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Housing and Service Options for Older Adults in Maine

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Background

Older adults want to live at home and in their community as independently as possible for as long as possible (Bayer & Harper L, 2000). The housing and service needs of older adults vary greatly by age, by condition, by setting, by geographic region, and over time. Some older adults do not require any supportive services; others need services that may range from assistance with shopping to extensive need for nursing care. Needs also fluctuate in response to acute events (often requiring hospitalizations), or other temporary changes in health status. The challenge is to have a mix of private and publicly funded housing and service options available that can meet the variety and changing needs of older adults.

Certain groups have special needs. Meeting the needs of people with Alzheimer's and dementia, for example, is particularly challenging due to the duration and complexity of the disease process. In some instances these needs can successfully be met at home, and in other instances the needs are best met in an alternate setting e.g. residential or nursing facility with specially trained staff. People at the end of life also have special needs such as pain management and emotional or spiritual support. In all instances, caregivers and family members are integral to successfully meeting the needs of older adults.

Many factors influence the supply and the demand for housing, services, and supports. In the last decade, the demand for institutional long term care has remained stagnant as other community based options have developed (Kochera, Straight, & Guterbock, 2005). The supply of independent and assisted living options has grown significantly to meet the increased demand. Furthermore, recent studies have shown that older adults are healthier and have fewer disabilities than in prior decades (Spillman, 2004) (Waidmann & Liu, 2000). The implications of a healthier older population that lives longer and the impact on housing and services needs are not fully known.

Problem Statement

The housing and service needs of older adults are closely linked. Older adults want housing that is affordable, accessible and available in their communities. They also want access to services that meet individual needs and are flexible enough to meet changing needs. The problem is that the policies that govern housing and services are not closely linked. Responsibility for financing, planning, and regulating housing, services, and health care is spread across multiple federal, state and local agencies.

This means it is difficult:

- **For older adults,** to find out about, understand or access housing and service options;
- **For communities**, to plan or promote local development or public-private partnerships;
- **For policy makers**, to plan, coordinate, and cost-effectively leverage multiple federal and state resources.

Trends

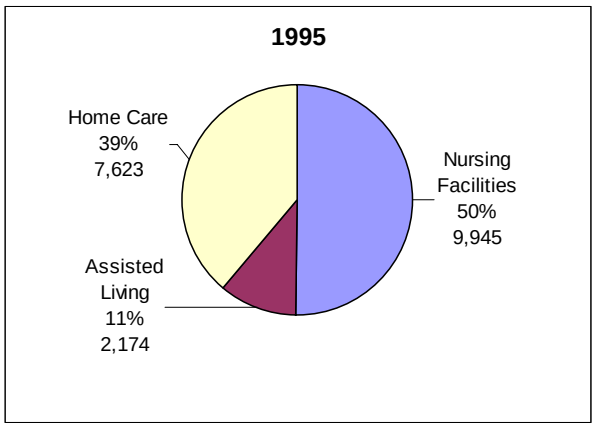
Housing and service options for older adults have changed dramatically in the last 15 years. At one time, nursing homes were the predominant and often only alternative for people who needed long term services or supports. Recent demand for home and community based services in combination with the growth of assisted living and other housing and service programs have changed the landscape significantly.

It is clear from national surveys that most older adults want to remain in their own homes. At the same time, the burden of housing costs can be significant. In Maine, almost one quarter of homeowners over the age of 65 pay 30% or more of their income for housing. This ranks Maine 11th in the nation on this indicator. Property taxes are also a burden for people who want to remain in their home. The challenge of providing housing and services options in Maine is further complicated by the rural character of the state. More than half of those over 65 in Maine live in rural areas. Appendix A provides a summary comparison of Maine and selected other states on key indicators related to long term care, housing and services.

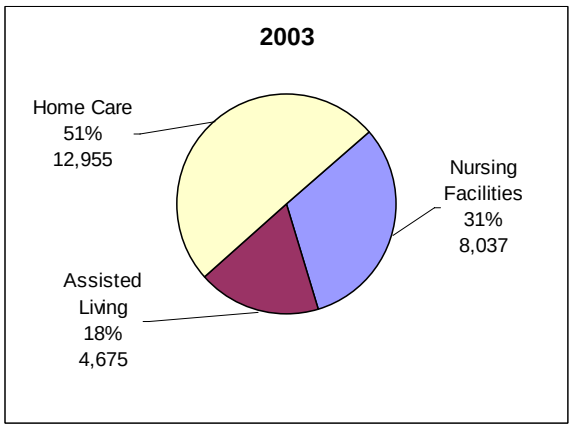
The national trend to increase home and community based service options has also occurred in Maine. In the last 10 years, Maine has significantly reduced its reliance on nursing homes while buttressing the availability of other options including assisted living and home and community based services. In 1996, Maine had 47 nursing home beds per capita (Bectel & NG, 1998). By 2003, there were 40 nursing home beds per capita in Maine, lower than the national average of 49 beds per capita. Maine also ranks second in the number of residential care facility beds per capita; and 4th in the number of adult day facilities (See Appendix A).

Between 1996 and 2003, the percent of people in the long term care system who received home care services increased from 39% to 51% while the proportion of long term care users who were in nursing homes declined from 50% to 31%.

Long Term Care in Maine[1]
Use of Services



Total Persons Served: 19,742

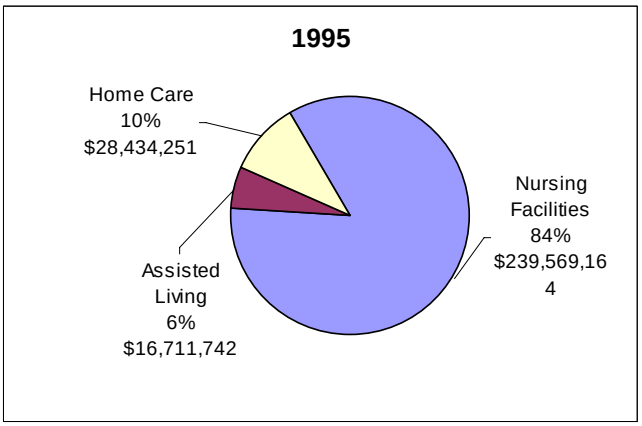


Total Persons Served: 25,667

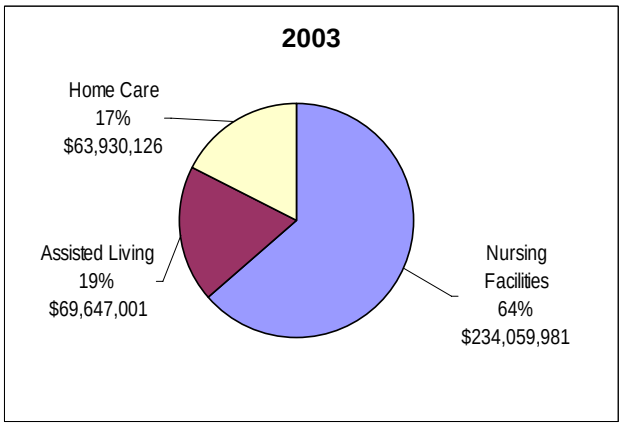
[1] Source: Maine Department of Health and Human Services. Services include those funded by MaineCare and State funded programs.

Similarly, the percent of state and MaineCare[2] spending devoted to home and community based care increased from 10% in 1995 to 17% in 2003. The proportion of spending for assisted living increased from 6% to 19% while the percent of public spending on nursing home care declined from 84% to 64%.

State and MaineCare Spending



Total Expenditures: $284,715,157



Total Expenditures: $367,637,108

Nursing Home Trends (Appendix B)

The characteristics of people receiving services in nursing homes have also changed in the last 10 years. Nursing homes are serving more people who need rehabilitation, and more people with special care and clinically complex needs. Overall the case mix (e.g. the acuity of the needs) of residents in Maine nursing homes increased about 6% between 1998 and 2005. In addition, nursing homes are serving more people who have Medicare coverage. In 1998 approximately 11% of the residents in nursing homes were Medicare beneficiaries and by 2005 this had increased to 15%. This reflects the increased use of the nursing home for skilled care and post hospital care.

Residential Care and Assisted Living Trends (Appendix C)

The number of people in residential care facilities[3] increased more than 40% from 1998 to 2005. The complexity of care needs of people in residential care facilities increased 10% from 1998 to 2005. In 2000, the average number of activities of living (ADLs) that people in residential facilities needed assistance with was 3.25. In 2005 that had grown to 3.9 ADLs. Almost one third of people in residential care homes need some help in managing a behavior (such as wandering, etc).

People with Alzheimer's or Dementia in Residential Care (Appendix C)

People with Alzheimer's and dementia have special care needs and for many these needs are being met in residential care and assisted living facilities. Fifteen percent (15%) of MaineCare residents in residential care facilities are in Alzheimer's special care units (SCUs). The number of people in SCUs more than doubled between 1998 and 2005. Furthermore, the level of case mix (e.g. the acuity of the needs) of people in Alzheimer's special care units is 3 times higher than the overall case mix of people in residential care facilities.

[2] MaineCare refers to the Medicaid program in Maine.
[3] Residential care facilities refers to Level 4 facilities that serve 7 or more residents.

Housing and Service Options

The increased availability of housing and service options has been accompanied by considerable confusion in the terminology used to describe what is available. Housing options include everything from modest renovations to existing homes, to independent housing with services, to assisted living facilities, all the way to emerging models of compassionate and individualized care in nursing homes, with many variations in between. Service options can include things such as meals on wheels, personal care assistance, home care, home health care, skilled nursing care, adult day care, and/or respite care.

In the housing with services market, in particular, the size, scope, funding and type of services vary considerably. In some instances, housing and services are bundled into one overall price and managed by a single entity. In other instances, the housing component is funded and managed by a housing development agency and the services are managed by a human services agency. The rules and regulations for housing, services, and assisted living tend to be defined on a state specific basis.

The following section provides a brief overview of some of the housing and service options that are available and some of their distinguishing characteristics.

Individual Homes

Most people over the age of 50 live in single family homes. While people report that they want to live at home as long as possible, a number of factors influence a person's decision and ability to do so. These factors include access to amenities (such as shopping and medical care), transportation, proximity to family, availability and health of spouse/caregiver, knowledge of neighbors, and attachment to the community. As people's needs change or they anticipate their needs changing, the accessibility of the home, access to community services and the availability and affordability of long term services and supports become increasingly important.

Existing Homes with Modifications

The ability to make home modifications is a critical component in supporting the ability to live at home as long as possible. The results of a survey by AARP indicated that people who felt their home would not meet their physical needs were less likely than other respondents to report that they wanted to remain in their own home as long as possible (Bayer & Harper, 2000).
Home modifications include things such as building ramps, grab bars, wide doorways etc. For many, cost is a major barrier to making home improvements. Other barriers include inability to do the work, uncertainty about the changes that are needed and uncertainty about contractors (Kochera, Straight, & Guterbock, 2005).

Accessible Design—New Homes

A report by the Brookings Institute estimated that almost 60 million more housing units will be needed to replace some of the nation's aging housing stock. As new housing is built, it will have to serve the needs of people with varying ages and disabilities. (Kochera, Straight, & Guterbock, 2005).

This has led to increased interest in the concepts of universal design. The features of universal design include easy access (step-free entry and slope from entry to main door); easy passage (width of interior passageways) and easy use (number of bathrooms on ground floor and

accessible faucets, counters, grab bars etc) (Kochera, Straight, & Guterbock, 2005). The importance of universal design extends to the homes where older adults may wish to visit. For many, the inability to visit the homes of family and friends because of restricted access contributes to the problems of loneliness and isolation.

Home Sharing

Shared housing is an appealing option particularly for those who want to share the cost of living expenses, to share chores, or for companionship. Shared housing is an arrangement where two or more unrelated older adults share a home or apartment (Kochera, Straight, & Guterbock, 2005).

Accessory Dwelling Units

Accessory dwelling units are independent units that are connected in some way to a larger home; an accessory dwelling unit can be a small apartment in the back of a house, or a small building on the property. These arrangements provide a way to give support to an older family member or friend, while allowing the older person the privacy of separate living quarters. They can also help homeowners to maintain their independence by providing supplemental income to offset property taxes and the costs of home maintenance and repair (Kochera, Straight, & Guterbock, 2005).

Independent Housing/Congregate Housing

Independent and/or congregate housing are usually apartment-style housing for people who want "hospitality" services, such as one or more meals a day or light housekeeping services. There may also be arranged social activities. This does not generally include personal care or health care although there is increasing interest in offering a set of services to residents, often by an outside health care or social service agency. It is usually up to the congregate housing resident to independently arrange for home health or other social services.

Assisted Living

The growth of assisted living facilities and other models of independent housing with services has served to fill what was once a gap between the institutional nursing facility and services provided in an individual private home (Wilson, 2005/2006). Demand for settings that were more responsive to consumer preferences, provided private and homelike environments and yet were able to provide both housekeeping as well as personal care services spurred the development of the assisted living and housing with services industry.

Assisted living options are characterized by the type of housing and the type of services that are offered:

Housing Component of Assisted Living: The housing options available under the umbrella of assisted living programs vary considerably. Assisted living can include small family homes with individual/shared rooms; small board and care homes with individual and/or shared rooms; apartment congregate housing with common meal or social areas; and private apartments with individual kitchens/kitchenettes and baths. The age of the building, the number of residents, the amount of private space, and the income of the residents are some of the features that distinguish the physical environments in assisted living homes and facilities. Older facilities that were once considered board and care homes or converted wings of nursing homes are likely to be smaller, feel less residential, and have shared sleeping areas and bathrooms. (Hernandez, 2005/2006).

Newer communities tend to be larger, have more private space, are designed to be accessible, and are often targeted to the higher end income market.

Service Component of Assisted Living: Services offered in assisted living generally include hospitality services one would find in a hotel including housekeeping, laundry, maintenance and meals. Most assisted living facilities provide or arrange for some assistance with activities of daily living, such as bathing, dressing, and using the toilet. Health related services typically include medication assistance, with varying amounts of nursing care, assessment, coordination of medical services and monitoring of health conditions (Hernandez 2005/2006). Features that differentiate types of facilities are the intensity, frequency, and availability (whether scheduled or unscheduled) of assistance provided.

When some amount of health and social services is provided as part of a "package of services", it is important to clarify the policies and circumstances under which additional individualized services may be necessary and/or when the needs of a person can no longer be met by a residential program. When services are publicly funded, the state has an interest in assuring that services are coordinated and not duplicative.

For more information on Maine's assisted living policies, see Appendix D.

Nursing Homes

For some, nursing homes provide the level of nursing, supervision, and supportive services that are required to care for higher level needs for assistance with activities of daily living, advanced stages of Alzheimer's disease and other chronic or medical conditions requiring skilled care. The medical eligibility criteria for nursing home level of care (and thus eligibility for Medicaid payment) varies from state to state. Generally, nursing home level of care requires a combination of need for assistance with 3 or more activities of daily living and some type of nursing supervision or assistance. Medicare will pay for short term skilled nursing services in a nursing home for people who have recently been in a hospital.

Emerging Practices and Models

The following is a brief description of some of the emerging models and practices in home care, assisted living and nursing homes in Maine and elsewhere.

eHope

A recent innovation in Maine is the creation of the eHope foundation, a nonprofit group that helps to create and organize day-to-day support networks for people with life-threatening illnesses and their families. In this program, volunteers identify a support network of family and friends that is focused on one person. Once the network is identified, a web site is set up for each person with a list of things that need to be done, the person who has agreed to do them, contact information and the person's condition. Volunteers help put the network in place and set up the information on the website (Routhier, 2006).

The Eden Alternative™

The Eden Alternative, developed by Dr. William Thomas in the 1990s, focuses on the development of an elder-centered community that nurtures the development of meaningful relationships and high quality of life (Bell, 2002). The core concept behind the Eden Alternative is to "see environments as habitats for human beings rather than facilities for the frail and the

elderly" (Bell, 2002). The Eden Alternative focuses around a number of key principles. First, that loneliness, helplessness, and boredom are responsible for most of the suffering elderly experience. Second, that the creation of a "human habitat" that focuses on constant contact with animals, plants and children to develop meaningful relationships is beneficial to both elderly and young people alike. (The Eden Alternative, 2002). The Eden Alternative is also committed to changing the culture of the organization. Elders within the facility are the key decision makers. The well-being of the caregivers is equally valued and caregivers are integrated into the decision-making concerning the daily lives and routines of the elders. More than 20 nursing facilities in Maine have been trained on the Eden Alternative and 5-6 facilities are actively implementing the model (Thomas and Johannson, 2003).

The Green House Project

The Green House Project is an outgrowth of the Eden Alternative and is an attempt to design, build, and test a radically new approach to residential long-term care. It is founded on the concept that the physical and social environments in which care is provided should be warm, smart and green (Thomas and Johannson, 2003). It focuses on the use of architectural design to achieve the mission of providing care that offers privacy, dignity and choices for residents. It uses the concept of "home" as an organizing principle where elderly and those who provide hands-on care are "empowered to define for themselves the rhythms and routines of the household, honoring the essential personhood of companionship" (Angelelli, 2006). The Green House Project designs flexibility into every aspect of operations and household life. Facility size, interior design, staffing patterns, and methods of delivering skilled professional services are altered to achieve the overall mission of Green House Projects. (The Green House Project, 2006).

Care for People with Alzheimer's and Dementia

Dementia Care Practice Guidelines: The Alzheimer's Association has recently announced a multi-year initiative to improve the quality of care for people with dementia. The foundation of the campaign is a set of evidence-based *Dementia Care Practice Recommendations for Assisted Living Programs:* Recommended practices for care include a comprehensive assessment and care planning as well as understanding behavior and effective communication. "Strategies for implementing person-centered care rely on having effective staff approaches and an environment conducive to carrying out recommended care practices." (Alzheimer's Association, 2005) Research is also being conducted to examine ways to provide environments (in the home and residential settings) that support people with dementia and their caregivers (Calkins & Namazi, 2006).

Best Friends Training: In Maine, nursing homes and residential care facilities have had extensive training, provided through the Maine Alzheimer's Project, in the Best Friends Approach to Caring for People with Alzheimer's and dementia. This is a nationally recognized curriculum which is based on the premise that what a person with dementia needs most of all is a friend, a "Best Friend". This can be a family member, friend, or staff member who empathizes with their situation, remains loving and positive and dedicated to helping the person feel safe, secure and valued. It also uses a Life Story approach that honors the person's past and provides a context for caregivers to learn more about and connect with the person with dementia.

Other emerging trends in the housing and services are based within communities. Some of these trends are discussed below:

Continuing Care Retirement Communities (CCRCs)

These are a form of congregate housing that allow seniors to live in a private lifestyle that is independent from others in the community; however health care and other services are available for those who want them (Kastenberg & Chasin, 2004). CCRCs are geared toward more affluent elderly and are also intended to provide services on a graduated basis as required by residents. To cover the cost, residents are required to pay an initial fee and then a monthly fee for services (Folts & Muir, 2002).

Naturally Occurring Retirement Communities (NORCs) and Supportive Services Programs

Naturally occurring retirement community refers to a "housing development, neighborhood, or geographic area not originally built for seniors that over time becomes home to a large concentration of seniors" (Rorer, 2001). It is different from other areas that have high concentrations of older adults, such as assisted living communities or continuing care retirement communities in that it is "naturally occurring", that is, it was not designed specifically as a community for older people but rather evolved in such a way that a large proportion of its residents are older (Ormond, Black, Tilly, & Thomas, 2004, p. 1). NORCs have also been the site of demonstration projects and other initiatives to provide and coordinate supportive services to people living in those communities.

Community Partnerships for Older Adults

The Robert Wood Johnson Foundation has funded a national program, called Community Partnerships for Older Adults, which fosters community partnerships to improve long term care and supportive services systems. This program supports communities in defining and preparing themselves for how best to care for their older adult population now and in the future. These partnerships are bringing diverse and sometimes competing organizations to the table to work together to find local solutions to improving long term supports and services. At the community level, partnerships are developed to create awareness, strengthen communication and coordination, leverage public and private resources and advocate for the needs of older adults. (Community Partnerships for Older Adults, 2004)

Other Community Based Initiatives

Older residents of Beacon Hill, Massachusetts have created a model concept called Beacon Hill Village. The Village is neither a facility nor a retirement community. Instead people 50 or older who live in the community can pay dues annually in exchange for an array of nursing and personal assistance care services that range from medication management to transportation assistance to medical appointments. The concept of the Beacon Hill Village stresses socialization and belonging to one's community. Residents remain in their own homes and weekly events are organized where people can socialize and enjoy special day trips or events (Basler, 2005).

Housing Assistance Programs

There are a variety of housing programs offered by HUD (U.S. Depart. of Housing and Urban Development) and USDA (U.S. Depart. of Agriculture) that are targeted to or have special features for the elderly. This includes rural housing repairs, multifamily construction and rehabilitation for low income elderly; public housing; rental assistance and housing vouchers. The following is a brief description of some of the housing assistance programs that serve the elderly.

Section 504 Rural Housing Repair and Rehabilitation

This program makes home repair and improvement grants available to rural elderly homeowners that have very low incomes; improvements must remove health and safety hazards or provide disabled access (General Accountability Office, 2005).

Section 202 Supportive Housing for the Elderly

This HUD program provides capital advances to nonprofit organizations to finance construction or rehabilitation of multifamily rental housing for very low income elderly. Elderly families with very low incomes are eligible to rent units financed with capital advances. Sponsors are able to offer rents that are generally equal to 30% of the tenant's adjusted income (General Accountability Office, 2005).

Section 811

Like the 202 housing, HUD's Section 811 funds the development of supportive housing, as well as operating assistance that subsidizes the rents in the project. The program's beneficiaries are disabled adults with low incomes (Community Partnerships for Older Adults, 2004).

Section 236

The program provides mortgage insurance and interest reduction payments to owners of multifamily housing for low and moderate income residents. Programs may be designed for low income elderly.

Section 8 Housing Choice Voucher

This program is HUD's largest assisted housing program. It assists extremely low income families including elderly and disabled, in obtaining safe, decent and sanitary rental housing. Through the program, eligible families are able to rent privately owned units that they would not otherwise be able to afford. Families pay a portion of the rent and the local housing authority pays the remainder directly to property owners (General Accountability Office, 2005).

Implications

Assuring affordable, accessible and available housing and flexible services requires planning and cooperation at all levels—with individuals and their families, communities and the state and federal government. Planning needs to take into consideration the rural nature of the state, the needs of low, middle and upper income individuals, and the importance of choice and flexibility in the design and development of housing and service options. Some of the areas where individuals, communities and policymakers can make a difference are summarized below.

Individuals

Become Informed: Older adults can become informed of housing and service options available in the communities of choice. This includes information related to home modification, weatherization, housing assistance, and home and community based services.

Plan for Changing Needs: Individuals need to discuss and plan for their housing and service needs. The affordability of available options becomes a significant factor in the planning process. Options tend to be more available to people with high incomes and people who qualify for low income financial and housing assistance. Middle income families may have fewer options available when planning.

Communities

Provide Information: Communities are a critical source of local information on housing, services and supports. In some areas, communities have provided referral networks for people who want to home-share; others have provided information on reliable contractors for home improvement; in general community based referral networks are a key source of information on formal and informal services and supports available.

Create Partnerships: Partnerships between public and private service providers, government agencies, advocates and other local organizations provide a way to improve communication, reduce duplication of services and leverage federal, state and local resources.

Policy Makers

Plan and Coordinate Resources: State and federal policymakers play a critical role in planning, financing, and coordinating housing and services for older adults. Coordination of planning efforts by state housing authorities, state aging programs, community aging and referral networks is key. This is particularly important given the regional differences in the projected population and income of older adults in Maine.

Support Home Modifications and Accessibility: States have played a role in promoting accessible design of new construction including regulations governing "visit ability" of homes in general. Some states have provided tax credits for including certain accessible features in new homes or in retrofitting an older home. State funds can also support home modifications, repairs and weatherization programs. Other options include the provision of state subsidies or other incentives to promote the development and design of creating housing programs.
Develop Strategies for Middle Income Older Adults: In the past, Maine has been a leader in funding home and community based services and residential care services through the MaineCare program and with state funds. This will continue to be an important source of affordable services for lower income adults. Strategies may need to be developed for middle

income adults who do not qualify for MaineCare or state funded services but who cannot afford the services offered in the higher end/private market.

Assure Availability of Workers and Promote: With the continued demand for and preference for home and community based services, the availability of direct care workers will be critical to assure ongoing access to services. This will require a continued commitment to training workers and monitoring of the quality of services provided.

Continue Evidence-based Care for People with Dementia: Care and training for people with Alzheimer's has come a long way. Maine has an exemplary program for training caregivers in the Best Friends Approach to caregiving. It will be important to continue to support and develop innovative and evidence-based approaches (both architectural and programmatic) that support caregivers, homes and facilities that care for people with Alzheimer's and dementia.

Promote Innovation: The last decade has seen many innovations in the long term care system. This includes emerging models of nursing home and residential care facilities—both in terms of architectural design and new ways of organizing staff and meeting the flexible and individual needs of residents. States can play a role in promoting and acknowledging innovation in the development of housing options and the design and provision of long term supports and services.

Appendix A
State Profiles[1]
Comparison of Maine and Selected States

Table 1: Demographics

	% of Those Aged 65+ Living in a Rural Area 2000	Rank	Median Household Income Age 65+ 2002	Rank	% of Pop. Aged 65+ at/Below Poverty 2002	Rank	% of Pop. Aged 65+ At 101-200% of Poverty 2002	Rank
Maine	55.8%	2	$25,254	28	10.7%	17	26.3%	12
New Hampshire	39.9%	13	$29,247	11	8.7%	30	20.1%	43
Vermont	58.7%	1	$24,839	31	7.5%	44	24.2%	28
Massachusetts	7.2%	47	$26,268	19	8.6%	32	23.2%	33
North Dakota	52.9%	3	$22,096	46	14.1%	7	26.3%	12
Iowa	41.4%	11	$23,931	38	8.8%	28	25.9%	16
US	21.7%	--	$26,322	--	9.7%	--	23.8%	--

Table 2: Housing

	% Home Ownership Rate Age 65+ 2002	Rank	Home Owners Age 65+ Paying 30% of Income for Housing 2002	Rank
Maine	78.4%	33	24.2	11
New Hampshire	76.6%	39	24.2	11
Vermont	76.9%	38	27.5	6
Massachusetts	68.9%	49	27.4	7
North Dakota	74.1%	46	17.6	41
Iowa	80.5%	27	52.2	40
US	78.6%	--	22.7	--

1. States that are similar to Maine in size, rural character, or region were included for comparison.

Appendix A
State Profiles[1]
Comparison of Maine and Selected States (Continued)

Table 3: Nursing Facility (NF), Residential Care Facility (RCF) and Adult Day Facilities

	NF Beds per 1000 Age 65+ 2003	Rank	RC Beds per 1000 Aged 65+ 2002	Rank	Adult Day Facilities per 1000 Age 65+ (2001-2002)	Rank
Maine	40	36	43	2	0.23	4
New Hampshire	51	22	26	21	0.15	12
Vermont	45	31	28	17	0.25	3
Massachusetts	61	16	11	42	0.15	12
North Dakota	70	9	16	34	0.23	4
Iowa	82	1	10	43	0.16	8
US	49	--	26	--	0.1	--

Table 4: Home Care Spending per Capita

	Home Health Spending per Capita 2003	Rank	Personal Care Spending per Capita 2003	Rank	HCBS Waiver Spending for Aged or Disabled per Capita 2003	Rank	State-Funded HCBS Spending for Older People (Millions) FY 2002	Rank
Maine	$5	26	$25	12	$20	19	$16.30	14
New Hampshire	$4	31	$3	27	$18	23	$0.00	42
Vermont	$8	19	$15	19	$42	4	$5.40	24
Massachusetts	$10	13	$51	4	$2	47	$150	4
North Dakota	$4	31	N/A	N/A	$9	37	N/A	N/A
Iowa	$22	4	N/A	N/A	$13	32	$7.30	22
US	$10	--	$22	--	$15	--	$1,411.90	--

All tables in Appendix A are referenced from:
(Gibson MJ, Gregory Sr, Houser AN, & Fox-Grage W. (2004). Across the States: Profiles of Long-term care 2004: AARP Public Institute.

Appendix B
Profile of Nursing Facilities in Maine[4]

Table 1: Characteristics of Residents in Nursing Facilities (NFs)

	Roster as of 9/15 1998	Roster as of 9/15 2005	Percent Change
Total No. of Residents	7722	6449	-16.5%
No.of MaineCare Residents	5469	4447	-18.7%
MaineCare Residents as a % of All Residents	70.8%	69.0%	-2.6%
No. of Medicare Beneficiaries in Nursing Facilities	800	942	17.8%
Medicare Beneficiaries as a % of All Residents	10.4%	14.60%	40.9%

Table 2: Complexity of Care Needs (Case Mix Index)[5]

Case Mix Index	Roster as of 9/15 1998	Roster as of 9/15 2005	Percent Change
All	1.421	1.514	6.3%
MaineCare	1.395	1.469	5.3%
Medicare	1.676	1.800	7.4%

Table 3: Average Length of Stay (in Days)

Average Length of Stay for:	1998	2005	Percent Change
Medicare Residents	36	39	6.9%
Medicaid Residents	741	496	-33.1%
Other Residents	292	202	-30.8%

[4] Source: MDS Data for Maine nursing facilities

[5] Case Mix index is a value that represents the complexity of the care needs of people in nursing facilities. A case mix index of 1.0 represents the overall average case mix of all residents in the state. A case mix of 1.05 would mean the acuity of residents in that group is 5% higher than the average. Case mix is computed by classifying residents into one or more groups based on their conditions and needs. The case mix groups in nursing homes are Rehabilitation, Extensive Care, Special Care, Clinically complex, Cognitively Impaired, Behavioral, and Physical. Based on a time study and the costs of staff time, a case mix index is computed that represents the relative costs of caring for people with certain conditions and levels of impairment with activities of daily living, Alzheimer's or other behavioral or physical needs.

Appendix B
Profile of Nursing Facilities in Maine (Continued)

Table 4: Case Mix upon Admission (Medicare and Medicaid)

	1998		2005		Percent
Percent of Residents in Case Mix Groups	**N**	**Percent**	**N**	**Percent**	**Change**
Case Mix Group upon Admission (Medicare)					
Rehabilitation	6051	70.8%	6065	73.8%	0.2%
Extensive	221	2.6%	457	5.6%	106.8%
Special Care	471	5.5%	740	9.0%	57.1%
Clinically Complex	1354	15.9%	704	8.6%	-48.0%
Cognitively Impaired	69	0.8%	25	0.3%	-63.8%
Behavioral	3	0.0%	1	0.0%	-66.7%
Physical	375	4.4%	231	2.8%	-38.4%
Case Mix Group upon Admission (MaineCare)					
Rehabilitation	703	28.6%	699	37.9%	-0.6%
Extensive	74	3.0%	69	3.7%	-6.8%
Special Care	211	8.6%	214	11.6%	1.4%
Clinically Complex	725	29.5%	449	24.3%	-38.1%
Cognitively Impaired	185	7.5%	49	2.7%	-73.5%
Behavioral	10	0.4%	0	0.0%	-100.0%
Physical	552	22.4%	365	19.8%	-33.9%

Table 5: Discharges by Destination

	1998		2005		Percent
Residents Discharged to:	**N**	**Percent**	**N**	**Percent**	**Change**
Boarding Home/RCF	1208	9.2%	1224	9.9%	1.3%
Deceased	3954	30.0%	2773	22.4%	-29.9%
Home	6115	46.3%	5335	43.0%	-12.8%
Hospital	1062	8.0%	1768	14.3%	66.5%
Nursing Facility	760	5.8%	513	4.1%	-32.5%

Appendix C
Profile of Residential Care Facilities (RCF) in Maine[1]

Table 1: Characteristics of Residents in Residential Care Facilities

	Roster as of 9/15 1998	Roster as of 9/15 2005	Percent Change
Total No. of Residents	2734	3851	41.0%
No. of MaineCare Residents	1988	3009	51.0%
MaineCare Residents as a Percent of all Residents	73.0%	78.0%	7.0%

Table 2: Complexity of Care Needs (Case Mix Index[1])

	Roster as of 9/15 1998	Roster as of 9/15 2005	Percent Change
Case Mix Index (All)	1.054	1.104	4.7%
Case Mix Index (MaineCare)	0.993	1.098	10.6%
Case Mix Index Alzheimer's SCUs	1.300	1.317	1.0%

Table 3: ADLs and Case Mix Groups upon Admission

	2000		2005		Percent
	N	Percent	N	Percent	Change
Residents in Case Mix Group Upon Admission					
Impaired	49	3.8%	32	2.4	-38.0%
Complex	283	21.9%	306	22.5	2.8%
Behavioral Health	313	24.2%	400	29.4	21.5%
Physical	544	42.0%	622	45.7	8.7%
Average Number of ADLs Upon Admission	3.25	n/a	3.9	n/a	20.0%

1. Date from MDS-RCA Data set for Maine residential care facilities that are level 4 facilities and reimbursed under the case mix payment system.

Appendix C:
Profile of Residential Care Facilities (RCF) in Maine (Continued)

Table 4: Residents in Alzheimer's Special Care Units of RCFs

	Roster as of 9/15 1998	Roster as of 9/15 2005	Percent Change
Residents in Alzheimer's Special Care Units (SCUs)	315	676	115.0%
Percentage of MaineCare Residents in SCUs	9.5%	14.9%	56.0%

Table 5: Average Length of Stay (days)

Average Length of Stay of:	2000	2005	Percent Change
All residents	772	723	-6.0%
MaineCare residents	878	824	-6.0%

Table 6: Discharge Destinations

	2000		2005		Percent
Residents Discharged to:	N	Percent	N	Percent	Change
Home	80	7.0%	121	9.3%	33.4%
RCF	97	8.5%	104	8.0%	-5.6%
Nursing Facility	588	51.5%	645	49.8%	-3.4%
Hospital	99	8.7%	92	7.1%	18.2%
Deceased	241	21.1%	300	23.2%	9.6%
Other	36	3.2%	34	2.6%	-6.0%
Total	1141	100%	1296	100%	13.6%

1. Case Mix index is a value that represents the complexity of the care needs of people in residential care facilities. A case mix index of 1.0 represents the overall average case mix of all residents in the state. A case mix of 1.05 would mean the acuity of residents in that group is 5% higher than the average. Case mix is computed by classifying residents into one or more groups based on their conditions and needs. (Impaired, complex, behavioral or physical needs). Based on a time study and the costs of staff time, a case mix index is computed that represents the relative costs of caring for people with certain conditions and levels of impairment with activities of daily living, Alzheimer's or other behavioral or physical needs).

Appendix D
Summary of Assisted Living in Maine

In Maine there are 2 types of assisted living facilities and 4 levels of residential care facilities.

"Assisted Living Program" means a program of assisted living services provided to consumers in private apartments in buildings that include a common dining area, either directly by the provider or indirectly through contracts with persons, entities or agencies. There are 2 types of assisted living programs:

- Type 1 – provides housing services and medication assistance services either directly or through individuals or agencies

- Type 2 – provides the same services as Type 2 plus nursing services

Assisted living services must offer at least one meal a day, coordination of services, assistance with activities of daily living, or instrumental activities of daily living, housekeeping/chore services, and other services identified in the resident's care plan.

"**Residential Care Facility**" means a house or other place that is maintained wholly or partly for the purpose of providing residents with assisted living services. Residential care facilities provide housing and services to residents in private or semi-private bedrooms in buildings with common living areas and dining areas. There are 4 types of residential care facilities:

- Level 1 – serves 1 or 2 residents

- Level 2 serves 3 to 6 residents

- Level 3 services 3 to 6 residents and employs at least 3 staff who are not owners or related to the owners

- Level 4 serves 7 or more residents

Residential care services are the same as those for assisted living facilities although Level 4 facilities must provide 3 meals a day.

Appendix E:
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Appendix F:
Housing and Service Options – Online Information Resources

Office of Elder Services (OES)
http://www.maine.gov/dhhs/beas

OES Resource Directory: Housing
http://www.maine.gov/dhhs/beas/resource/housing.htm

Home Care: Where to Find It
http://www.maine.gov/dhhs/beas/hcbook.htm

Maine State Housing Authority
http://www.mainehousing.org