

2008 SAGE USA Tour



Sage Aged Care Study Tour to Washington and Philadelphia commenced with a very comprehensive tour of the US national capital, Washington DC.

led by our very humorous guide Mike who filled each venue with local history and anecdotes, we quickly learned that he is an ardent opponent of George W Bush.

Nonetheless, he introduced the group to the Jefferson Memorial, Washington Memorial, The White House, Congress, Union Station, the Smithsonian, Library of Congress and much more.

The feature of the tour was that we had arrived on the day of the Cherry Blossom Festival which meant large crowds of people on the streets enjoying some sunshine and the cherry blossoms.

The Sage Tour attended the American Association of Housing and Services for the Aged (AAHSA) national policy setting conference where the major theme was workforce.

Two standout speakers were Mark Williams who looked at cultural influences on our assumptions and attitudes and how we all view others, our community, and our workplaces through a variety of lenses which colour our perception of the world and how we interact with others.

The other stand out presenter was Ann Rhodes, President, Jet Blue Airlines Association who has worked for a number of major US corporations dealing with culture and values and how you ensure the organisations objectives are achieved through employee engagement. Ann is a strong advocate of managers/leaders leading by example and going out of the way to recognise employee excellence and installing regular rewards or recognition activities eg: hand written thank you note sent to the employee's home.

Ann is particularly keen on developing shared workplaces where employees work as teams and fill positions collectively including team management of rosters.

She has also used employee self selection strategies very successfully. In this situation, management includes class 'A' employees to assist in the staff recruitment process. Strategies along these lines have helped South West Airlines maintain a staff turnover rate at below ten percent for many years even in a tight labour market.

One of the highlights of the tour was a visit to the Capital building with our guide being an intern to Senator Levin. We were able to sit in the Senate Chamber during a debate on the US housing crisis.

We visited four facilities in Washington and then moved to Philadelphia in Pennsylvania. This state has the highest number of continuing care retirement communities in reasonably close proximity in the US.

We visited a range of sites ranging from luxury to services focusing on the poor to middle class.

All these facilities offered a variety of financial packages however; the overall model is a comprehensive continuum of care with an upfront fee with a monthly service fee depending on size of purchase or level of service being provided.

The service fee would include options such as:

- one meal per day
- thirty meals over a month
- three meals per day
- access to gym and training
- access to sport and classes
- limited care services in assisted living
- full care services in skilled nursing facility

The comparable descriptions would be:

America	Australia
Independent living	Retirement Village or ILU
Assisted living	Hostel
Skilled nursing	Nursing Home

Stand out messages from the tour:

Government Regulation

In all instances, Government regulated the assisted living and skilled nursing facilities however; independent living had a much lower level of regulation.

All sites concerned about the day the Feds would arrive to undertake an inspection however, business model not solely dependent upon the regulated part of the operation and therefore appeared much lower level of pressure to pass the 'inspection'.

Financial

The CCRC model even at the lower income level provided income variety so that operators were not just dependent on government subsidy.

It also provided greater flexibility to scale the offering according to quality of building or level of service being provided.

An operator could charge a \$96,000.00 entry fee which is forfeited to the facility after a three month trial or an \$800,000.00 entry fee for a luxury villa which is 100% refundable.

The monthly fee can be as low as \$700.00 per month for an independent resident with one meal per day to \$8000.00 per month for an upmarket skilled nursing facility.

Generally speaking, the fees generate a higher level of income than in Australia. Even Medicare pays approximately \$185.00 per day. \$89.00 per day more than the average Australian facility receives from government subsidy.

Operations covered the spectrum of 100% self funded retirees with no government funding to sites that had in their assisted living/skilled nursing operations Medicare/Medicaid care recipients in the 30% to 40% range not that dissimilar to our own concessional rate.

Medical Services

There were a range of medical services available to clients however it was generally considered part of the service package to have a medical service arrangement in place.

At the 2,800 person Erikson campus they had a GP clinic with six primary care physicians in attendance and they tracked the medical services and medication regimen of their clients very closely. Part of their client agreement was the provision of medical assistance (usually a nurse aid) to attend any resident within minutes of an emergency arising. Another interesting feature of the Erikson campus was that they had entered an agreement with Medicare which was generating a large financial rebate each year as their medical services were substantially reducing calls on other parts of the health system especially unnecessary hospital admissions.

System Structure

There were three primary service offerings:

- **Type A** which consisted of a whole of life insurance plan managed by the facility so the operator took some risk on your longevity and service need though you paid a monthly service fee for the duration of your stay but the fee was fixed.
- **Type B** which consisted of a whole of like insurance plan but with a flexible fee that would increase across the service continuum as you moved from independent living to assisted living and skilled nursing.



- **Type C** which consisted of legal rights at entry but gave no assurances regarding lifetime care e.g. a person diagnosed with dementia could be moved to a specialist unit off site.

Legal Status

Persons on entering independent living usually received some form of legal title to entry and continued occupation of the unit in which they reside ranging from a licence to occupy to a form of real property title to space within the designated living area.

Insurance

Other than Medicaid/Medicare beneficiaries, most providers unless they are a self insurance model insist on incoming residents having long term care insurance which pays at best part of the monthly fee.

Building Quality

At the high end building quality, layout, finishes and landscape were of a very high order.

What was very interesting was the large land size of a number of the sites with 50 acres to 500 acres being some examples.

Another interesting aspect was older sites that had either incorporated an historical or existing building and converted to modern use or renovated and redesigned an existing complex to meet modern needs was t the norm rather than the exception. Knock down and rebuild were rare.

Societal Attitudes

There was a discernable public acceptance of seniors living partly generated, we

believe, by the removal of some of the negative terminology such as nursing home, aged care, aged care home, retirement village and facility.

Many operators describe their operations as communities or neighbourhoods with care service areas often described as the club house or village.

Also, the continuum of care concept means people are entering the complex whilst still in relatively good health though in the old old age bracket.

This means residents can be highly active in their community and be very involved in the operations of the service.

Most operations we saw provided accommodation for couples and if one person was transferred to skilled nursing supported daily contact and interaction between the couples including eating meals together.

Resident Profile

Most sites reported a resident profit something like:

Age at admission	76-77 years
Average age	83 years
Length of stay	5 years
Women	70%
Men	30%

Internal Socialisation

High emphasis on dining and food quality. We ate at a number of facilities and the food was exceptional.



Many activities were provided with outings, excursions, movies, activities, library and health.

Service Regime

Almost all residents ate in the various dining rooms so rare to see someone in a bed though in skilled nursing not unusual to see residents in wheelchairs.

The philosophical position was avoidance of isolation and depression and assurance of social interaction.

Many facilities had strategies in place to ensure residents had eaten at least one meal a day. One operator had also installed a sensor device on the refrigerators to record when the refrigerator was opened, thus confirming the resident had risen and was active.

Care in most assisted living units was minimal with an enrolled nurse equivalent being the only nursing staff member present.

The assisted living units are quite close to the skilled nursing units so assistance was readily available if needed.

Many skilled nursing units seemed to have better staff ratios than Australia with a carer ratio of approximately 1: 5 or 6 and a registered nurse ratio of approximately 1: 20 residents.

Admission to the assisted or skilled living units was in the main from the independent living unit but admissions could be accepted in some cases directly from the community.

There were a number of skilled nursing units contracted to local health services to provide short term rehabilitation thus generating another income stream.

Dining and Catering

All facilities had a variety of dining locations with a number providing a formal room for an evening meal with other areas being used for lunch or informal snacks.

A number of sites provided a home delivery service to independent living or a take away option. Home delivery would be for a small additional fee.

The dining experiences were exceptional with great emphasis placed on food quality and presentation.

Residents could usually dine anywhere in the various dining areas including a skilled nursing resident if physically able or if their partner or relatives wished to eat with them.

Rarely would a tray be delivered to a bedroom unless a resident was ill.

Wellness

There was a major emphasis on sustaining health. All facilities had a gym, workout area and many, a pool.

Great emphasis on weight training and general fitness.

Classes in a whole range of activities were provided and residents strongly encouraged to participate.

This appeared to have a considerable beneficial impact on resident health status.



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Communications and Technology

Most sites had well developed communication systems for residents using a variety of channels including:

- central TV monitor
- TV channel to whole site
- message to TV
- newsletters
- notice boards

Most used a magnetic swipe card to record meal usage or other service use for which a charge was to be raised eg: in a one meal a day plan, a resident could charge their card if they had a guest in the dining room and they would be billed at the end of the month.

Three facilities were using a form of electronic medical record in one case for all residents, in the other cases for skilled nursing residents.

Two facilities were using electronic data capture for care staff servicing residents in skilled nursing, one package was 'acunurse' the other a PDA activated device.

Two facilities had electronic prescribing systems linking skilled nursing/GP/ pharmacy. Both had greatly improved medication administration efficiency and considerably reduced medication error rates.

Most units used a bracelet alert system and external alarm to manage clients who had a tendency to wander.

Governance and Ownership

Of the ten facilities visited, nine were various forms of not for profit with one being for profit.

The not for profit took various forms ranging from traditional church ownership to a full blown cooperative where the residents literally owned and governed the facility.

In all instances, there was a board of governors usually with some resident representation or formal opportunity to contribute to the policy and governance issues of the organisation.

Animals

All facilities had a proactive and positive attitude towards animals with independent unit residents being able to keep a dog, cat, bird or fish, provided they were able to maintain and support their animals.

One woman had two cats and a cage of Australian cockatiels in her unit.

Bathing

Assisted living and skilled nursing units often had central bathing spas with ensuite, only containing a toilet and sink.

Most sites bathed assisted and skilled nursing residents two or three times per week unless otherwise required.

Conclusions

The CCRC model has much to recommend it and if Australian aged care and village operators are looking for different models of care, then they should closely examine this model as it has the benefits of:

- changing community attitudes to aged care
- providing enhanced services to the resident population
- based on previous studies extends the life and life quality of residents
- provides a distinct alternative for future client looking for a comprehensive service suite
- truly supports the client to age in one place
- cross supports capital and operational costs across a broader age range
- because of earlier entry, supports broader socialisation activities of the whole facility thus changing the high care only focus of the modern day nursing home

- could provide the impetus for an Australian long term care insurance product.

Site Visits

The following is a sample of the sites visited and some of the features observed together with some of the financial structures and client fees:

Riderwood (part of the Erickson Group)

Nearly 2800 persons on a 120 acre site accommodated in independent living apartments, assistive living and skilled nursing services on the one campus.

Residents pay a 100% refundable accommodation deposit and a monthly service fee ranging from \$1329.00 to \$2168.00 with an additional fee for skilled nursing services.

Ashbury

Ashbury is a multi function continuing care retirement community housing 1291 residents on a 130 acre site which has been operating since 1926. Six sites in group.

They are experiencing considerable competitive pressure due to additional places in the area. Up to two years ago had 58% of the local market share. That has shrunk to 21% so have had to become more aggressive marketers. Marketing department consists of eight staff. ■

Facility Fees continued next page →

Riderwood Facility Fees

Apartment Style	100% Refundable Entrance Fee	Monthly Service Package
Studio/Deluxe Studio	\$122,000-\$141,000	\$1,329-\$1,381
Large One Bedroom	\$172,000-\$187,000	\$1,527
Extra Large One Bedroom	\$212,000-\$270,000	\$1,571
Extra Large One Bedroom with Den	\$255,000-\$268,000	\$1,769
Two Bedroom, One Bath	\$247,000-\$272,000	\$1,786
Two Bedroom, One and a half Bath	\$309,000	\$1,940
Two Bedroom, Two Bath	\$330,000-\$536,000	\$1,940-\$2,168
Second Person Occupancy	None	\$657

Riderwood Facility Fees

Monthly Service Package

Covers the day-to-day cost of providing services and amenities such as:

- All utilities (except telephone)
- Property taxes
- Cable TV
- Landscaping and lawn care service
- Snow removal

- One meal a day in the Fireside, Windsor room, Seasons, Potomac Café, or the Overlook
- Apartment maintenance
- All-season swimming pool and hot tub
- Tennis courts and putting green
- Woodwork and hobby shop
- Billiards room
- Creative arts studio
- Gardening areas
- Card rooms
- Library
- 300-seat Encore performing arts centre
- 300-seat performance hall
- Reading lounges
- Walking trails
- Educational classes
- Meeting rooms for clubs and activities
- Garbage collection
- 24-hour security
- Scheduled local shuttle service

Ashbury Methodist Village Facility Fees

Assisted Living Fees

Daily Rate
Ashbury Resident
(single occupancy,
one-bedroom apartment)

Level 1	\$156.00
Level 11	\$202.00
Level 111	\$253.00

Studio \$500 less/month

Couple Rate Range for One
Apartment
\$213/day - \$408/day

Respite: One person
\$204/day

Assisted Living Rate Inclusions

The daily rate for Assisted Living is based on the level of care needed by the resident. There are 3 levels of care provided. The level of care is determined by the specific needs of the resident as assessed prior to coming to Assisted Living. An individual care plan is created for each resident.

The daily rate for all levels of care includes:

- 3 meals a day and daily snacks
- Weekly housekeeping services
- Weekly laundry services
- Cable television hook-up and basic cable services
- Emergency response system
- Basic telephone service for local calls
- Bed linens (for a single bed) and bath linens
- Tissues and toilet paper
- Heat, electricity, hot water and air conditioning
- Transportation is provided for residents of assisted living for appointments on campus and for group activities off campus

Type of Residence	Square feet	Standard Entrance Fee*	90% Refundable Entrance Fee	100% Refundable Entrance Fee**	Estimated Monthly Fee (\$)**
Example 1 (1st floor)	1,628	\$459,000	\$665,600	\$688,500	\$1,500
Example 2 (1st floor)	1,628	\$469,000	\$680,100	\$703,500	\$1,500
Example 3 (1st floor)	1,628	\$489,000	\$709,100	\$733,500	\$1,500
Example 4 (1st floor)	1,822	\$535,000	\$775,800	\$802,500	\$1,500
Example 5 (upper floors)	1,868	\$595,000	\$862,800	\$892,500	\$1,500
Example 4 (1st floor)	1,895	\$595,000	\$862,800	\$892,500	\$1,500
Example 5 (upper floors)	1,918	\$629,000	\$912,100	\$943,500	\$1,500

*standard entrance fees offer declining refund over a 60-month period

** refund dependent upon successor resident paying an entrance fee for the unit

*** monthly fees include exterior and interior maintenance and repairs, 24-hour security snow removal and all other campus amenities.