- Make the assisted living residence a valuable community asset

Appendix B

Lessons in Affordable Housing

Market of moderate- and low-income seniors, the group most likely to need assisted living, remains largely untapped. Now developers are finding regulators receptive to new ways to meet this group's demand for housing.

By Evelyn Howard and Edward Sheeby

Despite impressive gains in growth and development over the past seven years and an optimistic forecast, the cost of residency in assisted living communities remains out of reach for many low- to moderate-income elders.

Assisted living, for the most part, has been developed for higher-income individuals residing in targeted urban and suburban communities throughout the country. Few models are available for lower-income seniors (income less than $30,000 per year), even though they outnumber higher-income seniors two to one. Even when income and assets are combined, many people cannot afford today's assisted living services. More than 40 percent of individuals age 75 and older have net worth of less than $85,000. Take away home equity, and this group's net worth falls below $23,000.

Because lower-income seniors are more likely to be frail than their higher-income counterparts, they have a greater need for assisted living care. The most vulnerable are single people over age 75, a group that currently numbers 6.5 million and is projected to increase by 100,000 individuals in each of the next 10 years.

Seniors with income below $15,000 typically qualify for various housing and other entitlement programs, such as HUD Section 8 rent-subsidy vouchers, SSI welfare benefits, and Medicaid. Sponsors of affordable assisted living are challenged in utilizing these resources due to multiple funding mechanisms and conflicting regulations administered by state and federal agencies whose oversight complicates the delivery of housing and services in these types of publicly supported settings.

Many providers, however, are beginning to realize that the moderate to low-income population represents a large and mostly unserved portion of the service-eligible market. Developers are finding regulators are receptive to new ways to address a large unmet demand for affordable assisted living through the coupling of public-sector housing programs and Medicaid reimbursement.

ALFAcares, ALFA's affordability initiative, provides a forum for providers, lenders, developers, and state agencies to share information and form collaborations to make assisted living more accessible and available to lower-income seniors. ALFAcares' priorities include:

- Promoting affordable assisted living through state reimbursement polices, including Medicaid waivers, state Medicaid plans, and other long-term care benefits;
- Working at the state level to eliminate regulatory barriers that affect affordability.
- Enhancing and influencing federal and state funding programs that promote affordable housing, such as the Low-Income Housing-Tax-Credit Program, HOME and HOPE VI Programs, as well as Section 8 and 202 HUD programs and federal loan guarantees programs that reduce the cost of the shelter component of assisted living.
- Facilitating national replication of best practice models of affordable assisted living, utilizing a combination of public-sector resources.

REGULATORY AND LICENSING BARRIERS

Increasing the availability of assisted living to lower-income seniors depends on each state's willingness to make public policy decisions regarding the allocation of limited state dollars with respect to a set of financing and funding resources.

First, the state must make a policy decision about the use of Medicaid dollars, either through a waiver program or state plan, to support the service package and what form of reimbursement will be used, either a flat rate or tiered payment schedule based on resident acuity. Secondly, states must make a policy decision that recognizes senior housing with services (assisted living) as an important part of their overall housing

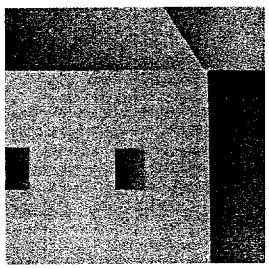
strategy and prioritize the allocation of state housing program dollars for assisted living.

"Assisted living affordable to lower-income seniors is produced by using government-based housing and service programs together," says John Rimbach, senior vice president, retirement housing, for A.F. Evans Co. and co-chair of ALFAcares. "The combining of various public-sector resources is key. However, these programs suffer from regulations that oftentimes conflict with one another. Funding priorities, fragmented delivery systems, excess competition for dollars, and differing agendas on how dollars should be spent also complicate the task.

"Despite these challenges," he continues, "providers have the opportunity to change public-supported long-term care in this country by bringing these resources together to create an environment that allows lower-income frail elderly and their families an alternative to institutional care."

In addition to the challenge of successfully bringing public resources together, developing an affordable model of assisted living can often be complicated by state regulatory and licensing requirements:

- Certificate of Need restrictions that artificially limit the number of projects that can be developed, resulting in less competition and higher prices.
- Admission and discharge criteria that limit the ability of a provider to meet resident care needs and delay premature nursing home placement.
- Limitations on medication administration by unlicensed caregivers under the supervision of a nurse even where such delegation is allowed under the state's Nurse Practice Act.
- Physical plant requirements that leave the state with little or no flexibility to consider alternative design or solutions that adequately meet resident health and safety needs.



PIECING TOGETHER COMPONENTS

The process of putting together an affordable assisted living project has often been compared to a patchwork quilt—a process involving the piecing together of various components in a creative way to conform to an overall vision. It is a complex and difficult undertaking. Several programs provide either equity or below-market-rate debt for affordable housing—which can reduce debt service, thus lowering rent payments—including Low-Income-Housing Tax Credits, Tax-Exempt Bonds, and gap-financing programs such as the Federal Home Loan Bank programs.

On the operations side, developers will look for public reimbursement programs, such as Medicaid waivers and state funds that can be used in conjunction with debt-reduction programs to bring the overall cost of housing and services within reach of many moderate- and low-income seniors.

Combining programs that reduce debt and subsidize services produces models of affordable assisted living that can differ markedly from one another in how they are built and who they serve. The following profiles illustrate the successful application of these tools of affordability:

- **Cache Valley Assisted Living, Ullin, Illinois.** NCB Development Corp. (NCBDC) and the Robert Wood Johnson Foundation, America's largest health-care philanthropy, created the "Coming Home" Program, which assists rural communities in creating affordable assisted living for seniors. Under this program, Cache Valley became one the first low-income assisted living housing projects in rural America. The 40-unit project totals 30,192 square feet on approximately five acres, and includes a fenced courtyard, substantial common space, a clinic, a laundry, commercial kitchen, and other amenities.

Payment for services comes from a combination of a Medicaid waiver and a state-funded program. The coverage paid by the state ranges from a low of $236 per month to a high of $1,598, depending on the care needs of the resident. Cache Valley was fully rented within five months of opening and currently has a waiting list.

Permanent financing consisted of $680,000 conventional loan; a $500,000 loan from the Illinois Trust Fund; and a $2.2 million equity investment raised through the sale of low-income tax credits. In addition, the project received a $90,000 grant for working capital from the Retirement Research Foundation. NCBDC provided gap financing during construction through a revolving loan.

- **Bartholomew House, Bethesda, Maryland.** The newest addition to the campus of St. Bartholomew's Catholic Church and elementary school provides affordable assisted living to 30 frail elderly residents. Victory Housing, the nonprofit housing development arm of the Archdiocese of Washington, D.C., developed Bartholomew House as part of its mission to provide affordable housing and social services.

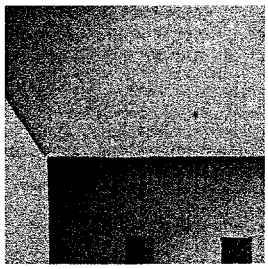
"It's possible to chip away at operating costs through group purchasing of supplies, universal workers, live-in caregivers, and volunteers," says Victory Housing President Jim Brown. "Without Medicaid, however, you can't save enough on the operations side to get the cost down far enough. The only way to make a real dent in the cost of care is to reduce the project's cost of capital—debt service—to a level that is supported by affordable rent levels."

At Bartholomew House, the financing package included a special $1.5 million grant from HUD, an $800,000 low-interest loan from Montgomery County, Maryland, and a $1.3 million Federal Home Loan Bank loan at a below market rate with flexible terms. Another significant piece of the package was the church's donation of the 1.5-acre parcel of land valued at $500,000. The land donation gave Victory Housing instant equity, which helps in approaching other lenders.

The end result is a community with a market rate fee of

$2,800 per month. Lower-income residents are assessed fees on a sliding-scale basis. The monthly fee is all-inclusive, which is important for maintaining an affordable rate structure.

■ **American House Senior Living Residences, Bloomfield Hills, Michigan.** American House has combined the Low-Income-Housing Tax Credit Program, a Section 8 voucher from HUD, and a Medicaid waiver program in six of its facilities. The net effect of this packaging of programs has been to create a dual-subsidy program, whereby qualified residents can receive the advantage of a rent concession and the services provided by the Medicaid waiver.



Within the six facilities are a total of 850 units of which 250 units are set aside for people who meet the tax credit program's qualifying income. Presently, 50 residents are benefiting from both the tax credit program and Medicaid Waiver Program.

Under the tax-credit program, services such as meals and personal care must be included in the rent or offered on an optional basis. The amount of rent that can be charged to a resident is limited by the rules governing tax credits, so the rent is too low to cover the cost of assisted living care. The services must be optional. It is assumed that residents who need assisted living care will opt for the services and either qualify for Medicaid coverage or use their assets (spend down) to cover the cost of assisted living care. Residents cannot receive significant financial help from families and still qualify for a tax-credit unit.

Historically, the Section 8 vouchers have been only available for use in specific HUD buildings. By creating a HUD voucher that can travel with a recipient to a community where they can receive services under the Medicaid waiver, housing and assisted living services are both met at a price the recipient can afford. The voucher covers rent so long as it is not higher than HUD's "fair market rent" threshold. It cannot be used for meals and activities.

U.S. Representative Joe Knollenberg (R-MI) hailed the approach by American House as an exciting new development in senior housing. "This pilot program will not cost taxpayers a single dime. By combining existing Medicaid waivers and housing vouchers, this is a savings for taxpayers because we won't be paying the health-care costs down the line. We will be providing better assistance for our seniors at no additional cost to the public."

"We are doing this to demonstrate nationally that there is a program that can provide assisted living to people who otherwise could not afford it and are at risk of nursing home placement. American House is opening up the door to HUD vouchers in order to make assisted living affordable for seniors," says J. Robert Gillette, American House president.

■ **Culpepper Garden, Arlington, Virginia.** Culpepper Garden, a senior rental community, is HUD's first Section 202 housing project licensed as assisted living. The eight story, 73-unit building, opened in March 2000 and quickly filled within a few months.

HUD was attracted to the project by Culpepper Garden's campus approach to a continuum of care, along with strong resident and community support, says residence administrator Bill Harris. The rest of the campus includes a HUD Section 236 project that has one of the few remaining rental assistance payment programs (RAP), and a 63-unit HUD Section 202 project where residents receive rent subsidies and pay 30 percent of their income for rent.

Permanent financing for the new assisted living addition consisted of a $5.1 million HUD grant that included a project rental assistance contract (PRAC) to subsidize tenant rents, $1.3 million grant from Arlington County Board of Supervisors in the form of a 40-year, no-interest, deferred loan, and $300,000 contribution from a fund controlled by the facility's board of directors. The 1.5-acre parcel of land was donated to the project by the Culpepper board.

The estimated fee is $1,585 per month for the one-bedroom apartments, including private bathrooms and full kitchens, three meals a day plus snacks, and approximately 1.25 hours of care per day/per resident. Culpepper residents have an average income of about $1,000 per month, says Harris, which is significantly lower than 50 percent of area median income for the Washington, D.C., area, which is $2,350.

Ongoing operating subsidies include the PRAC, auxiliary grant funds from the state of Virginia, and a small grant from Arlington County. Additionally, Culpepper Garden has set up a fund into which families may make tax-deductible donations. This fund is used to provide additional subsidies to residents with very low incomes. A Medicaid waiver to pay for the service component is currently not available in Virginia.

The challenge for the future at Culpepper Garden will be continued fund-raising and striving for balance in the resident mix among those who need deep subsidies and those who can afford to bear more of the actual cost of the care, says Harris.

STATE-LEVEL EFFORTS

Central to the success of efforts to rein in long-term care costs will be the willingness of states to explore new models of affordable care that are responsive to consumer preferences.

■ **Medicaid Consumer Account Program.** ALFA has proposed a model that emphasizes consumer-directed decision making and independence, while maintaining the fiscal integrity and account-

ability of the Medicaid program. Referred to as the Medicaid Consumer Account Program, the program is budget-neutral and maintains the same eligibility criteria for beneficiaries as those used for clients receiving services under a state plan or Medicaid home and community-based service (HCBS) waiver.

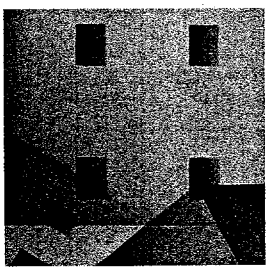
Unique to the Consumer Account Program is that the funding is "portable" because it will reimburse the consumer rather than the provider. "Portability allows the public clients to have the same options as private clients," says Bob Mollica, deputy director of the National Academy for State Health Policy. ALFA is actively seeking state partners to pilot the model.

■ **Maryland Grant Program.** The Assisted Living Facilities Grant Program, passed by the Maryland Legislature, will make capital grants available to nonprofit assisted living providers to acquire, construct, renovate, and equip facilities. The grant program will help providers reduce their debt service and, therefore, reduce the monthly rates to consumers.

The Maryland Assisted Living Association (MALA) led a statewide Coalition on Affordable Assisted Living to pass the legislation. For more information, contact Diane Dorlester, MALA executive director, at 410/290-8098.

■ **Oregon Waivers.** Medicaid HCBS waivers afford states the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals and nursing facilities. Under the Medicaid waiver, residents who qualify for coverage must be "at risk of needing nursing home care."

The qualifying income criteria are established by the states. Some states allow participation at 300 percent of SSI benefit, or roughly $1,536 a month for a single person, and provide that assets must be under $2,000 given certain disregards. Medicaid covers personal care assistance only, not shelter or meals.



Several states' experiences demonstrate that HCBS helps control the growth in overall public spending for long-term care by providing an important alternative to costly nursing facility placement. These state initiatives support the call for more consumer choice in the type of settings where the care is received.

In Oregon, for example, the use of HCBS instead of nursing facility care saved the state an estimated $227 million between 1981 and 1991 out of projected direct service expenditures of $1.35 billion for the period. Additionally, the shift to HCBS care has enabled the state to serve more beneficiaries with the Medicaid state dollars they have available. On a per-beneficiary basis, HCBS care is considerably less expensive than nursing facility care.

Data from Oregon and other states shows a trend toward increasing enrollments in the waiver programs, which will likely continue due in part to the recent Supreme Court decision in *Olmstead vs. L.C.* that may require states to expand access to community-based services for individuals with physical and mental disabilities.

Some providers have expressed fear of additional regulation as Medicaid funding becomes more widely available. On the plus side, the push from the states is away from more direct federal oversight and toward giving state Medicaid programs more flexibility in program design, with authority to set provider qualifications, negotiate rates, and control eligibility.

A shift in focus from federal oversight to a larger state role brings an opportunity for assisted living providers to be more involved in the design and operation of each state's program. Critical to success will be developing a provider/payor relationship based on a mutual understanding of each entity's role in the provision of care for frail elderly.

"Before we open a new residence, we have found that it's helpful to sit down with the local case managers or other representatives of the program to make sure we are all on the same page," says Mauro Hernandez, public policy director of Assisted Living Concepts (ALC) in Portland, Oregon, which serves Medicaid residents in seven out of the 16 states where it operates. Residents reimbursed through Medicaid waivers represent approximately 18 percent of ALC's total resident population. "Sometimes, we show them sample resident service plans and a copy of our residency criteria to give them a better picture of what we offer in our assisted living communities. One should not assume that these case managers have had a lot of experience working with assisted living providers," says Hernandez, who also serves as ALFAcares co-chair.

With new Medicaid programs, there is usually confusion and mismatched expectation about covered services, incide notification, service planning, and co.. pliance.

"Administrators should carefully review their Medicaid provider agreements and other program information to make sure they understand the facility versus the case manager's responsibilities," suggests Hernandez. "Then review them with the case manager if there is a problem."

As for overregulation in response to Medicaid expansion, Hernandez says, "Our biggest concern is that policy makers often seem to say, 'Well, this is how we solved that problem for nursing homes,' without figuring out if that really worked. As requirements pile up, affordability and other desirable characteristics become eroded."

Although there are notable success stories around the country, much work remains to ensure a sufficient supply of affordable assisted living for the seniors who need it, and service packages that are flexible and delivered in way that is consistent with assisted living philosophy and principals. ●

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Appendix C

The Informed Choice Act

An Act to strengthen the disclosure of essential information regarding assisted living to consumers and to strengthen the consumer's ability to make informed choices regarding assisted living;

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF _____:

1. The purpose of this Act is to empower consumers in two ways. First, to empower consumers by describing an assisted living community's services in a uniform manner. This disclosure gives prospective residents and their families consistent categories of information from which they can compare assisted living communities and services. By requiring this disclosure, the state is not mandating that all services listed should be provided, but provides a format to describe the services that are provided. The disclosure is not intended to take the place of visiting the assisted living community, talking with residents, or meeting one-on-one with assisted living community staff. Rather, it serves as additional information for making an informed decision about the care provided in each assisted living community.

   Second, to empower consumers by identifying how the resident would be able to remain in an assisted living community if their acuity exceeds the statutory or regulatory discharge criteria, if, all parties (resident, resident representative, physician, and assisted living community) agree and the resident has been evaluated, understands and accepts the health, safety, and financial impact of the decision.

2. All assisted living communities shall make the following information available to consumers, upon inquiry, in a form designated by the Department:

   a. A list of all services provided by the assisted living community;

   b. The current charges for all services provided by the assisted living community;

   c. Whether a resident may contract with a third party to receive services;

   d. Whether the assisted living community has licensed nurses or registered nurses on staff;

   e. Whether the assisted living community requires a payment prior to admission, and if so, the amount of the payment;

f. The circumstances or conditions which may require that the resident move out;

g. Whether the assisted living community allows residents to remain if they are receiving hospice services;

h. The process for establishing and updating the resident's service plan;

i. The number of daily meals offered or provided and whether specialized or therapeutic diets are offered;

j. The sources of payment that are accepted by the assisted living community including Medicaid, state grants or public funding; and

k. Whether the assisted living community offers programs specifically for individuals with Alzheimer's or related dementia and/or has a secured unit for individuals with Alzheimer's and related dementia.

3. Assisted living communities shall post information regarding the appropriate state agencies for addressing complaints and grievances.

4. All assisted living communities shall provide a detailed residency agreement to residents.

5. If a resident's condition or care needs exceed those allowed by section [insert reference] the resident shall be allowed to remain a resident of an assisted living community if all of the following conditions are met:

a. The resident and/or his/her designated representative desires that the resident remain in the assisted living community;

b. Prior to a physician's assessment, the assisted living community has disclosed to the physician the services that it will provide or make available to the resident;

c. The resident is assessed by a physician to determine whether the resident is appropriate to remain in the assisted living community. The physician's determination should be based upon the resident's condition, the services available at the assisted living community, and the resident or the resident or his/her designated representative's wishes that the resident be allowed to remain within the assisted living community;

d. The assisted living community agrees that continued residency is appropriate;

e. The assisted living community must disclose the cost of additional services that it will provide;

f. Sufficient financial resources are available for the resident to pay for the additional services to be provided;

g. The resident, his/her representative, and the assisted living community shall agree upon when the resident shall be reassessed to determine the appropriateness of continued residency. The reassessment shall be completed as scheduled or upon a significant change in the resident's condition, but in no event shall be later than six months after the agreement pursuant to this part;

h. The agreement of the resident, his/her designated representative and the assisted living community shall be in writing and constitute an addendum to the Residency Agreement; and

i. The assisted living community must develop a service plan which reflects the assessment, the resident's wishes regarding continued residency, the services to be provided to the resident, and the resident's wishes regarding services.

6. Nothing in this section shall be deemed to require a resident to remain in an assisted living community.

7. Nothing in this section shall be deemed to require an assisted living community to provide a higher level of care to residents unless expressly agreed to by all of the parties.

Appendix D

Unless otherwise noted, all statistics are 1999 results of the largest annual assisted living provider survey as reported in *2000 Overview of the Assisted Living Industry* by ALFA and PricewaterhouseCoopers, LLP

Size of the industry:

- An estimated 27,277 properties in 1999 offered assisted living as all or part of what they do. These properties feature a combined estimated capacity of 777,801 residents. (source: National Investment Center for Seniors Housing & Care Industries)

Resident characteristics:

- The "typical" resident nationwide is a single or widowed woman of about 84 years old, who needs help with, on average, three activities of daily living (ADL) such as bathing, dressing and medication management
- 45 percent of residents have cognitive impairments
- 41 percent use wheelchair or walker
- 26 percent have daily incontinence
- Roughly 20 percent of residents had been hospitalized before moving in; 24 percent had previously spent at least one night in a nursing home; 24 percent had received home health care before moving in
- Less than one percent are non-ambulatory or bedfast

Assisted living community characteristics:

- Assisted living communities serve an important local need, by helping people remain in their own community (70 percent of residents come from within a 15-mile radius; 78 percent have family members living within 20 miles)
- 78 percent of assisted living communities nationwide provide nursing services
- 96 percent of ALFs nationwide provide medication administration
- 48 percent of ALFs nationwide provide physical therapy services
- 24 percent of assisted living residences have a dedicated Alzheimer's unit.
- 80 percent of responding residences reported that home healthcare providers provide services in their assisted living residences and contract for such services directly with residents.

Regulations

- Assisted living is regulated in all 50 states. Thirty states use the actual term "assisted living" for their licensing category, with four more states pending.
- In a 2000 survey of state licensing officials conducted by the National Academy for State Health Policy (NASHP), issues related to abuse, access to medical care and billing/charges were ranked as receiving the lowest number of complaints nationwide.
- In the NASHP study, issues with medications were most often cited as the top or second-most commonly reported problem or complaint. However, the frequency of medication errors was not associated with state policy on who may administer or assist with medications. In other words, there seemed to be no correlation between the

frequency of reported problems and the type of credentials or training received by employees allowed to administer or assist with the medication.

Affordability/Importance of finding affordable options:

- 85 percent of assisted living residents are private-pay with an average annual income of $29,438 and assets averaging $160,092. About 27 percent have annual incomes less than $20,000 and 10 percent receive Medicaid or other state assistance.
- Assisted living unit generally costs one-half to two-thirds the cost of an equivalent nursing home unit in the same market. Average basic daily rate for private room (most common room type) is $73.97 nationwide.
- Lower-income seniors have higher frailty prevalence than those with higher incomes. Consequently, lower income households have a greater need for assisted living care. The most vulnerable are single people over 75. This group, which numbers 6.5 million nationwide, is expected to increase by 100,000 individuals each year for the next decade.
- Seniors with incomes below $15,000 typically qualify for various housing and other entitlement programs, such as HUD Section 8 rent-subsidy vouchers, SSI welfare benefits and Medicaid.
  Currently, 37 states cover services in assisted living-style settings through Medicaid, with several more states planning or pending.

Consumer satisfaction

- In a 1998-99 ALFA survey of 4,900 assisted living residents and family members nationwide, 80 percent of residents of freestanding assisted living residences and more than 88 percent of their family members reported their overall expectations had been met or exceeded.
- In the same survey, services that made the greatest impact on the overall satisfaction of residents differed somewhat from what family members regarded as most important. Personal care services seemed to matter most to family members, while the residents, themselves, tended to judge their satisfaction more on the basis of quality-of-life issues such as meals and activities.

Senator BREAUX. Well, let me thank you, Ms. Thompson, and all the members of the panel for being with us and for your statements, which I think have been very interesting and very helpful.

Let me start with you, Ms. Thompson. You all have nine assisted living facilities.

Ms. THOMPSON. Yes, sir.

Senator BREAUX. Now if I am looking at one of your facilities to place a relative, how do I know or can I know through any type of a structure or a system about the quality of care that your facilities meet?

Ms. THOMPSON. That is a very interesting question, and I was listening to the Senator's comments earlier. Right now the comparative quality issue is not one that has been addressed in a systematic way. The way that one accesses information is not a very good way. The access is to state survey reports for an individual facility if it is licensed.

Senator BREAUX. All of your facilities are licensed?

Ms. THOMPSON. Yes, sir.

Senator BREAUX. By the State? But I take it that license does not have anything to do necessarily with meeting certain standards of quality of care?

Ms. THOMPSON. No, and actually that is the reason why ALFA has been so aggressive in creating tools for providers to allow consumers to access that kind of quality information. There is not a system, but there are systems with ALFA's web site, for example, that have a very large consumer component. It has this consumer guide included in it, Senator Breaux, and oops, I have got it upside down.

In the middle of this consumer guide is something that my folks use everyday, every inquiry, every visit. And it actually gives consumers the opportunity to compare apples and apples. It is a very intimate process when one chooses an assisted living residence, and we are very strong proponents of folks being able to compare the pricing structures, the services that are included and not included, the array of things that are listed in this checklist, and it is very helpful.

Senator BREAUX. But somebody else operating across the street from you, for instance, in a licensed facility in one of your States does not have to do any of that if they do not think it is desirable perhaps?

Ms. THOMPSON. Excuse me? Isn't required to do? No. They are not required to do so. That is why ALFA is introducing in all the States a model disclosure act, which is part of my written testimony, and it is our goal to introduce that for just that purpose in each one of the States.

Senator BREAUX. Excuse me. So that would be a disclosure type of requirement, but it would not be setting standards for assisted living facilities as to what they have to meet; is that correct?

Ms. THOMPSON. Well, there are standards in each one of the States. And another example of one State solution to that real problem is what the State of Kentucky has done. They have created a consumer guide using some of the elements from this consumer guide, and what they have done is they are requiring their assisted living residents to provide this piece with every inquiry, and this

piece not only has a consumer checklist describing what assisted living is in the State, giving folks the same kind of guidance on how to compare, but it also has the statute in this piece.

Senator BREAUX. But does the statute just require the providing of information on what the assisted living facility does, or does it require the assisted living facilities to meet certain guidelines and certain standards with regard to the number of employees, the number of med techs that operate in the facility or anything of that nature?

Ms. THOMPSON. Yes, sir. Each one of the States has a set of guidelines that describes facility requirements, staffing requirements, minimum staffing requirements.

Senator BREAUX. Ms. Love, you are shaking your head. You do not agree with that. I just caught you right there in the act of disagreement so let me have you comment on what she is saying.

Ms. LOVE. There isn't consistency. Every State does not have——

Senator BREAUX. Use the mike, if you can. You all share that.

Ms. LOVE. That is one of the problems that there is that lack of uniformity and consistency. Not every one of the States has minimum staffing requirements or this disclosure information, but we are wonderfully heartened to hear that the industry is working on that. As you note, these are things that are important.

Ms. THOMPSON. I think information in this process is extraordinarily important, and we have found that the more disclosure we provide up front, the happier resident population we have.

Senator BREAUX. Let me, the thing that is striking me, I mean we went through this 2 years ago, and we talked to the industry about doing some things to try and voluntarily bring themselves into a structured situation where there were certain standards and requirements.

Ms. THOMPSON. And we still are in that process, Senator Breaux. I mentioned the model disclosure statement. The industry is now requiring its members to disclose—excuse me—to support the association's disclosure position before they become members. We are in the process of developing with regulators, providers and consumers a set of best practices. To do that and to do it in a way that protects the things we have described, it is a very complicated process. And those best practice standards will be introduced for the first time at a State regulator conference this fall.

Senator BREAUX. We had hoped that self-accreditation was going to be the answer to this, and I note that since 2 years ago that fewer than 20 facilities in the entire country have some type of a self-accreditation program, whether it is through the Joint Committee on Accreditation of Health Care Organizations or what have you.

I mean it is one thing for disclosure. I am happy that you have made progress in disclosing what you do. But for many, I am concerned about what they do. And are they meeting a minimum standard for the people that are in there? Are they being accredited by some either self-accreditation program or by the State, by the Federal Government, or by somebody?

Ms. THOMPSON. Well, I think the reason why we are so supportive of State level standards is, as I mentioned, that those level of

standards are at the level where consumers can access them more readily.

Second, we very much support in many States that the enforcement capability of the States be increased. That really is where, if there is a difficulty today, Senator Breaux, it is in the enforcement of existing regulations and not the imposition of another set of regulations.

In Alabama, for example, there are—with this change in regulations, we are, in fact, implementing very significant fines for serious problems in assisted living residences, and also tightening the State attorney general's ability to prosecute folks who are not providing good services.

Senator BREAUX. Well, what happens when you have 50 different sets of regulations? You operate in more than one State yourself.

Ms. THOMPSON. Yes, sir.

Senator BREAUX. Suppose you operated in all 50 States. Is it practical to have 50 sets of different rules and regulations and standards that you have to meet in each State? Wouldn't it be better to have a national standard that is enforced on a local level or is that not the right way to go?

Ms. THOMPSON. I think if you look, actually if you look at assisted living on a state-by-state basis, the system really is working. As I said, I think we really do need a better ability to enable States to enforce the existing regulations. And to operate in 50 States means that we are serving local populations in those 50 States, and I operate in five States. Tomorrow I might operate in six States. I really welcome the opportunity to create an environment in that State that fits the needs of folks in that State, and the diversity, the difference between operating a community in Mississippi and operating a community in Pennsylvania, we operate under those rules very successfully because we are serving people in those States.

I see no reason why a uniform standard would do anything other frankly than perhaps, and this is a risk for us, restrict exactly the kind of choices and the kind of innovation that we have been blessed to have under the current regulatory system.

Senator BREAUX. One other point and I will turn it over to Senator Wyden. Ms. Gallow, let me ask you a few things. I was very interested and have been aware of what you all are doing in Monroe, LA. The income levels of the people you are serving are obviously very disturbing. Three thousand to $5,000 a year does not allow a person in that category to pick and choose among the best of assisted living facilities with that kind of an income.

Why is my State and your State and our State not eligible for Medicaid assistance to people in your situation that you serve? I mean every one of them would be Medicaid eligible if Medicaid had a waiver in our State to cover assisted living facilities.

Ms. GALLOW. It is because we have a very strong lobbying group of nursing home advocates that do not want Medicaid waivers for assisted living.

Senator BREAUX. I mean I understand the bottom line here they don't want competition for their patients in assisted living facilities, but what in the world can they possibly argue publicly as to why they would oppose having those citizens eligible?

Ms. GALLOW. They can't really argue effectively. What we have been doing is lobbying down in Baton Rouge trying to get our representatives to see that the cost of putting a person in a nursing home in Louisiana is 30 percent more than putting them in an assisted living facility, and we are hoping that within the next year, they will hear our cries, but as of now, right now, we don't have it.

Senator BREAUX. Its just—it seems——

Ms. GALLOW. I know it is mind-boggling.

Senator BREAUX [continuing.] It is hard to believe. Of course, we are both from there, and I know——

Ms. GALLOW. It is Louisiana. [Laughter.]

Senator BREAUX. And I know what you are facing down there. Well, a number of other States are in that same situation. I think there are 38 States that have a Medicaid eligible waiver and the rest do not. I mean it seems to me that it is hard to understand why we don't.

Ms. GALLOW. Yeah. There are a number of us who have formed a coalition from northern Louisiana and also from southern Louisiana. We went to Baton Rouge a couple of weeks ago, and we plan to go back in about 3 weeks when they meet again because we are screaming louder and louder. And that is all we can do.

Senator BREAUX. I will tell everyone here that if the Federal Government is going to participate in helping to pay for the care of these patients——

Ms. GALLOW. That is right.

Senator BREAUX [continuing.] Through a Medicaid program, I am particularly disturbed that it could be in a facility of which there are no national standards. If we are going to give 75 percent, which in Louisiana is about a 75/25 Federal Government match——

Ms. GALLOW. Right.

Senator BREAUX [continuing.] For the State's match, I do not want to have that money being spent in facilities of which there are no standards. I am not saying it has to be Federal standards, but there have to be standards, and right now a lot of assisted living facilities really don't have to meet any standards. Maybe they do and they got some great examples of facilities that are providing the very highest quality, but then there are some that are perhaps not.

And if we are going to be spending tax dollars, I think we ought to be able to ensure everyone that it is being spent in a facility that meets certain standards.

Ms. GALLOW. I agree.

Ms. THOMPSON. Senator Breaux, can I respond?

Senator BREAUX. Yeah.

Ms. THOMPSON. I think that does show the benefit of having a model statute because as we move forward in the process of making access possible to this type of service for even a wider array of folks, I mean at this point 90 percent of folks in assisted living residences are paying with their own dollars or their family's dollars, and as we widen access with creating opportunities for folks who will use Federal dollars, I think to have a statute, a model, to alert States to the fact that this may be coming and create that model approach within each one of the States is an excellent idea.

It is not that we should have standards. We must have standards or consumers cannot evaluate who we are and what we do. Our point is that we want to make sure that the development of the details of those rules happen as close to the consumers as we can possibly get it.

Senator BREAUX. I appreciate that. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. I think your questions were excellent and I want to get into the same sort of areas. Dr. Kilby and Ms. Gallow, thank you for excellent presentations.

Ms. GALLOW. Thank you.

Senator WYDEN. To have advocates like you on the front line is a tremendous benefit to the nation's seniors and we really appreciate your being out there and the work that you do and your voices today.

I want to spend some time, Ms. Love and Ms. Thompson, looking at the common ground between the two of you. I was struck in many ways as I listened to the question Senator Breaux asked about the parallels between this discussion and discussions we had about nursing homes 25 years ago. Twenty-five years ago when I had rugged good looks and a full head of hair, the discussion was sort of the same as the discussions we are having right now. The question then was how do you get the essential consumer protections for vulnerable people? The question now is how to do that and at the same time give a critical industry enough flexibility to innovate and meet modern circumstances?

Suffice it to say today, 25 years later, both the nursing home industry and nursing home advocates are not particularly pleased with the decisions that were made 25 years ago. So what we are trying to do here is to avoid a replication of the next 25 years with respect to assisted living. That is the objective, and I think both of you would agree, and I appreciate your nodding your heads.

What would you think—because I have been talking about this model statute—this is a question for the two of you—of this committee working with both of you, consumers, industry, State health departments, and I also want to involve researchers in this field, gerontologists, because they will help us get some ideas about what is ahead, to develop a model state statute, a state statute, so that we could have the States leading, but have strong consumer protections, and then hypothetically say we will give the States a period of time to enact that model state statute, and if the States didn't do it within a period of time, then there would be some other consequences and we could work through this process to decide what that might be?

Ms. Love and Ms. Thompson, what do you think about our trying to go at it that way?

Ms. LOVE. I think it is an excellent suggestion, and I loved your example earlier of the Medigap, using that, where you had all the stakeholders kind of coming together, that the government didn't take predominant role, but they were certainly at the table, and I think that your similarly suggesting something for assisted living is right on target, that we could come up with model standards. It is something that at CCAL we have already partnered with the American Bar Association's Commission on Legal Problems for the Elderly and want to extend the net to all of the stakeholders.

And we don't think that model standards per se squelch the ability to have creativity and innovation. For example, we have a tremendous array of transportation, automobiles, SUVs, trucks, et cetera, so there is lots of creativity in designing different vehicles, but yet they all still have a similar set of standards, you know, on health, you know, different emissions requirements, tire safety and standards, et cetera.

I think that is something that we can include, you know, sitting at the table and we would want to include researchers. We would also want to include people within the States. For example, the different surveyors, the regulators, I think they would bring a lot to the discussion as well. You brought up a wonderful example about the nursing home 25 years ago, and that here we are 25 years later and the industry and consumers still aren't on the same page. And I think that the reason for that is because they weren't on the same page to begin with.

The advocates were not involved. The nursing home industry got off to a galloping start, and it was not until several decades later that the consumer advocates really had some impact. We are unfortunately almost at the same state here in assisted living. Twelve years and finally consumers are getting a chance, you know, to really step up to the plate and participate in some of the discussions. Had that happened at the outset, the emergence of the industry, maybe we would not be on such different pages now, and we hope to rectify that now.

Ms. THOMPSON. I think we are in that process. I think—I know the industry is very supportive of helping States help us do the best job for our consumers. I think the involvement of the State stakeholders might be the most problematic part of designing a model statute, Senator Wyden, because each one of the States has so much ownership over their own processes but also over this one because most of the States are currently very active in this arena. This is a very big area right this minute in the States.

So we are very supportive of the process that you are describing and we will help in any way we can to move it forward.

Senator WYDEN. I am going to interpret that as pretty much a sympathetic answer.

Ms. THOMPSON. That is a yes.

Senator WYDEN. Good.

Ms. THOMPSON. A long yes—sorry—but it is a yes.

Senator WYDEN. One of the things that I would hope, and I think that Ms. Love would agree with it, is that for the States that have done a good job, and there are a number of them, the model state statute wouldn't change their lives very much.

Ms. THOMPSON. Right.

Senator WYDEN. In other words, we are not talking about tearing up the concrete and starting all over. We are talking about States that are doing a good job pretty much being able to do their thing, recognizing that what works in Coos Bay, OR is often a little bit different than what works in Detroit, but we would also have a tool to get the States that haven't provided the consumer protection that both of you, to your credit, have said are needed.

We have a tool to get them up to speed, and that is what I would like to work with you both on, and as I say, I am just struck by

how similar the discussions are now about assisted living to discussions of 25 years ago on nursing homes, and both of you look like exactly the kind of people we want to have at the table, people who want to try to get some common ground here that is in the consumers' interest, because of the vulnerable people we are dealing with that lets the many people in the industry who want to do the right thing and deserve some predictability, by the way, to know what is going to be asked of them, to have an opportunity to do that. And I thank you for it.

Ms. Thompson, just a couple of business questions. The news media has been reporting, *The Wall Street Journal* and others, that there is a significant oversupply of facilities in the assisted living facility. Is that your judgment and what are the ramifications for the Congress in looking at oversupply kinds of questions?

Ms. THOMPSON. About 4 years ago, Senator Wyden, there was a great deal of capital that gravitated toward the idea of assisted living. And in the period from 4 years ago until about 18 months ago, that created a great deal of creation of supply in market areas where there had been none before.

And I think in some markets, particularly—well, really the markets are all over—the rural markets, that someone may have built a community that is a little too big for that particular area. There are urban areas where that has occurred as well.

When one looks at the demographics, it is a very slowly decreasing problem because capital has not been flowing into the industry except for very mature operators for the last year. And so the market has recognized that there was some overbuilding or some not saturated areas because of more buildings than had been in the past, and capital has tightened. So the market actually is giving operators the opportunity to catch up on their operations because of the lack of capital right now.

So in terms of a long-term problem with us continuing to build in areas that are oversaturated, the underwriting criteria that are being used by folks lending in the industry have tightened so much that lenders are very concerned and very conservative about the folks to whom they will lend. So I really don't think that it is an issue that the Congress needs to look at at this time.

Senator WYDEN. One of the reasons that I ask it is that because we know there are maybe 5 percent of the people in virtually every field on the planet that are a problem—5 percent of the lawyers, 5 percent of the doctors, 5 percent of the accountants, by the way, 5 percent of the Members of Congress—and I have been concerned about the question of whether running up these debts that have been documented is part of the reason for the 5 percent we see in this field, that those people get overextended, they have got to deal with the real estate side of the equation, and then patient care suffers.

Do you think that that has been a factor in that small percentage, the 5 percent, that the industry, to their credit, has been saying they are concerned about, too?

Ms. THOMPSON. I think we are a maturing business, and there are a lot of lessons that those of us who took on really the lion's share of expanding this option around the country we have had to learn. That one has to have the same systems in place if one has

a 100 residences as I have with nine. And they have to be of similar quality, and it is exponentially more difficult to do it with 100 than it is to do it with one or nine. And so I think that is a maturation process.

The fact that problems exist is heart-wrenching for all of us, but I think the decrease of the capital available in the markets right now has actually been a blessing for the industry because we have been able to focus on those issues, and hopefully we will resolve as much of the 5 percent as is humanly possible.

Senator WYDEN. Last question that I had dealt with this dire worker shortage that we are seeing in assisted living and virtually every other health care area. I would assume, Mr. Southerland, that in rural communities that this is particularly serious. I have well over half the communities in my State, you know, with very modest, you know, populations, and they are having difficulty. What are you all doing to recruit the workers that you need and any suggestions for how we might encourage it?

One of the things that I have been looking at is the idea that we ought to offer scholarships, particularly to low income students, to work in the aging field. I think that this might well be seen as a path of upward mobility, that you might, for example, in high school begin to start concentrating on developing an expertise in the aging field, continue it at perhaps a community college, and one day look at, you know, being an administrator of a facility.

But I would be interested, particularly from a rural viewpoint, what your experience has been in terms of getting qualified workers and whether you have any suggestions for the Congress about how to address it?

Mr. SOUTHERLAND. I think, Senator Wyden, your example is a very good example as far as scholarships are concerned. The problem exists in rural areas and large cities; it exists everywhere. It is actually a critical situation.

I personally have tried to deal with certain bonuses for employees for attendance, for staying an extra shift, something like that, so that we have qualified folks on duty. It is a problem, but I think the problem obviously is they need more reimbursement, they need more dollars per hour. That is one issue.

At the same time you are exactly correct, we need to make that position, that caregiver or attendant position, the person that is responsible for the care at the assisted living facilities, more something to be sought after. Right now it typically is not. We need to put a great deal of importance on those positions. They need to be like electrical engineers or aeronautical engineers. It has got to go to that level, and I think that is one way that the industry could change. That is a hard situation. That is a hard thing to do, but I think your suggestion looking at the high schools is a very good suggestion.

I know in Eagle where my son and daughters go to high school, they do have a class where they can actually get their CNA certification, and that is relatively new in high school. But it is a critical step toward a career in health care and hopefully in assisted living. So I think anything that can be done to make those areas more appealing and give them more significance is certainly warranted. It

has to be done. That and additional dollars you can pay them hourly, I think, are two critical, critical issues.

Senator WYDEN. Let us let the consumers and the industry talk about it. Part of what I have grappled with is that I think the additional hours/the per hour reimbursement helps you in the short term, but I do not think you then develop a group of people who are going to see aging as a career where they can have upward mobility, which is why Dr. Kilby's point was so important.

Dr. Kilby described what I have seen constantly in the aging field is that the people you see today and you get comfortable with aren't the people you are going to see 10 days later. If we are going to really develop this core of people in this country who are going to have a reason to stay in the aging field, there is going to have to be an advancement path, a path that suggests that if you start at the entry level in assisted living that you are going to have a chance to get down the road and be the top dog.

And would the industry or consumer folks want to comment on your ideas on the worker shortage?

Ms. LOVE. There was a wonderful suggestion or comment that Dr. Kilby made earlier that I think hits to the heart of things. She mentioned that in her particular home, because they weren't full, that the company had made the decision to decrease the direct care workload by essentially 20 percent, one day a week.

Now, I think that would be very difficult for me to absorb a 20 percent increase, and I make a little more than $7 or $7.50 an hour. To do that to a direct care workforce is a tremendous trauma and you end up then losing those workers because they have got to go somewhere else where they are guaranteed full-time work.

So there are, I think, some things that can be done, you know, right at the face value of keeping workers on board, incentives for them to stay. I love your idea, Mr. Southerland, of bonuses, and discussion, Senator Wyden, about looking at this in high schools and community colleges, because that gives individuals coming up in the ranks sort of something to aspire to, something to be interested in learning about. So thanks for bringing it up.

Ms. THOMPSON. I think the answer to our workforce shortage is working with this population must be seen of value in the culture, and the culture has not, to this point, seen it really as a valued position, and the place to start is in school.

In our company, as small as it is, when we identify a staff person who comes in at that entry staff level and appears to have the heart, as part of their evaluation process, they are given the opportunity to go to the local community college and gain an LPN license, if that is their choice. That has been a very successful program for us to stabilize our little operations, as has bonuses for something as simple as one's attendance everyday. That has been very successful strategy.

But I think you are right, Senator Wyden. We must particularly in the next decade create a culture in which service to this population is of value in the culture or we won't create in our caregivers the heart that it does require to do this work everyday.

Senator WYDEN. The chairman is back and he has given me a lot of time. I think this has been an excellent hearing, an excellent panel, and I am really hopeful that somewhere down the road, peo-

ple will look back at this hearing and say that this really played a role in coming up with the kind of solutions that folks tried to think about with the nursing home industry 25 years ago.

The fact that the two of you have said that there is some common ground that we can find—the chairman was out of the room, but we talked about an approach involving the consumer groups, the industry people, researchers in the field, working on a model state statute addressing the issues that you talked about both with respect to consumer protection and disclosure and perhaps giving the States a period of time to in effect meet those standards, and then if the States did not do it, then there could be some consequences and we could look at what those consequences ought to be.

And the fact that Ms. Love and Ms. Thompson on behalf of their organizations are willing to work together—there were certainly no fisticuffs at this table, and quite the opposite, there was an awful lot of willingness to work together—encourages me, and that is what we are going to need to have.

I mean the industry, for example, I think is right with respect to trying to make the waiver process, you know, easier, but as we make the waiver process easier and there are Federal dollars available, consumers have a right to say that there are going to be certain consumer protections accompanying those waivers.

So I think there has been a very constructive hearing and just look forward to working closely with all of you and thank you for the extra time, Mr. Chairman.

Senator BREAUX. Thank you, Senator Wyden. I think that I would echo that it has been an informative hearing and we thank all of you for coming and being with us. I know it has been difficult for some of you to be with us, and we appreciate it very much.

I think that the two things that stand out in my mind is how do we afford this type of long-term care for American citizens? We have not answered that problem. I mean it is a very expensive, no matter how efficient the delivery system is, this is very costly. And it is unfortunate that right now the only assistance from a Federal level is that you have to become so poor as to be eligible for Medicaid which doesn't cover all States and that is a real problem.

We have introduced legislation to provide Federal tax credits to people who purchase long-term care insurance, which is, I think, a way to help get more people involved in planning for the time in their lives when they will need some type of long-term care. Just as we prepare today for having unfortunately maybe to go to an emergency room, Americans need to be preparing for a time when they may need to have help financially through insurance to provide for long-term care for themselves and for their families. And we are trying to move in that direction, which I think is very important.

And the second thing that strikes me is that the standards, what are they going to be? Are they going to be State standards? Are they going to be local standards? Are we going to have 50 sets of rules and standards for assisted living facilities? Or is there a way to have a national standard that is enforced on a local level to make sure that when we treat these people, that everybody involved is at least meeting minimum standards with regard to qual-

ity of service that is being provided, particularly if tax dollars are going to be utilized in helping to pay for it? I think that something along these lines is needed.

I think this has been helpful. I want to make sure that if we come back in 2 years, that we have made some real progress in this area. And I think that we need to use the time between now and next hearing to be more involved in trying to move in that direction rather than less involved. So I thank all of you very, very much for being with us. This will conclude this hearing.

[Whereupon, at 10:55 a.m., the committee was adjourned.]

APPENDIX

American Seniors Housing Association

1991–2001 — CELEBRATING 10 YEARS OF LEADERSHIP

WRITTEN STATEMENT OF

MARK SCHULTE

CHAIRMAN

AMERICAN SENIORS HOUSING ASSOCIATION

IN CONNECTION WITH THE

UNITED STATES SENATE

SPECIAL COMMITTEE ON AGING

HEARING

"ASSISTED LIVING IN THE 21ST CENTURY:
EXAMINING ITS ROLE IN THE CONTINUUM OF CARE"

HELD ON
April 26, 2001

5100 Wisconsin Avenue, NW — Suite 307 — Washington, DC 20016
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STATEMENT OF
MARK SCHULTE
CHAIRMAN
AMERICAN SENIORS HOUSING ASSOCIATION

SUBMITTED TO THE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

My name is Mark Schulte and I am the Chairman and Chief Executive Officer of Brookdale Living Communities which is headquartered in Chicago, Illinois. Brookdale operates 46 senior housing residences in 23 states. This testimony is submitted in my capacity as Chairman of the American Seniors Housing Association (ASHA). ASHA represents approximately 250 of the nation's most prominent professional owners and managers of seniors housing and assisted living residences. Members of ASHA are involved in all aspects of the development and operation of seniors housing, including the construction, finance, and management of close to 500,000 housing units nationwide.

On behalf of ASHA, I want to commend this Committee for its ongoing commitment to studying the critically important issues surrounding assisted living and seniors housing generally. In the upcoming decades, as the American population ages, the need for quality assisted living and other seniors housing will grow dramatically. We look forward to continuing to work with this Committee to ensure that we are ready to meet those challenges.

BACKGROUND

Over the past 15 years, a new, consumer-driven long-term care alternative -- assisted living -- has developed in response to the desire of American seniors and their families to maintain the maximum possible independence and quality of life, while receiving needed assistance. Today, it is estimated that over 500,000 seniors reside in a diverse range of assisted living communities where they receive the care and support they require to age with dignity. The assisted living option is available in a host of settings and has greatly improved the range of choices available to the nation's elderly and their families. ASHA estimates that of the 7,000 purpose-built, professionally-owned and managed assisted living residences in the U.S., over 1,400 residences consisting of over 108,000 units have been built in the past five years alone.

While assisted living residents have a diverse range of needs, they typically require help with one or more activities of daily living (ADLs) (e.g., bathing, dressing, toileting, eating, and walking), and are unable to live independently. Assisted living residents typically receive three meals per day, snacks, assistance with medications, social activities, laundry and housekeeping, 24-hour emergency response, security services, and transportation.

In addition to these core services, some assisted living residences specialize in caring for persons with Alzheimer's disease or related dementias. Before the emergence of assisted living, someone with Alzheimer's disease had limited options. They could move in with a family member or move to an institutional setting, such as a nursing home, even if they did not need continuous medical care. For many persons with dementia, assisted living offers a more affordable and appropriate setting.

In most U.S. markets, prospective residents can choose from a wide variety of residences, ranging from small "cottage-type" designs of 20 to 40 units or larger models with 100 units or more. Additionally, there are assisted living residences available at a range of prices depending on the preferences, needs, and budgets of the resident. Regardless of the setting, well over 90 percent of all assisted living residents have their own private living unit that they furnish with their own belongings. Most assisted living apartments feature private bathrooms with showers, lockable doors, and other design features to maximize independence, dignity, and personal privacy.

The vast majority of assisted living residences operated by professional owners and managers have been built since 1990. These residences provide consumers with highly attractive and safe living environments that comply with state and local building and life safety requirements. Although they are residential in appearance, most are constructed to comply with institutional building code classifications, meaning a structural steel and concrete building with fire-rated walls, sprinklers, emergency response systems, and other safety features.

While there is considerable breadth and diversity among assisted living residents, a typical assisted living resident is an 83-year old widow who cannot live independently and needs assistance with two to three ADLs. In addition, approximately half of all assisted living residents have some degree of cognitive impairment.

While caring for an often frail population creates unique challenges for those who operate assisted living residences, the overall quality of life and safety of assisted living residents in professionally managed facilities is generally far superior to that which is found in nursing homes or small board and care homes.

FINANCING ASSISTED LIVING

While many prospective residents and their families find assisted living a highly desirable alternative to the institutionalized setting prevalent in nursing homes, private funding is generally required for assisted living expenses. Today, the greatest challenge facing most American families with respect to their long-term care needs is how to finance current or future long-term care costs. According to a recent study published by the National Investment Center for the Seniors Housing and Care Industries, nearly three-fourths (70 percent) of all assisted living residents have annual incomes below $25,000. Payment for assisted living comes primarily from the resident (65 percent receive no form of financial assistance); 16 percent of assisted living residents receive some financial assistance from

their families; a similar percentage (16.1 percent) receive some assistance in payment from either Supplemental Security Income and/or Medicaid.

The members of ASHA strongly believe that it is critical that we as a nation focus attention on the need to plan ahead for long-term care expenses. For many families who want to begin planning, long-term care insurance is an effective way to prepare for the future. Perhaps more than any other single step, enhanced tax incentives for long-term care insurance (e.g., through current proposals that would provide an above-the-line deduction for premiums and allow long-term care insurance to be provided as part of employees' benefit packages) would help American families meet their long-term care needs.

For this reason, ASHA strongly supports bipartisan proposals that would provide enhanced tax incentives for the purchase of qualified long-term care insurance. We commend Senator Breaux, for joining with Senators Grassley and Graham in introducing S. 627, a bipartisan bill that would provide meaningful tax incentives for long-term care insurance. President Bush has made similar proposals in his budget package. We are pleased that other members of this Committee have sponsored similar legislation in previous Congresses and strongly urge all members of this Committee to co-sponsor the Grassley/Graham/Breaux long-term care legislation (or similar legislation) and work towards its enactment in this Congress.

INDUSTRY EFFORTS TO PROMOTE QUALITY

The seniors housing industry, led by ASHA, has taken a number of important steps to provide educational tools to consumers concerning quality and consumer protection as summarized below. It is important to remember that assisted living is a relatively new and evolving type of service – one that holds great promise for continuing to improve the quality of life of millions of America's seniors as they age.

Model Assisted Living Act. In 1992, ASHA developed a model assisted living act to help state policymakers understand what was, at the time, a new industry. This effort was the first of several initiatives spearheaded by the industry to assist state lawmakers and regulatory agencies in creating appropriate regulatory mechanisms to ensure quality for assisted living consumers. The model act was distributed to every state licensing agency and legislature and represented the first "best practice" effort initiated by the industry to assist policymakers and others who sought to create a better long-term care option for the frail elderly. It is estimated that approximately 20 states in the 1990s utilized the Model Assisted Living Act in developing their state's assisted living statutes and regulations.

Model Residency Agreement. A collaborative effort, initiated in 1995, between ASHA and the American Bar Association's Section of Real Property Probate and Trust Law, Committee on Housing for the Elderly, resulted in the publication of a model Retirement Community Admission Agreement. This guide was prepared for attorneys and consumers to help identify issues that should be addressed and options to be

considered in admission contracts. Seven years later, the publication is still in print and has been distributed to thousands of consumers and their legal advisors.

Assisted Living Quality Coalition. The assisted living industry along with two of the nation's most respected consumer organizations, AARP and the Alzheimer's Association, came together in 1996 to form the Assisted Living Quality Coalition (ALQC). *The Assisted Living Quality Initiative*, published in 1998, accomplished two major objectives. First, it developed a system for measuring quality in assisted living by creating a partnership between consumers, regulators, and providers. Second, the initiative provided guidelines to state licensing agencies and policymakers to develop and refine their assisted living standards. A major feasibility study is currently being conducted on behalf of the organizations that comprise the ALQC and will likely provide a framework for subsequent collaboration.

Consumer Brochure. In 1997, ASHA created a brochure entitled "Assisted Living Residency Agreements, Key Points to Consider When Choosing a New Home." This consumer-friendly brochure provides consumers and their families with two-dozen critical questions that should be asked of prospective assisted living providers regarding services and care, payment and pricing, and other important considerations. The brochure, which can be accessed free-of-charge from ASHA's website (www.seniorshousing.org) has been downloaded by an estimated 75,000 consumers and has been made available to many more consumers by ASHA members.

Disclosure Form. In 1998, ASHA, in collaboration with the Assisted Living Federation of America created and began distribution of the Assisted Living Consumer Information Statement, a disclosure form that serves as a guide for assisted living consumers about the care and services provided in different assisted living settings. The Assisted Living Consumer Information Statement, which was recently used by Consumer Reports as a model for comparing assisted living residences, was revised in 2000 by ASHA to reflect issues identified during the Senate Special Committee on Aging hearing on assisted living quality in 1999.

The revised and expanded Assisted Living Consumer Information Statement offers consumers standard, comparative information about residency agreements, fees and services; move-out and discharge criteria; and staffing. This effort allows prospective assisted living residents to easily compare one residence to another in order to help make the most informed decision about which assisted living residence will best meet their needs. Copies of the Assisted Living Consumer Information Statement have been distributed to assisted living providers nationwide, and are available to the general public on the internet at no cost. It is estimated that over 100,000 consumers have accessed the Assisted Living Consumer Information Statement.

STATE REGULATION AND OVERSIGHT

Assisted living residences are regulated in all 50 states and the District of Columbia. Although not all states use the term "assisted living," states have been actively engaged in monitoring and ensuring quality in these settings through state licensing agencies. State policymakers have worked in collaboration with consumer advocates and providers to develop responsible regulations that are flexible and support quality care in a safe living environment, while allowing the diversity of assisted living settings to flourish.

For the past several years, ASHA has monitored regulatory and statutory developments related to assisted living in all 50 states, and that monitoring shows that state regulation has been extremely active. Between 1998 and 2001, 46 states and the District of Columbia modified their assisted living regulations or statutes. Nearly all of those jurisdictions have taken some steps since 1999 (38 states and the District of Columbia). Additionally, the remaining four states (Alaska, Georgia, North Dakota, and Wyoming) are all considering legislation related to assisted living in their 2001 legislative sessions. States (working with all local stakeholders) are best positioned to oversee assisted living in their own geographical areas. Recent activity shows that states are working diligently to refine statutory and regulatory regimes to ensure that assisted living residents in their communities receive the safe and quality care they deserve, while retaining appropriate independence and dignity.

Accreditation. Two nationally established accrediting organizations (the Joint Commission on Accreditation of Healthcare Organizations and the Rehabilitation Accreditation Commission) have begun offering accreditation for assisted living settings. To date, a relatively small number of assisted living settings have started the process of becoming accredited. ASHA believes that there are two primary reasons for this. First, the accreditation process essentially duplicates the state licensing process, adding an additional survey to the annual state survey requirement. Second, accreditation is expensive (several thousand dollars for a 60 to 100 unit residence), particularly since no state has accepted third party accreditation in lieu of the state licensing process. ASHA supports the concept of accreditation but believes that it must be accepted by states as an alternative to the current state surveying process if it is to gain widespread industry acceptance.

CONCLUSION

Over the past several years, state policymakers across the country have worked collaboratively with consumers and providers to create flexible and effective regulations and statutes for assisted living residences. ASHA remains committed to exploring and disseminating best practices and working with all stakeholders to ensure that America's seniors receive the quality of care that they deserve. Assisted living providers have maintained a very high standard of quality, and provide over a half million consumers with a long-term care option that offers a safe and dignified living environment and services. For most seniors and their families, assisted living is a preferred alternative to

entering a nursing home. As such, Congress should encourage policies that give Americans choices and alternatives that allow them to age with dignity.

We greatly appreciate the opportunity to provide this testimony to the Committee, and hope you will not hesitate to call on ASHA if we can be of further assistance.

Written Statement of

Robert Lohr

On Behalf of

The National Center for Assisted Living

For the Hearing Before the

U.S. Senate Special Committee on Aging

Assisted Living in the 21st Century:
Examining its Role in the Continuum of Care

Submitted April 26, 2001
For the Hearing Record

Chairman Craig and members of the Committee, on behalf of the National Center for Assisted Living, I would like to submit the following statement for insertion in the hearing record. My name is Robert Lohr and I am Founder and President of Peridot Enterprises, Inc., a Pittsburgh, PA company that operates several assisted living facilities in Florida. I am also the Chairman & CEO of a small public company that specializes in assisted living in Florida.

I have worked in the long term care profession for more than 20 years, starting my career in nursing homes and later diversifying into assisted living. During that time, I have developed, constructed or managed more than 35 assisted living facilities, including retrofitting vacated schools, convents, historic hotels and large homes into assisted living communities.

The National Center for Assisted Living (NCAL) is the assisted living voice of the American Health Care Association. NCAL represents 2200 proprietary and non-proprietary assisted living and residential care facilities nationwide. NCAL is committed to fostering growth in assisted living and ensuring that people have access to quality assisted living services by supporting responsible public policies, providing professional education and development services, and by being an information and research resource for the public, state and federal policymakers and the media.

Assisted Living: An Innovative Approach

Based on a Scandinavian model for senior living, assisted living first emerged in America during the mid-1980s. Unlike other medical models found in most health care settings, assisted living is based on a social model of care, which translates into a holistic approach toward serving residents. Independence, autonomy and choice are words that define assisted living, and are the concepts that have made assisted living so popular with the public. People living in assisted living residences receive help with their daily lives so they can retain their sense of individuality and belonging in their communities.

Numerous changes have taken place in the assisted living profession since the last Senate Special Committee on Aging hearing two years ago, and much research has been completed since that time about the preferences of assisted living consumers and their adult children. We have seen states rapidly escalate their regulation of assisted living and revise existing regulations to address changes that have occurred in the assisted living profession.

Findings from a 2000 study conducted by the National Academy of State Health Policy illustrate the importance states are placing on assisted living regulatory oversight. One-half of the states were actively working to revise their regulations last year, and 17 states have revised their regulations since June 1998. This level of activity demonstrates that states are taking a serious and responsible role in overseeing assisted living residences. It is a dynamic and ongoing process that should be allowed to continue.

There is also recognition that assisted living should be regulated differently than nursing facilities. In its 2000 report titled *Improving Quality of Long-Term Care*, the Institute of Medicine stated there was general consensus among Committee members assembled to develop the report that, "at this time, regulatory mechanisms for residential care do not need to mirror the extensive federal regulatory system that is in place for nursing homes."

A few states have incorporated exciting new approaches toward assuring quality in assisted living. For instance, in Washington and California, the states utilize state-employed consultants that assisted living providers and managers can call to help troubleshoot problems, answer questions about state requirements and share best practices. This type of assistance is invaluable to the provider community and more importantly, improves the quality and consistency of care and services delivered to assisted living residents. It's important to note these types of consultant programs are a supplement to – not a substitute for – the state's existing traditional enforcement system. NCAL fully supports these types of voluntary consultant programs and believes policymakers should encourage their development in other states. Further, it is important to note that these are the types of programs that are envisioned by the Assisted Living Quality Coalition.

One area of concern with state oversight that has been expressed by a few of NCAL's state affiliates is the underfunding of state assisted living oversight efforts. The net effect of this underfunding is an inadequate supply of surveyors to conduct facility inspections on schedule. Indeed, our affiliate in Kansas, the Kansas Center for Assisted Living (KCAL), has asked the state to increase its resources and hire more surveyors. It is KCAL's belief that underfunding these programs does a disservice to assisted living residents and the assisted living profession because a handful of facilities have had problems that have not been addressed.

NCAL firmly believes that regulation of assisted living should remain on the state level. While there are variations in how states regulate assisted living, the greater freedom that states have to design their own systems makes for more responsive and proactive oversight. We know too well the many problems and conflicts in the federal and state regulation of nursing homes. It would be a mistake to burden assisted living with a system that doesn't work. Indeed, it is consumers who have been driving the popularity of and growth in assisted living, not government programs, regulations or funding. This is an important fact to recognize and the primary reason that assisted living's primary focus must always be the assisted living resident.

NCAL further believes that policymakers should support research and testing of quality measurement systems based on performance outcomes. These are the measures most meaningful to consumers and most powerful for incorporating continuous quality improvements into the assisted living setting. One role that Congress could take in this matter is fostering and supporting research in this area, along with the funding of pilot programs in states. Quality measurement and assurance is and should be an ongoing

process.

Follow Up to the GAO Report

Two years ago, the General Accounting Office (GAO) released to the Committee its report on assisted living based on its evaluation of assisted living in four states. GAO raised concerns about the failure of some assisted living facilities to fully disclose certain information identified as critical information to a consumer's selection of an assisted living community. NCAL took these findings seriously and agreed that providers should freely disclose this type of information. As a result, NCAL developed a special insert to its consumer guide addressing the same elements identified by GAO. The insert contains a series of questions that NCAL recommends consumers ask before making a final decision to move into a particular assisted living facility. NCAL requests that a copy of this insert be included in the hearing record. NCAL's consumer guide, along with the insert, are distributed free of charge to any consumers who request copies and are available on NCAL's award-winning web site www.ncal.org which receives an average 67,000 "hits" each month.

NCAL also re-examined its guiding principles for assisted living providers. In addition to adding language reiterating our commitment to full disclosure and ethical marketing practices, we disclose how the provider handles emergency medical situations. Another area NCAL addressed was the use of the phrase "aging in place" and how it's used in marketing efforts. While originally intended as a consumer-friendly term to describe the practice of increasing services to meet changing resident needs, we have learned that the phrase led to confusion and misunderstanding. Therefore, NCAL now discourages the use of the term for marketing purposes unless accompanied by a list of all health-related reasons for which a resident would be asked to move out of the facility, regardless of whether those health-related occupancy restrictions are prescribed by state regulation or part of a facility's operational policies and procedures. I would like to submit a copy of NCAL's *Guiding Principles* for the hearing record.

Finally, NCAL has published a guide about appropriate marketing practices in the assisted living and residential care setting. Titled *The Power of Ethical Marketing,* this guide has been distributed to NCAL members and is available free of charge to anyone who requests a copy. The guide focuses on the importance of clear and consistent written and verbal communication and stresses the role that all staff members play in the ethical marketing of a facility. In addition, the guide includes the American Marketing Association's Code of Ethics to help educate facility staff about the elements of ethical sales and marketing programs. NCAL requests that a copy of this guide be submitted for the hearing record.

Government Oversight in the 21st Century

As previously stated, it is NCAL's strong belief that assisted living regulation and oversight should remain on the state level. Far greater focus needs to be placed on quality measurement systems for assisted living that focus on customer satisfaction and actual outcomes. Such a system could be utilized by providers, consumers and government to ensure that quality services and care are being maintained and, even more importantly, improved on a continuing basis. Developing a quality performance measurement system would better serve the interests of the assisted living customer by providing each resident with powerful input into the quality evaluation process and the delivery of services.

Performance Indicators

Beyond customer and staff satisfaction, any quality measurement system must also include measurement of actual performance in three primary three areas: clinical, quality of life and functional outcomes.

To be able to measure performance, certain data about each resident must be obtained, tracked and updated. From this data, quality indicators can be identified and utilized to track the outcomes of the care and services being provided by a facility. The benefit to such an approach from a facility operations standpoint is that problems can be quickly identified and fixed.

NCAL strongly believes that quality measurement is an ongoing process, not an annual inspection. More importantly, a facility can use this data as part of its continuous quality improvement program. This data gives facilities the ability to measure their performance over a period of time and identify trends on a facility and individual basis. Facility data can also be included in a network of data from facilities across the country, which would permit facilities to see how their performance compares to other facilities in their community, state, or nationwide. Continuous monitoring of performance is also a more dignified and reliable way for staff to evaluate how well they are doing their jobs.

More research needs to be completed in this area. We believe that Congress could help progress in this area by supporting research in the development of performance indicators and conducting pilot programs in various states. NCAL would welcome the opportunity to work with Congress on such an initiative.

Challenges Faced in the Assisted Living Profession

Increasingly, private long-term care insurance is helping older Americans pay for their assisted living needs. This reduces reliance on public programs to pay for long term care needs and helps seniors preserve the assets and savings accounts they have worked their entire lives to build. Congress is to be commended for opening long term care

insurance to the federal work force last year. NCAL also believes Congress should act on S. 627, *the Long-Term Care and Retirement Security Act of 2001*, offered by Senators Grassley and Graham. This bill will provide individuals an "above-the-line" deduction for the premium costs of their long term care insurance and access to long-term care insurance through cafeteria plans where they work.

The bill also provides a $3,000 tax credit to help individuals and family caregivers with long-term care costs. Passage of such legislation will provide the incentives necessary to encourage individuals to take personal responsibility for their own long term care planning and provide individuals and their family caregivers with the support they so rightfully deserve.

As members of the Committee are aware, our country is facing a nurse staffing crisis. This crisis impacts assisted living providers. We also face a shortage of frontline workers that is reaching crisis proportions in assisted living and other long-term care settings. The Committee is aware of the impact underfunding of important programs like Medicaid have on a long term care facility's ability to recruit and retain qualified staff. It's also important to remember that while many assisted living residents don't rely on these programs, they do live on fixed incomes and cannot afford to pay for dramatic increases in labor costs. The labor crisis is an issue that Congress must address now, given the rapidly growing number of elderly in this country. Public policy must get ahead of the curve and stave off what could be a catastrophic outcome.

To help address the nurse and frontline staff shortages, we propose that Congress implement income tax incentives for assisted living and other long term care workers to help attract and retain qualified employees in the long term care profession. Our country's policies have a long history of under-valuing and under serving older Americans with long term care needs.

The implementation of income tax incentives would be a proactive step Congress could take that sends a clear signal about the importance government and society places on ensuring our nation has a workforce in place that's equipped to care for the elderly, and the value government places on the work done by the long term care professional.

NCAL also encourages Congress to temporarily ease immigration rules that would allow essential workers to enter the country and help stem the current staffing crisis that we face. Virtually every assisted living residence in this country is experiencing severe difficulty hiring and recruiting workers. The simple fact is that these caregivers do not exist in this country today. We believe Congress needs to do a thorough reexamination of existing immigration laws to respond to the problems that a full employment economy poses on the health of long-term care communities.

Congress should reenact a program such as the now repealed H-1-A program. Further, Congress should enact a new visa category that allows essential workers to enter the country to fill openings in shortage jobs that are not seasonal or temporary.

Currently, there is no visa category that addresses these essential long-term care workers. This new visa program should be targeted to critical shortage areas such as long-term care.

Another area of concern is the level of public understanding about long term care and the host of other issues facing the elderly. Our society as a whole is youth-oriented, and we do little to prepare people for living to be age 85, 95 or 105. Yet, more and more people are living to those ages. These elderly and their families are ill prepared to manage the issues they face. This is a growing problem that NCAL believes must be addressed. We believe Congress should support public/private partnerships to help the elderly and their families better cope with the challenges they face.

We applaud the Committee for focusing today on the need to ensure that rural communities have access to assisted living services. NCAL could not agree more. One program that was helping rural states such as Iowa and Nebraska deliver assisted living to sparsely populated areas was the Intergovernmental Transfer of funds from the Medicaid program. Last year, Congress voted to phase out the ability of states to use these funds. This decision will leave a gap in rural America that needs to be filled. Many small communities cannot support assisted living without the government's help. It is our hope that this Committee will explore alternatives so that older citizens don't have to leave their hometowns to be able to access assisted living services when they need them.

The Committee should also be aware of a very real threat that looms for assisted living and all long term care providers: skyrocketing liability insurance premiums and the difficulty assisted living providers are having finding liability insurance policies. The availability and affordability of liability insurance for assisted living facilities has reached a crisis point that continues to grow worse each passing day. In Florida, where I own and operate several assisted living facilities, the state requires by statute that assisted living facilities maintain liability insurance as a condition of licensure, but this coverage is simply not available at an affordable rate, if at all.

In the past year, 15 insurance companies have left Florida due to the litigious environment. The annual cost for a liability policy with $300/$600,000 limits was about $500 *per small assisted living facility* in Florida. Now the liability insurance rates are $500 to $1000 *per licensed bed*. In many cases, there is no insurance available, except from a company that will offer a $25,000 limit for a rate of $526.60 per licensed bed.

An additional crisis is apparent because there are no insurance companies willing to write coverage for assisted living facilities that hold an extended congregate care (ECC) or limited nursing service (LNS) license. These assisted living facilities have to surrender their specialty licenses in order to receive any insurance quote at all. An ECC or LNS license is required for an assisted living facility to participate in Florida's Medicaid waiver program. Without the ECC or LNS licensed assisted living facility, it is reasonably foreseeable that 2,600 Floridians served by the waiver program will be moved from assisted living facility to assisted living facility as each facility's insurance policy

expires. Without participating assisted living facilities, these elderly people ultimately will end up in nursing homes even though they don't require that intensive level of care.

At a recent meeting of the Florida Center for Assisted Living, personnel from 23 facilities representing more than 1,500 beds were in attendance. Nine of the 23 facilities had already surrendered their ECC or LNS licenses, thus removing 447 assisted living beds from Florida's Medicaid waiver program. This is bad public policy. These 2,600 individuals matter. They matter to us. They matter to their families. They are poor and have no where else to go. I'm very concerned that they don't seem to matter to decision makers in Florida based on these recent developments.

As a result of the tort liability crisis being perpetuated in some states by personal injury lawyers, it's not uncommon to hear from providers in other states that their annual liability insurance premiums are escalating with annual premium increases of 200 to 800 percent. These increases negatively impact the elderly and the taxpayer because they are the ones who ultimately pay for the higher insurance premiums. We understand that insurance is largely a state issue but we believe this Committee needs to be aware of the crisis in Florida and other elsewhere, and should encourage states to address these matters before the situation becomes any worse or is repeated in your respective states.

Conclusion

Assisted living is an innovative long-term care model that is increasingly popular with the public. The profession is identifying better ways to serve the elderly, and state governments are taking an active role in insuring quality care and services in the assisted living setting.

The assisted living industry is in its formative state, and is still maturing and growing. Government policies should nurture this growth, not stunt it. As we're seeing in many states, and in many communities, the assisted living setting is the future of long-term care. All stakeholders have a collective interest in ensuring that, in the final analysis, the watchwords associated with assisted living are, "quality," "integrity," "choice," "flexibility," and "compassion."

NCAL welcomes the opportunity to work with this Committee, with Congress, with the Bush Administration and with other government officials in their efforts toward ensuring health care in general, and assisted living settings in particular, are the best that they can be for every citizen, from every walk of life. Thank you.

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ADDITIONAL COMMENTS FOR THE RECORD

FOR THE

SENATE SPECIAL COMMITTEE ON AGING

APRIL 26, 2001 HEARING

ON

"ASSISTED LIVING IN THE 21ST CENTURY: EXAMINING ITS ROLE IN THE CONTINUUM OF CARE"

SUBMITTED BY THE

ASSISTED LIVING FEDERATION OF AMERICA

ALFA
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May 10, 2001

The Honorable Larry E. Craig
Chairman, Special Committee on Aging
United States Senate
520 Hart Senate Office Building
Washington, DC 20510

The Honorable John Breaux
Ranking Member, Special Committee on Aging
United States Senate
503 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Craig and Senator Breaux:

On behalf of the more than 7,000 members of the Assisted Living Federation of America (ALFA), I want to thank you for giving Margaret M. Thompson, a founder and former board member, the opportunity to represent ALFA at the April 26th Senate Special Committee on Aging hearing on "Assisted Living in the 21st Century: Examining Its Role in the Continuum of Care". We greatly appreciated the chance to discuss the ongoing evolution of assisted living and the important role that it plays in the continuum of care for the nation's elderly.

Several issues were brought up during the hearing that we would like to address and clarify for the record. We respectfully request that this correspondence be made part of the hearing record.

The industry has been and will continue to be proactive in addressing the concerns raised by the Committee:

- **ALFA and its members have actively pursued several concurrent strategies to ensure quality care** for assisted living residents, to more consistently disclose information to consumers, to address the nationwide staffing shortage, and to increase caregiver training and administrator certification, since the Committee's first hearing on assisted living two years ago.

- **Our "Informed Choice" Campaign is taking these efforts to the next level to address the need for more consistency in state regulation of assisted living.** The cornerstones of the Campaign are: 1) the Informed Choice Act, model state legislation to improve consistency in consumer disclosure requirements at the state level, and 2) determination of "regulatory best practices" to serve as a model for states as they revise their assisted living regulations. Other aspects of the Campaign include educating the public about assisted living, and ensuring that assisted living residents and their families retain the right to make their own lifestyle choices.

- **ALFA will present the "regulatory best practices" at our state regulators summit this summer.** The summit will also address issues pertaining to enforcement of existing state assisted living regulations. ALFA has already begun providing the Informed Choice Act to states as they revise and update their regulations.

ALFA supports state regulation of assisted living and believes that states are the best path to quality assurance:

- **ALFA agrees wholeheartedly with the point made clear by members of the Senate Special Committee on Aging when they said that they do not want to take assisted living down the same path as nursing homes.** For that reason, ALFA and its members strongly support continued regulation of assisted living at the state level rather than introducing federal standards. State regulators naturally are closer to and more in touch with the individual needs and preferences of consumers in their state than is the federal government, which will help to avoid some of the unintended consumer backlash against the restrictive one-size-fits-all nature of federally regulated nursing homes. Our state affiliates work continuously with their state regulatory agencies to improve state regulation of assisted living.

- **States are actively revising regulations and are on the right track for quality assurance.** The regulations in many states are thorough and complete, and provide an excellent regulatory framework to ensure quality of care and quality of life for our nation's elderly. The year 2000 saw more assisted living legislation and regulatory change than virtually any other area in the continuum of care. In fact, the National Conference on State Legislatures reports that 450 assisted living bills were considered in the past year or so. This year, about half of the states are in the process of revising their regulations

- **State assisted living regulations have many similarities** in the areas they address such as admission and retention criteria, allowed services, and medication assistance/administration. While there are degrees of variation, this variation allows for innovation and experimentation without compromising quality.

- **Regulation of assisted living has not been achieved in a haphazard way, but by the thoughtful, professional, and diligent work of state regulators that has also included direct input by consumers in their states.** State regulators have invested countless hours in the development of the best assisted living regulations that meet the needs of the residents of their particular state.

- **It is important to keep in mind that where problems do occur, such incidents do not necessarily occur because a regulation was not in place, but because the regulation that was in place was not followed or enforced.** ALFA fully supports inspections by state licensing agencies and states having adequate resources to commit to them.

Licensed and unlicensed assisted living communities that accept Medicaid are subject to extra oversight:

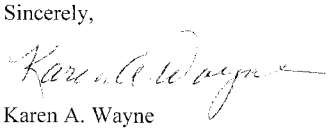
- **All states that reimburse assisted living care under a Medicaid Home and Community-Based Waiver (1915(c)) are required to provide specific assurances of consumer protection over and above their own state assisted living regulations.** The following are the standards required by the Health Care Financing Administration, as a condition of waiver approval:
  - The health and welfare of the waiver participants will be protected
  - Plans of care will be responsive to waiver participants needs
  - Only qualified providers serve waiver participants
  - The state will conduct level of care need determination consistent with the need for institutionalization
  - The state Medicaid agency will retain administrative authority over the waiver program
  - The state will provide financial accountability for the waiver

- **When applying for Medicaid renewal, states must prove to HCFA how they will meet the above standards and implement safeguards.** HCFA has determined that a reasonable measure of a state's ability to protect health and welfare is the presence of a quality assurance system. To that end, the *HCFA Protocol for Conducting Full Reviews of State Medicaid Home and Community-Based Services Waiver Programs* focuses on both the design and implementation of a state's quality assurance system. In that way, all assisted living communities that participate in the Medicaid waiver program, whether licensed or unlicensed, must adhere to this additional layer of government quality assurance oversight.

- **It is important to note that while participation in Medicaid has increased, fewer than 60,000 assisted living residents in 29 states participate in Medicaid.** Although 38 states have a Medicaid program for assisted living, ninety percent of assisted living residents are private pay and receive no public assistance whatsoever.

Again, thank you for inviting us to participate in this very important hearing. We look forward to working with you and will continue to keep you and members of the Senate Special Committee on Aging apprised of our progress on these and other quality initiatives over the months ahead.

Sincerely,



Karen A. Wayne
President/CEO