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How Continuing Care Retirement Communities Manage Services for the Elderly

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The Honorable Thomas J. Bliley, Jr.
Chairman, Committee on Commerce
House of Representatives

The Honorable James C. Greenwood
House of Representatives

The Congress has shown interest in various models of managed care as a way to both control the rapidly rising cost of health care services for the elderly and ensure quality care.[1] Managed care is intended to channel and coordinate individuals' use of health services to achieve appropriate utilization of those services and improve health outcomes. Risk-based managed care, such as that offered by health maintenance organizations (HMO) to over 50 million people, is also expected to control costs through arrangements in which the organization is responsible for providing or arranging health care for beneficiaries in exchange for payment of a fixed fee. Such arrangements are intended to create strong incentives for managed care organizations to manage care effectively and to help beneficiaries maintain health and functioning. The focus of managed care, however, has been primarily on serving working-age adults and children.

In contrast, continuing care retirement communities (CCRC) focus almost exclusively on managing various forms of care for the elderly to help them remain healthy and functioning. CCRCs offer retirement living in combination with a range of health and other services that vary by CCRC. The services a CCRC may provide—often in a campus-like setting—include housing; long-term care, such as skilled nursing facility care and assisted living; various medical services, including physician services and physical therapy; and services such as meals, housekeeping, and recreational activities. Most CCRCs are private, nonprofit agencies, and many have religious affiliations. Currently about 350,000 residents live in approximately 1,200 CCRCs. About one-third of CCRCs provide long-term care for their residents under lifetime contracts in which the CCRC assumes the residents' risk for the cost of long-term care services.[2] These CCRCs have incentives to encourage residents to use medical care to maintain or improve their health and functioning and to manage residents' use of both

[1]See, for example, the Medicare Preservation Act of 1995, H.R. 2425, which was included as title XV of the Balanced Budget Reconciliation Act of 1995, H.R. 2491.

[2]Typically these contracts are intended to last for the lifetime of the resident, although some can be canceled at the option of the resident. In some cases the contract may be for a shorter period and renewable at the option of the resident.

acute medical and long-term care services even though these CCRCs are generally only at risk for the cost of long-term care.

You asked us to review the processes of managed care in CCRCs and how these relate to health care costs. In response to your request, we examined (1) CCRC practices for promoting wellness, (2) practices for managing care for elderly people with chronic conditions, and (3) evidence regarding the possible effect of these practices on health status and costs.

To conduct our work, we reviewed literature on CCRCs and the clinical and cost effects of various health practices; interviewed CCRC experts, physicians in geriatrics, and officials from the Health Care Financing Administration's (HCFA) Office of Managed Care; and visited 11 CCRCs to examine their practices. We chose these CCRCs because they assume most residents' financial risk for the cost of long-term care, are accredited by the Continuing Care Accreditation Commission, and represent some geographic variation. During visits and follow-up contacts with these CCRCs, we interviewed executive officers, administrative officials, and medical staff. We also collected documentation from the CCRCs on health promotion, medical screening, and chronic disease management practices. For a complete description of our scope and methodology, see appendix I.

Results in Brief

To serve their elderly residents, CCRCs we examined manage care to meet the needs of both healthy individuals and those who have chronic conditions. They use active strategies to promote health, prevent disease, and detect health problems early by encouraging exercise, proper nutrition, social contacts, immunizations, and periodic medical exams and assessments for all residents. Many of these CCRCs also have multidisciplinary teams of nurses, social workers, rehabilitation specialists, physicians, dieticians, or others to plan and manage residents' care. These teams meet periodically to discuss residents' health and functional status; determine whether services are needed; and decide on the types of treatment, services, and supports that will be provided. CCRC staff coordinate a wide range of health and other services—whether provided on or off site—to enhance their benefit to the individual resident. Active monitoring of the health and functioning of residents who have chronic conditions—such as arthritis, hypertension, and heart disease—is an integral part of this coordinated, multidisciplinary approach to managing care.

Many of these CCRCs' practices are considered to be effective in improving the health and functioning of the elderly, although their effect on health care costs is largely undemonstrated. Regular medical exams and health assessments, immunizations, and counseling to encourage exercise, proper nutrition, and social interaction are all recommended by experts and the literature as effective health promotion and disease prevention strategies for the elderly. In addition, geriatric experts recommend a coordinated and multidisciplinary approach to manage chronic conditions among the elderly because their care may involve many modes of treatment and disciplines. While the health benefit of these practices has been demonstrated, little evidence exists to demonstrate health cost savings from either the CCRC package of services or most of the practices individually.

Background

CCRCs represent one form of managed care for the elderly. Many CCRCs have managed both acute medical and long-term care services for the elderly for decades. CCRCs plan, administer, and often provide these services, in combination with housing and other services, frequently in a campus-like setting.[3] The number of residents in a CCRC varies, but averages about 300, most of whom are elderly people leading active lifestyles and living in independent housing units. Some residents receive personal care, such as assistance in bathing and dressing, either in their own residential units or in special assisted living units, and some receive skilled nursing facility care. Residents may also receive physician, laboratory, and other care on site. Expenses for these and other medical services are reimbursable by Medicare on the same basis as for the elderly who do not live in CCRCs.

CCRCs assess prospective residents' health and financial status to ensure a fit with services offered and required fees. Residents commonly pay an entry fee to join the community and a monthly fee thereafter. These fees vary considerably depending on factors such as the level of CCRC financial risk for long-term care services, the size of the residential unit chosen, whether fees are for single individuals or couples, and the kinds of additional services and amenities provided. (See app. II for a description of the different financial risks CCRCs assume.) In the 11 CCRCs we visited—all of which assume residents' risk for long-term care costs—entry fees ranged from a low of $34,000 for a studio apartment for one individual to a high of $439,600 for a two-bedroom home for a couple.

[3]See The Consumers' Directory of Continuing Care Retirement Communities (Washington, D.C.: American Association of Homes and Services for the Aging, 1994) for a discussion of the philosophy of CCRCs and profiles of more than 500 individual communities.

Monthly fees in the 11 communities ranged from $1,383 for an individual to $4,267 for a couple.

CCRCs Use a Variety of Practices to Promote Wellness

The CCRCs we visited use a variety of practices for health promotion, disease prevention, and early detection of health problems to help residents maintain their health and functioning. These practices are part of an approach to care that encourages CCRC residents to adopt or maintain a lifestyle that is believed to promote good health. Providing activities and services, usually on site, encourages residents to take advantage of them.

CCRCs Encourage Exercise, Proper Nutrition, and Social Involvement

Many of the CCRCs we visited promote good health for their residents by encouraging exercise, proper nutrition, and social involvement. Encouraging regular exercise is a common practice that CCRCs we visited use to maintain or improve residents' health and functioning. CCRC efforts include having swimming pools and fitness equipment on site, providing staff for exercise programs, and sponsoring lectures and information on the value of exercise. Exercise classes and activities include aerobics, flexibility and strength exercises, swimming, yoga, lawn bowling, and square dancing. Residents may participate through a formal program or on an informal basis. Several CCRCs also strongly encourage walking. The campus-like designs of some CCRCs encourage walking by locating residential buildings within walking distance of commonly used services. Some campuses also incorporate nature trails or other attractive walks.

Another common health promotion practice at CCRCs we visited is the encouragement of proper nutrition. Residents at many of these CCRCs are offered three meals a day in common dining rooms, which encourages adequate consumption of healthy foods. Some CCRCs require residents to have at least one of their meals each day in these settings. For other meals, residents may cook at home or eat elsewhere. The foods offered and nutrition information provided encourage residents to eat appropriately for weight and other health considerations. Special diets may be provided. At most of the CCRCs we visited dieticians are often available for consultation and can help residents develop individual diet plans. CCRC officials told us that on-site dietary counseling and nutritionally balanced meals in congregate, attractively decorated dining areas help encourage adequate nutrition and healthy eating habits.

Encouraging residents to interact socially is also a common practice among the CCRCs we visited. CCRC officials told us that they encourage

interaction because social isolation is associated with poorer health and functioning among the elderly. They also said that the physical layout of CCRCs fosters social interaction and is an integral part of the CCRC model. Residents live next door to each other and may see each other frequently through visits or while eating in congregate settings, checking mail, and engaging in a wide range of CCRC activities. Recreational, educational, cultural, and volunteer activities are frequently initiated, planned, and organized by residents. Officials said that arranging and participating in these kinds of activities are an important part of residents' social interaction in the community. Activities may include on-campus lectures, movies, musical performances, woodworking, flower arranging, photography, and civic and charitable activities.

Disease Prevention and Early Detection Activities Include Immunizations and Periodic Medical Exams and Assessments

Many of the CCRCs we visited attempt to maintain their residents' health and functioning through disease prevention and early detection of health problems. These activities are carried out by nurses, social workers and physicians who may be either affiliated with or independent of the CCRC.

Most CCRCs we visited encourage immunizations against common preventable diseases, such as flu and pneumonia, to reduce illness and possible fatalities. They may encourage immunization in a number of ways, including inoculation clinics, seminars, distribution of printed materials, and reminders from medical staff when a resident makes an outpatient visit or has a medical examination.

Most of the CCRCs we visited encourage early detection of health problems through periodic medical exams and other health assessments. CCRC officials told us that these exams and assessments help staff and residents to be more proactive in using effective medical treatments and changing lifestyles to slow or reverse the loss of good health and function.

A combination of physicians, nurse practitioners, and social workers may conduct elements of these exams and assessments, which may include periodic inventories of prescription drugs used by a resident to assess potential unwanted side effects from drug interactions, examination of an individual's ease in walking or getting out of a chair, and observation of changes in an individual's mental state. CCRC medical exams may include testing blood pressure for hypertension and blood glucose levels for diabetes. They may also include tests for colon, breast, and prostate cancer as well as vision and hearing impairments. Residents' medical

records and staff are usually on site, making the periodic exams and assessments convenient for residents.

The CCRCs we visited typically encourage periodic medical exams through seminars, written materials, and reminders such as notices sent to residents on their birthdays asking them to schedule an exam. Some CCRCs follow up by telephone or other means when residents do not schedule or appear for medical exams. If a resident does not come for an exam after follow-up, some CCRC officials told us that this information is tracked and an exam conducted when the resident next comes in for outpatient care because of illness.

CCRCs Use a Multidisciplinary, Coordinated Approach to Manage Chronic Conditions

CCRCs we visited use a multidisciplinary, coordinated approach to manage care for their residents with chronic conditions such as hypertension and heart disease. Essential elements of this approach include a wide range of on-site services, coordination of services to ensure residents receive them in an appropriate and timely manner, and active monitoring of residents with chronic conditions. The prevalence of chronic conditions increases substantially with age, and CCRC officials told us that properly managing these conditions helps maintain residents' functioning while delaying or reducing use of costly services such as hospital care.

CCRCs Offer a Wide Range of Health and Other Services on Site

CCRCs we visited offer a wide range of services on site to manage care for residents with chronic conditions. These services may include primary health care, care by specialists, skilled nursing care, and laboratory testing. Other services may include physical therapy, social work, personal care, dietary counseling, home chore service, and transportation. Various combinations of services may be provided across a range of settings, including an outpatient clinic, a skilled nursing facility, or a resident's own home.

In addition, some of the CCRCs we visited adapt their health promotion and wellness programs to help meet the needs of residents with chronic conditions. For example, they may modify a regular exercise program to help people with arthritis retain the ability to walk. Similarly, these CCRCs may encourage and help those with chronic conditions to continue regular social interaction through special arrangements. For example, a resident who can no longer walk to recreational events and congregate eating areas may be provided with an electric cart so that he or she can remain independent.

CCRC officials told us that having a wide range of services on site makes it possible to manage most of the care of residents with chronic conditions within the community even when the needs are intense. CCRC officials said that residents less frequently need care at hospital emergency rooms or as many days of hospital care when admitted because they have access to physicians, nursing care, and other services at the CCRC. The availability of a skilled nursing facility where residents can easily be admitted from the hospital or from home for short stays may also help return residents more quickly to their homes, according to these officials.

Coordination and Active Monitoring Used to Meet Residents' Needs

CCRCs we visited typically coordinate services to enhance their benefit for residents. CCRC staff coordinate various services provided by both CCRC staff and other providers whether on site or off. For example, a CCRC may coordinate an arthritic resident's pain relief medication, specialized exercise program, home modifications, the availability of walkers or other ambulatory aides, and periodic assistance with dressing or bathing to help the resident stay as functional as possible and to reduce or delay the use of more intensive services. Multidisciplinary teams may facilitate coordination through joint team assessments and the development of a plan of care. Teams meet regularly to reassess needs and services. CCRC officials told us that nursing staff generally serve as the focal point for convening teams and providing ongoing coordination of services between team meetings. Some CCRC officials said that nursing and social work staff usually have day-to-day responsibility for coordinating services and troubleshooting when problems arise.

CCRC officials told us that they actively monitor residents with chronic conditions. Staff oversees the plan of care developed for each resident with chronic conditions to ensure that the resident is receiving needed services. Monitoring can include simply verifying that a resident has visited the clinic as prescribed or kept a scheduled appointment with the physical therapist. Or professional care staff may review medical records, visit or call the resident at home, or call other service providers to verify that care was received. Frequent monitoring is necessary in some cases because a resident's physical and mental condition can change quickly and require different services. For example, CCRC staff may check more frequently if episodes of pain may impair an arthritic resident's ability to walk or dress unassisted.

CCRC officials told us that nonmedical staff and the residents themselves can also be important in the monitoring process. Some CCRCs we visited

train food services staff, residential and grounds crews, and other staff to recognize potentially serious problems that residents may have and to report this information to clinical or social work staff. For example, a housekeeper may inform clinical staff that an individual with some memory loss has burned pots on the stove or that a resident with arthritis is unable to get out of bed on a particular day. In addition, some CCRCs encourage residents to notify them when they see or suspect that another resident may need assistance. In some CCRCs, buddy systems are developed in which two residents agree to contact or watch out for each other regularly. When problems are reported, clinical staff call or visit residents to investigate and respond as needed.

CCRC Practices May Provide Health Benefits but Effect on Costs Is Largely Undemonstrated

Many of the practices we identified in CCRCs for health promotion, disease prevention, and early detection of health problems are credited by experts and the literature with reducing the risk of disease and disability and improving health and functioning among the elderly.[4] Among the measures considered to be effective are regular physical exams that include screening for early detection of conditions such as hypertension, colon cancer, breast cancer, and vision and hearing loss, and immunization against flu and pneumonia. Education and counseling to encourage exercise and proper nutrition are also recommended. Regular aerobic or conditioning exercise reduces the risk of coronary heart disease, diabetes, and obesity, and exercises to improve strength, flexibility, and balance may reduce the risk of falls and fractures. Encouraging social interaction may also reduce isolation, which is associated with poorer health and functioning among the elderly.

The coordinated, multidisciplinary approach to chronic disease management used by the CCRCs we visited is also consistent with the recommendations of geriatric care experts and is supported in the literature as effective in slowing the progression of disease and restoring loss of function. Multiple interventions are often used in managing many chronic conditions that are common among the elderly, such as hypertension, cardiovascular disease, and arthritis. These methods may include drug therapy, physical and occupational therapy, behavior modification, counseling, and use of special medical equipment. Experts told us that because care for older people with chronic conditions may involve many modes of treatment and disciplines, it needs to be organized,

[4]See R.L. Berg and J.S. Cassells (eds.), The Second Fifty Years: Promoting Health and Preventing Disability (Washington, D.C.: Institute of Medicine, Division of Health Promotion and Disease Prevention, 1990). See also U.S. Preventive Services Task Force, Guide to Clinical Preventive Services, 2nd ed. (Baltimore, Md.: Williams and Wilkins, 1996).

coordinated, and managed. Crucial to effective care management, they said, is providing periodic monitoring and follow-up both to ensure that the chronic condition is being controlled and to minimize any negative effects of treatment.

While evidence exists for the effectiveness of many of the practices we found in these CCRCs, their effect on health care costs and use of health services has not been conclusively demonstrated. With the exception of flu immunizations and medical screening for certain forms of cancer, such as breast and colon cancer, little evidence exists to demonstrate clearly the cost-effectiveness of most of the individual health promotion and chronic disease management practices used by the CCRCs.[5] Furthermore, CCRC residents tend to be very different from the general elderly population on a number of important sociodemographic, health, and other measures. No studies have been conducted that adequately consider these factors in assessing the effect of the CCRC package of services on health costs.[6]

Agency Comments

Because no federal agency or program was the focus of our review, we did not seek agency comments. We did, however, have a number of experts in geriatric medicine and continuing care retirement communities review a draft of this report. They generally agreed with its contents and provided technical comments that we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services; the Administrator, Health Care Financing Administration; and other interested parties. Copies of this report will also be made available to other interested parties on request.

[5]The Second Fifty Years and Guide to Clinical Preventive Services.

[6]People choosing a CCRC tend to be better educated and wealthier than the general elderly population and are healthier when moving into the CCRC than others their age. The full effect of these differences has not been accounted for in studies comparing CCRC residents' use of health services with that of elderly residents living in non-CCRC settings.

If you or your staff have any questions, please call me at (202) 512-7119 or Bruce D. Layton, Assistant Director, at (202) 512-6837. Other major contributors to this report are James C. Musselwhite, Eric R. Anderson, Ron Viereck, and Carla Brown.

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Abbreviations

CCRC	continuing care retirement community
HCFA	Health Care Financing Administration
HMO	health maintenance organization

Scope and Methodology

We focused our work on practices that 11 continuing care retirement communities (CCRCs) use to maintain or improve the health and functioning of their elderly residents and to manage the use of health and other services by residents with chronic conditions. We also examined what is known about the possible health and cost effects of these practices. To address our study objectives, we (1) visited 11 CCRCs to examine care management practices, (2) reviewed the literature on CCRCs and on health and cost effects of CCRCs' practices, and (3) interviewed experts on CCRCs and geriatric medicine as well as officials from HCFA's Office of Managed Care.

The 11 CCRCs we visited in California, Maryland, Pennsylvania, and Virginia (see table I.1) were selected primarily for three reasons. First, they assume most residents' financial risk for the cost of long-term care (see app. II for a description of CCRC financial risk arrangements for long-term care costs).[7] These financial arrangements provide incentives to manage health and other services so that residents remain healthy and functioning as independently as possible and so that costs are controlled. Second, these CCRCs are accredited by the Continuing Care Accreditation Commission.[8] Third, they represent some range of geographic variation. Our findings from this sample of CCRCs, however, cannot be generalized to all CCRCs, to CCRCs that are at financial risk for most residents' long-term care costs, or to those that are accredited.

[7]In a 1995 survey of CCRCs by the American Association of Homes and Services for the Aging, 35 percent of the 456 respondents reported that they offer contracts placing them at full risk for a resident's long-term care not otherwise reimbursed by third parties such as Medicare.

[8]See Accreditation Handbook (Washington, D.C.: Continuing Care Accreditation Commission, 1994) for a description of the accreditation process.

Table I.1: CCRCs Visited by GAO

Name of community	Location
California	
Casa Dorinda	Montecito
Mt. San Antonio Gardens	Pomona
The Sequoias-San Francisco	San Francisco
The Tamalpais	Greenbrae
Maryland	
Broadmead	Cockeysville
Collington	Mitchellville
Fairhaven	Sykesville
Pennsylvania	
Foulkeways at Gwynedd	Gwynedd
Kendal at Longwood	Kennett Square
Pennswood Village	Newtown
Virginia	
Goodwin House	Alexandria

We conducted structured interviews to obtain information from CCRC executive officers, administrative officials, and medical staff regarding the practices used for health promotion, disease prevention, medical screening, and management of chronic conditions. In addition, we collected documentation on services provided and residents' contracts, and we directly observed some CCRC activities, programs, campus buildings, and grounds used by residents. We conducted telephone follow-ups to obtain additional information from CCRC officials as needed.

To examine the potential health and cost effects of CCRC practices, we reviewed the literature and interviewed selected experts in geriatric medicine regarding generally accepted practices or guidelines for health promotion, disease prevention, medical screening, and management of chronic conditions. We also interviewed officials from HCFA's Office of Managed Care.

We conducted our review between June and November 1996 in accordance with generally accepted government auditing standards.

CCRC Risk Arrangements for Long-Term Care Costs

CCRCs assume different levels of financial risk for the costs of their residents' long-term care services, such as nursing home care and assisted living services. These long-term care services are provided in combination with housing, residential services such as cleaning and meals, and related services. CCRCs' financial risks for residents' care are defined in lifetime contracts between the CCRC and the individual resident.[9] A CCRC may offer more than one type of long-term care risk arrangement from which residents may choose.

Full Risk

Some CCRCs are at full financial risk for the cost of long-term care services. This means that the CCRC must pay all the costs of long-term care services residents need except for those costs that may be reimbursed by third parties such as Medicare. These CCRCs typically require that residents pay an entrance fee and a monthly fee that includes prepayment for long-term care costs, similar to an insurance arrangement. The monthly fee can increase based on changes in operating costs and inflation adjustments but not because of the use of long-term care services. As a result, residents having these agreements are not at risk for covered long-term care costs. This kind of agreement is sometimes known as a life care agreement or an extensive or Type A contract.

Partial Risk

Some CCRCs are at partial financial risk for the cost of long-term care services. These CCRCs must pay some, but not all, of the costs of long-term care services for residents beyond those reimbursed by third parties such as Medicare. The financial risk of these CCRCs is limited by a cap on the amount of long-term care services for which the CCRC will pay. For example, for each resident, a CCRC may pay for a maximum of 30 or 60 days of nursing home care per year, whatever limit is specified in the resident's contract. Under these arrangements, CCRCs typically require that residents pay an entry and monthly fee, which may be lower than the fees for arrangements under which CCRCs assume full financial risk for the costs of long-term care. Until the cap on long-term care services is reached, residents' monthly fees under the partial risk agreement can increase based on changes in operating costs and inflation adjustments but not as a result of the use of long-term care services. If the contract cap is reached, however, the resident is at risk for the cost of all additional long-term care services not reimbursed by third parties. This kind of

[9]Typically these contracts are intended to last for the lifetime of the resident, although some can be canceled at the option of the resident. In some cases the contract may be for a shorter period and renewable at the option of the resident.

agreement is sometimes known as a modified, limited services, or Type B contract.

No Risk

Some CCRCs are not at risk for the cost of long-term care services. These CCRCs require residents to pay for services they use either through a combination of an entry fee and a monthly fee or through a monthly fee alone. Monthly fees in either payment arrangement can increase based on operating costs, inflation adjustments, and the use of long-term care services. As a result, residents are at risk for all long-term care service costs not reimbursed by third parties such as Medicare. When this kind of risk arrangement is based on a combination of an entrance fee and a monthly fee it is sometimes known as a Type C contract. When it is based only on a monthly fee it is sometimes known as a Type D contract. Under either Type C or D contracts, residents typically pay lower fees than under Type A or B contracts unless long-term care services are needed.

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