Senior Living

The Financial Viability of Building and Operating Household Projects

Once considered an impractical fringe approach, senior living practitioners and other stakeholders now accept – if not embrace – the concepts of the household model. With the fundamental precept of emphasizing the dignity of the individual through resident-directed care in a home-like setting, most people can agree that the household model is a goal to which senior living organizations can aspire. But is it financially viable?

Because the household model concept is relatively new and has taken off only over the last decade, data are just now coming available to indicate what works, and how. While there is no definite number of how many household projects exist (whether described as Green Houses, beehives, pods, or otherwise), some numbers suggest there are between 250 and 500, or 1.5% to 3% of about 16,000 nursing homes nationwide.

Basic examination of the financial case for the household model reveals that cultural change is not just the basis for improved care; it is also the key to feasibility. Any attempt to modify or construct facility layouts in pods or houses without simultaneously spending significant time and resources on workforce retraining are doomed to overstaffing, inefficient labor use, and inconsistent care. However, prudent designs combined with versatile, well-trained staff have been proven to succeed.

Can it be affordably financed?

In addition to the daunting challenge of effectuating the cultural change that is its basis, would-be adopters of the household model must consider the effect on an organization’s bottom line, not to mention the first step – financing changes to or erection of the physical plant.

Obviously, the household model requires a layout different from traditional senior living structures, which range from institutional to resort-like. Based on 12 recently constructed or proposed projects in which Lancaster Pollard is participating, it was found that skilled nursing household communities have roughly the same square footage per bed as traditional skilled nursing and assisted living designs. While resident space is typically larger in the household design, dedicated common space – especially single-function rooms – is reduced or eliminated.

Recognizing that the building cost is roughly equivalent under each model,
the relevant considerations are: What is price elasticity in the market area? What is the potential for Medicaid residents (for skilled nursing), what is the Medicaid capital cost reimbursement system, and what is the average market occupancy and growth potential? That is, the same questions an organization and lenders ask under the traditional model.

The market must also dictate room configuration. While the household model is often thought of as offering all-private rooms, this will not be feasible in every market, and providers must adapt to their local situations and payor mixes rather than adhere to a “preferred” conceptual orientation. A different layout and care delivery protocol will not change the characteristics of the market.

From a financing standpoint, creditors and enhancement providers ask the same questions that an organization’s board or ownership does. How much debt will be necessary to bring the household project to fruition? Can the design and operating plan support the debt service? Is the design consistent with the mission and culture of the organization?

Financing options vary for household projects. Bank-qualified financing is an option to involve local banks in smaller projects. FHA-backed financing has also been successfully used, as have conventional bonds supported by an obligated group or financial guarantor. For states with assisted living Medicaid waivers, low-income housing tax credits have also been used.

Can it be affordably operated?
The traditional health care workforce - with strict divisions of labor and little cross-training - is not functional in a household environment, according to consultants and providers who have made the leap. The new model relies on a flexible staff that can perform multiple tasks such as housekeeping, laundry, and basic food service in addition to routine resident assistance functions. Industrial engineering research suggests that such job designs are superior for building morale and reducing fatigue and/or stress-related injuries and accidents, so ancillary benefits are a byproduct.

With central control functions dispersed throughout the campus to better connect with resident needs – a fundamental requirement in resident-directed care – administrative staff can be reduced, and other roles can be combined as staff cross-train.

In addition, providers and project designers must consider the reality of operating a service business. In a household model with 10 or fewer units, staffing might include two or three staff members per module. Such a situation, however, does not provide much flexibility, and absenteeism can greatly stress the system, necessitating the addition of a staff member to create some redundancy. Since the staff level must be able to provide this redundancy anyway, the provider is best served by adding units up to the point that this level of staff can comfortably absorb absences without a negative impact on resident care. The experience of Lancaster Pollard’s clients indicates that a more appropriate model seems to be slightly larger houses (16 to 20 units) with a flexible staff and some labor division. Providers and industry consultants indicate staffing a community with 16- to 20-unit households is similar to staffing the 10-unit module because of this need for a certain level of staff redundancy, leading to a more stable labor force and additional revenue generation.

Performance Reviews
National data on operating and net income margins and/or expense data for stand-alone household models are limited, but an analysis of Medicaid cost report data for three household projects in Kansas – a state with many prominent household projects – indicated that nonprofit run household projects compare favorably to the other facilities in the state. Nonprofit household models slightly outperformed nonprofit senior living providers on average in Kansas, though they underperformed for-profit facilities.

Any attempt to change delivery practices at a licensed seniors care facility is likely to require training for the state regulatory bodies that survey health care facilities. Just as providers have a legacy of care practices, regulators have certain expectations and a comfort level with the status quo. The potential financial impact of regulatory influence, of which there is not enough history to produce good data, must be considered. This concern may be lessened in coming years, however, as recognition spreads of baby boomers’ changing expectations in the delivery of care.

Early adopters of the household model and many others think the resident-directed care protocol that is the basis for the household model is necessary to satisfy the new market. It remains to be seen when and if the household model provides a true marketing advantage, but the intuitive appeal is strong.