



Developing Affordable Non-Medical
Residential Care in Rural Communities:
Barriers and Opportunities



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**Developing Affordable Non-Medical
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Executive Summary

Non-medical residential care (NMRC)¹ represents the fastest growing long-term care service development in the late 1990s (Weiner, Stephenson, and Goldenson 1998). Consumers, their families, private developers and state policymakers are hopeful that NMRC will meet their different needs. Consumers are anxious to find suitable, affordable, and non-institutional accommodations as they begin to find that home maintenance and their personal care require additional external support. Developers are exploring housing and service options to meet consumers' demands, and communities are looking for ways to help their older residents stay close to home. State policymakers view NMRC as a means of reducing the expensive costs for nursing home care.

There is significant potential for NMRC development in rural communities, where reliance on nursing homes has been substantial. However, due to lower population density and lower incomes of older rural adults, NMRC development requires particular attention to the demand for residential alternatives that are both attractive to private paying consumers and affordable to lower-income consumers. This is a payer mix that is not typical for proprietary NMRC developers in urban areas.

This paper explores the challenges and opportunities for affordable NMRC development in rural areas. The aim of this project has been to understand perceptions of barriers and opportunities for rural NMRC development among state and regional governmental units that might be expected to provide technical assistance and support, and current developers of NMRCs. Project staff conducted interviews with state staff and NMRC developers in 14 states that were classified as an "early adopter," "in-process" or "demonstration" state.

The findings of this study indicate that the development of affordable NMRC is not only possible but is growing in rural communities. There are many examples of NMRC in remote and very small communities (Leitenberg 1999). For example, rural communities in Vermont and other New England states have developed NMRC variants using a cooperative ownership model that blends restoration of large old structures and tenant cost sharing for management, housekeeping, and meal preparation services (Bolda et al. 2000). The authors have visited assisted living facilities in remote Oregon communities with as few as 700 people. However, rural development is highly variable across states due to unclear or conflicting public policies, the lack of supportive public policies, and/or the lack of needed technical assistance, and differing perceptions among rural older adult populations. This paper summarizes the key elements identified by developers and policy makers that are important for affordable NMRC development in rural areas to succeed. In addition, there are key lessons learned from our interviews with state policy leaders regarding the definition of NMRC policy and the need for technical assistance.

¹ We use the generic name *non-medical residential care (NMRC)* to describe residential housing with service options for long term care consumers, excluding nursing homes and skilled nursing facilities. These types of care settings are governed by state laws and include a host of arrangements referred to by over 40 state-defined labels including: assisted living facilities, residential care facilities, adult foster care homes, family care homes, etc.

Need for Clear, Consistent Policies and Regulations

Clarity on state policy expectations, regulations, and public payment mechanisms is essential for fostering the development of NMRC. Such clarity is important to developers, lenders, and potential tenants and their families. In the absence of clear state policy expectations and incentives, rural developers have difficulty attracting investors. Consistency in the definition of program and physical plant requirements across state agencies, and between federal and state programs, is particularly important. Within one of the states included in this analysis, assisted living units may be licensed adult homes or unlicensed homes, with very little distinction between them. Other states such as Oregon have clear definitions regarding what constitutes an NMRC, what services might be expected, and what conditions might lead to a resident's discharge. In addition, conflicts between federal and state policies should be reconciled. For example, federal restrictions on the use of USDA money for "community space" (group dining rooms and common spaces) in multi-unit housing for older adults could be changed to make them more compatible with state-defined standards for non-medical residential care.

As with any policy development, all interested parties should monitor the mandated requirements on the level of care that NMRCs are expected to provide. These regulations must balance service costs and quality standards relative to other long term care settings such as nursing homes. Some consumers and advocates for the elderly maintain that residents should be allowed to age in place; this has implications for the level of services needed toward the end of life. Where is the line between non-medical residential care and nursing home care? Nearly two decades ago this issue was raised (Vladeck 1980) and it remains a continuing source of concern (GAO 1997). If there is little distinction between NMRCs and nursing homes, there will be increased pressure for more extensive state regulation of NMRCs similar to that governing nursing homes.

Technical Assistance

While many rural communities lack housing development expertise, this can be overcome with coordinated technical assistance. Rural communities interested in developing affordable, non-medical residential care should be able to seek advice from those who have successfully completed projects. State policy makers can aid such efforts by assuring that technical assistance is available to interested developers. Sources of technical assistance might include State Offices of Rural Health, State Units on Aging, State Housing Finance Agencies, and regional US Department of Agriculture (USDA) Rural Development Offices.

State Offices of Rural Health (SORH) represent a valuable though relatively untapped source of technical assistance. They often can define the potential market and community health needs. SORH staff generally understand state and local politics and may have information about pre-development resources and ways to organize community resources for supporting NMRC. SORH staff can identify underutilized hospital/nursing facilities or other public space within specific communities, defining both the potential locations and available structures amenable to retrofitting. Additionally, these offices can encourage rural health care providers to explore collaborative approaches to assuring consumer access to health services. The Rural Hospital Flexibility Program process also offers an opportunity for SORHs to urge rural communities to focus on the need for NMRC. In addition, SORH staff may help existing rural providers consider becoming developers of affordable NMRC.

To foster a more active involvement on the part of SORHs, regional meetings could be sponsored by the federal Office of Rural Health Policy to familiarize staff with the issues and opportunities for affordable NMRC development in rural communities. Such gatherings, including State Units on Aging and state Housing Finance Agencies, could also provide the impetus for development of technical assistance materials and networking opportunities for SORHs.

By creating inter-governmental understanding of housing and services, State Units on Aging (SUA) may also provide a valuable source of support for the development of affordable NMRC in rural communities. Educating one another and cross-pollinating the housing and services worlds can result in removal of unnecessary policy and regulatory barriers that make affordable development so difficult. As the state entity charged with advocating for older adults, an SUA can convene stakeholders and promote clear, uniform policies regulating publicly supported NMRC, housing/capital assistance, and services.

Working with regional Area Agencies on Aging (AAA), SUAs are in a unique position to understand the support systems needed by frail and disabled older adults living in rural NMRCs. SUAs may be ideally positioned to promote creative service packages through co-location and/or cooperation among home and community-based service providers (e.g., nutrition programs, adult day programs, and transportation assistance) that are supported through the AAA network.

State Housing Finance Agencies (HFA) are also well placed for assisting in the development of affordable NMRC in rural communities. In addition to helping secure pre-development resources, HFAs have the expertise to educate other state organizations and potential developers/applicants about the array of potential financing options designed to enable development of affordable NMRC. While access to capital varies, identification of HFA staff resources targeted to affordable rural development may be critical to success in some states.

Financial support through Medicaid waivers will continue to serve a central role in affordable NMRC. Oregon has developed assisted living services through innovative Medicaid waivers. Nebraska has recently completed its first year of low-interest loans and grants to nursing facilities for remodeling facilities, thereby converting excess nursing facility capacity into assisted living units. Under the conditions of these conversion grants, a portion of the units must be available to Medicaid beneficiaries. With a state appropriation of \$40 million, the Nebraska Health Care Trust Fund/Nursing Facility Conversion Cash Fund allows facilities to use grant funds for construction, start-up costs, training expenses, and first-year operating losses. The Trust projects that the \$35 million of grants awarded through December 1999 will be recovered in roughly 13 years. Under the Robert Wood Foundation's *Coming Home* initiative to foster rural development of affordable assisted living in rural areas, the Foundation is restricting grant support to those states that have Medicaid or Medicaid waivers for purchasing assisted living facility services.

Conclusions

With increasing interest and innovation in meeting the challenges of affordable rural NMRC development, and with the advent of financial and technical support for such development, the growth of affordable NMRC in rural communities is becoming a reality. In those states where

there is no clear policy leadership on NMRCs, there is an increased burden on staff within various agencies and on advocates for older adults to make rural NMRC projects happen. In the interim, rural communities with the will to develop NMRCs can try to find others with valuable experience to share and, in turn, can serve as models for other rural areas within their states. As local initiatives move forward, it is critical that state agencies provide support for new ideas emerging from rural communities. Creating support for coherent and consistent guidelines and requirements for affordable NMRC will continue to be a state responsibility. Federal agencies need to be flexible and recognize the vast differences among rural communities and the availability of financial and human resources in rural settings to support affordable rural NMRC development.

INTRODUCTION

Non-medical residential care (NMRC)² represents the fastest growing long-term care service development in the late 1990s (Weiner, Stephenson, and Goldenson 1998). Various interested parties--consumers, their families, private developers and state policymakers--are hopeful that NMRC will meet their different needs. Older adults are anxious to find suitable, affordable, and non-institutional accommodations as they begin to find home maintenance, household tasks, and personal care requirements increasingly difficult. Developers are exploring housing and service options to meet consumers' demands. Families and communities are looking for alternatives that will keep older residents close to home and in home-like environments. On the other hand, state policymakers view NMRC as a means of reducing state spending for long term care services, services that since the passage of Medicare and Medicaid have been provided primarily by nursing homes. NMRC can save state Medicaid money. Rural communities, where the reliance on nursing homes has been substantial, have perhaps the greatest potential for NMRC development. However, due to lower population density and lower income levels of rural elderly, NMRC development in rural communities must appeal to the private paying consumer and be affordable to lower-income consumers. This payer mix is not typical for urban-based proprietary NMRC developers, who can focus on the private pay market.

This paper explores the challenges and opportunities for affordable NMRC development in rural areas. We know that such development can be done because there are examples of NMRC in remote and very small communities. For instance, adult foster care is being developed by a local aging services agency in Arizona that is recruiting and assisting former child foster care families. In Vermont, several rural communities have developed NMRC variants using a shared housing model that blends restoration of large old structures (financed through state historic preservation funds), with tenant cost sharing for management, housekeeping, and meal preparation services. In these shared living arrangements, personal care services are provided through existing in-home care services within the community (Bolda et al 2000). During the mid-

² We use the generic name *non-medical residential care (NMRC)* to describe residential housing with service options for long term care consumers, excluding nursing homes and skilled nursing facilities. These types of care settings are governed by state laws and include a host of arrangements referred to by over 40 state-defined labels including: assisted living facilities, residential care facilities, adult foster care homes, family care homes, etc.

1990s in Oregon, small remote rural communities (populations less than 700 people and 75 miles from the nearest hospital) developed very successful assisted living facility model through innovative local and state efforts.

The success of affordable rural NMRC development depends on federal and state policy, local leadership, and the financial and service capacity of rural communities. Of these variables, state policy seems to be the most important. States that have focused on re-designing their long-term care services, *e.g.*, Oregon, have emphasized NMRC development. As a result, these same states are also much more likely to have developed rural models.

The first section of this paper provides a brief review of the history and literature of NMRC. The second section describes the methods and data used for this study. The third section synthesizes the perceptions of interviewees from the 14 states studied along with data from other sources. The final section presents policy recommendations for expanding affordable NMRC development in rural areas.

BACKGROUND

History of NMRC and Related Housing & Service Options

The history of housing with service options and the complications of its policy and regulatory structure shed light on the nature of the barriers to current efforts of development. In the 1930s, local governments divested themselves of "poor farms" and "county homes" in response to Social Security requirements that prohibited benefit payments to residents of publicly owned institutions. The net result of this privatization effort along with an increase in the demand for services due to increasing life expectancies was the creation of privately operated homes and life care communities. The introduction in the 1960s of federal funding for care and certification and licensure requirements for nursing homes established by Medicare and Medicaid resulted in the existing stock of out-of-home care options being redefined as one of two different types of providers: either nursing homes or NMRC. Following the introduction of federal support, the prevailing residential care options for consumers became Medicare and/or Medicaid funded nursing homes and NMRC facilities paid for through private resources (often referred to at that time as board and care homes, homes for the aged and infirm, *or* domiciliary care). Some states

provided assistance to help pay for care in NMRC facilities for low-income consumers, and in the 1970s most of these state programs were converted to income supplement programs as a state option under the federal Supplemental Security Income program.

Private pay "continuing care retirement communities" became the development wave of the late 1970s and 1980s (Winklevoss 1982). Competing for affluent consumers, these "campus" communities offer a continuum of housing and service options that support older adults: free standing bungalows surrounding golf courses and common gardens, apartments with shared dining and housekeeping services, and licensed nursing homes are among the more frequent offerings. The financial structure of these continuing care retirement communities, often guided by state banking and insurance oversight, includes entrance fees equivalent to home purchase, with monthly fees varying by housing arrangement and level of service support provided. In most rural areas, where older consumers are low to moderate income, continuing care retirement communities are virtual non-options.

For less affluent consumers in more densely populated areas, alternatives crafted by private developers in the mid-1980s began to incorporate rental unit options with an "a la carte" approach to housekeeping, meals, transportation, and other services. Often these rental housing and service options were located near, or developed by, organizations with licensed nursing homes. While these rental housing and service options required the commitment of fewer assets than were required by continuing care retirement communities, such options were often still beyond the financial reach of many older adults with limited incomes. Since fully private-pay facilities required a relatively large market area to include a sufficient number of middle and upper income consumers, few private efforts have targeted rural communities for such development.

Rental housing and limited service developments have encountered operational and licensing problems. As residents of these enhanced apartment settings began to require more services to meet their needs, managers were faced with the difficult choice of either asking them to move or expanding service offerings (Golant 1995). On the one hand, residents were reluctant to leave and managers faced the problems associated with "kicking out" people with extensive care needs. On the other hand, service expansion created an environment similar to traditional nursing home care that necessitated compliance with state licensing requirements. These

licensing requirements had been designed to meet the protective oversight expectations for a very different housing and service arrangement: shared sleeping quarters and bathroom facilities, round the clock staffing, and a single bundle of services provided to all residents. Further, traditional board and care licensing requirements frequently defined structural and care requirements designed for the safety of residents with severe physical and/or cognitive impairments (e.g., corridor width for evacuation safety, room size, no locks on doors, no ovens). These requirements both increased the cost of delivering the services and hampered a manager's capacity to respond to consumers' preferences for less oversight and fewer restrictions. In some cases, housing and service providers have been asked to remove cooking facilities from residents' apartments and to hire staff to comply with required traditional board and care licensure. As recently as 1991, rental housing with care services has been viewed as non-compliant or illegal under some states' rules (Bolda 1995).

Another variant of affordable rental housing with services appeared in the mid-1980's. There was a growing number of the "oldest-old" residing in subsidized apartment complexes for low- and moderate-income. Federal, state, and local housing policy makers and managers began concerted efforts to provide enhanced services in subsidized housing through coordination with, and expansion of, home and community-based services. Often referred to as congregate housing and service programs, there have been various demonstration projects developed under the auspices of the U.S. Department of Housing and Urban Development, State Units on Aging, and foundations. In the 1990s, managers of subsidized and affordable housing for older adults continued to offer service coordination assistance and to seek other means for improving care access for frail and disabled tenants. For example, they encouraged local service providers to co-locate services at housing complexes and they made agreements with area providers for discounted fees for services. A variety of housing with service models, largely developed through local efforts, continue to emerge.

Redefinition of Non-Medical Residential Care

Since the early 1990s and the introduction of assisted living (AL) in Oregon, NMRC has become both more responsive to consumer demand and more complex in its definition and nomenclature (Kane, Wilson and Clemmer 1993). The model that will be referred to here as "pure assisted living" is based on Oregon's policies. In that state, assisted living is defined as

housing that provides a self-contained private apartment (with private bath and cooking facilities), and services tailored to meet the needs and preferences of individual consumers. The philosophy of care is premised on respect for consumers' judgment and preferences. Informed risk-taking is viewed as a consumer right. The assisted living philosophy operating in Oregon relies less on traditional medical care and places a greater emphasis on the affordability of care and the ability of residents to make decisions about their lives. For example, Oregon's assisted living regulatory and financing programs, developed in part through a Medicaid waiver, allow payments directly to assisted living providers and allow case managers to contract for additional services. There is trust in internal and external case management and a reliance on market forces for quality (Kane 1995).

The environment created by Oregon's assisted living philosophy and regulatory structure is in contrast to that created in many other states with a more traditional approach to NMRC. Traditionally NMRC, and particularly NMRC designed for low-income consumers, has been less consumer-oriented. Most traditional board and care policies are based on group living arrangements that stress structural and process requirements. These have grown out of the early out-of-home care models and the need to convert publicly owned county homes for the aged and infirm to private care facilities subject to state licensure.

Newer NMRC policies base quality assurance more on outcomes of care and less on a building's structure and services. For example, in Oregon, staffing patterns are not defined using traditional staff-to-resident ratios; rather, facilities are required to have adequate staff to meet residents' needs. Flexible staffing patterns can accommodate the philosophy of aging in place. In addition, Oregon's nurse practice laws permit non-nursing staff to perform tasks previously restricted as nursing functions. Oregon also substantially departs from traditional regulatory standards by requiring that assisted living housing units have single occupancy self-contained apartments with lockable private access.

Not surprisingly, the combination of affordable housing and affordable services and the philosophical shift embodied in Oregon's assisted living approach have encouraged NMRC development offering consumers more flexible service options. For many developers elsewhere, state and local requirements for facility structure (*e.g.* single units, kitchen facilities) have been

perceived as barriers in rural areas due to the lower income levels of rural older adults and the fear that a rural NMRC cannot achieve the economies of scale needed for affordability. However, in Oregon there is an example of small (650 population) and remote (no physician and 75 miles from the nearest hospital) community that developed local non-profit assisted living facilities with 29 units of which 23 are assisted living. Communities have used creative financing to build or rehabilitate facilities, and Medicaid provides support for services provided to eligible residents.

The Impact of Policy and Market Factors on Rural NMRC Development

There is great variation in interstate regulation of assisted living facilities (Kane, Wilson and Clemmer 1993). In addition to state policy dynamics, demographic and economic characteristics of rural communities can have a significant impact on the development of affordable rural NMRC options. Factors contributing to the viability of local rural NMRC markets include the supply (proportionate to the population) of both nursing facility and NMRC current occupancy rates across settings; existing rental housing stock; home values and equity held by older adults; and older adult per capita income. These factors, when coupled with estimates of need for NMRC based on national estimates of the prevalence of functional dependence in the population calculated for each gender-specific age cohort (Pifer 1991), influence both potential developer interest and potential lending partners' evaluation of rural proposals.

Private developers are unlikely to be attracted to rural communities lacking the requisite population concentration of older adults who need NMRC and who have private resources to purchase NMRC services. In these areas, NMRC developments may need to be smaller and designed to be affordable for more mixed and lower income groups. Leaders in many rural communities may have little knowledge of or experience with affordable housing, the complexities of negotiating public-private partnerships, or the development of creative capital strategies essential to the development and operation of affordable NMRC services. Where local expertise does exist, there remain other challenges to offering affordable rural NMRC. Lack of local health and social services, distances to medical services, and availability of labor to serve residents, may be perceived as formidable barriers. However, as demonstrated by examples in Oregon and elsewhere, these barriers can be overcome with adequate support.

In states with well-defined policies regulating NMRC and state financial support for services to low-income residents, these potential barriers to affordable rural NMRC may be less daunting. In the absence of such policies, however, there is a sense that active development of affordable rural NMRC is not likely to occur, even in states that have policies designed to discourage the use of nursing home facilities.

These perceptions can be better understood through observation of state policy toward affordable NMRC care development and its implementation in rural communities. The following sections provide an analysis of existing data on NMRC supply as well as summaries of interviews to answer four basic questions:

1. How have factors such as state policy context, demographics, and existing nursing home bed supply influenced the development of affordable rural NMRC?
2. What is the supply of NMRC in rural areas, compared with urban areas?
3. What barriers and opportunities exist in the development of rural NMRC and how have states, developers and others overcome or taken advantage of these barriers and opportunities?
4. What lessons are there in the experiences of those who have developed affordable rural facilities?

METHODS

The primary sources of information for this study were interviews with more than 100 state policymakers and private developers/managers of NMRC in 14 states with substantial rural populations. A purposive sample of states was selected based on their characteristics at the time of sample selection (1996). States selected for study:

1. Were reported to be actively studying NMRC and considering policy changes, or
2. Had recently promulgated new or revised policies for NMRC, and
3. Represented different regions of the country, and
4. Historically had varying levels of reliance on NMRC as providers of long term care services to low and moderate income older adults, and
5. Had a substantial rural population.

The states selected included Alaska, Arizona, Colorado, Florida, Kansas, Maine, Minnesota, New York, North Carolina, Oregon, Pennsylvania, Texas, Vermont, and Washington.

Interviews were conducted with policymakers and program managers at State Units on Aging, Medicaid agencies, and State Housing Finance entities to obtain information about NMRC development and the impact of state policy on rural development of NMRCs. Staff members from State Offices of Rural Health and state/regional USDA Rural Development offices were surveyed for information on rural development policies. Telephone interviews with private developers and managers of rural affordable NMRC facilities and other knowledgeable individuals identified by state policymakers and state housing and aging services program managers were conducted to obtain information about barriers and opportunities for rural NMRC development.

Findings from these interviews and available descriptive literature are discussed below. Readers interested in a specific state's policy issues are encouraged to contact state policymakers and developers. Readers interested in a comparison of various states' policies will find State Assisted Living Policy, 1998 (Mollica 1998) a valuable resource.

Data on non-medical residential care (NMRC) supply came from multiple sources, including a sample frame created by the Research Triangle Institute in North Carolina to identify assisted living residences for a national study funded by the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services. To this sample frame, we added detailed data necessary for calculating urban-rural NMRC bed to population ratios, using primary data collected from the individual states' regulatory agencies. Following multiple contacts with the various units of state government within these states, we succeeded in acquiring reliable urban-rural NMRC bed distribution data for only five of the sample states. County population data with metropolitan and non-metropolitan service area descriptors from the Area Resource File (Bureau of Health Professionals, 1990) were used to construct urban-rural comparisons of NMRC bed supply. Finally, other state-specific descriptive data on NMRC and nursing facility bed to population ratios, and population data for 1992-1996 were abstracted from Across the States: Profiles of State Long Term Care for 1994 and 1998 (AARP 1994; AARP 1998).

FINDINGS

Sample State Characteristics and Policy Context

To understand how the challenges of developing NMRC facilities differ in rural and urban communities, it is essential to consider the context of state policies that have shaped the development of NMRC. First, historical incentives for the development and use of NMRC shape each state's approach. For example, the availability, definition, and payment levels for public assistance to low-income NMRC residents (through SSI state supplement programs, state general funds, and/or Medicaid funds) has a significant impact on the affordability of NRMC and the potential for rural development targeting a mixed- and lower-income and geographically dispersed market.

Geographic and age distribution of the population are also important considerations. Growth of the older population, and its shifting age structure (the proportion of older residents who are in the oldest age groups), influence the potential demand for long term care services and NMRC in particular, regardless of location. In considering state comparisons, readers are reminded that the number of adults age 65 and older is used as the denominator for bed-to-population ratios, and that this can obscure cross-state comparisons of nursing facility and NMRC supply changes over time since states have varying rates of population growth. A state with a more rapid growth in the number of people age 65 and older may have an equal number of new units being constructed. However, when compared to a state with slower population growth and equivalent numbers of new units, the bed/unit to population ratio will look higher in the state with more rapid population growth.

The following section presents comparison of urban and rural NMRC bed-to-population ratios in five states and provides a framework for discussing the study sample's experience with NMRC policy.

Comparison of NMRC Supply in Metropolitan and Non-metropolitan Areas

Relatively little is known about the supply or distribution of NMRC in rural communities. Previous research (Harrington *et al.* 1992) implies that there is an inverse relationship between

the supply of NMRC and nursing facilities. Bed-to-population ratios for nursing facilities are reportedly higher in rural areas compared with urban areas (Coburn and Bolda 1999). This suggests that NMRC unit/bed to population ratios would be lower in rural areas than in urban areas.

Urban-rural NMRC bed-to-population ratios (1997 data) are available for four of the states in this sample, and one non-study state (Wisconsin). County level analyses of NMRC data for these states indicate that non-metropolitan counties are somewhat less likely to have a NMRC facility than are metropolitan counties. However, as seen in Table 1, in all but one of the five states analyzed (Wisconsin), the distribution of NMRC beds is not significantly different for metropolitan areas compared to non-metropolitan areas of a state. In Oregon, the state that has actively been encouraging NMRC development for the longest time, one estimate suggests that as many as 53% of Oregon's assisted living facilities are in rural communities (Kane 1998).

Table 1: Urban-Rural Comparisons of NMRC Bed/Unit to Population Ratios in Metropolitan and Non-metropolitan Counties

| STATE | NMRC beds/units per 1000 Population Aged 65+ | |
|----------------|--|--------------------------------------|
| | Average in Metropolitan Counties | Average in Non-metropolitan Counties |
| North Carolina | 32.3 | 29.1 |
| Pennsylvania | 24.0 | 20.3 |
| Florida | 28.2 | 22.6 |
| Wisconsin | 6.2 | 2.3 |
| Kansas | 4.9 | 2.5 |

P<0.01

Framework for State Discussion

For ease of interpretation, sample states are discussed in three broadly defined groups. The first group is referred to as "early adopter" states. These states developed and began implementing NMRC policy changes through statutory, regulatory and/or reimbursement changes prior to 1996. The second group, referred to as "in process," adopted statutory, regulatory, and/or reimbursement policy changes and was in the midst of implementing new policies during the study period (1996 - 1998). The last group, referred to as "demonstration" states, was exploring NMRC

policy changes through demonstration projects and/or study groups, or had made statutory changes and was in the process of revising or devising the regulatory and/or reimbursement policies necessary for implementation of policy changes during the study period (1996-1998). This classification of states was developed from information on the status of policy changes provided by key informant interviews.

Table 2: State Policy Context Comparison Groupings Based on Policy Context, 1996

| <u>"Early Adopter"</u> | <u>"In-Process"</u> | <u>"Demonstration"</u> |
|-------------------------------|----------------------------|-------------------------------|
| Oregon | Maine | New York |
| Washington | Vermont | Florida |
| North Carolina | Minnesota | Alaska |
| | Texas | Arizona |
| | Kansas | Pennsylvania |
| | Colorado | |

This classification scheme also provided clarification of the disparity in state interviewees' responses to questions about the feasibility of affordable NMRC development in rural areas. Specifically, interviewees were asked about the level of activity within their respective organizations that was designed to encourage or support affordable NMRC development in rural areas. In particular, they were asked about the number of rural affordable NMRC development projects that had contacted them, the number with which they were familiar, and the number with which they had worked. Interviewees' responses to questions about their awareness of state NMRC definitions, policies, regulations, financing options and contacts within other involved governmental units also clustered within these classifications.

These groups are summary categories and are used simply to compare and contrast respondents' perceptions of the potential for affordable NMRC development in rural areas in the sample states. They are not intended to judge individual state policy activity. As is apparent from the description of the sample states' NMRC policy context (below), each state is proceeding with very different political, economic, and long-term care policies. These realities, fundamental to state policy changes, must be recognized as readers consider changes in their own states' policies.

State Perceptions of NMRC and Potential for Affordable Rural Development

State policymakers' and program managers' responses to our interviews varied with the level of state experience with new or recently revised NMRC policies. State respondents' perceptions ranged from enthusiasm and a sense of opportunity in the "early adopter" states to pessimism and a focus on perceived barriers in states with less experience, the "demonstration" states.

Early Adopters: In the states defined as "early adopters," representatives from the various organizations (State Units on Aging, Medicaid programs, State Housing Finance Agencies, State Offices of Rural Health and USDA Rural Development offices) had a common vocabulary to describe NMRC. Respondents were consistent in their reporting of current state policy toward NMRC, were aware of other state units involved with NMRC policy and could identify contact persons within these other units. Respondents in these states generally understood the functions and relationships with other state units and were able to articulate recent or needed policy changes being debated. In short, they had a common vocabulary and understanding of the issues.

More importantly, key state respondents in these "early adopter" states could identify rural development efforts within their states and viewed development of affordable NMRC in rural areas as viable. Policymakers and program managers in these states were optimistic and enthusiastic about rural NMRC development. State interviewees saw rural communities as having an advantage in the development and successful operation of affordable NMRC because residents know the NMRC staff and vice versa, thereby keeping the atmosphere homelike and appealing to potential residents. In these states there was a sense that affordable NMRC is a valuable long term care option for rural communities.

In the "early adopter" states, the experience of developers indicated that affordable assisted living services model could be provided in self-contained apartment complexes as small as 20-25 units with a private-public consumer payer mix. For example, developers could point to renovations of old schools or underutilized nursing facilities as opportunities for conversion of units to rural NMRC.

In-Process States: Responses from the "in-process" states varied considerably. Some interviewees were aware of current policies, changes needed in those policies, and other units in their states involved with related policies. The state housing finance and rural health offices were generally aware of current policy discussions, though some were not especially familiar with details of proposed policy changes or with other specific units involved (often they could not identify contact persons in other units). Perceptions of challenges and opportunities for rural, affordable NMRC development were mixed, with respondents generally offering few examples of recent/current rural development activity. The overall perception of the potential for rural, affordable NMRC was also mixed, with some interviewees expressing skepticism and others being guardedly optimistic. For example, in Maine's current policy environment, Medicaid nursing home eligibility has been restricted. Therefore, NMRC development represents a growing demand compared with the demand for nursing homes. As noted by one nursing facility administrator in rural Maine, conversion of part of a nursing facility could be more profitable than maintaining excess nursing facility capacity.

Demonstration States: In states where policy development has been limited to demonstration efforts, interviewees were unfamiliar with or used varying terms to describe NMRC options within their states. In addition, they were unfamiliar with (or unable to articulate) their state's policy toward NMRC development. Respondents had little familiarity with the roles of other state units relative to NMRC and were least likely to be able to identify a contact person within state units they thought might be involved. Knowledge of rural NMRC development was particularly challenging since interviewees often referred the study team to developers of nursing facilities or providers of subsidized housing without services.

Most significantly, key informants in these states were generally pessimistic about the potential for development of NMRC in rural communities. Paraphrased expressions of this skepticism included:

- Every little town wants one and it just isn't economical-there are not enough people to achieve economies of scale without a regional market approach;
- Rural residents do not want to move away from their gardens - they're not used to rental living;
- Rural communities lack development expertise/sophistication necessary for putting together a package to finance development;

- Rural communities lack medical facilities and community resources to support frail/disabled residents in rural NMRC settings.

Opportunities for and Challenges to Affordable Rural Development

The rural health literature generally discusses rural development of NMRC as an extension of nursing facility service offerings (Rowles, Beaulieu and Myers 1996). In our survey, however, state respondents rarely identified a single type of provider or developer as being dominant. Although nursing facilities and hospitals were discussed as potential developers, our respondent developers/managers of rural affordable NMRC agreed that developer type varied considerably. Local religious groups, senior housing programs, and non-profit nursing facilities developed some NMRC sites, and in other cases national developers with experience in several states were responsible. Nevertheless, both state respondents and developers/managers shared many of the same perceptions regarding the opportunities and challenges for affordable rural NMRC. They focused on the need for public education, the importance of thorough project preparation, and the lack of skilled labor and important services in rural areas.

Public Education: Several respondents noted that NMRC is not well understood in many rural areas. Often, both potential consumers and host communities confuse NMRC with nursing facility services. Existing long-term care providers, many of whom have strong ties with the community, view NMRC developments as a competitive threat. This is particularly true when "outside" (non-local) firms are involved in the rural NMRC projects.

Several developers of affordable rural NMRC explained the advantage of having potential consumers and community representatives involved as early as possible in the development and design process. This provides increased assurance that the community has clear and realistic expectations of the NMRC project. Interviewees viewed such involvement as critical in helping all parties understand the options and the difficult choices between desired amenities and affordability. Rural developers also noted that rural renters are accustomed to lower monthly rents than urban renters. However, the costs of development and construction for rural projects are the same or sometimes higher than those in urban areas. Therefore, early public education on the costs of NMRC is essential in helping to diffuse misperceptions about rental and service costs.

Project Preparation: Housing lenders and developers alike stressed the critical importance of thorough market research and project planning. They caution that developers must be sure to understand the full fiscal, construction, and regulatory implications of the project. Understanding the state's regulatory requirements is critical. For example, one developer cited a plan to convert an old rural hospital facility to NMRC. However, that project was thwarted because the state's regulations governing NMRC were in flux at the time; lenders were, therefore, reluctant to invest in an NMRC in the absence of clear state policies.

Some developers cited the failure to adequately prepare preliminary facility and service package designs and to accurately estimate needed resources as other reasons for financial problems among some affordable rural NMRC facilities. Two steps that were repeatedly noted as essential were 1.) making the significant investment in time and resources for information collection and 2.) developing a thorough plan for both housing construction/renovation and service operations. The information and estimates assure that the planned development is the appropriate size and encompasses the necessary services to maintain both affordability and marketability.

In states with more recent NMRC policy changes, developers and state housing finance agency respondents described lenders' inexperience with financing NMRC as an initial barrier that can change rapidly if state policies are clearly articulated. More savvy lenders now understand the importance of financial projections for both capital construction and service operating revenues and expenses. A common response to the challenge of assuring that operating costs remain affordable in rural NMRC was the ability to anticipate payer mix (including both private-pay and publicly supported tenants) with income-adjusted fee scales established for both rental and service fees. In mixed-income NMRC, revenue generated from privately paying residents contributes to expenses generated by lower income residents. This payment structure is not typical in a private market NMRC.

Interviewees noted that the time frame (pre-development planning, securing capital, construction and occupancy) was important. For first time developers, a period of three to five years was NOT an unusual time frame. Experienced developers suggested that the development

period is best measured in years, not months. Reports of fiscal solvency problems and unanticipated increases in operating costs were frequently attributed to occupancy delays and longer than anticipated periods from opening to full occupancy. To assure full occupancy at the earliest date, marketing in advance of opening was recommended. Indeed, achieving full occupancy in a rural NMRC can easily exceed six months, driving initial operating costs higher than estimated. Experienced developers say that a prospective tenant roster is necessary. Such a roster should have more names than available units since many who express interest may delay moving into the facility. This becomes more crucial for a rural NMRC than for an urban development because of the more limited consumer base and the need to assure affordability in generally lower income markets.

Another problem in rural development of affordable NMRC related to delays in securing financing. Interviewees agreed that obtaining financing for affordable developments takes much longer than one generally anticipates. Weakness on either side of the development planning process (housing or services) was viewed as a likely reason for lender reluctance. However, with a clear and solid description of the full package, private lenders in more experienced states were quite willing to partner in the financing of new construction of an affordable rural NMRC.

Keeping development costs down is important for several reasons. First, pre-development and capital costs must ultimately be rolled into rents. All such costs threaten affordability. A relatively common approach to keeping pre-development and design costs low among non-profit developers is to get local professionals (attorneys, bankers, architects, realtors, accountants, etc) to provide pro bono or reduced fee services. Although there are examples of creative partnerships between state agencies, private foundations and/or resourceful non-profit corporations establishing pre-development revolving loan or grant funds for NMRCs, few states provide public support for pre-development costs.

Mechanisms for reducing capital costs also help maintain affordability. Rural developers and managers shared strategies that had been successful for them. Some examples from rural areas included:

- Securing donated land for construction;

- Retrofitting existing structures (public schools, community buildings, sections of hospitals or nursing facilities);
- Securing mortgage guarantees (HUD) and low-interest capital through rural development funds (USDA) or State Housing Finance Agencies;
- Taking advantage of housing finance agencies' priority lending criteria for housing designed to serve older and disabled persons and/or priority lending criteria for investments in rural communities (available in several states).

Recently, the Robert Wood Johnson Foundation announced funding for additional states under their *Coming Home* initiative, which is targeted to the development of rural affordable assisted living facilities. In addition to grant support, grantee states will receive technical assistance through the NCB Development Corporation. Other examples of support include the revolving loan fund originally developed by the Kate B. Reynolds Healthcare Trust, in partnership with the North Carolina Housing Finance Agency and Division of Aging, and the Rural Community Assistance Corporation work in several western and southwestern states.

Several developers and some state informants expressed frustration with the incompatibility between building requirements defined by NMRC regulations and sources of low-cost loans or grants. Developers reported conflicts between regulatory requirements for common space and unit structure defined in state licensure regulations and design prohibitions defined by sources of low cost capital like the USDA rural development funds. Such conflicts tended to relate to the requirements/prohibitions on common space for tenants as well as fire safety construction issues.

Finally, most experienced developers and state-level housing related interviewees were very clear about the opportunities for putting together a viable financing package designed to keep rents affordable in rural communities. They cited a vast array of public and private possibilities, including low-income housing tax credit incentives, low-interest loans, and federally insured mortgage guarantees.

Rural Labor and Service Issues: Rural NMRC managers cited problems with the recruitment and retention of employees, particularly direct care staff, as a common source of frustration. No ready solutions were offered beyond recommendations for good management practices. It is

unclear whether such labor shortages are more challenging in rural communities than in urban areas, especially during periods of low unemployment.

Transportation costs and arrangements appeared to be more challenging in rural communities with limited or no public transport (including cab services). A rural NMRC in one state routinely used the county ambulance for client transportation, a solution not viewed as tenable by county officials responsible for ambulance expenses. Litigation as a result of this situation was avoided when the state established public payment for low-income NMRC residents' medical transportation.

The absence of medical services in rural communities was of concern to several respondents in "demonstration" states. However, "early adopter" respondents did not view distance to health care services as a significant barrier. In these states developers argued that older adults living in the surrounding community faced similar barriers; hence availability of medical care ought not to dictate suitability for NMRC development.

CONCLUSIONS AND POLICY IMPLICATIONS

The development of affordable NMRC is not only possible but is occurring and increasing in rural communities. In those states that have developed policy supports for the process, rural development may rival urban development. Rural development is highly variable across the states, however, due to unclear or conflicting state and federal policies, the lack of appropriate technical assistance to address limitations in state and local technical know-how, and uncoordinated state and local leadership. The following section summarizes the key policy and other lessons learned through this study.

Need for Clear, Consistent Policies

Clarity in state policy expectations, regulations, and public payment mechanisms is essential for fostering the development of NMRC. Such clarity is important to developers, lenders, and potential tenants. In the absence of clear state policy expectations and incentives, rural developers face added challenges to attracting investors. These potential delays may result in lost opportunities or higher costs. In one of the states classified as a "Demonstration State,"

assisted living facilities may be licensed or not, with very little if any difference in the facilities. It is important at the state level to have a consistent definition of NMRCs, a clear understanding of what services are to be provided, and a clear understanding of what conditions can lead to the discharge of a resident.

Consistency in the definition of program and physical plant requirements is particularly important. Low and moderate income consumers, state policy makers, and rural developers share a common interest in assuring that existing federal resources, particularly programs that provide access to low cost capital, are redefined in a manner that can support affordable development. For example, rural housing and health related development funding from USDA should eliminate restrictions on the use of federal resources for "community space" (group dining rooms and common spaces) in multi-unit housing for older adults. These restrictions may prevent the use of such funds for NMRC in some states.

State and regional representatives of federal agencies, such as the USDA's Rural Development offices, should have a more visible presence within states. These offices, along with other federal and state agencies (Housing Finance Agencies, State Units on Aging and State Offices of Rural Health at a minimum), must develop a common state-appropriate language regarding NMRC and identify available sources of technical assistance for rural communities. Such resources should include staff with expertise in the development and financing issues central to affordable rural development of housing and service options. At a minimum, these entities need to maintain a roster of trustworthy and knowledgeable developers who are willing to meet with local planning groups interested in developing an NMRC.

As with any policy development, all interested parties are well advised to carefully consider the expectations for care and the balancing of care costs and quality standards. In the absence of such vigilance, non-medical residential care may simply become nursing homes by another name. This warning was issued nearly two decades ago (Vladeck 1980) and is a continuing source of concern. This was reiterated in a 1997 General Accounting Office response to Senator Ron Wyden (GAO 1997). To paraphrase the sentiments of a non-profit NMRC group in Northern New England, the consumers know what they mean and want when they use the words "assisted living." It is the rest of us that have such a hard time agreeing on what we mean. Blurring the

distinction between NMRCs and nursing homes will also increase the pressure for increased regulation of NMRCs so that it parallels those for nursing homes.

Technical Assistance

While many rural communities lack housing development expertise, such deficits can be overcome with technical assistance. Rural communities with an interest in the development of affordable, non-medical residential care should seek the advice from those who have successfully completed such projects. State policy makers can aid in such efforts by assuring that technical assistance is available. NMRC developers with experience in rural areas urge those who are interested to visit existing rural NMRC and learn from the challenges they have encountered. Other sources of technical assistance, though varying dramatically by state, include: State Offices of Rural Health, State Units on Aging, and State Housing Finance Agencies.

State Offices of Rural Health as Potential Sources of Technical Assistance

State Offices of Rural Health (SORH) represent a valuable, though largely untapped source of technical assistance. They often can define community health needs relative to NMRC services and help rural communities define the potential NMRC market. SORH staff are likely to have insight into local politics. They may have information about pre-development resources and ways to organize community resources and support for NMRC. For example, SORH staff can identify an underutilized hospital/nursing facility or other public space that is a potential structure amenable for retrofitting as affordable NMRC.

SORHs are likely to have analyses of the medical care supply and access issues in various rural areas within a state. This becomes a valuable resource for rural communities that are struggling with packaging services for an NMRC. Furthermore, given their potential involvement in local health matters, SORH staff can help encourage rural health care providers to expand their horizons and explore collaborative approaches that will assure consumer access to health services.

The Rural Hospital Flexibility Program process defined by the Balanced Budget Act of 1997 offers the opportunity for SORHs and others to develop an NMRC in conjunction with other

changes in hospital services. Rural hospitals may not fully appreciate NMRC development as a mechanism to shore up fragile rural health systems by generating positive cash flow. Rural hospitals in one of the states studied reported receiving 70 percent of their revenues from nursing facility services.

One method to foster more active SORH involvement is for the federal Office of Rural Health Policy and the regional associations of State Offices of Rural Health to sponsor regional meetings to familiarize staff with the issues and opportunities for affordable NMRC development. Such gatherings could also include State Units on Aging and State Housing Finance Agencies. This could be the impetus for the preparation of technical assistance materials and networking opportunities.

State Units on Aging as Potential Sources of Technical Assistance

State Units on Aging (SUA) may also provide a valuable source of support for the development of affordable NMRC in rural communities by fostering inter-agency understandings of housing and services. Educating one another and cross-pollinating the housing and human service worlds can result in removal of unnecessary policy barriers and regulations that make affordable development so difficult. As the entities charged with advocating for older adults, SUAs can convene state stakeholders and become an advocate for policies to support NMRC development.

Due to their work with the community Area Agencies on Aging (Triple As) to define the needs and to provide services to older adults, SUAs have a clear understanding of the support systems needed by frail and disabled older adults living in NMRCs in rural areas. SUAs may be ideally positioned to promote creative service package financing through co-location and/or cooperation among home and community-based service providers supported through the aging network (e.g., nutrition programs, adult day programs and transportation assistance).

SUAs that invest resources in NMRC expertise can facilitate the development of NMRC prototypes to meet the unique and diverse needs of older adults. Such efforts, in concert with State Housing Finance Agency staff, have already provided the necessary leadership for establishing public-private partnerships to support development of affordable NMRC. For

example, an Area Agency on Aging in Arizona has developed NMRC expertise and is actively engaged in efforts to recruit, train, and provide technical assistance to encourage development of adult family or adult foster care in rural communities.

State Housing Finance Agency as a Potential Source of Technical Assistance

State Housing Finance Agencies (HFA) are well placed for working with SUAs and others interested in the development of affordable NMRC in rural communities. In addition to helping secure pre-development resources, HFAs have the expertise to educate other state organizations and potential developers/applicants about the array of potential financing options. While access to capital varies, identification of HFA staff resources targeted to affordable rural development may be critical to success in some states. Currently, most state HFAs have yet to become engaged in identifying financing packages for affordable NMRC. HFAs may benefit from developing closer ties with SUAs to gain a better understanding of the unique service needs of rural NMRC residents.

Other State Policy Initiatives

Medicaid programs in the study sample states generally viewed themselves as purchasers of services with little direct involvement in the development of affordable rural NMRC. However, Oregon developed assisted living services through innovative use of Medicaid waivers. During the period between data collection and final reporting for this research, Nebraska (a non-study state) implemented an innovative state-supported program that targets rural communities for the development of affordable assisted living. The program offers low-interest loans and grants for nursing facilities to remodel their facilities and convert excess capacity into assisted living units. Under the conditions of these conversion grants, a portion of all converted assisted living units must be available to Medicaid beneficiaries. With a state appropriation of \$40 million, the Nebraska Health Care Trust Fund/Nursing Facility Conversion Cash Fund allows facilities to use grant funds for construction, start-up costs, training expenses, and first-year operating losses. The program is designed as a mechanism to save Medicaid funds. Medicaid savings will recover the state grant funds awarded (\$35 million through December 1999) in 13 years. The savings will come from a difference of \$21 per day in the Medicaid rate for nursing facility care and assisted living care. Generally in such Medicaid programs, residents pay for the housing, housekeeping

and meal services from their own incomes. Potential savings as a result of private pay consumers being able to afford assisted living without applying to Medicaid have not been estimated in the Nebraska program.

While such policy changes may not be likely in many states, Medicaid Waivers have and will continue to serve a central role in enabling states to develop affordable NMRC. The Robert Wood Johnson Foundation's *Coming Home* initiative, designed to foster rural development of affordable assisted living in rural areas, restricts its grant support to states that have established policies permitting reimbursement by Medicaid or Medicaid home and community-based waiver for services in assisted living facilities.

Conclusions

With increasing attention and innovation in meeting the challenges of affordable rural NMRC development, and the advent of financial and technical support for such development, the growth of affordable NMRC in rural communities is a reality. In those states that have no clear state leadership on this issue, the burden is on state agencies, legislators, and advocates for older adults to identify such leadership. In the interim, rural communities with the will to develop an NMRC need to identify others with experience in rural communities. These communities and their mentors can serve as models for other rural areas in their states. As local initiatives move forward, it is critical that state agencies support new ideas emerging from rural communities. Nonetheless, the implementation of coherent and consistent guidelines and requirements for affordable NMRC will continue to be a state responsibility. In addition, federal entities such as USDA Rural Development programs should have greater flexibility to recognize the differences between rural and urban communities as well as among rural communities for NMRC development. At the same time, state programs responsible for financing long term care services must help identify operating funds and fiscal incentives for affordable rural care non-medical residential care options.

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