

Community-Residential Care for the Frail Elderly: What Do We Know; What Should We Do?

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The rapid growth of the assisted living population over the last decade is clear evidence of the appeal of this long-term care option and of what the industry describes as its core values: privacy, autonomy, dignity, and choice.

Recently completed research in Florida highlights the significance of these values (autonomy, privacy and dignity) to long-term care consumers. In a study of quality of life in nursing homes, ALFs and in-home long-term care programs in Florida, Salmon (2001) found that the major predictor of quality of life was the degree of personal control the respondent experienced.

Those in ALFs expressed the greatest satisfaction with their quality of life and the level of personal control they experienced.

The respondents in the home care programs expressed a clear preference for home care over nursing homes, but they reported less satisfaction with both their quality of life and personal control than the assisted living respondents.

However, the assisted living industry has received considerable negative media attention over the last two-to-three years. Most of this attention has focused on the quality of care received by some residents in a few facilities. A recent GAO study (1999) found that many facilities do not provide residents, or potential residents, with enough information about costs, services and retention policies. Some facilities may not be accurately representing their services and facility rules in their advertising.

Although these media reports are not evidence of extensive quality of care problems in the industry, they have sparked discussions in some quarters about the possible need to regulate assisted living more stringently. This emerging discussion has raised concern within the assisted living industry that it could lead to growing political support for a regulatory approach based on the way we currently regulate nursing homes. Some policy and consumer advocates argue that as the population of more seriously impaired residents and those with acute medical conditions in ALFs grows, the regulatory scheme should be more medically oriented and more stringent in terms of who is allowed to enter and remain; what kinds of services can be delivered and by whom.

The potential for significant regulatory reaction to these negative media makes it imperative that policy analysts, policymakers and advocates gain a clear understanding of the currently available research findings on assisted living and

pay careful attention to the results of research as they are reported over the next several years.

This is an area where research can have an enormous impact on policy, given the nature of the dilemma facing policymakers. The tension between independence and safety, between a homelike environment and fire-safety, and between autonomy, privacy and the risk of medication errors must be carefully balanced carefully. While no one wants to put assisted living residents at unreasonable risk, it is in defining and operationalizing “unreasonable risk” that the fundamental values of both assisted living and our commitment to protect the health, safety and welfare of vulnerable persons must be weighed and worked out.

What do we know about community-residential care?

The research on assisted living has grown along with the industry over the last ten years with the most extensive and significant findings becoming available in just the last few years. Although there are still major gaps in our knowledge of assisted living and important questions that remain largely unanswered, we now have a good deal of information that can help us think constructively about the future of the assisted living industry.

Among the most important sources of information are the three reports produced by Catherine Hawes, Charles Phillips and their colleagues since 1999. These reports, based on research funded by the office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services, have begun to give us a comprehensive, empirically sound view of assisted living, which addresses, directly or indirectly, many of the issues that are most integrally related to regulation.

In their first report, *A National Study of Assisted Living for the Frail Elderly: Results of a National Survey*, Hawes and her colleagues (1999) have focused their research on a national sample of high-privacy or high-service facilities or facilities that are characterized by both, which they estimate to be about 40% (4,300) of all ALFs across the country housing about 190,000 residents. Their sample consists of 1,500 residents drawn from 300 facilities.

The second report, *High Service of High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey* (2002), contains several findings relevant to regulatory and other policy issues in assisted living. During a 12-month period, 19% of the residents in the sample facilities were discharged. Only 8% were discharged to nursing homes and almost 4% to other ALFs. Overall, 60% of those who moved did so in order to receive a higher level of care.

Only 12% of those who moved indicated, through proxy respondents (family members), dissatisfaction with the care they had received in the facility they left.

A decline in cognitive status was the only resident variable that significantly increased the likelihood of entering a nursing home. The authors also found that:

Residents in facilities with a fulltime RN involved in direct care were half as likely to move to a nursing home. When different formulations of staffing/service variables were used (any RN staffing, RN hours per resident, aide staffing, arranging for nursing care), the relationship between services and outcomes was not significant. It appears that these alternative staffing arrangements, or just better staffed facilities, are no substitute for a fulltime RN who does direct care. These findings, along with those about the effects of cognitive status, would seem to have major policy implications for aging in place.

In their third report, *A National Study of Assisted Living for the Frail Elderly: Final Summary Report (2000)*, Phillips found that resident and staff assessments of their facilities were generally positive.

- The majority of residents reported that they were treated with affection (60%) and dignity (80%).
- They also, however, reported some level of concern about staffing levels and turnover rates and 26% indicated that they needed more help with toileting activities.
- Ninety percent of the residents thought they could stay in their facility as long as they wanted to remain, but most were uninformed about policies governing retention and discharge from their facility. This supports the GAO findings and indicates a need for more public disclosure regarding these and other (service costs) policies.
- The vast majority (85%) of their respondents reported that their top two priorities on entering the ALF were the availability of a private bath (#1) and private bedroom.
- Among those who had left an ALF (19% over 12 months) most (65%) continued to identify these same privacy-oriented priorities. The other 35% of those discharged identified the presence of an RN or staff and the quality of the staff as their top two priorities.

Rosalie Kane and her colleagues (1998) found that ALFs and nursing homes in Oregon achieve comparable outcomes in terms of activities of daily living (ADL) trajectories, pain and discomfort levels and psychological well being, after controlling for differences in baseline conditions. Although nursing home residents were substantially more impaired than those in ALFs, these findings are encouraging in terms of the capacity of ALFs to accommodate “aging in place” by providing necessary healthcare services. It should be recognized that Oregon has a relatively mature assisted living industry, regulatory policies and

public funding strategies designed to maximize the nursing home diversion potential of ALFs and the opportunity of assisted living residents to exercise choice, including the decision to “age in place.” We know that there are many seriously impaired residents in ALFs across the country and not just in Oregon. In Florida, about 25% of ALF residents in 1995 had three or more ADL impairments or had serious cognitive impairments (Polivka, Dunlop and Brooks, 1997). These are important “facts on the ground” that have major implications for the future of assisted living regulation and its role in the long-term care system.

These studies are based on relatively small samples and much more research on these questions is needed. We can speculate, however, about the significance of these findings for long-term care policy generally, and regulation more specifically. For example,

to the extent that personal control and autonomy are important determinants of quality of life in long-term care, assisted living may be the optimal setting of care, including many now receiving care in their own homes.

This is optimal in the sense that assisted living may be for many frail elderly persons the best setting for achieving an effective balance between control/autonomy and supportive services including healthcare, and more human interaction to combat loneliness. For many frail elderly persons with thin or non-existent caregiver networks, assisted living may also be the best setting in which to achieve personal control and autonomy. ALFs can offer the kinds of resources, especially staff services, transportation and social activities, necessary to make the achievement of control/autonomy a far more practical matter than may be possible in many in-home environments, where achieving the same level of opportunity to exercise personal control is beyond the financial means of most individuals or the public sector to provide, or too great a burden on the individual’s informal care providers. These possibilities should be kept firmly in mind as we think about assisted living regulation and the full potential of assisted living as a long-term care program.

Indirect, but compelling evidence supporting this perspective is provided in the third Hawes et al. (2000) report.

The vast majority (85%) of their respondents reported that their top two priorities on entering the ALF were the availability of a private bath (#1) and private bedroom. Among those who had left an ALF (19% over 12 months) most (65%) continued to identify these same privacy-oriented priorities. The other 35%

of those discharged identified the presence of an RN or staff and the quality of the staff as their top two priorities.

The importance of these privacy provisions indicates that many residents value the opportunities for privacy in assisted living very highly and expect to find these provisions in place. It should also be noted that privacy is often a necessary, if not always sufficient, condition for the effective exercise of personal control/autonomy and for maintaining interpersonal relations.

Sheryl Zimmerman and her colleagues (2001) have conducted extensive survey research in assisted living facilities and nursing homes in New Jersey, North Carolina, Florida and Maryland. They broke their assisted living sample into small (under 16 residents), traditional (16 and over residents) and new model facilities (purpose built and with 16 residents), and surveyed a total of 233 facilities in the four states. Among some of the more interesting, policy relevant findings, they found that:

. . . with the exception of a discharge policy related to the inability to walk, it makes no difference whether residents are in small, traditional, or new-model facilities in terms of whether the facility is likely to discharge them based on resident characteristics. Factors that do seem to make a considerable difference are the state in which the facility is located, who owns the facility, and the age of the facility. (p. 234)

For example:

Compared with facilities located in North Carolina, facilities in Florida are more likely to have a discharge policy for residents who are unable to get out of bed, who are unable to feed themselves, or who are unable to care for their appearance. . . . For-profit status is also associated with a greater tendency to discharge for ADL-related reasons, particularly an inability to bathe, dress, or maintain continence. Finally, as the age of the facility increases, so does the propensity to discharge residents who are unable to walk, eat independently, or maintain urinary or fecal continence. (p. 234)

The new model facilities score higher on policy choice, privacy and policy clarity than the other facility types. The traditional and new-model types both provide more health and social services than the small facilities.

These findings indicate that the larger and newer facilities are better able to provide services and meet the privacy and autonomy desires of residents. Small facilities, however, may provide more familial, home-like settings that many impaired elderly seem to prefer and that they are willing to give up some privacy and autonomy in order to live in such facilities. Many may also prefer to age in place in small facilities, even in the absence of some of the health services offered by larger facilities. The major point is that potential residents should have an array of facility types, including small, less-sophisticated facilities, to choose

among. It should also be noted that smaller facilities are often more willing to take Medicaid and SSI-supported residents than larger facilities, which has major implications for state long-term care policy, as Medicaid-waiver funds are increasingly used to expand congregate alternatives to nursing homes.

Morgan, Eckert, Gruber-Baldini and Zimmerman (2002) suggest that researchers, policymakers and regulators exercise caution in defining and comparing facilities for purposes of descriptive and evaluative analysis, and for regulating the range of facilities that may be described as assisted living. Small facilities, for example, may not be able to offer the same level of control and autonomy, or service as larger, purpose-built (new paradigm) facilities, but residents, as noted above, may well find them more homelike, more affordable and accommodating enough in terms of autonomy/control, especially in comparison to the nursing home setting or even their own homes. In sum,

the advantages and shortcomings of the whole range of assisted living options should be recognized without claiming that one style of assisted living is necessarily superior to another or better designed to meet everyone's needs, preferences or ability to pay.

Policies, funding and regulatory strategies should reflect our awareness of and support for the different forms of assisted living and the need to provide the consumers with as many options as possible to choose from, as long as they are consistent with the basic values of the assisted living philosophy and basic safety requirements. This means that small facilities should not be held to precisely the same standards, which they are not likely to meet, as the larger, purpose-built, new paradigm facilities. Zimmerman, Eckert, Morgan et al. (2002) note that if regulation and funding turns on adherence to the new paradigm's parameters, it may mean the demise of the smaller facilities. This perspective will undoubtedly complicate the way assisted living is regulated, but if it results in maintaining, or supporting the expansion of the range of community residential options available to consumers of housing with services, then it should be considered worth the additional complexity.

Community-residential care may also be provided in adult foster homes, which are much smaller and less formal than conventional assisted living facilities. Adult foster care (Adult Family Care Homes) in Florida is provided in small group residential settings, usually private homes, which, in Florida, are allowed to have up to five residents. Stark, Kane, Kane and Finch (1995) have described adult foster care homes as:

. . . a cottage industry of sorts. Typically, foster homes cannot make a profit unless they have a lean staff—perhaps limited to family members of the foster care provider and a few hired helpers for peak hours. Such foster homes obviously cannot use an elaborate division of labor; they depend on a flexible

ability to handle whatever needs to be done. Ordinarily, they will be unable to care for Medicaid or low-income clientele with heavy levels of disability unless state regulation permits nursing functions to be done by foster care personnel without nursing licenses or unless (for Medicaid) reimbursement is high enough to permit contracting with nurses.

According to Kane, who has closely observed the extensive adult foster home program in Oregon, this type of long-term care setting is especially appropriate for persons with early-to-mid-stage dementia who benefit from the small scale and relatively intimate environment of foster care. Oregon made adult foster home care a major pillar of their home- and community-based long-term care system in the 1980s, and now has over 12,000 foster home beds compared to fewer than 1,500 in Florida. Oregon covers adult foster homes under their home- and community-based Medicaid waivers, but 70% of the residents are paying their own way (private pay), which reflects both the affordability and consumer appeal of the program.

In short, adult foster care in Oregon has become a mainstream long-term care option available in both upscale, elaborate homes and in modest homes in less affluent neighborhoods. The Oregon experience demonstrates that Florida is absorbing considerable opportunity costs by not maximizing the potential of adult foster care. If Florida had the same ratio of foster homes in relationship to its 65+ population as Oregon, there would be as many foster home beds as Medicaid-supported nursing home beds—over 60,000.

In a comparative study of adult foster homes and nursing home residents in Oregon, Kane and her colleagues found that functional outcomes, controlling for a wide range of client health functional status and demographic characteristics, were comparable in the two settings and social and psychological outcomes have a propensity to favor foster care. These kinds of findings should help allay fears that adult foster care cannot serve seriously impaired persons and reduce nursing home utilization.

Community-residential care, whether in the form of assisted living or foster care, is not for everyone requiring long-term care assistance, especially those with extensive, complex medical care needs. As noted by Stephen Golant (2003), “ALFs will be neither the initial nor the final home for most frail older adults who seek alternatives to nursing homes.”

Golant also points out, however, that “. . . older residents who are admitted to these facilities may be able to enjoy relatively long stays—on average as much as three years. Thus, although they probably will not age in place in their ALFs, they may receive sufficient benefits to justify their having to move again to a higher care facility.”

I am a bit more optimistic in that I think a substantial amount of “aging in place” is already occurring in ALFs and the number of residents who “age in place” without ever entering a nursing home is likely to increase in the future. I

also think that, unless the federal government expands its commitment to subsidized housing, assisted living will increasingly become the “by default” housing option for many low-income, impaired elderly persons over the next 20 years.

As the population of more highly impaired residents increases, the pressure to impose a more medical-model oriented regulatory scheme on assisted living is likely to grow. Some of these regulatory changes may be necessary on a facility-by-facility basis. On the whole however, I think they should be resisted in order to maintain the fundamental character of the assisted living model.

Implications of what we know

Before addressing assisted living policy specifically, we should recognize that the vast majority of older people and their families strongly prefer home- and community-based alternatives to nursing home care. They simply and understandably do not want to live in a highly regulated institutional environment. The primary reasons for this strong preference are the desire to maintain a modicum of personal control and to preserve their privacy and dignity to the maximum extent possible. This consumer preference is the fundamental rationale for creating a far better balanced system of long-term care than is currently available to the frail elderly, particularly those dependent on public support. Over 80% of all public long-term care funds are spent on nursing home care in most states. Both assisted living and home care should be vastly expanded in response to the deep preference among the elderly for alternatives to nursing homes. At this point, however, assisted living is probably the most under-developed alternative program, at least in the public sector. Eighty to ninety percent of the assisted living growth since 1990 has occurred in the private sector and states, on the whole, are just beginning to develop and expand their assisted living programs, primarily through Medicaid waiver initiatives.

The pervasive preference among the elderly for alternatives, including assisted living, to nursing homes should not be frustrated by excessive or inappropriate regulation.

Assisted living has demonstrated the capacity to serve seriously impaired residents effectively (resident satisfaction, quality-of-care outcomes, etc.) and regulations should be designed to maximize this potential through the use of flexible, inclusive admission/retention criteria.

Providers can help maximize this potential by providing necessary care, including fulltime RN care, for residents with healthcare conditions that require continuing care. Older people value autonomy, privacy and the opportunity to

age in place very highly (often more highly than any other criteria in judging long-term care quality) and the preservation/enhancement of these values should be the top priority in the development of assisted living regulations.

As noted earlier, for many frail elderly, assisted living is a more propitious setting for achieving these values than even in their own homes. The only sure outcome of imposing a nursing home mode of regulation of assisted living would be precisely what we have achieved in nursing homes—a rigid, institutional environment that leaves little room for consumer-direction and resident autonomy, privacy and spiritual well-being. We should pay more attention to reversing these outcomes in nursing homes and avoid creating a regulatory framework that could have the same results in assisted living.

The wide variance in assisted living regulation across the states represents a natural laboratory and every effort should be made over the next five-to-ten years to determine the relative costs and benefits of their regulatory strategies.

We need this information before we prematurely decide to move to a single national regulatory framework. The work of Catherine Hawes, Rosalie Kane, Sheryl Zimmerman and others are already developing a body of knowledge that will be very helpful in the development of reasonable regulations over the next decade. Anecdotal accounts in the media should not lead to a “rush to judgment” and the implementation of conventionally stringent regulations that could kill the very thing we should be most committed to preserving—the fundamental values of assisted living.

Serious consideration, however, should be given to Hawes et al. (2000) findings concerning the impact of cognitive decline and the role of RN care in preventing movement to a nursing home or in facilitating aging in place. Providers should be prepared to use this information in the development and deployment of their services and policymakers/regulators should monitor these areas carefully and consult closely with providers and advocates before deciding how they should be interpreted from a regulatory perspective. Clearly, however, the provision of sound dementia care and skilled nursing care are essential components of any efforts to maximize the aging-in-place potential of assisted living. In Florida, for instance, I don’t think it would be too burdensome to require that ECC-licensed facilities ensure that each resident receiving personal services has an RN assessment on a quarterly basis—monthly would be better for some residents. Most high-end facilities as well as large lower-end facilities in Florida do this already, and Maine has a requirement for regular nursing assessments. Perhaps the state could build the cost into the ALF waiver rate.

I think we could also enhance the quality of care by requiring that residents taking more than four medications have their medication regimen

evaluated by a consultant pharmacist at least annually. Pharmacists are more generally knowledgeable than physicians or nurses about medications, and physicians are usually willing to listen to pharmacists and adjust prescriptions accordingly.

Given these research findings and their policy implications, we suggest the following posture toward assisted living regulation at this point. For the most part, we think states should continue to take a very cautious approach to assisted living regulation. We need to learn more about the effects of the different regulatory schemes across the states, the impact of Medicaid waiver funding on the demographics of assisted living and a wide range of outcomes, including the extent of assisted living's capacity to substitute for nursing home care and the capacity of assisted living to provide specialty care, especially dementia care. The already valuable body of research findings will grow substantially over the next few years and help us make far more informed decisions about regulation than we are prepared to make now.

- 1) **Disclosure.** The Assisted Living Federation of America (ALFA) and other organizations have already moved to develop programs for fully informing (potential) residents and their families about what services facilities offer, how much they cost and how costs change in response to changes in resident need, aging-in-place policies, physical environments and other issues identified by the GAO as full disclosure problems in assisted living. This is an issue that probably needs to be clarified by state regulators, especially in the area of dementia care. Residents and their families should not be surprised by provider decisions.
- 2) **Fire safety.** Appropriate fire protection provisions should be part of any regulatory scheme and there may be some need to standardize requirements across jurisdictions in order to ensure efficient approaches to a uniform level of safety which does not unduly restrict access to and availability of community-residential care.
- 3) **Admission and retention criteria and staffing levels.** In order to maximize consumer choice, admission and retention criteria should be as inclusive and flexible as possible and staffing should be sufficient to meet the needs of individual residents. Restrictive criteria would keep many frail elderly out of assisted living and the quality-of-life conditions they want and force them into nursing homes as would uniform staffing standards by making assisted living less affordable. Staffing should be based on assessed resident needs and regulated accordingly.
- 4) **Negotiated risk.** Negotiated risk contracts, if clear, non-coercive conditions are met, should be permitted on an expansive basis in assisted living. The use of risk contracts will continue to evolve in response to law and regulation over the next ten years and are likely to become an increasingly important

vehicle for consumer choice and direction and aging in place. Special provisions will need to be made for those who are cognitively impaired.

- 5) Dementia care.** The industry should develop a set of model guidelines for dementia care which could be used by states to develop regulatory standards designed to ensure an acceptable level of care for residents with dementia. Initially, these standards should be applied only to providers who claim to provide specialty services. There are a number of unresolved controversies (separation of residents) in this area and standards should be developed and implemented very carefully and in close collaboration with the industry. Assisted living has great potential to serve residents with dementia, including those in advanced stages, and every effort must be made to prevent regulation from curtailing this potential unnecessarily. The significance of this issue is evident in Hawes et al. findings that cognitive impairment is an extremely important variable in accounting for movement to a nursing home.
- 6) Physical plant/environmental design.** Physical plant/environmental design regulations should be designed to create as homelike a living environment as possible to provide privacy and enhance autonomy. We know from research by Kane, Hawes and others that assisted living residents and potential residents place a very high priority on privacy as a quality-of-life value. Most fundamentally, this means a strong preference for private rooms and bathrooms and, to a lesser but still very significant extent, kitchenettes. There seems to be a clear consensus in the industry and among policymakers that this level of privacy is not affordable for many assisted living residents, especially those who are publicly supported. The assisted living experience in Oregon, which requires these privacy provisions and where costs are within the industry norm, would seem to indicate otherwise. This affordability vs. desirability issue is extremely important and is likely to grow in significance over the next ten years as quality of life becomes as important as quality of care in shaping the future of long-term care policy and practice and consumer preference becomes an increasingly important factor in shaping policy outcomes. We should not forget that privacy is a necessary condition for the exercise of autonomy and maintaining dignity. We return to this issue later in the article.
- 7) Training.** The industry tendency to have employees play multiple roles is generally positive in that it can help dilute the stifling effects of hierarchy and avoid the alienation and detachment of command and control structures and help maintain staff morale, creativity and commitment. This tendency toward “generalist worker” roles can also contribute to a more integrated, familial, homelike environment and help contain staff costs. It also creates a greater need for cross training, both pre- and in-services training, especially for workers in facilities serving more physically and cognitively impaired residents. The training should also be designed to focus on the values of assisted living in all phases of caregiving and interaction with residents. The

industry can expect more regulatory activity in this area and should create guidelines in anticipation of state initiatives.

- 8) Quality of life criteria.** In lieu of standard, institutionally oriented structure and process quality-of-care regulatory criteria, advocates, providers and policymakers should press for resident-oriented quality-of-life outcomes measures based on the fundamental values of assisted living—autonomy, privacy, dignity and the experience of a fuller life, however impaired one may be. This approach to performance accountability would prioritize systematic consumer feedback on such variables as enjoyment, meaningful activity, quality of relationships, spiritual well-being, autonomy, privacy and dignity as well as the resident’s sense of security and physical comfort. Rosalie Kane’s (2001) research on the use of these measures in nursing homes should be carefully assessed for use in assisted living where the focus on quality of life makes their use most compelling. Even in the absence of regulatory requirements, assisted living providers should begin using these measures (as some already are) as essential components of an internal quality-monitoring program.
- 9) Certificate of need.** A certificate-of-need approach to containing the growth of assisted living would be, for the most part, ill advised at this point. Assisted living is overbuilt in some areas now, but market forces and the growth of the Medicaid waiver funded sector (and other sources of public funding) are likely to close the gap over the next five years.
- 10) Nurse delegation.** Properly supervised by nurses, non-nursing staff should be allowed to assist in administering medications. There is no evidence that current nurse delegation acts are harmful to residents who, in fact, benefit from the capacity of these acts to help contain costs. Universal workers will not be able to achieve their full potential without some form of nurse delegation.
- 11) Resident assessment.** We are not ready for a standard uniform resident assessment and case-planning instrument in assisted living á la the Minimum Data Set (MDS) now used in nursing homes. Maine’s initiative in this area is interesting and may prove helpful in the future. But, we need more research and development and debate about tradeoffs before requiring a single instrument. This is another area where states are a natural laboratory and we need to learn much more about comparative results and allow time for the emergence of a consensus.

As stated above, we think states should also begin to address the fundamental issue of privacy in assisted living—of single occupancy units for those who prefer them. Rosalie Kane (2001) has noted that the case for privacy needs to be made on two levels—value and price. According to Kane, the case for intrinsic value can be easily established. Private-pay assisted living residents overwhelming (88%+) chose single occupancy units:

People not yet in a facility dread the shared space above most things, and people already in facilities say they would much prefer to have private rooms and baths, and would be willing to accept much less in the way of planned programs and activities in exchange. People with Alzheimer's disease are often unable to speak for themselves on this issue, but many of their advocates believe that they too would, in the whole, flourish better if not forced to share living space.

As noted earlier, recent research by Hawes and Phillips (2002) found that:

The vast majority (85%) of their respondents reported that their top two priorities on entering the ALF were the availability of a private bath (#1) and private bedroom. Among those who had left an ALF (19% over 12 months) most (65%) continued to identify these same privacy-oriented priorities.

The major issue then is not consumer preference, but rather price, which most providers think would be too high to be affordable for publicly supported residents. Kane (1998), however, thinks this may be true, at least in the case of new developments.

According to one analysis, modeled by considering a 39-unit building under more or less expensive construction and more or less favorable lending arrangements, the difference between building for 78 residents in 39 units versus 39 residents in 39 units would range from \$6.30 a day to \$3.20 a day per tenant. This slightly higher construction cost and, therefore, higher debt service was projected to be offset by sharply lower operational costs in the single-occupancy apartments.

Among the reasons for greater costliness in operating shared facilities were higher maintenance (since frequent roommate switches cause more wear and tear and more need for moving assistance; higher housekeeping costs (because higher needs or costs in maintaining common-use areas and more demand for entertainment; increased needs for highly paid staff to deal with conflict resolution and behavior management; higher demand for tray service in rooms since the time a roommate is in the dining room is the only time the other roommate can be assured of being alone; and greater dependence than residence-provided snacks. By far the greatest extra cost of shared space, however, relates to the costs of vacancies and the difficulties in roommate matching. If a unit is vacant for a week more because of the difficulty in finding a new occupant, a whole year's savings on the development and construction costs are more than wiped out.

Given the deep preference of residents for single-occupancy rooms, the state should pay careful attention to Kane's argument for their financial feasibility, at least in the case of regulations governing new developments.

Oregon and Washington have operated with single occupancy provisions in their publicly assisted living programs for the past

several years and have found them affordable and consistent with their long-term care containment priorities.

In addition to quality enhancement approaches described above, there are two other strategies that I think can be used that are more consumer (resident) oriented than conventional nursing home regulatory schemes.

I have long felt that the use of case managers as care advocates for publicly supported assisted living residents is as efficacious an approach to ensuring an adequate quality of care and life as annual or semi-annual surveys and episodic reporting to ombudsmen and Adult Protective Services, as important as these activities often are. This approach has been built into the Florida Assisted Living Medicaid Waiver Program. As long as caseloads are kept manageable (40:1) and the case managers are appropriately trained as care advocates and quality monitors, I think this approach has the potential to be an effective method of ensuring that the individual resident has an acceptable quality of life and receives sufficient care. This approach also helps avoid the adversarial, spot check “gotcha” approach to regulation by allowing the case manager (care advocate) to work with providers, residents and family members in a kind of continuous quality assurance manner based on common agendas and collaboration.

The Assisted Living Federation of America’s call for making Medicaid “portable,” so that recipients can choose where they will receive care and who will provide it, has considerable quality of care improvement potential. The Medicaid Consumer Account Program would reimburse the consumer (resident) rather than the provider and allow the states to determine the value of the consumer account based on the results of the functional and health assessment and the type of services required. This takes consumer-directed care from in-home care, which has been the major focus of advocates for consumer-directed care, into residential care and substantially expands opportunities for consumer empowerment. This program is a logical extension of the guiding values (autonomy and control) of assisted living. The evaluations of consumer-directed programs in California (Benjamin, 2000), Arkansas and in Europe indicate that these programs generate high consumer satisfaction and are cost-effective. I also think that consumer direction of the kind proposed in the Medicaid Consumer Account Program represents the most effective way of ensuring long-term care quality in all of its dimensions by giving the consumer and her family the ability to make choices and exercise power in the assisted living market.

Conclusion

The best available information indicates that the assisted living industry, with the support of policymakers and the regulatory community, has built a sound foundation for continuing success. The industry is not perfect and some course corrections are in order. I’m impressed, however, by the extent of progress achieved over the last ten years. As head of the Florida State Aging Agency in

1989, I felt that the biggest gap in our long-term care system across the country was the absence of a congregate care program that would allow the frail elderly to “age in place” and offer them the same freedom (personal control, privacy) and level of service that had been made available in their own homes since the late 1970s. This kind of community-residential care has been substantially achieved through the growth of the assisted living industry for private-pay residents and is arguably the most positive development in long-term care in the last decade.

The biggest problem in assisted living at this point is not insufficient regulation.

The major problem confronting policymakers and those in need of long-term care is the relatively meager number of assisted living beds available to the less affluent elderly who require public support, have limited access to community resources and want to avoid ending up in a nursing home.

For many of these people, assisted living offers the optimal long-term care setting for not only receiving the physical care they need, but also for achieving a quality of life (autonomy, privacy) that may not be available in their own homes. Our primary goals for assisted living should be to expand access for publicly supported residents and avoid regulatory schemes that would undermine the quality of life features that constitute the fundamental appeal of assisted living as a long-term care program.

The recently completed report by the National Assisted Living Workgroup (2003) contains several recommendations that are fully consistent with the research findings reviewed here. Some members of the task force strongly opposed these recommendations and supported regulatory standards and procedures drawn from the more medical model-oriented regulatory framework used in nursing homes. The overall thrust of the report is more supportive of the fundamental principles of assisted living (autonomy, privacy, dignity) and the need to focus on quality of life as much as quality of care and safety and make assisted living more affordable for the less affluent. The report is, in my judgment, a valuable new resource for advocates of a resident-orient framework for assisted living policy and regulator. A longer version of this article, which includes a lengthy discussion of the workgroup report, may be found at the Policy Center’s website <http://www.fpeca.usf.edu>.

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