

Developing Assisted Living Housing on Tribal Lands in Washington State



Cowlitz Tribe, St. Mary's Center, Toledo, WA

Colville Reservation, Nespalem, WA



Rural Community Assistance Corporation
U.S. Department of Housing and Urban Development Office of Native American Programs

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Introduction:

This report has been funded by the U.S. Department of Housing and Urban Development -- Office of Native American Programs. It could not have been conducted without the assistance of the Washington State Department of Social and Health Services, and their deeply committed staff, specifically George Zimmerman, Residential Policy/Resource Developer. George patiently assisted us throughout our investigation in understanding the intricacies of the range of health care services available to the elderly throughout the State of Washington. We also appreciate the assistance of Kristina Smock, Program Manager for the Cluster Care program, for helping us understand its usefulness in addressing many of the continuum of care needs that Tribal communities are facing.

We wish to acknowledge the help and support of Larry Coyle, Cowlitz Housing Authority Executive Director and Tribal leader, in communicating their vision of making the Tribal Elders the focus for reconnecting the Tribe with their culture and heritage.

Sally Hutton, Administrator of the Colville Convalescent Center, was most helpful in sharing her vision for expanding services to Tribal Elders beyond the confines of the convalescent center. We appreciate the assistance of Larry Winders, Director of the Colville Indian Housing Authority, in defining the role of the Housing Authority in meeting the needs of the elders. Yvonne Misiaszek, HHSD Director gave us great help in conveying the interest and support of the Tribal Council in developing new alternatives and direction for meeting the assisted living needs throughout the Colville Reservation.

Respectfully submitted,

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Rural Community Assistance Corporation
December, 2003

The research and studies forming the basis for this report were conducted by RCAC staff pursuant to a contract with the HUD Office of Native American Programs. The statements and conclusions contained are those of the contractor and do not necessarily represent the views of the U.S. Department of Housing and Urban Development.

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HUD/ONAP INTRODUCTION

The HUD/Northwest Office of Native American Programs thanks the Rural Community Assistance Corporation, Cowlitz and Colville Tribes, and Washington State Department of Social and Health Services for their work on this study.

As the study indicates, the genesis of this work were the concerns raised by tribes and tribal members about the shortage of housing opportunities suitable for their frail elder population. In various meetings discussions often focus on projects commonly referred to as assisted living or assisted care facilities. Participants have been frustrated because subsequent discussions revealed that assisted living projects don't seem to work in Indian country, especially for small tribes. The Tribal assisted care projects that are successful have required broader marketing and/or greater tribal subsidy than was initially planned. This study was commissioned to investigate some of the reasons assisted care facilities are such a challenge and to provide alternative methods which tribes could consider to assist their aging populations.

There are many different challenges to providing for tribal elder's needs as they age, such as: market, small populations, often widely dispersed; costs, specialized and expensive construction and operating costs; regulations, regulations by various funding agencies often conflict with each other; culture, tribal and family culture often inhibits the demand to the point the projects can not be built and/or managed. This study looks at the regulatory conflicts with federal and state Medicaid program. The Northwest Office of Native American Programs (NwONAP) has added the ONAP Appendix (page 19) to further inform the reader on regulatory conflicts between the federal and state Medicaid Medicare programs and HUD low-income housing regulations.

Readers of this report are cautioned that the study and conclusions drawn are developed from Washington State operation of the Medicaid/Medicare programs. These are federal programs, which are delegated to the states to run, and each state has different rules and requirements. To this mix you add the different Tribal laws and programs. The result is that no one program will fit all situations. Tribal elder service providers and housing providers will need to work with their local State Medicaid/Medicare program officials to craft a set of programs and agreements that work for their local situation.

If you have any questions concerning the ONAP information, please call the Northwest Office of Native American Programs, Max Rice, Program Specialist, at (206) 220-6202.

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Development of Long Term Care / Assisted Living Services on Tribal Lands in Washington State:

On November 20, 2002, a Workshop on Long Term Care Options for American Indians and Alaska Native Elders was held as part of a Title VI Training sponsored by the Region X U.S. Administration on Aging. The experience of the elderly on tribal lands has been that though they qualify for long-term care services provided by the State Medicaid Program, services are not well coordinated and are not universally available. During the workshop, tribal members outlined the obstacles that have limited the development of assisted living facilities and long-term care services on tribal lands. The discussion relied heavily on the experience of the Lummi in the development of Little Bear Creek, a culturally appropriate assisted living facility, and on other tribe's efforts to develop assisted living facilities. Below is a summary of the obstacles discussed:

The issue of sovereignty manifests itself in several important components of the assisted living development process. Examples of issues related to sovereignty include:

- Debt Covenants associated with the financing of the project, where tribal assets are held as collateral and/or where the lender has recourse to tribal assets, represent a problem for both the tribe and potential lenders. In no event can tribal-owned properties, particularly land, be jeopardized by debt covenants.
- Facility Licensure and Annual Inspections can be a problem for Indian Nations with Self Governing Authority. As sovereign nations, many tribes will want, and have the right, to license their own assisted living facility and conduct their own inspections. One example occurred with the Lummi Nation which developed a 29 unit assisted living facility to be operated incorporating cultural values and norms. The Lummi were able to develop their own licensing process and conduct annual inspections. However, in Washington State, the Washington State Administrative Code (WAC) requires that providers contract with the State to receive Medicaid reimbursement for providing services to Medicaid clients. The Lummi believe the language in the contract was in conflict with their sovereignty as an independent nation. The Lummi eventually prevailed on the contract issues.
- The decision by some tribal nations to limit admissions only to tribal members in assisted living facilities may also pose difficulties with non-tribal funding and with the marketability of the project. Assisted living facilities require a large population from which to draw, and that self-imposed restriction reduces the available client base.

The requirement that Medicaid clients participate toward the cost of room and board and personal care services was also highlighted as an issue. Many Native Americans resent the Medicaid /COPEs regulations that require clients to participate in the cost of their care. This problem occurred with the Lummi's Little Bear Creek Assisted Living Facility where many elders decided to stay in their home setting rather than turn their SSI checks over to the facility. Only seven elders moved into the Lummi facility.

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Roots of this problem appear to be in understanding what was meant in the treaties between the U.S. Government and the tribes where the government promised to provide health care services. This issue also arises when the elder's income is used to help support other family members. Very few Native Americans can afford the private pay rates of a conventionally funded and operated assisted living facility.

Other issues discussed were:

- the perceived instability of the tribal government (as a result of changing leadership and new leaders' competing priorities) during the pre-development and development phases of the assisted living facility;
- the use of the tribal public works department (who are unfamiliar with the regulations around assisted living facility development) as the general contractor in building the facility; and
- inadequate training for the management and staff of tribal members to successfully operate an assisted living facility.

State and Federal Workgroup and Origins of This Report:

As the above discussion shows, the development of a licensed, regulated, resource-intensive and operationally complex assisted living facility presents many problems for tribal governments. After hearing the input from the Title VI Training and an emphasis from the U.S. Health and Human Services senior management on developing long-term care services on tribal lands, state staff from DSHS – ADSA, Region X federal staff from Housing and Urban Development (HUD), Medicaid, and Title VI and consultants from Rural Community Development Corporation (RCAC), met to examine alternatives to provide long-term care services on tribal lands.

This report, funded by HUD is intended to explore the issues raised. The goal of this effort has been to review the available programs and their regulations, identify obstacles and cultural issues impeding the development of long term care / assisted living services on tribal land, and to develop a plan to overcome them. Washington's Aging and Disabilities Services Administration (ADSA) was already working with the Cowlitz and Colville tribes on the development of services and these tribes were chosen as demonstration projects. This report focuses on alternatives for housing-with-services for the elderly, that was cited as the service most needed by the tribes.

During the Summer and Fall of 2003, a review of the programs and regulations as well as interviews and meetings with the tribes were conducted. The answer that presented itself respects the sovereignty of the tribes, was relatively simple and comparatively easy to implement.

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General Statement of Need:

Long-term care services for the elderly on Native American reservations in Washington State are almost non-existent. This is especially true of community residential settings such as Adult Family Homes or Boarding Homes (assisted living, enhanced adult residential care and adult residential care). Because of the lack of service support options most elders live at home in relative isolation. When friends or family members live close by and are able to offer support, they receive such care as their helpers are able to provide (in most cases, appropriate care). When in-home family or friend-provided care is no longer possible, the elderly have no other options but to live without service supports or to go to a skilled care nursing facility, often away from their reservation, their families and friends.

The shortage of decent affordable housing with social and medical assistance for the low- and moderate-income elderly is particularly acute in rural tribal areas. Numerous issues impede the development of tribally-owned and operated facilities, while the demand steadily grows as the adult population ages. The complexity of the housing development process is compounded by the uncertainties in the delivery of individualized personal care services, particularly for very-low income elderly. For example, on the Colville Reservation 55% of those 75 years and older have incomes below 50% of the area median income, with more than half of them below poverty levels. That is the age group most likely to need assistance with activities of daily living such as meal preparation, bathing, dressing, etc. Their access to Medicaid-supported services is crucial to their continued well being.

Tremendously diverse conditions exist on tribal lands. Those differences demand understanding and sensitivity to the culture and circumstances of the persons to be served. Flexibility and creativity are required in the development of facilities and in program delivery. In addition, Tribal entities are protective of their treaty status, and the retention of their sovereignty is an important component for preserving their identity. That occasionally puts them at odds with State or federally administered programs. The experience of the Lummi Tribe in Northwest Washington illustrates the results of conflicting cultural and regulatory issues.

Working with tribal communities is often much more relationship-based than the standard regulatory or business-based approach seen in non-tribal communities. A key ingredient to being effective in tribal communities is the development of a broad understanding of the cultural and political environment in which they operate. The approach taken in this report has been to secure understanding of the basic outcomes desired in the Tribal communities, and then seek alternatives within the existing regulatory environment that could accomplish those ends.

The Medicaid Program and Payment for Assisted Living Services:

Payment for “Assisted Living Services” or long-term care services may be handled via private pay (where individuals pay for the services with their own funds or through long-term care insurance) or by government programs, primarily Medicaid, where the government pays for the services. Demographic analysis shows that few elders from the Cowlitz and Colville tribes can afford private pay charges for assisted living services/long-term care services. Thus, this report will focus on service delivery options available under the Medicaid program of the Washington State Department of Social and Health Services - Aging and Disabilities Services Administration (DSHS - ADSA) programs.

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Assisted Living Solutions:

“Assisted Living” is a term of art, not a regulatorily defined description of a particular type of housing with services. Assisted Living is used to describe many forms of housing with services such as:

- a licensed facility delivering a specific menu of services, or
- generically, any housing in which any of a broad range of services may be delivered, or
- an organized package of comprehensive services that can be delivered effectively within the client’s own home or apartment setting.

An example of the first is the Washington Department of Social and Health Services’ licensing of Boarding Homes with an Assisted Living contract, enabling the Boarding Home to serve Medicaid clients in an Assisted Living setting. In this case, the package of housing and services is connected and compliance enforced through licensing and contractual oversight.

In the second case, the housing is independently operated and the services may be brought in by one or more independent service providers. The owner of the housing may, or may not, choose to provide oversight or supervision of the delivery of a limited array of services. Some of which may require licensing of the facility, depending on the services provided. The provision of transportation, counseling, occasional meals, and other supportive services in a HUD 202 project is an example of the second case.

The third case is when services are delivered in the client’s own home setting. Under in-home services, the Medicaid qualified client employs a home care agency or independent provider to deliver the services in their home. The home care agency or independent provider is paid by the appropriate Medicaid program. DSHS’s newly created “Cluster Care Services” program is a contractual model for providing in-home personal care services to a group of Medicaid clients who live in close proximity to each other. Personal care services are consolidated at cluster care sites in order to realize the greatest efficiencies in their delivery. Services are provided by a coordinated team of home care agency aides who provide personal care services according to the assessed need of the client. Case management responsibilities are delegated to a designated staff person of the local Area Agency on Aging (AAA). The care providers’ assistance is task- not time related for the delivery of services. An aide does not necessarily remain in the client’s home for a specified period of time to provide assistance, but may make multiple visits to the client during the day. The provider may also perform tasks for multiple clients, such as shopping or laundry.

In each example the State, through its Medicaid Waiver, is empowered to provide a range of services to income- and asset-eligible residents. The State of Washington has developed a generous and comprehensive menu of services available to low-income seniors. Under its Medicaid Waiver, Washington’s DSHS provides for three contractual Boarding Home programs (Assisted Living, Enhanced Adult Residential Care, Adult Residential Care), and three in-home assisted living options to seniors (with services provided by an Independent Provider, Home Care Agency, or Cluster Care), with services reimbursed by the State.

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Washington State Programs:

Washington State is a leader in the development of a system to provide services for its seniors and adults with disabilities. Services provided in institutional (nursing home) or community residential (boarding home and adult family home) settings are required to obtain a license and contract before they begin operations and admitting Medicaid residents. Services may also be provided in the client's own home or apartment.

Clients may be either private pay or have their required services paid for by the Medicaid program. To provide services to Medicaid clients, a licensed facility must obtain a contract with the Department of Social and Health Services (DSHS). This contract provides additional regulations beyond the licensing requirements regarding the services provided and, in some settings, specific standards for the physical facility itself. Medicaid clients receiving in-home services must use approved providers to comply with DSHS regulations.

The following is a description of the housing-with-services delivery options provided by the Washington State DSHS – Aging and Disabilities Services Administration (ADSA), to low income seniors and adults with disabilities under the State's Medicaid waiver program.

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Licensed Facilities

Medicaid eligible individuals may choose to receive services from three categories of licensed facilities

Nursing Homes are licensed facilities governed by federal and state regulations providing a full range of medically supported residential services.

Boarding Homes refer to any home or other institutional setting which is maintained for the express purpose of providing board and domiciliary care to seven or more aged persons not related by blood or marriage to the operator. In order to provide services to Medicaid residents, a facility must have a contract with Aging and Disabilities Services Administration. ADSA has three types of contracted services provided in Boarding Homes:

Assisted Living (AL) provides services in a licensed boarding home with an Assisted Living contract. Resident services may include room, board, assistance with activities of daily living (ADL) and institutional activities of daily living (IADL), and limited nursing services. Services are provided in a private apartment-like setting with a limited kitchen and private bathroom.

Enhanced Adult Residential Care (EARC) provides services in a licensed boarding home with an EARC contract. Services may include a shared room, meals, limited nursing services, assistance with ADL and IADL, and supervision.

Adult Residential Care (ARC) provides services in a licensed boarding home with an ARC contract. Services may include a shared room, meals and supervision.

Adult Family Homes (AFH) provides services in a residential home setting licensed as an AFH with an AFH contract. An AFH can provide services for two to six unrelated adults. Services may include room, board, assistance with activities of daily living (ADL) and institutional activities of daily living (IADL), and limited nursing services.

Setting	Services/Facilities											
	Negotiated Service Agrem't	Personal Care	Room and Board	Supervision	Nursing Services	Private Unit	Private Bath	Kitchen	Activities	Assist- w/ External Serv'ces	Nurse Delegation	Personal care and Supplies
Nursing Home	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No	No	Yes ¹
Boarding Home <i>Assisted Living</i>	Yes	Yes	Yes	Yes	Yes ²	Yes	Yes	Yes	Yes	Yes ³	Yes	Yes ⁴
<i>Enhanced Adult Residential Care</i>	Yes	Yes	Yes	Yes	Yes ⁵	No	No	No	Yes	No	Yes ⁶	No
<i>Adult Residential Care</i>	Yes	Yes	Yes	Yes	No	No	No	No	Yes	No	Yes ⁷	No
Adult Family Home	Yes	Yes	Yes	Yes	Yes ⁸	No	No	No	Yes	No	Yes	No

^{1,4} At no additional cost to the resident, provide generic personal care items such as: soap, shampoo, toilet paper, toothbrush, deodorant, sanitary napkins and disposable razors.

^{2,5} Intermittent nursing services available 24 hours a day 7 days a week

³ External services means a BH may allow a resident to choose a home health agency, hospice provider, etc to provide resident arranged services.

^{6,7} A licensed BH can do nurse delegation throughout the facility

⁸ Nursing services are available in AFH run by a RN, LPN or a nurse delegator

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In Home – Personal Care Services:

Personal care services promotes independent living, prevents institutional placement and overcomes common barriers of the frail elderly to living at home. Assistance with personal care services enables a client to remain in or return to their own community through the provision of coordinated comprehensive in-home support services. Contracts for home care, whether traditional home care or cluster care, will be between the AAA and the home care agency or independent provider.

Cluster Care Services:

Cluster care is a contract between a Home Care Agency and a grouped setting of Medicaid qualified individuals to receive services. Cluster care would be an option when there are sufficient aggregate hours of personal care in a location. When that point is reached, it will require coordination between DSHS, the AAA, home care agency(ies), and the housing provider. A Cluster Care contract calls for all the hours allocated to “in-home” services to be totaled up. Based on the savings from “clustering,” locating individuals in close proximity, such as administration, travel and service delivery efficiencies, the contract calls for delivering all the services with 80 percent of the total hours otherwise necessary.

The services a person receives under Cluster Care will depend upon the Medicaid program for which they are qualified – COPES or MPC. So the contract sets the performance and payment standards under which the service provider is to deliver the services to qualified individuals. The services remain the same as in-home under COPES or MPC.

Services are Provided Through the Following Programs:

The Medicaid Waiver program is administered by ADSA. Clients need to be income and functionally qualified to be eligible for Waiver Services. Depending upon their income, clients may participate in the payment of the costs associated with residential services by using their personal income to pay for all or part of their room and board expenses and some of their personal care services. Participation (co-pay) is computed according to individual circumstances. Persons who have an income that is not above the federal poverty level (currently \$749/mo) are not liable for participation. The amount of participation for people with incomes higher than the federal poverty level would never leave them with less than the federal poverty level income.

Client’s access to ASDA administered community residential and in-home services depends upon two factors:

Financial, and
functional eligibility determinations.

Following is a brief description of the Medicaid and the State programs that fund services for ADSA clients in residential and in-home settings. **Assistance with personal care** tasks is provided and funded through one of two funding sources depending on the client’s financial and functional eligibility:

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Washington State Medicaid Waiver Program:

Community Options Program Entry System (COPES) Waiver Services eligibility requires that a person is functionally eligible for nursing facility care:

a. and needs substantial or total assistance with two or more of the following tasks:

Eating	Toileting	Ambulation	Self-medication
Transfer	Positioning	Bathing	

- b. has cognitive supervision needs and requires supervision with one or more of the tasks in a. above; or
- c. requires minimal, substantial or total assistance in three or more of the tasks in a. above; or
- d. currently resides in a nursing facility and is unable to return or remain in the community without assistance with one or more of the COPES services listed.

COPES available services include:

- 1. Personal care
- 2. Environmental modifications
- 3. Skilled Nursing Service
- 4. Transportation service
- 5. Personal emergency response system
- 6. Home health aide service
- 7. Adult Day Care
- 8. Client Training
- 9. Home Delivered Meals

Washington State Medical Personal Care:

Medical Personal Care (MPC) service eligibility requires that a person has unmet need for substantial assistance with at least one direct personal care task, or have unmet needs for minimal assistance with three direct personal care tasks.

MPC does not require client participation in the cost of care. People whose only income is SSI, and who need help with activities of daily living will qualify for MPC. They keep all of their SSI benefit.

Eating	Toileting	Ambulation	Self-medication
Transfer	Positioning	Specialized body care	
Personal hygiene	Bathing	dressing	

MPC available services include assistance in the following tasks as needed:

- 1. Ambulation
- 2. Personal hygiene
- 3. Eating
- 4. Bathing
- 5. Positioning
- 6. Transfer
- 7. Body care
- 8. Self- medication
- 9. Dressing
- 10. Toileting

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Proposed Demonstration Projects:

Cowlitz Tribe:

The Cowlitz is a newly recognized Tribe with no reservation or large land holdings. The approximate 2650 enrolled Tribal members are scattered among a population of 7300 Native Americans over a five county area in southwest Washington. The Tribal administrative center is located in Longview, WA.

Using Native American Housing Assistance and Self-Determination Act (NAHASDA) funds, the Cowlitz Housing Authority purchased the St. Mary's Convent and school near Toledo, WA, and are attempting to develop it into a housing and services delivery center for the Tribe. The St Mary's facility is being developed as a center for Tribal social services, with expanded services and support programs to meet the needs of the Tribal Elders, many of whom attended school there. It presently houses the Meals on Wheels program and provides Senior meals programs on Mondays and Fridays.

We met with Larry Coyle, Housing Authority Director, who is leading the effort within the Tribe to develop a continuum of services for elderly tribal members and their families to bring the tribal members and cultural traditions back together. The plan includes the redevelopment of the convent into an assisted living facility. St Mary's would be a place for the scattered senior population to "come home" to the historic center of their traditional Tribal lands.

Census information for the area immediately surrounding the facility indicates an aging Native American population with 25-30% of the total over age 65, and 12-16% over the age of 75. The Housing Authority is in the process of developing a housing needs assessment for tribal members and the community, focusing on the service and affordability needs of the elderly.

Cowlitz Elderly Demographics and Situation:

A substantial percentage of the Cowlitz seniors exhibit a critical need for assisted living. The seniors of the tribe need assistance in addressing their supportive services requirements. According to the 2000 Census, the following are some indicators of those needs:

- Nearly half of the elderly have some form of disability. Those disabilities increase as they age. 46% of males between 65 and 74 years old claimed some disability. That increased to 58% for those over 75 years of age. The change is even more evident in females, with 37% between 65 and 74 indicating some disability, rising to 54% of those over 75 years of age.
- One-third of the elderly have very-low or poverty-level incomes. Very-low incomes (below 50% of the Area Median Incomes) increase from 29% for those between 65 and 74, to 48% over age 75 – a 36% increase. Poverty levels also increase with age, from 9% of the elderly between 65 and 74 years to 16% of those over 75 years.
- The elderly homeowners and renters pay a large portion of their incomes for housing. One in five homeowners pays more than 30% of their income for housing, with more than one in ten paying more than 50%. For renter households, the burden is even heavier, with two in five paying more than 30% of their income for housing and more than one-tenth paying more than 50%.

Elderly Needs ⁹	W/Disabilities		Household Income		Housing burden	
	Males	Females	Very-Low	<Poverty	Homeowners	Renters
Age 65-74	46%	37%	29%	9%	20%>30%	41%>30%
75 and older	58%	54%	48%	16%	11%>50%	11%>50%

⁹ US Census Bureau, Census 2000, Summary File 3 (SF3)

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Colville Reservation:

The Colville Reservation represents 8500 members from twelve bands of Northwest Indians. They have an aging population with few service support options other than the Colville Tribal Convalescent Center, the Tribally owned nursing home in Nespelem. Seniors live in dilapidated housing, generally overcrowded, with few services available as they "age in place."

We met with Sally Hutton, Nursing Director of the Convalescent Center; Yvonne Misiaszek, Tribal HHSD Director; and Larry Winders, Director of the Tribal Housing Authority, to discuss the possible development alternatives for meeting the aging-in-place needs of the elders on the reservation. We analyzed the survey they had conducted of the desires of their population.

Colville elderly demographics and situation:

The elderly have critical needs for assistance in daily living services throughout the Colville Reservation. Some of the most telling indicators of those needs include:

- More than half of the elderly indicate they have some form of disability, and the incidence of those disabilities increase as they age. 53 % of males between 65 and 74 years of age claim some disability. That increases to 58% when over 75 years of age. The change is even greater for female tribal members, with 46% indicating some disability between 65 and 74, and rising to 63% over 75 years of age.
- A large proportion of the elderly have very-low or poverty-level incomes. Very-low incomes (below 50% of the Area Median Incomes) increase from 36% for those between 65 and 74, to 49% over age 75 – a 36% increase. Poverty levels increase as well, from 24% of the elderly between 65 and 74 years to 30% of those over 75 years.
- Elderly homeowners and renters pay a high percentage of their incomes for their housing. One in four homeowners pays more than 30% of their income for housing, with one in ten homeowners paying more than 50% of their income for housing. Renting households are even more heavily burdened, with nearly one-third paying more than 30% of their income for housing and one in eight renters paying more than 50% of their income for housing.

Elderly Needs ¹⁰	W/Disabilities		Household Income		Housing burden	
	Males	Females	Very-Low	<Poverty	Homeowners	Renters
Age 65-74	53%	46%	36%	24%	23%>30%	31%>30%
75 and older	58%	63%	49%	30%	10%>50%	13%>50%

Under Sally Hutton's direction, the Tribe conducted a Tribal Elder Health Needs Survey in the spring of 2003. 80 completed surveys were returned. Some of the results of the survey that are significant for this report include:

- While 24-30% of the elders appear to be income qualified for Medicaid-supported assistance, only 5% of the respondents indicated they were using the services.
- The respondents overwhelmingly (90% said yes) approved the need for some form of assisted living being made available, but want it where they currently live – in the four primary communities on the reservation – in Keller, Nespelem, Inchelium and in Omak.
- Generally one in eight indicated a personal need for assistance with one or more of the following: transportation, assistance with medications, home making and cleaning, meals, handicapped accessibility modifications.

¹⁰ US Census Bureau, Census 2000, Summary File 3 (SF3) Colville Reservation

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Assessing the Need:

It is clear there are substantial unmet needs for assisted living services in Tribal communities. Both the Cowlitz and the Colville Tribes began by exploring an assisted living solution that would combine both housing and services – basically either a Boarding Home or Adult Family Home alternative. They have identified problems in meeting regulatory guidelines, and enduring perceptions of potential residents that they believe can't be overcome.

Census data from the Colville Reservation (no such Census data is available from the scattered families of the Cowlitz) confirms problems of Tribal poverty, particularly among the elderly. The median household income on the Colville Reservation in 2000 was \$27,826, only 60% of the State of Washington's \$45,776 median household income. Poverty levels among the elderly are nearly three times the poverty of the state's comparable age groups. And family assets, of which owned homes are typically the largest single asset, lag even more significantly with home values at only 43% of the statewide value.

	Median Household Income	Poverty Rate		Median Home Value
		Age 65-74	75 years and older	
Colville Reservation	\$27,826	15.8%	15.8%	\$71,900
Washington	\$45,776	6.5%	8.6%	\$168,300

For a significant number of the elderly, access to Medicaid provided services is crucial to their continued well-being. In evaluating assisted living choices with Tribal leadership from the Cowlitz and the Colville Tribes the preferred alternative appears to be some form of in-home services, or Cluster Care. Considerations related to the development of an Adult Family Home or a Boarding Home decision included:

- Under residential care programs, for those on SSI subsistence, the resident of a Boarding Home or an Adult Care Facility turns over all their income to the provider except for a subsistence Personal Needs Allowance (\$58.84/month). For the more than 200 grandparents living with their grandchildren, 125 (59%) are responsible for their grandchildren's care. The frequently expressed perception is that those families depend on the elder's income for their sustenance. Many of the elders believe that foregoing their financial help to families would be culturally irresponsible.
- In a scattered site setting such as exists on the Colville Reservation, and for the Cowlitz for slightly different considerations, a fixed Boarding Home or Adult Family Home does not appear to meet their elderly assistance needs. In their survey of seniors, the response was support for a set of services—not a facility. The Cowlitz are seeking to serve a broader range of seniors with a continuum of service supports that also meets the elders preference to age-in-place at the St. Mary's Site near Toledo.
- Neither tribal group expressed a desire to expand health-care facilities beyond those already available. They have made a distinction between services and facilities. They are seeking to develop a more comprehensive program of outreach and support for elders in their own family and neighborhood settings, thereby allowing more of the seniors to have access to and receive the benefits of assistance with their daily living activity needs.

There is great concern among Tribal leaders about the lack of services and supports for the elderly. The obvious advantage of a residential care facility is that there is accountability and a presence available to the seniors. The lack of participation (only one in five of the respondents to the Colville

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Elders Survey indicated they were receiving Medicaid supported assistance) and access to Medicaid can be seen as proof of the need for such a program. The Tribal leaders we met with were determined that an in-home care or Cluster Care model would be the preferred alternative for addressing the needs of the frail elderly more fully.

Potential Solutions / Summary:

An in-home services or Cluster Care model provides a flexible menu of services to the elderly in their own homes or apartments and thus offering a wide range of supports to the elderly. The concept appears to offer the most effective option for the tribal elderly. The range of programs available through DSHS/ADSA can meet the needs of nearly all of those elderly while requiring less than full time nursing care. Both in-home care agencies and individual providers will be contracted with and under the supervision of the local AAA. Washington State regulations require that the agency providing the housing be independent of and legally distinct from the agency providing the in-home services. The following is a description of how in-home or Cluster Care models would work for the two Tribal groups we studied:

Cowlitz

The proposed plan to develop an elderly living campus on the St. Mary's Convent site appears sound financially and programmatically. The Cowlitz Housing Authority can develop the 20 elderly apartments in the St. Mary's Convent as small independent efficiency apartments for the frail elderly. They would use the dining and community room for meals and for community activities and social events. Activities conducted there would not be restricted to the use of residents, but can bring other community, family and friends to the site, enriching the social experience of the residents there.

The old school building would be developed into one-bedroom units for the more independent-living individuals and couples. They would participate in the social and cultural events in the newly constituted Tribal Cultural and education center which will be accessible to all tribal members. The existing school multi-purpose building will be expanded to serve a wide range of community activities, bringing the scattered Tribal activities together into one center.

The Housing Authority would coordinate with an independently constituted home-care agency, created either through the Inter-Tribal health care program or through another private agency, to provide for a full range of in-home services to the residents. Once established, the home-care agency could also provide services to the elderly living in their own homes adjacent to the center. DSHS/ADSA would contract with the local AAA for Medicaid services and case management for persons living relatively independently in their own homes or apartments. The AAA, in turn, would contract with home care agencies and individuals to provide the personal care and other services. It is not likely that the needs of the seniors would constitute a full-scale "cluster care" program at the outset, but would grow into a complete program as the facility fills and as the residents begin "aging in place."

Colville

The Convalescent Center in Nespelem acts as the center for skilled nursing care on the Colville Reservation. It can expand its programs – helping assure that all the elderly in need of service supports can have access to Medicaid funded services. In close collaboration with the clinics in the other three communities of Keller, Inchelium and Omak, the Convalescent Center would become, or develop a

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separate, home-care agency to contract through DSHS/ADSA and the AAA to provide Medicaid services and case management services to the elderly in each community. People will be free to choose to have their care provided by the agency or through an individual provider, or a mix of the two. If the program can be efficiently managed through the Convalescent Center and coordinated with local clinics and the Area Agency on Aging for meals and other services, it can offer the elderly a full range of service supports – allowing them to remain in their homes and communities.

They would then expand the outreach of the Housing Authority to upgrade existing elderly housing, making their housing fully accessible, weather-tight and assuring a healthy living environment for them to receive assistance and expanded care. The Housing Authority would continue its focus on the production, maintenance and operation of its housing, independent of service support responsibilities of the elderly they house.

In both cases, the Tribal housing authorities can focus their attention on the development of appropriate senior housing solutions for their elderly. Utilizing HUD 202, USDA 515 and other non-Tribal housing resources such as HOME, FHLB and Tax Credits they can expand the supply of senior housing, as well as a broad scope of housing-with-services to meet the needs of their tribal elderly.



RCAC staff is committed to help find solutions to housing and community development challenges facing rural and Tribal communities throughout the West. If you think we could be of further assistance to you and your community, please feel free to give us a call:

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Rural Community Assistance Corporation
is dedicated to assisting rural communities
achieve their goals and visions by
providing training, technical assistance
and access to resources.

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Resources and Programs for Assisted Living List of References

Washington Department of Social and Health Services

Washington Administrative Codes (WAC) relating to long term care are listed below.

WAC 388-71 -- Home and community services and programs.

<http://www.leg.wa.gov/wac/index.cfm?fuseaction=chapterdigest&chapter=388-71>

WAC 388-76 -- Licensing regulations for Adult Family Homes

<http://www.leg.wa.gov/wac/index.cfm?fuseaction=chapterdigest&chapter=388-76>

WAC 388-78A -- Boarding Home Licensing Washington Administrative Code (WAC) - Boarding Homes Licensing Rules.

<http://www.leg.wa.gov/wac/index.cfm?fuseaction=chapterdigest&chapter=388-78A>

WAC 388-110 -- Contracted residential care services: Assisted living services, enhanced adult residential care, and adult residential care.

<http://www.leg.wa.gov/wac/index.cfm?fuseaction=chapterdigest&chapter=388-110>

Creating Community-Based Assisted Living Housing, Blake Chambliss and Elisabeth Borden,
Published by: Rural Community Assistance Corporation, 1998.

hud.gov	U.S. Department of Housing and Urban Development
dshs.wa.gov	Washington Department of Social and Health Services
rcac.org	Rural Community Assistance Corporation
ncbdc.org	National Cooperative Bank Development Corporation
aahsa.org	American Association of Homes and Services for the Aging
usda.gov	Rural Development - Services and Programs
census.gov	U.S. Census Bureau

ONAP APPENDIX

There were several purposes in commissioning this study. Two major goals were to shed some light on the challenges of blending funding for elder care and the second was to encourage discussion on possible alternatives for Tribes, TDHEs, and tribal members. This Appendix is being added to RCAC's study to continue the dialog. The Appendix discusses issues of NAHASDA housing programs interfacing with Medicaid assistance for personal care services. The references to both programs are for general discussion purposes and any Tribe or TDHE planning an elderly project with Medicaid funded services should discuss the plan with the local HUD office as well as the state agency funding Medicaid services.

At this point the reader may be asking himself or herself, why go through all of the work with the State when we have HUD NAHASDA funding for low-income housing? Elderly housing is NAHASDA eligible; why not just build the project?

The answer to those questions is **funding for needed personal services**. Tribes and frail tribal members need funds to pay for personal care services (see Study, page 9). Such services are generally eligible under different Medicaid or Medicare programs, but typically are not eligible for funding under the HUD/NAHASDA program.

The statutory and regulatory basis for all HUD rental-assisted housing programs assumes independent living by the resident. This is the assumption of HUD multifamily, public housing, and Indian housing programs. With rental assistance (which includes housing and utilities), the resident is presumed to be able to live and manage their affairs on their own. The regulations go so far as to prohibit using HUD housing assistance funds for services (meals, personal, or nursing care) in several housing programs.

The prohibition against services extends to the one program that provides rental assistance to non-independent living facilities. The HUD Capital Grant Program Section 811, Group Home for Persons with Disabilities, provides for group home design and common living facilities to include a caregiver living on site. However, even this program does not breach the prohibition against funding services. The funds for the caregiver and all personal services needed by the group home residents must come from other sources.

How can Tribes use NAHASDA for frail elder needs?

- *Independent living elders.* Tribes have always used HUD funds for construction and operation of independent living elder homes, in both individual and multifamily style buildings. Such housing continues to be eligible.
- *Frail elders:* This is the challenge of the study. As elders age, they typically become dependent upon others for personal care such as meals, dressing, and other needs. NAHASDA requires the home or apartment be designed as independent living, but where care is needed, allows a caregiver to live on site or visit as necessary. In a multifamily building or project, the physical structure may include community facilities such as kitchens and meeting areas, but services must come from other funding sources.

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If NAHASDA can build a project and Medicaid can fund services, why not build a true assisted care facility?

Medicaid eligible financial assistance in an assisted care facility general covers:

- **MEALS:** The program generally requires that a licensed home provide three nutritious meals per day plus snacks.
- **SERVICES:** Services as needed by the tenant include assistance with walking, bathing, dressing, transfer, using the toilet, and eating. It includes 24-hour monitoring, housekeeping, laundry, health monitoring, medication assistance, social and recreational activities, and assistance with other daily activities. Medicaid reimbursement for services varies with the level of services provided (see Study, pg. 9).
- **RENT:** Rent payments cover the cost of building operation and maintenance.

State programs providing Medicaid support are different between states. Consequently Tribes may design and operate an Assisted Care Facility in some states more easily than Tribes in other States. In Washington State a facility is licensed as an assisted care facility, which must provide the whole package of services. NAHASDA rules apply to the rent and where the rent is part of the Medicaid package, it is difficult to adjust the different requirements. In other States the program may provide separate allowances for each category and it would be easier to incorporate both NAHASDA and a Medicaid contract in the same facility.

Other issues include NAHASDA requirements for: units being capable of independent living and assisted living restrictions on full kitchens; Medicaid's mandatory enrollment of all residents in a facility; and the payment of Social Security or other income to pay for personal services to the extent the resident has resources; and State licensing and inspection requirements. These will remain issues that must be resolved on a State-by-State and Tribe-by-Tribe basis.

So with all of these impediments, do Tribal elders have any opportunity to access the Medicaid assistance for which they are eligible?

Yes, in the long term, working with the various programs will reduce the conflicts and clarify the confusion. In the short term, "Tribal Elder Services Department" should consider the recommendations of this study. Expand the discussion to providing services rather than providing facilities. Consider expanding tribal capacity to provide "In-Home-Personal Care Services" and "Cluster Care Services" (pg. 10). Tribal capacity may be developed by training tribal members to provide care service, or networking with an already existing care service provider or non-profit. The titles, acronyms, and fees are Washington State, but similar services should be available in other States.

The In-Home Care Service allows the elder to live at home as long as possible and still get specialized care for specific needs. The home care provider visits the home on a scheduled basis to assist the elder in their qualified personal services. Since the eligibility, fees, and Medicaid reimbursement are individual need and income related, services could be provided regardless of whether the elder's housing is HUD or non-HUD assisted, rental, Mutual Self-Help, or privately owned housing.

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Cluster Care Services builds on the In-Home concept by encouraging grouping of recipients in the same generally area and contracting with a single service provider. It promotes efficiency and blends well with Tribes who have provided elderly housing projects, which now have elders aging in-place who need personal care services. The service provider can efficiently visit several different homes grouped together and provide the personal assistance as scheduled, and based on need (see pg 11). The concept could be incorporated in a new project and NAHASDA could include kitchen and community space for meal or other services to be provided by other sources.

Which Tribal Department should manage the care providers?

The skills and background to oversee an elderly care service program are generally developed from working in the health or human service fields. The section above refers to a specialized group or department as “Tribal Elder Services.” Such a department can specialize in elder need-based services and funding development for such services. The type of program developed will depend upon the needs of a tribe, its population, and partners. Larger tribes such as Colville may develop staff to manage and provide services directly under contract with Washington State Department of Social and Health Services. Smaller tribes such as Cowlitz may just develop a senior care counselor, or contract with a local non-profit, who will counsel the elder and family on options available for assistance and introduce them to a Medicaid approved contract service provider. The senior will contract with the provider for services, and Medicaid will reimburse the contractor for eligible costs.

The program should not reside in the housing department or TDHE. Maintaining compliance with HUD and other housing programs plus developing, managing, and maintaining the housing stock and tenant compliance is challenging and requires different skills. Also the elderly client group requiring services may be different from those enrolled in the housing programs. Since the meals and personally services are generally not NAHASDA eligible, the housing department lacks funding for such activities.

Should there be agreements between housing and elder services?

An agreement or MOU is recommended between the housing and elder service departments when a more complex “cluster care” type facility is planned. Such an agreement was negotiated between housing and elder services on the Lummi Reservation when one of their facilities was converted to cluster care type services. Housing agreed to manage the building, tenants, and maintenance pursuant to the HUD low-rent requirements. Elder Services agreed to provide the personal care services, manage and maintain the kitchen and dining areas for meals and community service. It is a new relationship and the issues are worked out as they develop.

Other types of agreements could include levels of cooperation, assistance in handicapped accessibility issues, or additions or modifications to improve in-home care of elder relatives by family members.

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Is Cluster Care or In-Home Care the final word for blending NAHASDA with Medicaid?

No. The concepts and tools for helping frail elders and their families are still in their infancy. There is potential for progress in several areas.

- Elder Day-Care facilities and services. The burden of caring for a failing parent or relative can be reduced if there are “day care” facilities where they can be looked after for a few hours during the day. These are set up in several cities and can provide care daily or on an as-needed basis during a day. Tribal needs are often smaller, consequently more challenging to develop and maintain, but consideration for developing such services should be part of the package when discussing elder services.
- Adult Family Home or Group Home. Cluster Care and In-Home Care models work well within a supportive family or social network. The services are added to an already existing support system. When such support is not available or it is stressed to the point of breaking, other living arrangements may be necessary. In most Indian communities, the group needing such a high level of care is still too small to support a large assisted care facility.
- An Adult Family Home or Adult Group Home may fit such a small market. Individuals or companies who provide care services under state licensing and inspection and reimbursement develop these homes. They provide housing, meals, and services for 4 to 6 people in a group home residential setting. In this program the client’s resources such as Social Security are required to contribute for his or her meals and personal services. It is not the preferred option by most families, but where no other alternative is available, such a facility can care for failing elders in their community. The challenge is to develop and train tribal members, tribal non-profits, or tribal elder service departments who wish to develop adult family homes. There are also regulatory issues that will need to be resolved with NAHASDA. These issues will vary between different tribes, states, and projects proposed so it will be necessary to work with the local ONAP Office.
- Other variations and funding sources: As stated earlier, there is no single program that will fit all needs. States develop different programs for assisting elder communities. There are also different federal programs. For example the HUD Section 202 program for elderly provides Capital Grants to non-profits for developing independent elderly complexes. An accompanying grant now can provide limited funding for a service coordinator. The USDA has a Section 515 Program, which can develop elderly housing. Rental vouchers, low-income tax credits, or state bond programs offer potential for blending with either NAHASDA or Medicaid funding. It is important to develop expertise and include as many programs as possible so the right tools are available to assist the tribal elders needs.

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- The issue of providing long-term care for elders is also an issue with Health and Human Services. The website for the Centers for Medicare & Medicaid Services consultation issues indicates Tribes have asked for assistance in developing options for home and community based options for long-term care. (<http://cms.hhs.gov/aian/summiss.asp>)

Item #16 on the list of the Centers for Medicare & Medicaid Service's (CMS) Consultation Issues indicates:

“Home and Community-based Long Term Care in Indian Country: Tribes have indicated their desire to operate their own long-term care programs for elders. They have asked for assistance from CMS in pursuing home and community-based options to facility-based, nursing home care.”

Decisions between Health and Human Services/Indian Health Service and Medicaid/Medicare Programs will also impact how future programs could be designed and (hopefully) provide additional funding sources for assisting frail tribal members with personal services.