

riskreporter

for senior living facilities

A QUARTERLY PUBLICATION BY CHURCH MUTUAL INSURANCE

Industry experts predict trends for 2005

As the new year begins, it's a good time to consider what the next 12 months are likely to hold for the assisted living industry. We've asked two industry experts--Dave Kylo, vice president of the National Center for Assisted Living (NCAL), and Don Redfoot, senior policy advisor at the AARP Public Policy Institute--to share their thoughts about important issues for the upcoming year.

Resident populations will continue to trend older

In the short term, the burgeoning elderly population will be highly skewed to what Redfoot refers to as "the oldest old," (age 75+) rather than the "young old" (55-74). According to the AARP and NCAL, today's typical resident is an 85-year-old widowed white woman who's mobile but needs assistance with more than two activities of daily living.

This changing resident demographic is likely to increase the need for a host of services, including medication management and dementia care, especially given residents' strong desire to age in place.

"Facilities need to have a well-defined assessment process in place so that they're only accepting residents whose needs they can meet over time," said Kylo.

According to Kylo, roughly one-third to one-half of senior living facilities currently offer some kind of dementia care.

"There will be new guidelines coming from the Alzheimer's Association in



The increasing number of seniors will push the need for additional services throughout the senior living industry in the years ahead.

2005 that will address pain and pain management, nutrition and hydration and appropriate activities for this population," Kylo said. "This will be a valuable tool for (assisted living) facilities."

Resident changes also are driving another trend--on-staff nurses.

According to Provider (June 2004), a 1993 study by Catherine Hawes, a professor at Texas A&M University and a well-known long-term care researcher, found that 21 percent of homes (in a 10-state study) had licensed nurses on staff at least part of

the time. By 1999, an update of this study showed that the numbers had jumped to 71 percent for part-time nurses (either RN or LPN) and 40 percent had an RN on staff full time.

The boomers are coming--but not yet!

To those facility operators who have been anticipating an imminent boomer-induced building explosion, Redfoot delivers this splash of cold water--the oldest boomers are just turning 58 this year.

[see Trends on page four](#)

Facilities need to keep up on mental health issues

Depression, paranoia and anxiety are three of the most common mental health problems faced by the elderly. According to the American Association for Geriatric Psychiatry, nearly 20 percent of Americans age 55 and older suffer from a mental disorder that is not part of normal aging, and studies suggest that mental disorders are underreported for this age group. Within the senior living environment, residents can experience symptoms of these conditions for short periods of time--for instance, in the transition following a move, after a hospitalization or when dealing with a loss--or chronically. With the proper combination of a caring, well-trained staff, a nurturing environment and appropriate intervention from medical professionals, it is possible to dramatically improve the quality of life for residents who suffer from these conditions.

The first step is proper diagnosis, which can prove to be quite challenging. The symptoms of dementia and depression, for example, are often nearly identical, and physical problems frequently manifest themselves in ways that look strikingly similar to mental illness.

"A resident might be agitated because they're in pain," said Kathleen Koepke, psychotherapist and elder specialist in Wisconsin. "They might be delusional because of an infection, a medication imbalance or a brain tumor. You always have to rule out physical causes first."

To gauge a resident's mental health prior to admittance, most facilities rely on health histories, family and resident input and the Mini Mental Exam and/or the Global Deterioration Scale. Koepke said an analysis performed by someone properly trained is needed.

"You want people who are empathetic, not controlling or punitive," she said. "They must be patient, caring and able to recognize that each resident is bringing a certain amount of emotional baggage with them. They have to be willing to allow the residents to have some choice, some autonomy."

Training helps staff to be aware of the signs of mental illness, the role

<i>Mental health symptoms</i>	
<p>Depression</p> <ul style="list-style-type: none"> • Atypical pain* • Irritability* • Somatic complaints* • Loss of interest/pleasure • Change in sleep • Change in appetite • Feeling tired/restless • Guilt or worthlessness • Problems with concentration • Hopeless/helplessness • Forgetfulness/confusion • Recurrent thoughts of death/suicide <p><small>*Atypical symptoms/likely to be present with elderly only</small></p>	<p>Dementia</p> <ul style="list-style-type: none"> • Impairment in judgment • Memory impaired • Language disturbance • Impaired motor skills • Failure to recognize/identify objects • Inability to plan, organize or have abstract thoughts • Gradual and not caused by treatable medical condition • Personality change
<p>Delirium</p> <p>At least two of the following:</p> <ul style="list-style-type: none"> • Perceptual disturbance • Incoherent speech • Disturbed sleep cycle • Agitation or motor retardation • Memory impairment and disorientation • Fluctuation of cognitive functions • Rapid onset of symptoms 	<p>Delusional Disorder</p> <ul style="list-style-type: none"> • Non-bizarre delusions (example: being poisoned or having a disease) • Auditory or visual hallucinations • Apart from delusions, behavior is not obviously odd. If mood disorder present, duration has been brief <p>(Source: Kathleen Koepke)</p>

medication can play and how their actions can impact a resident's behavior.

Mary Ann Larsen, program director at 3801 Grand Assisted Living in Des Moines, Iowa, brings in a mix of local resources to train her staff, including a gerontologist and a pharmacist, and offers in-services on grief and dementia.

"Through this training, we've learned how to deal with residents more effectively," she said. "For instance, we have a resident who suffers from anxiety, and she is very concerned about getting her lunch at a specific time. We've learned that her day--and ours--will go more smoothly if we serve her first."

Training also can help staff learn when to involve a medical professional.

"If a person is sad because they've lost a dear friend, we wouldn't necessarily label that as depression, but if a resident has symptoms that haven't abated in three to six months, it's time to get outside help," Koepke said.

An environment that nurtures and supports residents can help to foster improved mental health.

During a resident's first days at her facility, Jill Tyler, executive director of Brookside Landing in Orofino, Idaho, assigns extra staff so that there will always be someone there to listen and offer support.

Larsen recommends that families visit more often during the early weeks. "We work diligently to make sure residents don't feel abandoned," she said. "We also recognize that this is a period of grief--grief over the loss of a loved one, a family home or their own physical abilities--and take the time to be there for them."

Residents should have opportunities to participate in activities they enjoyed in the past. A realignment of expectations can prove crucial in strengthening a resident's mental health. Koepke strongly believes in Abraham Maslow's "psychogogic approach" to help residents prevent

Ensure protection by reviewing policies annually

When reviewing insurance policies, business owners often express surprise that a particular cause of loss or operation is excluded from coverage. The popular opinion is that exclusions are created by insurance companies to avoid paying claims. This, of course, is not the case.

In fact, there are three basic reasons for exclusions in insurance policies. Only one refers to “uninsurable” situations. The other two are best described as attempts to provide coverages in the most efficient and economical way. The three reasons are:

- Covered elsewhere
- Coverable by extra cost or modification
- Uninsurable

“Covered elsewhere” is focused on efficiency. These exclusions are added to policies when another policy is intended to cover the specific operation or activity. For example, automobiles are excluded under general liability policies because the liability for operating is addressed by

your business automobile policy. The efficiency arises from eliminating duplication of coverage.

The goal of “covered only by extra cost or modification” is keeping coverage economical. Causes of loss and operations that might not typically be associated with your business will be excluded. Why charge everyone to include coverage that might apply to only a few? If you need or want the coverage, you can add it by endorsement and pay the additional premium.

“Uninsurable” represents the smallest number of exclusions. These are causes of loss or operations such as intentional damage or harm, war, earthquake, nuclear activities and flood--to name a few. These exclusions usually represent a potential loss that is catastrophic, intentional or so dangerous that general principles of insurance do not apply.

A key part of your risk management program should be performing an annual comprehensive review of your insurance program with a qualified

insurance professional. There are specific areas of potential loss or claims that should be reviewed:

- Coverage should be reviewed for property, systems and equipment, business income, general and professional liability, employee benefits, employment practices, employee dishonesty, workers’ compensation, business automobile, directors, officers and trustees and excess liability.
- Limits of insurance should be reviewed to confirm that there are adequate amounts of coverage to pay for losses and expenses that would result from a “worst-case scenario” incident.
- Potential premium savings might be available through deductibles, “packaging” of coverages or excluding coverages that do not apply to your operation.

Your annual insurance review with a qualified insurance professional will provide you peace of mind that an efficient and economical insurance program adequately protects your assets and financial well-being.

Health from page two

or heal from emotional breakdowns.

The approach has three components:

- Educate the resident and help them to tap inner resources. For example, if the resident has had a stroke, provide recovery statistics so that they have a realistic understanding of what they can expect. Work with the resident to understand what’s helped them through hard times in the past: working in a garden, talking to a friend and religion.
- Revalidate the person. Show them that they are still themselves and that they are worthwhile and have strengths.
- Help them to redefine their goals. A person who walked two miles a day and has had a stroke might have to start with a walk down the hall.

It’s important to recognize that some residents are just more naturally

resilient, positive and adaptive than others. Koepke believes that to some degree these qualities can be learned either through modeling--pairing up a newcomer with a more established resident who has these characteristics--or through counseling.

“People are living much longer, and we’re really just learning how to ‘do’ aging,” Koepke said. “As we find people who are mentally intact and have great characteristics--resiliency, curiosity--we can try to emulate them.”

These efforts don’t guarantee a resident’s mental health and stability, and for that reason, it’s important for a facility to form ongoing relationships with mental health professionals.

Larsen works with her county’s elderly outreach program, which provides social workers, a psychiatrist

and an RN who will come right to the facility to offer counseling. Tyler, whose facility is located in a small town, has ready access to local doctors.

Dr. William Haley, professor and director of the School of Aging Studies at the University of South Florida, said older adults respond just as well as younger adults to counseling and psychotherapy and that interventions are often as effective as medications for improving conditions such as depression, anxiety and insomnia.

“We should never underestimate the elderly. If we work to accommodate them, to give them as much control of a situation as possible, we can help them to understand the wisdom of interdependence and to develop a sense of self-trust and peace,” Koepke said.

“With the average age at admission of 82 or 83, we’re still decades away from another building boom,” he said.

In fact, the next wave of senior living residents--children of the Depression and WW II--will be smaller than the current crop of elderly, leading to increased competition in the industry. Many in this group will have the resources to pay for private care and the desire to avoid nursing homes.

Industry is working diligently to police itself

In 2004, media coverage pointed out the broad disparities in what “assisted living” meant across the country as well as the problems that occurred in states with low levels of regulation such as New York and West Virginia.

Should assisted living be federally regulated? Will it?

The industry is attempting to counter the push for federal regulation with the formation of the Center for Excellence in Assisted Living (CEAL). Founded in 2004, CEAL is comprised of 11 groups representing a cross-section of AL-linked groups (including both NCAL and AARP).

“Providers want market-driven, consumer-responsive facilities,” Redfoot said. “They want state regulations.

“There are some excellent states who have been engines for innovation, but there are other states who, when left to their own devices, haven’t stepped up to the plate,” he said. “It’s a balance to promote diversity and innovation while making sure that basic standards are met. These are the things we’re

hoping to address with CEAL.”

Kyllo attended the recent CEAL inaugural summit.

“People of all different constituencies are against the federal regulation of AL,” he said. “They saw what happened in nursing homes and the problems that overregulation has caused, and they don’t want to go down that path. I think that the average consumer believes they’ll get better, more responsive care with state regulation.”

AL funding will continue to be a hot topic

“State budgets are showing some signs of recovery, but it’s definitely a period of retrenchment,” Redfoot said. “A lot of states are honing in on Medicaid reform because this is their most rapidly growing budget segment. They’re asking themselves hard questions about whether to simply pare down to meet federal minimums or whether they really want to try to get innovative--like Oregon, Washington and, recently, Vermont--and revamp their systems so that it doesn’t all ride on the most expensive and least popular option, nursing homes.”

Kyllo said there is quite a bit of experimentation going on at the state level regarding delivering AL to low-income individuals. In the past, there’s been a push to keep people in their homes for as long as possible, which isn’t always the best option.

“Medicaid reform is definitely going to come, and it’s important for the AL community to be involved in this debate,” he said.

There have been some tentative attempts to create less expensive AL facilities to provide the low-income elderly with more care options. Efforts between AARP and a variety of financial players have been stymied to date.

“Investors and lenders don’t always understand the unique attributes of an AL facility,” Redfoot said. “We need large common rooms and smaller apartments, but the developers want to create standard apartment buildings in case the project fails, and this drives up costs.”

Staffing levels will become even more critical

According to news articles, turnover in the assisted living industry currently runs as high as 40 percent.

“To stay competitive, facilities will need to identify strong staff, train them and focus on staff retention,” Kyllo said. “Compensation is an important issue as is creating a positive work environment for staff. Administrators need to recognize and address cultural and generational differences between staff and residents.”

Redfoot said the low pay and poor benefits provided in the industry make it difficult to compete.

“We need to create an environment where employees feel they’re helping to provide dignity and a quality of life,” he said. “We need to attract people who really want to help others, and we have to show them that they can have a career in this industry--that they can grow in their jobs.”

READER INPUT

To receive Risk Reporter for Senior Living Facilities or submit a comment or story idea, please call Rick Schaber at (800) 554-2642, select Option 4 and enter Extension 4587 or send an e-mail to rschaber@churchmutual.com.

riskreporter
riskreporter
for senior living facilities



Church Mutual Insurance Company
3000 Schuster Lane, P.O. Box 357
Merrill, WI 54452-0357
www.churchmutual.com

Editor: Rick Schaber
(800) 554-2642 Ext. 4587