Housing with Services for Elderly Half-Dependent Couples

by

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Submitted to the Department of Urban Studies and Planning,
School of Architecture and Planning,
in partial fulfillment of the requirements for the degree of

Master in City Planning

at the

MASSACHUSETTS INSTITUTE OF TECHNOLOGY

September 2004

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TABLE OF CONTENTS

Abstract 5

Biographical Note 7

Acknowledgements 9

Introduction 13

Chapter 1. Elderly Half-Dependent Couples and Caregiving 19
   Elderly Half-Dependent Couples: A Definition 20
   Estimating the Current Number of Elderly Half-Dependent Couples in the U.S. 20
   The Effects of Caregiving on Elderly Caregivers 23
   Future Projections 27

Chapter 2. U.S. Policy, Caregiving, and the Need for a New Residential Model 33

Chapter 3. The Existing Continuum of Housing and Services for Elders 39
   Criteria Set #1: Housing and Service Needs of Elderly Half-Dependent Couples 39
   Criteria Set #2: Development Quality Assessment 43
   The Existing Elderly Housing Continuum 45
   Misguided Assumptions 63

Chapter 4. Innovative Solutions Offering Hope to Elderly Half-Dependent Couples 65
   Elderly Housing and Care Innovations 66

Chapter 5. A New Typology 93
   The Senior Life Home 94
   Next Steps 100

Conclusions 101
   Lessons Learned 101
   Final Thoughts 104
   A Day in the Life 106

References 109
Abstract

The existing elderly housing continuum makes little provision for couples that pose very different levels of independence and do not have sufficient wealth to purchase home care. As a result, Elderly Half-Dependent Couples (EHDCs) are coping through strategies which could be harmful to both members of these couples. A number of innovative typologies and programs offer hope to EHDCs for a better solution. By learning from these models, original typologies that seek to better meet the demands of EHDCs can be established; the Senior Life Home is one such possibility. This hypothetical prototype affordably provides a complete continuum of care for elders in one apartment style unit, and is a worthwhile venture for developers who will find it easy to site. In order to develop these homes, Medicaid and senior housing regulations would have to adapt, as would government funding of senior housing. Future efforts on behalf of Elderly Half-Dependent Couples should seek to continue identifying new innovative solutions to the unique housing and service dilemmas they pose.
Raymond John Hodges hails from Hancock, Michigan near the shores of Lake Superior. After graduating as valedictorian of his high school class in 1996, Ray attended the University of Michigan in Ann Arbor, Michigan where he graduated Suma Cum Laude with a Bachelor of Science in Psychology as a part of the class of 2000. After working in the field of regional planning research at the University of Michigan School of Natural Resources and Environment, Ray left Michigan for Cambridge Massachusetts and the Massachusetts Institute of Technology’s Department of Urban Studies and Planning in 2002. This thesis, completed in August of 2004, is the final requirement for Ray’s Master in City Planning degree from MIT.
ACKNOWLEDGMENTS

Special thanks goes to John de Monchaux and Lang Keyes for their guidance and assistance during their “vacation” months. Thank you, Todd and Tracy for your support and editing skills, and thanks Alex for keeping me company in the CRN.

A big thank you goes to Robert Jenkens for access to the Coming Home program and great information. Thanks also to Don Redfoot for help with caregiving data. Thanks to all of the managers, directors, and social workers of elderly housing typologies and programs who donated time in interviews.

Finally a very special thank you to all of the Elderly Half-Dependent Couples and their families who helped me think through this project, especially Carol Boulriss and Ann Anderson.
This thesis is dedicated to two of my grandparents, Robert and Ruth Hodges, and a number of members of my family who have done so many things over the last five years to help keep them smiling. This list includes my aunts, Ann Anderson and Carol Rossio; their husbands, Mark Anderson and John Rossio; and my parents, Robert and Christine Hodges.

July 5th, 2004
Medical advances have brought about life expectancy increases for all Americans, but Crimmins (2001) argues that these “improvements” may cause longer lives with lower quality of life. Her study points to the fact that these medical breakthroughs allow people to survive formerly lethal diseases only to experience other health problems such as Alzheimer’s, blindness, cognitive impairments, and arthritis. Crimmins highlights data showing increases in chronic diseases even while death rates drop. This is just one of many reasons that all groups of dependent elders, including those in Elderly Half-Dependent Couples can be expected to grow over the next two to three decades. However, it also suggests that if we are to continue striving to increase life expectancy, new innovations will be necessary in order to assure that these lengthened lives are lived happily.
Nearly three years ago, Ruth Hodges moved to a nursing home in Hancock, Michigan, ten miles away from her husband, Robert, who lives in Laurium, Michigan. The Hodges family’s decision to move Ruth was a difficult one; the couple had lived together since they were married in 1947, and no one was excited about the idea of Ruth having to live in a nursing home environment.

The move was necessitated by a series of strokes, the first of which Ruth suffered in June, 1999. While visiting her sister that summer in Milwaukee, Wisconsin, Ruth suffered a severe stroke, and over the past few years her condition has gradually worsened due to a series of smaller strokes which physically paralyzed much of her body, slowed her comprehension, and stripped her of the ability to speak. However, she is still quite alive and attentive, largely due to the fantastic care she has received from a group of un-hired family caregivers. These caregivers include her husband, Robert; their daughter, Carol Rossio, who moved to Laurium to care for Ruth and Robert shortly after her first stroke; another daughter, Ann Anderson, who took over for Carol and has lived at her parents’ home since late 1999; their son Bob, who lives in Hancock; and other loving family members.

Ruth spent one-and-one-half months at St. Luke’s Hospital in Milwaukee following her first stroke. There, she received intensive care until her condition stabilized and she was able to begin a rehabilitation program. When she was released from St. Luke’s, Ruth returned home to Laurium with her husband and their daughter, Carol who helped the couple adapt to their new lifestyle. After three weeks in Laurium, Carol returned home to make preparations for a longer stay, while her sister, Ann, and then brother, Robert Jr., stayed with their parents. After one month away, Carol returned to Laurium, and moved into her parents’ home where she and her father cared for Ruth with continued support from Robert Jr., and his wife, Christine. Carol’s husband continued working at his job 530 miles away in Charlotte, Michigan. After three-and-a-half months, Ann returned to Laurium and took over for her sister. Ann has remained in Laurium since December, 1999 with the blessing of her husband, Mark who stayed at their home in Rock Island, Illinois, 550 miles away, to continue his job. The support Ruth has received from
this team of committed family caregivers has been nothing short of phenomenal.

Since Ruth’s first stroke, her husband and children have attempted to provide the couple with the most amiable living arrangements they could fashion. Ruth’s transition back to Laurium from Milwaukee required that some changes be made to the Hodges’ home since it was not designed to accommodate a wheelchair-bound individual. The only bathroom with a shower was located on the second floor, and each bedroom in the three-story home was located on the second or third floor, so a first-floor living room and dining room were converted into a bedroom and living area for Ruth complete with a rented hospital bed.

During the first half of 2000, Ruth suffered two or three smaller strokes requiring short stays at the local hospital, Keweenaw Memorial Medical Center (KMMC). In October of the same year, she fell and sustained an uncontrolled bleed that forced her to stay at the hospital for treatment. On her third day there, Ruth suffered another stroke, a common occurrence following a fall. After three more days at KMMC, Ann transported her mother to Marquette General Hospital, a two hour drive from Laurium, for nearly four weeks of intensive therapy, before returning home.

During October of the following year, Ruth suffered a major stroke which paralyzed her right side. Ruth returned to KMMC and then went to the Houghton County Medical Care Facility, a nursing home in Hancock, to begin a short-term stay at the facility for another round of rehabilitation. However, Robert and Ann were very unsatisfied with the institutional nature of this facility, its low staff to patient ratios, and the care provided there.

Further complicating matters, Robert and Ann knew at that point that it would be difficult to care for Ruth at home in Laurium, so they put her name on the nursing home bed waiting list for their area. The Hodges felt that one nearby nursing home, Cypress Manor, was overwhelmingly the best option for Ruth as it was known for providing quality care; it was quite clean, fresh-smelling, and relatively pleasant compared to other nursing homes in their area; and it was located in Hancock, ten miles from Robert’s home in Laurium. They waited three weeks before a bed became available at Cypress Manor. During this period, Ann instructed her father
never to answer the phone as other nursing homes would call, and turning them down would mean forfeiture of Medicare benefits. When calls did come from a facility located 45 miles from Laurium, Ann pretended to be a friend of the family with no idea of Robert's whereabouts. Over the past year, Ann had gotten to know two social workers through rehabilitation programs in which Ruth participated. These social workers and one of Ruth's doctors helped gain her admittance to Cypress Manor through connections at the facility and by lending their expertise with the necessary applications. In the end, Ruth attained a bed at Cypress Manor, because of Ann's skillful management of the process and help from people who knew the local nursing home system well. This clever maneuvering prevented Ann, her father, and others from having to travel 45 miles each way to visit Ruth.

While caring for Ruth following her strokes and enduring a series of moves and lifestyle changes, Robert and his children had to learn the ins and outs of a set of industries about which they previously knew little. Coordinating and finding information on residential options, medical care, rehabilitation services, and methods of financing these options, was an added challenge for the family during this difficult time period, especially in the earliest, most tumultuous stages.

Ruth's first two months at Cypress Manor were covered by Medicare. When the one hundred day Medicare entitlement ended, Robert began private pay at a monthly rate of $5000 for his wife's care at the facility. After eight months, his assets had been reduced enough for Ruth to gain Medicaid eligibility, and her stay at Cypress Manor was covered by Medicaid after that point. During this process, Robert hired a lawyer who helped him protect as much of his savings and possessions as was possible legally through safe harbor, but says he does not have much to his name any longer. Another lawyer handles Robert's financial and insurance paperwork because, he says, it is too complicated for him to deal with alone.

Robert and Ann traveled daily to visit Ruth at Cypress Manor, but they still had plans to bring her back home. During this stint at the facility (November, 2001 to September, 2002), Robert had a new addition built on to the rear of his home. As Ruth could only be moved using a wheelchair at this point, the addition included a large, handicapped accessible bathroom with
roll-in shower, and even more importantly, an accessible entrance with a long ramp stretching to the front of the house. Robert also purchased an assortment of medical equipment necessary to help Ruth live at home. With Ruth in relatively stable health and the addition in place, she returned home to Laurium with Robert and Ann. Unfortunately, only six weeks after returning home, Ruth suffered another major stroke which paralyzed much of her left side forcing her to enter the Keweenaw Memorial Medical Center intensive care unit for 9 days to recover. Following this stroke, Robert and Ann decided they could not care for Ruth at home without expensive 24 hour assistance, largely because of the need to move her regularly during the night, in addition to the problems bathing, toileting, and changing presented with her decreased muscle function. After her condition stabilized at the hospital, Ruth returned to Cypress Manor in October of 2002, this time waiting only 5 days for a bed to open. She has lived there since.

As far as nursing homes go, Cypress Manor is relatively pleasant. The facility employs a full time social worker, dietician, and activities director. Staff members are friendly. Rooms are comfortable, very clean, and all located at ground level. Daily activities are planned for residents; three meals are provided each day; and many types and levels of rehabilitative services are either present on site or can visit residents as needed. The facility offers every resident restorative therapy, a program for maintaining muscle flexibility and mobility, at no additional charge, as it is considered a nursing service rather than a therapeutic program. Ruth also participated in speech and occupational therapy, to stop, or at least slow the loss of these capacities, but these services have since been discontinued due to lack of improvement.

With only 30 rooms holding 60 residents, Cypress manor is small in comparison to the average nursing home, but it is still an institutional environment. The rooms are located along two long corridors. Two unrelated individuals are separated by a curtain in each room and share a bathroom with another room of two elders. Unexciting meals are served on cafeteria trays to most residents in a large, lavender, linoleum-floored dining hall. Few outsiders who do not personally know a resident enter the facility, and only some occupants receive regular visitors.

In this environment, Ann and Robert have become favorites of many Cypress Manor
residents as they spend more time there than some staff members. Aides comment that Ruth receives far and away the most support of any resident at the facility as Ann and Robert travel daily from Laurium to feed, move, bathe, and dress her (all tasks aides would otherwise do for residents), as well as to read to her, speak to her, listen to music with her, and otherwise entertain her with the help of Ruth’s son, Robert, his wife, Christine, and others who visit regularly or occasionally. No other resident receives as much personal time with visitors as Ruth.

Though they do the best they can to “grin and bear it,” the toll this situation takes on the Hodges family is immeasurable. Both Ann and Carol have spent considerable amounts of time away from their immediate families and homes while living in Laurium to help care for their mother. Though Robert Jr. and Christine have not had to alter their living arrangements, they have also spent countless hours at Cypress Manor with Ruth. However, this situation has been most difficult for Ruth’s husband, Robert who says the toughest thing for him to do is leave her at the nursing home at the end of the day. Not surprisingly, after living together for 55 years, being physically separated from his wife has been extremely difficult for Robert.

While Cypress Manor is fair as far as nursing homes go, it is not a place Robert or Ann would ever choose to spend their days, and even if they wanted to do so, neither requires skilled nursing care, a prerequisite for admittance. As a result, this difference in health status causes a housing mismatch which forces Ruth and Robert to live miles apart from each other. Were a housing and service model available that allowed Robert and Ruth to live together in an affordable, yet dignified residential environment appealing to a relatively healthy elder, but capable of providing the medical care necessary to support a care-dependent individual, this difficult, inconvenient situation would not have to continue.
ELDERLY HALF-DEPENDENT COUPLES AND CAREGIVING

The case of Robert and Ruth Hodges is one example of the difficult situation faced by Elderly Half-Dependent Couples (EHDCs) as they search for a living situation that provides comfortable housing and medical services fitting the needs of both individuals. The underlying problem for Elderly Half-Dependent Couples is the very different health conditions presented by the two individuals. This thesis contends that no combination of housing and services available in the United States currently meets the needs posed by both members of an Elderly Half-Dependent Couple. The first three chapters explore this premise in depth. The final two chapters examine some innovative solutions to the problems posed by the mainstream housing and service models available to Elderly Half-Dependent Couples today.

The information found in this study is intended for developers of elderly housing, service providers, and U.S. policy makers who oversee the system described here. It is also intended for Elderly Half-Dependent Couples and their families and friends. They should know that many people are unsatisfied with what they are experiencing on a day-to-day basis.

Much of the new data presented in this report comes from a series of interviews and should not be construed as rigorously gathered data. That said, I think the data suggests that there are a number of shortcomings inherent in the existing system of elderly housing and services that have strong negative impacts upon the lives of EHDCs. Future research in this realm should seek to make use of a more systematic methodology through which to examine this
Elderly Half Dependent Couples: A Definition

For the purposes of this study, EHDCs are defined by the following characteristics:

- Two people, self-defined as a “couple,” married or unmarried.
- The couple either lives together or did so until the health status of one member required the couple to live in separate locations.
- Both members of the couple are elderly. For this study, the exact age at which a person is considered elderly is not important, but 65 years can be used as an approximation.
- One member of the couple experiences functional limitations necessitating assistance with at least one activity of daily living (ADL) or instrumental activity of daily living (IADL) (explained below). This need for assistance can be brought about by a stroke, Parkinson’s disease, cancer, Alzheimer’s disease, a brain injury, muscular dystrophy, AIDS, or any number of other health problems.
- The health of the dependent member of the couple is not expected to improve to the point at which he or she can regain independence.
- The other member of the couple is relatively healthy and independent and either does not require help with any ADLs and IADLs or requires assistance with fewer than his or her less healthy partner.

Estimating the Current Number of Elderly Half Dependent Couples in the U.S.

Difficulties performing personal care tasks and home management tasks are often referred to as “functional limitations” which measure elders’ ability to live independently or to determine the level of support an individual requires. The most commonly used physical personal care tasks for assessing an elder’s ability to live independently are Activities of Daily Living (ADLs). This list includes tasks such as bathing, changing, toileting, eating, dressing, and rising from a seated or lying position. However, ADLs do not cover all of the disabilities
that could cause an elder to require care. Another oft-used list of activities is meant to measure individuals' cognitive abilities. These more complicated tasks are called Instrumental Activities of Daily Living (IADL's). Controlling one's personal finances, preparing meals, completing house chores, taking medications, and traveling to and from the home (especially to shop or visit a doctor's office), are often listed as IADLs. These two sets of daily activities are used as criteria by which to judge an individual's level of independence.

Though these measures are widely used, estimates of the dependent elderly population vary depending upon the amount and types of ADLs and IADLs used to assess dependency (Hobbs & Damon, 1996). Wiener, et al. (1990), reviewed a collection of national surveys carried out during the 1980s and estimated that between five and eight percent of non-institutionalized elders (those elders not living in nursing homes) were functionally dependent. Their list of activities to which elder functioning was compared included five ADLs: bathing, dressing, rising from beds and chairs, toileting, and eating. Hing and Bloom (1990) used a much more extensive list of seven ADLs plus seven IADLs, and also included functionally dependent nursing home residents in their analysis of data from the mid 1980s. Using this definition of dependency, Hing and Bloom estimated that 6.7 million elders were functionally dependent and living outside of nursing homes in the mid 1980s. They further determined there to be an additional 1.3 million dependent elders living in nursing homes for a total of 8.0 million functionally dependent elders.

Using data from the 1990 and 1991 Survey of Investment and Program Participation, and based on a different list of ADLs, McNeil (1993) determined that 4.5 million non-institutionalized American elders were functionally dependent. Though his analysis uses only ADLs, McNeil's data derives results between those of the Wiener, et al. meta-analysis and the Hing and Bloom findings. McNeil also gives a detailed breakdown of the percentage of dependent elders by age (Figure 1). This newest, and most detailed data can be used to estimate the number of dependent elders living in the United States today by multiplying the percentages of dependent elders by the number of elders in each age group in the 2000 U.S. Census.
Figure 1-1. Percent of Persons Needing Assistance with Everyday Activities by Age: 1991

(Civilian noninstitutional population)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Dependent Percentage, 1991</th>
<th>Age Group Population, 2000</th>
<th>2000 Estimate of Dependency by Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 - 69</td>
<td>9.2%</td>
<td>9,533,545</td>
<td>877,000</td>
</tr>
<tr>
<td>70 - 74</td>
<td>11.0%</td>
<td>8,857,441</td>
<td>974,000</td>
</tr>
<tr>
<td>75 - 79</td>
<td>19.5%</td>
<td>7,415,813</td>
<td>1,446,000</td>
</tr>
<tr>
<td>80 - 84</td>
<td>31.2%</td>
<td>4,945,367</td>
<td>1,543,000</td>
</tr>
<tr>
<td>85 +</td>
<td>49.5%</td>
<td>4,239,587</td>
<td>2,099,000</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>34,991,753</td>
<td>6,939,000</td>
</tr>
</tbody>
</table>

Sources: U.S. Census Bureau, Summary File 1, 2000; U.S. Census Bureau, 1990 and 1991 panels of the Survey of Income Program Participation files

Using the percentages in Figure 1, estimates for 2000 show 6,939,000 dependent elders living outside of nursing homes (Figure 2). This translates to 19.8% of United States residents 65 years of age or older living outside of nursing homes.

Figure 1-2. Calculation of Functionally Dependent Elders in the United States, 2000

In the year 2000, 55% of the non-institutionalized U.S. population aged 65 or more
lived with a spouse (Administration on Aging, 2002). Using this data, the number of the nearly seven million elders requiring assistance with ADLs who live with a spouse can be estimated by multiplying 6,939,000 by 55%. This calculation gives 3,820,000 elders with spouses requiring care. It is important to treat the result of these calculations as an estimate because it assumes that married and unmarried elderly couples are evenly distributed across both couples that include one partner bearing an ADL deficiency, and those that do not present a member in this situation. Furthermore, the percentage of elders requiring assistance with ADLs would not hold perfectly constant between 1991 and 1999 when Census 2000 data was collected. However, this number is a starting point.

To make it more accurate, two additional adjustments must be made to the calculation. First, this number does not include EHDCs split between nursing homes and non-institutional living places. Year 2000 estimates show 1,560,000 nursing home residents at or over the age of 65 (U.S. Census Bureau, 2000). A random survey of nursing homes found that very few of their residents have a spouse or partner living off-site. This number is almost always less than 10% of residents (Interviews, 6-2004). Thus it is unlikely that more than 150,000 individuals at 65 years of age or older live in nursing homes and have a partner living elsewhere. Second, the calculation includes only spouses, not unmarried heterosexual couples or same-sex couples. However, non-institutionalized elders sharing their living space with persons who are not family members or spouses make up less than 2.5% of all elders that do not live alone (U.S. Census Bureau, 2000). Furthermore, because this group includes elders in living situations other than only unmarried couple settings, the number of elders in this living situation must be quite small. Given this information, the number of Elderly Half-Dependent Couples in the United States is probably in the neighborhood of four million.

The Effects of Caregiving on Elderly Caregivers

A number of studies of caregiving in the United States have been published in the last few years detailing the prevalence and importance of unpaid informal family caregiving. For
instance, the most recent studies estimate that there are approximately 22.4 million family caregivers providing care to older family members nationwide today (NAC & AARP); roughly four million of these caregivers, this investigation estimates, are healthy members of EHDCs. Comparing these numbers to the current amount of nursing home residents in the United States reveals that family caregivers, not nursing homes or hired home care nurses, are carrying the major load in providing for America’s elders today. Even more remarkable is the fact that this caregiving saves the United States government (Center for Medicare and Medicaid Services) an estimated $257 billion annually (NAC & AARP). This is because a sizeable portion of the 22.4 million U.S. caregivers provide assistance to someone who would otherwise utilize Medicare and Medicaid to fund their residence at a nursing home.

The Department of Health and Human Services New Freedom Initiative Caregiver Support Workgroup defines “informal caregivers” or “family caregivers” as

...unpaid individuals such as family members, friends, neighbors and volunteers who provide help or arrange for help. These individuals can be primary or secondary caregivers, full time or part time, and can live with the person being cared for or live separately. They provide help with household chores, finances, or with personal or medical needs. This definition does not include formal caregivers who are paid care providers associated with a service system (HHS New Freedom Initiative Caregiver Support Workgroup, 2003).

In the case of EHDCs, the caregiver, or one of multiple caregivers, is the dependent individual’s partner.

However, some recent studies have begun to examine the effects of caregiving on older care providers. Earlier this spring, the National Alliance for Caregiving (NAC) and AARP (formerly the American Association of Retired Persons) published a report detailing the situation faced by caregivers in the United States (2004). While the report did not specifically highlight the needs of Elderly Half-Dependent Couples as they are defined in this project, it presented a number of telling statistics that shed light on the characteristics of this group, including the following:

- Caregivers who provide more than 40 hours of care per week tend to be:
  - 65 years of age or older
- In fair or poor health
- Earning lower incomes than other caregivers

Providing long hours of care is correlated with poor health, and older caregivers are likely to provide long hours of care for their dependent recipients. Caregivers providing 40+ hours of assistance per week also tend to earn lower incomes than other caregivers.

- Caregivers who do not live with their care recipients but visit more than weekly are likely to be:
  - Level 4 and 5 caregivers (caregivers with the highest levels of perceived burden)
  - In fair or poor health

Making frequent trips to provide care to a recipient living outside of the caregiver’s home correlates with high perceived burden and poor health. Thus, the caregiving members of EHDCs that are forced to live in separate locations because of vastly different medical service needs are likely to feel highly burdened and unhealthy. Tornatore and Grant (2002) found that caregivers who were older perceived more burden after institutionalizing their care recipient (placing him or her in a nursing home) and still providing care.

- Caregivers who report their health to be fair or poor are more likely to be:
  - 50+ years of age
  - Lower income earners
  - Level 5 caregivers (highest perceived burden)
  - Primary caregivers

These are all likely characteristics of the care-providing member of Elderly Half-Dependent Couples, suggesting that being an EHDC could correlate with poor health as well as any or all of these characteristics. Whitlach, et al. (2001), also found that the best predictor of depression among caregivers is age.

- Given the amount of time caregiving can demand, it is not surprising that it impacts the ability of caregivers to hold jobs.
- 57 percent of working caregivers say they have gone to their jobs late, left early, or taken time off in order to carry out caregiving responsibilities.
- An additional 10 percent have shifted to part-time work.
- Another 15 percent left the workforce or turned down promotions (Robertson, 2004).

This report discusses the hardships of “elderly” caregivers who naturally are less likely than younger caregivers to desire employment. However, 21.1% (9,668,604) of Americans over the age of 60 are members of the workforce (U.S. Census, 2000).

Though such a hypothesis has not been tested, it could even be that the high costs of 24 hour care at home or in a skilled nursing facility would drive some healthy members of EHDCs to seek some form of paid work if they had time to do so. Holding even a part-time job could be an attractive option to some of these healthier partners, both to help offset some of the high costs of housing and services, but also as an activity to free their thoughts from caregiving for a few hours.

- Time devoted to caregiving forces caregivers to cut back time spent with other family members and on leisure activities.
  - 51% of caregivers have less time for family and friends.
  - 44% give up vacations, hobbies, social activities.
  - 26% get less exercise than they did before.

These data demonstrate no specification for elderly caregivers. However, they do show that at any age, caregivers are forced to give up time with family and friends as well as reduce time spent exercising and on leisure activities in order to complete their caregiving agendas.

- The following three groups of caregivers spend significantly more money each month on caregiving than others:
  7. Caregivers 65+ years old
  8. Level 5 caregivers
9. Primary caregivers

These are *all* characteristics that caregiving members EHDCs are likely to present, suggesting they spend more money on caregiving.

Six characteristics seem to show up next to each other repeatedly, suggesting some level of correlation between these traits. This list of traits includes the following:

1. Elderly
2. Poor Health
3. Overworked or Overburdened (Level 4 and 5 caregivers)
4. Earners of low incomes
5. Lack of time for work
6. Lack of time for family, friends, and play.

This set of characteristics does not present a particularly positive view of the conditions faced by caregiving member of EHDCs. It suggests that elderly caregivers, caregiving members of EHDCs included, are more likely to display each of the above traits than is the average caregiver. Furthermore, this picture assumes the healthier members of EHDCs remain healthy and can continue caring for their partners indefinitely. Of course, this will be the case for very few EHDCs; most of the healthier partners will one day also become care dependent to some degree.

**Future Projections**

The importance of the above data is underscored by two important trends detailed in an insightful report by Redfoot and Pandya (2002). First, many caregivers are opting to forego placing loved ones in nursing homes in favor of taking on the responsibility of caregiving themselves. Second, the population of Elderly Half-Dependent Couples will grow rapidly over the next three decades due to aging of the baby boomer population and increases in life expectancy rates, especially for males.

As was already mentioned, the lion's share of care provided to dependent individuals comes from informal family caregivers, not nursing homes. In the earlier rough calculation of the
current number of EHDCs, the number of elderly individuals receiving care in nursing homes who had partners living elsewhere was estimated at less than 150,000. This number is miniscule compared to the estimated 3.82 million dependent elders who live with a spouse.

What is even more important for future considerations of EHDCs, is the fact that nursing home utilization is dropping at a high rate, especially within the oldest age groups of elders – those who are most likely to present dependency problems. Figure 3 illustrates the decrease in nursing home utilization rates for elders age 65 or more between 1973 and 1999. Figure 4 highlights the difference between actual utilization and what utilization would have looked like if 1973 rates had continued through 1999. Given the higher rates of health maladies and other problems that elderly, level 4 and 5 caregivers present, the fact that fewer elders are entering nursing homes cannot be ignored.

*Figure 1-3. Nursing Home Utilization Rates Per Thousand Elderly Population, 1973-1999*

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<tbody>
<tr>
<td>Ages 65-74</td>
<td>12.3</td>
<td>14.4</td>
<td>12.5</td>
<td>10.2</td>
<td>10.8</td>
<td>10.8</td>
<td>-12.2%</td>
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<td>Ages 75-84</td>
<td>57.7</td>
<td>64.0</td>
<td>57.7</td>
<td>46.1</td>
<td>45.5</td>
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<td>-25.5%</td>
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<tr>
<td>Age 85+</td>
<td>257.3</td>
<td>225.9</td>
<td>220.3</td>
<td>200.8</td>
<td>192.0</td>
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<td>-29.1%</td>
</tr>
</tbody>
</table>

Redfoot and Pandya also discuss the rate at which elderly cohorts will grow as the baby boomer population begins to enter the 65 and over age group. During the next decade, the oldest members of this group will begin turning 65, with the major growth in the 65+ age category coming between 2020 and 2030. Prior to that time, most growth in the elderly population will be within the 65-74 year old cohort (see Figure 1-5). From this data, it is evident that the number of EHDCs can be expected to grow rapidly over the next two or three decades, but this trend will not really take off until after 2010.
The continually increasing of life expectancy rates of U.S. residents is another reason to expect the number of EHDCs to rise in the future. As was mentioned earlier in this chapter, medical advances are allowing people to live longer than ever before, but these longer lives might be of a lower quality. Crimmins attributes this possibility to the fact that allowing people to live with chronic diseases increases the number of disabled, care-dependent elders.

Lakdawalla and Philipson (2002) discuss a final, and very interesting reason to expect the number of EHDCs to grow in the near future. They argue that to associate expected increases in the elderly population with increased nursing home usage, is to ignore an important secondary effect of declining disability rates.

...disability reduction has not only a direct negative effect on nursing home demand, but also an indirect supply effect, because it expands the supply of nonmarket (informal) care by other elderly people (p. 297).

They argue that because more elders will not require nursing home care, besides not living in the facilities, they will be able to provide care for other family members of the same age, especially
partners. In this way, health care advances can be expected to increase the amount of partner caregiving and the amount of EHDCs that will live together rather than being split between a nursing home and the couple's home.

During the 1960s and 1970s, the number of women age 75 or older grew at twice the rate of men of the same age, resulting in large numbers of widows with no partner to care for them. As a result, many of these women entered nursing homes as they aged. However, during the 1980s and 1990s, the life expectancy of males increased much more rapidly than that of females (See Figure 1-6). During this same time period, nursing home utilization rates declined despite an increase in the number of people in these elderly age groups. Lakdawalla and Philipson (p. 297) showed that “a ten percentage point increase in the ratio of men per woman appears to reduce the per capita stock of nursing home residents by as much as 16 percent.” They argue that the increased life expectancy of males and resultant decrease in widowed females caused more informal partner caregiving to take place, increasing the number of EHDCs living together.

**Figure 1-6. Ratio of Males to Females (Number of Males per 100 Females)**

<table>
<thead>
<tr>
<th>Ages</th>
<th>1990</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-54</td>
<td>95.6</td>
<td>96.4</td>
</tr>
<tr>
<td>55-64</td>
<td>89.4</td>
<td>92.2</td>
</tr>
<tr>
<td>65-74</td>
<td>78.1</td>
<td>82.3</td>
</tr>
<tr>
<td>75-84</td>
<td>59.9</td>
<td>65.2</td>
</tr>
<tr>
<td>85+</td>
<td>38.6</td>
<td>40.7</td>
</tr>
</tbody>
</table>

Sources: U.S. Census 1990, 2000

Each of these trends suggests that the number of EHDCs will increase significantly from the current estimate of approximately 4,000,000 over the next two or three decades. Given the problems faced by elderly caregivers presented earlier in this chapter, innovative ways to help these couples are needed.
Chapter 1 demonstrated that caregivers, especially related family caregivers, rather than nursing homes, bear the brunt of the caregiving load for dependent elders. However, it is also evident that caregiving is not always a healthy choice for caregivers, or for the loved ones to whom they provide care. Elderly Half-Dependent Couples are particularly prone to problems that can result from providing high levels of assistance to loved ones. Compared to the average U.S. caregiver, caregiving members of EHDCs are more likely to be depressed or unhealthy, feel overburdened, and give up time that was used for other activities in order to provide care to a family member. Given this problematic situation experienced by many caregivers and the persons for whom they care, it is not surprising that millions of public dollars are being used to examine their circumstances closely and find ways to improve upon them. It is however, surprising to find that nearly all energy focused upon improving the lives of caregivers concentrates on ways of improving their caregiving abilities or ways of supporting them at their caregiving work, rather than attempting to rid at-risk caregivers of the need to provide care at extreme, unhealthy levels.

Consider for instance, that in 2001, Congress entrusted the U.S. Department of Health and Human Services Administration on Aging with discretionary funds to support competitive grants meant to “foster the development and testing of new approaches to sustaining the efforts..."
of families and other informal caregivers of older individuals,” (Administration on Aging, 2003, p.3). The word, “sustaining” suggests that these programs are not seeking ways to prevent caregivers from entering adverse caregiving situations, but instead, they are attempting to make it possible for people to persevere at their caregiving jobs. The Administration on Aging (AoA) recently published a list of 39 of top programs, none of which investigated new alternatives in housing and services that could relieve caregiving members of EHDCs from the need to care for loved ones (AoA, 2003a).

The AoA is the United States Federal Government agency devoted to dealing with the problems of aging, caregivers, services, and housing for elders. One of the agency’s goals is to prevent elders from having to move to nursing homes – a worthwhile ambition. However, the AoA “Housing” webpage offers information only on existing housing typologies, all of which prove inadequate for supporting the needs of care dependent elders, especially EHDCs. Support for this statement will be explored in depth in chapters 3 and 4.

The New Freedom Initiative, President George W. Bush’s plan to reduce barriers of all types that hinder disabled Americans, recently established the New Freedom Initiative Caregiver Support Workgroup – a council with similar objectives to those of the AoA. One of their publications from 2003 highlights 46 government-funded programs working to support and train family caregivers (New Freedom Initiative Caregiver Support Workgroup, 2003). Aside from funding a small number of programs investigating uses for Medicaid vouchers, the New Freedom Initiative has funded no initiatives seeking to create new and better ways of dealing with the need for caregiving (The White House website, 2004).

One reason for this could be the choice of government agencies examining the problems faced by caregivers. For instance, the New Freedom Initiative Caregiver Support Workgroup is made up of the following agencies, none of which specialize in housing:

- Administration on Aging
- Administration for Developmental Disabilities
- Agency for Healthcare Research and Quality
This group of agencies is much more qualified to deal with issues of caregiving support and training than they are to deal with new housing models that could be paired with support services. However, as was mentioned, supporting caregivers might not be the best direction for research hoping to improve their lives. To illustrate this point, three examples of demonstration projects listed in AoA’s *Promising Practices* publication are presented below.

**Caregivers in Crisis/Caregiver Assistance Network (CAN)**

This is a special program meant to support caregivers in crisis situations so that they are able to continuing caregiving. Consider the following statement from AoA’s summary of the CAN program:

> CAN is a special program now available to caregivers in crisis. The demands of caregiving become so great that the caregiver needs a break before they break. The Alliance for Aging now has a Family Caregiver Support Specialist who can arrange for services to assist and support these caregivers who are in a heightened state of need (p.8).

It seems that perhaps caregivers in such dire straights would be better served by being relieved of caregiving duties, or given the opportunity to provide the amount of caregiving they wish to provide to their loved one. This program suggests that a solution for caregivers in “crisis” situations is to give them a “break” so that they can recharge and return to caregiving under the same conditions that drove them into a crisis situation once already.

**The National Family Caregiver Support Program**
This initiative which by itself is funded at $155.2 million, offers a range of supportive services to caregivers including the following:

- Information about services available to help in caring for a dependent family member, and assistance in gaining access to them
- Counseling, organization of support groups, and training to help caregivers make decisions about caregiving, and solve problems that arise from carrying out this function
- Respite care to allow caregivers to escape from their caregiving roles for a matter of time
- Limited supplemental services to complement the care given by family caregivers

These are services that can help caregivers stay the course through a difficult caregiving situation.

**The Care Team Model**

This program offers services such as caregiver training, respite, and resource counseling to caregivers in order to allow them some reprieve from caregiving and to educate them about caregiving. A team of 2-3 individuals is paired with a caregiver and provides respite when needed, runs errands for a caregiver, helps with coordinating and navigating the systems of care services available, all with hopes of allowing the desperate caregiver to continue providing care.

Considering the adverse conditions faced by many caregivers today in the U.S., the wisdom of devoting so many resources to supporting caregivers through programs like these three is questionable. An alternative way to approach this problem would be attempting to create new and better forms of housing and care that could truly improve caregivers' quality of life by freeing them from the need to continue caregiving at unhealthy levels. This is not to say that caregiver support programs are unimportant or not useful, but rather they should not be the only approach taken to improving the lives of caregivers. This thesis seeks to examine possibilities for new housing and service models that could better support the needs of one specific set of caregivers and care-receivers – Elderly Half-Dependent Couples.

A number of possible explanations exist as to why caregiving is so accepted in U.S. policy today. First, caregiving saves the U.S. government $257 billion each year by preventing care-dependent elders from seeking beds at nursing homes and paying for this service with Medicaid
funds (AoA, 2003b). Another possibility is that policy makers have not realized that supporting caregivers may only prolong a very painful situation for some caregivers who are forced to provide more care than they are able to provide in healthy fashion. Evidence for this possibility lies in the fact that the government department dealing with elderly caregiving (Health and Human Services) has little to do with housing and associated programmatic innovations. Rather than assigning a department like Housing and Urban Development to create a new typology that could better serve the needs of caregivers, HHS is instead examining medical and social support programs, which is its business. Finally, it could be that officials have realized that the existing housing options created to house and care for elderly dependent individuals have thus far failed on many accounts to adequately deal with this population (especially those dependent individuals with low incomes, as we will see in the next chapter). In the meantime, perhaps they have chosen to place funding in research that can allow caregivers to hold out until help arrives in the form of a new and better typology that can meet the needs of care dependent individuals and their caregivers.

Some truth probably exists to each of these suggestions, but I am concerned about the need for a new solution, and the fact that this need for a typology that can truly improve the lives of dependent elderly individuals and their families, has received little attention from the U.S. government. Because much can be learned from existing models of elderly housing and care, this thesis examines the existing continuum of elderly housing and care in the U.S. in Chapter 3, then goes on in Chapter 4 to examine three promising typological innovations from which other clever ideas can be garnered. Following this discussion of typological research, the positive points for EHDCs are sifted from each typology and a novel solution is posed by knitting them together.
Though specialists in the field of elderly housing and care assistance continually attempt to improve this system for the aged U.S. population, for various reasons to be discussed in this chapter, the existing options still do not effectively support the needs of Elderly Half-Dependent Couples. In order to examine the deficiencies of the currently available typologies, specific criteria must be put to use. First, a set of criteria must reflect the particular needs of EHDCs so that the existing elderly housing and service models can be evaluated in terms of this group’s unique situation. Thus, using the discussion of EHDCs’ unmet needs found in Chapter 1, a set of seven criteria was developed to examine how well each typology or program examined in this report deals with those issues. A second set of more general principles should help to judge whether or not the typology makes a good project for potential developers to undertake. An additional set of three criteria were developed in this vain from Porter, et al.’s 1995 writings for the Urban Land Institute on developing senior housing.

Criteria Set #1: Housing and Service Needs of Elderly Half-Dependent Couples

1. Care Assistance

   The definition of Elderly Half-Dependent Couples presented in the beginning of
Chapter 1 states that the dependent members of EHDCs require help with ADLs and/or IADLs. However, the chapter also shows that elderly caregivers tend to provide longer hours of care and be more physically distressed than the average (younger) caregivers. Because of these findings, any residential model aimed at providing housing for EHDCs should offer care assistance on site. This assistance should range from help with basic ADLs/IADLs to 24 hour nursing care in order to support the variety of service requirements that elderly individuals can present. Additionally, very few healthier members of the couples will remain completely independent until death. Models of care provided to EHDCs also must be prepared to provide for the future needs of the healthier members of these couples, and both members together as care-dependent individuals. Besides supporting the basic medical and personal needs of care-dependent individuals, this assistance could act as respite to healthy care-providing partners, allowing them to leave their dependent loved ones to pursue their own activities and interests as they wish.

2. Affordability

Chapter 1 data showcased the tight financial constraints experienced by large numbers of EHDCs. Prices for all elderly housing and care models, no matter how comprehensive the available care might be, are a common topic of complaint for elders. The speed with which these options can erase even a relatively wealthy couple’s lifetime savings is staggering. Today, the only elderly residential option covered by Medicaid is the nursing home, but access to Medicaid requires that a couple either qualify for low-income status or spend down their assets to the point at which they qualify. In order to meet the needs of all EHDCs, any new model aimed at housing these couples must either be covered by Medicaid or better yet, offer an innovative financing program that could improve the state of elderly housing and care finance.

3. Ability to Live Together

EHDCs presenting very different levels of medical need are often forced to live in different locations. Separating EHDCs because they require different levels of health care seems a peculiar way to deal with two people who already find themselves in a difficult situation. In order to provide a truly dignified housing and service option for Elderly Half-Dependent...
Couples, such a model must allow the couples to live together. That said, not all EHDCs want to live together (EHDC Interviews, 2004), so this should not be a requirement, but rather an option.

4. **Dignified Residential Environment**

Though they provide 24 hour nursing care and can be paid for using Medicaid, few people choose to live in skilled nursing facilities unless they are forced to do so because of an adverse health condition. Many healthy members of EHDCs state they would not choose to live with their dependent partners in nursing homes because they are perceived as unpleasant, institutional, medical facilities (EHDC Interviews, 2004). In order for a new housing and service typology to meet the needs of both members of EHDCs, its programmers and designers must note that healthy members of EHDCs often keep their dependent partners out of nursing homes because they do not feel they are comfortable, residential settings (discussed in this chapter). This means they must be offered a living environment comparable to that found in residents’ homes, independent living communities, or assisted living facilities, each of which are highly preferred to nursing homes as places to live (EHDC Interviews, 2004). One relevant issue is that both members of EHDCs need to have activities available that appeal to their abilities and interests. This could be as simple as having individuals in similar situations around to engage in conversation, rather than only dependent individuals (as in a nursing home) or only healthy individuals (as in an Independent Living Community). Independent living communities and nursing homes will both be examined in this chapter.

5. **Aging in Place**

This chapter will go on to show that a range of housing options are available to elders. Most differ by the level of services provided on site. However, fragmenting different levels of care across a number of typologies assumes that elders will smoothly transition from one typology to the next. Many exceptions to this assumption exist and will be discussed in the following pages. As a result, innovative housing and service models for EHDCs should strive to minimize the number of moves, and the distance of any necessary moves, that an EHDC must make.
6. **Dealing with Death**

One major challenge to the ideal of aging in place is the issue of what happens to an elderly couple when one member of the couple dies. Quite often the death of one member of an elderly couple forces the surviving individual to move out of the couple’s residence. A home or unit built for a family can be too large for one elderly person to maintain, and he or she may not require the same amount of space as the couple previously needed. The price of upkeep, heating/cooling, taxes, and other home costs can also be too high for the income of one person to meet.

A second phenomenon can also cause elderly widows and widowers to move. One member of a couple that may be quite independent and living at home might have to move to a setting with more support following the death of his or her partner. This is because the support provided by the living partner was enough to keep the person independent. This phenomenon is also observed at ALFs as elders requiring some level of personal care with a living partner often require more care from staff or sometimes even need to move to a nursing home following a partner’s death (Porter, et al., 1995).

7. **Organization and Ease of Access**

A 1992 study by AARP found that the majority of elders who moved from their homes to a new form of residence planned less than a year in advance for this move. This should not be surprising given that a stroke or unfortunate accident can cause medical and personal care dependency quickly and without warning.

As would be expected, when a new EHDC and their family members are dealing with the trauma of an unexpected health incident, they find it unduly difficult to navigate a set of systems with which they have no previous experience (EHDC Interviews, 2004). A new model of housing and service provision aimed at the meeting the needs of EHDCs should simplify the process of finding proper medical services, rehabilitation programs, other available services, information on the pros and cons of various residential models, and strategies for financing each of these options, by including them within their program (preferable), or offering unbiased
counseling concerning those topics with which they are not directly involved.

Criteria Set #2: Development Quality Assessment

1. Nimble Product

   In this document, the word “nimble” is meant to describe a housing typology that is easy to develop in many different types of settings. In other words, it is easy to find places to develop nimble housing projects. This is an important issue because, like any other group of people, elderly persons have preferences for certain locations. The great majority of seniors want to stay close to home. Over the years, seniors establish many friendships, choose favorite places to shop, relax, and participate in activities. The trauma experienced by an EHDC because of changing health status forces many modifications to daily patterns. Elderly Half-Dependent Couples relate that being able to find housing that successfully supports their needs within their existing surroundings would be a huge comfort. Many EHDCs fear having to move away from their acquaintances and familiar territory in order to support a dependent spouse properly (EHDC Interviews 2004).

   Another way to look at desirable locations for EHDC housing is in terms of proximity to amenities. Of course, the term “amenities” means different things to different individuals. In 1982, Carp and Carp asked older women what facilities and services were most important to have located within walking distance of their place of residence. The results of this study are shown in figure 4-1. Walking distance for elderly people is generally considered no more than one-quarter to one-third of a mile. Interestingly, the only facility that received a high score for locating within a block was a bus stop; most respondents wanted other services to be farther away, presumably because of noise and traffic concerns. Thus, while locating elderly housing near services is important, may also be advisable to keep from locating it next to busy services or having it front on busy streets (Porter, et al., 1995). Nimble projects will more easily find locations for development near these and other amenities.
Figure 3-1. Facilities and Services Desired by Elderly Women Living Alone

<table>
<thead>
<tr>
<th>Facility or Service</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bus Stop for Buses to Important Places</td>
<td>91%</td>
</tr>
<tr>
<td>Favorite Grocery Store</td>
<td>79%</td>
</tr>
<tr>
<td>Own Bank</td>
<td>68%</td>
</tr>
<tr>
<td>Favorite Library</td>
<td>67%</td>
</tr>
<tr>
<td>Own Place of Worship</td>
<td>65%</td>
</tr>
<tr>
<td>Seniors’ Center</td>
<td>65%</td>
</tr>
<tr>
<td>Favorite Drugstore</td>
<td>62%</td>
</tr>
<tr>
<td>Favorite Restaurant</td>
<td>56%</td>
</tr>
<tr>
<td>Nutrition Site for Seniors</td>
<td>55%</td>
</tr>
<tr>
<td>Another Drugstore</td>
<td>55%</td>
</tr>
<tr>
<td>Own Doctor</td>
<td>53%</td>
</tr>
<tr>
<td>Another Bus Stop</td>
<td>51%</td>
</tr>
<tr>
<td>Favorite Beauty Shop</td>
<td>51%</td>
</tr>
<tr>
<td>Fire Station</td>
<td>51%</td>
</tr>
</tbody>
</table>

Source: Carp & Carp, 1982

2. Contextual Fitness Capacity

A housing typology with high capacity for contextual fit can be easily adapted to myriad environments. Contextual fit is extremely important for gaining support from surrounding stakeholders and from city agencies that decide whether a development will be allowed to proceed. Unless they are out of scale in comparison with their surroundings, elderly housing projects are generally some of the more well-received proposals for multi-unit housing. This is because among other things, elderly neighbors are perceived as being quiet, clean, and unlikely to cause significant increases in local traffic (Porter, et al., 1995).

It is important that a housing typology fit into its context or it will stand out as something different. A second way to consider a housing type’s ability to fit with its context is to consider how easily it can be adapted to serve other uses should the market it intends to serve not fill to capacity as expected. Products that can be easily adapted to different uses are always preferred by loan underwriters to those built strictly with one use in mind.

3. Cost

Cost must always be taken into consideration when evaluating the development potential
of a housing project. However, like any other housing type, senior housing varies greatly in price depending on the location and the number and types of amenities it includes. Two particular cost measures will be discussed in as much depth as existing data allows. First, cost per resident gives a good baseline quantitative gauge of how expensive a project truly is. Cost per resident is different than the criterion of affordability already included as a particular need of EHDCs because an expensive project can be made affordable to residents through funding support. Second, a more qualitative way of looking at cost is to examine the cost effectiveness of a housing typology. This takes into account the success of the project according to different stakeholders and compares it to the cost (per resident, per square foot, etc).

The Existing Elderly Housing Continuum

The continuum of housing options available to the elderly in the U.S. is an oft-studied topic. Many different typologies ranging in both form and function have been created to help preserve or improve seniors’ quality of life. Today, elderly housing typologies offer many different amenities in order to attract residents, and a “sense of community” is stressed in many advertisements. Still, for years, this continuum has been defined by the level of personal and medical support provided by each piece of the continuum, with each successive step providing more assistance for an aging couple or individual (see Figure 4-1).

It is rare for an elder to use all four steps of the continuum as it exists. Rather, each stage seeks to meet the needs of elders at relatively specific levels of independence so that the needs of elders requiring any level of care will be met by one of the facility types. Residents are expected to move to the next step in the continuum when his or her care or medical needs become too great for staff, technology, and licenses at an elder’s current place of residence.

While in theory, this appears to be an excellent design, in practice, it is far less effective at meeting the needs of elders, especially Elderly Half-Dependent Couples. There are many reasons underlying this failure of the current U.S. elderly housing system that will be discussed in the rest of this chapter, but perhaps the biggest problem posed by the existing continuum is its
discontinuity. While together, these four typologies can meet the medical and care needs of most elders, they force elders to move from one setting to the next in order to access these different services. One result of this problem is that it is rare for an elder to use all four steps of the continuum, even if they do progress through each level of care and medical need. This issue, and a host of others are discussed in the remainder of Chapter 3.

Figure 3-2. The Existing Elderly Housing Continuum

Home and Home Care Services

The basic continuum, as it exists today for elderly persons, begins with a couple, still independent and relatively healthy, living at home. AARP periodically publishes studies that report living at home is far and away the most-preferred housing choice for seniors. In fact, 85% seems to be a magic number, as roughly this percentage of elders repeatedly testifies that they would prefer to “age in place” at home (Novelli, 2002).

This strong desire to remain at home prevents some EHDCs from accessing middle
stages of the existing housing continuum. Dependent members of these care-dependent “home holdouts” often move directly from their homes to nursing homes, skipping independent living communities and assisted living facilities altogether, after their healthier partners struggle to care for them until the burden becomes so great that the caregivers are forced to move their partners to nursing homes (CCRC Interviews, 2004). In these holdout cases, the move to a nursing home is made long after the dependent partner has qualified medically for nursing home care. In other words, the caregiver has been attempting to do the work that would otherwise be handled by nursing home staff. Given this evidence of elders’ strong desire to remain at home, it is easy to see why AoA devotes so many resources to supporting elders in place at home. However, there are many EHDCs (and other elders) for whom living at home is not a palatable option because the burden of caregiving becomes too much to handle alone or even with help from family and friends (chapter 1).

Functional limitations and medical problems can render a home uninhabitable or unsafe for some seniors. For many couples, their three, four, or five bedroom home was the location where they raised a family. When their children moved out, this large home suddenly became difficult to care for, expensive to maintain, and oversized for their needs. In an effort to remain at home, many EHDCs make alterations to their homes to accommodate dependent partners. 39% of all caregivers in the U.S. report having made changes to their homes such as adding wheelchair ramps, widening doorways, installing handicapped-accessible showers, and converting first floor rooms to bedroom space for wheelchair bound individuals (National Alliance for Caregiving & AARP, 2004).

Ahead in this chapter, we will see that each of the existing alternatives to aging in place at home has shortcomings in terms of providing for EHDCs. Thus, it could be argued that some elders would like to take advantage of a housing with care model but currently choose to remain at home because they do not consider any of the existing alternatives preferable to staying at home and providing care or hiring home assistance.
Criteria for Supporting Elderly Half-Dependent Couples

1. Care Assistance

Other than what can be provided by family and friends, no care services are provided at one’s own home. This lack of care support is what normally drives EHDCs to seek alternate forms of housing. One program that many elders use to prolong their time at home when care from a partner or other family and friends cannot by itself meet their needs, is home health services. Home health care provided by personal aides offers personal services like cooking, bathing, washing clothes, and other non-medical support. Medical needs can be covered by nursing staff who visit elders’ homes to dispense medicines; monitor, maintain, and change medical devices; and to complete other tasks that require medical training. These services can be bought from outside agencies which visit a dependent person’s home to provide the care. However, these home health care programs are quite expensive and thus, are not a long term option for all but the some of the most wealthy EHDCs (Coming Home Interviews, 2004). The affordability (or lack thereof) of home care services will be discussed in the coming pages of this section.

Even with home health services, there are some elders for whom the home is a very difficult or dangerous place to live. For instance, many elders with Alzheimer’s disease wander and can get into problematic situations this way. In order for someone in this condition to be safe, they must have 24 hour supervision which is impossible for a healthy elderly partner to provide at home without a lot of help and probably a night time personal aide.

2. Affordability

Assuming a couple already owns their home or pays a rental rate that they can afford, staying at home keeps housing costs manageable for EHDCs. This assumes the house is in good shape and does not require major repairs or maintenance work. This also assumes, however, that no home care is accessed from an outside agency. In other words, another person (like a healthier partner) must provide the care.

If hiring personal or medical care is necessary, the cost to an EHDC living at home
becomes much more significant since home health care generally costs around $20 per hour. For an EHDC with one member who requires constant supervision, $20 an hour becomes very expensive, very quickly. For instance, if this couple hired home care for 10 hours a day to stay with the dependent individual for eight hours each night, one hour of help with bathing, toileting, clothing, and medicines in the morning, plus one hour of help readying the person for bed at night, this would come out to $200 daily, or $1400 each week.

Many states are using Medicare and Medicaid waivers as a way to help elderly individuals pay for home care. This is a nice solution for helping low-income dependent elders remain at home, but given the difficulty the Centers for Medicare and Medicaid Services (CMS) already experience in making these programs work for American elders, making one-to-one home care a viable option for all elders seems nearly impossible at this time.

3. Ability to Live Together

Staying at home allows couples to continue living together.

4. Dignified Residential Environment

Afore-mentioned AARP studies show that 85% of Americans want to age at home, compelling proof that the home is considered the most dignified and desirable residential environment.

5. Aging in Place

The fact that no personal or medical support services are provided at home makes it difficult for dependent individuals to age in place in their homes. In the case of EHDCs, this means the more healthy partner provides care to their dependent partner. As was noted in Chapter 1, depending on the severity of the dependent individual's condition and the resulting time devoted to caregiving by the healthier partner, this situation can be inconvenient and even unhealthy for the caregiver.

As was mentioned above, hiring home care services can allow many couples to age in place at home even with severe disabilities, but there are some elders for whom even home care is not always the safest option. Additionally, home care is extremely expensive and the ability to
make such a service affordable to all elderly Americans is more than questionable.

6. Dealing with Death

Living at home allows no special flexibility in care services for a surviving widow or widower. In fact, it is probably at home that the least support exists for a senior in this situation. One could argue though, that being in one’s home – a comfortable and familiar place, is an important support for someone who has just suffered the loss of a partner.

7. Organization and Ease of Access

Living at home provides no additional ease of access to information and coordination of housing, services, and finance.

*Development Quality Assessment*

Because this discussion of homes assumes EHDCs’ existing homes are not newly developed, the three Development Quality Assessment criteria are not useful for examining this first stage of the existing elderly housing continuum.

*Independent Living Communities*

The second stage of the continuum is the Independent Living Community (ILC). While most elders say they wish to age in place at home, some do choose to move to new environments for a variety of reasons other than health problems. Furthermore, in a 2003 survey of 44-56 year old baby boomers carried out in 2003 by Del Webb, an ILC developer, 59% reported that they planned to move after retiring. ILCs are designed to attract this healthy group of boomers who will soon be empty-nesters, as well as healthy elders who wish to move from their large family homes to smaller units requiring less care and maintenance, typically in desirable climates, neighborhoods perceived as being safe and secure, or near children (Porter, et al., 1995). Leaving a large family home also allows many empty nesters to access their most significant source of long-term financial stability. ILC units are meant to be easier and cheaper to maintain than a larger home, while offering the comfort of living in a community of peers.

ILCs come in all shapes and sizes. Some are large, sprawling planned communities with detached homes rented or owned by seniors. Some of these collections even offer golf courses,
natural lands, and other outdoor amenities. Other ILCs are found in tall city center high rises offering apartment or condominium units.

Prices of ILC units vary widely depending upon the number and types of benefits and amenities they provide. These can include housekeeping, dining plans, transportation, a desirable location (waterfront, urban environment, countryside, etc.), proximity to attractions (beach, shopping, natural lands, family, public transit, etc.), athletic facilities (fitness center, golf course, pool, tennis courts, etc.), provisions for “community” gatherings (common spaces, fireplaces, meeting rooms, planned outings, etc.), and more. Many ILCs are owned or operated by public housing authorities or nonprofit organizations. These properties are meant to serve elders with little monetary resources.

Criteria for Supporting Elderly Half Dependent Couples

1. Care Assistance

No personal care assistance is provided to residents at Independent Living Communities. While ILCs can make seniors’ lives easier by relieving them of the need to complete some undesirable house chores, no personal care or medical provisions are built into ILC programs because they are designed for healthy elders. They are also not licensed by the appropriate state government agencies to provide personal care or skilled nursing medical care. This lack of licensure is the largest barrier to providing services on site in an ILC.

Home care services can be hired by residents and brought into ILCs to help dependent elders. Like the “home holdouts,” couples that become half-dependent while living in an ILC sometimes remain in the ILC if the healthy partner, family, or friends are willing and able to provide the necessary care, or if the couple can afford to bring in hired care assistance. Some ILCs however, do not allow dependent individuals to remain on site because of liability concerns and the threat of complaints from healthier residents who fear their community of independent elders “will become a nursing home” (CCRC Interviews, 2004).

2. Affordability

Many new ILCs are geared toward the wealthier population of elders who owned large
homes, often in the suburbs, and wish to downsize their place of residence so they can use their money to live in an exciting area with a variety of amenities (Porter, et al., 1995). Most charge an up front buy-in fee plus a monthly fee. Some ILCs are run on an ownership/condominium basis. At these facilities, the up front cost is much higher, with monthly fees covering only maintenance, meals, activities, and other continuous operating costs. Other ILCs collect money on a rental basis with monthly fees covering rent plus the ongoing costs.

A small number of Independent Living Communities accept section 8 vouchers, and the HUD 202 program has established a significant number of affordable independent elderly units in many cities. Public Housing Authorities and nonprofit developers also create affordable units specifically for elderly persons. However, private funds are most often used to cover the costs of living at an ILC. These costs, especially those paid upfront, limit the range of income levels, ethnicities, and household structures one would expect to find in ILCs (Homestore, 2004). Since no healthcare is provided in ILCs, Medicare and Medicaid do not cover payments. As was mentioned above, home health care services can be hired and brought into units at ILCs, but the price of hiring skilled nursing care added to the costs of living in an ILC would prevent this from being an option for all but the most wealthy EHDCs. Given the high health care costs paid by EHDCs, ILCs probably select against EHDCs through income filtering, in addition to the lack of care services they provide.

3. Ability to Live Together

Independent Living Communities do offer couples the opportunity to live together in their own condominium or apartment unit. Singles also purchase their own units. Only residents who request to share a unit with another resident do so.

4. Dignified Residential Environment

Because ILCs are meant to attract healthy elders who wish to downsize from larger homes, they must compete for residents with other forms of housing not specific to the elderly. In order to compete with condominiums, apartments, and smaller homes, ILCs are first and foremost designed to be residential communities, not locations where medical or even
personal care services are provided. ILCs go beyond simply providing places to live by adding amenities of particular interest to elders in order to attract their target audience. Because they are collections of units, ILCs also offer community camaraderie and support, putting elders in the presence of many other people of similar ages. ILCs provide a generally pleasant, dignified place of residence for elders.

5. Aging in Place

Since they do not offer personal or medical care services on site, it would be quite difficult for most EHDCs to age in place at an ILC without the healthy members of the couples providing a great deal of care to their partners. As was already mentioned, hired help can be brought in to ILC units, but at high costs to residents.

6. Dealing with Death

Besides offering a nearby set of elders who can help to console a senior who is suffering from the death of his or her partner, ILCs provide no means of increasing the support available to an elder who may require more care because of a partner’s death.

7. Organization and Ease of Access

Independent Living Communities offer only housing with some basic amenity services; no medical, rehabilitative, or personal care services are available. Thus, it would be up to a resident and his or her family to find these services and coordinate with their personnel about how to best serve a dependent ILC resident. ILCs can help residents set up payment plans for their units, but counseling about other services would likely not be widely available.

Development Quality Assessment

1. Nimble Product

ILCs usually take the form of either large multi-unit buildings or collections of smaller structures with fewer units in each. Both typologies require relatively large plots of land rendering ILCs a difficult project to develop through new construction in densely built areas. However, because they are little different in terms of design than any other apartment or condominium complex, ILCs can often be developed by retrofitting older residential buildings,
not to mention the abandoned factory, warehouse, and office buildings that are rapidly being converted to urban residences today.

In the same way, ILCs can easily be adapted for general residential use should the elderly market not effectively fill a structure.

2. Contextual Fitness Capacity

ILCs can fit within their surroundings somewhat well because they can be developed as either large multi-unit structures or collections of smaller home-like buildings. This second option is more expensive to construct, and is often used in less dense suburban locations.

3. Cost

Developing an ILC is no more expensive an undertaking than developing a typical apartment or condominium complex on the same property. Their cost effectiveness for residents is relatively neutral also. As opposed to assisted living facilities and nursing homes, ILCs provide no personal or medical care to residents, and their prices reflect this.

Assisted Living Facilities

The third stage of the continuum, the Assisted Living Facility (ALF), is the first in the array that offers personal care as an on-site option. ALFs strive to provide these services in a residential, non-institutional environment pleasing to healthy elders. For this reason, ALFs can appear to EHDCs to be an attractive alternative to nursing homes. However, the assistance offered at ALFs is non-medical rendering this typology unsupportive to the most medically-dependent elders.

Like ILCs, ALFs are generally expensive compared to similar nearby housing because they try to provide apartment-style units, but add personal care and other amenities. Most of these services are not covered by the buy-in cost or base monthly fees.

Criteria for Supporting Elderly Half Dependent Couples

1. Care Assistance

Assisted Living Facilities offer residents assistance with daily personal care needs in a setting that is meant to feel much more residential and less institutional than nursing homes.
They are not, however, licensed by state agencies to provide skilled nursing care. The support at these facilities is designed to provide assistance with activities of daily living (ADLs) such as bathing, eating, toileting, and transferring, as well as instrumental activities of daily living (IADLs) such as balancing finances, cooking, and housework, rather than attending to medical needs. Some ALFs offer the security of 24 hour assistance while others only staff personnel at certain hours. ALFs can effectively support the needs of EHDCs until one member of the couple requires medical support.

As might be expected, ALF staff note the existence of “holdouts” in their facilities. These people enjoy the residential feel of the facilities and the personal care they offer, but become increasingly more dependent upon caregivers while living at ALFs. For the healthy members of “holdout” couples, the caregiving can be burdensome enough to endanger their health (ALF Interviews, 2004).

2. Affordability

Most ALFs charge for personal care services by the amount and types of care provided to a resident. That is to say, an elderly resident who requires assistance toileting, showering, taking medications, and transferring to and from bed will pay more than a resident who only purchases assistance with food preparation. In addition to these costs, the price of residing at an Assisted Living Facility varies according to the amenities offered at a given location, with more amenities bringing higher costs. Also like Independent Living Communities, the base cost of living at Assisted Living Facilities is generally expensive – more expensive than comparable nearby condominiums or apartments; this is due to the provision of personal care as well as added amenities. Two recent industry estimates suggest that average monthly fees, which must cover both the unit rental cost as well as the provision of personal care, are approximately $2,000 (AARP,1999). While expensive, this is significantly less than the monthly costs of the average nursing home. This figure is also much lower than the amount that would be paid each month by the EHDC used an example earlier that hired 10 hours of home services daily at $20 an hour. For 30 days, this cost would reach $6000 per month. Because of the economies of scale that
can be reached in a congregate setting, an ALF can provide 24 hour supervision to residents at a fraction of home care costs.

A small number of insurance policies cover the costs of residing at an ALF, but the vast majority of ALF residents pay out of pocket (Homestore, 2004). As is the case for ILCs, Medicaid and Medicare cannot be used to cover costs at most ALFs because medical support is not provided by ALF staff. However, some states are experimenting with Medicaid waiver programs which would allow Medicaid payments to cover the costs of services needed by a resident at an ALF. Some states are also trying to develop assisted living projects that are completely affordable. These innovative programs are discussed in the next chapter. Aside from these new programs, like ILCs, assisted living facilities are largely affordable to only wealthy Elderly Half-Dependent Couples.

3. Ability to Live Together

Like ILCs, ALFs offer residents their own private apartment-style units. Units are designed to comfortably house both couples and singles.

4. Dignified Residential Environment

The ALF design is special because it was the first housing model designed for elders that was meant to feel completely residential (unlike a nursing home), but provided some level of assistance to residents who needed it (unlike independent living communities). In terms of residential comfort, they are designed to be at a par with ILCs. ALF designers usually call for full size units striving to provide the look and feel of condominiums or smaller homes. Because Medicare and Medicaid cannot generally be used to cover the expensive costs of living at an ALF, they seek to attract wealthier elders who, unlike those sought by ILCs, require some assistance with ADLs and IADLs.

5. Aging in Place

Assisted Living Facilities offer more care options for aging in place than does living at home or in an independent living community. If an elderly person needs help with personal tasks, staff are provided at ALFs to offer assistance. This is useful both for EHDCs that require
personal care assistance and relatively healthy couples who anticipate needing assistance in the future.

ALFs do not, however, offer the full spectrum of support services needed to allow an EHDC to remain on site indefinitely as dependency needs develop and change. Those members of EHDCs that require medical care will not find ALFs supportive of their needs, and since by definition, one member of all EHDCs already requires some level of care, entering an ALF is a risky move for an EHDC unless the couple is unfettered by the prospect of moving again. Just like at ILCs, Elderly Half-Dependent Couples residing at assisted living facilities can arrange for additional care to be provided by partners, other family members, friends, or by a hired nursing program.

6. Dealing with Death

Because ALFs offer personal care services, they can help recently widowed elders cope if their dependency increases following a partner’s death. Formerly independent elders who come to require some personal care can easily access it, and those elders who formerly required some care, but now need even more, can change the amount of support they receive. However, were a death to bring about medical needs in a surviving resident, he or she would not be able to access the necessary care at an ALF.

7. Organization and Ease of Access

Because ALFs offer housing and some level of personal services in the same facility, they more easily coordinate housing and service needs for residents than can an ILC. That said, ALFs do not provide medical care which would have to be coordinated and financed outside of the ALF umbrella.

Development Quality Assessment

1. Nimble Product

Like ILCs, ALFs are somewhat nimble in that they can be developed in two different designs – the high rise or the collection of smaller structures. However, because of the importance of on-site care services at ALFs, giving each unit its own detached building becomes
a less cognizant wish of residents. In fact, many ALF residents say they moved to their new
home to be in a congregate group of peers from whom they can access help, and to whom they
can provide the same (ALF Interviews, 2004).

Because ALFs usually offer apartment-style units, they can easily be converted to other
forms of residential housing, providing contingency plans to developers, should a project's lease-
up not go according to plan.

2. Contextual Fitness Capacity

Like ILCs, ALFs can blend into different surroundings with some degree of success.
While the buildings tend to be larger than a typical urban residential neighborhood, ALF
structures do not have to be large, and can instead be spread across multiple smaller buildings.
This design is not the norm for ALFs, however.

3. Cost

ALFs offer the same apartment-style units found in ILCs making their development costs
nearly identical to those of independent living communities.

Nursing Homes

The last stage of the current elderly housing continuum is the nursing home (NH) or
skilled nursing facility (SNF). None of the former three stages of the elderly housing continuum
examined here are capable of providing care sufficient to support EHDCs harboring medical
needs. At home, ILCs, and ALFs, the most severely dependent elders require assistance from
healthier partners, family, friends, or hired services. Nursing homes, on the other hand, provide
24 hour personal and medical assistance to support these elders. Nursing homes were created to
care for the nation's most frail elderly.

However, Figure 3-2 illustrates why nursing homes cannot accommodate EHDCs:
They are not geared toward serving couples. In each of the four stages of the elderly housing
continuum shown in the figure, the structure and resident pictures were taken from the same
website advertising housing in the building shown. However, at each of the first three stages of
the continuum, the residents pictured appear to be couples, whereas for the nursing home, an
elderly woman is pictured lying by herself in a hospital style bed. No partner is shown with the nursing home resident. Even if a healthy member of an EHDC wanted to live in an SNF, he or she would not receive a bed in the facility because NHs require certain levels of dependency in order to gain admittance. Furthermore, the cost of housing, 24 hour licensed nursing staff, and other amenities included in a given nursing home package are extremely expensive. Without Medicare/Medicaid the cost would be prohibitive to most EDHCs given their financial limitations.

Criteria for Supporting Elderly Half-Dependent Couples

1. Care Assistance

At Skilled nursing facilities, individuals who need personal or medical care are supported with 24 hour nursing attention provided by registered nurses, licensed practical nurses, and their aides. Nursing homes are licensed and regulated by state agencies to provide medical care on site and dispense medications to residents. SNFs offer EHDCs the wide range of personal and medical assistance they could need at all stages of dependency.

2. Affordability

Nursing Homes usually charge a basic daily or monthly fee that increases with the addition of more intensive services. The average annual cost of care in a nursing home was approximately $56,000, $4670 per month, or $153 per day. While these costs are certainly high, due to economies of scale, they are far less than the cost of hiring 24 hour medical care at home.

Since SNFs can accept Medicare and Medicaid payments, they are a more palatable option for the less affluent elderly than Assisted Living Facilities or Independent Living Communities. Medicare covers up to 100 days of skilled nursing home care per benefit period. However, after 20 days, beneficiaries must pay a coinsurance ($99 per day in 2001). Medicare will only pay for nursing home care preceded by a three-day hospital stay which could cause an added inconvenient move for an EHDC. About 70 percent of nursing home residents are supported, at least in part, by Medicaid, which will begin reimbursing nursing home fees for those who financially and medically qualify, when Medicare payments end. Medicaid reimbursement systems for nursing
homes vary considerably from state to state and averaged $95.72 per day in 1998 (Pandya, 2001). For those elders who do not qualify for Medicaid, the high costs of living and receiving care at a nursing home can quickly drain a lifetime's savings. Once this savings is whittled away to a small enough amount, SNF residents can begin receiving Medicaid coverage. Total national expenditures for nursing home care in 1998 amounted to $78.6 billion, 40% of which, or $31.4 billion of which was covered by Medicaid (Pandya, 2001) (see Figure 3-3).

Figure 3-3. Payment Sources for Nursing Home Care, 1998

<table>
<thead>
<tr>
<th>Payment Source</th>
<th>Percentage</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket</td>
<td>36%</td>
<td>$28.5 billion</td>
</tr>
<tr>
<td>Other Private</td>
<td>2%</td>
<td>$1.6 billion</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>6%</td>
<td>$4.7 billion</td>
</tr>
<tr>
<td>Medicaid</td>
<td>40%</td>
<td>$31.4 billion</td>
</tr>
<tr>
<td>Other Public</td>
<td>3%</td>
<td>$2 billion</td>
</tr>
</tbody>
</table>

Source: HCFA National Expenditures Data, 1998

3. Ability to Live Together

Though NHs can in theory house both members of an elderly couple, in order to gain admittance to a SNF, an individual must present enough dependency issues to require skilled nursing care. For example, an elderly individual who only requires help cooking and getting out of the house would probably not be admitted to a nursing home. For this reason, it is not correct to say EHCs can live together at a nursing home. Couples cannot live together at Skilled Nursing Facilities until the dependency status of both members of the couple warrants admittance.

4. Dignified Residential Environment
Nursing homes are often criticized for closely resembling hospitals for the elderly, rather than homes elderly persons would choose to inhabit. Nursing homes have always had an institutional feel because they share many functions with hospitals. However, though SNFs are medical environments, they are also residential environments. These facilities have come under increasing pressure in recent years to provide more comfortable settings in which elders can age.

5. Aging in Place

Skilled nursing facilities offer the personal and medical services needed to cover all possible dependency situations an EHDC could present, but they do not accept persons who pose no dependency needs. Thus it would not be accurate to say that SNFs allow elders to age in place because no one can enter a nursing home until they have reached a state of high personal dependence. Once an elder has reached this stage, they can move to a nursing home and “age in place” from that point on.

6. Dealing with Death

For residents who are already in a nursing home, the death of a partner who does not live on site has no effect on care provided to the nursing home resident. NHs are also able to increase services to a resident whose condition worsens with the death of a loved one.

As they do not accept residents requiring less than skilled nursing care, nursing homes can do little for a widowed elder who is dependent upon others for medical care.

7. Organization and Ease of Access

Because nursing homes have the ability to cover all of the bases in caring for very frail elders, they are somewhat effective at coordinating housing and care plans for severely dependent members of EHDCs. The problem here is the decision must be made to send the dependent elder to the SNF in order to take advantage of these services. Thus, this relatively coordinated set of services is not available to elders who are not sure whether a nursing home is the best option for him or her. In other words, the link between housing, personal care, medical assistance, rehabilitation and finance that is present within the nursing home structure is available only to members of EHDCs who know they will live in a given SNF where they can then access
Development Quality Assessment

1. Nimble Product

Nursing homes are usually quite large developments, typically housing over 100 residents. For this reason, they cannot be sited on small or irregular lots with ease, making it difficult to find places to develop nursing homes in densely developed areas.

Nursing homes also utilize vastly different room types than do average residential apartments, or even ALF units. Because no kitchen areas or room delineations are present within units at SNFs, they are difficult to retrofit for other residential uses, making them more risky potential developments. That said, because Medicaid supports elders at nursing homes, there is typically little shortage of potential residents for a nursing home developed in a fairly well-populated area.

2. Contextual Fitness Capacity

One reason nursing homes are seen more as medical institutions than residences is their propensity to stand out in a neighborhood context (SNF Interviews, 2004). The nursing homes that blend most effectively into their surroundings are those located on hospital campuses. A sprawling low-lying building or a 12 story high rise located in a residential neighborhood of four story row houses will stand out as something very different. When passersby notice the large regularly spaced windows in each building face, a circular drop-off access road, and a set of people sitting in wheelchairs on an adjacent patio, it is no wonder the idea of a medical institution enters their mind.

3. Cost

Because nursing home units are much smaller and less complicated than those of ILCs and ALFs, they are generally less expensive to construct than those typologies. Nursing homes do, however, require medical equipment not found in other elderly residential typologies. While per unit development costs of nursing homes might be low, the additional costs of medical equipment adds to those amounts.
From the perspective of a resident receiving Medicaid payments, a nursing home probably seems like quite a cost-effective typology. However, minus this support, they do cost residents a steep $5000 per month.

Misguided Assumptions

The existing elderly housing continuum is meant to adequately house elders at any stage of aging and dependency. However, the previous discussion shows that in fact, the continuum is disjointed and does not meet the needs of all elders, especially Elderly Half-Dependent Couples (See Figure 32 above). The research presented thus far shows this mismatch of needs and provisions to be due to the following ill-conceived assumptions:

1. Elders will smoothly relocate in order to situate themselves in the appropriate stage of the continuum when necessary.

   Given the case of “home holdouts,” this notion can certainly not be assumed true for all elders. As AARP reports, roughly 85% of seniors state that they in fact, plan to follow an alternative elderly housing model known as “aging in place,” at home until death.

2. Seniors will correctly choose the facility that best matches their needs.

   Lacking perfect information and a housing and service model that can offer answers to all of the needs of EHDCs, this will certainly not always be the case. Given the aggressive advertising used by some development companies to attract seniors to their projects, this challenge could become even greater in the near future.

3. All seniors have the means necessary to live in each of these typologies.

   EHDCs in particular have less financial means than most elders and would have trouble affording many elderly housing options. Independent living communities and assisted living facilities in particular are known for being expensive options, as are nursing homes for those elders who do not meet Medicaid financial eligibility requirements. Additionally, purchasing home care in order to make living at home,
an ILC, or an ALF possible for a more severely dependent elder is also an extremely expensive proposition.

4. When necessary, members of elderly couples will be willing to live in separate locations in order to receive proper health care.

   Again, the case of “home holdouts” disproves this claim. Were EHDCs not extremely distressed by the need to live apart from one another, each member would simply move to the appropriate type of facility when suitable. Instead, this scenario rarely proceeds as it is meant to do. As we saw in Chapter 1, very often, caregiving members of EHDCs work so hard at caregiving for a severely dependent partner that they feel overburdened, become unhealthy, and have little time for other family, friends, and interests. However, this is seen by these individuals as preferable to living separately.

These findings clearly demonstrate a mismatch between the needs of Elderly Half-Dependent Couples and the housing typologies currently available to them.
INNOVATIVE SOLUTIONS OFFERING HOPE TO ELDERLY HALF-DEPENDENT COUPLES

While only 15% of elders age 65 and over said they wanted to move out of their homes, perhaps this number would have been higher if a better option existed for America’s seniors. In fact, new typologies and programs that offer better housing and care opportunities for elders evolve through the creativity of private developers, service providers, and organizations, as well as government agencies. This could be one reason for the much higher percentage (59%) of 44–56 year old baby boomers who said they plan to leave their current residence when they retire. Some of the new typologies that offer promising solutions for EHDCs are discussed in this chapter.

Chapter 3 paints a bleak picture of the housing and service models available to EHDCs in the U.S. today. The disjointed nature of the existing elderly housing continuum poses a number of problems for most elders, but as we saw in Chapters 1 and 3, it is particularly difficult to reconcile the needs of Elderly Half-Dependent Couples with this set of available housing options.

That said, there is hope that an innovative combination of housing and care provision can make the lives of EHDCs better in the very near future. In fact, a number of novel typologies and programs are attempting to change the face of the elderly housing continuum for the better.
None of these options succeeds in meeting all of the specialized needs of EHDCs for some of the same reasons that the components of today’s elderly housing continuum fail to do so. However, each of these new innovations offers creative solutions to at least one of the problems hindering the existing continuum. It is my belief that by knitting the promising characteristics of these new options together with the positive points of the existing residence and service models, a new and better solution can be generated which meets the housing and care needs of EHDCs.

Before discussing how these pieces might fit together, Chapter 4 will examine these new innovations from which creative strategies can be garnered. In order to do so, they will be compared to the two sets of criteria developed in Chapter 3. One of these sets of criteria examines how well each typology supports EHDCs, while the other set attempts to look at elderly housing typologies more generally from the standpoint of a potential developer.

**Elderly Housing and Care Innovations**

Four relatively new housing with service models offer unique solutions to some of the problems posed by the existing elderly housing continuum as it relates to Elderly Half-Dependent Couples. The first two are largely innovations in physical design. The third is a programmatic advance aimed at making elderly housing and care more affordable. The fourth innovation is a new flexible model for licensing facilities.

**Continuing Care Retirement Communities**

Continuing care retirement communities (CCRCs) are the oldest and most widespread of the four housing and service options presented in this chapter. To an EHDC residing at a CCRC, this residential option might not appear any different than an independent living community with an assisted living facility next door and a nursing home one more building away. The basic premise of the CCRC model is to provide each of these three elderly housing alternatives on one campus, so that when an elderly individual’s health changes to the point where he or she requires more care than is provided at a current unit, the person can move to an adjacent building and be surrounded by an environment that provides the appropriate level of care. In
this way, CCRCs offer a new take on the “Aging in Place” model of elderly housing which argues that seniors should have services wrapped around them so that they need not relocate as their personal, medical, and housing needs evolve. Given the popularity of elderly independent living communities and the aforementioned statistics showing the high numbers of baby boomers who plan to move after retiring, it makes great sense to put forth a typology that allows healthy seniors to move to an ILC facility with apartment-style units offering a number of amenities, but also offering units with higher levels of care nearby.

Criteria for Supporting Elderly Half-Dependent Couples

1. Care Assistance

Because CCRCs offer independent living, assisted living, and skilled nursing units in one location, the entire range of personal and medical care conditions that could be presented by members of EHDCs can be met on site. CCRCs allow healthier members of EHDCs to provide the level of care for their partners that they wish to give, saving remaining tasks for staff to handle. Rather than paying an outside contractor to come to the unit at specific times at exorbitant rates, staff are already present on site around the clock.

Surprisingly though, the “holdout” phenomenon exists even at these facilities. Some residents opt to hire assistance (personal or medical) from outside agencies in order to remain in their independent or assisted living unit. Skilled nursing staff from the nursing home areas of CCRCs cannot provide nursing care in the other portions of CCRCs due to the same licensing regulations that keep independent ILCs and ALFs from offering nursing care in their facilities (CCRC Interviews, 2004).

2. Affordability

CCRCs offer a range of contracts and fees. On one end of the spectrum, residents can pay for housing and only the services they choose to receive (maybe none), sometimes even on a month-to-month basis. On the other end of the spectrum, an “Extensive” contract offers unlimited long-term nursing care if it becomes necessary, with little or no increase in monthly fees. A “Modified” contract includes a specified amount of health care beyond which additional
fees are incurred (Brecht, 2002). No matter which finance route is chosen, CCRCs are expensive. Each of these payment schedules begins with a large up-front cost, which is often difficult for poorer elders to finance, followed by monthly payments. These entrance fees range from lows of $20,000 to highs of roughly $400,000, while monthly payments can range from $200 to $2,500 (AARP, 2004). Medicare and Medicaid cannot be used to pay for housing at a CCRC. Because they are not eligible to receive low-cost government financing (at least to the same degree that nursing homes do), it is difficult for CCRCs to offer packages affordable to elders with low incomes. These are obvious barriers to entry for financially constrained EHDCs.

Most elders in the U.S. have the largest portion of their wealth tied up in their homes, with the average home valued at $50,000 - $70,000 (Porter, et al., 1995). The typical up-front buy-in price for a CCRC is higher than these figures (ULI, 2004); in addition, monthly fees must be paid by the residents.

In terms of affordability, the positive aspect of CCRCs is that like any other nursing home, the SNF portions of CCRCs are covered by Medicare/Medicaid since they are licensed in the same manner as all other skilled nursing facilities. The problem is, few elders who are eligible for Medicaid can afford the costs associated with living in the independent or assisted living portions of a CCRC.

3. Ability to Live Together

The ILC and ALF portions of Continuing Care Retirement Communities offer apartment-style units where couples can reside together. Problems do arise when a severely dependent member of an EHDC requires skilled nursing care. For EHDCs in this situation, the nursing home areas of a CCRC are preferable to independent SNFs because they are adjacent to the building where the healthier members of the couples live. Thus, one could visit a dependent partner without leaving the residential campus. At some CCRCs, an independent partner can even choose to live in the skilled nursing unit with his or her partner.

Although they provide a much improved alternative for serving EHDCs who want to live together in spite of different care needs, CCRCs still experience the problem of “holdouts”
who remain in their independent living or assisted living units longer than medical staff advise, often with the help of a devoted caregiving partner. CCRC managers believe this is because the independent members of these couples do not want to see their partners moved away from them, even to a different part of the same building. An additional possible reason for EHDCs unwillingness to move to the more intensely serviced units is that they require higher monthly payments unless the resident qualifies for Medicaid (CCRC Interviews, 2004).

4. Dignified Residential Environment

Because they seek to attract relatively wealthy elders, CCRCs tend to offer quite attractive living environments complete with a host of amenities including restaurant-style meal service, shuttle transportation, regular outings, café rooms, and more. CCRCs receive higher monthly fees per resident than the average nursing home (due to a higher percentage of residents on private pay), and they are generally newer than the average nursing home; therefore, the skilled nursing areas of CCRCs tend to be more pristine and comfortable than older independent nursing homes (CCRC Interviews, 2004).

5. Aging in Place

When an independent couple moves to a CCRC, they usually move into an independent living unit; however, should the health of one or both members of the couple deteriorate, assisted living units are next door. Moving to an adjacent building is physically much easier than across town or to another city altogether, and CCRC staff will move residents’ belongings for them. Some CCRCs are even located within one building with different levels of care provided on different floors or different regions of one floor. Another advantage to this short move is that by staying in the same facility, the complicated processes of buying and selling properties, deciding upon the best facility available, setting up the right level of care, and so forth, are not necessary.

As was mentioned earlier, because of nursing home regulations, skilled nursing units must be located in their own separate structure, floor, or area of a CCRC. The licensing regulations that require this structure generally call for independent, assisted living, and skilled nursing
units to be “separate and distinct.” This is because nursing homes have very strict staffing and reporting requirements that would become very difficult to manage in a setting where skilled nursing, assisted living, and independent units were mixed. While it is good that these facilities are regulated in order to make sure that no corners are cut leaving residents in unsafe situations, it is sad that elders must move from room to room or facility to facility in order to make licensing easy. The move to an adjacent skilled nursing facility at a CCRC is easier than a longer-distance move, but it is a move, nonetheless.

6. Dealing with Death

Because each stage of the continuum is present on site at continuing care retirement communities, they offer EHDCs better opportunities for dealing with death than do any typologies in the existing housing continuum. When one’s partner dies at a CCRC, this loss of support can be compensated by increasing staff support delivered to the surviving person’s room. Another option is moving him or her to a new, more supportive environment at the campus. The coordination of this move can be handled to a great degree by staff of the CCRC.

7. Organization and Ease of Access

Because continuing care retirement communities offer the range of housing and service options that an EHDC could require at any point of the aging process in one location, coordinating the necessary programs as an EHDC’s needs change is a relatively easy task at these developments.

Development Quality Assessment

1. Nimble Product

One result of CCRCs offering ILC, ALF, and SNF units all on one site is that they are large. Assuming each building is average size for its typology, finding a location to develop a CCRC requires finding a property with enough space to situate three large buildings next to each other. Alternatively, an even larger campus would be needed were a lower density design utilizing a number of smaller structures chosen. An additional consequence of this special typological consideration is that new construction is almost always required to create a CCRC. While finding
a building that can be renovated to provide independent living, assisted living, or perhaps even skilled nursing units is a possibility, the chance of finding one with two buildings next to it that can be converted into ALF and SNF units is highly unlikely. As a result of these characteristics, CCRCs are usually located outside of the most developed portions of metropolitan areas.

Figure 4a – d compares the locations of ILC, ALF, NH, and CCRC members of the American Association of Homes and Services for the Aged, a nationwide collection of nonprofit elderly housing facilities. The metropolitan area boundaries used were created by mapping the 101 cities and towns that make up the Boston Metropolitan Area Planning Council, a Boston area metropolitan planning organization. While ILC, ALF, and NH facilities are spread across the region but roughly centered at Boston, the heart of the most densely developed area in the region, CCRCs are located away from the most central cities and towns – those that are the most built out. AAHSA CCRCs are noticeably absent from Boston, far and away the most populated city in the region, both in terms of general population and aged.

*Figure 4-1 a. Location of Boston Area Independent Living Communities with Median Home Values of Towns and Cities*
Figure 4-1 b. Location of Boston Area Assisted Living Facilities with Median Home Values of Towns and Cities

Figure 4-1 c. Location of Boston Area Nursing Homes with Median Home Values of Towns and Cities
2. Contextual Fitness Capacity

As discussed above, CCRCs are large developments which causes two problems dealing with contextual fit. First, were a CCRC to have trouble filling its units, the size of a typical CCRC development makes it more difficult to convert to another use. Though ALF apartments and nursing home units are typically relatively easy to convert to other multi-family housing types, the market must be in place to support a large influx of units to make CCRC conversion to purely residential units feasible. Second, CCRCs usually do not resemble any sort of established residential area in which a developer might wish to undertake a CCRC project. As a result, CCRC development strategists are investigating new locations where they can better blend into their surroundings, and provide their residents with a larger spectrum of nearby amenities.

Two locations have emerged as interesting options for siting CCRCs. The first is the hospital campus. Since hospital campuses normally consist of collections of large buildings,
Dozens of the estimated 17,000 traditional nursing homes in the United States have already embraced Eden alternative ideas. A study by Southwest Texas State University found Edenized facilities experience a 60-percent reduction in behavioral incidents, a 57-percent drop in bedsores, an 18-percent decrease in use of restraints and a 48-percent reduction in staff absenteeism (Ransom, forthcoming). Because the only existing Green House facilities are so new, it is unknown whether utilizing the Green House design will further enhance these positive changes, but nearly all residents at Traceway report they far prefer their new Green House units to the traditional nursing home units they left behind (Meyer, 2004).
options. In turn, these elders demand a high level of amenities, and distinctive or convenient locations, further driving up the cost of residing at a CCRC (Porter, et al., 1995). It should come as no surprise, then, that CCRCs tend to locate in more expensive towns and cities, those in which residents expect to pay large sums to buy or rent a housing unit. As an example, Figure 4-2 shows that in the Boston region, the median of median home value for towns and cities in which AAHSA member CCRCs are located is $338,000 versus $220,000, $218,000, and $226,500 for the median of median home values of those towns and cities in which ILCs, ALFs, and NHs are respectively located. Figure 4-1a-d also shows this spatially.

Figure 4-2. Median of Median Home Values for Metro Boston Cities and Towns in which AAHSA Elderly Communities are Located

<table>
<thead>
<tr>
<th>Typology</th>
<th>Median of Median Home Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Living Communities</td>
<td>$220,000</td>
</tr>
<tr>
<td>Assisted Living Facilities</td>
<td>$218,000</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>$226,500</td>
</tr>
<tr>
<td>Continuing Care Retirement Communities</td>
<td>$338,000</td>
</tr>
</tbody>
</table>

Sources: U.S. Census, 2000; Metropolitan Area Planning Council; American Association of Homes and Services for the Aging

Besides the cost of this range of amenities that might be provided in a CCRC, the variation in facility size and location and the limitless combinations of independent, assisted living, and skilled nursing units that they can offer cause CCRC development costs to range widely. For example, per unit development costs of the three continuing care retirement communities advertised as demonstration projects by the Urban Land Institute (ULI) range from $89,000 in Lemont Illinois, to $185,000 in Hilton Head North Carolina, and to $270,500 in San Mateo, California. As was mentioned earlier, CCRC developers normally receive little government assistance to produce their housing and care model for elders, so resident payments are expected to cover this entire cost, making them generally expensive for potential residents.

The discussion of cost effectiveness is difficult for CCRCs because their costs vary so widely. While they provide a valuable alternative to the existing elderly housing continuum only
the wealthiest cohort of elders can afford to purchase most units at a given CCRC. In the end, the determination of cost effectiveness for CCRCs comes down to how highly one values the ability to live out senior years at one location, and how much he or she appreciates the location and amenities provided by the facility. For Medicaid-eligible EHDCs, having a pool behind their unit is probably not as high a priority as finding a comfortable, affordable living environment that meets their specific care needs.

**Green House Nursing Home Model**

The Green House nursing home model is a form-based strategy for making the nursing home environment more residential and comfortable, rather than institutional. The model was created by Dr. Bill Thomas, founder of the Eden Alternative, a movement to redesign elder care facilities to make them more residential in feel, and fill them with life through plants, pets, and children. Thomas also more recently founded the Green House Project, an organization that trains and educates groups about the Green House model, encourages its dissemination and growth, and assists developers who wish to construct Green Houses.

The Green House model is Thomas' physical manifestation of Eden Alternative principles. The Green House design calls for groups of small residential buildings housing 8-10 elders each in private rooms with private baths surrounding a central hearth area with kitchen, dining, and living space (see Figures 4-3 and 4-4). The prototype Green House nursing home center called the Green Houses at Traceway, was completed in April of 2003 in Tupelo, Mississippi. Another project in Redford Township, Michigan is set to break ground in the fall of 2004.
Dozens of the estimated 17,000 traditional nursing homes in the United States have already embraced Eden alternative ideas. A study by Southwest Texas State University found Edenized facilities experience a 60-percent reduction in behavioral incidents, a 57-percent drop in bedsores, an 18-percent decrease in use of restraints and a 48-percent reduction in staff absenteeism (Ransom, forthcoming). Because the only existing Green House facilities are so new, it is unknown whether utilizing the Green House design will further enhance these positive changes, but nearly all residents at Traceway report they far prefer their new Green House units to the traditional nursing home units they left behind (Meyer, 2004).
Though this radical change from traditional nursing home design faced many regulatory challenges, meeting early on with state regulators helped the Traceway design and development team get around these barrier. While the nursing home industry is highly regulated, it may be that the movement to change the institutional feel of nursing homes now has enough momentum that new alternatives will gain favor with regulators. This will obviously vary from state to state.

Criteria for Supporting Elderly Half-Dependent Couples

1. Care Assistance

Because Green Houses offer skilled nursing care, staff members are on site 24 hours each day to provide this assistance, just like a conventional nursing home. Due to their small size, a
small number of workers can staff each Green House allowing residents and workers to better get to know each other. In this way, staff members also become more familiar with the medical and care needs of each resident. Because of the small number of residents in each building, one or two staff members are normally enough to handle resident needs throughout the day. Besides the added benefits for residents to having a small number of staff who know their needs well, staff report receiving greater satisfaction from working in a comfortable, residential environment and getting to know residents (The Green House Project, 2003).

2. Affordability

Like any other certified nursing home, residents living at Green Houses can be funded by Medicare and Medicaid if they are eligible to receive these payments. In this way, Green House nursing homes can be affordable to nearly all elders. That said, for those elders who must spend down assets to reach Medicaid criteria, just like living at a conventional nursing home, living at a Green House can quickly erase a lifetime’s savings. Furthermore, with Medicaid as the only method for making Green House residency affordable to EHDCs, problems arise due to the fact that many EHDCs have only one member medically eligible to receive these benefits. Were healthy partners allowed to live in these facilities, under current conditions, they would have to privately pay to live onsite.

3. Ability to Live Together

Like other nursing homes, Green Houses offer care at only the skilled nursing level, so partners with fewer care needs are not eligible to live on site. Additionally, current Green House designs call for small individual rooms which, though they are designed to accommodate queen-sized beds, could be difficult for couples to share.

The Green House Project will soon help a Florida developer who wishes to construct assisted living Green Houses. The rooms in the assisted living Green Houses will be slightly larger studio-style residences, each with a small kitchenette. HUD is providing some funding for this development and requires kitchenettes for its funded ALF projects. However, Jude Rabig, project manager for the Green House Project, stated in an interview that their organization is not
keen on kitchenettes because they believe every effort should be made to draw elderly residents out into the common hearth areas. Cooking and eating times are the most natural periods to do this. These ALF units would be more suitable for housing EHDCs than single nursing home-style rooms.

The design of each Green House at the Tupelo campus also includes at least one set of two bedrooms located such that the wall separating the two rooms could be removed at minimal cost in order to provide a larger space to house a couple. This is a unique solution to the problem of housing couples. At the Tupelo campus, a couple would have to be made up of two skilled nursing dependent individuals in order to live in this expanded double unit (Interview: Jude Rabig, 2004).

4. Dignified Residential Design

Aside from the problem of room size, Green Houses offer an extremely comfortable, pleasant environment for elders to inhabit. Rooms are private – not shared with previously unmet individuals, and include private bathrooms. These rooms surround a large living area called the hearth, complete with fireplace, open kitchen, a breakfast bar area, and a large dining table meant to hold 12 persons at once so that all residents can eat together in a friendly environment. The relationship of the private rooms to the hearth allows the elders to easily control their own level of social engagement by closing their door for privacy, opening their door to observe activities in the hearth, or to join the group and engage in various activities from menu planning, preparation of meals (or at least watching), and setting the table to recreational activities. Figure 4-5 shows some distinctive physical qualities of the Green House model versus a traditional nursing home.
5. Aging in Place

Since Green Houses are nursing homes, they currently only provide housing for elders who require skilled nursing care. Once an elder moves into a Green House unit, he or she can expect to keep that unit until death. Yet it would be wrong to say that this constitutes aging in place since nursing homes are typically the last stop in an elderly housing continuum characterized by moves caused by decreasing independence. This is still the case for Green Houses because only individuals requiring skilled nursing care can reside within them.

6. Dealing with Death

Because Green House nursing homes offer a wide range of personal and medical services like all other nursing homes they are well-prepared to deal with a widowed individual whose care and medical needs increase after the death of a spouse. That said, in order to live in a Green House nursing home, residents must already require skilled nursing care.

7. Organization and Ease of Access
Once again, like conventional nursing homes, only residents reaching the final stage of the elderly housing continuum will live in Green Houses. Since they are nursing homes, a case manager at a Green House should be able to coordinate a wide range of services for residents from medical care and rehabilitative services to meal plans and finance options. However, in order to access these coordination and counseling services, an EHDC must move to the facility which means they must require enough physical and medical care to necessitate skilled nursing support. Less dependent elders would not be able to access these services.

*Development Quality Assessment*

1. **Nimble Product**

   Green House nursing centers, because they are made up of a number of small structures rather than one large facility, can fit well on odd-shaped properties making them easier to site than larger standard nursing homes. They even have the potential to fit across a series of tightly packed scattered site properties. This makes the Green House nursing home model particularly interesting for urban locations where large undeveloped properties are difficult to locate.

2. **Contextual Fitness Capacity**

   Again, the smaller scale of Green House structures makes the design more likely to fit into a range of finer grains of development than typical skilled nursing facilities. Developers normally try to locate nursing homes in or along the edge of residential zones, and the finer grain of the Green House design allows it to blend well with surrounding housing districts.

   Due to the fact that only one Green House development currently exists, it is impossible to judge how readily adaptable to renovations and use changes Green House structures are. However, like average nursing homes, the Green House design most closely resembles that of a single room occupancy (SRO) residential structure. Since new SROs are permitted by few zoning codes today, retrofitting a Green House will probably require redesigning the interior layout of the structure.

3. **Cost**

   Given the large, comfortably furnished common spaces and the pleasant individual rooms
with private baths in the Tupelo Green Houses, it is not surprising that these structures are more expensive, per bed, than the average U.S. nursing home. At Tupelo, the cost per Green House was $803,000 ($80,300 per unit-bed), and these figures do not include land costs. Costs are expected to be nearly equivalent in Redford Township, Michigan.

With respect to staffing, the Green House model retains the advantage of economies of scale in order to keep costs down. Rather than six nurses covering 30 residents on one floor of a standard nursing home for example, two nurses might cover ten residents in one Green House at the same nurse to resident ratio. Nurse managers and other administrative staff go between structures and oversee the entire complex of Green Houses. In this way, like at a conventional nursing home, staffing Green Houses should be cheaper than hiring 24 hour skilled nursing care at home.

In terms of cost effectiveness, the few residents living in Green Houses rave about their experiences at these new facilities versus their former SNF units (Meyer, 2004). In this way, they appear to be an effective use of development funds.

Affordable Assisted Living Programs

The number of elders who can afford market rate senior housing (defined as those seniors with incomes higher than $25,000 annually) are outnumbered by those who cannot by a 2 to 1 margin. Studies have shown that developers of ALFs have nearly or completely saturated the market for market-rate assisted living units. However, there are many elders with low incomes that would like to live in an ALF but cannot afford to do so due to the high cost associated with ALFs (NCBDC, 2003).

As was mentioned in Chapter 3, assisted living fees, while expensive, are less costly than those charged at nursing homes. This is because the equipment and level of staffing necessary at an ALF cost much less than they do at a skilled nursing facility. Many elders who could survive quite well in an ALF are currently living in more institutional nursing homes and costing either the government or themselves more money than is necessary for one of two reasons: One possibility is they live in a rural area offering few housing and care options for elders. Since
nursing homes are partially funded by the government, they are much more widespread than ALFs. Secondly, Medicaid does not normally cover any costs for assisted living residents. This means ALF residents must cover their monthly fees through private pay alone. However, nursing home costs are covered completely by Medicaid, for those who qualify. For elders with little financial savings who require some care assistance but have no family or friends who can provide it, living at a nursing home under Medicaid coverage might be the only financially feasible option.

Because of these conditions, a number of programs were created in the past decade to investigate means of making assisted living more affordable for elders. A number of states have tested affordable ALF programs as have some non-profit organizations. The basic premise of these affordable assisted living programs is that general affordable housing subsidies can and should be paired with Medicaid waivers to make assisted living an affordable option providing housing and some supportive services for elders. These programs face a number of challenges, most of which deal with funding questions and are discussed in the following pages.

In most respects, affordable ALFs differ from the average assisted living facility only in the way they are financed and the fees their residents pay. For this reason, affordable assisted living will be evaluated in terms of only those criteria that present different outcomes than were seen in the discussion of ALFs found in chapter 3.

Criteria for Supporting Elderly Half-Dependent Couples

2. Affordability

The cost of ALF fees paid by residents must cover two expenses. First, like any other housing development, the fees must pay for the costs incurred by a developer in creating the units, plus any profit margin the developer decides to add to resident costs. This payment is referred to as the rent. However, housing options that offer services are generally more expensive than general housing developments because of these services. At an ALF, the other portion of resident fees covers the personal care services provided to residents. The sum of these different expenditures often cost elders 80% of their income.

For decades, subsidies have been available from a variety of sources to developers
who wish to create housing affordable to people with incomes too low to afford market rate housing in a given area. Affordable assisted living projects have begun to take advantage of these subsidies to bring down the rent portion of ALF resident fees. The financing mechanisms utilized by developers of affordable assisted living include Low-Income Housing Tax Credits (LIHTCs), taxable and tax-exempt bonds, and the U.S. Department of Housing and Urban Development’s HOME Investment Partnerships grants program and Community Development Block Grant program (Citro & Hermanson, 1999). Through these and other programs, affordable assisted living developers can obtain grants and low interest loans that decrease the rents the developer must charge in order to break even or make a profit on the real estate. A survey of state housing finance agencies (HFAs) found that, in recent years, they provided financing for the construction of some 2,500 to 5,000 affordable assisted living units (Bader, forthcoming).

One large problem is created by using these funds to pull down the costs passed on to ALF residents through rents: the demand for affordable housing subsidies already far outstrips the supply available, so any new use for these funds will only spread them more thinly unless new sources become available.

Besides rent, resident fees at an ALF must also cover the cost of services provided to residents on site. In order to bring down the cost of these services, some states have begun granting Medicaid waivers (typically 1915c waivers) to individuals who require financial assistance to reside in either an ALF or nursing home. Medicaid historically has only covered elders’ care at nursing homes, but the Medicaid program has begun testing a number of waivers, granting some applicants the ability to use Medicaid dollars to cover the cost of other available care options. Covering the costs of personal care for ALF residents is one such waiver program.

This program has benefits for both elders and the Medicaid program itself. The waivers help provide seniors who do not require skilled nursing care the ability to live in a more comfortable, residential setting at an affordable rate and receive the level of care they need. Additionally, given that the average monthly cost of housing and care for a nursing home resident
is nearly $5000, this program also saves Medicaid a significant amount of money because not only are ALF fees less than those of nursing homes, the waivers, in most cases, cover only the costs of personal care services for ALF residents, not the entire cost of living at an ALF (rent + services). For those elders who do not require skilled nursing care but would otherwise have to live at a nursing home because of Medicaid restrictions, Medicaid can save large sums of money by funding this program.

Unfortunately, there are barriers to implementing such a program on a wide scale. First, state and federal Medicaid regulators must allow the waiver program to expand into more states in order for elders to gain access to it. 28 states have still not approved this waiver program. All states that have approved Medicaid waivers for use at Assisted Living Facilities require that applicants be eligible for skilled nursing care in order to receive a waiver. In order for the waivers to help elders at all levels of dependency, this rule would have to be changed. Additionally, financial dilemmas faced by the Medicaid program threaten to decrease the amount of available funds it can give to all of its programs, or even to end the program altogether.

*Development Quality Assessment*

3. Cost

The cost of developing an assisted living facility is generally less than that of an ILC since ALF rooms are normally smaller and offer fewer amenities than ILCs. However, ALF rooms usually feature kitchen areas, private bathrooms, and other features of a normal residential apartment. For this reason, they are generally more expensive to develop than skilled nursing facilities which typically offer rooms holding two residents with a shared bathroom. Identifying an average development cost for ALFs is difficult because of the amount of variables involved from one facility to the next, but in this way we can assume it to be more than SNFs and less than ILCs.

The cost effectiveness of these projects is rated highly since residents live in an environment that they far prefer to nursing homes, and they do so at a very minimal cost. As was explained above, affordable assisted living programs can also save the Medicaid program a
significant amount of money. In terms of cost effectiveness, the only negative aspect of these programs is the fact that they take development subsidies away from other deserving affordable housing projects and programs. The loss to these others programs must be taken into account when considering the cost effectiveness of using these funds to develop assisted living projects.

Three Existing Affordable Assisted Living Programs

One of the first state programs for producing affordable assisted living units was created in Oregon. This program uses Medicaid waivers to cover the cost of services for individuals at an ALF, and uses SSI funds (for those who qualify) to reduce rental costs. State of Oregon regulations declare that in order for an individual to qualify for a Medicaid waiver through this program, he or she must meet requirements for skilled nursing care. In 1999, monthly Medicaid payments for personal services ranged from $601 (individuals requiring little assistance) to $1,697 (individuals with the highest level of need). The SSI payment for room and board, $494 a month in 1999, was added to the Medicaid monthly payment, resulting in a range of $1,095 to $2,191 per month. In 1999, the monthly Medicaid rate for a nursing home stay in Oregon was estimated at $2,736, significantly more than the range of funding provided by the state per individual to live at an affordable ALF (Citro & Hermanson, 1999).

In Massachusetts, the efforts of several public and quasi-public agencies have produced more than 1,000 affordable assisted living units. Half of these affordable assisted living units were partially financed with $4.7 million in Low Income Housing Tax Credits that the state allocated to assisted living projects from 1994 through 1998. The Massachusetts Housing Finance Agency and the Massachusetts Development Finance Agency financed much of the remainder by issuing tax-exempt and taxable bonds (NCBDC, 2003).

A third example, the Coming Home Program, is run by the National Cooperative Bank Development Corporation, a nonprofit developer of affordable cooperative housing and affordable assisted living facilities. The program provides technical assistance, grants, and reduced-rate loans to states that are willing to make regulatory changes necessary to make affordable ALFs a palatable development option. The goal of the program is to develop assisted
living projects that are affordable for frail, low-income elders living in rural areas where nursing homes may be the only other Medicaid-covered housing and service option. Coming Home seeks to cut shelter (rent) payments to $350 - $400 per month with services covered by Medicaid waivers. In this way, the Coming Home Program seeks to keep elders who do not require skilled nursing care out of nursing homes (NCBDC, 2003).

**Floating Licenses**

Very recently, the assisted living licensure boards of Wisconsin and Illinois began to grant “floating licenses” to developers of assisted living projects in their states. These licenses allow elderly facilities to mix independent and assisted living units throughout a development unrestricted by a need to keep them separate and distinct. Because of this, a healthy couple that moved into a facility with floating ALF licenses could remain on site if one of its members became care dependent. The facility could shift an ALF license to the EHDC’s unit and the necessary services could then be provided by staff without causing the couple to move to a separate assisted living facility or to another nearby unit, as would happen in a CCRC.

Developing a policy that changes the face of elderly housing licensure so vastly takes a great deal of work from lobbyists, regulators, and policy makers who must agree to work with less-strict licensing regulations. As this is a relatively new program, it is difficult to judge, though it appears quite promising for adding another layer to the narrative of aging in place.

One concern with the floating license program is that facilities that receive them obtain a set number of the licenses. It is yet to be seen how facilities and licensing bodies will deal with the situation of a facility that needs more licenses than it has been granted. Floating licenses also have the potential to cause staffing difficulties since the amount of staff required to tend to residents needing personal care will vary with the amount of ALF unit licenses being used at one time.

For floating licenses to truly change the face of elderly housing with services, policy makers should experiment with allowing licenses for ALF and SNF units to be transferred between rooms as well. This would allow a couple to enter a facility in an independent state,
receive ALF-standard care when needed, and later, take advantage of skilled nursing care when it becomes necessary. This could all take place in the comfort of a couple’s first unit in the elderly community. There are numerous challenges to this ideal, but the existing floating licenses hold promise that it could become a reality in the future.

Criteria for Supporting Elderly Half-Dependent Couples

1. Care Assistance

Floating licenses provide no special care assistance that could not otherwise be accessed. However, allowing personal care to be delivered to an EHDC’s formerly independent living unit would be expected to increase the amount of elders who receive the level of care for which they qualify because they would not have to fear a possible unit change.

2. Affordability

Floating licenses have no direct effect on affordability of housing or services.

3. Ability to Live Together

Floating licenses would be expected to allow more elders to live together because an elder whose health deteriorates enough to require many hours of personal care would not have to leave a unit where he or she was formerly independent to gain access to personal care services, even if his or her partner could provide no assistance.

4. Dignified Residential Environment

By preventing one change of unit that is currently called for in the existing elderly housing and service continuum, floating licenses allow couples to stay together longer in the same unit they called home before requiring personal services. By allowing this to take place, floating licenses can make an elderly housing community more pleasant, dignified, and less institutional than other developments that cause elders to move out according to personal care dependency needs.

5. Aging in Place

Because elders are not required to move from an independent living unit to access assisted living care, floating licenses are a major victory for advocates of aging in place. When
an individual living in an independent unit develops the need for some care, the facility managers can transfer a floating ALF license to the individual's room where he or she will begin to receive personal care services.

6. Dealing with Death

Were the death of a partner to cause a formerly independent senior to require some amount of personal services, a facility that could use floating licenses could support a widow or widower in her or his current unit rather than moving the individual to another unit during an already trying period. In this way, floating licenses can greatly improve a facility's ability to deal with the death of a resident's partner.

7. Organization and Ease of Access

Like CCRCs, providing more than one level of care in one development takes much of the work out of moving from one level of dependence to the next because staff and coordinators familiar with both typologies are present, and no move is required. However, since floating licenses currently only cover ALF rooms, they do not improve the ease of transferring from ALF units to a nursing home.

Development Quality Assessment

1. Nimble Product

Floating licenses can make a development much more nimble since it can more flexibly react to the needs of residents. Rather than needing to find new residents each time a formerly healthy tenant moves on to an ALF, floating licenses allow a senior housing project to support residents longer.

Floating licenses do not change the actual size of a development so they have little effect on the ease with which a project holding floating ALF licenses can be sited.

2. Contextual Fitness Capacity

Floating Licenses do not significantly change the overall design or aesthetics of an elderly housing development. Thus, they should have little effect on its capacity to fit within different varieties of surroundings.
3. Cost

Floating Licenses should have no effect on the development costs of elderly housing projects that utilize them. They may require more labor intensive licensing procedures, which could bring about increased licensing costs. However, because of the positive benefits for elders who wish to age in place, the cost effectiveness of this program must be rated high.
This chapter presents a new typology which seeks to provide a place where elderly individuals and couples presenting any level of health and care needs can live in a content, dignified manner without having to move if their health deteriorates. Trying to create such a typology makes sense given the fact that 59% of 44-56 year old boomers say they plan to move upon retiring, and 85% of elders aged 65 or older say they wish to age in place where they are. Thus, it seems in coming years that many elders will be seeking new homes, probably smaller than their current family home, with certain amenities, providing a place where they can age in place and not be forced to move again due to health problems. I also believe that a typology that suitably dealt with each of the ten criteria used in Chapters 3 and 4 would attract even more elders than just this group who are already identified as likely candidates to be interested in the product.

Chapters 3 and 4 demonstrate that no existing typologies effectively meet the varied and changing needs of EHDCs. However, these typologies and programs have slowly improved upon the options available prior to their creation. Today there are more and better options available to seniors. Before ALFs, no housing option delivered services in a comfortable residential environment. Prior to the creation of CCRCs, elders had no option that allowed a couple to live in one development throughout all stages of aging. Before affordable assisted living programs were begun, only nursing homes were an affordable option for care-dependent
elders with low incomes. And before floating licenses, no typology allowed elders to age in one unit over different levels of dependency.

The goal of the final chapter of this report is to increase the speed of the evolutionary process that has brought about these and other innovations in the elderly housing and care industry. By learning from the conditions faced by EHDCs today (chapters one and two), and from the models of elderly housing and services available today (chapters three and four), a new hypothetical typology that could better support EHDCs will be posed. This new model is termed the Senior Life Home. What follows is a list of elements shown by the research presented in chapters one through four, to be necessary in order to adequately house EHDCs. Combined in one program of housing and services for the elderly, this set of features could greatly improve living conditions for EHDCs.

**The Senior Life Home**

**Adaptive service units**

The basic ideas of CCRCs and floating licenses are good starting points from which to consider this feature of a new typology. Aside from living at home and hiring personal home care services, CCRCs offer the closest model to “aging in place” available today to elders. They also allow elderly couples to live together in the same facility, and even the same unit until the health condition of one member of the couple forces him or her to move to a skilled nursing unit.

Considering the desire shown by EHDCs to live together in the same unit and to limit the number of moves made due to changing health conditions (consider the case of home holdouts particularly as they applied to CCRCs), a best case scenario would allow EHDCs to move into a unit that is attractive to both members of a couple and remain in that unit regardless of the level of care required by either member. This could be done by layering a set of floating licenses in a facility that allowed an EHDC to age in one unit and receive anywhere from no care to full medical care services in that unit.
Such a unit must provide an environment that fits both members of an EHDC. To meet the demands of relatively healthy, independent elders, these units should be at least studio size with private bathrooms and kitchenettes. One bedroom units with kitchens would be preferable. Making sure the units are truly apartments rather than a single rooms will help prevent healthy individuals from feeling that they live in an institutional environment. This would certainly be a positive point for dependent members of EHDCs as well.

In order to meet the care and medical needs of dependent members of EHDCs, units must also be fully handicap-accessible. Showers must allow wheel chair access, doorways and halls must be wide enough for wheel chairs, and sink/counter areas must allow wheelchair access. Bedroom space design will be a challenge as they should be designed to easily allow addition of hospital-style beds and lift machines, should an individual require this equipment.

The death of one member of an EHDC would also be more easy to handle in the Senior Life Home than any of the existing models presented earlier. This is because the surviving individual would never have to move, not even to an adjacent building, no matter what changes occurred in his or her health and personal care service requirements.

By designing a unit to meet the constantly changing demands of both healthy and dependent elders, a couple could age in place in this type of adaptive service unit regardless of the changing health needs presented by either member of the couple.

**Barriers to Implementation**

State and federal regulations currently prevent elderly housing and service developments from providing assisted living (personal) care and skilled nursing care in the same unit. These regulations would have to be adapted to allow the Senior Life Home model to come to fruition. As was already discussed, a model like the floating license program could be expanded to allow this to take place.

The other barrier to making the adaptive service unit a reality is the amount of space necessary to implement some necessary features of this type of unit. A bedroom that can accommodate two beds and a lift machine would have to be much larger than most existing ALF
or CCRC bedrooms. This would push up the costs of a development that included units like these in its design.

**Smaller Scale**

A number of the typologies discussed in chapters three and four are bent on creating a more pleasant environment than nursing homes provide for aging elders that require care. The first model to do so was the Assisted Living Facility, followed by Continuing Care Retirement Communities. Dr. William Thomas’ Green House nursing home design is the latest in this set of less institutional designs for supportive elderly housing.

To take a page from the design goals of Green Houses, reducing the perceived size of a nursing home from 100 beds to eight to ten beds significantly reduces the feeling of institutionalization for residents by fostering a sense of community within this smaller group of residents (The Green House Project, 2004). The provision of a central “hearth” area with a warm fireplace, and a communal dining table and kitchen area are certainly pleasant amenities for most any elderly community, and have been provided in ALFs and CCRCs for these reasons, but the element of vastly reduced scale is unique to Dr. Thomas’ design of Green House nursing homes. Besides creating an environment that looks more like a standard “home,” the smaller scale Green Houses also allow residents to become more familiar with staff members, and vice-versa, building comfort in this most important relationship.

A smaller scale housing with service design can also provide opportunities for creative methods of siting urban Senior Life Homes. For instance, a 10-bed Senior Life Home could be located in an empty floor of a mixed use mid rise elevator building. Finer grain developments, such as a series of Senior Life Homes could also fit in a densely developed urban neighborhood where some empty or abandoned lots are scattered relatively close to one another in a series of blocks. Such a model could also be adapted to work in large rehabilitated homes.

**Barriers to implementation**

The main barrier to implementation of smaller scale elderly housing typologies is experience. Few attempts have been made to build communal living environments for elders in
such small size. Regulators’ inexperience with a new typology will mean developers will have to take time to sit down with senior housing regulators ahead of time and work out the regulatory amendments necessary to build Senior Life Homes. For developers, their inexperience with the new product will mean estimates and pro formas will be less exact and involve more risk. While economies of scale would still be beneficial in some respects through grouping a number of smaller Green House-like facilities together on one campus, there will be additional costs to dividing 100 beds among 10 to 12 buildings rather than collecting them all in one structure like a typical nursing home does.

**Siting Ease**

In order to serve populations at a wide spectrum of incomes, this new typology cannot relegate itself to the suburban locations CCRCs have tended to gravitate toward. Additionally, in order to allow EHDCs to remain within familiar surroundings when they leave their homes, this new typology should be easy to site on different property types, layouts, sizes, and locations. As was already discussed, the smaller, more house-like design of Green Houses allows them to fit on smaller lots, and even on scattered site properties, though an elder community built on a scattered site property would need individual properties that are quite close together to allow personnel to move between buildings quickly.

**Barriers to implementation**

As this is simply a benefit of designing a collection of structures that are individually at a smaller scale than typical CCRCs, ALFs, or nursing homes, there are no additional barriers to including this benefit in our discussion of a prototypical new solution for housing EHDCs.

**Organization and Ease of Access**

Since this new typology seeks to provide all levels of service to EHDCs on-site, coordination of housing, personal care, medical care, rehabilitation, and financing can all be taken care of by on-site case management coordinators. In this way, little planning is required ahead of time to help an EHDC set up the necessary services they deem necessary at their new homes. This is especially comforting to couples who decide they must move out of their home
immediately following a traumatic change in the health condition of one member.

*Barriers to implementation*

This element of the new program should require no unexpected effort on the part of Senior Life Home program designers.

*Affordability*

A new typology that meets the needs of EHDCs must be affordable to couples at all income levels. To meet this challenge, state elder agencies, and housing finance agencies should look to the established state models of affordable assisted living for guidance. By pairing affordable housing development subsidies with Medicaid waivers, a typology that sought to make elderly housing affordable could do just that. Low Income Housing Tax Credits, the Federal Home Loan Bank’s HOME program, Community Development Block Grants, and other subsidies can be used to bring down development costs thereby reducing rent charged to tenants. If state and federal regulators approved Medicaid waivers to cover services (both personal care and medical skilled nursing care) for residents, this would in turn reduce fees paid by residents. There is little reason to believe monthly fees at this new typology could not be brought down to the same $350 - $400 monthly goal of the Coming Home Program.

Were development subsidies expanded to allow developers to more affordably construct supportive elderly housing like the model posed here, it is conceivable that the Medicaid program could save a great deal of money because it would no longer have to cover the entire monthly cost charged to a Medicaid-eligible nursing home resident. Since development costs would be significantly reduced, the rental portion of resident fees (paid by Medicaid for nursing home residents) would be significantly reduced.

Coordination of waivers for personal (assisted living) care and those for skilled nursing care would be made much easier since residents would not be moving from facility to facility or even room to room within the same facility. When a resident needed to add skilled nursing care, a Senior Life Home staff member could simply notify Medicaid of this change and the change in cost associated with this modification.
Barriers to Implementation

Currently, waiver services are available only to Medicaid beneficiaries who meet state health eligibility criteria for nursing home care. This policy would have to change to cover personal care services as it has already in 22 states. Also, states limit the amount of funds that can be spent on waiver services because they must demonstrate to the federal government that Medicaid long-term care expenditures under the waiver will not exceed expenditures that would have been made in the absence of a waiver.

At a more basic level, Medicaid policy would have to adjust to cover services at this new housing type. Since many states have adapted their Medicaid policies to cover the service costs charged to Medicaid eligible residents at assisted living facilities, it would appear this further change would not be difficult to bring about.

Furthermore, as was mentioned in chapter 4, the number of subsidies available today to develop affordable housing of any kind already does not meet the demand they create. Finding enough subsidies to develop this type of project in large numbers would be difficult.

To sum, the Senior Life Home model consists of the following components:

1. *Adaptive service units* which allow couples to live together and to age in place rather than moving as health conditions of either member change.

2. Grouped facilities of much *smaller scale* than typical nursing homes, continuing care retirement communities, or assisted living facilities.

3. A design and scale that provides *siting ease* resulting in facilities that are much easier to locate in any number of property types.

4. *Organization of and ease of access* to a number of services needed by EHDCs to make the process of setting up housing, various services, and finance options much easier.

5. *Affordability* for EHDCs at all levels of income.
Next Steps

As was mentioned above, a number of barriers do exist to bringing a typology of this nature to fruition. Thus, a set of next steps is given below to help policy makers and developers consider the part they can play in improving living conditions for elders including EHDCs through the Senior Life Home model.

1. Eldercare regulations must be loosened in order to allow both personal care and medical skilled nursing care to be delivered in the same unit. It does not seem that changing these regulations would be an overly difficult process considering two states have already implemented floating license programs. This further layer of change would, however, require time.

2. Medicare regulations must also be relaxed in order to make different types of waivers possible. Progress is being made on this front with 22 states adopting waivers for assisted living, but similar programs could make CCRCs or a new typology more affordable. The best case scenario for Medicaid funding of the Senior Life Home model would, of course, be allowing Medicaid to fund these facilities outright, rather than continuing to fund nursing homes.

3. The dedication of federal and state subsidies to fund affordable elderly housing would both reduce the work involved in finding appropriate funding sources for affordable elderly housing, and prevent Senior Life Home developers from preying on housing subsidies that are already in short supply.

4. Ultimately, the subsidies provided to developers of nursing homes today by the government could instead be used to develop Senior Life Homes. This would be a giant step toward developing them in plentiful numbers and charging affordable rates.
Lessons Learned

A number of important lessons can be learned by examining the state of Elderly Half-Dependent Couples in the U.S. and comparing their housing and care demands to the existing framework of options available to seniors today.

**Elderly Half-Dependent Couples**

- The housing and care requirements of Elderly Half-Dependent Couples are unique because they are made up of two individuals who display very different levels of independence. While the dependent members of EHDCs may need skilled nursing assistance and wheelchair accessible housing, the independent members of these couples prefer to remain in housing that does not offer such amenities, preferably their own home.

- Because no typology exists in the current elderly housing continuum that meets the demands of both the dependent and independent members of Elderly Half-Dependent Couples, this group is coping by remaining at home for as long as they are able to do so. This situation may be detrimental to the health of dependent members of EHDCs because they are not surrounded by the level of medical support that they are eligible to receive.

**Government Responses to the Problems Faced by Caregivers**

- Government programs have contributed large sums of money to projects seeking to support caregivers in their caregiving roles, rather than seeking to identify or create new alternatives in the realms of elderly housing and care that could solve the problem of over-burdensome caregiving altogether. Given the harmful effects that caregiving has on some providers, it may not be wise to support all caregivers in their roleS as such.

- Family caregiving saves CMS $257 billion annually and fills a gap in the elderly support industry that has left EHDCs with no suitable housing and care option.
• The length of time an EHDC will remain at home depends upon how readily care can be provided for the dependent member of the couple. This, in turn, depends upon the ability and willingness of the healthy partner to provide care, the amount of care that can be provided by other family and friends, and the financial means the couple has to hire paid caregivers.

• A nearly identical story can be told for couples who become half-dependent while living in independent living communities, and to a lesser degree, while living in assisted living facilities. Most EHDCs attempt to remain in their independent or assisted living units as long as is possible, depending upon their access to skilled nursing care.

Affordability of Elderly Housing and Care

• Because in most cases, Medicaid and Medicare can only be used to cover costs associated with skilled nursing facilities, these facilities are much more likely than the other elderly housing typologies to house residents with lower incomes.

• Without applicable subsidies, the high costs of continuing care retirement communities, skilled nursing facilities, assisted living facilities, and independent living communities will continue to have very negative effects for EHDCs because they are more likely than other elderly couples to be in dire financial straights due to the high medical costs they bear. These effects could include preventing a couple from living together in a facility, or even barring an EHDC from such a facility altogether.

• These results are profound considering the findings of the 2004 NAC and AARP study which found that elderly caregivers are far more likely than other caregivers to provide 40+ hours of care per week, present high levels of perceived burden, and report poorer health than the average caregiver.

New Programs

• CCRCs allow healthier members of EHDCs to provide for their partners the level of care they wish to give, saving remaining tasks for staff to handle. Rather than paying an outside contractor to come to the unit, staff are already present on site. They also provide EHDCs
with the opportunity to live in the same unit, or at least very near each other for as long as they wish. Yet, no matter which finance route is chosen, CCRCs are expensive. They also require EHDCs to make an initial move out of the home and into the continuing care retirement community. These are barriers to entry for EHDCs.

- Locating all three typologies (independent and assisted living plus skilled nursing units) on one campus (like a CCRC) does not change EHDCs’ desire to remain in their original (least supported) unit. This has major implications for determining the usefulness of CCRCs.
- Nursing homes and the portions of CCRCs that offer skilled nursing care are the only existing typologies that provide the medical support necessary to care for fully medically dependent members of EHDCs.
- ALFs and CCRCs prove that 24 hour assistance can be made available in a residential, non-institutional environment.
- The Green House nursing home model provides an alternative to the institutional environment which characterizes nursing homes today by offering a smaller scale design, private rooms with private bathrooms, and a large central common area where residents and staff can congregate.
- Models of affordable assisted living demonstrate how pairing affordable housing development subsidies with Medicaid waivers can produce affordable housing and assisted care products.
- Floating licenses show how loosening of licensure requirements can allow elders to truly age in place throughout a spectrum of dependency levels.

**The Senior Life Home Model**

- Like the existing programs have in the past, a new typology which learns from each of the present options and improves upon their shortcomings can offer a better solution for EHDCs.
- The proposed Senior Life Home model tackles unmet EHDC needs by
  - providing apartment-style units that meet the dependency needs of EHDCs,
o offering a smaller scale design that fosters community building and familiarity with staff,
o supplying a product that can easily be sited on many different types of properties, affording the model greater ease in entering urban markets,
o helping the organization of, and ease of access to housing, services, and finance opportunities,
o and making affordability of elderly housing with care a reality.

• In order to bring the Senior Life Home to fruition, a number of changes must be made to the current regulatory and policy system overseeing elderly housing and care. These changes include,
o allowing personal assistance and skilled nursing care to be provided in one unit,
o expanding the Medicaid waiver program and loosening its definition of eligible elderly housing and care options,
o creating development subsidies dedicated to the construction of affordable elderly housing,
o and ultimately moving funds that are currently used to support nursing home development and operations to instead fund this new alternative,

Final thoughts

The existing elderly housing continuum makes little provision for couples that pose very different levels of independence and do not have large sums of money to purchase home care or a CCRC unit. As a result, Elderly Half-Dependent Couples are coping through strategies which could be harmful to both members of these couples. EHDCs are remaining in housing that offers less medical support for dependent partners than they are eligible for, creating a situation that could be detrimental to the health of these dependent individuals. Because it is likely that the independent partners are providing many hours of care in these situations, the “home holdout” situation, as it is termed here, may create harmful circumstances for these caregivers as well.
Independent Living Communities and Assisted Living Facilities do not offer skilled nursing care, which is required by many dependent individuals. These housing options are also quite expensive. Nursing homes offer skilled nursing care but in an institutional environment where couples can generally not cohabitate.

A number of innovative typologies and programs offer hope to EHDCs for a better solution. Continuing Care Retirement Communities offer some benefits over the existing elderly housing continuum by offering a continuum of care in one location and allowing couples to live together. However, CCRCs are quite expensive and still require EHDCs to relocate from their home to the community, and maybe even an additional move or moves between units within the facility. Green House nursing homes offer a new take on the scale and residential design of elderly care-assisted housing. Affordable assisted living programs demonstrate that elderly housing with care can be made affordable. Floating licenses prove that creative programs can allow elders to truly age in place no matter what their level of care dependency might be.

By learning from these existing typologies and programs, both old and new, new typologies that seek to better meet the demands of EHDCs can be posed; the Senior Life Home is one such possibility. In order to develop these homes, Medicaid and senior housing regulations would have to adapt, as would government funding of senior housing and general affordable housing.

Future efforts on behalf of Elderly Half-Dependent Couples should seek to continue identifying new innovative solutions to the dilemmas posed by the unique situations of Elderly Half-Dependent Couples.
A Day in the Life

Robert took his time returning from the grocery store one afternoon. It was a beautiful autumn day in Laurium and he wanted to have a look at some of the leaves turning bright oranges, reds, and yellows before they fell to the ground later that October. Robert took comfort in the fact that his wife, Ruth was safe under the watchful eyes of two of his favorite aides back at their home on 7th Street, two blocks from the store.

That summer, Robert and Ruth had moved into a beautiful newly rehabbed Victorian home not far from their old family home. However, they shared their 7th Street address with four other elderly couples and five single elders. This home was one of seven brand new Senior Life Homes developed in the southwest portion of Laurium to house seniors at all levels of care dependence. Theirs was one of five Senior Life Homes that was actually a large, rehabilitated, older home. The other two structures were newly built on nearby lots that had laid empty for the past two decades. All of the seven structures were located on three adjacent blocks allowing easy movement of staff between the homes. Each of the seven homes was also within three blocks of downtown Laurium, a feature Robert found most useful when he needed a bag of flour and a gallon of milk from the grocery store, as was the case that day. His son Bob, and his wife, Christine, were coming to dinner tonight and Robert was planning to make a batch of his famous New England Clam Chowder – a family favorite.

While Robert prepared his soup that afternoon in the kitchen he chatted with a few of the other residents who as a group, presented a wide range of dependency needs. Ruth and two other individuals in the home received skilled nursing care directed by one of four nurses that traveled between the seven Senior Life Homes. Robert, and all but two of the other residents received various amounts of personal care assistance. Robert specifically liked having a few meals prepared for him each week and it was nice to have help with some chores in his apartment and with some financial bookkeeping. However, even finances had become much easier since moving to the Senior Life Home because all services were provided through floating licenses and paid for
by Medicaid for those who qualified, like Robert and Ruth. As always, Laura, one of his favorite aides, repeatedly offered to help him with the chowder, but Robert told her it was his special recipe which was a “one-man job.”

Bob and Christine arrived in the late afternoon to catch the end of a college football game in the great room with father Robert and the other football lover in the house, Ivan. Bob and Christine loved to visit the friendly environment of the Senior Life Home regularly. They enjoyed seeing Robert and Ruth receiving such excellent care. After the game, Laura wheeled Ruth over to the kitchen table from the great room and the rest of the group gathered for dinner. Bob was a big eater and his effort to get his share of the batch of chowder did not go unnoticed. Bob knew there would be more competition for his father’s cooking when Ann and Carol came to vacation at their parents’ home for ten days beginning at the end of the next week. Robert was also excited for his daughters to visit as he missed not having them around as much as they used to be prior to his move to the Senior Life Home. Yet it was good to get to see them when they came, and as was the case during their previous experience at a nursing home, the aides always welcomed the assistance Ann and Carol offered when they visited.

Robert also liked being able to provide as much assistance to Ruth as he felt inclined to give. He sure appreciated getting to live with her again and keep a close eye on her condition, but some days when he felt more tired, it was good to have two aides who he knew quite well and respected, close at hand. They, in turn, knew both Robert’s and Ruth’s needs quite well, and enjoyed working with such pleasant residents.

After helping Laura tuck Ruth into bed that night, Robert laid down in his bed next to that of his wife. He was already planning the coming weekend’s menu for when his daughters would arrive. He knew he would have a lot of work to do, but if he needed it, plenty of help would be nearby.
REFERENCES


ALF Interviews: Phone interviews with directors and managers of Assisted Living Facilities. 5-2004.


Bader, A. A National Perspective on Affordable Assisted Living. Clarion Consulting Group for AARP, forthcoming.


CCRC Interviews: Phone interviews with directors and managers of Continuing Care Retirement Communities. 5-2004.
Coming Home Interviews: Phone interviews with national managers, directors, funders and state-level directors of the Coming Home Program. 8-2004.


EHDC Interviews: Personal interviews with healthy members of Elderly Half-Dependent Couples. 6-2004 through 7-2004.


ILC Interviews: Phone interviews with directors and managers of Independent Living Communities. 5-2004.

Jenkens, Robert. Executive Vice President, National Cooperative Bank Development Corporation. Phone Interview. 7-04.


National Alliance for Caregiving & AARP. *Caregiving in the U.S.* 2004.


SNF Interviews: Phone interviews with directors, managers, and social workers of nursing homes. 6-2004.


United States Census Bureau, Census 2000, Summary File 1.


