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001. letter	Holly Bannister to the President re:address and phone number (partial) (1 page)	06/24/1998	P6/b(6)

COLLECTION:

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FOLDER TITLE:

Assisted Living [Folder 4]

2012-0463-S

rc720

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

What is Assisted Living?



Assisted Living

The new housing and health care alternative combining independence with personal care in a warm, dignified, community setting.

What is Assisted Living?

ALFA Home

The Assisted Living Federation of America (ALFA) defines an Assisted Living residence as a special combination of housing, personalized supportive services and health care designed to meet the needs—both scheduled and unscheduled—of those who need help with activities of daily living.

Assisted Living Facts

What is the philosophy of Assisted Living?

ALFA members subscribe to a 10-point philosophy of care:

1. Offering cost-effective quality care that is personalized for individual needs
2. Fostering independence for each resident
3. Treating each resident with dignity and respect
4. Promoting the individuality of each resident
5. Allowing each resident choice of care and lifestyle
6. Protecting each resident's right to privacy
7. Nurturing the spirit of each resident
8. Involving family and friends, as appropriate, in care planning and implementation
9. Providing a safe, residential environment
10. Making the Assisted Living residence a valuable community asset

Who lives in Assisted Living residences?

Currently, more than a million Americans live in an estimated 30,000 Assisted Living residences. Assisted Living residents can be young or old, affluent or low income, frail or disabled. A typical resident is age 83 or older, is female, and is either widowed or single. Residents may suffer from Alzheimer's disease or other memory disorders. Residents may also need help with incontinence or mobility.

What does an Assisted Living residence look like?

Assisted Living residences can range from a high-rise apartment complex to a converted Victorian home to a renovated school. Residences may be free standing or housed with other residential options, such as independent living or nursing care. They may be operated by non-profit or for-profit companies. Most facilities have between 25 and 120 units. There is no single blueprint, because

consumers' preferences and needs vary widely. Units may vary in size from one room to a full apartment.

How is Assisted Living regulated?

Regulations and licensing regulations vary from state to state contributing to the wide range of senior housing models considered Assisted Living. Most providers and their staff have special training as a result either of state requirements or company policy. Some states require special staff certification and training. Residences must comply with local building codes and fire safety regulations. ALFA believes the most successful regulations are consumer drive, balancing the safety concerns we all share with the consumers' desires to retain their independence and freedom of choice.

What types of services are offered in Assisted Living residences?

Services provided in Assisted Living residences usually include:

- Three meals a day served in a common dining area
- Housekeeping services
- Transportation
- Assistance with eating, bathing, dressing, toileting and walking
- 24-hour security and staff availability
- Emergency call systems for each resident's unit
- Health promotion and exercise programs
- Medication management
- Personal laundry services
- Social and recreational activities

What about costs?

Costs vary with the residence, room size, and the types of services needed by the residents. Across the nation, daily basic fees range from approximately \$20 to \$100 -- generally less than the cost of home health services and nursing home care. A basic Assisted Living fee may cover all services or there may be additional charges for special services. Most Assisted Living residences charge month-to-month rates, but a few residences require long-term arrangements.

Who pays the bill for an Assisted Living residence?

Residents or their families generally pay the cost of care from their own financial resources. Depending on the nature of an individual's health insurance program or long-term care insurance policy, costs may be reimbursed. In addition, some residences have their own financial assistance programs. Government payments for Assisted Living residences has been limited. Some state and local governments offer subsidies for rent or services for low income elders. Others may provide subsidies in the form of an additional payment for those who receive Supplemental Security Income (SSI) or Medicaid. Some states also utilize Medicaid waiver programs to

help pay for Assisted Living services.

How to find an Assisted Living residence?

- Consumers interested in locating Assisted Living facilities should visit the searchable ALFA Online Directory of Assisted Living providers at CareGuide. The site is searchable by state, county, city or metropolitan area.
- Call the national Eldercare locator service at (800) 677-1116. Calls are accepted between 9 am - 5pm Monday through Friday.
- Contact your local area agency on aging. These agencies are generally listed in the blue pages of your telephone directory.
- Check your library for the National Directory of Retirement Facilities.
- Or for a state listing of Assisted Living residences contact Gloria Lewis, Consumer Referral Manager, gl@alfa.org



POWERED BY:

careguide
www.careguide.net

For more information about Assisted Living contact Whitney Redding, Director of Media & PR wr@alfa.org.

Send mail to lc@alfa.org with questions or comments about this web site.
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AAHSA

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ONLINE SURVEY

AAHSA American Association of Homes and Services for the Aging		
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● Publications	● Member Links	● Member Central

About AAHSA

The American Association of Homes and Services for the Aging (AAHSA) represents not-for-profit organizations dedicated to providing high-quality health care, housing and services to the nation's elderly. Its membership consists of over 5,000 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community services. AAHSA organizations serve more than one million older persons of all income levels, creed and races.

Through education, advocacy, grassroots action and coalition work, AAHSA influences public policy pertaining to health, housing, community and related services to ensure that the aging population receive the services they need, and to protect and enhance the viability of not-for-profit providers. AAHSA also offers timely newsletters, publications and other communications to keep members up-to-date on Congressional and regulatory action, and trends and issues in the field of aging services.

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AAHSA Menu

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American Association
of Homes and Services
for the Aging

AAHSA Affiliated State Associations

AAHSA is a national nonprofit organization representing over 5,000 not-for-profit nursing homes, continuing care retirement communities, assisted living residences and senior housing facilities and community service organizations for the elderly.

Here is a listing of AAHSA Affiliated State Associations-for more information about homes and services for the aging in a specific state, please use this contact list.

Alabama

Alabama Association of Homes and Services for the Aging, Inc.
C/o St. Martin's In-the-Pines 4941 Montevallo Road
Birmingham AL, 35210-2497
Phone: 205-956-1831 Fax: 205-956-9124

- Alabama Association of Homes and Services for the Aging, Inc.

Arizona

Arizona Association of Homes and Housing for the Aging
3839 North 3rd Street, Suite 201
Phoenix AZ, 85012
Phone: 602-230-0026 Fax: 602-230-0563

California

California Association of Homes & Services for the Aging
7311 Greenhaven Drive Suite 175
Sacramento CA, 95831-3572
Phone: 916-392-5111 Fax: 916-428-4250

- California Association of Homes & Services for the Aging

Colorado

Colorado Association of Homes and Services for the Aging
1888 Sherman Street, Suite 610
Denver CO, 80203-1160
Phone: 303-837-8834 Fax: 303-837-8836

Connecticut

Connecticut Association of Not-for-Profit Providers for the Aging
300 Research Parkway
Meriden CT, 06450-7137

Phone: 203-237-4556 Fax: 203-237-4908

- Connecticut Association of Not-for-Profit Providers for the Aging

Delaware

Delaware Association of Homes & Services for the Aging
c/o Ingleside Homes 1010 North Broom Street
Wilmington DE, 19806-4514
Phone: 302-777-0130 Fax: 302-777-0131

Florida

Florida Association of Homes for the Aging
1812 Riggins Road
Tallahassee FL, 32308-4885
Phone: 850-671-3700 Fax: 850-671-3790

- Florida Association of Homes for the Aging

Georgia

Georgia Association of Homes and Services for the Aging
1655 Tullie Circle, NE Suite 108
Atlanta GA, 30329-2316
Phone: 404-728-0223 Fax: 404-636-6753

Iowa

Iowa Association of Homes and Services for the Aging
100 East Grand, Suite 140
Des Moines IA, 50309-1800
Phone: 515-283-9380 Fax: 515-283-9382

- Iowa Association of Homes and Services for the Aging

Illinois

Life Services Network of Illinois
911 North Elm Street Suite 228
Hinsdale IL, 60521-3634
Phone: 630-325-6170 Fax: 630-325-0749

Life Services Network of Illinois - Springfield
2 Lawrence Square
Springfield IL, 62704-2523
Phone: 217-789-1677 Fax: 217-789-1778

Indiana

Indiana Association of Homes and Services for the Aging, Inc.
P O Box 68829
Indianapolis IN, 46268-0829
Phone: 317-733-2380 Fax: 317-733-2385

- Indiana Association of Homes and Services for the Aging, Inc.

Kansas

Kansas Association of Homes and Services for the Aging
700 SW Harrison Street Suite 1106
Topeka KS, 66603-3759

Phone: 785-233-7443 Fax: 785-233-9471

- Kansas Association of Homes and Services for the Aging

Kentucky

Kentucky Association of Homes and Services for the Aging
1244 South Fourth Street
Louisville KY, 40203-3051
Phone: 502-635-6468 Fax: 502-635-9286

Louisiana

Louisiana Association of Homes and Services for the Aging
P O Box 14615
Baton Rouge LA, 70815-4169
Phone: 225-201-9933 Fax: 225-201-9944

Massachusetts

Massachusetts Aging Services Association, Inc.
45 Bromfield Street, Suite 200
Boston MA, 02108-4106
Phone: 617-423-0718 Fax: 617-423-2109

- Massachusetts Aging Services Association, Inc.

Maryland

MANPHA - A Senior Service Alliance
10280 Old Columbia Road Suite 250
Columbia MD, 21046-1709
Phone: 410-381-1176 Fax: 410-381-0240

- MANPHA - A Senior Service Alliance

Michigan

Michigan Association of Homes and Services for the Aging
6215 West St. Joseph Highway
Lansing MI, 48917-4852
Phone: 517-886-1302 Fax: 517-886-1670

Minnesota

Minnesota Health & Housing Alliance
2550 University Avenue West Suite 350 South
St. Paul MN, 55114-1900
Phone: 612-645-4545 Fax: 612-645-0002

Missouri

Missouri Association of Homes for the Aging
308A Monroe Street
Jefferson City MO, 65101-3106
Phone: 573-635-6244 Fax: 573-635-6618

Mississippi

Mississippi Association of Homes & Services for the Aging
c/o Naval Home 1800 Beach Drive
Gulfport MS, 39507-1597
Phone: 228-896-3110 Fax: 228-897-4013

Montana

MHA - An Association of Health Care Providers
P O Box 5119
Helena MT, 59601-4657
Phone: 406-442-1911 Fax: 406-443-3894

- MHA - An Association of Health Care Providers

North Carolina

North Carolina Association of Non-Profit Homes for the Aging, Inc.
3700 National Drive, Suite 218
Raleigh NC, 27612-4842
Phone: 919-571-8333 Fax: 919-571-1297

Nebraska

Nebraska Association of Homes and Services for the Aging
1701 K Street, Suite B
Lincoln NE, 68508-2699
Phone: 402-436-2165 Fax: 402-436-2169

New Hampshire

Northern New England Assn. of Homes & Svcs for the Aging
345 Edward J. Roy Drive Suite 201
Manchester NH, 03104-4149
Phone: 603-626-3479 Fax: 603-626-3763

New Jersey

New Jersey Association of Non-Profit Homes for the Aging
13 Roszel Road, Suite B 113
Princeton NJ, 08540-6211
Phone: 609-452-1161 Fax: 609-452-2907

New York

New York Association of Homes & Services for the Aging
150 State Street, Suite 301
Albany NY, 12207-1698
Phone: 518-449-2707 Fax: 518-455-8908

- New York Association of Homes & Services for the Aging

Ohio

Assn of Ohio Philanthropic Homes, Hsng & Svcs for Aging
855 South Wall Street
Columbus OH, 43206-1921
Phone: 614-444-2882 Fax: 614-444-2974

- Assn of Ohio Philanthropic Homes, Hsng & Svcs for Aging

Oklahoma

Oklahoma Association of Homes and Services for the Aging
P O Box 1383
El Reno OK, 73036-5699
Phone: 405-640-8040 Fax: 405-262-5252

Oregon

Oregon Alliance of Senior and Health Services

7360 South West Hunziker St. Suite 207
Tigard OR, 97223-8288
Phone: 503-684-3788 Fax: 503-624-0870

- Oregon Alliance of Senior and Health Services

Pennsylvania

Pennsylvania Association of Non-Profit Homes for the Aging
Executive Park West, Suite 409 4720 Old Gettysburg Road
Mechanicsburg PA, 17055-8419
Phone: 717-763-5724 Fax: 717-763-1057

- Pennsylvania Association of Non-Profit Homes for the Aging

Rhode Island

Rhode Island Association of Facilities & Services for the Aging
210 Cahir Street
Providence RI, 02903-4039
Phone: 401-453-0040 Fax: 401-453-1160

South Carolina

South Carolina Association of Non-Profit Homes for the Aging
P O Box 2708
Myrtle Beach SC, 29578-2708
Phone: 843-497-3506 Fax: 843-497-5362

South Dakota

South Dakota Association of Healthcare Organizations
3708 Brook Place, Suite 1
Sioux Falls SD, 57106-4211
Phone: 605-361-2281 Fax: 605-361-5175

Tennessee

Tennessee Association of Homes and Services for the Aging
500 Interstate Boulevard South
Nashville TN, 37210-4634
Phone: 615-256-1800 Fax: 615-726-3082

Texas

Texas Association of Homes and Services for the Aging
2205 Hancock Drive
Austin TX, 78756-2508
Phone: 512-467-2242 Fax: 512-467-2275

- Texas Association of Homes and Services for the Aging

Virginia

Virginia Association of Non-Profit Homes for the Aging
Innslake Place Building 4401 Dominion Blvd., Suite 200
Glen Allen VA, 23060-3322
Phone: 804-965-5500 Fax: 804-965-9089

- Virginia Association of Non-Profit Homes for the Aging

Washington

Washington Association of Housing and Services for the Aging

16300 Christensen Road Suite 203
Seattle WA, 98188
Phone: 206-248-7434 Fax: 206-241-2595

- Washington Association of Housing and Services for the Aging

Wisconsin

Wisconsin Association of Homes & Services for the Aging, Inc.
204 South Hamilton Street
Madison WI, 53703-3212
Phone: 608-255-7060 Fax: 608-255-7064

- Wisconsin Association of Homes & Services for the Aging, Inc.

Wyoming

Quality Health Care Foundation of Wyoming
520 Randall Avenue P O Box 3050
Cheyenne WY, 82003
Phone: 307-637-7575 Fax: 307-634-0804

About Assisted Living

The National Center for Assisted Living

Assisted Living Quality Coalition: Summary of Recommendations

#1 The members of the Assisted Living Quality Coalition, along with other partners, should study and, if feasible, establish an independent National Assisted Living Quality Organization with sufficient staff to develop the information sources and manage the quality improvement system we are proposing to implement.

#2 Among the first tasks undertaken by a National Assisted Living Quality Organization should be the development and validation of performance measures in areas such as consumer satisfaction, clinical, and functional performance outcomes.

#3 Based on the guidelines developed by the Assisted Living Quality Coalition (see Appendix B), the National Assisted Living Quality Organization should establish, regularly review and update as necessary, guidelines for minimum standards for the assisted living industry. These guidelines should improve the ways in which standards are established through:

1. The process by which the guidelines are established - Guidelines issued by the NALQO should be established by a consensus approach involving all interested parties.
2. The substantive emphasis of the guidelines - The focus of the NALQO guidelines should be enhancing consumer autonomy and promoting industry innovation in the delivery of quality services.
3. The rigor with which the guidelines are tested and updated - NALQO guidelines should be routinely tested against practical experience and outcomes data generated from quality indicators to assure that they are the best predictors of quality outcomes.

#4 The NALQO should develop model practice protocols and intervention strategies for commonly experienced problem areas.

#5 Each assisted living setting should establish and effectively use its own internal quality improvement team to identify problem areas, develop action plans, and monitor the results of actions taken.

#6 The NALQO should examine ways to recognize excellent performance.

#7 The NALQO should promote consumer choice and a competitive assisted living market by ensuring that consumers and their advocates have access to appropriate setting-specific information necessary to do effective comparison shopping.

#8 The experiences of consumers and their advocates should be tapped by each setting's internal quality improvement team.

#9 States should enlist the input of consumers, their advocates, and other parties who have contact with assisted living settings as incidental monitors of performance.

#10 States should enlist the input of ombudsmen and other community resources.

#11 States should adopt any future guidelines established by the National Assisted Living Quality

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Organization as the basis for their minimum standards for regulating quality. In the interim, the Coalition encourages states to use the general guidelines in Appendix B in developing their regulations.

#12 States should improve licensure review by focusing on both provider capacity and past performance. States should never use certificates of need, license moratoria, or any other means to artificially limit the supply of assisted living or other supportive housing settings.

#13 State monitoring efforts should evolve in the following directions:

1. Greater focus on performance outcomes.
2. Greater focus on quality improvement through consultation.
3. Greater reliance on other actors who can demonstrate that they are better equipped to accomplish specific monitoring roles.
4. Greater reliance on ongoing communication and less reliance on annual survey approaches.
5. Greater targeting of monitoring efforts on settings that serve more disabled residents and settings that have histories of poor performance.
6. Greater focus on specific areas of problematic performance.

#14 States should employ a consultative role when possible to correct problems but vigorously enforce standards when:

1. the consultative approach has failed to achieve acceptable results within a reasonable time frame;
2. the problems identified through monitoring are extensive, or result in actual harm or an immediate threat to health and safety;
3. outcomes data are inaccurate due to fraudulent or negligent behavior by provider staff with respect to their data-gathering responsibilities.

#15 The NALQO should assist states with the task of implementing new quality improvement systems.

#16 In introducing assisted living coverage, third party payers, both public and private, should reward outcomes consistent with the philosophy of assisted living - especially those related to consumer satisfaction and quality of life. In particular, third party payers should reimburse services at a level that permits private rooms for all consumers who want them and assures adequate reimbursement for the services provided.

#17 The NALQO should provide a forum for discussing risk factors that affect financial underwriting of projects in order to assure that the philosophy of assisted living is not jeopardized.

#18 Nurse practice acts should be amended to allow delegation of nursing services with appropriate professional oversight within assisted living settings.

#19 Accessibility standards set under the Americans with Disabilities Act should be modified to give greater flexibility in dealing with different types of disabilities - especially those most common among the frail elderly.

#20 Guardianship laws should ensure that guardianship occurs only when the individual is unable to make decisions, and then only on a limited basis in order to maximize the independence and autonomy of the individual.

#21 Building codes should be reviewed to ensure that assisted living services can be provided in buildings with residential scale and characteristics while assuring life safety and encouraging affordability.

About Assisted Living

THE NATIONAL CENTER FOR ASSISTED LIVING

Assisted Living Quality Coalition: Executive Summary

Background

In early 1996, several organizations representing consumers and providers formed the Assisted Living Quality Coalition to address issues of quality improvement in assisted living as the industry rapidly expanded. Coalition members have been united by two common purposes:

Promote the highest possible quality of life for older persons and consumers with disabilities by advocating for the assisted living philosophy of independence, privacy, dignity and autonomy.

Lay a foundation for the continued growth of assisted living by fostering a quality improvement system that demands and rewards high quality outcomes.

During its deliberations, the Assisted Living Quality Coalition sought the counsel and advice of numerous individuals and organizations representing consumers, providers, state regulators, ombudsmen, third party payers, and investors. The Coalition also examined a variety of approaches to promoting quality, including traditional state regulation, accreditation, contracts, and quality indicators.

The Coalition borrowed freely from the best of these various approaches and attempted to address the inherent weaknesses of each as it attempted to construct a solid system for promoting quality and balancing the interests of various parties. The report that follows includes two major sections: 1) the first section is a quality initiative outlining how the roles and responsibilities of the various interested parties would change under a system emphasizing quality outcomes; and 2) the second section includes guidelines to states on minimum standards. Perhaps the best way to understand the quality initiative is to summarize the roles that each of the interested parties would play.

National Assisted Living Quality Organization

Providers

The Coalition believes that the best way to enhance the quality of life experienced by consumers is to support and build upon the provider's own efforts. Imposing quality from outside the setting has its limits if a provider lacks the commitment or the organizational capacity to promote quality from within. The success of the Coalition's proposed quality improvement system hinges on the assumption that providers will create organizational structures, including quality improvement teams, that regularly monitor quality and take actions to promote quality outcomes.

Such quality improvement teams should draw broadly from staff at all levels, residents, family members, local service providers and state consulting agents, and should take advantage of the tools approved by the NALQO to measure and improve quality. On the basis of this information, the quality improvement teams should review practices and take appropriate action to improve performance.

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Consumers

Consumers can improve quality by becoming informed and selecting providers known for high quality. To do this, consumers and their advocates must receive more comparative information about quality to enhance their decision-making capacity. The inclusion of residents and their advocates on the setting's internal quality team is essential to the team's capacity to focus on quality as the residents experience it.

Providers and states should develop better means to enlist the input of consumers, their advocates and other parties who have contact with assisted living settings as incidental monitors of performance. Ombudsmen, in their role as independent consumer watchdog, are an additional valuable source of input to providers, consumers and their advocates, and state monitors.

States

The Coalition's quality improvement approach calls for a reinvention of the state role in licensing, establishing minimum standards, monitoring and enforcement.

- **Licensing** - Many quality problems in assisted living settings could be averted if states would effectively use licensing standards to predict performance and weed out poor performers. State licensure review should consist of two parts: a capacity review and a performance review.
- **Establishing minimum standards** - The Coalition encourages states to use the general guidelines developed by the Coalition in developing their regulations. NALQO will provide further refining and updating for states to adopt in the future.
- **Monitoring performance** - By using performance measures, such as quality indicators developed by the NALQO, state monitoring efforts can focus more on outcomes and continuous feedback. Such an approach is intended to allow for a more consultative approach to routine monitoring, more delegation of monitoring roles to other actors, and a significantly diminished role for formal on-site surveys for settings that have solid performance histories. Such an approach should also allow states to target monitoring efforts on settings that serve residents with greater service needs or have poor performance records, as well as on specific areas of problematic performance within settings.
- **Enforcement** - States should vigorously enforce standards when: a) the consultative approach has failed to achieve acceptable results within a reasonable time frame; b) the problems identified through monitoring are extensive or result in actual harm or an immediate threat to health and safety; or c) outcomes data are inaccurate due to fraudulent or negligent behavior by provider staff with respect to their data-gathering responsibilities.

Third Party Payers

In introducing assisted living coverage, third party payers, both public and private, should reward outcomes consistent with the philosophy of assisted living - especially those related to consumer satisfaction and quality of life. In particular, third party payers should reimburse services at a level that permits private rooms for all consumers who want them and assures adequate reimbursement for the services provided.

Investment and Financial Communities

Efforts by the Coalition and the NALQO to establish a clearer product definition and develop performance measurements should help underwriters for investors and financiers to evaluate current risk and potential rewards in the assisted living industry. The NALQO may also provide a useful forum for discussing and researching important investment and financing issues such as the consequences of separating the financing of housing and services and the development of underwriting criteria.

Conclusion: Phasing in a System of Quality Improvement

Not all of the Assisted Living Quality Coalition's recommendations are likely to be implemented

immediately. Fully implementing the quality improvement system will require a sustained commitment by all interested parties over several years. The quality indicators, practice protocols and intervention strategies have yet to be developed and validated. Effective consultation and intervention strategies will require some experimentation. While continuing to assure quality during the transition, states should begin to phase in these aspects of the quality improvement system as they prove effective. For its part, the Coalition will examine the feasibility of a National Assisted Living Quality Organization, its potential tasks, and its potential impact upon all stakeholders.



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caregiving



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Housing Options

Housing Options

"I hate for my loved one to give up her home, but she's having increasing difficulty climbing the stairs, bathing and fixing meals. What can she do?"

Home Modification

There are many home modifications that can make houses and apartments safer and easier to get around in --including improving lighting, adapting bathrooms and kitchens, widening doors, and modifying treads and risers on stairways.

For detailed instructions about home modification, order a free copy of AARP's *The Doable Renewable Home (D12470)* from

AARP Fulfillment
601 E St. NW
Washington, DC 20049.

"My loved one can no longer live alone, but doesn't need a nursing home. What other choices are there?"

Assisted Living

Assisted living is a residential care model that combines private apartment-like living with services delivered to older persons needing assistance with daily living activities such as bathing, grooming, dressing, and toileting. These services include oversight and monitoring by the assisted living staff and are available 24 hours a day to meet unscheduled needs for services.

Currently, regulation of Assisted Living varies from state to state. Be familiar with your state's requirements and be sure the facility you choose is in compliance. Assisted Living facilities charge between \$1,000 and \$3,000 a month. A few states may be able to help low-income elderly pay for assisted living. Check your local Medicaid office for information about your state.

Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRC's) offer a range of housing options and services all on one campus. These

communities usually consist of independent housing, assisted living and a nursing home component. Residents who initially move into independent housing can move to assisted living when they need help with activities of daily living. Residents requiring on-going skilled nursing care can move to the nursing home component.

A CCRC is not an affordable option for many older people. Expenses are almost exclusively out-of-pocket. A large entrance fee is required and monthly rates can be costly.

Board and Care Homes

A board and care home is a community-based residence that provides room, meals, help with activities of daily living, and some degree of protective supervision to residents whose physical and/or mental impairments prevent them from being able to live independently, but do not require skilled nursing care. Board and care homes provide an array of services to the residents.

They are not nursing homes. In some states, some nursing services can be provided in board and care homes by staff or by outside agencies, but board and care homes are not medical facilities.

The cost of a board and care facility can range from **\$350 to \$3,000** a month. If your loved one's income is very low, the Supplemental Security Income (SSI) program may help.

It is very important to choose a board and care facility that is licensed.

For more information about board and care facilities and SSI, check the Eldercare Locator for the numbers of your state and local offices on aging and your state and local long-term care ombudsmen.

Write for a free copy of *A Home Away from Home: A Consumer Guide to Board and Care Homes and Assisted Living Facilities (D12466)* from

AARP Fulfillment
601 E St. NW
Washington, DC 20049.

"My loved one needs someone to assist him on a 24-hour basis and also needs ongoing nursing care. The family can't provide this anymore. Where can I go for information about choosing a nursing home, and making sure my loved one gets good care?"

Nursing Home Care

The Health Care Financing Administration publishes a free booklet called *How to Select a Nursing Home*. Write to

HCFA Publications Dept.
7500 Security Blvd., Room N1-26-25,
Baltimore, MD 21244-1850.

AARP's booklet, *Nursing Home Life: A Guide for Residents and Families (D13063)*, gives information about getting good care and finding help when there are problems. Write for a free copy to

AARP Fulfillment,
601 E St. NW
Washington, DC 20049.

The National Citizens' Coalition for Nursing Home Reform has a 166-page book with advice for families and friends of nursing home residents. Called *Nursing Homes: Getting Good Care There*, it is \$14, plus \$3 for postage and handling, from

NCCNHR
1424 16th St. NW, Suite 202
Washington, DC 20036.

Every state and many communities have a **Long-Term Care Ombudsman** program to investigate complaints and to be an advocate for nursing home residents. The ombudsman may also provide information about how to select a nursing home in your area, including where to get annual inspection reports. Contact your state or local office on aging, or the Eldercare Locator, to get the phone number of your state ombudsman.

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What is Assisted Living?



Assisted Living

The new housing and health care alternative combining independence with personal care in a warm, dignified, community setting.

What is Assisted Living?

ALFA Home

Assisted Living Facts

The Assisted Living Federation of America (ALFA) defines an Assisted Living residence as a special combination of housing, personalized supportive services and health care designed to meet the needs—both scheduled and unscheduled—of those who need help with activities of daily living.

What is the philosophy of Assisted Living?

ALFA members subscribe to a 10-point philosophy of care:

1. Offering cost-effective quality care that is personalized for individual needs
2. Fostering independence for each resident
3. Treating each resident with dignity and respect
4. Promoting the individuality of each resident
5. Allowing each resident choice of care and lifestyle
6. Protecting each resident's right to privacy
7. Nurturing the spirit of each resident
8. Involving family and friends, as appropriate, in care planning and implementation
9. Providing a safe, residential environment
10. Making the Assisted Living residence a valuable community asset

Who lives in Assisted Living residences?

Currently, more than a million Americans live in an estimated 30,000 Assisted Living residences. Assisted Living residents can be young or old, affluent or low income, frail or disabled. A typical resident is age 83 or older, is female, and is either widowed or single. Residents may suffer from Alzheimer's disease or other memory disorders. Residents may also need help with incontinence or mobility.

What does an Assisted Living residence look like?

Assisted Living residences can range from a high-rise apartment complex to a converted Victorian home to a renovated school. Residences may be free standing or housed with other residential options, such as independent living or nursing care. They may be operated by non-profit or for-profit companies. Most facilities have between 25 and 120 units. There is no single blueprint, because

consumers' preferences and needs vary widely. Units may vary in size from one room to a full apartment.

How is Assisted Living regulated?

Regulations and licensing regulations vary from state to state contributing to the wide range of senior housing models considered Assisted Living. Most providers and their staff have special training as a result either of state requirements or company policy. Some states require special staff certification and training. Residences must comply with local building codes and fire safety regulations. ALFA believes the most successful regulations are consumer drive, balancing the safety concerns we all share with the consumers' desires to retain their independence and freedom of choice.

What types of services are offered in Assisted Living residences?

Services provided in Assisted Living residences usually include:

- Three meals a day served in a common dining area
- Housekeeping services
- Transportation
- Assistance with eating, bathing, dressing, toileting and walking
- 24-hour security and staff availability
- Emergency call systems for each resident's unit
- Health promotion and exercise programs
- Medication management
- Personal laundry services
- Social and recreational activities

What about costs?

Costs vary with the residence, room size, and the types of services needed by the residents. Across the nation, daily basic fees range from approximately \$20 to \$100 -- generally less than the cost of home health services and nursing home care. A basic Assisted Living fee may cover all services or there may be additional charges for special services. Most Assisted Living residences charge month-to-month rates, but a few residences require long-term arrangements.

Who pays the bill for an Assisted Living residence?

Residents or their families generally pay the cost of care from their own financial resources. Depending on the nature of an individual's health insurance program or long-term care insurance policy, costs may be reimbursed. In addition, some residences have their own financial assistance programs. Government payments for Assisted Living residences has been limited. Some state and local governments offer subsidies for rent or services for low income elders. Others may provide subsidies in the form of an additional payment for those who receive Supplemental Security Income (SSI) or Medicaid. Some states also utilize Medicaid waiver programs to

help pay for Assisted Living services.

How to find an Assisted Living residence?

- Consumers interested in locating Assisted Living facilities should visit the searchable ALFA Online Directory of Assisted Living providers at CareGuide. The site is searchable by state, county, city or metropolitan area.
- Call the national Eldercare locator service at (800) 677-1116. Calls are accepted between 9 am - 5pm Monday through Friday.
- Contact your local area agency on aging. These agencies are generally listed in the blue pages of your telephone directory.
- Check your library for the National Directory of Retirement Facilities.
- Or for a state listing of Assisted Living residences contact Gloria Lewis, Consumer Referral Manager, gl@alfa.org



POWERED BY:
careguide
www.careguide.net

For more information about Assisted Living contact Whitney Redding, Director of Media & PR wr@alfa.org.

Send mail to lc@alfa.org with questions or comments about this web site.
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 AAHSA American Association of Homes and Services for the Aging		
● Welcome to AAHSA	● Provider Resources	● State Associations
● Consumer Information	● Upcoming Events	● Grassroots Network
● Job Mart	● Press Room	● International
● Publications	● Member Links	● Member Central

About AAHSA

The American Association of Homes and Services for the Aging (AAHSA) represents not-for-profit organizations dedicated to providing high-quality health care, housing and services to the nation's elderly. Its membership consists of over 5,000 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community services. AAHSA organizations serve more than one million older persons of all income levels, creed and races.

Through education, advocacy, grassroots action and coalition work, AAHSA influences public policy pertaining to health, housing, community and related services to ensure that the aging population receive the services they need, and to protect and enhance the viability of not-for-profit providers. AAHSA also offers timely newsletters, publications and other communications to keep members up-to-date on Congressional and regulatory action, and trends and issues in the field of aging services.

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American Association
of Homes and Services
for the Aging

AAHSA Affiliated State Associations

AAHSA is a national nonprofit organization representing over 5,000 not-for-profit nursing homes, continuing care retirement communities, assisted living residences and senior housing facilities and community service organizations for the elderly.

Here is a listing of AAHSA Affiliated State Associations-for more information about homes and services for the aging in a specific state, please use this contact list.

Alabama

Alabama Association of Homes and Services for the Aging, Inc.
C/o St. Martin's In-the-Pines 4941 Montevallo Road
Birmingham AL, 35210-2497
Phone: 205-956-1831 Fax: 205-956-9124

- Alabama Association of Homes and Services for the Aging, Inc.

Arizona

Arizona Association of Homes and Housing for the Aging
3839 North 3rd Street, Suite 201
Phoenix AZ, 85012
Phone: 602-230-0026 Fax: 602-230-0563

California

California Association of Homes & Services for the Aging
7311 Greenhaven Drive Suite 175
Sacramento CA, 95831-3572
Phone: 916-392-5111 Fax: 916-428-4250

- California Association of Homes & Services for the Aging

Colorado

Colorado Association of Homes and Services for the Aging
1888 Sherman Street, Suite 610
Denver CO, 80203-1160
Phone: 303-837-8834 Fax: 303-837-8836

Connecticut

Connecticut Association of Not-for-Profit Providers for the Aging
300 Research Parkway
Meriden CT, 06450-7137

Phone: 203-237-4556 Fax: 203-237-4908

- Connecticut Association of Not-for-Profit Providers for the Aging

Delaware

Delaware Association of Homes & Services for the Aging
c/o Ingleside Homes 1010 North Broom Street
Wilmington DE, 19806-4514
Phone: 302-777-0130 Fax: 302-777-0131

Florida

Florida Association of Homes for the Aging
1812 Riggins Road
Tallahassee FL, 32308-4885
Phone: 850-671-3700 Fax: 850-671-3790

- Florida Association of Homes for the Aging

Georgia

Georgia Association of Homes and Services for the Aging
1655 Tullie Circle, NE Suite 108
Atlanta GA, 30329-2316
Phone: 404-728-0223 Fax: 404-636-6753

Iowa

Iowa Association of Homes and Services for the Aging
100 East Grand, Suite 140
Des Moines IA, 50309-1800
Phone: 515-283-9380 Fax: 515-283-9382

- Iowa Association of Homes and Services for the Aging

Illinois

Life Services Network of Illinois
911 North Elm Street Suite 228
Hinsdale IL, 60521-3634
Phone: 630-325-6170 Fax: 630-325-0749

Life Services Network of Illinois - Springfield
2 Lawrence Square
Springfield IL, 62704-2523
Phone: 217-789-1677 Fax: 217-789-1778

Indiana

Indiana Association of Homes and Services for the Aging, Inc.
P O Box 68829
Indianapolis IN, 46268-0829
Phone: 317-733-2380 Fax: 317-733-2385

- Indiana Association of Homes and Services for the Aging, Inc.

Kansas

Kansas Association of Homes and Services for the Aging
700 SW Harrison Street Suite 1106
Topeka KS, 66603-3759

Phone: 785-233-7443 Fax: 785-233-9471

- Kansas Association of Homes and Services for the Aging

Kentucky

Kentucky Association of Homes and Services for the Aging
1244 South Fourth Street
Louisville KY, 40203-3051
Phone: 502-635-6468 Fax: 502-635-9286

Louisiana

Louisiana Association of Homes and Services for the Aging
P O Box 14615
Baton Rouge LA, 70815-4169
Phone: 225-201-9933 Fax: 225-201-9944

Massachusetts

Massachusetts Aging Services Association, Inc.
45 Bromfield Street, Suite 200
Boston MA, 02108-4106
Phone: 617-423-0718 Fax: 617-423-2109

- Massachusetts Aging Services Association, Inc.

Maryland

MANPHA - A Senior Service Alliance
10280 Old Columbia Road Suite 250
Columbia MD, 21046-1709
Phone: 410-381-1176 Fax: 410-381-0240

- MANPHA - A Senior Service Alliance

Michigan

Michigan Association of Homes and Services for the Aging
6215 West St. Joseph Highway
Lansing MI, 48917-4852
Phone: 517-886-1302 Fax: 517-886-1670

Minnesota

Minnesota Health & Housing Alliance
2550 University Avenue West Suite 350 South
St. Paul MN, 55114-1900
Phone: 612-645-4545 Fax: 612-645-0002

Missouri

Missouri Association of Homes for the Aging
308A Monroe Street
Jefferson City MO, 65101-3106
Phone: 573-635-6244 Fax: 573-635-6618

Mississippi

Mississippi Association of Homes & Services for the Aging
c/o Naval Home 1800 Beach Drive
Gulfport MS, 39507-1597
Phone: 228-896-3110 Fax: 228-897-4013

Montana

MHA - An Association of Health Care Providers
P O Box 5119
Helena MT, 59601-4657
Phone: 406-442-1911 Fax: 406-443-3894

- MHA - An Association of Health Care Providers

North Carolina

North Carolina Association of Non-Profit Homes for the Aging, Inc.
3700 National Drive, Suite 218
Raleigh NC, 27612-4842
Phone: 919-571-8333 Fax: 919-571-1297

Nebraska

Nebraska Association of Homes and Services for the Aging
1701 K Street, Suite B
Lincoln NE, 68508-2699
Phone: 402-436-2165 Fax: 402-436-2169

New Hampshire

Northern New England Assn. of Homes & Svcs for the Aging
345 Edward J. Roy Drive Suite 201
Manchester NH, 03104-4149
Phone: 603-626-3479 Fax: 603-626-3763

New Jersey

New Jersey Association of Non-Profit Homes for the Aging
13 Roszel Road, Suite B 113
Princeton NJ, 08540-6211
Phone: 609-452-1161 Fax: 609-452-2907

New York

New York Association of Homes & Services for the Aging
150 State Street, Suite 301
Albany NY, 12207-1698
Phone: 518-449-2707 Fax: 518-455-8908

- New York Association of Homes & Services for the Aging

Ohio

Assn of Ohio Philanthropic Homes, Hsng & Svcs for Aging
855 South Wall Street
Columbus OH, 43206-1921
Phone: 614-444-2882 Fax: 614-444-2974

- Assn of Ohio Philanthropic Homes, Hsng & Svcs for Aging

Oklahoma

Oklahoma Association of Homes and Services for the Aging
P O Box 1383
El Reno OK, 73036-5699
Phone: 405-640-8040 Fax: 405-262-5252

Oregon

Oregon Alliance of Senior and Health Services

7360 South West Hunziker St. Suite 207
Tigard OR, 97223-8288
Phone: 503-684-3788 Fax: 503-624-0870

- Oregon Alliance of Senior and Health Services

Pennsylvania

Pennsylvania Association of Non-Profit Homes for the Aging
Executive Park West, Suite 409 4720 Old Gettysburg Road
Mechanicsburg PA, 17055-8419
Phone: 717-763-5724 Fax: 717-763-1057

- Pennsylvania Association of Non-Profit Homes for the Aging

Rhode Island

Rhode Island Association of Facilities & Services for the Aging
210 Cahir Street
Providence RI, 02903-4039
Phone: 401-453-0040 Fax: 401-453-1160

South Carolina

South Carolina Association of Non-Profit Homes for the Aging
P O Box 2708
Myrtle Beach SC, 29578-2708
Phone: 843-497-3506 Fax: 843-497-5362

South Dakota

South Dakota Association of Healthcare Organizations
3708 Brook Place, Suite 1
Sioux Falls SD, 57106-4211
Phone: 605-361-2281 Fax: 605-361-5175

Tennessee

Tennessee Association of Homes and Services for the Aging
500 Interstate Boulevard South
Nashville TN, 37210-4634
Phone: 615-256-1800 Fax: 615-726-3082

Texas

Texas Association of Homes and Services for the Aging
2205 Hancock Drive
Austin TX, 78756-2508
Phone: 512-467-2242 Fax: 512-467-2275

- Texas Association of Homes and Services for the Aging

Virginia

Virginia Association of Non-Profit Homes for the Aging
Innslake Place Building 4401 Dominion Blvd., Suite 200
Glen Allen VA, 23060-3322
Phone: 804-965-5500 Fax: 804-965-9089

- Virginia Association of Non-Profit Homes for the Aging

Washington

Washington Association of Housing and Services for the Aging

16300 Christensen Road Suite 203
Seattle WA, 98188
Phone: 206-248-7434 Fax: 206-241-2595

- Washington Association of Housing and Services for the Aging

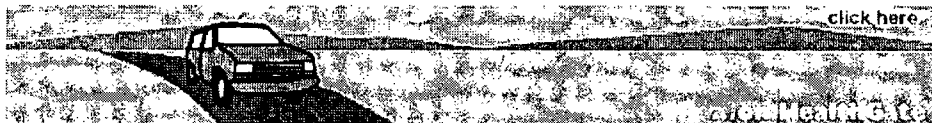
Wisconsin

Wisconsin Association of Homes & Services for the Aging, Inc.
204 South Hamilton Street
Madison WI, 53703-3212
Phone: 608-255-7060 Fax: 608-255-7064

- Wisconsin Association of Homes & Services for the Aging, Inc.

Wyoming

Quality Health Care Foundation of Wyoming
520 Randall Avenue P O Box 3050
Cheyenne WY, 82003
Phone: 307-637-7575 Fax: 307-634-0804



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Record 1 from database: **MEDLINE**



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Title

Devolution and aging policy: racing to the bottom in long-term care.

Author

Estes CL; Linkins KW

Address

Institute for Health and Aging, University of California, San Francisco School of Nursing
94143-0612, USA.

Source

Int J Health Serv, 1997, 27:3, 427-42

Abstract

For two decades, New Federalism, devolution, and other challenges to the federal role in domestic health and human services policy have fundamentally shaped the structure and delivery of long-term care in the United States. Devolution evokes crucial questions concerning the future of universal entitlement programs such as Social Security and Medicare and, with them, the future of aging and long-term care policy. This article examines the implications of the "devolution revolution" for long-term care in the context of the sociodemographics of aging and the managed care movement. Central issues are the extent to which state-level discretionary policy options (1) alter priorities, services, and benefits for the elderly and disabled; (2) foster a race to the bottom in long-term care; (3) promote generational, gender, racial and ethnic, and social class trade-offs; and (4) fundamentally alter the role and capacity of nonprofit sector services that comprise a significant part of the long-term care continuum.

Language of Publication

English

Unique Identifier

97431182



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MeSH Heading (Major)

Health Policy|*TD; Health Services for the Aged|*EC/OG; Long-Term Care|*EC/OG

MeSH Heading

Aged; Community Health Planning|EC; Community Health Services|EC/OG; Human; Managed Care Programs|EC/OG; Medicaid|TD; Politics; State Health Plans; Support, Non-U.S. Gov't; United States

Publication Type

JOURNAL ARTICLE; REVIEW; REVIEW, TUTORIAL

ISSN

0020-7314



From birth to age three are the most important
years in a child's brain development.
The time that defines who they become.



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Title

Giving voice to elderly people: community-based long-term care.

Author

Krothe JS

Address

Indiana University School of Nursing, Bloomington 47406-1370, USA.

Source

Public Health Nurs, 1997 Aug, 14:4, 217-26

Abstract

Information gained from elderly people regarding their needs for community-based long-term care is necessary for informed and responsive policy development. Informed policy development is essential given demographic projections and the need to develop cost-effective alternatives to institutionalization. The purpose of this study was to understand the context within which elderly people would be able to continue residing in their communities. Programs have been developed based on providers' perceptions of services that are necessary to maintain elderly people at home. There is a lack of information about elderly people's perceptions. Data were collected from 9 elderly people who represented the phenomenon of being at risk for institutionalization. Participants were interviewed serially and contingently in stages using naturalistic methodology. The interviews were tape-recorded, transcribed verbatim, and analyzed by the inquirer. Findings of the study indicated that the desire of elderly people to stay at home is motivated by their need to maintain control over their daily lives and have their individualized needs addressed. Perceptions related to nursing homes, roles of family, essential services, and future needs for assisted living emerged as major themes. The findings suggest policy implications for professional nurses related to the long-term care system, providers, and nursing homes.

Language of Publication

English

Unique Identifier

97416281



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MeSH Heading (Major)

Aged*PX; Attitude to Health*; Community Health Services*OG; Health Services for the Aged*OG; Health Services Needs and Demand*; Home Care Services*OG; Long-Term Care*OG

MeSH Heading

Aged, 80 and over; Female; Human; Institutionalization; Male; Nursing Methodology Research; Questionnaires



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Title

Transforming the long-term care system: policy and managerial challenges.

Author

Miller NA; Clauser SB

Address

Division of Aging and Disability, Health Care Financing Administration, Baltimore, MD, USA.

Source

Health Care Manag, 1997 Jun, 3:1, 9-22

Abstract

As the need for long-term care of people with disabilities increases, the model of care faces crucial changes, including a shift from institutional to independent living, significant changeover in organizational auspices, and policies created by the Americans with Disabilities Act. Such systemic changes pose fiscal, technological, and social challenges to policymakers and managers of care delivery.

Language of Publication

English

Unique Identifier

97415192



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MeSH Heading (Major)

Health Policy|*; Long-Term Care|*

MeSH Heading

Disabled Persons|LJ; Health Expenditures; Health Services Research; Insurance, Health; Organizational Innovation; Private Sector; Public Sector; United States

Publication Type

JOURNAL ARTICLE; REVIEW; REVIEW, TUTORIAL

ISSN

1069-6571

Country of Publication

UNITED STATES





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Title

Long-term care design: strategies for planning the next generation of assisted living facilities.

Author

Regnier V

Address

University of Southern California, Los Angeles, USA.

Source

J Healthc Des, 1996, 8:, 47-51

Abstract

Abstract unavailable online.

Language of Publication

English

Unique Identifier

96383701



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MeSH Heading (Major)

Facility Design and Construction|*MT/ST; Housing for the Elderly|*OG/ST; Long-Term Care|*OG

MeSH Heading

Aged; Comparative Study; Demography; Europe; Human; United States

Publication Type

JOURNAL ARTICLE

ISSN

1068-1124

Country of Publication

UNITED STATES



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Title

Stats & facts. The growth of assisted living facilities.

Address**Source**

Manag Care Interface, 1998 Jan, 11:1, 44-5

Abstract

Abstract unavailable online.

Language of Publication

English

Unique Identifier

98263124



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MeSH Heading (Major)

Housing for the Elderly|EC/SD/*SN

MeSH Heading

Aged; Data Collection; Human; United States

Publication Type

JOURNAL ARTICLE

Country of Publication

UNITED STATES



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Title

Improve continuity of care through collaboration. The growth of assisted living provides opportunities for nursing homes.

Author

Thompson JM; Marinaccio L

Address

Health Services Administration Program, James Madison University, Harrisonburg, VA, USA.

Source

Balance, 1997 Oct, 1:3, 14-5

Abstract

Abstract unavailable online.

Language of Publication

English

Unique Identifier

98218467



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MeSH Heading (Major)

Continuity of Patient Care|*OG; Housing for the Elderly|*OG; Skilled Nursing Facilities|*OG

MeSH Heading

Aged; Cooperative Behavior; Health Care Surveys; Human; Interinstitutional Relations; Managed Care Programs; Patient Admission; Virginia

Publication Type

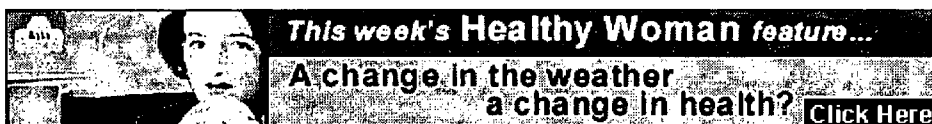
JOURNAL ARTICLE

ISSN

1094-6195

Country of Publication

UNITED STATES



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Title

Reimbursement. Striking the right balance with assisted living.

Author

Lusky K

Address**Source**

Contemp Longterm Care, 1997 Sep, 20:9, 37

Abstract

Abstract unavailable online.

Language of Publication

English

Unique Identifier

97457742



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MeSH Heading (Major)

Housing for the Elderly|*EC/OG; Skilled Nursing Facilities|*EC/OG

MeSH Heading

Aged; Costs and Cost Analysis; Fraud|PC; Human; Medicaid|EC; Medicare|EC; United States

Publication Type

JOURNAL ARTICLE

ISSN

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Title

Assisted living: opportunities for partnerships in caring.

Author

Marosy JP

Address

HM Associates, Worcester, MA, USA.

Source

Caring, 1997 Oct, 16:10, 72-4, 76, 78

Abstract

Throughout the United States, a variety of state government bodies license or certify assisted-living facilities. States have taken a variety of approaches in setting standards and protecting consumers. Consumers will respond to innovative solutions that enable elders to remain independent while assuring peace of mind of their adult children.

Language of Publication

English

Unique Identifier

98028807



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MeSH Heading (Major)

Consumer Advocacy|*; Housing for the Elderly|EC/*LJ/ST

MeSH Heading

Aged; Aged, 80 and over; Certification; Data Collection; Economic Competition; Home Care Services|EC/OG/ST; Human; Licensure; Medicare; Models, Organizational; State Government; United States

Publication Type

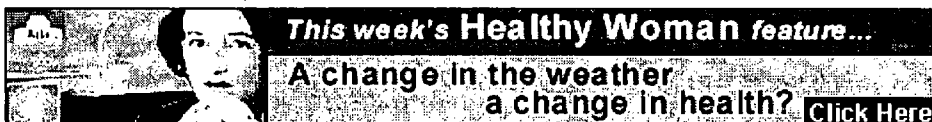
JOURNAL ARTICLE

ISSN

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Country of Publication

UNITED STATES





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Title

Mutual benefit. Study boosts hospital links with assisted-living firms [news]

Author

Snow C

Address**Source**

Mod Healthc, 1997 Oct, 27:40, 56

Abstract

Abstract unavailable online.

Language of Publication

English

Unique Identifier

98028279



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MeSH Heading (Major)

Hospital Restructuring[*]; Housing for the Elderly[*]/EC/OG

MeSH Heading

Human; Investments; Skilled Nursing Facilities|EC/OG

Publication Type

NEWS

ISSN

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Title

Managed care and assisted living: trends and future prospects.

Author

Mollica RL

Address

National Academy for State Health Policy, Portland, USA.

Source

J Health Hum Serv Adm, 1998 Winter, 20:3, 264-80

Abstract

With its emergence as a new, residential long-term care option, more than half of the states have established policy on assisted living. In 1996, over 30 states had created a state licensure category or passed legislation authorizing development of regulations. Known primarily as a resource for wealthy elders needing assistance with activities of daily living and health care needs, assisted living is increasingly being covered as a service under state Medicaid programs. Assisted living is widely seen as a resource for managed care organizations enrolling Medicare beneficiaries. Flexible capitation payments and incentives to substitute services create opportunities for assisted living facilities and HMOs to form partnerships. Enrollment of beneficiaries in Medicare HMOs has reached 4.5 million and is growing over 30% a year. In addition, state Medicaid agencies are developing programs to enroll elders, most of whom are also Medicare beneficiaries, in managed care programs that include long-term care. The move toward managed care and the increasing interest in integrating acute and long-term care for dual eligibles signals a growing role for assisted living facilities as a major resource for elders who need a supportive and service-rich residential living environment.

Language of Publication

English

Unique Identifier

98351220; AHA/98351220



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MeSH Heading (Major)

Health Maintenance Organizations|EC/*TD; Housing for the Elderly|EC/*TD

MeSH Heading

Aged; Capitation Fee; Human; Interviews; Medicaid; Medicare; Organizational Affiliation; Rate Setting and Review; Reimbursement Mechanisms; United States

Publication Type

JOURNAL ARTICLE

ISSN



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Title

An empirical study of the influence of demographic variable on the choice criteria for assisted living facilities.

Author

OBryan D; Clow KE; OBryan J; Kurtz D

Address

Gladys A. Kelce School of Business, Pittsburg State University, KS 66762, USA.

Source

Health Mark Q, 1996, 14:2, 3-18

Abstract

Despite the growth and prevalence of assisted-living facilities, empirical marketing research for these facilities is scarce. The objectives of this study were to determine the relative importance of three sets of evaluation criteria in the initial selection of an assisted-living facility, and determine whether the relative importance of these three sets of criteria differed by gender, marital status, level of household, age, or income of the consumer. Survey responses from 279 households indicates that primary service criteria are relatively more important than facilities amenities or organized social activities in the initial selection of an assisted-living facility. The relative importance of the choice criteria differed markedly by gender of the consumer, but marital status, level of household income, and age of the consumer did not have as great an impact on consumers' choice criteria.

Language of Publication

English

Unique Identifier

97182464



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MeSH Heading (Major)

Consumer Satisfaction[*SN; Housing for the Elderly|EC/*ST/UT

MeSH Heading

Age Factors; Aged; Arkansas; Female; Health Care Surveys; Human; Income; Leisure Activities; Male; Marketing of Health Services; Marriage; Middle Age; Recreation; Retirement; Security Measures

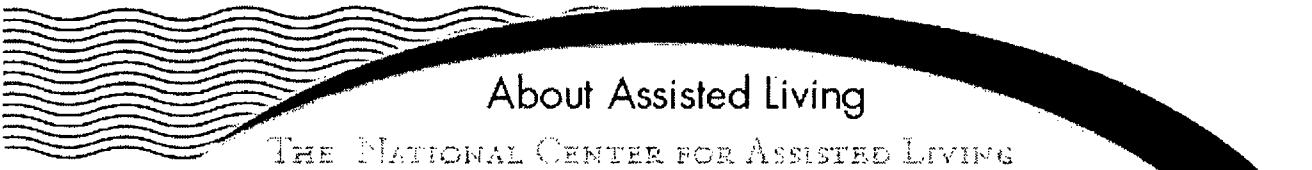
Publication Type

JOURNAL ARTICLE

ISSN

0735-9683

Country of Publication



About Assisted Living

THE NATIONAL CENTER FOR ASSISTED LIVING

Assisted Living Quality Coalition: Summary of Recommendations

#1 The members of the Assisted Living Quality Coalition, along with other partners, should study and, if feasible, establish an independent National Assisted Living Quality Organization with sufficient staff to develop the information sources and manage the quality improvement system we are proposing to implement.

#2 Among the first tasks undertaken by a National Assisted Living Quality Organization should be the development and validation of performance measures in areas such as consumer satisfaction, clinical, and functional performance outcomes.

#3 Based on the guidelines developed by the Assisted Living Quality Coalition (see Appendix B), the National Assisted Living Quality Organization should establish, regularly review and update as necessary, guidelines for minimum standards for the assisted living industry. These guidelines should improve the ways in which standards are established through:

1. The process by which the guidelines are established - Guidelines issued by the NALQO should be established by a consensus approach involving all interested parties.
2. The substantive emphasis of the guidelines - The focus of the NALQO guidelines should be enhancing consumer autonomy and promoting industry innovation in the delivery of quality services.
3. The rigor with which the guidelines are tested and updated - NALQO guidelines should be routinely tested against practical experience and outcomes data generated from quality indicators to assure that they are the best predictors of quality outcomes.

#4 The NALQO should develop model practice protocols and intervention strategies for commonly experienced problem areas.

#5 Each assisted living setting should establish and effectively use its own internal quality improvement team to identify problem areas, develop action plans, and monitor the results of actions taken.

#6 The NALQO should examine ways to recognize excellent performance.

#7 The NALQO should promote consumer choice and a competitive assisted living market by ensuring that consumers and their advocates have access to appropriate setting-specific information necessary to do effective comparison shopping.

#8 The experiences of consumers and their advocates should be tapped by each setting's internal quality improvement team.

#9 States should enlist the input of consumers, their advocates, and other parties who have contact with assisted living settings as incidental monitors of performance.

#10 States should enlist the input of ombudsmen and other community resources.

#11 States should adopt any future guidelines established by the National Assisted Living Quality

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Organization as the basis for their minimum standards for regulating quality. In the interim, the Coalition encourages states to use the general guidelines in Appendix B in developing their regulations.

#12 States should improve licensure review by focusing on both provider capacity and past performance. States should never use certificates of need, license moratoria, or any other means to artificially limit the supply of assisted living or other supportive housing settings.

#13 State monitoring efforts should evolve in the following directions:

1. Greater focus on performance outcomes.
2. Greater focus on quality improvement through consultation.
3. Greater reliance on other actors who can demonstrate that they are better equipped to accomplish specific monitoring roles.
4. Greater reliance on ongoing communication and less reliance on annual survey approaches.
5. Greater targeting of monitoring efforts on settings that serve more disabled residents and settings that have histories of poor performance.
6. Greater focus on specific areas of problematic performance.

#14 States should employ a consultative role when possible to correct problems but vigorously enforce standards when:

1. the consultative approach has failed to achieve acceptable results within a reasonable time frame;
2. the problems identified through monitoring are extensive, or result in actual harm or an immediate threat to health and safety;
3. outcomes data are inaccurate due to fraudulent or negligent behavior by provider staff with respect to their data-gathering responsibilities.

#15 The NALQO should assist states with the task of implementing new quality improvement systems.

#16 In introducing assisted living coverage, third party payers, both public and private, should reward outcomes consistent with the philosophy of assisted living - especially those related to consumer satisfaction and quality of life. In particular, third party payers should reimburse services at a level that permits private rooms for all consumers who want them and assures adequate reimbursement for the services provided.

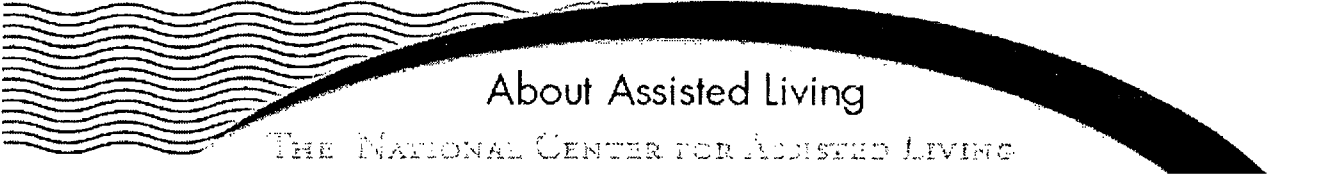
#17 The NALQO should provide a forum for discussing risk factors that affect financial underwriting of projects in order to assure that the philosophy of assisted living is not jeopardized.

#18 Nurse practice acts should be amended to allow delegation of nursing services with appropriate professional oversight within assisted living settings.

#19 Accessibility standards set under the Americans with Disabilities Act should be modified to give greater flexibility in dealing with different types of disabilities - especially those most common among the frail elderly.

#20 Guardianship laws should ensure that guardianship occurs only when the individual is unable to make decisions, and then only on a limited basis in order to maximize the independence and autonomy of the individual.

#21 Building codes should be reviewed to ensure that assisted living services can be provided in buildings with residential scale and characteristics while assuring life safety and encouraging affordability.



About Assisted Living

THE NATIONAL CENTER FOR ASSISTED LIVING

Assisted Living Quality Coalition: Executive Summary

Background

In early 1996, several organizations representing consumers and providers formed the Assisted Living Quality Coalition to address issues of quality improvement in assisted living as the industry rapidly expanded. Coalition members have been united by two common purposes:

Promote the highest possible quality of life for older persons and consumers with disabilities by advocating for the assisted living philosophy of independence, privacy, dignity and autonomy.

Lay a foundation for the continued growth of assisted living by fostering a quality improvement system that demands and rewards high quality outcomes.

During its deliberations, the Assisted Living Quality Coalition sought the counsel and advice of numerous individuals and organizations representing consumers, providers, state regulators, ombudsmen, third party payers, and investors. The Coalition also examined a variety of approaches to promoting quality, including traditional state regulation, accreditation, contracts, and quality indicators.

The Coalition borrowed freely from the best of these various approaches and attempted to address the inherent weaknesses of each as it attempted to construct a solid system for promoting quality and balancing the interests of various parties. The report that follows includes two major sections: 1) the first section is a quality initiative outlining how the roles and responsibilities of the various interested parties would change under a system emphasizing quality outcomes; and 2) the second section includes guidelines to states on minimum standards. Perhaps the best way to understand the quality initiative is to summarize the roles that each of the interested parties would play.

National Assisted Living Quality Organization

Providers

The Coalition believes that the best way to enhance the quality of life experienced by consumers is to support and build upon the provider's own efforts. Imposing quality from outside the setting has its limits if a provider lacks the commitment or the organizational capacity to promote quality from within. The success of the Coalition's proposed quality improvement system hinges on the assumption that providers will create organizational structures, including quality improvement teams, that regularly monitor quality and take actions to promote quality outcomes.

Such quality improvement teams should draw broadly from staff at all levels, residents, family members, local service providers and state consulting agents, and should take advantage of the tools approved by the NALQO to measure and improve quality. On the basis of this information, the quality improvement teams should review practices and take appropriate action to improve performance.



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Consumers

Consumers can improve quality by becoming informed and selecting providers known for high quality. To do this, consumers and their advocates must receive more comparative information about quality to enhance their decision-making capacity. The inclusion of residents and their advocates on the setting's internal quality team is essential to the team's capacity to focus on quality as the residents experience it.

Providers and states should develop better means to enlist the input of consumers, their advocates and other parties who have contact with assisted living settings as incidental monitors of performance. Ombudsmen, in their role as independent consumer watchdog, are an additional valuable source of input to providers, consumers and their advocates, and state monitors.

States

The Coalition's quality improvement approach calls for a reinvention of the state role in licensing, establishing minimum standards, monitoring and enforcement.

- **Licensing** - Many quality problems in assisted living settings could be averted if states would effectively use licensing standards to predict performance and weed out poor performers. State licensure review should consist of two parts: a capacity review and a performance review.
- **Establishing minimum standards** - The Coalition encourages states to use the general guidelines developed by the Coalition in developing their regulations. NALQO will provide further refining and updating for states to adopt in the future.
- **Monitoring performance** - By using performance measures, such as quality indicators developed by the NALQO, state monitoring efforts can focus more on outcomes and continuous feedback. Such an approach is intended to allow for a more consultative approach to routine monitoring, more delegation of monitoring roles to other actors, and a significantly diminished role for formal on-site surveys for settings that have solid performance histories. Such an approach should also allow states to target monitoring efforts on settings that serve residents with greater service needs or have poor performance records, as well as on specific areas of problematic performance within settings.
- **Enforcement** - States should vigorously enforce standards when: a) the consultative approach has failed to achieve acceptable results within a reasonable time frame; b) the problems identified through monitoring are extensive or result in actual harm or an immediate threat to health and safety; or c) outcomes data are inaccurate due to fraudulent or negligent behavior by provider staff with respect to their data-gathering responsibilities.

Third Party Payers

In introducing assisted living coverage, third party payers, both public and private, should reward outcomes consistent with the philosophy of assisted living - especially those related to consumer satisfaction and quality of life. In particular, third party payers should reimburse services at a level that permits private rooms for all consumers who want them and assures adequate reimbursement for the services provided.

Investment and Financial Communities

Efforts by the Coalition and the NALQO to establish a clearer product definition and develop performance measurements should help underwriters for investors and financiers to evaluate current risk and potential rewards in the assisted living industry. The NALQO may also provide a useful forum for discussing and researching important investment and financing issues such as the consequences of separating the financing of housing and services and the development of underwriting criteria.

Conclusion: Phasing in a System of Quality Improvement

Not all of the Assisted Living Quality Coalition's recommendations are likely to be implemented

immediately. Fully implementing the quality improvement system will require a sustained commitment by all interested parties over several years. The quality indicators, practice protocols and intervention strategies have yet to be developed and validated. Effective consultation and intervention strategies will require some experimentation. While continuing to assure quality during the transition, states should begin to phase in these aspects of the quality improvement system as they prove effective. For its part, the Coalition will examine the feasibility of a National Assisted Living Quality Organization, its potential tasks, and its potential impact upon all stakeholders.



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[III. Systematic Approach to Quality](#) | [IV. Redefining Relationships that Promote Quality](#) |
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Housing Options

Housing Options

"I hate for my loved one to give up her home, but she's having increasing difficulty climbing the stairs, bathing and fixing meals. What can she do?"

Home Modification

There are many home modifications that can make houses and apartments safer and easier to get around in --including improving lighting, adapting bathrooms and kitchens, widening doors, and modifying treads and risers on stairways.

For detailed instructions about home modification, order a free copy of AARP's *The Doable Renewable Home (D12470)* from

AARP Fulfillment
601 E St. NW
Washington, DC 20049.

"My loved one can no longer live alone, but doesn't need a nursing home. What other choices are there?"

Assisted Living

Assisted living is a residential care model that combines private apartment-like living with services delivered to older persons needing assistance with daily living activities such as bathing, grooming, dressing, and toileting. These services include oversight and monitoring by the assisted living staff and are available 24 hours a day to meet unscheduled needs for services.

Currently, regulation of Assisted Living varies from state to state. Be familiar with your state's requirements and be sure the facility you choose is in compliance. Assisted Living facilities charge between \$1,000 and \$3,000 a month. A few states may be able to help low-income elderly pay for assisted living. Check your local Medicaid office for information about your state.

Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRC's) offer a range of housing options and services all on one campus. These

communities usually consist of independent housing, assisted living and a nursing home component. Residents who initially move into independent housing can move to assisted living when they need help with activities of daily living. Residents requiring on-going skilled nursing care can move to the nursing home component.

A CCRC is not an affordable option for many older people. Expenses are almost exclusively out-of-pocket. A large entrance fee is required and monthly rates can be costly.

Board and Care Homes

A board and care home is a community-based residence that provides room, meals, help with activities of daily living, and some degree of protective supervision to residents whose physical and/or mental impairments prevent them from being able to live independently, but do not require skilled nursing care. Board and care homes provide an array of services to the residents.

They are not nursing homes. In some states, some nursing services can be provided in board and care homes by staff or by outside agencies, but board and care homes are not medical facilities.

The cost of a board and care facility can range from **\$350 to \$3,000** a month. If your loved one's income is very low, the Supplemental Security Income (SSI) program may help.

It is very important to choose a board and care facility that is licensed.

For more information about board and care facilities and SSI, check the Eldercare Locator for the numbers of your state and local offices on aging and your state and local long-term care ombudsmen.

Write for a free copy of *A Home Away from Home: A Consumer Guide to Board and Care Homes and Assisted Living Facilities (D12466)* from

AARP Fulfillment
601 E St. NW
Washington, DC 20049.

"My loved one needs someone to assist him on a 24-hour basis and also needs ongoing nursing care. The family can't provide this anymore. Where can I go for information about choosing a nursing home, and making sure my loved one gets good care?"

Nursing Home Care

The Health Care Financing Administration publishes a free booklet called *How to Select a Nursing Home*. Write to

HCFA Publications Dept.
7500 Security Blvd., Room N1-26-25,
Baltimore, MD 21244-1850.

AARP's booklet, *Nursing Home Life: A Guide for Residents and Families (D13063)*, gives information about getting good care and finding help when there are problems. Write for a free copy to

AARP Fulfillment,
601 E St. NW
Washington, DC 20049.

The National Citizens' Coalition for Nursing Home Reform has a 166-page book with advice for families and friends of nursing home residents. Called *Nursing Homes: Getting Good Care There*, it is \$14, plus \$3 for postage and handling, from

NCCNHR
1424 16th St. NW, Suite 202
Washington, DC 20036.

Every state and many communities have a **Long-Term Care Ombudsman** program to investigate complaints and to be an advocate for nursing home residents. The ombudsman may also provide information about how to select a nursing home in your area, including where to get annual inspection reports. Contact your state or local office on aging, or the Eldercare Locator, to get the phone number of your state ombudsman.

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What is Assisted Living?



Assisted Living

The new housing and health care alternative combining independence with personal care in a warm, dignified, community setting.

What is Assisted Living?

ALFA Home

The Assisted Living Federation of America (ALFA) defines an Assisted Living residence as a special combination of housing, personalized supportive services and health care designed to meet the needs—both scheduled and unscheduled—of those who need help with activities of daily living.

Assisted Living Facts

What is the philosophy of Assisted Living?

ALFA members subscribe to a 10-point philosophy of care:

1. Offering cost-effective quality care that is personalized for individual needs
2. Fostering independence for each resident
3. Treating each resident with dignity and respect
4. Promoting the individuality of each resident
5. Allowing each resident choice of care and lifestyle
6. Protecting each resident's right to privacy
7. Nurturing the spirit of each resident
8. Involving family and friends, as appropriate, in care planning and implementation
9. Providing a safe, residential environment
10. Making the Assisted Living residence a valuable community asset

Who lives in Assisted Living residences?

Currently, more than a million Americans live in an estimated 30,000 Assisted Living residences. Assisted Living residents can be young or old, affluent or low income, frail or disabled. A typical resident is age 83 or older, is female, and is either widowed or single. Residents may suffer from Alzheimer's disease or other memory disorders. Residents may also need help with incontinence or mobility.

What does an Assisted Living residence look like?

Assisted Living residences can range from a high-rise apartment complex to a converted Victorian home to a renovated school. Residences may be free standing or housed with other residential options, such as independent living or nursing care. They may be operated by non-profit or for-profit companies. Most facilities have between 25 and 120 units. There is no single blueprint, because

consumers' preferences and needs vary widely. Units may vary in size from one room to a full apartment.

How is Assisted Living regulated?

Regulations and licensing regulations vary from state to state contributing to the wide range of senior housing models considered Assisted Living. Most providers and their staff have special training as a result either of state requirements or company policy. Some states require special staff certification and training. Residences must comply with local building codes and fire safety regulations. ALFA believes the most successful regulations are consumer drive, balancing the safety concerns we all share with the consumers' desires to retain their independence and freedom of choice.

What types of services are offered in Assisted Living residences?

Services provided in Assisted Living residences usually include:

- Three meals a day served in a common dining area
- Housekeeping services
- Transportation
- Assistance with eating, bathing, dressing, toileting and walking
- 24-hour security and staff availability
- Emergency call systems for each resident's unit
- Health promotion and exercise programs
- Medication management
- Personal laundry services
- Social and recreational activities

What about costs?

Costs vary with the residence, room size, and the types of services needed by the residents. Across the nation, daily basic fees range from approximately \$20 to \$100 -- generally less than the cost of home health services and nursing home care. A basic Assisted Living fee may cover all services or there may be additional charges for special services. Most Assisted Living residences charge month-to-month rates, but a few residences require long-term arrangements.

Who pays the bill for an Assisted Living residence?

Residents or their families generally pay the cost of care from their own financial resources. Depending on the nature of an individual's health insurance program or long-term care insurance policy, costs may be reimbursed. In addition, some residences have their own financial assistance programs. Government payments for Assisted Living residences has been limited. Some state and local governments offer subsidies for rent or services for low income elders. Others may provide subsidies in the form of an additional payment for those who receive Supplemental Security Income (SSI) or Medicaid. Some states also utilize Medicaid waiver programs to

help pay for Assisted Living services.

How to find an Assisted Living residence?

- Consumers interested in locating Assisted Living facilities should visit the searchable ALFA Online Directory of Assisted Living providers at CareGuide. The site is searchable by state, county, city or metropolitan area.
- Call the national Eldercare locator service at (800) 677-1116. Calls are accepted between 9 am - 5pm Monday through Friday.
- Contact your local area agency on aging. These agencies are generally listed in the blue pages of your telephone directory.
- Check your library for the National Directory of Retirement Facilities.
- Or for a state listing of Assisted Living residences contact Gloria Lewis, Consumer Referral Manager, gl@alfa.org



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www.careguide.net

For more information about Assisted Living contact Whitney Redding, Director of Media & PR wr@alfa.org.

Send mail to lc@alfa.org with questions or comments about this web site.
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About AAHSA

The American Association of Homes and Services for the Aging (AAHSA) represents not-for-profit organizations dedicated to providing high-quality health care, housing and services to the nation's elderly. Its membership consists of over 5,000 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community services. AAHSA organizations serve more than one million older persons of all income levels, creed and races.

Through education, advocacy, grassroots action and coalition work, AAHSA influences public policy pertaining to health, housing, community and related services to ensure that the aging population receive the services they need, and to protect and enhance the viability of not-for-profit providers. AAHSA also offers timely newsletters, publications and other communications to keep members up-to-date on Congressional and regulatory action, and trends and issues in the field of aging services.

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American Association
of Homes and Services
for the Aging

AAHSA Affiliated State Associations

AAHSA is a national nonprofit organization representing over 5,000 not-for-profit nursing homes, continuing care retirement communities, assisted living residences and senior housing facilities and community service organizations for the elderly.

Here is a listing of AAHSA Affiliated State Associations-for more information about homes and services for the aging in a specific state, please use this contact list.

Alabama

Alabama Association of Homes and Services for the Aging, Inc.
C/o St. Martin's In-the-Pines 4941 Montevallo Road
Birmingham AL, 35210-2497
Phone: 205-956-1831 Fax: 205-956-9124

- [Alabama Association of Homes and Services for the Aging, Inc.](#)

Arizona

Arizona Association of Homes and Housing for the Aging
3839 North 3rd Street, Suite 201
Phoenix AZ, 85012
Phone: 602-230-0026 Fax: 602-230-0563

California

California Association of Homes & Services for the Aging
7311 Greenhaven Drive Suite 175
Sacramento CA, 95831-3572
Phone: 916-392-5111 Fax: 916-428-4250

- [California Association of Homes & Services for the Aging](#)

Colorado

Colorado Association of Homes and Services for the Aging
1888 Sherman Street, Suite 610
Denver CO, 80203-1160
Phone: 303-837-8834 Fax: 303-837-8836

Connecticut

Connecticut Association of Not-for-Profit Providers for the Aging
300 Research Parkway
Meriden CT, 06450-7137

Phone: 203-237-4556 Fax: 203-237-4908

- Connecticut Association of Not-for-Profit Providers for the Aging

Delaware

Delaware Association of Homes & Services for the Aging
c/o Ingleside Homes 1010 North Broom Street
Wilmington DE, 19806-4514
Phone: 302-777-0130 Fax: 302-777-0131

Florida

Florida Association of Homes for the Aging
1812 Riggins Road
Tallahassee FL, 32308-4885
Phone: 850-671-3700 Fax: 850-671-3790

- Florida Association of Homes for the Aging

Georgia

Georgia Association of Homes and Services for the Aging
1655 Tullie Circle, NE Suite 108
Atlanta GA, 30329-2316
Phone: 404-728-0223 Fax: 404-636-6753

Iowa

Iowa Association of Homes and Services for the Aging
100 East Grand, Suite 140
Des Moines IA, 50309-1800
Phone: 515-283-9380 Fax: 515-283-9382

- Iowa Association of Homes and Services for the Aging

Illinois

Life Services Network of Illinois
911 North Elm Street Suite 228
Hinsdale IL, 60521-3634
Phone: 630-325-6170 Fax: 630-325-0749

Life Services Network of Illinois - Springfield
2 Lawrence Square
Springfield IL, 62704-2523
Phone: 217-789-1677 Fax: 217-789-1778

Indiana

Indiana Association of Homes and Services for the Aging, Inc.
P O Box 68829
Indianapolis IN, 46268-0829
Phone: 317-733-2380 Fax: 317-733-2385

- Indiana Association of Homes and Services for the Aging, Inc.

Kansas

Kansas Association of Homes and Services for the Aging
700 SW Harrison Street Suite 1106
Topeka KS, 66603-3759

Phone: 785-233-7443 Fax: 785-233-9471

- Kansas Association of Homes and Services for the Aging

Kentucky

Kentucky Association of Homes and Services for the Aging
1244 South Fourth Street
Louisville KY, 40203-3051
Phone: 502-635-6468 Fax: 502-635-9286

Louisiana

Louisiana Association of Homes and Services for the Aging
P O Box 14615
Baton Rouge LA, 70815-4169
Phone: 225-201-9933 Fax: 225-201-9944

Massachusetts

Massachusetts Aging Services Association, Inc.
45 Bromfield Street, Suite 200
Boston MA, 02108-4106
Phone: 617-423-0718 Fax: 617-423-2109

- Massachusetts Aging Services Association, Inc.

Maryland

MANPHA - A Senior Service Alliance
10280 Old Columbia Road Suite 250
Columbia MD, 21046-1709
Phone: 410-381-1176 Fax: 410-381-0240

- MANPHA - A Senior Service Alliance

Michigan

Michigan Association of Homes and Services for the Aging
6215 West St. Joseph Highway
Lansing MI, 48917-4852
Phone: 517-886-1302 Fax: 517-886-1670

Minnesota

Minnesota Health & Housing Alliance
2550 University Avenue West Suite 350 South
St. Paul MN, 55114-1900
Phone: 612-645-4545 Fax: 612-645-0002

Missouri

Missouri Association of Homes for the Aging
308A Monroe Street
Jefferson City MO, 65101-3106
Phone: 573-635-6244 Fax: 573-635-6618

Mississippi

Mississippi Association of Homes & Services for the Aging
c/o Naval Home 1800 Beach Drive
Gulfport MS, 39507-1597
Phone: 228-896-3110 Fax: 228-897-4013

Montana

MHA - An Association of Health Care Providers
P O Box 5119
Helena MT, 59601-4657
Phone: 406-442-1911 Fax: 406-443-3894

- MHA - An Association of Health Care Providers

North Carolina

North Carolina Association of Non-Profit Homes for the Aging, Inc.
3700 National Drive, Suite 218
Raleigh NC, 27612-4842
Phone: 919-571-8333 Fax: 919-571-1297

Nebraska

Nebraska Association of Homes and Services for the Aging
1701 K Street, Suite B
Lincoln NE, 68508-2699
Phone: 402-436-2165 Fax: 402-436-2169

New Hampshire

Northern New England Assn. of Homes & Svcs for the Aging
345 Edward J. Roy Drive Suite 201
Manchester NH, 03104-4149
Phone: 603-626-3479 Fax: 603-626-3763

New Jersey

New Jersey Association of Non-Profit Homes for the Aging
13 Roszel Road, Suite B 113
Princeton NJ, 08540-6211
Phone: 609-452-1161 Fax: 609-452-2907

New York

New York Association of Homes & Services for the Aging
150 State Street, Suite 301
Albany NY, 12207-1698
Phone: 518-449-2707 Fax: 518-455-8908

- New York Association of Homes & Services for the Aging

Ohio

Assn of Ohio Philanthropic Homes, Hsng & Svcs for Aging
855 South Wall Street
Columbus OH, 43206-1921
Phone: 614-444-2882 Fax: 614-444-2974

- Assn of Ohio Philanthropic Homes, Hsng & Svcs for Aging

Oklahoma

Oklahoma Association of Homes and Services for the Aging
P O Box 1383
El Reno OK, 73036-5699
Phone: 405-640-8040 Fax: 405-262-5252

Oregon

Oregon Alliance of Senior and Health Services

7360 South West Hunziker St. Suite 207
Tigard OR, 97223-8288
Phone: 503-684-3788 Fax: 503-624-0870

- Oregon Alliance of Senior and Health Services

Pennsylvania

Pennsylvania Association of Non-Profit Homes for the Aging
Executive Park West, Suite 409 4720 Old Gettysburg Road
Mechanicsburg PA, 17055-8419
Phone: 717-763-5724 Fax: 717-763-1057

- Pennsylvania Association of Non-Profit Homes for the Aging

Rhode Island

Rhode Island Association of Facilities & Services for the Aging
210 Cahir Street
Providence RI, 02903-4039
Phone: 401-453-0040 Fax: 401-453-1160

South Carolina

South Carolina Association of Non-Profit Homes for the Aging
P O Box 2708
Myrtle Beach SC, 29578-2708
Phone: 843-497-3506 Fax: 843-497-5362

South Dakota

South Dakota Association of Healthcare Organizations
3708 Brook Place, Suite 1
Sioux Falls SD, 57106-4211
Phone: 605-361-2281 Fax: 605-361-5175

Tennessee

Tennessee Association of Homes and Services for the Aging
500 Interstate Boulevard South
Nashville TN, 37210-4634
Phone: 615-256-1800 Fax: 615-726-3082

Texas

Texas Association of Homes and Services for the Aging
2205 Hancock Drive
Austin TX, 78756-2508
Phone: 512-467-2242 Fax: 512-467-2275

- Texas Association of Homes and Services for the Aging

Virginia

Virginia Association of Non-Profit Homes for the Aging
Innslake Place Building 4401 Dominion Blvd., Suite 200
Glen Allen VA, 23060-3322
Phone: 804-965-5500 Fax: 804-965-9089

- Virginia Association of Non-Profit Homes for the Aging

Washington

Washington Association of Housing and Services for the Aging

16300 Christensen Road Suite 203
Seattle WA, 98188
Phone: 206-248-7434 Fax: 206-241-2595

- Washington Association of Housing and Services for the Aging

Wisconsin

Wisconsin Association of Homes & Services for the Aging, Inc.
204 South Hamilton Street
Madison WI, 53703-3212
Phone: 608-255-7060 Fax: 608-255-7064

- Wisconsin Association of Homes & Services for the Aging, Inc.

Wyoming

Quality Health Care Foundation of Wyoming
520 Randall Avenue P O Box 3050
Cheyenne WY, 82003
Phone: 307-637-7575 Fax: 307-634-0804



HealthGate Document

Record 1 from database: **MEDLINE**



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Title

Devolution and aging policy: racing to the bottom in long-term care.

Author

Estes CL; Linkins KW

Address

Institute for Health and Aging, University of California, San Francisco School of Nursing
94143-0612, USA.

Source

Int J Health Serv, 1997, 27:3, 427-42

Abstract

For two decades, New Federalism, devolution, and other challenges to the federal role in domestic health and human services policy have fundamentally shaped the structure and delivery of long-term care in the United States. Devolution evokes crucial questions concerning the future of universal entitlement programs such as Social Security and Medicare and, with them, the future of aging and long-term care policy. This article examines the implications of the "devolution revolution" for long-term care in the context of the sociodemographics of aging and the managed care movement. Central issues are the extent to which state-level discretionary policy options (1) alter priorities, services, and benefits for the elderly and disabled; (2) foster a race to the bottom in long-term care; (3) promote generational, gender, racial and ethnic, and social class trade-offs; and (4) fundamentally alter the role and capacity of nonprofit sector services that comprise a significant part of the long-term care continuum.

Language of Publication

English

Unique Identifier

97431182



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MeSH Heading (Major)

Health Policy|*TD; Health Services for the Aged|*EC/OG; Long-Term Care|*EC/OG

MeSH Heading

Aged; Community Health Planning|EC; Community Health Services|EC/OG; Human; Managed Care Programs|EC/OG; Medicaid|TD; Politics; State Health Plans; Support, Non-U.S. Gov't; United States

Publication Type

JOURNAL ARTICLE; REVIEW; REVIEW, TUTORIAL

ISSN

0020-7314



From birth to age three are the most important
years in a child's brain development.
The time that defines who they become.



HealthGate Document

Record 1 from database: **MEDLINE**



[→ Order full text for this document](#)

Title

Giving voice to elderly people: community-based long-term care.

Author

Krothe JS

Address

Indiana University School of Nursing, Bloomington 47406-1370, USA.

Source

Public Health Nurs, 1997 Aug, 14:4, 217-26

Abstract

Information gained from elderly people regarding their needs for community-based long-term care is necessary for informed and responsive policy development. Informed policy development is essential given demographic projections and the need to develop cost-effective alternatives to institutionalization. The purpose of this study was to understand the context within which elderly people would be able to continue residing in their communities. Programs have been developed based on providers' perceptions of services that are necessary to maintain elderly people at home. There is a lack of information about elderly people's perceptions. Data were collected from 9 elderly people who represented the phenomenon of being at risk for institutionalization. Participants were interviewed serially and contingently in stages using naturalistic methodology. The interviews were tape-recorded, transcribed verbatim, and analyzed by the inquirer. Findings of the study indicated that the desire of elderly people to stay at home is motivated by their need to maintain control over their daily lives and have their individualized needs addressed. Perceptions related to nursing homes, roles of family, essential services, and future needs for assisted living emerged as major themes. The findings suggest policy implications for professional nurses related to the long-term care system, providers, and nursing homes.

Language of Publication

English

Unique Identifier

97416281



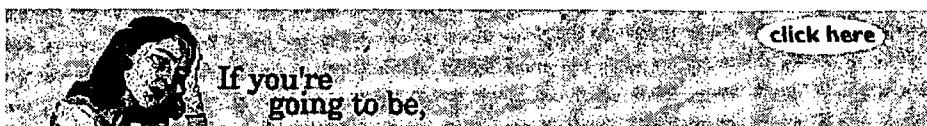
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MeSH Heading (Major)

Aged*PX; Attitude to Health*; Community Health Services*OG; Health Services for the Aged*OG; Health Services Needs and Demand*; Home Care Services*OG; Long-Term Care*OG

MeSH Heading

Aged, 80 and over; Female; Human; Institutionalization; Male; Nursing Methodology Research; Questionnaires



HealthGate Document

Record 1 from database: **HealthSTAR**



[→ Order full text for this document](#)

Title

Transforming the long-term care system: policy and managerial challenges.

Author

Miller NA; Clauser SB

Address

Division of Aging and Disability, Health Care Financing Administration, Baltimore, MD, USA.

Source

Health Care Manag, 1997 Jun, 3:1, 9-22

Abstract

As the need for long-term care of people with disabilities increases, the model of care faces crucial changes, including a shift from institutional to independent living, significant changeover in organizational auspices, and policies created by the Americans with Disabilities Act. Such systemic changes pose fiscal, technological, and social challenges to policymakers and managers of care delivery.

Language of Publication

English

Unique Identifier

97415192



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MeSH Heading (Major)

Health Policy[*]; Long-Term Care[*]

MeSH Heading

Disabled Persons[LJ; Health Expenditures; Health Services Research; Insurance, Health; Organizational Innovation; Private Sector; Public Sector; United States

Publication Type

JOURNAL ARTICLE; REVIEW; REVIEW, TUTORIAL

ISSN

1069-6571

Country of Publication

UNITED STATES





HealthGate Document

Record 1 from database: **HealthSTAR**



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Title

Long-term care design: strategies for planning the next generation of assisted living facilities.

Author

Regnier V

Address

University of Southern California, Los Angeles, USA.

Source

J Healthc Des, 1996, 8:, 47-51

Abstract

Abstract unavailable online.

Language of Publication

English

Unique Identifier

96383701



[Order full text for this document](#)

MeSH Heading (Major)

Facility Design and Construction|*MT/ST; Housing for the Elderly|*OG/ST; Long-Term Care|*OG

MeSH Heading

Aged; Comparative Study; Demography; Europe; Human; United States

Publication Type

JOURNAL ARTICLE

ISSN

1068-1124

Country of Publication

UNITED STATES



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HealthGate Document

Record 1 from database: **HealthSTAR**



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Title

Stats & facts. The growth of assisted living facilities.

Address**Source**

Manag Care Interface, 1998 Jan, 11:1, 44-5

Abstract

Abstract unavailable online.

Language of Publication

English

Unique Identifier

98263124



[→ Order full text for this document](#)

MeSH Heading (Major)

Housing for the Elderly|EC/SD/*SN

MeSH Heading

Aged; Data Collection; Human; United States

Publication Type

JOURNAL ARTICLE

Country of Publication

UNITED STATES



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Title

Improve continuity of care through collaboration. The growth of assisted living provides opportunities for nursing homes.

Author

Thompson JM; Marinaccio L

Address

Health Services Administration Program, James Madison University, Harrisonburg, VA, USA.

Source

Balance, 1997 Oct, 1:3, 14-5

Abstract

Abstract unavailable online.

Language of Publication

English

Unique Identifier

98218467



[→ Order full text for this document](#)

MeSH Heading (Major)

Continuity of Patient Care|*OG; Housing for the Elderly|*OG; Skilled Nursing Facilities|*OG

MeSH Heading

Aged; Cooperative Behavior; Health Care Surveys; Human; Interinstitutional Relations; Managed Care Programs; Patient Admission; Virginia

Publication Type

JOURNAL ARTICLE

ISSN

1094-6195

Country of Publication

UNITED STATES



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Title

Reimbursement. Striking the right balance with assisted living.

Author

Lusky K

Address**Source**

Contemp Longterm Care, 1997 Sep, 20:9, 37

Abstract

Abstract unavailable online.

Language of Publication

English

Unique Identifier

97457742



[Order full text for this document](#)

MeSH Heading (Major)

Housing for the Elderly|*EC/OG; Skilled Nursing Facilities|*EC/OG

MeSH Heading

Aged; Costs and Cost Analysis; Fraud|PC; Human; Medicaid|EC; Medicare|EC; United States

Publication Type

JOURNAL ARTICLE

ISSN

8750-9652

Country of Publication

UNITED STATES



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Title

Assisted living: opportunities for partnerships in caring.

Author

Marosy JP

Address

HM Associates, Worcester, MA, USA.

Source

Caring, 1997 Oct, 16:10, 72-4, 76, 78

Abstract

Throughout the United States, a variety of state government bodies license or certify assisted-living facilities. States have taken a variety of approaches in setting standards and protecting consumers. Consumers will respond to innovative solutions that enable elders to remain independent while assuring peace of mind of their adult children.

Language of Publication

English

Unique Identifier

98028807



[Order full text for this document](#)

MeSH Heading (Major)

Consumer Advocacy[*]; Housing for the Elderly|EC/*LJ/ST

MeSH Heading

Aged; Aged, 80 and over; Certification; Data Collection; Economic Competition; Home Care Services|EC/OG/ST; Human; Licensure; Medicare; Models, Organizational; State Government; United States

Publication Type

JOURNAL ARTICLE

ISSN

0738-467X

Country of Publication

UNITED STATES





HealthGate Document

Record 1 from database: **HealthSTAR**



[Order full text for this document](#)

Title

Mutual benefit. Study boosts hospital links with assisted-living firms [news]

Author

Snow C

Address**Source**

Mod Healthc, 1997 Oct, 27:40, 56

Abstract

Abstract unavailable online.

Language of Publication

English

Unique Identifier

98028279



[Order full text for this document](#)

MeSH Heading (Major)

Hospital Restructuring[*]; Housing for the Elderly|*/EC/OG

MeSH Heading

Human; Investments; Skilled Nursing Facilities|EC/OG

Publication Type

NEWS

ISSN

0160-7480

Country of Publication

UNITED STATES



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HealthGate Document

Record 1 from database: **HealthSTAR**



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Title

Managed care and assisted living: trends and future prospects.

Author

Mollica RL

Address

National Academy for State Health Policy, Portland, USA.

Source

J Health Hum Serv Adm, 1998 Winter, 20:3, 264-80

Abstract

With its emergence as a new, residential long-term care option, more than half of the states have established policy on assisted living. In 1996, over 30 states had created a state licensure category or passed legislation authorizing development of regulations. Known primarily as a resource for wealthy elders needing assistance with activities of daily living and health care needs, assisted living is increasingly being covered as a service under state Medicaid programs. Assisted living is widely seen as a resource for managed care organizations enrolling Medicare beneficiaries. Flexible capitation payments and incentives to substitute services create opportunities for assisted living facilities and HMOs to form partnerships. Enrollment of beneficiaries in Medicare HMOs has reached 4.5 million and is growing over 30% a year. In addition, state Medicaid agencies are developing programs to enroll elders, most of whom are also Medicare beneficiaries, in managed care programs that include long-term care. The move toward managed care and the increasing interest in integrating acute and long-term care for dual eligibles signals a growing role for assisted living facilities as a major resource for elders who need a supportive and service-rich residential living environment.

Language of Publication

English

Unique Identifier

98351220; AHA/98351220



[→ Order full text for this document](#)

MeSH Heading (Major)

Health Maintenance Organizations|EC/*TD; Housing for the Elderly|EC/*TD

MeSH Heading

Aged; Capitation Fee; Human; Interviews; Medicaid; Medicare; Organizational Affiliation; Rate Setting and Review; Reimbursement Mechanisms; United States

Publication Type

JOURNAL ARTICLE

ISSN



HealthGate Document

Record 1 from database: **HealthSTAR**



[→ Order full text for this document](#)

Title

An empirical study of the influence of demographic variable on the choice criteria for assisted living facilities.

Author

OBryan D; Clow KE; OBryan J; Kurtz D

Address

Gladys A. Kelce School of Business, Pittsburg State University, KS 66762, USA.

Source

Health Mark Q, 1996, 14:2, 3-18

Abstract

Despite the growth and prevalence of assisted-living facilities, empirical marketing research for these facilities is scarce. The objectives of this study were to determine the relative importance of three sets of evaluation criteria in the initial selection of an assisted-living facility, and determine whether the relative importance of these three sets of criteria differed by gender, marital status, level of household, age, or income of the consumer. Survey responses from 279 households indicates that primary service criteria are relatively more important than facilities amenities or organized social activities in the initial selection of an assisted-living facility. The relative importance of the choice criteria differed markedly by gender of the consumer, but marital status, level of household income, and age of the consumer did not have as great an impact on consumers' choice criteria.

Language of Publication

English

Unique Identifier

97182464



[→ Order full text for this document](#)

MeSH Heading (Major)

Consumer Satisfaction[*SN; Housing for the Elderly|EC/*ST/UT

MeSH Heading

Age Factors; Aged; Arkansas; Female; Health Care Surveys; Human; Income; Leisure Activities; Male; Marketing of Health Services; Marriage; Middle Age; Recreation; Retirement; Security Measures

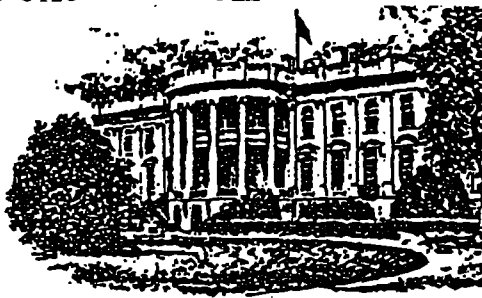
Publication Type

JOURNAL ARTICLE

ISSN

0735-9683

Country of Publication



THE WHITE HOUSE
WASHINGTON

Devorah -
we received this fax
from Matt Pitcher. Sarah
has marked which one's
she has info. on and can
help Matt with. She's
marked one's with your
Jeanne's name ~~to~~ to
help Matt out with.

-Karen

FACSIMILE FROM: MATT PITCHER
OFFICE OF PRESIDENTIAL LETTERS AND MESSAGES
OLD EXECUTIVE OFFICE BUILDING, ROOM 97

VOICE: (202) 456-5517

FAX: (202) 456-5426

NUMBER OF PAGES (INCLUDING COVER):

12

DATE:

11/23

TO:

Sarah Bianchi

VOICE:

FAX:

X6-5557

[X] INCOMING LETTER(S) FROM: multiple authors

RE: health care policy (the governor's letters are most pressing!!)

[X] FOR YOUR REVIEW

[] PER MY E-MAIL OR VOICE-MAIL MESSAGE TO YOU

[] PER YOUR REQUEST

ADDITIONAL COMMENTS:

Perhaps we should meet on some of these.
I have provided drafts to letters where I felt
confident I knew our policy. But, I need help
w/ the others ASAP. Thanks!!

ext 1000

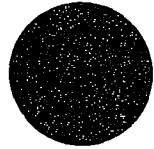
HOWARD DEAN, M.D.
Governor



State of Vermont
OFFICE OF THE GOVERNOR
Montpelier 05609

Tel.: (802) 828-3333
Fax: (802) 828-3339
TDD: (802) 828-3345
August 5, 1998

274/22
Dean
Denise



Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear President Clinton,

I am writing to regretfully inform you that Vermont has made a decision to not participate in the State Child Health Insurance Program and will be withdrawing its application. We submitted our application in March and since then have been negotiating our plan with HCFA. We have concluded that the restrictions and administrative requirements of SCHIP are such that it has become impossible to design a program that can be both efficiently managed and makes sense within the programs currently offered in Vermont. I personally asked the Secretary to exercise her waiver authority, given our unique circumstances, with no results. Given the current restraints, we will only be able to use a pittance (less than 25%) of our allotment of \$3.5 million dollars.

It is ironic and a sad commentary that states like Vermont that have served as national leaders in expanding health care coverage, are not able to access this program. SCHIP is designed for states that have done the last to provide coverage, and offers no flexibility to states such as Vermont.

Vermont expanded coverage to children in family with incomes up to 225% of FPL, and through our 1115 waiver, to uninsured adults with incomes up to 150% of FPL. Our plan was to build on these programs, expand coverage for children to 300% of FPL, and to essentially provide universal coverage for all children in the state, a goal many in Congress and the Administration embrace.

Vermont will only experience an annual net gain of \$100,000 over the regular matching rate. We have concluded that the lack of program flexibility and added administrative burdens are not worth the incremental benefits available under SCHIP. To establish a new program with separate administrative and eligibility requirements for the small number of uninsured children

11/23/98 MON 10:12 FAX 202 450 3420 FLM 003

Honorable William J. Clinton, President of the United States

August 5, 1998

Page Two

(approximately 1,000) that we can cover under SCHIP is not cost effective. The added administrative expenses and systems requirements will more than use up the incremental increase in federal matching funds available under SCHIP, as compared to using traditional Medicaid.

Vermont's plan as it evolved during the HCFA review required us to use both traditional Medicaid and SCHIP. The disjuncture between the two programs becomes impossible to explain because of its irrationality. As an example, SCHIP crowd-out provisions require a child without insurance to wait for three months before becoming eligible, while an insured child eligible under traditional Medicaid, in a household with the same income, would be eligible immediately. This child would then never be eligible for SCHIP because they had coverage under Medicaid.

We are still committed to going the extra mile to provide universal access for all children. Thus we will be pursuing an expansion of coverage to children up to 300% of FPL using the 1092 (r) (2) provisions available under the existing Medicaid program, and expansion of coverage to adults using the 1931 (b) provisions of PRWORA. We expect to offer this coverage by October 1 of this year. However, implementation of these coverage expansions will require HCFA to grant us waivers under the existing program.

I am asking, as strongly as I possibly can, that you be a partner with us, and use every available mechanism to assist us in achieving these coverage expansions. I also hope that your Administration and Congress will be willing to address the limitations in the Title XXI law, so that the handful of states, such as Vermont, that have done the most to expand health care can experience some benefit from this new program.

Sincerely,



Howard Dean, M.D.
Governor

HD/dr

cc: Donna E. Shalala, Ph.D., Secretary
Senator Patrick Leahy
Senator James Jeffords
Congressman Bernard Sanders
Nancy Ann Min DeParle, Administrator
Ronald Preston, Ph.D., Associate Regional Administrator
Cornelius Hogan, Secretary, Vermont Agency of Human Services
M. Jane Kitchel, Commissioner, Vermont Department of Social Welfare

8-18-98

[Handwritten signature]



The Honorable William Jefferson Clinton
President of the United States of America
1600 Pennsylvania Avenue, NW
Washington, DC 20500

August 13, 1998

Dear President Clinton:

On behalf of the American Cancer Society and its 2 million volunteers, we appreciate your leadership and vocal support for provisions in managed care reform legislation that will help cancer patients, such as assuring access to specialists and safeguarding continuity of care. As the largest voluntary health organization dedicated to improving cancer care, we urge you to assert that any patient protection bill that any patient protection that comes across your desk for enactment must have a provision assuring access to clinical trials for managed care patients with serious and life-threatening illness, such as cancer. Any managed care reform bill that does not includes such a provision fails to address the unique needs of cancer patients.

As part of a broader patient protection legislative agenda, the American Cancer Society has been advocating a provision to ensure that patients under managed care have access to clinical trials by assuring that their routine patient costs are covered. By providing these patients access to potentially lifesaving therapies through clinical trials, we will help to improve patient outcomes and advance medical knowledge. As you may know, such a provision is included in both the Patients' Bill of Rights (S 1890) and the recently introduced bipartisan bill, "Promoting Responsible Managed Care Act." Both of these bills recognize that patients under managed care, for whom standard therapy has proven ineffective, need to have access to new therapies that may be potentially lifesaving. The American Cancer Society has prepared the attached document, "Top Ten Myths About Increasing Access to Clinical Trials Under Managed Care", to help you and your staff to better understand the key issues about this critical patient protection provision.

As Congress moves to fulfill its commitment to doubling the NIH budget over the next five years, which we support and appreciate, we need to ensure that we not only advance biomedical research but translational and clinical research -- taking what we learn at the laboratory bench and bringing it to the bedside to improve the health of individuals. NIH has noted that enrollment in clinical trials is decreasing and some of that is attributable to the changes in our health care delivery system and the subsequent growth of managed care. We believe that increasing national funding for NIH and biomedical research while failing to take the essential

steps to ensure adequate enrollment in the clinical trials necessary to study the benefits of various new therapies is not a wise investment.

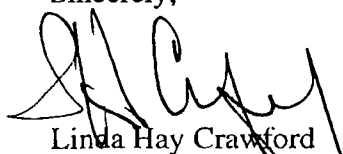
When someone is being treated for cancer routine patients costs are covered -- blood work, physician visits, anti-nausea medication, hospital stays, etc. Those costs are covered even if that treatment proves ineffective. What we want is to ensure that if such a patient has the opportunity to participate in a clinical trial testing a particular, possibly lifesaving, therapy that those same routine patient costs are covered. The cost of the therapy being tested and any other services associated with the clinical trial are covered, as always, by the study's sponsor.

As you know, in many cases, health plans deny coverage for these routine patient services because the therapy is "experimental." These patients often are therefore denied participation in the clinical trial. Many times when these patients appeal such decisions, ultimately the costs are covered. Yet, there is a window of opportunity to enroll in clinical trials and a window of opportunity to reap the potential benefits of the therapy being tested. Too many times the decision comes too late. Explicit assurance, as in the "Patients' Bill of Rights" and the "Promoting Responsible Managed Care Act," that these routine costs are covered up-front gives cancer patients peace of mind and relieves them of the burden of having to jump through bureaucratic hoops to get coverage for these services. Insured patients have a reasonable expectation that their policies will cover those costs, and it is critical that we have a national standard to ensure that expectation is fulfilled.

We appreciate your attention to this critical health and research matter. We are confident that what is learned from prevention and treatment clinical trials will benefit future patients, may reduce health care costs through the development of more effective therapies, and could help to the incidence of cancer. We look forward to working with you and your staff on elevating the importance of access to clinical trials as the debate on patient protection legislation moves forward.

Please feel free to contact me (202-661-5701) or Susan Polan, Director Federal Government Relations, (202-661-5715) should you have any questions or require additional information.

Sincerely,



Linda Hay Crawford

National Vice President State and Federal Government Relations

*Hope you are well.
It was good to see
Hillary at the breast
cancer stamp announcement
My Best -
Linda*



OFFICE OF THE GOVERNOR
INDIANAPOLIS, INDIANA 46204-2797

FRANK O'BANNON
GOVERNOR

July 14, 1998

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, N. W.
Washington, D. C. 20050

Dear President Clinton:

Today I wrote to Secretary Shalala at the U.S. Department of Health and Human Services (HHS) to ask for reconsideration of the recent decision by the Health Care Financing Administration (HCFA) to mandate Medicaid coverage for the prescription drug Viagra. I have attached a copy of my letter to Secretary Shalala for your review and consideration.

As you know, the introduction and use of Viagra have proven very controversial. HCFA's announcement on July 2 that state Medicaid programs would be required to pay for Viagra came without consultation with state officials and is likely to increase significantly the cost of Medicaid outpatient drug programs to federal and state taxpayers. I am very concerned about this new requirement and am hopeful that your administration will work with states to find a way to eliminate this national mandate either through administrative action or a statutory change.

I understand that the entry of a new type of drug into the marketplace poses a special challenge to federal regulators. However, given the controversy surrounding Viagra and your administration's efforts to provide states with new authority to administer federal programs flexibly and efficiently, I do not believe states such as Indiana should be forced to cover Viagra under their Medicaid programs. I therefore urge you to direct the Department of Health and Human Services and Health Care Financing Administration to work with states and the Congress to address concerns arising from HCFA's decision.

Sincerely,

Frank O'Bannon

Frank O'Bannon

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Holly Bannister to the President re:address and phone number (partial) (1 page)	06/24/1998	P6/b(6)

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Clinton Presidential Records
Domestic Policy Council
Devorah Adler
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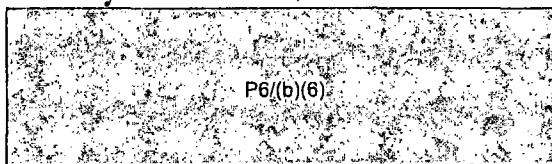
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Holly M. Bannister, M.D.

[001]

7-10-98



P6/(b)(6)

24 June, 1998

DeVore

The President of the United States
The White House
1600 Pennsylvania Avenue
Washington, DC 20002

Dear Mr. President,

It was truly a pleasure to meet you with my daughter, Olivia, at Martha Stewart's luncheon on June 8th. It was obvious to me that you have a sincere interest in children's issues when I mentioned my position as a physician in Pediatric Emergency Medicine at Bellevue Hospital/NYU in New York City.

When we spoke briefly, you asked me if the budget cuts had much effect on us, and I thought I would write to answer your question. As you know, Bellevue Hospital is one of the municipal hospitals in New York City. These are the hospitals that take care of the poor people in New York. Unfortunately, they are the hospitals with the least amount of funding, and present changes in health care economics are threatening their funding even more.

We reach out to and affect the people in many ways. For example, I know Mrs. Clinton is very interested in the Reach Out and Read Literacy Program for children. Our hospital is the head of the New York City Coalition, and furthermore, we have a Reach Out and Read Program in our Emergency Room.

I invite you and the First Lady to inquire or better yet to come anytime to visit our model pediatric emergency service program and to discuss any health issues. We are full of information and ideas.

Again, many thanks for your concern and the special moment you gave to my daughter.

Sincerely,

Holly M. Bannister, MD
Holly M. Bannister, MD

*Matt: CC Scheduling on
incoming, and draft AP
reply. Thx. Paula
To B. Christ*

7/13

Reuben

AP reply

Tr

B.

for reply



Paul

7/10

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April 16, 1998

President Bill Clinton
 The White House
 1600 Pennsylvania Avenue, NW
 Washington, DC

Dear President Clinton:

I would first like to thank you and the First Lady for your efforts on behalf of health care reform in the United States. I know it is not an easy or popular agenda to pursue, but it is a crucial one and it means a lot to people like myself who are trying to make a difference in the status quo.

Because you have been sensitive to health care issues, I am sure that you get many letters from advocates of various diseases/syndromes who are working hard to promote research and public education for very "deserving" illnesses and syndromes. I would like to take a few moments to tell you (1) why fibromyalgia syndrome (FMS) is different from other medical conditions, and (2) how increased support of FMS research and education can have far-reaching effects on other chronic conditions as well.

As you will see from the enclosed materials, fibromyalgia syndrome is a complex chronic condition which causes widespread pain in the muscles and connective tissue of the body along with a variety of other disabling symptoms. An estimated seven to ten million Americans suffer from this condition, 80% of them women. Although all age groups can develop FMS, the syndrome seems to predominate among working-age adults with obvious consequences in terms of employment and increased family stress. Since inadequate research has been conducted on women's health issues in past years, FMS would be a worthy candidate for increased attention on this basis alone. However, there are other compelling reasons.

As I indicated above, FMS commonly involves not only musculoskeletal pain but a wide array of associated symptoms/syndromes which involve the nervous system, the cardiovascular system, the endocrine system, the gastrointestinal system, the genitourinary system, and more. Accordingly, both treatment and research necessarily span many disciplines. Today, fibromyalgia syndrome is officially under the auspices of the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) of the NIH. However, because available research advises that FMS may be caused by abnormalities in the neuroendocrine system (not in the musculoskeletal system as in arthritic diseases) and because effective treatment of its many symptoms encompasses a variety of medical specialties, fibromyalgia syndrome has become a child with

many caretakers. As a result, research into etiology, pathophysiology, and treatment has neither been optimally coordinated nor adequately far-reaching.

The good news is that because fibromyalgia syndrome involves so many body systems, interdisciplinary FMS research can have profound benefits for other chronic conditions as well. Not only can important advances be made in the important field of pain research, but they can also be realized for conditions like irritable bowel syndrome, chronic fatigue syndrome, Persian Gulf syndrome, interstitial cystitis, temporomandibular (jaw) joint dysfunction, vulvodynia, sleep disorders, and other health problems which overlap significantly with fibromyalgia syndrome, according to new research.

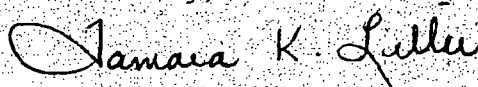
To improve the quality of life of millions of Americans with fibromyalgia syndrome and to give them hope for the future, your assistance is greatly needed in the following areas.

1) Greater emphasis on FMS research in general and interdisciplinary FMS research in particular via the National Institutes of Health and other research institutions: Dr. Stephen Katz, Director of the NIAMS Institute at NIH has made several good faith efforts to promote interdisciplinary research for FMS. A multi-institute RFA for fibromyalgia research was issued late last month. However, this is only a first step for a syndrome which has seem very little research money to date. Dr. Harold Varmus, Director of the NIH, (and medical research centers in general) need to be asked to promote/fund rigorous interdisciplinary FMS research and stimulate the creation of research centers nationwide devoted to the study of FMS and allied conditions.

2) Financial support for aggressive fibromyalgia education in the medical and lay communities: It is already unfortunate that the cause of FMS is unknown and that its successful treatment is complex and often limited. What is perhaps even worse is that awareness of the condition among medical professionals and the lay community is very low which means unconscionable delays in diagnosis and treatment for many patients--sometimes several years. To date, funds for public education are not available through the NIH, and grants for this purpose (because of low FMS awareness) are very difficult to obtain. While many grass roots organizations have sprung up across the country, their operating funds are minimal, and staff members are either unpaid or wildly underpaid. Since many activists are unable to work and earn an income in traditional settings due to the limits imposed by their fibromyalgia, their financial situations are already very precarious, if not downright disastrous. Even attempts at fund-raising by regional or national FMS organizations are hindered (as they are for all non-profit organizations) by requirements that registration be made in every state where soliciting is to be done--a time-consuming and expensive proposition even if staff are available to do the work. (Consideration of a federal system for fund-raising registration would benefit non-profits in all fields of charitable work.) In short, there are people out there willing and able to provide fibromyalgia education if only they had some financial assistance, federal or otherwise.

Thank you for listening to my brief overview of the current state of fibromyalgia in America and to my suggestions for needed improvements.

Sincerely,



Tamara K. Liller
President

DRAFT OF BC LETTER

INITIALS: BC / mwp /

DOCUMENT TITLE: /slr/p/liller.t.mw

DRAFT DATE / LETTER DATE: Jul 02 1998 /

CORRESPONDENCE #: 4012628

CLEAR WITH:

WHCC:

CC: Neal Sharma, 97
Anne S. Tatem, NIH

CORRESPONDENCE ADDRESSED TO:

Ms. Tamara K. Liller
President
Fibromyalgia Association of Greater
Washington, Inc.
13203 Valley Drive
Woodbridge, Virginia 22191-1531

APPROVAL/ENCLOSURES/SPECIAL INSTR:
clear with Bianchi

Dear Ms. Liller:

Thank you for your very thoughtful and informative letter concerning fibromyalgia. I appreciate knowing of your concern and recommendations on how to further advance research in this area.

I have shared your letter, outlining your recommendations for greater emphasis on fibromyalgia research and the need for more education of the lay and medical communities, with Dr. Stephen Katz, the Director of the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

When sharing your letter with Dr. Katz, I learned that you serve as a member of the National Arthritis and Musculoskeletal and Skin Diseases Advisory Council. I applaud your efforts as a member of this council and as an advocate for biomedical research and fibromyalgia research, in particular. The voluntary and professional advocacy groups play an extremely important role in furthering disease awareness and in shaping research priorities.

Please be assured that biomedical research is a priority of this administration and we will continue to support the National Institutes of Health and its efforts to better understand and treat painful and

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this w/ Bianchi

debilitating diseases, such as fibromyalgia.

Again, thank you for sharing your suggestions with me on enhancing fibromyalgia research and education.



3000 Michael

The President
The White House
Washington, D.C. 20500

James Beutner

October 7, 1998

Dear Mr. President:

The nation's Governors adamantly oppose reductions in the federal government's commitment to the administration of the Medicaid program. Cuts in Medicaid administrative funds would hamstring states' ability to serve their most vulnerable citizens and would greatly undermine the longstanding federal-state partnership of providing quality services to families in need.

We strongly oppose an across-the-board, perpetual cut in the Medicaid administrative match rate. Extending the cost allocation methodology from P.L. 105-185, the Agricultural Research Act -in its current form- is equally as troubling to Governors. Both proposals would be viewed as an unfunded mandate on states. Cuts in Medicaid administrative funds would have a real and devastating impact on children's health outreach, fraud and abuse prevention and detection, and eligibility processing.

Medicaid has already made an enormous contribution to budgetary savings through controlled program growth rates. In the late 1980s and early 1990s, Medicaid spending grew at an annual average rate of more than 20 percent. Since 1995, Medicaid growth has been in the range of 5 percent. These savings, combined with the far-reaching reforms enacted last year through the Balanced Budget Act, have already reduced actual and projected Medicaid spending by more than \$100 billion between 1995 and 2002.

As you complete budget negotiations for the year, we strongly urge you to reject any cuts in Medicaid administrative funds. A constructive federal-state partnership and support for our most vulnerable citizens are at stake.

Sincerely,

Tom Carper

Governor Thomas R. Carper

Lawton Chiles

Governor Lawton Chiles

Tommy G. Thompson

Governor Tommy G. Thompson

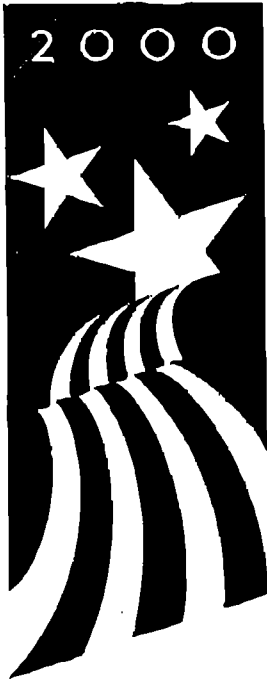
Michael O. Leavitt

Governor Michael O. Leavitt

Frank O'Bannon

Governor Frank O'Bannon

OCT - 8 1998



Administration on Aging

Honor the Past, Imagine the Future: Towards a Society for All Ages

Older Americans Month, May 1999

Department of Health and Human Services Office of the Assistant Secretary for Aging

Date: 4.27 240
To: Devoral
Phone: _____
Fax: _____
FROM: _____

Phone: (202) 401-4634 or (202) 401-4541

Fax: (202) 401-7741

Jeanette C. Takamura
Assistant Secretary for Aging

Diane Justice
Deputy Assistant Secretary for Aging

☒ Moya Benoit Thompson
☐ Dave Bunoski
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☐ Nadine Langon
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☐ Sunday Mezurashi
☐ Chris Rhatigan
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☐ Evelyn Yee

Comments: Hi - Pls. discard the original
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Number of Pages (including cover sheet): _____

Most current

LEGAL SERVICES

QUESTION:

Please summarize the changes and explain the rationale for revising the legal services provisions in the current Older Americans Act statute.

ANSWER:

ISSUE ONE -- PRIORITY SERVICES:

The primary and most significant provisions in the Act related to legal assistance services are retained in the Administration's reauthorization proposal. Legal assistance is provided under the authority in Title III. Sections 306(a)(2)(C) and 307(a)(22) -- commonly referred to as the "priority services" sections -- require that a "minimum percentage" of funds under Title III-B be allotted for access services, in-home services, and legal assistance. Additionally, an assurance must be provided in each area plan that the minimum percentage is an "adequate proportion" to meet the need. In the past, there have been threats to the retention of legal assistance as one of the three priority services. By retaining these and the complete list of specific state plan provisions with respect to legal assistance in section 307(a)(15), the Administration demonstrates its support for legal assistance, and signals its significance.

Currently, legal assistance advocates have raised concerns about the provisions in our proposal to require a state first to evaluate the need for legal assistance and other services, including the extent to which the need already is met. They have expressed concern that this would weaken the operation of legal assistance programs. The requirement to first evaluate the unmet need for supportive services (including legal, and transportation), nutrition services, and senior centers within the state should be current practice, as it is required under the current statute in section 307(a)(3)(A). Perhaps it has become more visible because our proposal attempts to realign disaggregated provisions of the current Act with similar requirements for each service or activity. Additionally, the advocates have expressed concern over the clarification of the current language in the statute related to the determination of the extent to which existing *public or private programs* meet such need. We clarified in our draft that such *public or private programs* should include *resources, such as volunteers and programs and services of voluntary organizations*. They indicated since no definite commitment can be made from voluntary programs, they should not be a factor in the determination of the extent to which the need for legal services is met.

ISSUE TWO -- TITLE VII-LEGAL ASSISTANCE DEVELOPMENT:

The second set of key provisions in the Act related to legal assistance is found in Title VII. Chapter 4 of Title VII requires states to establish a program to provide leadership for improving the quality and quantity of legal and advocacy assistance as a means of ensuring a comprehensive elder rights system. Previously, threats have been made to the retention of Title VII, and this provision in particular. Although established and authorized in 1992, funds have yet to be appropriated for legal assistance development.

The Administration's proposal consolidates the authorization of appropriations for the four

activities in Title VII (ombudsman; elder abuse; legal assistance development; and outreach, counseling and assistance). Currently, only two of these activities receive appropriations under the four separate authorizations. This consolidation would provide states the flexibility to fund one or all of the four activities from the consolidated funds received. It is important to note that our proposal would establish a floor for funding ombudsman activities. Our proposal is another example of the Administration's support for legal assistance. First, we retain the provisions in the current law, including all the functions related to coordination, technical assistance, consultation, and education and training, and then we proposed a method by which these provisions could be funded.

ISSUE THREE -- COST SHARING:

The Administration's 1995 proposal for reauthorization of the Act included an option for states to implement cost sharing methodologies as a means of achieving equity and enhancing coordination with programs funded by other funding streams. Our current proposal retains the inclusion of this option and the exemptions from the prior proposal. It prohibits states from implementing cost sharing in the following areas:

- information and assistance, outreach, or case management services;
- ombudsman or other protective services; or
- congregate or home-delivered nutrition services; and

also exempts individuals who declare that they have incomes below a low-income threshold set by the State.

Concerns have been raised by legal assistance advocates that we have changed our position since 1995 by now not including legal assistance in the list of exempted services. There has been no change in policy regarding the exempted list of services. The Older Americans Act is not the primary funding source of legal assistance services for the elderly. Our proposal would allow states to achieve a greater sense of coordination and equity in administering legal assistance services funded by the Act and those funded by other sources for which cost sharing, after the exemption of low-income individuals, is permitted.

ISSUE FOUR -- SPECIAL DEMONSTRATION AND SUPPORT PROJECTS:

Title IV of the current Act provides for training, research and discretionary projects and programs. It has evolved over time into a very specific listing of authorities and mandates to fund identified categories of demonstrations, education, and training. One such specific reference is Section 424, *Special Demonstration and Support Projects for Legal Assistance for Older Individuals*.

In developing the Administration's 1995 proposal for reauthorization, we took into account the criticism lodged against the degree of specificity in Title IV. It was often referred to as a "Christmas tree, overflowing with ornaments from each special interest group." Our 1995 proposal streamlined the authorizations and activities in Title IV into major categories, but retained a degree of specificity (including a reference to legal assistance) in listing the types of

centers and demonstrations to be conducted. In response, we were informed that our streamlining efforts did not go far enough. As a result, the current proposal attempts to remove the specific types of centers and demonstrations to be conducted, and merely references the authority to carry out the core functions of the title. These include:

- education and training;
- applied social research and analysis, and evaluation;
- development of methods and practices to improve quality and effectiveness;
- demonstration of new approaches to design, deliver and coordinate programs and services;
- technical assistance;
- dissemination of information; and
- other similar activities to achieve the purposes of the title.

The current proposal, with the additional degree of streamlining, is part of a strategy to make the provisions and activities carried out under this title more acceptable to members of Congress who previously expressed concern. A second part of that strategy was to rename the title from *"Training, Research, and Discretionary Projects and Programs"* to *"State and Local Innovations and Programs of National Significance."* It should be noted that we would be able to fund all of the current grantees and activities under the new authorities and functions in our proposal.

COST SHARING

QUESTION:

Why has the Administration proposed cost sharing? What is the basis for this proposal?

ANSWER:

The Administration initially proposed granting states the option to implement cost sharing in its bill introduced in 1995. The proposal was in response to discussions with the network and reflected the desire to grant additional flexibility and devolve responsibility to the state and local level. The discussions with the network followed a 1989 GAO review which showed a growing number of state and area agencies with cost sharing programs funded through private and government sources. They found that states and area agencies favored cost sharing primarily because it enabled them to serve more clients and offer a broader range of services. In addition, they reported both agencies that cost share and those that do not would like to see the Older Americans Act (OAA) changed to authorize the practice.

Our proposal was designed to enhance the coordination of the OAA programs with other similar programs administered by the aging network's service delivery infrastructure, such as those funded by State General Revenue. The GAO reported that states often apply cost-sharing methodologies to higher-cost services such as adult day care, and in-home services. A subsequent report by the DHHS Office of Inspector General in 1996 showed that states continue to have widespread usage of cost sharing practices for these services funded from other sources.

The Administration proposal would grant states the option of implementing cost-sharing methodologies in a number of programs, but would exempt low-income individuals. In addition, the proposal would not permit cost-sharing methodologies to be used in gatekeeper or access services, such as information and assistance, outreach or case management; in protective services, such as the ombudsman program; or in nutrition services.

During the discussions in the 104th and 105th Congresses the issue of whether or not nutrition should be exempted was raised. We were concerned about changing the nature of the nutrition program. It is often considered one of the cornerstones of the Act, and unlike other home and community-base services, is primarily funded through the Act. It has been very successful with seniors, and has relied upon a strong sense of local ownership and participation. In the last year, more than \$161 million were collected through voluntary contributions in this program.

As stated above, the rationale for providing an option for cost sharing is based on enhancing coordination with programs from other funding streams. It is important to note that as a general rule, for other home and community-based programs the Act is the smaller contributing funding source. But with regard to nutrition, the Act is the primary funding source. Our proposal is based on achieving a sense of equity in policy with the primary funding sources for home and community-based programs within states.

The Administration proposal takes a middle-ground position. It rests between those proposals which are opposed to any form of cost sharing, and those which would impose a mandatory, intrusive, income-verified, means-tested eligibility requirement. Most recently, advocates opposed to any form of cost sharing have characterized our proposal as a form of "mandatory cost sharing" because it would permit a state to require some form of cost sharing. Our proposal provides an option to the states to implement a cost sharing methodology. Our current proposal is consistent with our initial 1995 bill, except in one area. It clarifies that the states in implementing a cost sharing methodology would have to permit seniors to merely declare their incomes. This is designed to address concerns about the development of intrusive reviews of seniors' incomes and assets, and new administrative structures. The GAO found this practice to be the most commonly used method for determining the fee for services.