U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

CONTINUING CARE RETIREMENT COMMUNITIES:

A BACKGROUND AND SUMMARY OF CURRENT ISSUES

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This report was prepared by a student intern of HHS's DALTCP. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The Project Officer was Robert Clark.

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Jacquelyn Sanders

U.S. Department of Health and Human Services

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ABSTRACT

Continuing Care Retirement Communities (CCRCs) are presently becoming a more viable option for seekers of long-term care for the elderly. CCRCs have been recognized for their unique strategy of combining various levels of health care within one community setting, as well as their potential for providing cost-effective care. As the industry undergoes tremendous growth and as many CCRCs gradually lose their reputation for being 'financially unstable', more elderly individuals are finding this longterm care option more attractive. However, because the costs of a community are most often too high, the majority of the elderly population are not able to afford them. This problem has drawn the attention of many both in and outside the industry who hope to discover how the benefits of a CCRC can be accessible to more of the elderly population. Most present research on CCRCs deals with defining a CCRC or describing its structure. This paper analyzes CCRCs in a somewhat broader sense by focusing not only on the internal workings of CCRCs, but by also looking at issues currently surrounding the industry, such as affordability, managed care and regulation.

I. INTRODUCTION

Continuing Care Retirement Communities (CCRCs) provide both housing and health care for the elderly, in addition to emphasizing social involvement and community life. A CCRC is intended to supply a *continuum of care* throughout the life-time of its elderly residents. It does so by maintaining an assortment of on-site medical and social services and facilities. This allows residents to enter into the community while still relatively healthy and then move on to more intensive care as it becomes necessary.

A. Why the Need to Study CCRC's?

CCRCs represent a steadily growing and gradually more stable option for seekers of long-term care for the elderly. The industry, which originated in the early 19th century, mainly through the initiative of religious groups and fraternal organizations, has recently been gaining a more respectable reputation after a series of financial setbacks during the late 1970's and early 1980's. The number of CCRCs across the country has now reached approximately 1200, with about 350,000 residents (Scanlon and Layton, 1997:1). This number is up from 800 CCRCs only 7 years ago (Netting and Wilson, 1991:267). This growth stirs up numerous questions concerning its possible causes. Do CCRCs present better quality care than other forms of long-term care? Do the elderly prefer the type of age-segregated community life that CCRCs offer? These are questions that can best be answered through an established understanding of the basic structure and philosophy of CCRCs.

It is well-documented that America's older population is rapidly expanding. "Between 1990 and 2130 the elderly population is expected to double to 65 million people" (DHHS, 1992). As the baby-boomer generation gets closer to the age of retirement and as advances in health care increase the average person's life-span, concern over how to provide affordable, quality long-term care to the elderly with disabilities and chronic care needs will grow. CCRCs offer an option that appeals to many older individuals. Because this area of long-term care will most likely be playing a major role in the future, it is important to learn more about it.

The possibility that CCRCs represent a more cost-effective form of long-term care is the most vital reason that this option deserves attention. Being a form of managed care, a CCRC has an incentive to provide complete care for its residents at the lowest cost possible. Whether this incentive is actually effective in reducing costs, while maintaining quality, should be examined more closely.

B. Importance of Related Issues

Despite the overall positive outlook for CCRCs, some problems have arisen which cast doubt on the assertion that the industry is now completely stable. Issues such as affordability, managed care, and regulation have been identified factors affecting CCRC growth and improvement. Therefore, it is of interest to gain not only an understanding of the internal structure of CCRCs, but also to learn more about the matters surrounding them--matters that may effect their long-term success.

By looking at CCRCs in this light, this paper provides an overview of the role CCRCs play in the long-term care system and suggest areas where further research may be needed.

C. Methodology

Research and information collection for this paper took three main forms. A review of the literature on CCRCs, with a stronger emphasis placed on more current studies and reports, provided the main framework for the paper. Interviews with a few knowledgeable participants in the industry, and an on-site visit to a Washington DC area CCRC provided added insight into developing an understanding of CCRCs and their current status in the health care world.

II. WHAT IS A CCRC?

As defined by the American Association of Homes and Services for the Aging (AAHSA), a CCRC is "an organization that offers a full range of housing, residential services, and health care in order to serve its older residents as their needs change over time". It is a community that attempts to give the elderly a sense of independence throughout the later years of their lives.

There are both for-profit and not-for-profit CCRCs. Although the first CCRCs were almost exclusively not-for-profit, there has been a relatively recent increase in the number of for-profit communities. "For-profit systems accounted for the largest share of the CCRC increase with 200 communities in 1994, a 13 percent increase since 1993" (Modern Healthcare, 1995). Not-for-profit communities, however, still constitute a definite majority of the CCRC industry.

Numerous services, both residential and health care related, are provided in CCRCs, but may vary from one community to the next. Some basic services common to most include meals, grounds maintenance, local transportation, security systems, and on-site physician services. Some communities may offer a greater number of services than others, such as housekeeping, laundry service, or the processing of Medicare and insurance reimbursement forms. Basic services are most often covered with the cost of the housing unit, but others may have to be paid for separately, depending on the CCRC.

It is important to recognize that CCRCs have rather distinguishing differences in their basic structure and environment. CCRCs come in many shapes and sizes. They range from luxury high-rises with balconies, to one and two-bedroom cottages, to ranch-like configurations. Communities in different areas of the country also vary in their basic method of carrying out daily activities. For instance, a CCRC within a city may serve meals in a classy, restaurant-like setting to cater to the desires of its residents who are used to city life. A community in the Amish areas of Pennsylvania, on the other hand, might serve family-style meals where the food is passed around the table as if you were at home. Small distinctions like these make an enormous difference in the overall atmosphere of a community.

A. Continuum of Care

CCRCs are unique to the area of long-term care in that they provide various levels of care within one community for elderly residents whose needs change over time. In other words a CCRC maintains a *continuum of care*. "Contrary to the belief that most people who need long-term care are severely disabled, 48 percent of those at risk (for nursing care) are frail but do not have significant physical limitations" (Montague and Pitman, 1995). This makes CCRCs an attractive option for those who want the

extra help offered by a nursing home, but also the freedom that they would have in their own home. There are three main stages of care.

Independent Living Unit (ILU)

Almost 98 percent of CCRCs offer independent living care (AAHSA, 1996). The main purpose of an ILU is to provide a sense of independent living for older adults who are capable of doing the basis chores of everyday life, but who may need occasional help from others. It allows the resident to feel safe and secure, as well as free and independent. Units come in a variety of forms including studio apartments, one-bedroom, two-bedroom and larger units. Residential services are often available, such as meals, housekeeping, and laundry service. For residents with acute care needs, Medicare home health services, such as skilled nursing, physical therapy, and assistance with personal care needs, are included within an ILU.

Assisted Living

Available in 81 percent of CCRCs, "assisted living is an intermediate step between independent living and nursing care" (AAHSA, 1996). It provides assistance for residents with chronic care needs excluding complete 24-hour skilled nursing care. Assisted living services include helping a resident with bathing, dressing, taking medications, and other daily activities.

Skilled Nursing Care

Over 95 percent of CCRCs provide short-term and long-term nursing care such as rehabilitative and round-the-clock nursing services (AAHSA, 1996). Nursing care is often located within the CCRC or at a related facility nearby. Some CCRCs provide nursing or assisted living units that are designed for people with special medical needs, such as the care of persons with Alzheimer's disease.

Movement to the higher levels of care may be only temporary to restore the health of the resident. However, if a change in care level is meant to be permanent, there are different ways in which the decision for transition can be made. Some CCRCs have specific standards that they use to assess the residents' need for certain levels of care. Others are more lax in the decision-making process. In most communities, the decision for a permanent change within the CCRC structure is made by the resident along with his or her family and director (Wilcox, 1996:65). However, not all CCRCs are the same. Some may put more emphasis on the opinions of the staff, while others will listen most closely to the resident.

B. Agreements

(AAHSA, 1996)

CCRCs provide housing and health related services for their residents under an agreement effective for the life of the resident or for a specific period. There are three main types of agreements or contracts within CCRCs. A CCRC most often offers a single type of contract, but may provide more. The services offered in a contract include, but are not limited to, any of the following: Priority admission to assisted living or nursing care, medical and nursing services or assistance with activities of daily life.

Extensive Agreement (Type A)
(AAHSA, 1996) (Scanlon and Layton, 1997:16)

Extensive agreements include housing, residential services and amenities, and unlimited long-term care without substantial increases in periodic payments (except for normal operating cost and inflation adjustments). It provides for the prepayment of medical expenses, similar to an insurance arrangement, and have been known as "life care" agreements. With this type of contract the CCRC is at full financial risk for the cost of long-term care services. This means that the CCRC must pay all the costs of the services residents need except for those costs that may be reimbursed by third parties such as Medicare. Approximately 43 percent of CCRCs offer extensive agreements.

Modified Agreement (Type B)
(AAHSA, 1996) (Scanlon and Layton, 1997:16)

Modified agreements cover housing, residential services and amenities, and limited nursing care without any substantial increases in periodic payments. Care is paid for a specified amount of days each year. After all these days are used up, the resident then pays a daily charge. This charge may be discounted from what non-residents pay. A modified agreement places a partial risk on the CCRC because it is at partial financial risk for the cost of the long-term care services beyond those reimbursed by third parties such as Medicare. However, once the resident pays for care beyond the specified amount of days covered, he or she assumes full financial risk aside from what is paid by third party reimbursement. Modified contracts are offered by 29 percent of CCRCs.

Fee-for-Services Agreement (Type C)
(Cassel, 1993:10) (Scanlon and Layton, 1997:17)

Fee-for-service agreements include housing, residential services and amenities. Residents are guaranteed access to health care services by paying prevailing rates. Essentially, residents only pay for health care services used. Under this type of agreement there are usually lower fees. However, the resident also accepts the risk of paying for care which may eventually become too expensive for him or her to pay for. The CCRC, on the other hand, assumes no financial risk. Thirty-eight percent of CCRCs offer fee-for-service contracts.

C. Payment Plans

Although different CCRCs offer various forms of payment, a resident may choose from three main types.

Entry and Monthly Fee

The most common method of payment is an entry fee plus a monthly fee. With this form of payment a lump sum entry fee paid up-front is combined with monthly fees for a living unit, services, and specified care items. The entry fee may or may not be refundable.

Rental

Rental or paying only the monthly fee is also rather common. This typically covers housing and designated services. Sometimes fees include health care services.

Equity

Equity or ownership is an option in some CCRCs. With this type of payment plan, the purchase process is similar to purchasing a condominium, cooperative or membership. However, the sale and resale usually are limited to those who meet the community's entrance eligibility criteria. Sometimes the CCRC may share in the financial appreciation of the unit. An owner's association usually governs the residential services and health care. Also, for an additional fee, residents may purchase service and health care packages.

D. Refunds

(Cassel, 1993:11)

As mentioned before, depending on the particular CCRC, the entry fee paid by the resident may or may not be refundable in certain cases (i.e. the resident leaving, transfer, or death). There are three common types of refunds available.

Refundable on a Declining Scale

With this type of refund, the agreement made specifies a period of time in which the entry fee will be refundable to the resident on a declining basis. For example, if an entry fee is refundable and declines at the rate of one percent per month, then 94 percent of the entry fee would be refundable in six months.

Partially Refundable

Partially refundable entry fees guarantee a specific percentage of the refund that will be returned within a certain period of time. For example 50 percent of the entry fee may be refunded, but only within a two year time period.

Fully Refundable

Full refunds are rare, but sometimes offered. A fixed charge may be deducted before the refund is made and the agreement will state for how long the refund is valid and usually under what conditions a refund is due. Entry fees that offer full refunds are typically more expensive than those without refunds or those that are refundable partially or on a declining basis.

III. QUALITY OF LIFE IN CCRCS

The information within this section relies heavily on the findings of William Scanlon and Bruce Layton in the United State GAO Report to Congressional Requesters. Statistics show that CCRC residents have a life-expectancy which is 1½ to 2 years longer than other elderly individuals. It has also been found that CCRCs reduce the risk of disease and disability and improve the health and functioning of their residents. Although little research has been done on what exactly causes these noticeable health benefits, many have attributed it to the more active approach that CCRCs take towards health care.

CCRCs combine a variety of services which may effect the overall wellness of their residents. These services, along with a clear strategy of health promotion by the communities, attempt to encourage the elderly to be more involved in maintaining their own health.

A. Exercise and Nutrition

By having a variety of activities and sports facilities, most CCRCs encourage active lifestyles for the elderly. Many have on-site fitness centers and activity areas which allow residents to have some type of physical activity. Swimming pools, tennis courts, and even golf courses are offered by the more expensive CCRCs. Exercise classes, such as aerobics, flexibility and strength exercises, yoga, and Tai-chi are just some of the choices that exist for residents who want to remain active. Walking is also a popular form of exercise, due at least partially to the nature trails and other scenic pathways incorporated into many CCRC campuses. Health promotion and wellness programs may be adapted to meet the needs of residents with chronic conditions, allowing them to remain active as well.

Proper nutrition is encouraged by many CCRCs by offering three balanced meals a day. However, because residents may eat in their individual units, especially for breakfast and lunch, greater efforts to promote healthy eating is usually necessary. Dieticians are often available to set up special diets designed to get the resident to eat proper amounts considering weight and other health circumstances. Nurses and staff may also make suggestions to the residents if they see that they are not eating enough. In some CCRCs, such as Hyatt and Marriott, well-experienced chefs compete with each other to provide elaborate meals that provide the perfect balance of nutrition (Restaurants and Institutions, 1996).

The importance of a balanced diet and exercise is stressed not only through the services offered, but through individual encouragement from the CCRC staff. Pamphlets, flyers, and lectures which advertise events and promote healthy lifestyles are a major part of the effort to keep the elderly healthy. However, personal

encouragement from a nurse may often be more effective to residents who may be reluctant to try new things.

B. Proper Medical Care

By focusing on disease prevention and early detection, CCRCs appear to have created noticeable benefits for the elderly. Nurses, social workers, and physicians coordinate their services in an effort to prompt residents to take proper medical precautions. Immunizations against common preventable diseases, such as the flu and pneumonia are important in preventing strains on the health of the elderly. Periodic medical exams which may test for high blood pressure and diabetes are also stressed by CCRCs. Some may even provide tests for various forms of cancer and hearing impairments. Psychiatric consultation and assessment can also be used to assure that residents remain mentally stable. Immunizations and medical exams are often encouraged through seminars, written materials, and reminders from staff.

C. Social Involvement

Knowing that social isolation has been associated with poor health and functioning among the elderly, CCRCs have attempted to keep residents involved within the community. By creating an environment which promotes socialization, CCRCs may have helped to make the lives of their residents not only more enjoyable, but longer. Social involvement is promoted in a variety of ways. Communities are most often organized so that residents live right next to each other and may easily interact. Recreational, educational, cultural, and volunteer activities organized by staff and residents help to get the elderly to participate in their community. On-site lectures, movies, musical performances, crafts, and even civic and charitable activities are just some of the projects that residents participate in and attend. These activities, which may give residents a sense that they are important to their friends and the community as a whole, appear to be an important part of maintaining overall health.

D. Other Aspects of a CCRC

Other practices common to CCRCs may also help to explain the healthier lives of their residents. The continuous care offered by an on-site nursing staff and social workers may play a part in preventing sickness and poor health. This constant care and companionship is most likely very significant in maintaining the overall happiness and therefore wellness of residents. In addition, the removal of responsibility for the care and maintenance of a private home reduces demands on elderly people and may also contribute to increases in longevity.

CCRCs are also different from other communities in that they attempt to maintain residents as independent as possible throughout all areas of their lives. Physical

restraints are most often prohibited, unless absolutely necessary (Wilcox, 1996:66). CCRCs also avoid thinking institutionally. They may purposely use the language of a resort hotel or luxury condominium complex, rather than that of a skilled nursing facility in order to make residents feel more independent (The Brown University LTC Quality Letter, 1995:20). This raises the possibility that basic differences in resident treatment may be responsible for the healthier and longer lives of the CCRC elderly.

Some experts have questioned, however, whether the increase in life-span among CCRC residents is actually due to the practices of the industry. It may be possible that the type of elderly that reside in CCRCs are from a more affluent group that have always had better diets and medical care (Underwood, 1992:3). This must be considered as a possible explanation for the health differences found between CCRC residents and the elderly population as a whole (Wilcox, 1996).

IV. ADMISSIONS AND RESIDENT CHARACTERISTICS

Few studies have been done on exactly what type of people CCRCs attract. There do, however, appear to be some basic trends in resident characteristics when the admission criteria of most CCRCs are considered. Because communities assume risk for providing long-term care, they take certain measures to determine the chances that a resident will use more in long-term care than what he or she pays. Admission criteria, which include assessing such characteristics as income, health, age, gender, and marital status are one way in which CCRCs gain a better understanding of how likely it will be that a resident will need extremely expensive medical care over the amount paid.

One study found that CCRCs rejected 50 percent of applicants for health reasons and 39 percent for financial reasons in 1988. CCRCs offering extensive contracts were more likely to reject applicants for health reasons, most likely because they are at full financial risk for their long-term care (Sloan, 1995).

A. Income

Although not all CCRCs have specific formulas for determining the appropriate income for a potential resident, most do have some standard which they employ. A common requirement is that the individual have an annual income which is a multiple of the monthly fee. "Among the newest CCRCs (1988-1991), 40.7 percent required an income of 1.5 times the monthly fees and a quarter required an income twice the monthly fee" (AAHSA, 1991:41). Assets of potential residents are also important in many communities. However, almost 20 percent of CCRCs reported that they did not use a minimum asset test as a requirement.

Because residents may not be required to disclose all financial information, it is often difficult to assess their actual wealth. Residents simply must show that they have enough in income, and often assets, to cover the expenses of the CCRC. Therefore, it is possible that many assets beyond what is required are not reported (Walters Interview). Despite the limits to gaining information, one study in 1993 using selfreported data, showed that the typical CCRC resident had a higher income level than a traditional community resident (Ruchlin, 1993). Other research shows that in 1991, on average, 11.5 percent of incoming residents had annual incomes of less than $15,000. However, for CCRCs with extensive contracts, the percentage was one-half of this. This suggests that the affluence of residents vary based on contract types. In fact, "extensive contract CCRCs had a much larger mean percentage of incoming residents with assets of more than 500,000--27.3 compared with 15.2 for modified and 7.2 for fee-for-service contracts" (Sloan, 1995).

B. Health

Determining the health of potential residents involves understanding a variety of factors which culminate to provide a relatively reliable understanding of the life-expectancy and possible need for expensive medical care of each resident. Because residents must be capable of living independently if they are going to live in an ILU, communities most often require physical examinations by either the doctor of a prospective resident or one the community selects. Residents in 92.3 percent of communities, in a report done in 1989, were also required to demonstrate mental competence (Netting and Wilson, 1991:269).

CCRCs also seldom accept applicants who are already debilitated by stroke or Alzheimer's disease. Although financial concerns are at the forefront of the decision to deny admission to those with serious disabilities, some feel that it is also important for maintaining the atmosphere of a residential environment. CCRCs, however, do not necessarily deny admission to all elderly with serious health concerns. Communities will often accept some people with health problems, but make them pay extra for nursing care that arises from health conditions they had at the time they entered the CCRC (Consumer Reports, 1990:129).

C. Age

The age of prospective residents is another way in which CCRCs predict how much health care a resident will need. Fees may or may not vary based on the age of an incoming resident. A few communities charge younger residents more for extensive contracts because they will most likely be residing at the community longer. However, many CCRCs have older residents pay the same entrance and monthly fees as younger ones because they are more likely to need the expensive nursing care (Consumer Reports, 1990:125).

The average age of an incoming resident into an ILU is 78.8, while the average age of all residents in ILU's is 81.2. The average ages for those in assisted living and nursing care are 83.7 and 84.2 respectively (AAHSA, 1991).

D. Gender

CCRCs also recognize the fact that women tend to live longer than men in their considerations for determining life-expectancy and cost (Walters Interview). This could be related to the fact that CCRCs are approximately 75 percent female and 25 percent male (AAHSA, 1991). It could be assumed that CCRCs admit more women or that the women are simply outliving the men. Others, however, point out that men are less likely to want to move into a CCRC, unless prompted by some major health concern. It is also important to note that women are more likely to be living alone because their husbands have died.

E. Marital Status

The cost of a unit for couples is almost always more expensive than for a single person. This comes from the fact that there is a greater risk that one person in the couple will die and it will be necessary to find new occupants for the unit (Walter, 1997). There are also fewer couples in CCRCs than there are single people. Approximately 29.7 percent of CCRC residents were married in 1990. Among assisted living residents, 11 percent were married and 15 percent of nursing home residents were married. (AAHSA, 1991).

Another noticeable characteristic which distinguishes CCRC residents from the rest of the elderly population is higher levels of education (Ruchlin, 1993). It has been recognized that todays CCRC residents come from academia, the professions, and the business world. This offers at least some support for the idea that CCRC residents are from a more affluent class than the typical elderly individual.

V. AFFORDABILITY

Prices among CCRCs vary greatly. Numerous CCRC characteristics, such as the amount of care provided, type of contract, size of unit, and geographic location, play a role in determining the cost of a community. Other factors dealing with the expenses to the care provider, such as cost of development, construction and financing, are also significant indicators of fees. Entry fees range from lows of around $20,000 to highs of approximately $400,000. Monthly fees go anywhere from $200 to $2500.

The greatest variations in cost are among the three types of agreements or contracts offered. Because the CCRC assumes more risk, extensive contracts are considerably more expensive than modified or fee-for service agreements. In 1991 the average low for an extensive contract entry fee was $41,462. It was $27,850 for modified and $22,306 for fee-for-service contracts (AAHSA, 1991). Prices may also differ based on whether payment type is rental or equity.

Variations by unit size are also notable. Average studio unit entry fee prices ranged from lows of approximately $22,000 to highs of around $41,000 in 1991. One-bedroom units went from averages of around $34,000 to $71,000; two-bedroom units from approximately $74,000 to $108,000; larger units from about $97,000 to $132,000 (AAHSA, 1991).

Though differences in cost by region are not quite as significant as those by contract type and size, they are still evident. According data gathered by AAHSA in 1991, CCRCs in the Great Lakes and Central United States regions appear to have slightly lower prices than those in the South, West, and Northeast (AAHSA, 1991).

Opinions differ on exactly how affordable these CCRC prices are to the elderly. Consumer Reports stated that CCRCs are within reach of about 50 percent of the elderly (1990:126). "Others have estimated that between 15 and 25 percent of persons over 75 could 'easily afford' a CCRC, and that as many as one-third might find CCRCs affordable" (Conover and Sloan, 1995:445). These percentages, though some view as improving, are still relatively consistent with the overall opinion that CCRCs cater mainly to the more affluent elderly.

Efforts to Make CCRCs More Affordable

In many areas of the country specific efforts are being made to make CCRCs a more viable option for low-income elderly. Many CCRCs are attempting to incorporate the concept of affordability into to their overall mission and goal statements. Some communities, such as Greencroft in Goshen, Indiana have taken steps to provide lower cost units for the elderly by offering government subsidized housing. Out of 1000 residents, 250 are considered to be low-income. They are housed in HUD apartments on the CCRC campus. The private pay residents also help subsidize services to these elderly who can not afford the CCRC on their own (Gregory Interview). Although this

type of funding is not widespread, it may prove to be an effective way to make other CCRCs more affordable.

Older CCRCs (those over 25 years old) also may be able to offer lower prices than most other communities. Newer communities face construction costs which are at least partially passed on to the residents (Kohn Interview). CCRCs that do not have to deal with these costs are in a much better position to offer cheaper contracts.
It has also been noted that "because of the high volume of previously under performing properties now available, acquiring CCRCs can be substantially cheaper than building from the ground up" (Pallarito, 1996). This too may be important in the development of CCRCs which can afford to offer lower fees to the elderly.

VI. PUBLIC FINANCING

CCRCs are mainly privately funded institutions. However, Medicare, and at times Medicaid, can be used to fund the cost of specific services. Eighty-two percent of CCRCs offer either Medicare or Medicaid (Scruggs, 1996:14). This creates a certain level of interest in how much public money is actually involved in CCRCs and whether it is used efficiently.

A. Medicare

Many CCRCs require that residents have both Medicare A and B coverage. A community may also require that residents have Medicare supplemental insurance or Medigap (Cassel, 1993:12). Although Medicare does not generally cover long-term nursing care, it often covers specific services in a long-term care setting, such as physician care and hospitalization. Twenty-one percent of CCRCs offer only Medicare, while 49 percent offer both Medicare and Medicaid (Scruggs, 1996:14).

In an attempt to understand how Medicare is used in CCRCs, as compared to traditional communities, a study was done in 1993 comparing the two institutions. Two possible outcomes were suggested. It could be assumed that because of the services provided by a CCRC, the use of Medicare-covered services would be reduced as social services and non-covered long-term care services provided by the CCRC substituted for those covered by Medicare. On the other hand, CCRCs could be able to cause reimbursable skilled medical services covered by Medicare to substitute for less intensive non-Medicare-covered services for which they are at risk. The study found that living in a CCRC was not associated with significantly lower annual expenditures for medical care services that are covered by Medicare. However, in their last year of life CCRC residents displayed significantly lower expenditures for hospital care ($3,854 versus $7,268) but higher expenditures for Medicare or non-Medicare-covered nursing home care ($5,565 versus $3,533) (Ruchlin, 1993).

Although this study suggests that there is no major difference in Medicare costs among CCRCs as compared to traditional communities, there is not complete agreement among those in the industry.

B. Medicaid

Medicaid dollars do not play a very large role in the funding of CCRC care and services. Because the financial requirements for residence within a CCRC are rather strict and the costs are relatively high, very few residents meet the qualifications to receive Medicaid. There are, however, at least over 12 percent of CCRCs that offer the Medicaid program (Scruggs, 1996:14).

C. Other Government Programs

As of yet, CCRCs receive little or no money from other government programs. As mentioned before, government subsidized housing through HUD may become an important part of the CCRC industry. However, for now, government funding for CCRCs is not typical.

VII. MANAGED CARE

There has been a tremendous increase in the appeal of managed care to the elderly. "About nine percent of the elderly presently covered under Medicare have opted for HMO coverage. If the proposals now under consideration in Washington to overhaul Medicare by emphasizing lower cost managed care are enacted, then projections indicate that as many as 40 percent of all Medicare beneficiaries will opt for HMOs within the next five years" (Gamzon, 1996).

"Manage care is intended to channel and coordinate individuals' use of health service to achieve appropriate utilization of those services and improve health outcomes" (Scanlon and Layton, 1997:1). Because CCRCs offer contracts that put the community at full or partial risk for providing long-term care at a set price, the industry is considered a type of managed care. Despite the classification of CCRCs as a form of managed care, some experts suggest that the growth in managed care poses a threat to the CCRC industry.

A. Managed Care as a Challenge to CCRCs

Dina Elani, director of managed care and services integration for AAHSA, stated that many of the "CCRCs the AAHSA represent have found they are not prepared to compete for Medicare and Medicaid managed care business" (Snow, 1996). She went on to say that one example of this problem occurred in Southern California when some CCRCs did not screen their patients for enrollment in HMOs and later discovered their facilities were not covered by their patients plans.

Also, in "California and Florida, where many seniors are already enrolled in Medicare HMOs, residents of CCRCs following discharge from hospitals can be transferred to skilled nursing beds outside the CCRC. This obviously undermines the entire premise of providing all necessary long-term care on campus to CCRC residents" (Gamzon, 1996).

Other than the basic difficulties that CCRCs face in dealing with managed care, there are also concerns about whether the demand for CCRCs will be greatly effected by the growth in managed care. Some question whether the elderly will feel the need for a CCRC when their managed care organization can provide for all of their long-term care needs (Visions, 1996). Another aspect of CCRCs which may possibly deter potential residents and make managed care packages appear more attractive is the move that comes along with going into a CCRC. The change in environment can be very hard for many elderly individuals who have lived in the same place for many years. This may make a long-term care plan that does not require moving seem much more appealing.

Others in the CCRC industry, however, do not see these possible problems as real threats to the overall success of the industry. Gail Kohn from Collington Episcopal Life Care Community states that because Medicare managed care packages can not offer the full range of services provided by a CCRC, they pose no real threat to the industry. She goes on to say that, rather than competing, the two long-term care areas are working together to provide the best possible care for the elderly.

B. Alliances

This idea of working together has been proposed as a way to overcome what at least some CCRCs see as, the threat of managed care. Strategic health care alliances are important, not only to the success of the industry, but also for maintaining the continuity of care and assuring quality care to residents (Visions, 1996). Dina Elani stated that presently "almost all long-term care providers are in the first steps toward forming a network" and that those who are not are will face problems (Snow, 1996).

Deborah Hiller, president and CEO of Eliza Jennings Group, states that "managed care organizations want to be able to deal with a single entity that is standard in its operations and is geographically dispersed" (Snow, 1996). She suggests that "if we are more consolidated, we can present to them a group of high-quality not-for-profit organizations".

C. Marketing

Advertising the benefits offered by CCRCs is another way in which the industry may hope to fight off any possible dangers created by the growth of managed care (Visions, 1996). Many elderly are unaware of exactly what CCRCs provide. By developing proper marketing strategies CCRCs will be able to show the full range of benefits they offer, beyond the financial security of long-term nursing care.

VIII. REGULATION

Presently, 35 states across the country have some form of regulation for CCRCs. These regulations, which came about mostly as a response to concerns raised by numerous bankruptcies during the 1980s, vary greatly in stringency.

Because many CCRCs provide insurance-like coverage, they are often regulated by the department of insurance. "Other states regulate CCRCs through departments, such as health, consumer affairs, or aging" (Cassel, 1993:14).

"Government involvement may take the form of measures designed to improve the ability of prospective residents to make informed decisions (e.g. consumer disclosure requirements), entry regulation (e.g. certification as a prerequisite for selling CCRC contracts), and measures to mitigate the adverse financial consequences to residents when bankruptcies actually occur" (Conover and Sloan, 1995:445). Reserve requirements are mandated in a few states. Qualifications for newly-forming CCRCs are also on the rise. For example, "regulations often require market and financial feasibility studies plus a substantial number of resident reservations for occupancy before permitting construction of a CCRC to begin" (Cassel, 1993:14).

Reform advocates are presently calling for increased regulation among CCRCs to protect the elderly consumer. Although there is a consensus that the benefits of regulation are desirable, some fear that the negative impacts, such as higher costs, may be harmful to the industry as a whole. In an effort to prevent strong government involvement in the industry and in hoping to maintain security for the elderly without the negative side-effects of regulation, CCRCs have formed their own type of regulating agency, the Continuing Care Accreditation Commission (CCAC).

A. CCAC as a Surrogate for Regulation

The CCAC has adopted basic standards which focus on finance, governance, residential life, and health care. In order to qualify for accreditation, CCRCs must perform self-evaluations that focus on these aspects of operation, as well as undergo inspections from the CCAC. CCRCs must be recertified every five years and submit annual financial statements in the interim (Consumer Reports, 1990:129). Only 207 CCRCs meet the stringent financial and health requirements (Brod, 1997).

"The CCAC standards have three major purposes, which are to assist a CCRC in developing, interpreting, improving and evaluating all components of its operation, to provide the basis for accreditation decisions, and to assure consumers that the CCRC has met pre-determined standards" (CCAC Handbook, 1991). This final purpose attempts to ease the concerns of those who promote government regulation. Through self-regulation, CCRCs hope to raise the standards of the industry and to provide

assurance to consumers about the physical and financial security that they can expect in a CCRC.

Despite the relatively high standards for accreditation, the CCAC does not require that accredited CCRCs guarantee long-term care coverage throughout the lives of their residents. Only if benevolent care is part of a CCRC's mission statement, will the CCAC assure that a community provides coverage until the end of a resident's life (Washington Interview).

Others have also noted that "more depth is needed in standards for resident life and health care" (Netting and Wilson, 1991:271). For example, a CCRC could be accredited without assessment guidelines in place to protect staff and residents in making accommodation and relocation decisions. The CCAC is said to be studying these areas and hopes to propose more specific standards.

B. Benefits of Government Regulation

Promotion of Financial Stability

Regulation, such as reserve requirements and at least 50% occupancy before construction, are intended to assure that a CCRC is financially capable of maintaining itself. It pushes a CCRC to have on hand at all times enough funds to handle unexpected problems, rather than simply spending as new entry fees are received. Regulation also attempts to guarantee that there is sufficient demand for a CCRC before it is constructed. These standards protect residents, who most often have invested their life savings into a community, by warding off any potential for bankruptcy.

Protection of Quality Services for Residents

As regulation protects the financial stability of a CCRC, the quality of a residents surroundings may also be secured. "If any community is undercapitalized, or too small, or fails to project future costs accurately, its residents may suffer" (Consumer Reports, 1990:128). CCRCs that are in financial trouble often cut back on maintaining the grounds and extent of services within their community. Therefore residents suffer the effects of poor financial management through a loss of quality services, although the CCRC may not be at a point of bankruptcy.

Discouragement of Unsatisfactory CCRCs

Among those who manage financially stable CCRCs, probably the most lauded reason for regulation is that it rids the industry of "fly-by-night" communities (Walters Interview). By enforcing basic rules for the establishment of a CCRC, the building of weakly managed communities is discouraged, if not prevented. This protects not only the elderly residents, but the industry as a whole by making it more legitimate in the eyes of consumers and investors.

C. Drawbacks of Government Regulation

Increased Costs

Like most forms of regulation, greater rules and restrictions placed on an industry involve a need for greater time, energy, and money devoted to adhering to those rules. The costs associated with increased planning and paperwork are most often passed on to the elderly residents of CCRCs through higher fees.

Loss of Incentive to Develop New CCRCs

At times the requirements of regulation may be so high as to prevent new CCRCs from developing. In particular, Edythe Walters noted that by regulating CCRCs in the same way as insurance companies, reserve requirements that are too large for a typical CCRC to meet can be imposed on the industry. This, she says, may have prevented the development of CCRCs in certain states. Therefore regulation, if not kept at respectable levels, may in some ways hurt the industry by limiting its potential for growth.

D. Studies

Little research has been done on the actual effects of regulation on CCRCs. One study, however, found that varying the degrees of regulation stringency had no effect on indicators of CCRCs financial performance relating to bankruptcy risk (Conover and Sloan, 1995). This suggests that regulation may actually do very little to protect the financial security of elderly residents. However, the study also points out that "the level of staffing in regulatory agencies devoted specifically to CCRCs is minimal. Further, there appears to be room for improved record keeping" (Conover and Sloan, 1995:453). Therefore, it could be possible that the benefits of regulation may only be reached through improvements made within the regulatory system.

IX. ADVANTAGES OF A CCRC

CCRCs provide numerous advantages which apply both to residents and the industry as a whole.

A. The Residents

The residents of CCRCs obtain a variety of benefits, all of which can not be fully described. However, some of the basic advantages residents receive are outlined below.

Unlimited Access to Health Care

CCRC residents are able to obtain all forms of care necessary through the continuum of care provided. Movement between the three levels of care is made while attempting to keep the resident as independent as possible, thereby making the increasing need for extensive health care less disruptive and difficult. On-site nurses and physicians are also available to provide round-the-clock service for elderly who may suffer minor or major emergencies. This may cause hospital emergency room use to be decreased.

Supportive Environment

CCRCs offer support and caring, not only from residents, but from staff as well. The focus on social interaction and involvement encourages residents to develop family-like ties to their community. This type of community life can be very important to elderly individuals who are not necessarily that close to their own families or who may have lost their spouses or other loved ones.

Physical and Financial Security

For CCRCs that are well-managed and stable, residents receive a sense of security and assurance in the final years of their lives. "One of the defining features of CCRCs is the promise to provide housing, care and services to residents for the rest of their lives, even if they live a very long time and become unable to pay all fees and expenses" (Cassel, 1993:13). Agreements most often specify what should happen if a resident's funds are exhausted. The most common ways of covering these shortfalls is through charitable gifts, special resident assistance funds, memorials and bequests. It is important to recognize, however, that the assurance that residents gain comes only when the CCRC itself is financially secure.

B. The Industry

CCRCs have been only recently recognized for their possible positive effects in the world of health care. The industry's ability to deliver quality care at a minimum of cost has not yet been proven, but is realized as potentially significant.

Potential to be Cost-Effective

"CCRCs were developed from the vision that the delivery of services to an elderly population was more efficient under a socialized arrangement than under one in which each of the individuals obtained the services separately" (Hamilton, 1993:38). This brings up questions as to whether or not the industry truly has incentives to provide cost-effective long-term care. A handful of studies have focused specifically on the utilization of these health care services in CCRCs. Two studies agree that hospital use tends to be lower in CCRCs. A study in 1994 found that hospital admissions and average days per resident among hospital users has a tendency to be slightly lower among CCRC residents than elderly in other community settings (Newcomer and Preston, 1994). Another study noted that hospital use by residents of CCRCs was lower in the 1980s than for the general population of the same age (Strumpf and Spears, 1993:27).

Nursing home use, in one study, has been found to be slightly higher in CCRCs than other communities (Newcomer and Preston, 1994). However, when distinctions are made by contract type, extensive contracts have been shown to have lower nursing home use than other agreements (Bishop, 1988) (Strumpf and Spears, 1993) (Newcomer and Preston, 1994) (Sloan, 1995). A study done in 1995 found that the share of residents in the CCRCs nursing home was 15 percent less for extensive contract CCRCs than for fee-for-service, the share for modified type was 10 percent less (Sloan, 1995). This "suggests that CCRCs with a life-care guarantee have built in incentives to provide residents with appropriate and cost-effective care" (Strumpf and Spears, 1993).

Because CCRCs offer some level of care beginning at entry into an ILU, it could be possible that this may play an important part in lowering hospital and nursing care use. Studies have found that providing personal care in independent care and personal care units reduces use of nursing homes. In fact, in one study when personal care was provided in both the ILU and personal care center, the fraction of residents in nursing homes decreased by 10 percent (Sloan, 1995). A study from 1988 agrees that communities offering personal care have significantly lower nursing care use (Bishop, 1988).

Exactly how the more effective utilization of health care service is achieved must be more closely looked at. If the positive results are due to extremely strict patient selection, these findings may mean very little. However, if they were obtained by the introduction of meaningful efficiencies in providing care, they could have important implications, especially for extensive contract CCRCs.

Although the utilization of health care services has been examined, little research exists to give legitimacy to the claim that costs are lower among CCRCs.

X. DISADVANTAGES OF A CCRC

Although CCRCs, overall, offer a number of advantages, they still have at least a few problems that both residents and the industry must face.

A. The Residents

Cost

As noted early, CCRCs are generally not that affordable for the average elderly individual. Extensive contracts, in particular, are most often too expensive. Fee-forservice contracts, though much more accessible to the elderly, do not offer the same level of security for long-term care.

Change In Lifestyle

Moving into a CCRC may be difficult for certain individuals in the elderly population, not only because of the apprehension that many have about leaving their homes, but also because of the adjustment process that is often necessary for a move to group living. Group living imposes some restrictions on individual lifestyle. "House rules" exist that may appear very limiting to many residents. Rules can "cover such areas as parking, pets, gardening and cleaning schedules, that must be standardized to work for as many people as possible" (Cassel, 1993:15). This change may be hard for residents who are not used to living in a close community setting.

B. The Industry

Fragmentation

Because CCRCs tend to be concentrated in separate "pockets" across the country (e.g. Pennsylvania, Florida, California, Kansas), there exists very little unity among the industry. This leaves CCRCs at a disadvantage in developing uniform standards to improve the industry.

Financial Stability

In the past, the financial stability of the CCRC industry was a serious concern, resulting from a number of bankruptcies among various CCRCs. Today fears are alleviated somewhat as the industry has gained more experience in management and as regulation has taken hold in many states. Concern over possible bankruptcy, however, still exists to some extent. Opinions on exactly how much of a threat financial failure is appears to vary among those studying the industry.

A study in 1995 found a rather low bankruptcy rate of .33 percent among the CCRCs examined. However, compared to similar facilities that combine housing and personal health care, the risk of bankruptcy was shown to be somewhat higher in CCRCs. It was also determined that CCRCs with extensive contracts were in worse financial health compared to fee-for-service facilities. "They were less profitable, more indebted, less able to cover their debt levels, more likely to be in poor financial health, and less likely to meet some indicators of excellent financial health" (Conover and Sloan, 1995:452).

Although the financial state of CCRCs in this study appears somewhat bleak, it was also noted that comparably the industry has improved from earlier years. Supporting this trend of financial improvement, in 1994 it was found that 86 percent of CCRCs covered their debt service. This number is up from 75 percent in 1993 (Pallarito, 1996:36). Occupancy rates, as well, have increased and are over 90 percent in most CCRCs.

The "vast majority of CCRCs are now on a sound financial footing" (Underwood, 1992:3). However, because the industry is riddled with a minority of poorly managed communities, the fear of bankruptcy is (and should be) still alive among consumers.

XI. TRENDS

There appear to be some basic trends among CCRCs which give more insight into what direction the industry is headed.

A. Growth in For-profit CCRCs

The lifecare industry has traditionally been nonprofit, however, as CCRCs have become a more stable and viable industry, a growth in for-profit communities has developed. In the late 1980s, large corporations with their roots in the service sector, such as Marriott Corporation, began to recognize the market opportunity and became actively involved. "The boom has progressed into the 1990s, and as the population ages and the percentage of elderly poor continues to decline, consumer demand seems unlikely to diminish" (The Brown University LTC Quality Letter, 1995:4).

B. Increase in Fee-for-Service Agreements

More and more new CCRCs are adopting the fee-for-service approach because it is easier to predict their future financial obligations and because prospective residents often resist paying for health care they may never use (Wilcox, 1996:65). In 1987, 28 percent of CCRCs offered fee-for-service contracts. That number has now risen to 38 percent (Brod Interview). The increase in fee-for-service CCRCs may also be attributable to the fact that they are much more affordable to elderly who may not be able to pay the large entry fees. In fact some suggest that "the fee-for-service alternative may be the best choice because of its flexibility in matching services to the income levels of the residents" (Hamilton, 1990:49).

This trend, however, raises some concern over the fact that the fee-for-service agreements do not offer the full long-term care protection of extensive agreements and that they give CCRCs a lesser obligation to their residents. But, "Sherwood, Ruchlin, and Sherwood (1990) indicated that although the fee-for-service contract type minimizes the CCRC's risk of providing care beyond the levels implicit in the fees, they 'know of no instance in which residents have been asked to leave a CCRC because of inability to pay the fees'" (Netting and Wilson, 1991:267).

XII. NEEDED RESEARCH

There is still much to be learned about CCRCs. Because the industry has received such great attention only recently, little thorough research has been done. Much of the literature on CCRCs deals with the structure and evolution of the industry, rather than on questions that may be more relevant to improving the health of the elderly. By analyzing CCRCs in more detail, much can be learned about providing quality care to the elderly. "Although the CCRC was not conceived as a model to demonstrate improved long-term care, these communities are, in effect, a type of laboratory for control of risk through health promotion and disease prevention, integration and appropriate utilization of services, and social psychological, and environmental supports at the end of life" (Strumpf and Spears, 1993:33).

Future research should take the form of national comparisons among CCRCs and their residents. All studies to this date have used only a small sample of CCRCs to make generalizations about the industry as a whole. Although this does provide some insight, it fails to give a thorough understanding of the variations within the industry and how some CCRCs may be more effective than others in maintaining health at a reasonable cost.

Research should also focus more on actual CCRC residents than simply on the services of the facility. "To measure levels of health and functional status of residents with an acceptable degree of accuracy, it is necessary to survey residents rather than CCRCs" (Sloan, 1995:95). Comparisons of CCRC and non-CCRC residents should control for income and education levels. By having the opinions of residents on CCRC living more can be learned about what makes CCRCs different and possibly better than traditional community settings. Elderly individuals who live within the CCRC community are likely to have an insightful view of what exactly the positive and negative aspects of CCRCs are.

Questions

Within the industry there are specific questions that should be addressed:

How is a better utilization of health care services achieved? Lower rates of hospital use suggest that CCRCs are responding to incentives to use services more efficiently. However, it can only be said that CCRCs are truly better at utilizing health care services if health care allocation processes are understood. It is important to determine if CCRCs are better at using less extensive health care services in order to lessen the need for nursing care and hospital care, or whether lower uses of this care is due to the strict health standards for residents at entry into a CCRC.

How does the cost of providing health care in a CCRC compare to the costs for typical elderly individuals? Although it has been shown by some that the utilization of health care services for CCRCs is better than in traditional communities,

does this mean that the costs to the CCRC are necessarily less? Although it may hint at the idea that CCRCs may be more cost-effective, this can not be determined without an actual comparison of costs.

How may HUD funding become available in more CCRCs? Currently only a few CCRCs receive HUD funding to provide the housing aspect of a community. What have these CCRCs done to receive this funding and how successful is the program? What prevents other communities from receiving HUD funds?

How may Medicaid play a bigger role in the CCRC industry? "Medicaid is a potential vehicle for providing subsidies to its eligible elderly applicants. However, to undertake such a program would require the current multiplicity of subsidized services available to the low-income elderly to be bundled into a single package (for example, food stamps, low-income housing, social services)" (Sloan, 1995:96). How feasible is it then to expand Medicaid into CCRCs? Closer attention should be paid to CCRCs that presently use Medicaid in order to determine how it is integrated into the CCRC program.

What exactly causes the better quality of life for elderly in CCRCs? It is widely recognized that the life-span of a CCRC resident is longer than the typical older person. However, what part of CCRC living causes this? The philosophy of independent living combined with focuses on activity, nutrition, health care, and social involvement are generally given the credit for better health. But little actual proof exists to show that these truly improve the health of the elderly. Is the personal care received by nurses and social workers a factor? Does a resort-like atmosphere play a role in improving the outlook and therefore health of residents? Research should be done do gain a more concrete understanding of these and possible other reasons for improved health and increased life-span.

How are the decisions for transitions to higher levels of care made and does the process need to be standardized? It is recognized that the decision processes for transition to higher levels of care differ among CCRCs. Are the assessments that are made appropriate? In order to be sure that proper levels of care are being received by residents, it may be necessary to develop well-researched standards for movement. These standards, combined with opinions of resident and staff, may assure that a desire for lower costs does not prevent residents from receiving the appropriate levels of care.

XIII. CONCLUSION

As CCRCs continue to grow in number, the impact that the industry has on the elderly population will also expand. It is important to assure that with this growth, the quality of care traditionally received in a CCRC is not lost and that the industry maintains financial stability.

In an effort to avoid extreme government regulation, which may bring higher costs to the elderly, CCRCs should continue to stress the CCAC as a regulator. Financially stable and healthy CCRCs should also make consumers more aware of what to look for in a community through their marketing strategies. This will aid in protecting the consumer, as well as the legitimacy of the industry.

Because CCRCs enable residents to live as they would in their own homes with the added benefits of hotel-like services and medical care, many of the younger elderly are finding this to be a very attractive option for their years after retirement. It is often looked at as a move to a resort, rather than a transition to a home for the elderly. By directing CCRC advertising to the younger elderly, it may be possible to increase the occupancy rates of many communities, thereby lowering the risks of financial trouble. On the other hand, housing the elderly for longer periods of time, if not done effectively, could be a drain on funds.

Most importantly the potential for this industry to offer insight into proper care for the elderly, and possibly other individuals who require lifetime care, should be recognized. The signs of the industry's success in improving quality care are recognized, but the techniques used must be more thoroughly understood and utilized in other settings.

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NOTE

Jacquelyn Sanders is a third-year undergraduate student at Colgate University. She prepared this paper as part of a six week internship in the Office of Disability, Aging, and Long-term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

For further information, contact: Robert F. Clark, D.P.A, DHHS/OS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, DC 20201 (bclark@osaspe.dhhs.gov).