

# Developing 21st Century Models of Care for Seniors in Challenged Urban Settings

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This is an account of the revitalization of an urban area as its hospital closed but was replaced by community involvement, business, and new healthcare services to meet the needs of the aging people in the surrounding community. **Key words:** *community, senior care, urban revitalization*

## IMAGINE

Imagine one of the poorest ZIP codes in the poorest city in the United States.<sup>1</sup>

Imagine this city is in a state that has the highest unemployment rate<sup>2</sup> and is home to the Big Three auto companies.

Imagine the 3 closest community hospitals serving this ZIP code all closing within the last 9 years, with no replacement hospital being built.

Imagine a city whose population between the ages of 60 and 74 dies at a rate 48% higher than their peers in the rest of the state and for the ages 50-59, the rate is 122% higher,<sup>3</sup> with rates determined *prior to* the hospitals closings.

Imagine what might happen to the senior population in these neighborhoods.

What actually is happening may be quite different—and much more encouraging—then where your imagination has led you so far.

## THE ENVIRONMENT FOR CARE OF SENIORS IN CHALLENGED URBAN SETTINGS

Recent national trends are not encouraging for comprehensive senior care.

### Changing local economies

One often-overlooked result of the shift from a manufacturing to service economy is the effect this transformation has had on seniors in these urban environments, specifically on the environments in which large heavy manufacturing was the norm. As the younger, more mobile, and employed population left for the suburbs or the Sunbelt, the demographics of these urban areas change dramatically. The senior, less affluent population is essentially not mobile. On the other end of the scale, the neighborhoods are seeing an increase in the percentage of very young, and increasingly, unemployed people—who are also less mobile.

### Pressure on pensions and retirees' healthcare benefits

The recent economic crisis is spawning multiple bankruptcies. Seniors who have relied on pension income or retiree health benefits may find their income and healthcare benefits slashed in bankruptcy courts.

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### **The subprime loan crisis**

During the loan bonanza, predator lenders sought out seniors in these markets, convincing them to refinance with such instruments as reverse mortgages based on inflated values of homes. Seniors were interested because they believed they could stretch fixed incomes to meet daily needs, including, in many cases, managing chronic disease.

### **Pressure on states to reduce Medicaid budgets**

The lifeline for seniors in challenged areas is Medicaid, which provides subsidy to many of the seniors in nursing homes. Frequently, one of the largest line items of states' budgets, even before the recent financial crisis, many states had targeted Medicaid for cuts in efforts to shore up deficits.

### **Closure of short-term stay hospitals in challenged urban settings**

In 1981, there were 5813 community hospitals in the United States; in 2006, there were 4927 community hospitals,<sup>4</sup> whereas the number of beds decreased from 4.37 per 1000 people to 2.68.<sup>5</sup> In Detroit, between the years 1980 and 2000, 23 hospitals (5899 beds) closed.<sup>5</sup>

### **Increased pressure on nursing homes in inner cities**

Pressure from states and accrediting bodies to upgrade facilities comes at a time when loans for facility upgrades are hard to find. Also, new models of care advocate different designs emphasizing private rooms and "pods," assisted living, and continuing care retirement communities. (The number of continuing care retirement communities is projected to grow 2620 in 1996 to 7700 by 2016. The number of assisted living beds is expected to grow from 370 000 beds to 980 000 in the same period.<sup>5</sup>) Older nursing homes are finding it increasingly hard to compete. In addition, staffing is an issue, with turnover rates in long-term care homes exceeding 50% annually.<sup>5</sup> States are moving toward managed

care models in an effort to reduce increases in their Medicaid budgets, providing incentives for people to stay in their homes longer. (In Detroit, between 1997 and 2003, 10 nursing homes closed and none were replaced.<sup>6</sup>)

### **DEVELOPING NEW MODELS OF CARE FOR SENIORS IN COMMUNITY**

Change can be chosen or imposed by outside forces. This story begins with a phone call from a short-term stay healthcare provider that can no longer sustain losses at its inner-city hospital. The call was placed to Dynamis Advisor's consulting staff who began working with the entities who were about to be affected by the closure of the inner-city hospital.

Critical keys to transformation of neighborhood care delivery were found by conducting interviews with organizations and people who must deal with the aftermath—those serving the people who have relied on these hospitals. The interviews involved several hundred people who, after dealing with the trauma of the news of the closure, were anxious to begin to stitch together a new model of care, a model based on interdependence and collaboration not possible before. The presence of the hospital was, in many ways, an inhibiting factor, and the emergency department treating symptoms masked the root issues: Remove the emergency department and attached short-term stay hospital beds and the central problems are there for all to see, and resolve.

A sustainable solution is complicated and takes extraordinary skill and commitment from the care providers, with a strong emphasis on commitment. But a Growing in Place model can and will work in the most distressed settings. (Growing in Place is a term utilized by Dynamis consultants that involves the design of neighborhoods based on primary healthcare, chronic disease management, education and training, and multi-income and multigenerational housing.) The work of the caregivers *providing service across corporate lines of organization in the*

*local neighborhood* is the real story, as is the case at the Samaritan Center in Detroit, Michigan.

## **INTRODUCTION TO THE SAMARITAN CENTER**

In 1999, Mercy Detroit Hospital was continuing its downward spiral. Its origin began 80 years earlier as the St Joseph Mercy Hospital (1923) and the Evangelical Deaconess Hospital (1917) built on the east side of Detroit to serve the surging population working in the automobile plants and related businesses nearby. In 1983, the city took, by eminent domain, the former hospitals and the Sisters of Mercy (now Trinity Health), consistent with its mission and commitment to these neighborhoods, built a new hospital nearby. In the 17 years the Sisters operated this hospital, it never produced a positive operating margin and, in fact, lost more than \$200 million. After an exhaustive review, with losses approaching \$2.5 million per month, the decision was made to transform the facility.

Initial interviews revealed a high percentage of services being conducted for seniors, which was not surprising given the demographics of the neighborhood. Also, not so evident was the social network the hospital was providing to seniors. Many local senior residents came to the hospital both to eat in the cafeteria and to socialize with other seniors since safe and affordable places to eat in the neighborhood simply had ceased to exist. (The health department reported an increase in diseases in the area caused by malnutrition due to lack of access to fresh vegetables and fruits after the grocery stores had closed.) The hospital's community relations staff worried about the impact of withdrawing their numerous senior activities sponsored throughout the year, such as a program called Senior Prom—an annual dance/social event for area seniors at the hospital that had become an important part of many of the seniors' life in this community.

Over a 5-month period, continuing interviews uncovered numerous other upcoming

voids in the care of seniors and other local community residents. Alternatively, several organizations wishing to occupy space at the soon-to-be-vacant hospital were also identified. They were eager to provide some essential local services, and many of these organizations could benefit from being near to each other. After 5 months, enough interest was developed to bring in financial analysts, architects, and neighborhood planners to suggest redesigns of the property based on interests of multiple potential users while also helping develop a business plan for the property's transformation.

While committing to operate a primary care clinic for the uninsured in perpetuity at their former hospital, Trinity Health no longer desired to own and operate the vast complex. This decision was consistent with the Dynamis consultants' recommendations since Trinity Hospital's expertise is in the operation of hospitals, not multitenant, multiuse urban real estate ventures. After an exhaustive request for proposal process that produced no tangible owner/developer, the consultants suggested that the larger organizations interested in occupying space come together to form a new organization to own and operate the venture. Leasing would be to themselves and an organized variety of other interested parties that might benefit from being near to each other.

In early 2001, Ser Metro, a contract provider of workforce training for the city, and Boysville (now called Holy Cross Children Services) formed a new tax-exempt organization and bought the facility for \$1. Holy Cross Children Services became the manager. The facility was renamed the Samaritan Center. (While no longer owning the facility, Trinity Health remains an important sponsor, operating a primary care clinic and providing grants for worthy initiatives.)

## **THE SAMARITAN CENTER TODAY**

Samaritan Center today is now home to more than 90 "partners" (although the

business structure is a landlord-tenant relationship, tenants are viewed as partners). Numerous providers offer services to people of all ages, with a large number of these providers serving seniors. The “neighborhood feel” allows for employees and customers of the various entities to experience a real sense of community. A great deal of the ambience is intentionally created by the owner/manager carefully managing the mix of partners-tenants, their placement in the facility, and the day-to-day experience of the people. This is not a community bound together by the Internet. It is one bound together by face-to-face daily encounters fostered by Brother Francis and Mark Owens of Holy Cross Children Services. Often the most productive “meetings” are unplanned and occur in the hallways.

The building, which once housed a community hospital, now offers the following services to seniors who live in the neighborhood:

1. *Nursing home:* The 120-bed facility is organized in 4 clusters of 30 each along the lines of the greenhouse concept, managed by a minority-owned nursing home operator. Many of the residents and their families find time to shop and obtain services in the retail section of the building, giving employment and business opportunities to local area residents, some of whom are seniors themselves.
2. *Behavioral health:* When the nearby Riverview hospital closed in 2007, the inpatient behavioral health beds were transferred to this facility and are now operated by a for-profit management company specializing in this service, which includes a 24-hour crisis center. A separate tenant/partner operates the outpatient center and specifically provides “neighborhood safety” classes to seniors living in the neighborhood who still think of it as the open and safe environment of their past. Once their clients experience support and recovery, they can work as “peer mentors” to others in crisis. Many of them go on to school for additional education and true career opportunities.
3. *Outpatient dialysis* is provided by an international corporation. One-third of the dialysis patients live in the nursing home, eliminating the \$750/wk transportation costs simply by being transported down 3 stories in a wheelchair. These residents do not have to face the challenges of the weather or the discomfort of long waiting periods.
4. *Independent senior living apartments* exist in an attractive building constructed in the parking lot. Mobile residents meet friends and colleagues for a “shopping spree” in the multiple retail shops and a few residents have been transferred into the nursing home. A strong social network is woven between residents and the service providers who tailor products to their unique interests/needs.
5. *Neighborhood support services* include family and community counseling, along with adult day care for adults with mental and developmental disabilities. The programs assist with management of issues that impede quality of life and participation in demands of school, work, and social commitments beyond family.
6. Healthcare is offered at 3 levels; urgent care, primary care, and specialty care. A clinic operated and funded by Trinity Health offers primary services and grant-supported medications at no cost to neighborhood residents with no insurance. Housed in the former hospital emergency department, the decontamination showers were converted into a spa, offering more than 4000 showers a year to the homeless along with laundry facilities. A second nurse-run clinic supported by the University of Detroit-Mercy, cares for the Medicaid and the Medicare population, and there

is a close working relationship between these 2 clinics (which share a common lobby and waiting room), so referrals are seamless. The College Nursing Department utilizes the clinic for faculty practice, clinical rotations, and research opportunities. Law school students assist neighborhood clients with legal issues, whereas engineering school students develop assistive devices for residents with physical impairment. School of Informatics students gather neighborhood data to assist with qualification for grants and programs offered by government.

7. *Retail convenience services* are identified by area elderly persons as a most preferred offering within the center. Within walking distance inside the complex is access to a barber shop, a beauty salon, a convenience store, a gift shop, a pharmacy, and tax preparation services. The gift shop owner operates a "high-end" boutique downtown but has placed an outlet in this center as a tribute to her mother. She stocks it with the highest-quality but affordable merchandise available, allowing neighborhood residents to "put it up" when they buy accessories to their clothing, 50 cents down and 50 cents per month. She helps them get "a new look" and then refers them to the beauty shop for a new haircut, or new outfit at the clothing store. Many stories were told of lives transformed when formerly house-bound individuals could once again engage in the simple act of gathering with friends for coffee or shopping for some little thing to give a new lift to their wardrobe. (The Senior Prom has been reestablished). It is, however, the respect and caring offered by these service providers that makes the biggest contribution to their clients.
8. A 1-stop shop, the largest in Michigan, offers job training/placement. Workforce development programs and services are coupled with child day care,

life skills support programs, and a Dress For Success program that provides quality clothing for the job interview. Growing categories for employment for these job seekers are healthcare related and experiential learning possibilities within the Samaritan Center are well utilized.

9. *Temporary assistance services* are offered to area residents. A travel agency takes family members to area prisons on weekends to visit incarcerated family members in an effort to maintain relationships during this stressful time. Thirty area churches have created a Welcome Home program that offers temporary housing and work opportunities for those returning to the community.
10. *Rental housing services* provide temporary housing. Once a job and salary are obtained, they can move into affordable housing.

With the many services offered across corporate lines, the Samaritan Center can offer the 1-stop convenience of continuing care retirement communities in a rich, diverse environment that is truly a community rooted in the neighborhood.

### IMPACT ON QUALITY OF LIFE

Eight years after this project began, the neighborhood surrounding Samaritan Center transformed from a hospital with 26 armed guards to a multitenant center with none. Health, safety, and quality of life have been dramatically improved as the community began to own and rebuild its neighborhood. It is a giant testimony to the power of interdependence and collaboration in a networked way. Gone are the long delays to change fostered by hierarchy and control. Gone is the fragmentation of services plagued with gaps or overlap that make integration impossible. Cooperation, collaboration, and codependence truly foster a way to provide seniors and their caregivers with a lifestyle of meaning and beauty as they contribute to the revitalization of their neighborhood.

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