

4719



# Policy Synthesis on Assisted Living for the Frail Elderly

**Final Report**

Submitted **To:**

**Department of Health & Human Services**  
Office of ~~The~~ Assistant Secretary  
for Planning and Evaluation

Submitted By:

Lewin-VHI, Inc.

**Contract** Number:

HHS-100-89-0032

December 16, 1992

**POLICY SYNTHESIS ON  
ASSISTED LIVING FOR THE FRAIL ELDERLY**

**FINAL REPORT**

*Submitted To:*

OFFICE OF THE ASSISTANT SECRETARY FOR  
**PLANNING AND EVALUATION**

*Submitted By:*

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## EXECUTIVE SUMMARY

### CHAPTER I: INTRODUCTION AND OVERVIEW

The term “assisted living” refers to a type of care that combines housing and services in a homelike environment that strives to maximize the individual functioning and autonomy of the frail elderly and other dependent populations. This policy synthesis focuses exclusively on assisted living for the frail elderly. Chapter I provides an overview of why assisted living is increasingly important from a policy perspective, why the synthesis on assisted living for the frail elderly has been undertaken, and how the synthesis is organized to address relevant policy issues.

- **Why this synthesis was undertaken.** The synthesis was undertaken because of policy concerns generated by an increasing aged population: between 1990 and 2030 the elderly population is expected to double to 65 million people. The costs of delivering long-term care to that population are rising rapidly. Assisted living has been proposed as one approach to mitigating those rising costs, as well as potentially improving quality of life **for the frail elderly.** **Addressing** issues related to assisted living involves the coordinated efforts of researchers and policy-makers with substantive expertise in several different **fields — Including both services and housing.** To that end, the Office of the Assistant Secretary for **Planning** and Evaluation (ASPE) sponsored the development of this synthesis. It initially served as a background piece for a meeting on assisted living for the frail elderly jointly sponsored by ASPE and the National Academy for State Health Policy (NASHP) that brought together **researchers**, policymakers, and practitioners who contributed to a policy relevant discussion of housing and supportive services for the frail elderly. Discussions at the meeting, which included developing issues **for future** research, are incorporated **in this synthesis.**
- **Sources of information used for the synthesis.** The field of supportive housing for the elderly is evolving rapidly from both a public and private perspective. What was current in the field two months ago may be out-of-date today. This synthesis is based on a review and analysis of over 350 books, reports, and documents (both published and unpublished), and on extensive telephone interviews with related association representatives, policymakers, and academicians/researchers.

- **How this synthesis is organized.** The synthesis is organized into eight chapters. Chapters II through V provide general background information on assisted living — who assisted living is intended to serve and why, and what its perceived advantages are over other long-term care options. The remaining chapters provide more detailed information on available federal and state resources in addition to federal and state initiatives specifically directed at increasing the availability of assisted living options. In addition, potential research questions are provided at the end of Chapters IV, V, VI, and VII.

### **Chapter I — introduction**

### **Chapter ii -What is Assisted Living?**

Provides an overview of what is meant by the term assisted living, other terms used to refer to the assisted living concept, how assisted living fits into the long-term care continuum, and estimates on the numbers of assisted living facilities.

### **Chapter iii — Who are the Frail Elderly?**

Includes estimates of the number of frail elderly in addition to selected demographic and socio-economic characteristics.

### **Chapter IV — Matching Needs and Services**

Includes a discussion of the segment of the population for whom assisted living is considered an appropriate option, how service needs and eligibility are assessed, and how services are organized and delivered to meet those needs.

### **Chapter V -The Effectiveness and Cost of Assisted Living**

Examines the empirical and logical basis for the reasons that assisted living is believed to be a preferred living alternative for the frail elderly, namely: that the elderly prefer assisted living over nursing home care, assisted living improves outcomes and quality of life, and assisted living costs less than other long-term care alternatives.

### **Chapter Vi — issues in Regulating Assisted Living**

Considers the myriad of assisted living regulatory issues faced by policymakers, researchers, consumers, and providers by raising the theoretical and practical reasons why regulation of assisted living is an important and challenging question, general approaches for regulating assisted living, and specific regulatory issues that arise.

— **Chapter VII — Public Financing of Assisted Living**

Discusses the host of public **resources** potentially available to fund housing and supportive services and presents more recent initiatives to combine funding for those housing and services and how to target resources more specifically to the elderly at risk of institutionalization.

— **Chapter VIII — State Experiences**

Provides an overview of some major issues and approaches considered by states in developing assisted living programs in addition to a description of specific state programs.

*CHAPTER II: WHAT IS ASSISTED LIVING?*

Assisted living is a **term** that is used broadly to define the combination of housing and services in a home-like environment; This chapter provides an overview of the assisted living concept, how the term assisted living is typically used, other terms used for assisted living and estimates of the numbers of assisted living facilities. More detail on how assisted living facilities are operated, financed, and regulated is included in subsequent chapters. This chapter address the following questions:

- **What do people mean by the term assisted living?**

The term assisted living is **used** to refer to a type of care that combines housing and services in a homelike environment that maximizes individual functioning and autonomy. Beyond this basic definition, there is wide variation in how the term is used, the specific services provided, and the appropriate target population.

- **What other terms are used to refer to assisted living facilities?**

Many other terms are used to refer to assisted living — terms such as: board and care, residential care, personal care, foster care, domiciliary care, and congregate care. Federal regulations often place assisted living facilities under the rubric of “board and care;”. Only a few states explicitly use either the terms “board and care” or “assisted living” when licensing or regulating facilities that provide services similar to those provided in “assisted living.” Private developers use a wide **range of** terms (including assisted living), but typically avoid the term “board and care” which is viewed as less marketable.

- **Where does assisted living fit into the long-term care system?**

The literature typically describes assisted living as falling between boarding homes (facilities that only provide room and board) and skilled nursing facilities on the long term care continuum. How facilities are categorized on that continuum depends, in large part, on the nature and scope of services provided and the level of need of clients served. Thus, it is difficult to place assisted living firmly on the long term care continuum.

- **What general types of assisted living facilities are there?**

In general, assisted living facilities may be categorized into three types - each of which tends to be discussed in a separate literature: public housing, units in continuing care retirement communities, and freestanding facilities (that may or may not be on the campus of a nursing facility). These facilities differ in their target populations, funding, and how services are organized and delivered.

- **How many assisted living facilities are there?**

Estimates in the literature of the numbers of assisted living facilities vary widely. There is no definitive source estimating the precise number of assisted living facilities in the literature or through the various associations whose members include assisted living facilities. Representatives of the Assisted Living Association of America stated that a major goal of this new association is to quantify the numbers of assisted living facilities. Estimates of the number of assisted living facilities range from approximately 40,000 to 65,000 facilities that are believed to serve up to 1,000,000 elderly people, depending on definitions used.

### **CHAPTER III: THE FRAIL ELDERLY AND THEIR LIVING ARRANGEMENTS**

This chapter provides descriptive data on the frail elderly, describes correlates of nursing home use by identifying the elderly population "at risk" for institutionalization, and describes trends over the past century in the elderly's use of different types of residential settings with services. These data provide valuable insight into the question of whether assisted living can serve as a substitute for nursing homes for some frail elderly.

The chapter addresses the following questions:

- **Who are the frail elderly?**

The "frail elderly" form a heterogeneous cross section of elderly people representing a diversity of ages, incomes, living arrangements, and lifestyles. For the purposes of this synthesis, the term is used to differentiate a segment of the long-term care population from other dependent groups such as persons with mental retardation. Depending on the measure of functional impairment used, the frail elderly includes from 2 to 11 million people, or between 7 to 30 percent of the total population over age 65.

- **How are age, functional impairment, and other factors related to the use of nursing homes?**

The nursing home population is considerably older and more likely to have functional impairments than those in the community. These two factors alone, however, are not very good predictors of nursing home use, although they are sometimes used to specify people thought to be "at risk" for institutionalization. There are a number of better assessment tools available such as Morris, Sherwood, and Gutkin's (1988) instrument.

- **How has the elderly's use of different types of residential settings with services changed over time?**

Over the last century, the population of the elderly in institutions and group quarters of all types has changed very little (it averages around 4-5 percent of all those 65+). But the types of residential group settings available to house those who need to help others has changed dramatically. These changes — from almshouses, and mental hospitals to certified skilled nursing facilities and homes for the aged — have been largely precipitated by changes over time in how society views old age and dependency and the sources of, funds available to support those who need help, but lack sufficient money to pay privately for care. These historical trends suggest that viable substitutes for nursing homes (such as assisted living) can be developed.

#### **CHAPTER IV: ASSISTED WING: MATCHING NEEDS AND SERVICES**

This chapter explores issues surrounding the question of which segment of the frail elderly population should be targeted for assisted living and how eligibility for assisted living is determined. In addition, the chapter provides an overview of the types of services available

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in assisted living facilities as well as typical staffing configurations designed to manage and deliver those services:

- **For which segment of the frail elderly population is assisted living an appropriate option?**

**Nowhere** in the literature is it disputed that assisted living is appropriate for medically stable individuals who are not in need of 24-hour nursing care. Opinions vary, however, on the appropriateness of assisted living for the cognitively impaired, nursing facility eligible individuals and those who are not ambulatory.

- **How is eligibility determined?**

There are three main criteria used to determine eligibility for assisted living facilities: age, income and functional capacity. How the criteria are applied varies from facility to facility.

- **Who screens for eligibility?**

Who screens for eligibility also varies from facility to facility. In 202 housing, housing managers often perform the initial assessments, they may contract with an outside case manager, or employ their own case manager. In CCRCs and private facilities, case managers and housing managers typically **have** more distinct functions in the assessment process.

- **How are transfer decisions made?**

Little is known about transfer decisions and policies except in CCRCs and HUD facilities. These transfer decisions are based on written policies and procedures. Who applies these policies and procedures varies across facilities, from professional assessment committees, to head nurses, housing managers, and physicians. Transfer decisions also typically rely heavily on input from friends and family.

- **What services do assisted living facilities provide?**

There are substantial variations in the range of services that assisted living facilities provide in part because different facilities target different populations. Some facilities might target more independent populations that may not require more intensive personal care services while others might provide services to the more functionally impaired elderly. Services provided also vary according to funding sources.

- **How are service needs initially assessed and routinely reevaluated?**

Screenings are performed to varying degrees to ensure that potential residents can be cared for safely in a non-institutional environment. The frequency of screenings is variable; some facilities perform screenings as often as monthly while others conduct screenings only after residents are hospitalized, or their physical or mental condition changes.

- **How are facilities staffed?**

The types and ratios of staff are influenced by the size of the facility, available funding resources, and the functional capacity of the residents. In addition, there are wide variations among facilities in the degree to which they employ their own staff or rely on outside providers.

- **What staffing limitations are there and how can they be overcome?**

- A major issue in the industry is how to attract and retain capable staff when assisted living facilities often have to compete with facilities paying higher salaries. Cross-staffing, enhanced opportunities for staff to attend national conferences, using part-time outside contractors, and developing shared staffing arrangements with other facilities are just a few of the alternatives.

## **CHAPTER V: THE COST AND EFFECTIVENESS OF ASSISTED LIVING**

Why has assisted living emerged as an important living alternative for the frail elderly in the view of so many policy officials, advocates, and consumers? The answer resides, in part, in the belief that assisted living represents an autonomy-enhancing, home-like environment preferred by the frail elderly, while at the same time providing a level of care difficult to deliver in homes or apartments. Assisted living is also thought to be a **cost-effective** alternative to nursing home care. Although these beliefs are often grounded in sound logic, professional experience, and in some cases empirical research, this chapter explores underlying assumptions and elucidates areas of uncertainty. Available research from the assisted living literature is presented and reviewed. Because a paucity of detailed research on assisted living per se exists, research on home and (non-residential) community-based settings and congregate housing facilities is also reviewed, though the applicability of this work to assisted living is an open question. This chapter addresses the following three general questions:

- **Do the frail elderly prefer assisted living to nursing homes?**

Little research exists on the preferences of frail elderly for assisted living. Existing research does suggest **that they** do prefer these settings to nursing homes. Moreover, elderly people overwhelmingly prefer to stay in their own homes, or reside in congregate living arrangements, over living in nursing homes. Whether these findings extend to assisted living facilities will depend, in part, on whether the needs of the frail elderly can be met without creating an “institutional” assisted living environment,

- **Does assisted living improve the quality of life and produce better “outcomes” for the frail elderly?**

Important outcomes to measure for assisted living include life satisfaction, nursing home placement, functional capacity, health outcomes, and caregiver satisfaction. Limited research suggests that the frail elderly residing in assisted living settings are happier than nursing home residents, may avoid institutional placement (but the empirical evidence is weak on this point), and caregivers of assisted living tenants also exhibit higher levels of satisfaction. Limited and preliminary **research** suggests some improvement in health and functioning for assisted living residents.

**In the absence of detailed empirical work on assisted living** per se, findings from research on home and (non-residential) community-based care are also reviewed in this chapter. In contrast, this research suggests that there are few, **if any**, differences in functioning or health outcomes, between community and nursing home dwelling frail elders. This literature also questions whether community-based care serves as a substitute for nursing home care and can successfully avert nursing home placement. The extent to which these findings apply in the assisted living context is an open question.

- **Does assisted living cost less than nursing home care?**

Again, the assisted living literature is sparse, but the limited evidence points to some cost savings as assisted living is substituted for nursing home care. In contrast, a comparably well developed body of literature indicates that home and community-based care does not reduce aggregate costs since it is difficult to target those frail elders who are truly **“at risk”** of nursing home placement, and because the costs of **home and (non-residential) community-based care** for a dependent population can approach nursing home costs. Assisted living facilities, however, may be able to achieve economies of scale impossible to achieve for individuals living in their homes and some states have been more successful at “targeting” frail elderly most likely to use a nursing home. The applicability of the **home and community-based care literature is therefore an open question.**

## **CHAPTER VI: ISSUES IN REGULATING ASSISTED LIVING**

This chapter considers the myriad of assisted living regulatory issues faced by policy makers, researchers, consumers, and providers. The chapter has two parts. Part One raises basic theoretical and practical reasons why regulation of assisted living is an important and challenging question. Three basic philosophical tensions inherent in regulating assisted living are explored: the tension between the “medical model” (traditionally used in caring for the frail elderly) versus the “social model” (advocated by proponents of assisted living); the tension between “paternalism” (the **government's/provider's** predilection and perceived obligation to protect the frail elderly) versus “autonomy” (which encourages frail elders to exercise control over decisions in their lives); and the tension between “safety” versus “risk”, or the extent to which assisted living environments should protect frail elders versus permitting both clients and providers to take “risk” by facilitating autonomous actions. Part One also discusses the range of regulatory approaches that might be considered for assisted living in light of these tensions, including a free market approach, where few aspects of operations are regulated; a nursing home regulatory approach, where nearly all aspects of structure, process and outcome are regulated; an approach that regulates the philosophy of assisted living and certain aspects of structure and process, but outcomes are not regulated; and an approach that regulates structure, process and outcomes, but leaves many assisted living operations unregulated to promote provider innovation and protect client autonomy.

Part Two addresses raises specific regulatory issues, without providing concrete answers, that arise in the assisted living context, including:

- **Do board and care licensure laws apply to assisted living? Should they?**
- **What role (if any) should the federal government play in regulating assisted living?**
- **Should regulatory approaches change as assisted living evolves from demonstration projects to publicly-subsidized, for-profit, operations?**
- **How can ‘risk’ be regulated in assisted living? Should risk be regulated?**
- **Should the supply of assisted living facilities be regulated?**

- **Should there be different regulations for the cognitively impaired frail elderly?**
- **To what extent can (should) “aging in place” be regulated?**
- **Should marketing and advertising be regulated?**

How some of these issues manifest themselves in particular states is discussed in Chapter VIII.

## **CHAPTER VII: PUBLIC FINANCING**

Compared to the private sector, public programs have played a limited role in financing the development of assisted living for the frail elderly, but over the past several decades a variety of programs to support housing with services have been developed. Financing has included resources to fund both housing (the construction of new units and rental assistance in existing units) and services. Three major trends have occurred with regard to this financing. First, over time resources have shifted from producing new housing units to increasing support for rental assistance, Second, some efforts have been made to combine bricks and mortar financing with services financing. These programs have largely been in the domain of the Department of Housing and Urban Development (HUD), though HUD has traditionally considered human services to be in the domain of other agencies. Third, Congress and others have encouraged partnerships between the federal government and states to develop innovative housing alternatives for the elderly.

This chapter examines public financing that can potentially be used for assisted living by addressing the following topics:

- **Federal programs that can potentially increase the supply of assisted living units by directly financing the construction of new facilities.**

The federal government has been a major generator of publicly funded housing through the Department of Housing and Urban Development (202 and public housing authority programs) and through Farmers Home Administration funding, though few of these projects can accurately be called “assisted living.” **The** percentage of frail elderly served across these facilities and the services

provided within them vary widely across facilities; however, in the aggregate approximately 40 percent of all federally assisted units are estimated to be occupied by the elderly (Special Committee on Aging, United States Senate, 1991). This funding has traditionally **focused** on the housing and not the services components of these facilities.

- **Federal programs that can promote the construction of new units by providing incentives for other investors to fund units.**

The mainstays of the types of federal incentives designed to generate investments in low-income housing by other investors are federal mortgage insurance, tax-exempt bonds, and more recently low income tax credits. These incentives are available to both the for-profit and **non-profit** sectors.

- **Federal programs that can promote assisted living by paying rental subsidies directly to low income households.**

In addition to providing project based housing assistance, the federal government provides rental subsidies directly to households. These subsidies are in the form of rental certificates which are limited to the difference between 30 percent of tenants' income and fair market rent as set by HUD, and more recently rental vouchers which, unlike rental certificates, allow tenants to pay any excess between 30 percent of income and fair market rents out-of-pocket. Housing vouchers are intended to provide tenants with more flexibility in their choice of housing arrangements.

- **Traditional sources of federal/state funding that can be used to provide services in housing for the elderly.**

Traditional sources which have been used to finance services in elderly housing include Medicare, Medicaid, Social Services Block Grants, the Older Americans Act, and the Supplemental Security Income Program. Medicare and Medicaid in particular largely have been limited to funding medical models of care in institutional settings.

- **Options for financing additional home and community-based services in assisted living settings under Medicaid waivers and new optimal services provisions.**

It is frequently said that the availability of Medicaid to pay for nursing home care and Limited public funds for community-based care creates a "bias" toward institutionalization. Partly in response to those concerns, Congress amended the Social Security Act (which governs state options under Medicaid) to expand states' ability to pay for home and community care. The federal government has authorized a selective expansion of Medicaid services to the frail elderly in the community under Medicaid Home and Community Based Service Waivers.

- **Federal programs designed to integrate financing for housing and services.**

A major criticism of policies for funding assisted living is that **historically** disparate funding sources for housing and service have created a fragmented delivery system that does not optimally address the needs of the frail **elderly**. Recently, more coordinated programs (albeit limited in scope) have been developed to begin to address these concerns. One of the earlier programs was the congregate housing services program; more recently, the National Affordable Housing Act of 1990 has generated combined housing/services initiatives as well.

- **Additional ways in which states finance assisted living.**

States rely on a variety of sources to finance assisted living that include: **state** general revenue appropriations, state-levied fees or trust funds, **and** state general obligation bonds.

This chapter focuses only on the major sources of public financing and not the **myriad** of other programs through which 'assisted living could be funded. An extensive listing **of the** programs available through 1988 has been developed by Pynoos (1988).

## **CHAPTER VIII: STATE EXPERIENCES**

Many states have under development or are currently considering assisted living programs for the frail elderly. Different states have different goals in pursuing assisted living as a housing alternative: cost savings by reducing nursing home care; promoting independence among the frail elderly; improving health and psychosocial outcomes; and the range of **other assisted** living goals discussed in this synthesis. Several recent works have described in detail state programs in assisted living, as summarized in Exhibit VIII.1. Rather than replicate this extensive work, this chapter identifies some major issues faced by states **in** developing assisted living for the frail elderly, and how various states have addressed these issues. The chapter is divided into two parts. Part One highlights the important challenges faced by states considering assisted living for the frail elderly, reviews how various states have dealt with these issues, and discusses the pros and cons of these approaches:

- Should states develop assisted living programs by investing in new assisted living facility stock, or by supplementing services available in

**existing settings that provide some level of care (e.g., board and care homes or congregate living apartments)?**

The answer depends on **which** segment of the frail elderly population the state intends to serve, how quickly the **state** wants to implement its program, cost containment considerations, and the availability of existing facilities that can be used, or adapted for **use, for assisted living purposes.**

- **How should a state fund its assisted living program? Through Federal Medicaid Waivers? Through Use of State Funds Only? What are the pros and cons of different funding mechanisms?**

The answer depends on how much a state needs federal matching funds, the degree of flexibility the state needs (Le., freedom from federal restrictions), a state's cost containment goals, and funding stability issues.

- **How should states approach regulation of assisted living? What are regulations intended to achieve?**

**The answer depends,** in large measure, on the philosophy of assisted living the state wants to advance. The benefits of regulation (assuring quality of care) must be balanced against the risk of overregulation; i.e., inadvertently creating an "institutional" environment and infringing on the frail elderly's autonomy and independence.

- **How much should a state aggressively develop assisted living for the frail elderly as compared with state subsidized programs for other groups (such as the developmentally disabled, or children)?**

The answer depends on political and equity issues peculiar to each state. Fundamentally, states must decide how to allocate state funds between worthy recipients. If state officials believe assisted living can save money as compared to current long term care alternatives (e.g., nursing homes), the allocation decision might be easier to make.

- **Should states consolidate assisted living programs into a single agency, combining funding, programmatic, and regulatory functions?**

Some states have found consolidation of financing, regulatory, and programmatic functions into a single agency to be more efficient from economic and operations perspectives.

- **Should states control the supply of assisted living facilities through regulatory means?**

Some states view assisted living as an integral part of the continuum of their long term care system. As such, they have chosen to monitor supply through traditional regulatory means (e.g., licensing).

Part Two presents a more **detailed** summary of assisted living programs in **Oregon**, New York, Florida, Washington state, Maryland, New Jersey, Maine, Rhode Island, Connecticut, and New Hampshire.

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## EXECUTIVE SUMMARY

### CHAPTER I: INTRODUCTION AND OVERVIEW

The term “assisted living” refers to a type of care that combines housing and services in a homelike environment that strives to maximize the individual functioning and autonomy of the frail elderly and other dependent populations. This policy synthesis focuses exclusively on assisted living for the frail elderly. Chapter I provides an overview of why assisted living is increasingly important from a policy perspective, why the synthesis on assisted living for the frail elderly has been undertaken, and how the synthesis is organized to address relevant policy issues.

- **Why this synthesis was undertaken.** The synthesis was undertaken because of policy concerns generated by an increasing aged population: between 1990 and 2030 the elderly population is expected to double to 65 million people. The costs of delivering long-term care to that population are rising rapidly. Assisted living has been proposed as one approach to mitigating those rising costs, as well as potentially improving quality of life for the frail elderly. Addressing issues related to assisted living involves the coordinated efforts of researchers and policy-makers with substantive expertise in several different fields — including both services and housing. To that end, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) sponsored the development of this synthesis. It initially served as a background piece for a meeting on assisted living for the frail elderly jointly sponsored by ASPE and the National Academy for State Health Policy (NASHP) that brought together researchers, policymakers, and practitioners who contributed to a policy relevant discussion of housing and supportive services for the frail elderly. Discussions at the meeting, which included developing issues for future research, are incorporated in this synthesis.
- **Sources of information used for the synthesis.** The field of supportive housing for the elderly is evolving rapidly from both a public and private perspective. What was current in the field two months ago may be out-of-date today. This synthesis is based on a review and analysis of over 350 books, reports, and documents (both published and unpublished), and on extensive telephone interviews with related association representatives, policymakers, and academicians/researchers.

- **How this synthesis is organized.** The synthesis is organized into eight chapters. Chapters II through V provide general background information on assisted living — who assisted living is intended to serve and why, and what its perceived advantages are over other long-term care options. The remaining chapters provide more detailed information on available federal and state resources in addition to federal and state initiatives specifically directed at increasing the availability of assisted living options. In addition, potential research questions are provided at the end of Chapters IV, V, VI, and VII.

**Chapter I — Introduction**

**Chapter II -What is Assisted Living?**

Provides an overview of what is meant by the term assisted living, other terms used to refer to the assisted living concept, how assisted living fits into the long-term care continuum, and estimates on the numbers of assisted living facilities.

— **Chapter III -Who are the Frail Elderly?**

Includes estimates of the number of frail elderly in addition to selected demographic and socio-economic characteristics.

**Chapter IV — Matching Needs and Services**

Includes a discussion of the segment of the population for whom assisted living is considered an appropriate option, how service needs and eligibility are assessed, and how services are organized and delivered to meet those needs.

— **Chapter V -The Effectiveness and Cost of Assisted Living**

Examines the empirical and logical basis for the reasons that assisted living is believed to be a preferred living alternative for the frail elderly, namely: that the elderly prefer assisted living over nursing home care, assisted living improves outcomes and quality of life, and assisted living costs less than other long-term care alternatives,

— **Chapter VI — Issues in Regulating Assisted Living**

Considers the myriad of assisted living regulatory **issues faced by** policymakers, researchers, consumers, and providers by raising the theoretical and practical reasons why regulation of assisted living is an important and challenging question, general approaches for regulating assisted living, and specific regulatory issues that arise.

– **Chapter VII – Public Financing of Assisted Living**

Discusses the host of public resources potentially available to fund housing and supportive services and presents more recent initiatives to combine funding for those housing and services and how to target resources more specifically to the elderly at risk of institutionalization.

– **Chapter VIII – State Experiences**

Provides an overview of some major issues and approaches considered by states in developing assisted living programs in addition to a description of specific state programs.

**CHAPTER II: WHAT IS ASSISTED LIVING?**

Assisted living is a term that is used broadly to define the combination of housing and services in a home-like environment; This chapter provides an overview of the assisted living concept, how the term assisted living is typically used, other terms used for assisted living and estimates of the numbers of assisted living facilities. More detail on how assisted living facilities are operated, financed, and regulated is included in subsequent chapters. This chapter address the following questions:

• **What do people mean by the term assisted living?**

The term assisted living is used to refer to a type of care that combines housing and services in a homelike environment that maximizes individual functioning and autonomy. Beyond this basic definition, there is wide variation in how the term is used, the specific services provided, and the appropriate target population.

• **What other terms are used to refer to assisted living facilities?**

Many other terms are used to refer to assisted living — terms such as: board and care, residential care, personal care, foster care, domiciliary care, and congregate care. Federal regulations often place assisted living facilities under the rubric of “board and care”, Only a few states explicitly use either the terms “board and care” or “assisted living” when licensing or regulating facilities that provide services similar to those provided in “assisted living.” Private developers use a wide **range** of terms (including assisted living), but typically avoid the term “board and care” which is viewed as less marketable.

- **Where does assisted living fit into the long-term care system?**

The literature typically describes assisted living as falling between boarding homes (facilities that only provide room and board) and skilled nursing facilities on the long term care continuum. How facilities are categorized on that continuum depends, in large part, on the nature and scope of services provided and the level of need of clients served. Thus, it is difficult to place assisted living firmly on the long term care continuum.

- **What general types of assisted living facilities are there?**

In general, assisted living facilities may be categorized into three types - each of which tends to be discussed in a separate literature: public housing, units in continuing care retirement communities, and freestanding facilities (that may or may not be on the campus of a nursing facility). These facilities differ in their target populations, funding, and how services are organized and delivered.

- **How many assisted living facilities are there?**

Estimates in the literature of the numbers of assisted living facilities vary widely. There is no definitive source estimating the precise number of assisted living facilities in the literature or through the various associations whose members include assisted living facilities. Representatives of the Assisted Living Association of America stated that a major goal of this new association is to quantify the numbers of assisted living facilities. Estimates of the number of assisted living facilities range from approximately 40,000 to 65,000 facilities that are believed to serve up to 1,000,000 elderly people, depending on definitions used.

### **CHAPTER III: THE FRAIL ELDERLY AND THEIR LIVING ARRANGEMENTS**

This chapter provides descriptive data on the frail elderly, describes correlates of nursing home use by identifying the elderly population "at risk" for institutionalization, and describes trends over the past century in the **elderly's use of different types of residential settings with services. These data provide valuable insight into the question of whether assisted living can serve as a substitute for nursing homes for some frail elderly.**

The chapter addresses the following questions:

- **Who are the frail elderly?**

The “frail elderly” form a heterogeneous cross section of elderly people representing a diversity of ages, incomes, living arrangements, and lifestyles. For the purposes of this synthesis, the term is used to differentiate a segment of the long-term care population from other dependent groups such as persons with mental retardation. Depending on the measure of functional impairment used, the frail elderly includes from 2 to 11 million people, or between 7 to 30 percent of the total population over age 65.

- **How are age, functional impairment, and other factors related to the use of nursing homes?**

The nursing home population is considerably older and more likely to have functional impairments than those in the community. These two factors alone, however, are not very good predictors of nursing home use, although they are sometimes used to specify people thought to be “at risk” for institutionalization. There are a number of better assessment tools available such as Morris, Sherwood, and Gutkin’s (1988) instrument.

- **How has the elderly’s use of different types of residential settings with services changed over time?**

Over the last century, the population of the elderly in institutions and group quarters of all types **has** changed very little (it averages around 4-5 percent of all those **65+**). But the types of residential group settings available to house those who need to help others has changed dramatically. These changes — from almshouses, and mental hospitals to certified skilled nursing facilities and homes for the aged — have been largely precipitated by changes over time in how society views old age and dependency and the sources of funds available to support those who need help, but lack sufficient money to pay privately for care. These historical trends suggest that viable substitutes for nursing homes (such as assisted living) can be developed.

#### **CHAPTER IV: ASSISTED LIVING: MATCHING NEEDS AND SERVICES**

This chapter explores issues surrounding the question of which segment of the frail elderly population should be targeted for assisted living and how eligibility for assisted living is determined. In addition, the chapter provides an overview of the types of services available

in assisted living facilities as well as typical staffing configurations designed to manage and deliver those services:

- **For which segment of the frail elderly population is assisted living an appropriate option?**

Nowhere in the literature is it disputed that assisted living is appropriate for medically stable individuals who are not in need of 24-hour nursing care. Opinions vary, however, on the appropriateness of assisted living for the cognitively impaired, nursing facility eligible individuals and those who are not ambulatory.

- **How is eligibility determined?**

**There are three main criteria** used to determine eligibility for assisted living facilities: age, income and functional capacity. How the criteria are applied varies from facility to facility.

- **Who screens for eligibility?**

Who screens for eligibility also varies from facility to facility. In 202 housing, housing managers often perform the initial assessments, they may contract with an outside case manager, or employ their own case manager. In CCRCs and private facilities, case managers and housing managers typically have more distinct functions in the assessment process.

- **How are transfer decisions made?**

**Little** is known about transfer decisions and policies except in CCRCs and HUD facilities. These transfer decisions are based on written policies and procedures. Who applies these policies and procedures varies across facilities, from professional assessment committees, to head nurses, housing managers, and physicians. Transfer decisions also typically rely heavily on input from friends and family.

- **What services do assisted living facilities provide?**

There are substantial variations in the range of services that assisted living facilities provide in part because different facilities target different populations. Some facilities might target more independent populations that may not require more intensive personal care services while others might provide services to the more functionally impaired elderly. Services provided also vary according to funding **sources**.

- **How are service needs initially assessed and routinely reevaluated?**

Screenings are performed to varying degrees to ensure that potential residents can be cared for safely in a non-institutional environment. The frequency of screenings is variable: some facilities perform screenings as often as monthly while others conduct screenings only after residents are hospitalized, or their physical or mental condition changes.

- **How are facilities staffed?**

The types and ratios of staff are influenced by the size of the facility, available funding resources, and the functional capacity of the residents. In addition, there are wide variations among facilities in the degree to which they employ their own staff or rely on outside providers.

- **What staffing limitations are there and how can they be overcome?**

A major issue in the industry is how to attract and retain capable staff when assisted living facilities often have to compete with facilities paying higher salaries. Cross-staffing, enhanced opportunities for staff to attend national conferences, using part-time outside contractors, and developing shared staffing arrangements with other facilities are just a few of the alternatives.

## *CHAPTER V: THE COST AND EFFECTIVENESS OF ASSISTED LIVING*

Why has assisted living emerged as an important living alternative for the frail elderly in the view of so many policy officials, advocates, and consumers? The answer resides, in part, in the belief that assisted living represents an autonomy-enhancing, home-like environment preferred by the frail elderly, while at the same time providing a level of care difficult to deliver in homes or apartments. Assisted living is also thought to be a cost-effective alternative to nursing home care. Although these beliefs are often grounded in sound logic, professional experience, and in some cases empirical research, this chapter explores underlying assumptions and elucidates areas of uncertainty. Available research from the assisted living literature is presented and reviewed. Because a paucity of detailed research on assisted living per se exists, research on home and (non-residential) community-based settings and congregate housing facilities is also reviewed; though the applicability of this work to assisted living is an open question. This chapter addresses the following three general questions:

- **Do the frail elderly prefer assisted living to nursing homes?**

Little research exists on the preferences of frail elderly for assisted living. Existing research does suggest that they do prefer these settings to nursing homes. Moreover, elderly people overwhelmingly prefer to stay in their own homes, or reside in congregate living arrangements, over living in nursing homes. Whether these findings **extend to assisted living facilities will depend**, in part, on whether the needs of the frail elderly can be met without creating an “institutional” assisted living environment.

- **Does assisted living improve the quality of life and produce better “outcomes” for the frail elderly?**

Important outcomes to measure for assisted living include life satisfaction, nursing home placement, functional capacity, health outcomes, and caregiver satisfaction. Limited research suggests that the frail elderly residing in assisted living settings are happier than nursing home residents, may avoid institutional placement (but the empirical evidence is weak on this point), and caregivers of assisted living tenants also exhibit higher levels of satisfaction. Limited and preliminary research suggests some improvement in health and functioning for assisted living residents.

In the absence of detailed empirical work on assisted living per se, findings from research on home and (non-residential) community-based care are also reviewed in this chapter. In contrast, this research suggests that there are few, if any, differences in functioning or health outcomes between community and nursing home dwelling frail elders. This literature also questions whether community-based care serves as a substitute for nursing home care and can successfully avert nursing home placement. The extent to which these findings apply in the assisted living context is an open question.

- **Does assisted living cost less than nursing home care?**

Again, the assisted living literature is sparse, but the limited evidence points to some cost savings as assisted living is substituted for nursing home care. In contrast, a comparably well developed body of literature indicates that home and community-based care does not reduce aggregate costs since it is difficult to target those frail elders who are truly “at risk” of nursing home placement, and because the costs of home and (non-residential) community-based care for a dependent population can approach nursing home costs. Assisted living facilities, however, may be able to achieve economies of scale impossible to achieve for individuals living in their homes and some states have been more successful at “targeting” frail elderly most likely to use a nursing home. The applicability of the home and community-based care literature is therefore an open question.

## **CHAPTER VI: ISSUES IN REGULATING ASSISTED LIVING**

This chapter considers the myriad of assisted living regulatory issues faced by policy makers, researchers, consumers, and providers. The chapter has two parts. Part One raises basic theoretical and practical reasons why regulation of assisted living is an important and challenging question. Three basic philosophical tensions inherent in regulating assisted living are explored: the tension between the “medical model” (traditionally used in caring for the frail elderly) versus the “social model” (advocated by proponents of assisted living); the tension between “paternalism” (the government’s/provider’s predilection and perceived obligation to protect the frail elderly) versus “autonomy” (which encourages frail elders to exercise control over decisions in their lives); and the tension between “safety” versus “risk”, or the extent to which assisted living environments should protect frail elders versus permitting both clients and providers to take “risk” by facilitating autonomous actions. Part One also discusses the range of regulatory approaches that might be considered for assisted living in light of these tensions, including a free market approach, where few aspects of operations are regulated; a nursing home regulatory approach, where nearly all aspects of structure, process and outcome are regulated; an approach that regulates the philosophy of assisted living and certain aspects of structure and process, but outcomes are not regulated; and an approach that regulates structure, process and outcomes, but leaves many assisted living operations unregulated to promote provider innovation and protect client autonomy.

Part Two addresses raises specific regulatory issues, without providing concrete answers, that arise in the assisted living context, including:

- **Do board and care licensure laws apply to assisted living? Should they?**
- **What role (if any) should the federal government play in regulating assisted living?**
- **Should regulatory approaches change as assisted living evolves from demonstration projects to **publicly-subsidized, for-profit, operations?****
- **How can “risk” be regulated in assisted living? Should risk be regulated?**
- **Should the supply of assisted living facilities be regulated?**

- **Should there be different regulations for the cognitively impaired frail elderly?**
- **To what extent can (should) “aging in place” be regulated?**
- **Should marketing and advertising be regulated?**

How some of these issues manifest themselves in particular states is discussed in Chapter VIII.

## **CHAPTER VII: PUBLIC FINANCING**

Compared to the private sector, public programs have played a limited role in financing the development of assisted living for the frail elderly, but over the past several decades a variety of programs to support housing with services have been developed. Financing has included resources to fund both housing (the construction of new units and rental assistance in existing units) and services. Three major trends have occurred with regard to this financing. First, over time resources have shifted from producing new housing units to increasing support for rental assistance. Second, some efforts have been made to combine bricks and mortar financing with services financing. These programs have largely been in the domain of the Department of Housing and Urban Development (HUD), though HUD has traditionally considered human services to be in the domain of other agencies. Third, Congress and others have encouraged partnerships between the federal government and states to develop innovative housing alternatives for the elderly.

This chapter examines public financing that can potentially be used for assisted living by addressing the following topics:

- **Federal programs that can potentially increase the supply of assisted living units by directly financing the construction of new facilities.**

The federal government has been a major generator of publicly funded housing through the Department of Housing and Urban Development (202 and public housing authority programs) and through Farmers Home Administration funding, though few of these projects can accurately be called “assisted living.” The percentage of frail elderly served across these facilities and the services

provided within them vary widely across facilities: however, in the aggregate approximately 40 percent of all federally assisted units are estimated to be occupied by the elderly (Special Committee on Aging, United States Senate, 1991). This funding has traditionally focussed on the housing and not the services components of these facilities.

- **Federal programs that can promote the construction of new units by providing incentives** for other investors to fund units.

The mainstays of the types of federal incentives designed to generate investments in low-income housing by other investors are federal mortgage insurance, tax-exempt bonds, and more recently low income tax credits. These incentives are available to both the for-profit and non-profit sectors.

- **Federal programs that can promote assisted living by paying rental subsidies directly to low income households.**

In addition to providing project based housing assistance, the federal government provides rental subsidies directly to households. These subsidies are in the form of rental certificates which are limited to the difference between 30 percent of tenants' income and fair market rent as set by HUD, and more recently rental vouchers which, unlike rental certificates, allow tenants to pay any excess between 30 percent of income and fair market rents out-of-pocket. Housing vouchers are intended to provide tenants with more flexibility in their choice of housing arrangements.

- **Traditional sources of federal/state funding that can be used to provide services in housing for the elderly.**

Traditional sources which have been used to finance services in elderly housing include Medicare, Medicaid, Social Services Block Grants, the Older Americans Act, and the Supplemental Security Income Program. Medicare and Medicaid in particular largely have been limited to funding medical models of care in institutional settings.

- **Options for financing additional home and community-based services in assisted living settings under Medicaid waivers and new optimal services provisions.**

It is frequently said that the availability of Medicaid to pay for nursing home care and limited public funds for community-based care creates a "bias" toward institutionalization. Partly in response to those concerns, Congress amended the Social Security Act (which governs state options under Medicaid) to expand states' ability to pay for home and community care. The federal government has authorized a selective expansion of Medicaid services to the frail elderly in the community under Medicaid Home and Community Based Service Waivers.

- **Federal programs designed to integrate financing for housing and services.**

A major criticism of policies for funding assisted living is that historically disparate funding sources for housing and service have created a fragmented delivery system that does not optimally address the needs of the frail elderly. Recently, more coordinated programs (albeit limited in scope) have been developed to begin to address these concerns. One of the earlier programs was the congregate housing services program: more recently, the National Affordable Housing Act of 1990 has generated combined housing/services initiatives as well.

- **Additional ways in which states finance assisted living.**

States rely on a variety of sources to finance assisted living that include: state general revenue appropriations, state-levied fees or trust funds, and state general obligation bonds.

This chapter focuses only on the major sources of public financing and not the myriad of other programs through which assisted living could be funded. An extensive listing of the programs available through 1988 has been developed by Pynoos (1988).

## *CHAPTER VIII: STATE EXPERIENCES*

Many states have under development or are currently considering assisted living programs for the frail elderly. Different states have different goals in pursuing assisted living as a housing alternative: cost savings by reducing nursing home care; promoting independence among the frail elderly; improving health and psychosocial outcomes; and the range of other-assisted living goals discussed in this synthesis. Several recent works have described in detail state programs in assisted living, as summarized in Exhibit VIII.I. Rather than replicate this extensive work, this chapter identifies some major issues faced by states in developing assisted living for the frail elderly, and how various states have addressed these issues. The chapter is divided into two parts. Part One highlights the important challenges faced by states considering assisted living for the frail elderly, reviews how various states have dealt with these issues, and discusses the pros and cons of these approaches:

- **Should states develop assisted living programs by investing in new assisted living facility stock, or by supplementing services available in**

**existing settings that provide some level of care (e.g., board and care homes or congregate living apartments)?**

The answer depends on which segment of the frail elderly population the state intends to serve, how quickly the state wants to implement its program, cost containment considerations, and the availability of existing facilities that can be used, or adapted for use, for assisted living purposes.

- **How should a state fund its assisted living program? Through Federal Medicaid Waivers? Through Use of State Funds Only? What are the pros and cons of different funding mechanisms?**

The answer depends on how much a state needs federal matching funds, the degree of flexibility the state needs (i.e., freedom from federal restrictions), a state's cost containment goals, and funding stability issues.

- **How should states approach regulation of assisted living? What are regulations intended to achieve?**

The answer depends, in large measure, on the philosophy of assisted living the state wants to advance. The benefits of **regulation** (assuring quality of care) must be balanced against the risk of overregulation; i.e., inadvertently creating an "institutional" environment and infringing on the frail elderly's autonomy and independence.

- **How much should a state aggressively develop assisted living for the frail elderly as compared with state subsidized programs for other groups (such as the developmentally disabled, or children)?**

The answer depends on political and equity issues peculiar to each state. Fundamentally, states must decide how to allocate state funds between worthy recipients. If state officials believe assisted living can save money as compared to current long term care alternatives (e.g., nursing homes), the allocation decision might be easier to make.

- **Should states consolidate assisted living programs into a single agency, combining funding, programmatic, and regulatory functions?**

Some states have found consolidation of financing, regulatory, and programmatic functions into a single agency to be more efficient from economic and operations perspectives.

- **Should states control the supply of assisted living facilities through regulatory means?**

Some states view assisted living as an integral part of the continuum of their long term care system. As such, they have chosen to monitor supply through traditional regulatory means (e.g., licensing).

Part Two presents a more detailed summary of assisted living programs in Oregon, New York, Florida, Washington state, Maryland, New Jersey, Maine, Rhode Island, Connecticut, and New Hampshire.

## CHAPTER I INTRODUCTION

The term “assisted living” refers in general to a type of care that combines housing and services in a homelike environment that strives to maximize the individual functioning and autonomy of the frail elderly and other dependent populations.

Chapter I provides an overview of why assisted living is increasingly important from a policy perspective, why this synthesis on assisted living for the frail elderly has been undertaken, and how it is organized to address relevant policy issues.

### I. WHY THIS SYNTHESIS HAS BEEN UNDERTAKEN

This synthesis was undertaken for three key reasons:

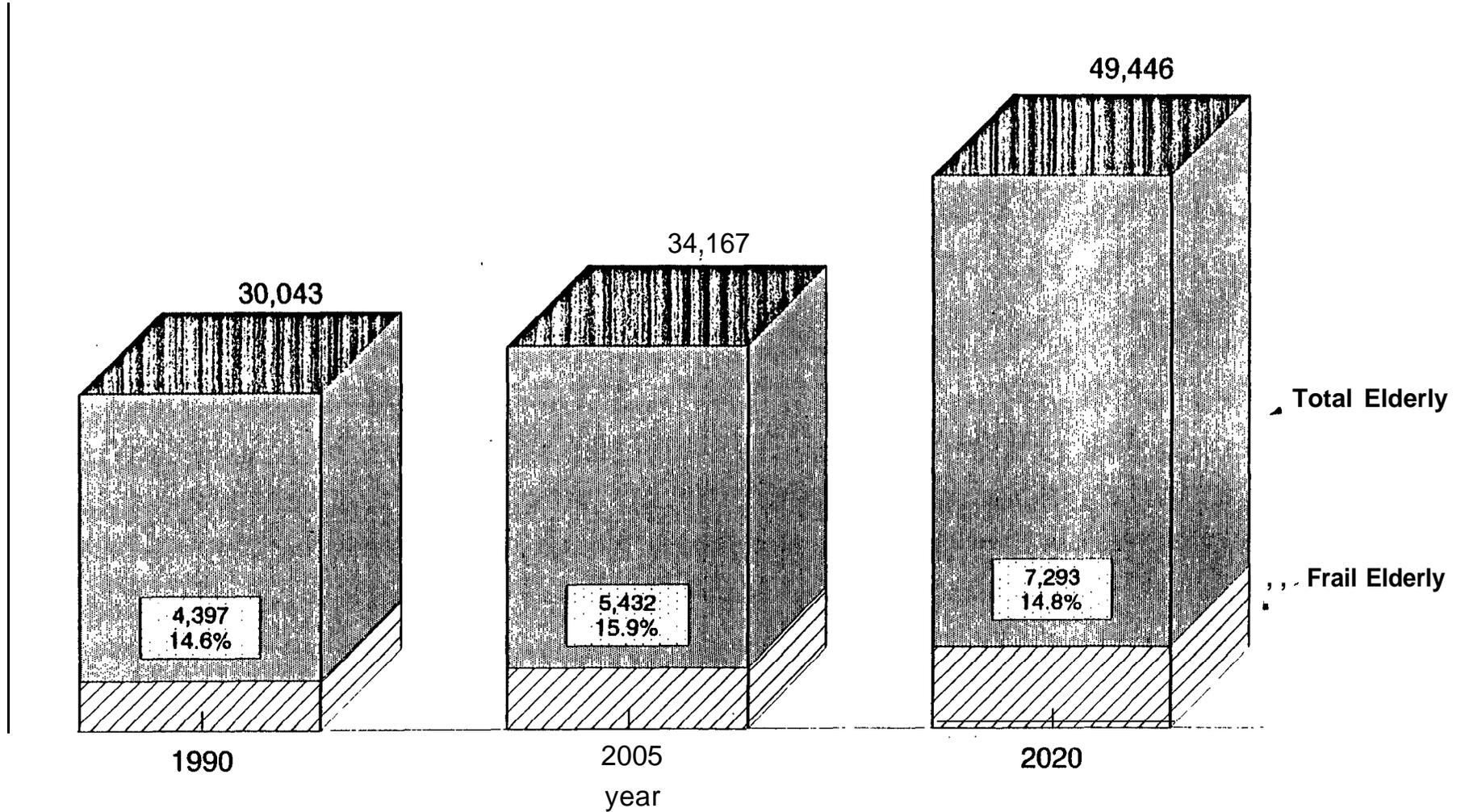
- The population is aging; the cost of long-term care for that population is increasingly expensive; and many are dissatisfied with current service options.
- Assisted living may be one preferred and less expensive alternative.
- There is a need to develop an agenda for future data collection and research efforts that involves the coordinated efforts of researchers and policy-makers with expertise **in a variety of different** fields, including services and housing.

#### A. **The Population is Aging; the Cost of Long-term Care for that Population is Increasingly Expensive; and Many are Dissatisfied with Current Service Options.**

Between 1990 and 2030 the elderly population is expected to double to 65 million people. The frail elderly — those who require assistance performing one or more activities of daily living (feeding, transfers, bathing, etc.) and household management tasks (shopping, managing finances, etc.) — currently comprise almost 15 percent of the total elderly population or about 4.4 million people. By the year 2020 as illustrated in Exhibit 1.1, the number of frail elderly is estimated to grow to 7.3 million.

# Exhibit I-1

## Estimates of Non-Institutionalized Frail Elderly (in thousands)



Source: Lewin/ICF estimates based on data from the 1984 Survey on Aging (SOA), the Current Population Survey (CPS), and the Brookings/ICF Long Term Care Financing Model

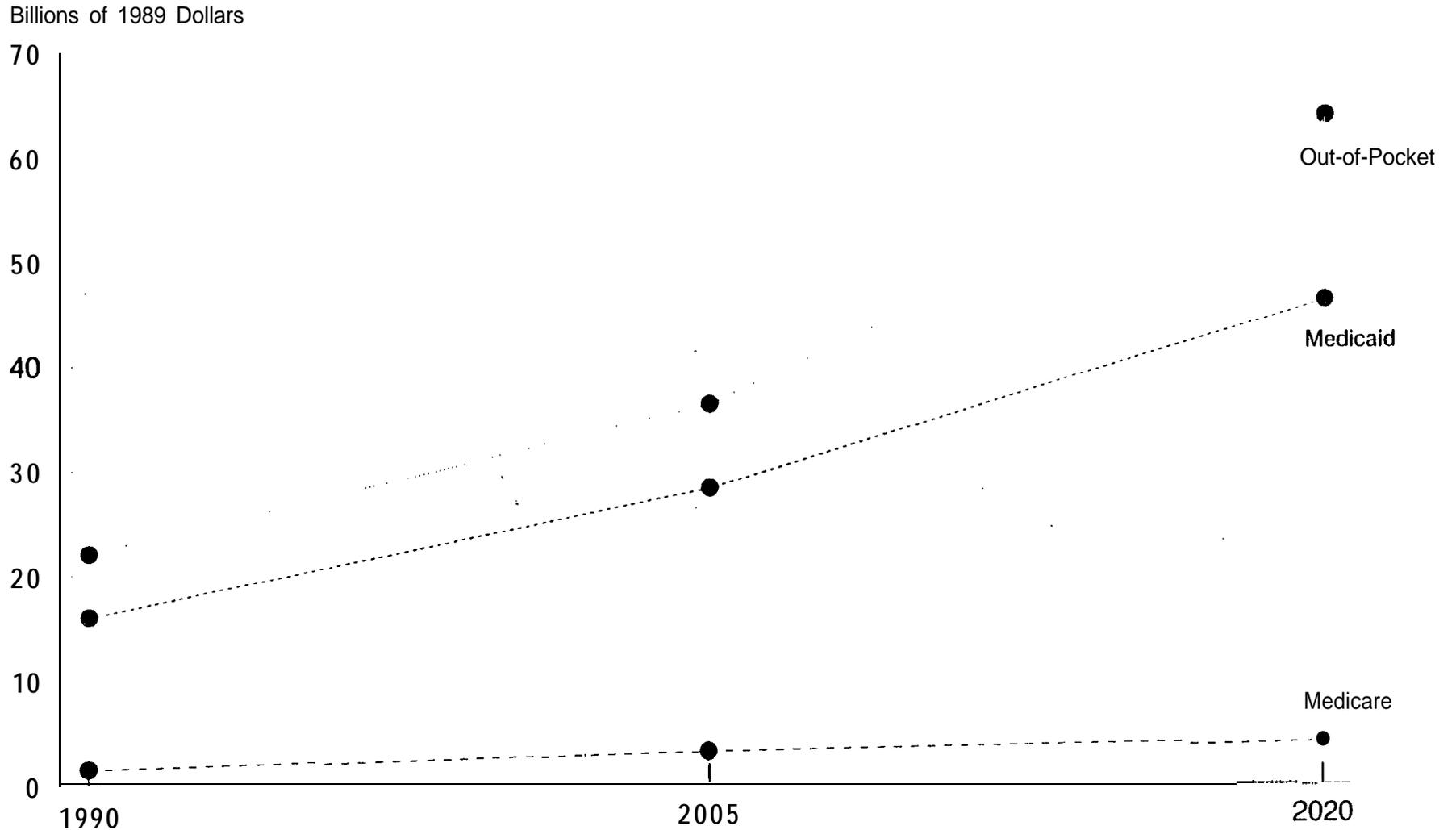
Out-of-pocket and public costs of long-term care are increasing at an alarming rate. Estimates of current nursing home expenditures as a percentage of each state's total budget range from between 2 and 10 percent and these expenditures are rising yearly (Ladd, 1992). As illustrated in Exhibit 1.2, in real dollars, out-of-pocket and Medicaid costs are projected to grow to approximately \$60 and \$40 million respectively.

**B. Assisted Living May Be One Preferred and Potentially Less Expensive Alternative**

There is a growing interest in assisted living as a concept that promotes independence and dignity for the frail elderly, and as a preferred living option for a frail population who might otherwise be placed in a nursing home. In addition, assisted living is viewed by some as a less expensive alternative to nursing homes, particularly for the estimated 20-30 percent of the nursing home population that is currently receiving largely custodial or intermediate type care. Many states are in the process of or considering the development of assisted living programs. In Oregon, fundamental reorganizations of related state agencies have been addressed to make the oversight and delivery of programs related to the elderly and assisted living more efficient. Related activities at the federal level include recent Department of Housing and Urban Development (HUD) initiatives and passage of new Medicaid home and community-based optimal services provisions. Increasing interest in assisted living has also been evidenced by the burgeoning growth in the number of conferences sponsored on assisted living. For example, the 1992 agenda of the Gerontological Society of America has major sections devoted to topics on assisted living. In addition, there are numerous major research projects currently underway on assisted living. For example, as discussed in Chapter VIII, there are at least six current projects underway on various aspects of state initiatives.

# Exhibit I-2

## Projected Nursing Home Expenditures for People Age 65+, By Source of Payment: 1990-2020



Source: Brookings/ICF Long-Term Care Financing Model, unpublished data, 1990

**C. There is a Need to Develop an Agenda for Future Data Collection and Research Efforts that Involves the Coordinated Efforts of Researchers and Policymakers with Substantive Expertise in a Variety of Different Fields, Including Services and Housing,**

This synthesis also has been undertaken to support the development of an agenda for future data collection and research efforts that involves the coordinated efforts of researchers and policy-makers with substantive expertise in assisted living. To that end; the Office of the Assistant Secretary for Planning and Evaluation sponsored the development of this synthesis. It initially served as a background piece for a meeting, jointly sponsored by ASPE and the National Academy of State Health Policy (NASHP), on assisted living for the frail elderly that brought together researchers, policymakers, and practitioners who contributed substantively to a policy relevant discussion of housing and supportive services. Discussions at the meeting, which included identifying issues for future research, are incorporated in this synthesis: Research questions are provided at the end of Chapters IV, V, VI, and VII. A list of meeting participants is included in Appendix B.

## **II. SOURCES OF INFORMATION**

The field of supportive housing for the elderly is evolving rapidly from both a public and private perspective. What was current in the field two months ago may be out-of-date today. The rapid evolution of the field is not the only factor that makes developing a synthesis difficult. Gaining information related to the frail elderly and supportive housing is also limited by the current lack of a centralized data base on assisted living facilities and wide variations on how assisted living is defined. Therefore, to develop this synthesis we relied not only on the over 350 books, **articles**, and documents (both published and unpublished) referenced in the bibliography, but on extensive telephone interviews with related association representatives, policymakers, and academicians/researchers. In addition to providing information for the synthesis, the bibliography is intended as a resource for those working in the field.

### III. HOW THIS SYNTHESIS IS ORGANIZED

The remainder of this synthesis is organized into seven chapters. Chapters II through V provide general background information on assisted living — who assisted living is intended to serve and why, and what its perceived advantages are over other long-term care options. The remaining chapters provide more detailed information on available federal and state resources, in addition to specific federal and state initiatives specifically directed at increasing the availability of assisted living options. An overview of each chapter is provided below:

- **Chapter II -What is Assisted Living?** provides an overview of what is meant by the term assisted living, other terms used to refer to the assisted living concept, how assisted living fits into the long-term care continuum, and estimates on the numbers of assisted living facilities.
- **Chapter III -Who are the Frail Elderly?** includes estimates of the number of frail elderly in addition to selected demographic and socio-economic characteristics.
- **Chapter IV — Matching Needs and Services** includes a discussion of the segment of the population for whom assisted living is considered an appropriate option, how service needs and eligibility are assessed, and how services are organized and delivered to meet those needs. Research questions for Chapters I-IV are also included.
- **Chapter V -The Effectiveness and Cost of Assisted Living** examines the issues that are typically espoused by advocates of assisted living, namely: the elderly prefer assisted living over nursing home care, assisted living improves the outcomes and quality of life, and assisted living costs less than other long-term care alternatives. Research questions for Chapter V are also included.
- **Chapter VI — Issues** in Regulating Assisted Living considers the myriad of assisted living regulatory issues faced by policymakers, researchers, consumers, and providers by raising the theoretical and practical reasons why regulation of assisted living is an important and challenging question, general approaches for regulating assisted living, and specific regulatory issues that arise in the assisted living context. Research questions for Chapter VI are also included.
- **Chapter VII — Public Financing of Assisted Living** discusses the host of public resources available to fund housing and supportive services and presents more recent initiatives to combine funding for those housing and services and how to target resources more specifically to the elderly in the community at high risk of institutionalization. Research questions for Chapter

VII are included here.

- **Chapter VIII – State Experiences** provides an overview of the major issues faced by states in developing **assisted** living programs in addition to description of specific state programs.



## CHAPTER II OVERVIEW OF ASSISTED LIVING

### I. INTRODUCTION

At the heart of the assisted living debate is “What is assisted living?” Policymakers, academicians, representatives of associations, and owners/operators of assisted living facilities alike typically begin conferences attempting to define what they mean by assisted living (AARCF, 1992). Assisted living is a term that is used broadly to define combined housing and services in a home-like environment. This general definition offers little guidance to those who need a precise description. Rather than attempting to apply a concrete definition to an evolving concept, this chapter provides an overview of the assisted living concept, how the term assisted living is typically used, other terms used for assisted living, and estimates of the numbers of assisted living facilities. More detail on how assisted living facilities are operated, financed, and regulated is included in subsequent chapters. This chapter address the following questions:

- **What do people mean by the term assisted living?** The term assisted living is used to refer to a type of care that combines housing and services in a homelike environment that maximizes individual functioning and autonomy. Beyond the basic definition, there is wide variation in how the term is used, the specific services provided, and to whom.
- **What other terms are used to refer to assisted living facilities?** Many other terms are used to refer to assisted living, though these terms should not necessarily be viewed as interchangeable — terms such as: board and care, residential care, personal care, foster care, domiciliary care, and congregate care. Federal regulations tend to include assisted living facilities under the broad term “board and care”. Only a few states, however, use either the terms “board and care” or “assisted living”, when licensing or regulating facilities that provide services like those provided in “assisted living”. Private developers use a wide range of terms (including assisted living) except the term “board and care” which is viewed as less marketable in the private sector.
- **Where does assisted living fit into the long-term care system?** In the literature, assisted living falls anywhere in between boarding homes (facilities that only provide room and board) and skilled nursing facilities on the long

term care continuum. Where facilities fall on the continuum, is determined largely by the intensity of services provided, the level of need of the individuals being served, and policies delineating when and under what circumstances individuals need higher levels of care (including admissions, retention, and discharge standards).

- **What general types of assisted living facilities are there?** Assisted living facilities may be roughly categorized into three types - each of which tends to be discussed in a separate literature: public housing, units in continuing care retirement communities and freestanding facilities (that may or may not be on the campus of a nursing facility). These facilities largely differ in their target populations, funding and how services are organized and delivered.
- **How many assisted living facilities are there?** Estimates in the literature of the numbers of assisted living facilities vary widely. There is no very good source of the number of assisted living facilities in the literature or through the various associations whose members include assisted living facilities. A representative of the Assisted Living Association of America stated that a major goal of this new association is to quantify the numbers of assisted living facilities. Estimates of the number of assisted living facilities range from approximately 40,000 to 65,000 facilities that are estimated to serve up to a total of 1,000,000 elderly.

## II. WHAT DO PEOPLE MEAN BY THE TERM ASSISTED LIVING?

Virtually all observers agree that “assisted living” facilities are homelike or non-institutional residential settings that offer more assistive services (e.g., medication monitoring or help with some activities of daily living) than room and board. Virtually all observers also say that nursing homes are not assisted living facilities, in **part** because nursing homes are seen by the proponents of assisted living as overly institutional and medicalized.<sup>1</sup>

Defined broadly, assisted living sounds a lot like board and care. The proponents of assisted living, however, assert that assisted living is as much a special philosophy and attitude as a particular configuration of housing and services.

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<sup>1</sup> Some, however, **assert** that most of the **services** currently provided in a nursing home could be provided in settings that reflect the assisted living philosophy.

## A. The Philosophy of Assisted Living

What makes the assisted living concept different? Assisted living is said to embody a set of principles that include promoting the concept of environmental normalization to maximize the functional capacity of individuals while promoting the concept of community, dignity and respect for privacy and individuality. In doing so, assisted living replicates to the extent possible functional, emotional and social elements of “home” in non-familial group living situations (Wilson, 1988).

Those who see assisted living as a philosophy note that particular **spacial** designs are critical to the best or fullest expression of the concept:

*“While assisted living concepts will change the operation of existing licensed board and program and the operation and design of nursing facilities. The real potential for this mode/ is-in new construction or rehabilitation to realize the full scope of the concept (home-like buildings, single occupancy units with baths and cooking capacity, privacy, shared responsibility and risk sharing, and skilled nursing and support services available to nursing facility eligible residents.)” Mollica, et. al., 1992, p. iv.*

The philosophy of treating the environment as “prosthesis” was developed in the early 1960’s by an innovative researcher on aging and the environment, Powell Law-ton. Over time, an increasingly sophisticated literature on design principles has stressed the importance of providing opportunities and space for social interaction, empowerment, and maximizing individual functioning.

## B. variations in the Use of the Term Assisted Living

Beyond the basic definition of assisted living as a combination of housing and services in a homelike environment, there is great variation in how the term is used. For example, some **authors refer** to assisted living in terms of facilities that only care for residents who are not eligible for nursing home care; others target more dependent highly cognitively impaired patients. Public facilities that have assisted living units may have limited access to congregate space and services. Private facilities targeted to middle and higher income residents may offer amenities such as spacious rooms, 24-hour RNs, and extensive social

programs (see Exhibit II.1).<sup>2</sup>

Exhibit II.2 illustrates the broad variation in how the term assisted living is used. Interestingly, according to the University of California at Los Angeles/San Diego National Resource Center on Long Term Care, the term assisted living as used to describe a specialized housing type and a philosophy of care is relatively new and did not appear in computer searches of the formal literature until the mid-1980s. (Regnier, Hamilton, and Yatabe, 1991) Trade publications like Contemporary Long-Term Care Provider, and Retirement Housing Report, were among the first publications to use this term. The relative newness of the term may in part account for the inconsistency in how it is used across providers.

More detail of how assisted living facilities differ in terms of the services they offer and their staffing is provided in Chapter IV.

### C. Eight Definitional Qualities of Assisted Living

Since assisted living is an evolving concept not susceptible to a facile or concrete definition, some scholars have identified the “qualities” of assisted living that serve to define it as a unique housing alternative for the frail elderly. Victor Regnier, an architect and professor in the Andrus School of Gerontology, recently identified eight definitional qualities of assisted living as a way to operationalize a concept for which “there are no universally accepted definitions” (Regnier, 1992):

**“Appear Residential in Character** -- the form and character of assisted living is derived from the house and not the hospital.

**Perceived as Small in Scale and Size** -- the setting should be as small as possible without sacrificing monthly cost stability and the capability to provide 24 hour assistance.

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<sup>2</sup> Exhibits II.A-1 and II.A-2 at the end of this chapter summarize the prices charged and services provided at a range of privately-operated assisted living facilities in California and the Washington, D.C. area.

Sample Ads for Assisted Living  
(Washington Post, September 29, 1992)

WASHINGTON POST HEALTH/SEPTEMBER 29, 1992



## A Caring Assisted Living Retirement Community

offers gracious assisted living in a tranquil, park-like setting within the Shopping Plaza. A non-denominational retirement community, we provide a cordial and secure home environment.

- No Entrance Or Hidden Fees
- Professional Caring Staff
- Housekeeping-Laundry Service
- 24 Hour Security
- Intensive Personal Care Program
- Month To Month Leases
- Spacious suites, Studios, And One Bedroom Units
- Gracious Dining
- Social Activities



Please send Me More Information



NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 PHONE \_\_\_\_\_ Best Time To Call \_\_\_\_\_



Mom is full of life and really cherishes her independence. Still... She does need some care... That is why we are glad we found

### The Retirement Community With a Difference:

More Care • More Choices • More Flexibility • More Experience

- \* A choice of Independent or Licensed Assisted Living with my degree of cue in between, as needed, when needed
- \* Full time Registered Nurse
- \* Three elegant meals available on a flexible plan
- \* Full range of personal services including MEDICATION ADMINISTRATION
- \* Housekeeping services
- \* Flexibility in fees charged as well as in services offered
- \* Daily scheduled transportation
- \* The largest apartments of any community in the area
- \* Extensive social programs
- \* SEASONED, CARING STAFF
- \* 24-hour emergency response with medically trained personnel around-the-clock
- \* NO ENTRY FEE
- \* GREAT VALUE FOR QUALITY

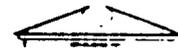
Please call our Information Center Mon-Fri 9-6. Sat 10-4

COME SEE WHY THERE IS NO SUBSTITUTE FOR EXPERIENCE!

WE INVITE YOU TO COMPARE OUR RATES!

Yes, please send me more information

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone (\_\_\_\_) \_\_\_\_\_



WP9-29

WASHINGTON POST HEALTH/SEPTEMBER 29, 1992

**EXHIBIT 11.2**

**A REPRESENTATIVE SAMPLE OF THE RANGE OF DEFINITIONS FOR ASSISTED LIVING**

<b>SOURCE</b>	<b>DEFINITION</b>
The Assisted Living Facilities Association of America (ALFAA)	“A special combination of housing and personalized health care designed to respond to the individual needs of those who need help with activities of daily living. Care is provided in a way that promotes maximum independence and dignity for each resident and involves the resident’s family, neighbors, and friends.”
Long-Term Care National Resource Center at UCLA/USC. (1989).	“Assisted living is a residential Environment that provides supportive services to the semi-independent elderly whb are functionally impaired, but do not require nursing care.”
Kane, et. al., “Meshing Services with Housing: Lessons from Adult Foster Care and Assisted Living in Oregon”. (1990).	“Assisted living is generally deemed appropriate for people whose non-medical needs are similar to those persons in nursing homes; e.g., meals, housekeeping, laundry, and medication supervision. But, compared to foster care residents they may also need more intensive personal care and more nursing services such as catheter care, injections, behavior management, care for <b>Alzheimer’s</b> Disease, and care related to incontinence.”
David Seip. “Hot Concepts in Assisted Living”, <u>Contemporary Long Term Care</u> , (August, 1987).	“Facilities which provide a more extensive array of services and are based on a more sophisticated concept than board and care. A range of services are provided in a “structured environment” to help those who do not require nursing home level care. Assisted living is that level of care which is provided to residents who cannot live independently but do not require skilled care. Don’t confuse them with boarding homes, which in most states are governed by the same licensure and certification. The contemporary assisted living facility is much more sophisticated in concept.”

EXHIBIT 11.2

A REPRESENTATIVE SAMPLE OF THE RANGE OF DEFINITIONS FOR ASSISTED LIVING [continued]

SOURCE	DEFINITION
<p>Victor Regnier, et. al., <u>Best Practices in Assisting Living</u>. (1991).</p>	<p>"In contrast to board and care, assisted living serves to delay institutionalization and to maintain varying degrees of independence by offering personal care services delivered in a unique way in a residential environment. It is a housing alternative based on the concept of outfitting a residential environment with professionally delivered personal care services, in a way that avoids institutionalization and keep older frail individuals independent as long as possible. As a housing type, assisted living fits between congregate housing and skilled nursing care.</p>
<p>Nancy Coleman and Joan Fairbanks, "Licensing New Board and Care for the Elderly" <u>Saint Louis University Public -Law Review</u>. (1991).</p>	<p>"It is a more marketable label for a level of care offering the equivalent of a board and care arrangement, although they tend to offer a more extensive array of services. The new term "assisted living" is simply a more palatable and appealing way to describe board and care, a term which conjures up images of frail older people with bed sores living in dilapidated old houses. While many types of assisted living offer a great deal more in terms of services and assistance than do most traditional board and care facilities, the level of allowable care is the same."</p>
<p>Oregon (Administrative Rules)</p>	<p>"Assisted Living requires the Residential Care Facility/Assisted Living Facility to provide each resident a separate living unit with a lockable door to guarantee their privacy, dignity, and independence. Assisted living means a program approach, within a physical structure, which provides or coordinates a range of services, available on a 24-hour basis, for support of resident independence in a residential setting. Assisted living promotes resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence, and home-like surroundings."</p>

**Provide Residential Privacy and Completeness** -- the housing unit should be complete and not a hotel room.

**Foster Independence, Interdependence, and Individuality** -- the focus of care should be on self-maintenance with assistance.

**Focus on Health Maintenance, Physical Movement and Mental Stimulation** -- the setting should stabilize decline, improve competency and build reserve capacity.

**Support Family Involvement** -- a care giving partnership should be forged that shares responsibility rather than isolate residents from community resources and contacts,

**Maintain Connections With The Surrounding Community** -- the setting should integrate rather than isolate residents from community resources and contacts.

**Serve the Frail** -- residents should include those in danger of being institutionalized because of their need for assistance and support." (Regnier, forthcoming).

### III. WHAT OTHER TERMS ARE USED TO REFER TO ASSISTED LIVING FACILITIES?

As stated above, assisted living is not the only term used to refer to housing combined with services in facilities that promote the concept of client and environmental normalization; e.g., a homelike setting that maximizes dignity and individual functioning. Residential care, personal care, board and care, foster care, congregate care, etc. are all terms used to refer to facilities that some might classify as assisted living facilities. Exhibit II.3 presents some definitions and descriptions of other terms used for assisted living and related facilities.

EXHIBIT 11.3

OTHER TERMS USED FOR ASSISTED LIVING **AND** RELATED FACILITIES

SOURCE	TERM	DEFINITION/DESCRIPTION
Vincent Mor, "A National Study of Residential Care for the Aged" <u>The Gerontologist</u> . (1986).	Residential Care Facilities/or Domicile Care/Congregate Care/Adult Foster Homes	In a residential setting, food and housing are provided as well as "Supervision and protective oversight" for functionally impaired elderly.
Special Committee on Aging, United States Senate, and the Select Committee of Aging of the House of Representatives, <u>Board and Care: A Failure in Public Policy</u> , (1989).	Board and Care	"Board and care is a catchall term used to describe a wide variety of non-medical residential facilities. These include group homes, foster homes, personal care homes and rest homes. There is a great deal of variance among board and care with regard to size, type of resident, the range of services offered, and the ownership. They usually provide room, meals, assistance with activities such as bathing, dressing and the taking of medication, and can be anywhere from one to 100 residents."
Sandra Crawford Leak, "State Housing-With-Services Programs: New Initiatives, Striking Diversity" <u>Long Term Care Advances</u> (1991).	Congregate Housing and, Services Program As defined and used by State of New Jersey)	"Congregate housing facility" means that part of a residential housing facility which incorporates subsidized senior citizen housing consisting of individualized apartment units and supportive services needed by project residents who are functionally or socially impaired to enable them to maintain or return to a semi-independent lifestyle and to avoid premature institutionalization.

**EXHIBIT II.3**

OTHER TERMS USED TO DEFINE ASSISTED LIVING CONCEPTS [continued]

<b>SOURCE</b>	<b>TERM</b>	<b>DEFINITION/DESCRIPTION</b>
Laventhol and Horwoth, <u>Retirement Housing Industry</u> (1988).	Personal Care/Sheltered Care	"A transition level of care between independent living and the lowest level of nursing care."
Sandra Crawford Leak in "State Housing-With-Services Programs: New Initiatives, Striking Diversity" <u>Long Term Care Advances</u> . (1991).	Congregate Housing (As defined and used by State of Massachusetts)	"A noninstitutional residential share living environment which integrates shelter and services needed by the functionally impaired or socially isolated elder who does not require the constant supervision or intensive health services provided in an institution. The shared living environment includes at least two of the following: 1) shared accessible community space, b) shared kitchen; c) shared dining facilities; or d) shared bathing facilities."
Mary Bear, "Use of Adult Congregate Living Facilities: Impact on Network Characteristics on Health Severity and Time of Entry"	Adult Congregate Living Facilities	"A less restrictive version of board and care where room, board, and personal services are offered to semi-independent elderly who do not require skilled nursing care."
David Seip, "Building Awareness of Assisted Living" <u>Contemporary Long Term Care</u> . (1989)	Adult Congregate Living Facilities (As defined and used by State of Florida)	In order to be classified as assisted living, the facility must provide assistance to residents with at least one routine of daily living.

**A. Assisted Living is a subset of Board and Care in key federal regulations and data sets.**

People use different terms for various reasons. The federal government, uses the term board and care to refer to the broad category of private and public housing where housing and services are combined (Senate Special Committee on Aging, **House** Select Committee on Aging, 1989). **Since** the term “board and care” in federal regulation and law has been associated with public scandals over poor quality in these facilities, many in private industry avoid the term “board and care” to avoid evoking the image of poor quality, low-income housing.

In 1989, recognizing the need to develop better information on residential settings with services, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Center for Health Statistics (NCHS) commissioned a study to develop a comprehensive list of licensed “board and care”<sup>3</sup> homes in the United States (Lewin-ICF, et. al., September, 1990). The following is a description of the characteristics of facilities that were included in the study and will now be categorized as “board and care” facilities in future federal studies:

Board and Care facilities in the inventory:

- Offer personal care services in addition to room and board. Personal care services include assistance with: eating, bathing, dressing, taking self-administered medication, and arranging personal affairs.
- Provide supervision on a 24-hour basis. Residents may not require continual supervision, but assistance must be available at all times from an on site attendant.

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<sup>3</sup> More specifically, **Lewin-ICF** generated a list of potential licensed board and care homes. That listing was merged with other data on nursing homes, personal care homes, and Intermediate Care Facilities for the Mentally Retarded maintained by the National Center for Health Statistics (NCHS). The merged data were then transmitted to the Census Bureau which, in turn, contacted the listed care facilities to determine which were in fact nursing homes, board and care homes, etc. From this merged data set, NCHS **issued the National Health Provider Inventory (NHPI)**. The NHPI also included hospice facilities and home health agencies.

- Provide a long-term living arrangement. Generally, we attempt to include all facilities with typical lengths of stay of six months or more.
- Be licensed by a state agency. However, we included facilities which were certified or registered at the state level when data were available and the facility characteristics fit the working definition of board and care homes.

It was agreed to exclude the following types of facilities from the inventory:

- Facilities providing intensive medical services such as hospitals, Skilled Nursing Facilities (SNF), Intermediate Care Facilities (ICF) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR).
- Dual-certified facilities. For example, a SNF or ICF with a personal care or rest home component would not be included.
- Short term treatment facilities such as alcohol detoxification programs.
- Facilities exclusively serving drug and alcohol dependent clients.
- Domestic violence and other types of shelters.
- Facilities serving primarily children.
- Facilities licensed by counties or local districts rather than the state.
- Semi-independent living programs. These arrangements often involve widely different **levels** of service to residents within a particular licensure category which may range from having staff on the premises on a **24-hour** basis to as little as two hours per week. Because these arrangements differ dramatically and in many cases would be difficult to survey, the working group decided not to include them in the computerized database. However, we provided ASPE with a non-computerized file and description of semi-independent programs which were identified.

**B. Currently, few States use the term “assisted living” in licensing/regulating facilities, except for those serving persons with mental health service needs.**

To develop the federal inventory of Board and Care facilities, among other things, researchers called officials in all 50 states to determine what terms states use when licensing and/or when licensing and/or regulating facilities meeting the above descriptions (a complete listing of terms is found in Appendix A of this document). The researchers found that:

- Among the 50 states (and the District of Columbia), there are a total of 272 separate regulatory categories for “board and care” facilities.
- Not one state was found to use the term “board and care”.
- Four states use terms similar to board and care - such as “boarding care home”.
- Not one state used the term “assisted living”, except for homes providing services to people with mental health care needs.

#### IV. WHERE DOES ASSISTED LIVING FIT INTO THE LONG-TERM CARE “SYSTEM”?

There are at least two major views of the long-term care system. Some see the system as a continuum of care, **with** facilities organized in ascending order from those providing fewer services to those providing more. At best, according to this view, there should be different types of facilities to match the different levels of care or needs that people have. Another view is that the long term care system should be conceptualized to promote “aging in place.” In that concept, facilities change with people as they age. Below we describe one view of how assisted living fits into the long-term care system, conceptualized as a continuum of care..

Exhibit II.4 provides one view of what that long-term care continuum is, and how assisted living may be defined more or less broadly to fit within the continuum. The framework for classifying the long term care continuum is defined by two basic dimensions: 1) intensity of services provided **and**, 2) the level of need of the residents served by the facilities. The vertical axis of the exhibit represents the **service** intensity provided by facilities, the horizontal the level **of need**.

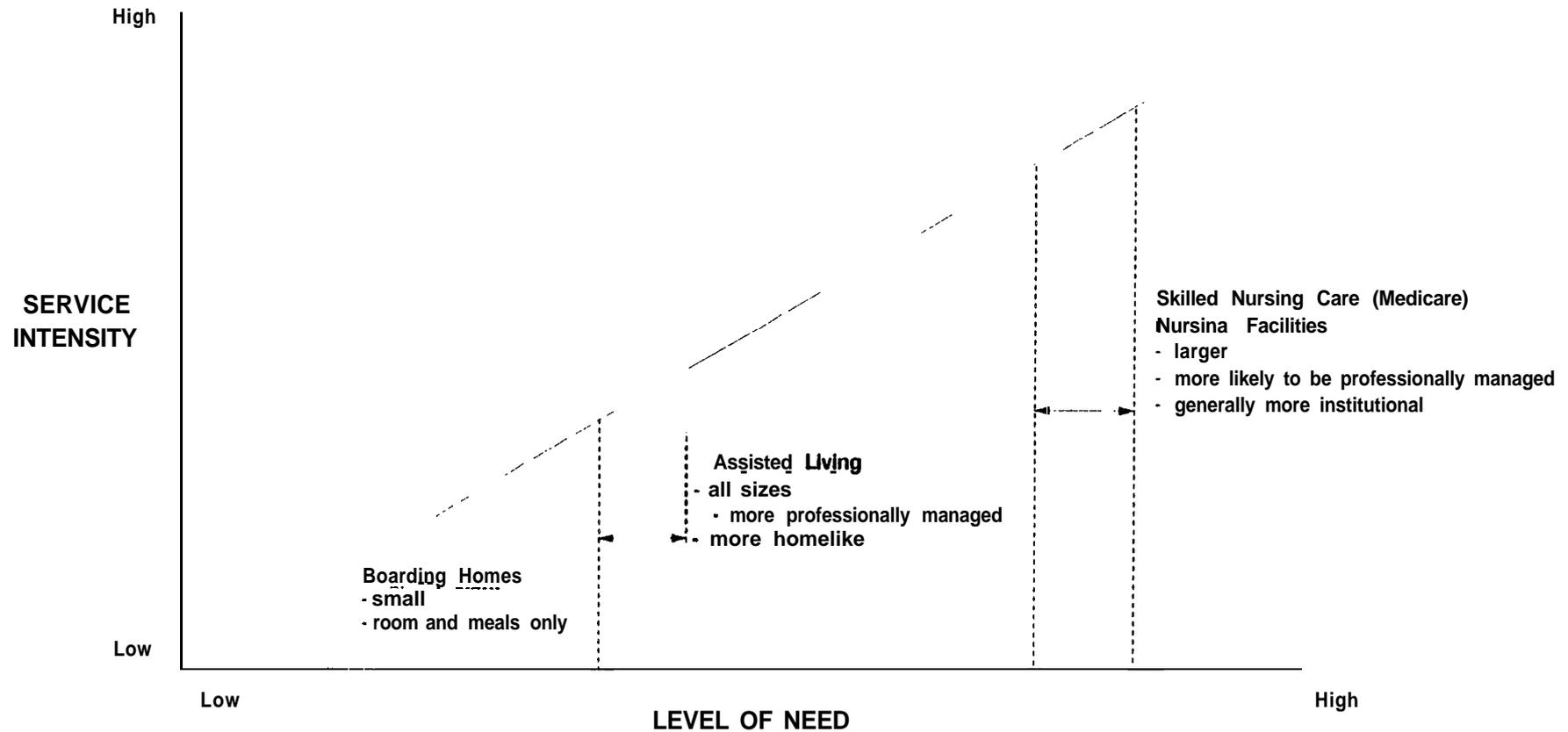
The **service intensity**, represented on the vertical axis, may range from low to high; for example from those facilities that provide just meals to those that provide a combination of

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<sup>4</sup> It should be noted that both Oregon and Washington state currently use the term “assisted living” in regulation.

EXHIBIT 88.4  
ONE VIEW OF LONG-TERM CARE CONTINUUM

# One View of Long-Term Care Continuum



Source: Lewin-ICF

24-hour nursing services, social services, etc. The level of need, represented on the horizontal axis, may also range from low to high — a low level of need would be characterized by an elderly individual who is independent and a high level of need would characterize an individual for instance who is cognitively impaired and unstable medically.

Assisted living as a category in the long term care continuum falls in-between boarding homes (defined as facilities that provide room and board or eats and sheets”, as it is sometimes called) and skilled nursing facilities. How broad or narrow the category of assisted living is defined varies as illustrated in the definitions of assisted living above. It also has implications from a policy perspective; for example, in defining which types of residents are eligible for public support. There are a multitude of other dimensions by which facilities in the continuum are defined such as: size, type of management, the degree of homelikeness, the availability of medical services, etc. Moving from right to left along the continuum, facilities tend to be smaller, and more homelike. Moving from left to right, facilities tend to larger, have more professional management structures, and, for skilled nursing facilities anyway, to be more institutional.

Though useful to place assisted living on a continuum for definitional purposes doing so may be inconsistent with assisted living’s philosophy of promoting “aging in place.” It is important to emphasize that one important intent of assisted living is to design environments to accommodate individual needs that change over time. A continuum of care orientation, therefore, may emphasize facility types more than individual needs.

## V. WHAT ‘GENERAL TYPES OF ASSISTED LIVING FACILITIES ARE THERE?

The types of assisted, living facilities may be classified into three categories: public housing, assisted living units that are a part of continuing care retirement communities. and freestanding assisted living facilities (that may or may not be on a campus with a nursing facility). The key differences among these categories of facilities are their target populations, their funding sources and their service delivery systems. These are briefly described below and in more detail in subsequent chapters.

**A. Target populations**

Differences in income eligibility constitute the primary distinguishing characteristic among categories of assisted living facilities with regard to the populations they target. Public housing targets low income individuals. For the most part, private facilities target middle and upper income elderly, but that may vary according to the degree to which private facilities depend on federal subsidies; e.g., federal mortgage insurance, or low income tax credits. Federal subsidies typically require set-asides of a certain number of units for low income individuals. In addition, some state programs require a set aside for low-income people. Otherwise the categories of facilities appear to vary within and across categories in terms of the eligibility criteria based on functional capacity, ages, etc. More detail are provided on these types of criteria in **Chapter IV**.

**B. Funding**

Publicly funded facilities have not generally included assisted living units but may be a potential source in the future, Public facilities are largely subsidized with federal dollars for both capital and operating expenses (as described in more detail in Chapter VI). Private facilities also use a variety of publicly subsidized programs, though primarily to support construction costs. For example, the range in the types of financing methods used by CCRCs to fund construction includes\*:

Conventional mortgage	54.1%
FHA-insured mortgage	14.5
Private taxable bonds	4.8
Tax-exempt revenue bonds.	15.5
Public taxable bonds	1.9
Gifts and donations	30.4
Entry fees	33.8
Other	11.6

\* THE FIGURES ARE FOR 1984; IN ADDITION, VALUES DOUBLE-COUNT INSTANCES IN WHICH THE STATED METHOD IS USED IN COMBINATION WITH ANOTHER METHOD.

SOURCE: AAHA AND ERNST AND YOUNG, CCRCs: AN INDUSTRY IN ACTION

### C. Service Delivery Systems

Categories of assisted living facilities also differ in the way that delivery systems are funded and organized. Services in public facilities are funded through tenant rents and other public sources and are therefore limited in amenities. In addition, service delivery systems in public facilities tend to be more fragmented and delivered by providers from a wide range of outside agencies. Service packages in private facilities are often less fragmented and delivered by providers employed by the facilities themselves or through contracts with outside providers. In addition, service delivery may also be a function of regulatory and code requirements. More detail is provided on service delivery systems, including the range of services, staffing, etc., in Chapter IV.

### VI. HOW MANY **ASSISTED LIVING UNITS ARE THERE?**

Assisted facilities are difficult to count for two reasons. First, there is a great deal of variation in how assisted living units are defined; for example where estimates of the number of residential care facilities are given it is not clear what types of facilities are included in those estimates. Board and care? Congregate Housing Services Program funded units? The few surveys that exist rely on the facilities themselves to define assisted living. Survey questions are stated more generally as “how many assisted living units does your **facility** include.” What one facility reports as assisted, living may differ from what another facility reports. For example, one facility might report the number of units that have access to communal meal services. Another facility may only report those units that have broader access to housekeeping, medication, personal care and communal meal services. Secondly, where particular facilities would not characterize themselves as assisted living facilities, the wide range of services that outside organizations provide within those facilities may make them look like assisted **living** facilities. Various estimates of the number of assisted living and related facilities (and the number of individuals served) are presented in Exhibit II.5.

**EXHIBIT II.5**

**ESTIMATES OF NUMBERS OF ASSISTED LIVING (AND RELATED) FACILITIES/PERSONS SERVED**

<b>SOURCE</b>	<b># OF FACILITIES</b>	<b>UNITS/PERSONS SERVED</b>	<b>DEFINITION</b>
Assisted Living Facility Association of America (1991)	30,000 - 40,000	1,000,000 <sup>t</sup>	Broadly defined estimate of facilities that provide more than room and board but less than skilled nursing care.
Lewin-ICF count (prepared for ASPE and the National Center for Health Statistics), 1990	65,372	N/A	All potential licensed "Board and Care" facilities (for adults) in the U.S., regardless of the term used. <sup>a</sup>
National Association of Residential Care Facilities	41,000	563,000	Estimates of licensed residential care facilities
National Association of Residential Care Facilities, unpublished data, 1987	N/A	513,550	Estimated licensed residential care facilities (aggregated from state level data) for age 65+
U.S. Census, 1980	N/A	849,582	Age 65+ in "Homes for the Aged" not known to have nursing care <sup>b</sup>
	N/A	135,045	Age 65+ in "Other Group Quarters" (not institutions)
U.S. Census, 1990	N/A	104,803	Age 65+ in "Other Group Quarters" (not institutions)
The 1985 National Nursing Home Survey (all persons)	N/A	170,000	People in facilities classified in the 1984 Master Facilities Inventory (NCHS) as "personal care" and "domiciliary" facilities. Excludes those classified as "board and care" and "residential".
The 1985 National Nursing Home Survey (persons age 65+)	N/A	129,600	
Tilson, D., et. al., <u>Aging in Place</u> , 1990	N/A	350,000 - 700,000	Includes broad range of definitions from board and care facilities, to adult congregate living facilities, adult foster care, etc.
Newman, Sandra: "The Frail Elderly in the Community: An Overview of Characteristics", <u>Aging in Place</u> , 1990	align="center">N/A	align="center">1,000,000	<b>Congregate housing (400,000 - 500,000)</b>
			Residential care facilities (350,000 - 700,000) Continuing care retirement communities (200,000)
Struyk, Raymond: <u>The Frail Elderly in Federally Assisted Housing</u> , 1987	N/A	105,000	Definition limited to the number of frail elderly in federally assisted public housing

<sup>a</sup> See text of this chapter for the definition of "Board and Care"  
<sup>b</sup> The 1990 Census does not have this category.  
<sup>c</sup> The 1980 and 1990 Census included under this category all "foster homes" (any size) and other group homes with 10 or more unrelated individuals in settings such as: Rooming Houses, Homes for the Mentally-Ill, and Homes for the Physically-Handicapped. The category excludes "Homes for the Aged"

## VII. SUMMARY

There is wide variation in what people mean by the term assisted living in terms of the services provided and appropriate target population for those services. More detail on services and target populations are included in Chapter 4. The common denominator for the terms used is combined housing and services in a homelike environment. Rough estimates of the number of such facilities exist, but these estimates are not based on rigorous analyses of existing facilities.

EXHIBIT II.A-1

COSTS AND SERVICES PROVIDED IN A RANGE OF PRIVATE ASSISTED LIVING FACILITIES IN THE WASHINGTON D.C. AREA (1991)

Name	Accommodation	Entrance Fee	Monthly Maintenance Fee	Meal Plan	Services	Medical Care
Canton Merchant House (in Manassas)	78 apartments with kitchenettes	None	Studio: \$1,535, Alcove: \$1,765 Single: 62.400 Dbl shared bedrm: \$2,020 Dbl own rm: \$2,650	3 meals a day included in monthly lee	Weekly house-keeping Planned social activities	Wellness clinic assists with medication for \$45 monthly and affiliated with a local SNF and hospital
CountrySide Manor (in Sterling)	47 of the 100 beds are assisted living suites	Furnishing fee required equaling 2 months rent	Studio: \$1,145' Two bedrm with balcony: \$2145  (\$425 more monthly with a second resident)	3 meals a day included in monthly fee	Daily maid Laundry/linen service Personal asst Mental health care Dietary nutrition care Resident relations Social activities	Medical and physical therapy offices on site, 24-hr on call physician, monitoring and admin of medication and health status assessment done weekly
The Manor at Gunston (in Lorton)	53 1 and 2 bedrm assisted living apts	None	<b>Semi-private</b> daily fee: \$55-65, Private daily fee: \$70-90 and furnishing fee, 60 times the daily rate which is refunded on a prorated basis	3 meals a day and snacks included in monthly fee	Dally maid svcs. Laundry/linen svcs	Private physician on-site
Potomac Place (in Woodbridge)	31 assisted care apts in a 93 apt facility	None but a \$500 security deposit	\$627 per person	3 meals a day and snacks included	Weekly cleaning/laundry Help bathing and dressing Religious Social Rec. activities	Assistance with ADL's <sup>*****</sup> , admin of medication and protective oversight
Sunrise Retirement Homes (in Arlington)	50 Assisted living units	None	\$26 daily minimum rate \$852/month	3 meals a day and snacks included	Housekeeping daily Social Programs Help with resident relations Transportation Counseling	Assistance with ADL's and administering medication
Sunrise Retirement Home of Fairfax	50 assisted living units	None	\$47 daily minimum rate \$1,430/month	3 meals a day and snacks included	Housekeeping Social Programs Help with resident relations Transportation Counseling	Assistance with ADL's and administering medication
Independence Court (in Hyattsville)	119 units and 134 beds	None	\$1,400-\$2,400	3 meals a day and snacks included	Housekeeping Social Recreational Programs	Administration of medic&i on RN's on staff to provide ADL help

Many assisted living setting categorize assistance with ADLs under "services" rather than "medical care."

**Exhibit II.A-1**

COSTS AND SERVICES PROVIDED IN A RANGE OF PRIVATE ASSISTED LIVING FACILITIES  
IN THE WASHINGTON D.C. AREA (1991) [continued]

<b>Name</b>	<b>Accommodation</b>	<b>Entrance Fee</b>	<b>Monthly Maintenance Fee</b>	<b>Meal Plan</b>	<b>Services</b>	<b>Medical Care</b>
The Westwood (in Bethesda)	63 suites (not all assisted living)	None	Studio: \$105 daily Two rm suite: \$123 \$57 daily for additional relative	3 meals a day and snacks included	Maid Linen svcs daily Assist with bathing, dressing Adm of medication Variety of social and Rec. programs Outside trips Community Involvement	24 hr RN supervision Priority admission to 2 nearby SNF's
Marshall Manor (in Marshall)	126 beds in 64 suites: a lifecare community	\$65,000 partially refunded over time or pay-as-you go	\$1,900 of \$72-66 daily for those who don't pay entrance fee	3 meals a day and snacks included	Frequent hskg Help with dressing, bathing and eating	24 hr RN Help with medications Special unit for those with cognitive dysfunctions

Monthly rates in a sample of 20 Oregon assisted living facilities are as follows: for private pay patients, rates range from \$2,115.00 to \$1,418.00 per month; the average monthly Medicaid rate averages \$1,417.00, with a low of \$664.00 and a high of \$1,828.00, depending on the intensity of service required. The basic rate includes rent, meals, personal care, recreation, and routine nursing. The higher rates cover more intensive nursing services. (Wilson, 1992 personal communication)

EXHIBIT II.A-2

COSTS AND SERVICES PROVIDED IN A RANGE OF PRIVATE ASSISTED LIVING FACILITIES IN THE STATE OF CALIFORNIA (1990)

Name	Accommodation	Entrance Fee	Monthly Maintenance Fee	Meal Plan	Services	Medical Care
The Heritage (in San Francisco)	110 units	Varies with age and financial status: studio: \$40,000, double: \$70,000	Studio: \$765 Shared bedrm: \$1500	NA	Diverse programs, assistance with ADLs	Nursing and health care facility on-site, physician available 3 x a week and 24 hrs on call
Westgate Villa (in San Jose)	31 units	None	<b>Semi-private:</b> \$650 Private: \$1475 and some beds set aside for SSI eligibles	3 meals included	A range of activities, as well as personal care provided	Located near a hospital and SNF, assistance with medications and other needs provided by professional staff
Sunnyside Court (in Fremont)	36 units	None	Semi-private: \$1,400-1600 Private: \$1,800-2,000	3 meals included	A range of recreational programs and staff, made up entirely of RNs or nurse assistants, provide help with ADLs	Physician services are available on-call
The Chateau (in Pleasant Hill)	37 units which adjoin independent units	None	Studio: \$1,425 One bedroom: \$1,725  couples pay \$385 for second resident	3 meals included	Diverse activities, including trips and personal assistance	Associated with a medical center, on-site staff and physician referral and home health option available
The Family Affair (in Concord)	100 units (some reserved for independent living)	None	Studio: \$1,125 Shared studio: \$650 One bdrm: \$1,090-1,200, Shared one bdrm: \$730-850	3 meals included	A range of activities and assistance with ADLs	RN station on-site

SOURCE: Ravel, Sally and Wolfe. Lee Ann, Retirement Living: A Guide to the Best Residences in Northern California, Conari Press, Berkeley, California, 1990

## CHAPTER III OVERVIEW: THE FRAIL ELDERLY AND THEIR LIVING ARRANGEMENTS

### I. INTRODUCTION

The purpose of this chapter is threefold. First, it is designed to provide essential descriptive data (and introduce key data sources) to policy-makers, practitioners, and others from the diverse fields that are concerned with assisted living. Second, it describes correlates of nursing home use, because understanding the advantages and limitations of various approaches to determining who is “at risk” for institutionalization is critical to the design and evaluation of assisted living programs. Finally, the chapter describes trends over the past century in the elderly’s use of different types of residential settings with services because this provides considerable insight into the question of whether or not assisted living facilities can serve as a substitute for nursing homes for some frail elderly.

The chapter is organized around the following questions:

- **Who are the frail elderly?** ‘The frail elderly’ is a term used to differentiate a segment of the long-term care population that uses these services, from others such as persons with mental retardation. Depending on the measure of functional impairment used, the frail elderly includes from 2 to 11 million people or anywhere from 7 to 30 percent of the total population over age 65.
- **How are age, functional impairment, and other factors related to the use of nursing homes?** The nursing home population is considerably older and more likely to have functional impairments than those in the community. These two factors alone, however, are not very good predictors of nursing home use, although they are sometimes used to specify people thought to be “at risk” for institutionalization. There are a number of better assessment tools available.
- **How has the elderly’s use of different types of residential settings with services -changed over time?** Over the last century, the population of the elderly in institutions and group quarters of all types has changed very little (it averages around 4-5 percent of **all** those **65+**). But the types of residential group settings available to house those who need to help others has changed dramatically. These changes — from almshouses, and mental hospitals to certified skilled nursing facilities and homes for the aged — have been largely precipitated by changes over time in how society views old age, and

dependency, as well as the sources of funds which have been available to support those who need help, but lack sufficient money to pay privately for care.

- While beyond the scope of this synthesis to discuss international innovations in assisted living, it is important for American researchers and policy makers to take stock of developments occurring abroad. (See Victor Regnier (forthcoming). New Concepts in Assisted Living: Desian Innovation for the United States and Northern Europe. New York: Van Nostrand Reinhold

## II. WHO ARE THE FRAIL ELDERLY?

The frail elderly represent a heterogeneous cross section of people representing a diversity of ages, incomes, living arrangements, and lifestyles. As illustrated in Exhibit 111.1, the frail elderly population is estimated to include from two to 11 million individuals or anywhere from approximately seven to 30 percent of the total population over 65 years old. These estimates are based on degree of functional impairment as measured by one or more limitations in Activities of Daily Living (**ADLs**) or Instrumental Activities of Daily Living (**IADLS**).

Forty-three different indexes to measure functional impairment exist with widely diverse approaches in selecting tasks, scoring and in establishing cutoffs (Feinstein, et. al., 1986). The most commonly measured **ADLs** are the five “core” **ADLs** — bathing, dressing, eating, transferring, and walking — and three additional ones — getting outside, continence, and using the toilet (Rowland, et. al., 1988). The **IADLS** that are also used as measures of functional impairment include: preparing meals, shopping, managing money, using a telephone, housework and taking medication. The distinction between **IADLS** and **ADLs** is that **IADLS** are considered home management-type tasks and **ADLs** are considered activities essential to basic functioning (Senate Special Committee on Aging, 1991).

**ADLs** and **IADLS** are used to assess frailty because functional impairment appears to provide the best indication of both people’s ability to live independently and the type and degree of care that they require to meet their basic needs. It is a measure that is widely applicable to the heterogenous elderly population. Medical conditions are not used to assess

EXHIBIT III.1

ESTIMATES OF THE NUMBER OF FRAIL ELDERLY

Source	Date	# of Frail Elderly	Definition Used	In a Nursing Home/ Institutionalized	In the Community
J. Leon and T. Lair, <u>Functional Status of the Noninstitutionalized Elderly: Estimates of ADL and IADL Difficulties</u> , DHHS Publication 1990	1987	3.2 M	1 + ADL impairments out of core 5	N/A	N/A
Dawson, et. al. from analysis of Health Interview Survey	1984	5.9 M	At least 1 out of 7 ADLs (includes walking and going outside)	N/A	N/A
Dawson, et. al. from analysis of Health Interview Survey	1984	2.6 M	Received assistance in performing at least 1 ADL	N/A	N / A
Lewin-ICF — Based on CPS and Brookings/ICF Long-Term Care Model, 1990	1984	5.9 M	At least' 1 ADL impairment out of core 5 and mobility	N/A	4.3 M
The Public Policy Institute, using SOA 1984	1984	N/A	At least 1 ADL impairment	N/A	3.7 M
Rowland, et. al. 1988 Analysis based on NCHS 1984 Supplement on Aging.	1984	N/A	Limitations in 2 specific ADLs: toileting and eating	N/A	1.3 M
K. Manton, "Epidemiological, Demographic and Social Correlates of Disability Across the Elderly,' <u>The Millbank Quarterly</u> , v. 67, 89)	1985	6.8 M	N/A	1.3	5.5 M

frailty, although a large portion of frail do suffer from chronic illnesses, because the variance of disability caused by a particular ailment is too large to serve as a helpful measure. For example, two people might be diagnosed with congestive heart failure that renders one bedfast and the other mildly breathless on moderate exertion but otherwise independent.

A number of factors account for the wide variation in the estimates of the size of the frail elderly population. Common among them are the following:

- **The specific number of ADL impairments used to define frailty varies across surveys.** For example, one source may define frailty as impairments in one or more ADL while another defines frailty by two or more ADL impairments.
- **There is a great range in what is counted as a disability even within an agreed upon category.** What is reported as an impairment may vary widely — from being able to perform a task with some difficulty, albeit independently, to complete inability carrying out the task, even with assistance.
- **Differing combinations of ADLs may be used across surveys.** For example, one may base the count on the absence or presence of impairments in the five core ADLs. Another survey may be based on impairments in additional ADLs as well.

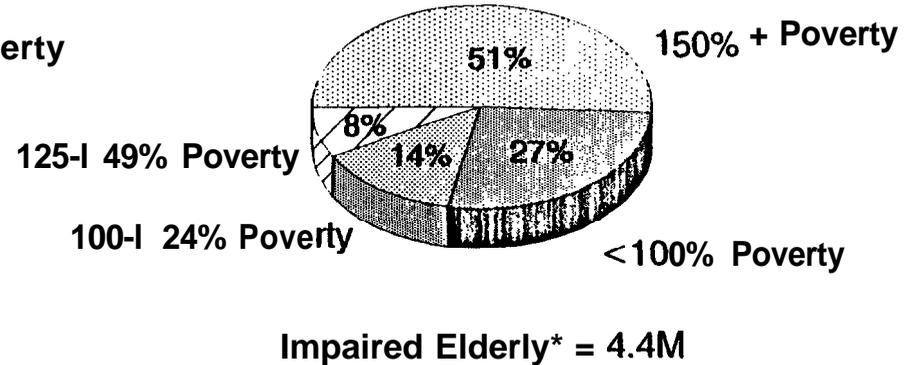
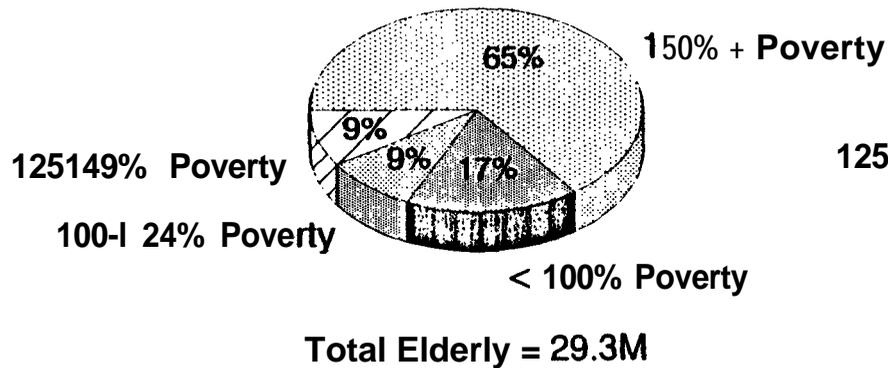
Functional impairment and advancing age are correlated with a number of additional factors such as the loss of a spouse and poverty that contribute to the frail elderly's need for assistance. As can be seen in Exhibit 111.2, about half of the impaired elderly, but 65 percent of all those over age 65 have incomes at least 150 percent of the poverty level. The economic circumstances of the frail elderly (as with all the elderly) are expected to substantially improve over the next few decades as a result of the expected growth in pension coverage, increases in real earnings, and higher rates of female labor force participation (Exhibit 111.3).

### **III. HOW ARE AGE; FUNCTIONAL IMPAIRMENT, AND OTHER FACTORS RELATED TO THE USE OF NURSING HOMES?**

Age and ADL/IADL limitations are often used by public programs (such as HUD subsidized congregate housing programs) to specify those thought to be "at risk" for nursing

## Exhibit III-2

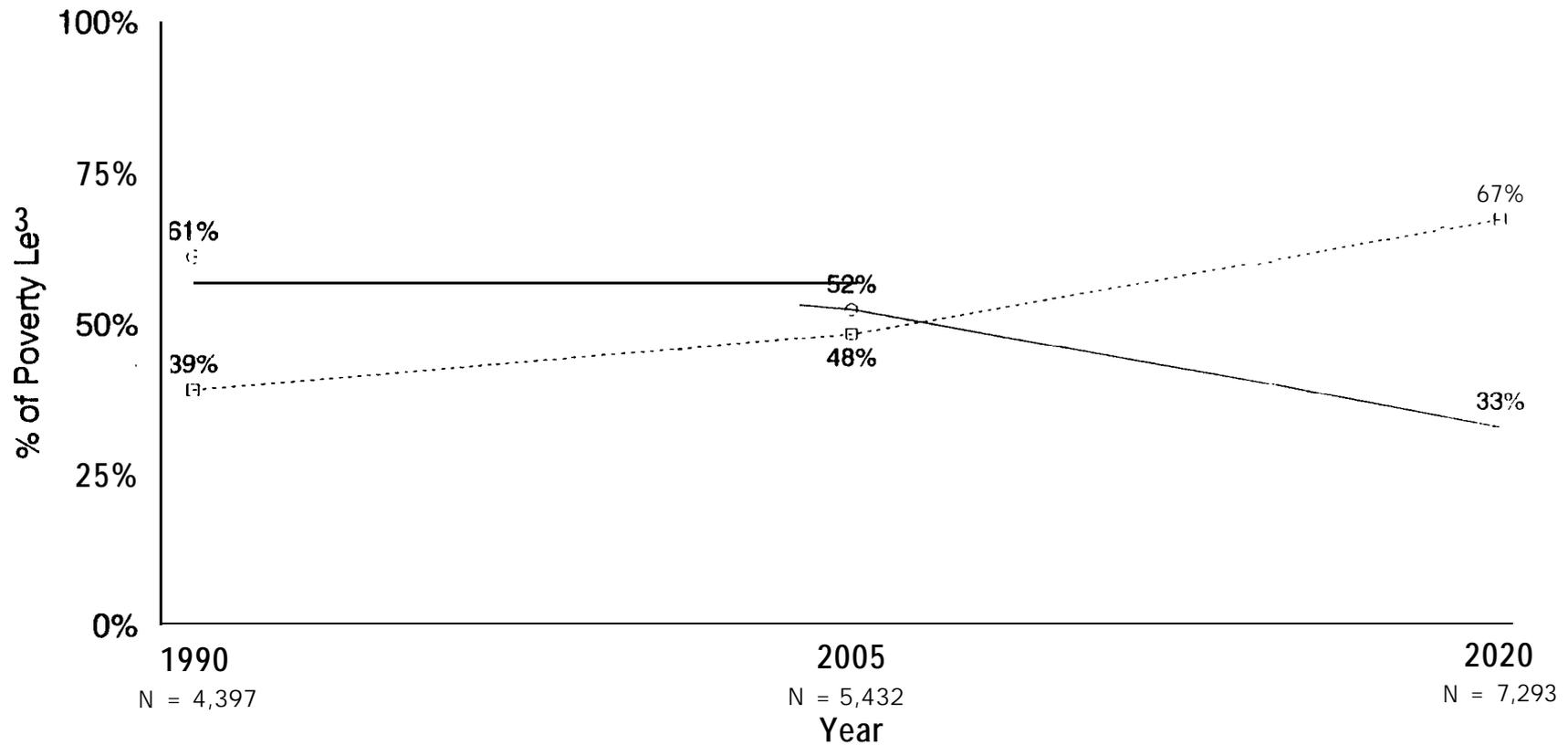
### Income Distribution of People Age 65+ By Impairment Status: 1990



Source: Lewin/ICF estimates based on 1984 SOA, CPS, Brookings/ICF LTC Financing Model

Note: Impaired elderly- 1 +ADLs; c 100% poverty- less than \$6234 a year for a single person age 65+

## Exhibit III-3 Projected income for the Frail Elderly' as a Percent of the Poverty Level



————○————
.....□.....

<200% of Poverty Level    200%+ Poverty Level.

Projections assume constant age/sex/marital status rates of disability for persons living in the community

1. Frail was defined as having difficulty with at least one of five Activities of Daily Living (ADLs)-- eating, bathing, dressing, transferring, and toileting

Source: Lewin/ICF estimates based on data from the 1984 Survey on Aging (SOA), the Current Population Survey (CPS), and the Brookings/ICF Long Term Care Financing Model

home placement or use. These factors are associated with nursing home use, but when used without consideration of other factors (e.g., social supports and cognitive status) they are not very efficient predictors of nursing home use.

The nursing home population is both older and more functionally-impaired than those in the community (Exhibits III.4 and III.5). The chance of developing a functional impairment increases substantially with age. Those aged 85 and older are over four times as likely to have at least one ADL/IADL impairment as those age 65-74 (Exhibit 111.6). As age and functional impairment increase so does the risk of institutionalization; and if only one factor is considered, functional impairment is the better predictor (Exhibit 111.7). The problem of predicting nursing home use is further complicated by the availability of options (discussed below).

There has been considerable research on the topic of predicting the use of nursing homes. Morris, Sherwood, and Gutkin (1988) have developed a tool that is in the public domain and particularly well suited for use in a variety of programs, because it is based on a relatively short questionnaire. The predictive ability of their measure "INST-RISK II" is shown in Exhibit 111.8..

- Data from the U.S. Census, however, indicate a much greater use of non-institutional residential care settings by the elderly (Exhibit III.1 2). From 1960 to 1980, the number of the elderly in "Homes for the Aged" not known to include nursing care increased 395 percent. The number in "Homes for the Aged" known to have nursing care, increased **substantially** less.

#### IV. HOW HAS THE ELDERLY'S USE OF DIFFERENT TYPES OF RESIDENTIAL **SETTINGS** WITH SERVICES CHANGED OVER TIME?

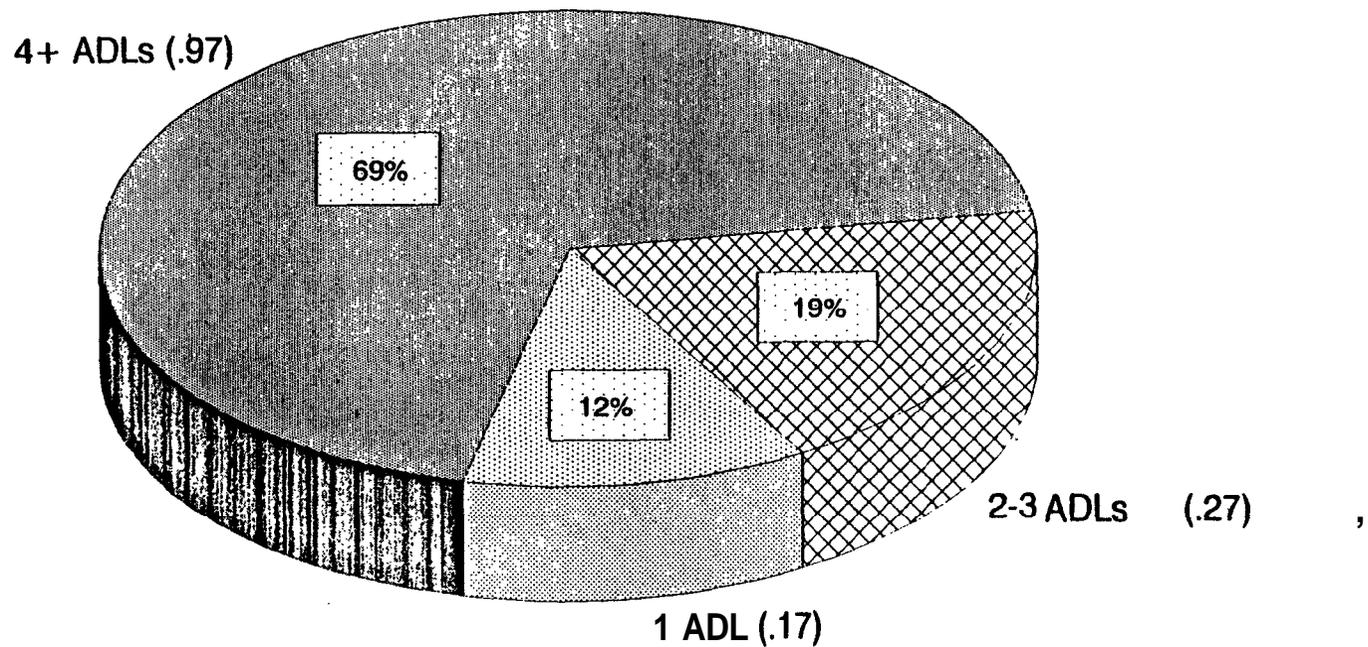
We have assembled for this chapter data on the elderly in different types of group settings from the two key publicly-available national sources: The U.S. Census, and the National Nursing Home Surveys. Examination of these data reveals the following trends over time:

- Over the last century, the proportion of the elderly in institutions and group quarters of all types has changed very little (it averages around 4-5 percent of all those 65+) (Exhibit 111.9).

- Data from the 1985 National Nursing Home Survey, which includes information on “personal care” facilities identified as such in the MFI, indicates that less than 1 percent of the elderly were residents of these facilities at the time of the survey (Exhibit III.1 1).

Data on the types of group living arrangements of elderly over the past century strongly suggest that it is possible (and indeed probable) that new forms of housing with services will emerge in the future. Assisted living — as one form of matching needs and services for the frail elderly — is discussed in the following chapter.

# Exhibit III-4 Level of Impairment of Elderly Nursing Home Residents: 1990

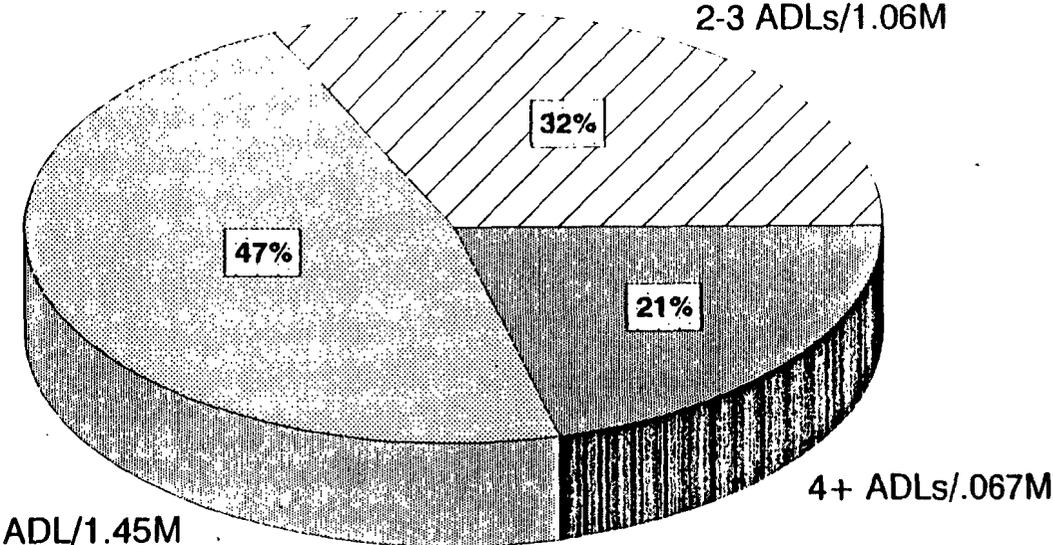


Total = 1.4 Million with 1 + ADL

Source: Lewin/ICF estimates based on data from the 1985 National Nursing Home Survey (NHHS), and the Brookings/ICF Long Term Care Financing Model

Note: Projections assume constant age/sex specific rates of institutionalization and level of disability

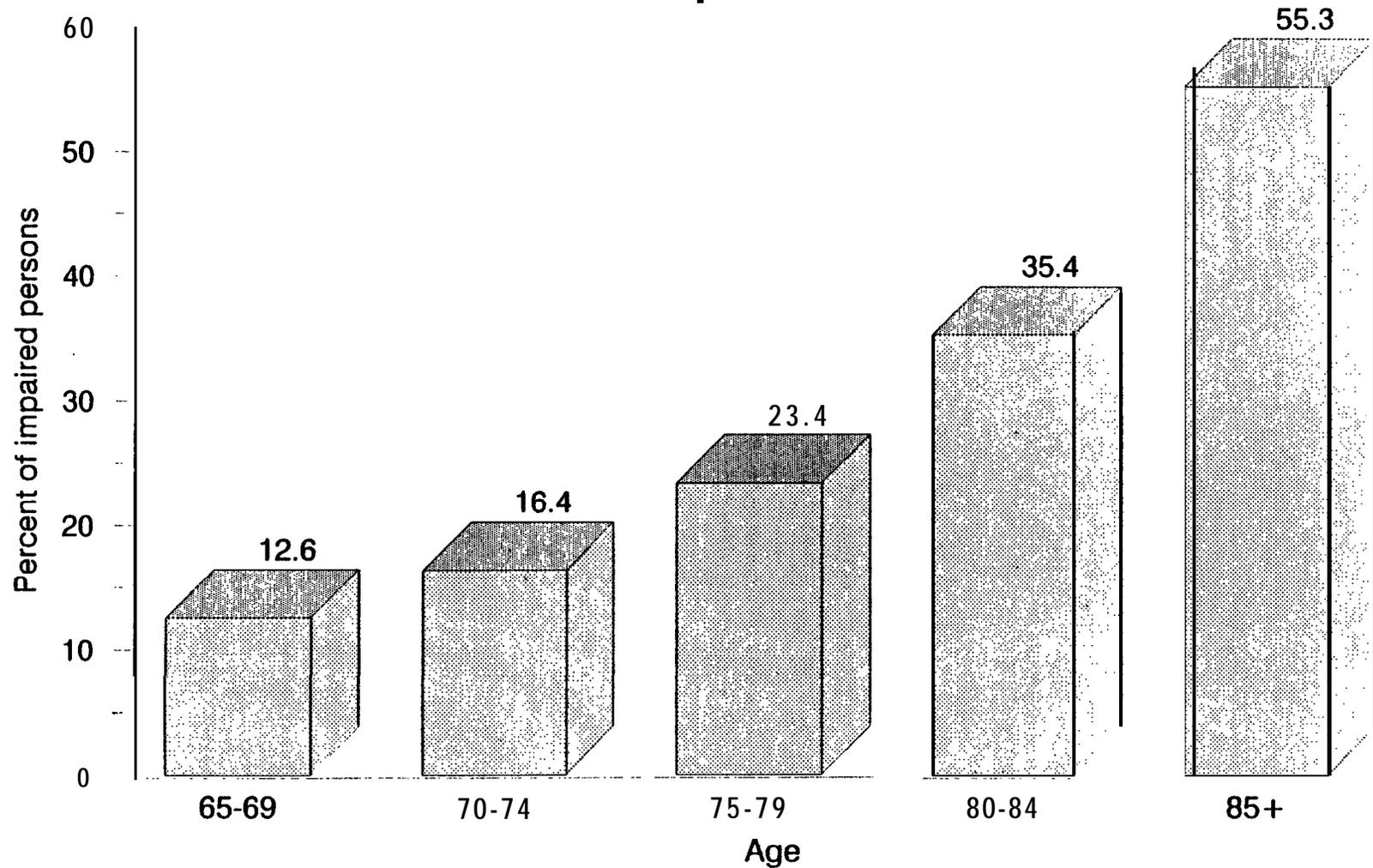
**Exhibit III-5**  
**ADL Limitations of Non-Institutionalized People**  
**Age 65+, By Number of Limitations: 1987**



TOTAL = 3.2 MILLION  
WITH +1 ADL

Source: J. Leon and T. Lair. Functional Status of the Non-Institutionalized Elderly: Estimates of ADL and IADL Difficulties. DHHS Pub. No. (PHS)90-3462 (June 1990). National Medical Expenditure Survey Research Findings 4, Agency for Health Care Policy and Research, Rockville, MD: Public Health Service

### Exhibit III-6 Effect of Age on the Probability of Having an IADL or ADL Impairment: 1984-89



Note: IADL is instrumental activities of daily living; ADL is activities of daily living

Source: Developed by Health Care Financing Review in 1988 Annual Supplement from data in Macken, 1986, and Hing, 1987.

**EXHIBIT III.7**

**PROPORTION OF THE ELDERLY POPULATION IN NURSING AND RELATED CARE FACILITIES BY AGE AND FUNCTIONAL STATUS: 1984/1985**

FUNCTIONAL STATUS	AGE		
	65-74	75-84	85+
Not dependent in either IADLs or ADLs	...	.	.
Dependent in IADLs only	2.5%	5.0%	8.0%
1-2 ADL dependencies	2.7%	7.0%	15.0%
3-4 ADL dependencies	12.3%	26.0%	40.0%
5-7 ADL dependencies	37.0%	58.0%	72.6%
<b>TOTAL</b>			

Note: These data are derived from the 1984 Supplement on Aging, which surveyed the disabled population, "Not in institutions", (it included "rooming houses") and the 1985 National Nursing Home Survey. The elderly in "other institutions" such as mental hospitals are excluded. Those in most "Board and Care" facilities are also likely to be excluded.

SOURCE: Calculated from Tables 2, 3, and 7. Ester Hing, et. al., "Long-Term Care for the Functionally Dependent Elderly.", Vital and Health Statistics. (13) 104, DHHS, (PHS) 90-1765, 1990

**EXHIBIT III.8**

**PREDICTING RISK OF INSTITUTIONALIZATION USING "INST-RISK II"**

24-Month Institution Stays by Samples of Elderly Massachusetts Residents  
and Home Care Clients (All Were in the Community as Baseline)

	<b>Percent of Elderly in Category</b>	<b>Percent in Category Who Had an Institutional Placement in a 24-Month Period</b>	<b>Of all Institution Stays, Distribution in Each of the Risk Categories</b>
<i>Community Sample [N=2,538]</i>	100.0%	6.2%	100.0% IN=1581
<b>Inst-Risk II Groups</b>			
Very Low Risk	39.9	0.7	4.4
Low Risk	25.6	3.2	13.3
Some Risk	16.2	6.6	17.1
High Risk	18.3	22.2	65.2
<i>Home Care Sample [N = 1,136]</i>	100.0%	18.0%	100.0% [N=204]
<b>Inst-Risk II Groups</b>			
Very Low Risk	7.3	4.8	2.0
Low Risk	17.2	6.7	6.4
Some Risk	10.7	10.7	6.4
High Risk	64.8	23.6	85.3

SOURCE: Table 1 in Morris, Sherwood, and Gutkin, "INST-Risk II: An Approach to Forecasting Relative Risk of Future Institutional Placement," Health Services Research, Vol. 23, No. 4, October 1988.

**EXHIBIT III.9**

LIVING ARRANGEMENTS OF THE ELDERLY (65+): 1900-1990

U.S. CENSUS CATEGORIES	1900	1910	1940	1950	1960	1970	1980	1990
<b>Counted in institutions and group quarters</b>	<b>N/A</b>	<b>N/A</b>	<b>4.0%</b>	<b>5.0%</b>	<b>4.7%</b>	<b>5.5%</b>	<b>5.8%</b>	<b>5.7%</b>
. Institutions	1.4%	2.0%	2.3%	3.1%	3.7%	4.0%	5.2%	5.4%
. Group Quarters	N/A	<b>N/A</b>	1.7%	1.9%	1.0%	0.7%	0.5%	0.3%
<b>In households</b>	<b>N/A</b>	<b>N/A</b>	<b>96.0%</b>	<b>95.0%</b>	<b>96.3%</b>	<b>95.4%</b>	<b>94.2%</b>	<b>94.3%</b>
TOTAL (65 +)	<b>100.0%</b>							
(in thousands)	5,621	6,949	9,019	12,269	16,560	20,097	25,498	31,241

**SOURCES:** For 1900-1970: Manard, Kart, van Gils, Old Age Institutions. Lexington, Mass.: D.C. Heath and Company, 1975, pp. 126-127.  
 For 1980: 1980 Population 60 Years and Older by Household Type and Relationship, Study Area Summary, Census Bureau.  
**For 1990:** 1990 Census of Population and Housing Summary tape File 7C, Census Bureau print-out, 1992.

EXHIBIT III.1 0

DISTRIBUTION OF THE ELDERLY (AGE **65+**) KNOWN TO BE IN INSTITUTIONS AND GROUP QUARTERS  
BY TYPE OF FACILITY: 1890-1 990

Distribution	1890	1900	1910	1940	1950	1960	1970	1980	1990
Homes for the Aged	(10,354)	N/A	(35,980)	33.7	35.2	49.7	72.4	83.6	94.7
Prison, reformatory, other correctional	(974)	(2,851)		0.8	0.5	0.4	0.2	0.2	...
Local jail or workhouse				0.5	0.4	0.3	0.2	...	...
Menial Institutions	(6,000)	(20,374)	(34,610)	23.5	22.9	23.2	10.3	3.5	...
Tuberculosis Hospitals					1.1	1.8	0.5	0.2	..
Other Chronic Disease Hospitals	(2,322)				1.4	2.9	3.2	2.2	..
Homes/Schools for the mentally handicapped		(34)			0.7	0.6	1.0	0.8	
Almshouses	(23,318)	(52,795)	46,032)						
Other Institutions	(280)			0.9				6.2	...
Other Group Quarters				40.5	37.8	21.2	12.3	9.1	5.3
<b>Total Population</b>				<b>100.0</b>	<b>100.0</b>	<b>100.8</b>	<b>100.1</b>	<b>100.0</b>	<b>100.0</b>
65t In Institutions & Group Quarters		(76,054)	(80,642)	373,000	617,000	780,000	, 100,000	1,475,000	1,781,000

Note: The census category "Homes for the Aged" for 1940-1980 includes nursing homes and other facilities. Currently available data from the 1990 census divides the living arrangements of the elderly into "Nursing homes", (which includes "homes for the aged") and "other group quarters" (which includes institutions like mental hospitals).

Source: US. Census, various years.

EXHIBIT III.1 1

DATA FROM THE NATIONAL NURSING HOME SURVEY:  
PROPORTION OF THE ELDERLY POPULATION IN NURSING AND  
RELATED CARE FACILITIES BY AGE AND BY TYPE OF FACILITY: 1985

Living Arrangement	Age Group							
	65-74		75-84		85+		TOTAL	
	N	%	N	%	N	%	N	%
Facility certified for skilled nursing only <sup>a</sup> (Medicare/Medicaid)	35,400	0.2%	93,200	1.8%	116,400	1.8%	245,000	0.9%
Facility certified for skilled nursing and intermediate care <sup>c</sup> (Medicare/Medicaid)	91,200	0.5%	237,300	4.0%	281,500	4.4%	609,900	2.1%
Facility certified for intermediate care only <sup>a</sup> (Medicaid)	54,700	0.3%	127,300	5.4%	151,800	2.3%	333,800	1.1%
Non-certified related care facility <sup>a</sup>	30,800	0.2%	51,200	1.0%	96,600	0.7%	129,600	0.5%
Other <sup>b</sup> (includes other institutions, group quarters, and private households)	16,782,900	98.8%	4,402,000	87.1%	5,863,700	90.8%	27,191,700	95.4%
<b>TOTAL<sup>c</sup></b>	<b>16,995,000</b>	<b>100.0%</b>	<b>5,054,000</b>	<b>100.0%</b>	<b>6,461,000</b>	<b>100.0%</b>	<b>28,510,000</b>	<b>100.0%</b>

<sup>a</sup> Data from the National Nursing Home Survey, 1985 Summary for the U.S., DHHS Publication No. PHS 89-1'758, Tables 41 and 42

<sup>b</sup> Calculated by subtraction: c - a

<sup>c</sup> US. Bureau of the Census. Statistical Abstract of the United States: 1987. (107th Edition) Washington, DC: US Government Printing Office, December 1986. Data abstracted from Tables 13 and 37.

EXHIBIT III.1 2

DATA FROM THE U.S. CENSUS:  
DISTRIBUTION OF THE ELDERLY-(AGE 65+) POPULATION IN  
"HOMES FOR THE AGED" BY TYPE OF FACILITY: 1960 - 1980

	1960		1970		1980		Percent Change 1960-1980
	N	%	N	%	N	%	
<b>Known to Have Nursing</b>							
· Federal and state	973	0.3	14,180	1.8	13,701	1.1	1.408%
· City and county	26,887	6.9	20,482	2.6	31,750	2.6	18%
· Private non-profit	45,303	11.7	42,051	5.3	98,075	7.9	216%
· Private proprietary	99,616	25.7	180,595	22.7	239,850	19.4	241%
· All (Subtotals)	172,779	44.6	257,308	32.3	383,376	31.0	282%
<b>Not Known to Have Nursing</b>							
· Federal and state	12,886	3.3	8,007	1.0	25,322	2.0	197%
· City and county	17,821	4.5	34,523	4.3	65,324	5.0	367%
· Private non-profit	48,432	12.5	107,554	13.5	176,767	14.0	365%
· Private proprietary	136,634	35.2	388,415	48.8	583,169	47.0	427%
· All (Subtotals)	215,174	55.4	538,449	67.7	849,582	69.0	395%
<b>TOTAL</b>	<b>387,953</b>	<b>100.0<sup>a</sup></b>	<b>795,807</b>	<b>100.0<sup>a</sup></b>	<b>1,232,958</b>	<b>100.0<sup>a</sup></b>	<b>318%</b>

<sup>a</sup> Columns may not add to 100 percent due to rounding.

SOURCE: Lewin-ICF analysis of data in the following sources:

U.S. Bureau of the Census, U.S. Census of Population: 1960. Subject Reports. Inmates of Institutions. Final Report, Washington, DC: Government Printing Office, 1963. Compiled from Tables 4-10.

U.S. Bureau of the Census, U.S. Census of Population: 1970. Subject Reports. Inmates of Institutions. Washington, DC: Government Printing Office, 1973. Compiled from Tables 3-10.

U.S. Bureau of the Census, U.S. Census of Population: 1980. Subject Reports. Persons in Institutions and Other Group Quarters. Washington, DC: Government Printing Office, 1984. Compiled from Table 17.



## CHAPTER IV ASSISTED LIVING: MATCHING NEEDS AND SERVICES

### I. INTRODUCTION

When is assisted living an appropriate option for the frail elderly? When do the risks inherent in these more independent living arrangements outweigh the benefits? In this chapter, we provide information on how regulators and providers attempt to answer those questions. We also provide an overview of the types of services available in assisted living facilities as well as typical staffing configurations designed to manage and deliver those services. Because so little information is available about assisted living, per se, this chapter draws heavily on the experience from related housing types such as CCRC and HUD 202 or congregate living sites. The reader should bear in mind, however, that the experience of these settings may be only indirectly related to assisted living. These issues are examined in the context of the following questions:

- **For which segment of the frail elderly population is assisted living an appropriate option?** Nowhere in the literature is it disputed that assisted living is appropriate for medically stable individuals who are not in need of 24 hour nursing care. Opinions vary on the appropriateness of assisted living for the cognitively impaired, SNF eligible individuals and those who are not ambulatory.
- **How is eligibility determined?** There are three main criteria used to determine eligibility for assisted living facilities: age, income and functional capacity. How the criteria are applied varies from facility to facility.
- **Who screens for eligibility?** Who screens for eligibility also varies from facility to facility. In HUD 202 housing, housing managers often perform the initial assessments or they may contract with an outside case manager or employ their own case manager. In CCRCs and private facilities, case managers and housing managers are more typically distinct functions.
- **How are transfer decisions made?** Little is known about transfer decisions and policies except in CCRCs and HUD facilities. These transfer decisions are based on written policies and procedures. Who applies these policies and procedures varies across facilities, from professional assessment committees, to head nurses, housing managers, and physicians. Transfer decisions generally rely heavily on input from friends and family.

- **What services do assisted living facilities provide?** There are substantial variations in the range of services that assisted living facilities provide in part because different facilities target different populations. Some facilities might target more independent populations that may not require more intensive personal care services while others might provide services to the more functionally impaired elderly. Services provided also vary according to funding sources and state regulations.
- **How are service needs initially assessed and routinely reevaluated?** Screenings are performed to varying degrees to ensure that potential residents can be cared for safely in a non-institutional environment. The frequency of screenings is variable: some facilities perform screenings as often as monthly while others only after residents are hospitalized or their physical or mental condition changes.
- **How are facilities staffed?** The types and ratios of staff are influenced by the size of the facility, available funding resources, and the functional capacity of the residents. In addition, there are wide variations among facilities in the degree to which they employ their own staff or rely on outside providers.
- **What staffing limitations are there and how can they be overcome?** A major issue in the industry is how to attract and retain capable staff when assisted living facilities often have to compete with facilities paying higher salaries. Cross-staffing, enhanced opportunities for staff to attend national conferences, using part-time outside contractors, and developing shared staffing arrangements with other facilities are just a few of the options.

## II. FOR WHICH SEGMENT OF THE FRAIL ELDERLY POPULATION IS ASSISTED LIVING AN APPROPRIATE OPTION?

Nowhere in the literature is it disputed that assisted living is an appropriate option for the medically stable frail elderly who are not in need of round-the-clock professional medical or nursing supervision. Opinions vary, however, on the appropriateness of assisted living for the cognitively impaired, SNF-eligible individuals, and those who are not ambulatory.

Those who believe in assisted living as an option for the cognitively impaired believe that it may be the preferred option in some instance because of the more tailored environment, staff-resident interaction, the de-emphasis on psychotropic drugs, and the emphasis on ability rather than sickness. There are two primary concerns among those for whom placing the cognitively impaired in assisted living facilities is more controversial: safety

and the impact on attracting residents who are cognitively intact. Many assisted living facilities lack the security required for wandering patients; although new “wander guards” can help overcome this concern. In facilities equipped with kitchens there is concern about the hazard of fires; however, this limitation also can be overcome by disconnecting stoves or installing stoves that turn-off automatically.

Given the prevalence of Alzheimer’s and the projected growth rate of the population with this disease, this is a large issue. In Oregon, 36 percent of the private pay and 22 percent of the Medicaid funded residents were reported to have some form of dementia. In a survey of 230 residential care facilities across five states, conducted by Mor and his associates, 22 percent of the residents were said to be disoriented. (Mor, et. al., 1986). In estimates derived by linking 1978 AHS and 1982-84 National Long-Term Care Surveys, Struyk and his associates estimated that approximately 28 percent of all of the occupants of Federally assisted housing are cognitively impaired.

The main debate with regard to physical disabilities is whether or not residents who are otherwise eligible for nursing homes are appropriate for assisted living facilities. Historically, assisted living facilities have screened out these residents. More recently, this notion has been challenged. In Oregon, for example, many patients eligible for placement in nursing facilities have been placed in assisted living facilities under the 2176 Waiver option. Oregon intended from the inception of their program, to organize a mainstream effort to target frail elderly nursing facility residents both as a way to drastically downsize the nursing home industry and because it was firmly believed that there were elderly living in nursing facilities who would reap greater benefits from assisted living. However, the literature on assisted living appears to indicate that many states envision residents who are less dependent than those normally found in nursing facilities (Kane, 1990). It is a critical issue because of the impact this decision would have on the future role and size of nursing facilities. Given the number of nursing facilities presently, and the expenditures involved in providing for the elderly in nursing homes, changes to this industry would reverberate through the entire health care system, affecting costs, access and delivery of long-term care.

**The answer to the question of who can and should be served by assisted living has**

profound impact on the long-term care industry particularly with regard to the projected demand for long-term care beds but also with regard to the ultimate costs of assisted living to the public sector. Targeting individuals who could otherwise live in more independent settings would be unnecessarily costly; too narrow a definition would preclude access by needy populations.

### **III. HOW IS ELIGIBILITY DETERMINED?**

From the limited evidence available, it appears that there are three main formal criteria used by facilities in screening new applicants: income, age, and functional capacity. Free-standing assisted living facilities often apply a combination of assets, age, and disability criteria together. Some facilities are chartered to give preference to members of a certain group (e.g., a CCRC in Ft. Belvoir, Virginia, that targets military retirees), others are limited to certain groups (e.g., members of a particular fraternal order) and still others may informally select members on the basis of certain social characteristics. Substantially more information is available about federally funded facilities. The Keys amendment, in an effort to upgrade the quality of care in board and care facilities required states to set admission standards for facilities with a significant number of SSI recipients (Code of Federal Regulations 1989). This amendment has been difficult to enforce due to lack of funding and administrative authority at the federal level (Conley, 1989).

#### **A. Income Criteria**

Public facilities target low income populations. Income criteria varies by the type of federal funding utilized as discussed in more detail in Chapter VII. Income limits typically include no more than 50 percent of the area median income. Income eligibility for state-funded congregate care facilities varies across states. For example, in Massachusetts applicants must first be income eligible for public housing. In New Jersey applicants' incomes must be no more than 126 percent of the Office of Management and Budget poverty level (Struyk, 1989).

It is widely perceived that non-public facilities target the wealthier segments of the population. There are some surveys that substantiate these claims. In a survey of 175 non-profit and for-profit retirement facilities (with varying numbers of assisted living units), applicants (couples) were required to have between \$100,000 to \$120,000 in assets, and \$20,000 and \$23,000 in gross annual income (Laventhol and Horwath, 1988). Another survey of 275 CCRCs reveals that most facilities use the monthly fee as a standard to measure a resident's income, requiring a monthly income of twice the monthly fee (AAHA and E&Y, 1989). Even if they largely target wealthier populations, non-public facilities are required to set aside units for low income populations to the extent that they use federal subsidies for construction (e.g., low income tax credits, federal mortgage insurance). Fully private facilities do not have to set aside units **for low income populations**. More detail on income criteria as it is tied to specific federal subsidies is included in Chapter VII.

## **B. Age Criteria**

HUD facilities screen applicants only for financial and functional eligibility. HUD facilities draw applicants of all ages including the young disabled, young old and old/old (Select Committee on Aging Report, 1989). Most state-funded congregate housing programs limit entry to adults who are over 60 years old (Struyk, 1989), while free-standing assisted living facilities generally are targeted for the over-65 cohort. To enter a CCRC, applicants usually must be at least 62 years old (Winklevoss, et. al., 1984). A later survey of CCRCs found that 41 percent of facilities require that applicants be at least 62 years of age while 35.8 percent set 65 as their minimum age requirement (AAHA and E&Y, 1989).

## **C. Functional Capacity Criteria**

Functional capacity criteria vary widely within and across federally funded, state and private facilities (Rowland, et. al., 1988). One reason these criteria are used is to ensure that facilities have the resources required to **care** for an individual with any given level of functional impairment. Another reason they are used, is to target resources to those individuals at greatest risk for institutionalization. Major issues in developing criteria to assess risk are:

- the difficulty in developing tools that accurately predict the risk of institutionalization as noted in several demonstration and research projects (Justice, 1988); and,
- the difficulty in interrater reliability in using these tools,

Examples of criteria used in both public and private facilities are included below:

- In a study of ten level I and level II licensed congregate care facilities in Florida,<sup>1</sup> Kalymun found that generally emphasis was placed on being active, mobile, and alert, with limiting as opposed to disabling conditions that require assistance with daily routines. Physically, residents were expected to be fairly self-sufficient, ambulatory, continent, able to feed themselves, and achieve bathroom functions with assistance. Of the ten facilities studied, she reports that only three accepted patients in wheelchairs, they all accepted patients who required walkers. Seven of the facilities did not accept incontinent patients; however some latitude was noted in defining incontinence, some degree of urinary incontinence was considered more manageable than bowel incontinence (Kalymun, 1990).
- Residents under HUD's Congregate Housing Services Program (CSHP) funding must be "at risk of institutionalization." Overtime the definition of risk has become more stringently defined. Between 1979 and 1982, residents needing assistance in one ADL qualified. Currently residents must lack an adequate informal support network and need assistance in at least three ADL/IADL limitations, one of which must be in eating or preparing food (Struyk, 1989).<sup>2</sup>
- To be admitted to state funded assisted living facilities, a majority of states' eligibility requirements target elderly who require assistance with at least one ADL task. Exceptions include Massachusetts and New Jersey which allow for some leniency in that elderly who are functionally independent may be admitted to assisted living facilities if there is evidence that they suffer from social isolation.
- Seip asserts that many states require residents of assisted living facilities to have a complete physical by a licensed physician within at least 60 days of admission. He states that the typical assisted living facility (not further defined) also requires: keeping the date of the physical exam on file; a description of the applicants physical and mental health; a statement that continuous care is

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<sup>1</sup> Level I was defined as representing residents who require **occasional** assistance with one or more services related to daily routines such as dressing, bathing, meals and reminders regarding medications and Level II represents residents requiring consistent assistance with one or more services on a daily basis.

<sup>2</sup> CHSP application of **ADLs** is somewhat idiosyncratic and different from other conceptions of the ADL criteria.

not needed: a diagnosis of functional limitations; a statement that the applicant requires supervision or assistance with activities of daily living; recommendations for care, medications, etc.; a statement that the resident can take his or her medications without supervision; and a statement that the applicant is free of communicable diseases (Seip, 1990).

- Eligibility screening for applicants to be covered under the 2176 and 1915 waivers are stringent. The 2176 waivers allow states to expand Medicaid funding to cover assisted living services, as long as commensurate savings are demonstrated in nursing home expenditures, Oregon, for example, requires that assisted living residents funded through a 1915 waiver meet current Medicaid nursing home eligibility standards.

A major issue with regard to assessing functional capacity is the degree of discretionary judgement involved. For example, deciding whether the level of impairment is sufficient to require assistance but not so severe as to require constant supervision often involves a discretionary judgement that is difficult to make (Struyk, 1989). Ability to feed oneself for example may be open to 'a wide range of interpretations. Incontinence is another area where room is left for interpretation even where admission criteria are specific.

#### **D. Recent Legislative Developments that could Affect Eligibility**

Though beyond the scope of this synthesis to describe in detail the impact of recent legislation on assisted living, it is important to emphasize that passage of the Fair Housing Amendments Act of 1988 and the Americans with Disabilities Act could have significant ramifications for assisted living. The Fair Housing Amendments Act, for example, included persons with disabilities as a newly protected class with respect to housing discrimination and is being used aggressively by advocates to challenge admission and termination policies that are based on disabilities. The ADA likewise could be used by advocates to protect the rights of assisted living tenants who "age in place" and become more disabled. The implications for assisted living are clear: if project managers cannot discharge a tenant on the basis of disability because of legal constraints, then many more older people will "age in place" and influence the very nature of assisted living itself. The far reaching impact of these laws on assisted living is yet to be determined, largely because many unresolved issues remain to be answered. Several of the looming questions include: Is there a level of disability where it is appropriate to evict a resident, even if they are lease-compliant and managing to

secure the care they need independently? What about the liability issues that providers must face if they allow residents to age-in-place? Should assisted living be defined as housing or a health care facility? A health care facility is **exempt** from the Affordable Housing Act mandates but a housing facility must attempt to comply with nondiscriminatory policies while also making sufficient assessments for admission and termination decisions. As for HUD-specific issues, the Act mandated the establishment of a task force to look into its termination and admission policies related to disability.

#### **IV. WHO SCREENS APPLICANTS FOR ELIGIBILITY?**

Who screens applicants for eligibility also varies across facilities. In public assisted living facilities housing managers often perform the initial assessments. Less frequently those facilities employ case managers full-time or contract with outside service coordinators; although, the facility may also **employ** a service coordinator who screens applicants. In CCRCs and private facilities, property managers and case managers are more typically distinct functions, and case managers perform the screening function (Hofland, 1990). In a survey of 275 CCRCs, in 22.5 percent of the facilities screenings were conducted by the facility's own doctor or nurse. Screening tools vary from informal questionnaires to more formal assessment instruments.

#### **V. HOW ARE TRANSFER DECISIONS MADE?**

Little is known about transfer decisions and policies in assisted living, per se. More information is available about CCRCs and HUD 202 facilities. Transfer decisions may be based on written policies that spell out criteria for transferring residents to nursing care facilities. In a survey of 275 CCRCs 72 percent reported to have formal written policies regarding transfers (AAHA and E&Y, 1989).

Transfer procedures across 1269 HUD 202 facilities are summarized in Exhibit IV.1.<sup>3</sup>

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<sup>3</sup> Not all HUD-funded housing is identical.

EXHIBIT IV.1

TRANSFER PROCEDURES USED IN 202 PROJECTS  
FOR THE ELDERLY BY AGE OF FACILITY

Procedure Used	Total	
	Number	Percent
Notify family or guardian	672	53.0
Resident is notified that their lease will not be renewed	38	3.0
Established PAC <sup>4</sup> committee decides retention or transfer	55	4.3
Manager or staff puts together an informal group to decide	184	14.5
Manager or staff turns procedures over to an outside agency	155	12.2
Situation has never occurred	72	5.7
No procedure — varies from case to case	80	6.3
Other	13	1.0
<b>Total</b>	<b>1269</b>	<b>100.0</b>

SOURCE: Gayda and Heumann, 1988 Survey of Section 202 Housing for the Elderly and Handicapped; 1989

<sup>4</sup> A Patient Assessment Committee (PAC) is a permanent committee established to monitor and evaluate resident functional independence. The structure of the committee might include a public nurse, a social worker, a physician, the manager of the facility., and others.

They illustrate the strong reliance on family and friends for transfer decisions.

In a survey of CCRCs, personnel required to approve the transfer decision varied across facilities: among individuals authorized to approve transfers were head nurses, (71 .1 percent); physicians, (84.8 percent); other, including social workers and admissions directors (63.5 percent); community directors (61 percent); and medical directors (35.2 percent) (Seip, 1990).<sup>5</sup>

## VI. WHAT SERVICES DO ASSISTED LIVING FACILITIES PROVIDE?

There are substantial differences among assisted living facilities in the range of services they provide. Reported variations are in part due to the fact that surveys may include a range of types of facilities (Laventhol & Horwath, 1988; Seip, 1990). One facility might be defined as an assisted living facility and yet include a high proportion of independent elderly who only require meals and housekeeping. Others might be characterized by a high proportion of more dependent elderly who require a wider range of services to remain independent, for example in needing help with medication and bathing. The type of funding available also influences the services provided (Struyk, 1989). Differences in state funding provide one example. Some states have explicitly chosen not to apply for Medicaid waivers in order to have more flexibility in the types of services that they can provide under Medicaid even if that means foregoing federal matching funds (Justin, 1988). And finally, service provisions vary according to the age of the facility. Older facilities whose residents have aged in place tend to provide more services than newer facilities that often have higher proportions of the young elderly who have lesser needs (Gayda and Heumann, 1989).

Exhibit IV.2 summarizes information from several surveys regarding services provided by assisted living facilities. Moving from left to right-across the surveys provided, the definition of assisted living becomes more restrictive. Where assisted living facilities limit their

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<sup>5</sup> Percentages do not add up to 100 percent because multiple responses were allowed.

target to those frail elderly who could otherwise not live independently in the community, 100 percent of the facilities provide all of the following:

- Meals
- Personal care services (help with grooming, dressing and bathing)
- Housekeeping
- Laundry
- Help with medications

Other types of services commonly but less consistently provided in assisted living facilities, according to ALFAA, that are not included above include podiatric services, occupational therapy, speech therapy, ophthalmologic services, social and recreational activities, health promotion, exercise programs, and 24-hour security and awake staff (ALFAA, 1991).

#### VII. HOW ARE SERVICE NEEDS INITIALLY ASSESSED AND ROUTINELY REEVALUATED?

A fundamental tenant of the assisted living movement is that the elderly should be free to make their own choices among a range of service options that exist to create opportunities for maximum independence without fostering over-dependence. However, screenings are performed to varying degrees to ensure that potential residents can safely be cared for in non-institutional environments. The comprehensiveness of the screening is highly variable — from a brief questionnaire that relies on family or self-reporting, to more detailed medical exams by physicians, and cognitive, ADL and IADL evaluations. This variability in screening exists even within Section 202 housing.

Routine screening to assess ongoing service needs is also highly variable. The federal Medicaid 1915(d) waiver requires that plans of care be developed on a monthly basis to ensure that it is adequate to meet the needs of the residents (Federal Register, June 30, 1992). Most state congregate service programs require periodic evaluations of service needs

EXHIBIT IV.2

SERVICES PROVIDED IN ASSISTED LIVING FACILITIES

AUTHOR	GAYDA AND HEUMANN [1989]	MOON, M., et. al., (1989)	SEIP [1990]	KALYMUN [1990]
Sample	Approximately 2,000 Section 202 Housing Facilities Across Nation	Seven State Survey of 602 Non-Medicaid Certified Facilities, Licensed or Non-licensed That Provided Room and Board, Personal Care and Protective Oversight to Four or More People	A Survey of 200 Assisted Living Facilities Across the United States	10 Assisted Living Facilities Certified as Adult Congregate Living Facilities in Florida
<b>Services</b>				
Housekeeping	18%		100%	100%
Transportation	22%	65%	91%	100%
Personal laundry	-		97%	100%
Personal Care	20%			
Grooming		59%	92%	100%
Dressing		62%	93%	100%
Bathing		82%	95%	100%
Toileting	-	42%	78%	
3 Meals/Day	50%*		97%	100%

EXHIBIT IV.2

SERVICES PROVIDED IN ASSISTED LIVING FACILITIES [continued]

AUTHOR	GAYDA AND HEUMANN [1989]	MOON, M., et. al., (1989)	SEIP [1990]	KALYMUN [1990]
Assist with Medications			96%	100%
Physical Therapy			71%	-
Psychological Counseling			61%	
24-Hour Licensed Nurse			70%	-
Social Services			-	-

\* 50 percent state offer meals; number per day is not specified.

on an “as needed” basis, for example, when a resident’s behavior and/or physical condition changes (Struyk, 1989). Some facilities conduct bimonthly screenings! others only screen residents if they have been hospitalized and plan to return to assisted living. In an attempt to improve quality in board and care homes, the 1976 Keys amendment included provisions that required states to set standards for routinely reassessing needs and making referrals where appropriate; however, due to the absence of a unit within HHS, limited funding, and related restrictions, enforcement has been limited (Conley, 1989).

## VIII. HOW ARE FACILITIES STAFFED?

Below we discuss three key issues related to how assisted living facilities are staffed: the types and ratios of staff, whether or not the staff are employees of the facility itself or provided externally, and the level of professionalization required of staff members.

It bears re-emphasis that much of the material reviewed below comes from housing settings related to, but not the same as, assisted living (e.g., congregate housing).

### A. **Types and Ratios of Staff**

Several factors influence staffing decisions including the size of the facility, available funding sources, state regulations, and the functional capacity of the residents; therefore, a blueprint for the ideal staffing of any one facility, is difficult to develop. However a few generalities apply. First and foremost, staff roles in assisted living facilities are less differentiated than those typically found in facilities providing more traditional care. The staff are said to typically consist of housekeepers, kitchen workers, maintenance personnel, transportation staff, and managerial and clerical staff. The type of twenty-four hour “medical staff” available might include nurses aides, licensed practical nurses, registered nurses, and in some instances a physician on call (Kane, 1990).

Of the large surveys in the literature<sup>6</sup> that address assisted living facilities, only two deal with the level of staffing in any detail — the 1988 Survey of 202 Housing and the AARP's Survey of Board and Care Facilities. While useful sources, these surveys are limited by the fact that facilities are broadly defined, and staffing requirements are not standardized by the average age and degree of frailty of the residents.

A summary of the findings from the Section 202 Housing Survey is included in Exhibit IV.3. In the summary, service staff refers to management, social activity, and direct service staff (staff that provide support services such as meals, housekeeping or personal care).

In the AARP study of 602 assisted living facilities defined as non-Medicaid certified facilities, licensed or non-licensed, which provided room, board, personal care, and protective oversight on a 24-hour basis to four or more adults, staffing among the facilities was summarized as follows:

- A mean staffing ratio of 3.2 residents per staff member. Of the seven states surveyed including, California, Colorado, Florida, Massachusetts, Minnesota, Texas and Washington, Washington had the most staff at 2.8 residents per staff member, and Texas the least with 4.7 residents per staff member (Moon, 1989).
- Non-family workers who were paid a wage to work in the facility, were more likely to use those staff to provide assistance with housekeeping (67.4 percent of facilities) or kitchen tasks (67.9 percent), than to provide personal care for residents (58.5 percent) or professional services (19.7 percent).

A more recent unpublished survey by the American Healthcare Association of members who represented residential care facilities<sup>7</sup> revealed that the average facility employs a management staff of 3, 5 nurses, 13 aides, 9 dietary staff, and 4 housekeepers. Of the facilities, 82 percent employed an activities director; 45 percent, a dietitian; 36 percent, a physical therapist; and 46 percent, a social worker. Seventy percent and, 60 percent, respectively, employed a pharmacy consultant and RN consultant. Many facilities (not quantified) reported that the facility's director was an RN (AHA, 1992).

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<sup>6</sup> Laventhol and Horwath (staffing ratios in this survey not specific to assisted living facilities); Ernst & Young/American Homes for the Aged: Survey of Board and Care Facilities by AARP, and Contemporary Long Term Care national survey of assisted living facilities.

<sup>7</sup> 228 respondents out of 1,100 residential care facilities typified averaging 50 beds in size.

## B. Employees or Outside Contractors/Providers?

There are wide variations among facilities in the degree to which they employ their own staff or rely on outside providers. Relying on outside contractors to provide management or service or both is not uncommon.

An early survey of 207 CCRCs reported that about one-third of those CCRCs had outside management contracts. Of those, more than half purchased their services from for-profit companies. The remaining 43 percent who had management contracts with non-profit firms were more likely to: have a lower percentage of their residents receiving health care, be in the middle range in terms of their fees, have larger resident populations, and/or be built before 1970 (Winklevoss, 1984).

Another survey conducted in 1988 reported a similar proportion of CCRCs having outside management contract; however, the number of management contracts with non-profits exceeded those of for-profits by three to one (Laventhol and Horwoth, 1988). This may reflect the fact that one survey was conducted in 1984 and the other in 1988; or differences in the types of facilities surveys.

Case management services may be provided by outside contractors, or the facilities themselves as well (Gayda and Heumann, 1989; Struyk, 1989). To provide services, most state sponsored congregate facilities hire case managers themselves and rely on those case managers to broker services from outside agencies (Struyk, Theilen, 1987). A representative of the American Health Care Association, stated that there is increasing interest on the part of free-standing facilities in how to contract with outside providers for services that the facilities would otherwise have to provide. For example, facilities contract with home health agencies who then lease space within the facility itself. Increasing interest is the result of a desire to decrease costs, avoid regulation, and achieve economies **in staffing**. Many 202 facilities rely on their case managers to **coordinate service** delivery by a variety of outside public agencies and providers (Gayda and Heumann, 1989).

EXHIBIT IV.3

TOTAL STAFF HOURS PER WEEK WORKED IN 202 PROJECTS FOR THE ELDERLY WITH AND WITHOUT CONGREGATE CARE SERVICES\*

	AVAILABILITY OF CONGREGATE SERVICES —		
	No services provided	Housekeeping and/or meals provided	Total
Staff type:			
Management	37.6	43.2	39.2
Secretarial	15.7	28.4	19.4
Maintenance	45.7	71.9	53.9
Social Activities	4.1	13.1	6.7
Direct Services	3.0	54.5	17.7
Other	14.2	29.3	18.6
<b>TOTAL</b>	<b>120.3</b>	<b>240.4</b>	<b>155.5</b>
Staff hours and ratios:			
Total FTEs per resident	1.5	2.1	1.7
Total service staff hours per week	44.7	110.7	63.5
Total service staff per unit	.5	1.0	.7
Average number of frail residents	9.8	19.5	12.2
Total staff hours per frail resident	12.3	12.4	12.7
Total service staff hours per frail resident	4.6	5.7	5.2

Source: 1988 National Survey of Section 202 Housing

\* It should be emphasized that many services in these settings are provided by outside agencies, contracted for by the facility, the individual client, or a "case management" agency (such as an Area Agency on Aging).

### C. Level of Professionalization

A key issue with regard to assisted living facilities is what services should/can safely be delegated by a nurse and what training should be required of the service coordinator or case manager.

Nurse delegation is an important issue in assisted living facilities particularly given the difficulty recruiting nurses to these facilities and the general shortages in nurses industry-wide. Nurse delegation refers to delegating authority for certain RN tasks to be performed by a non-RN under the supervision of an RN. The ultimate responsibility for which tasks can be delegated is left in each individual care situation to the registered nurse (Kane, 1990). The ability to delegate nursing tasks varies from state to state, due to differences in state laws and regulations. One level of delegation is in administration of medication. Nursing associations are often resistant to nurse delegation. For example, the Oregon Nurses Association initially objected and continues to have reservations regarding nurse delegation in assisted living facilities. And efforts to implement nurse delegation in the state of Washington have been made difficult by pressures from professional groups. Some have concerns about the effect of nursing delegation on the safety, quality and level of nursing care provided (Kane, 1990). Of course, objections to delegation by professional groups, should be evaluation in the context of perceived competition between professional and non-professional groups.

With regard to service coordinators or case managers, some states require a bachelors degree with several years experience working with the elderly or a Masters in social services (New York and Massachusetts (Struyk, 1989).

### IX. **WHAT STAFFING LIMITATIONS ARE THERE, AND HOW CAN THEY BE OVERCOME?**

There are several problems perceived with regard to staffing assisted living facilities. With the anticipated growth in assisted living, the availability of staff is an issue that must be explored. As the population ages and the demand for staff to care for the elderly increases the competition for those staff across the long-term care industry will increase. Assisted living

facilities often lack ongoing training opportunities, Salaries are less competitive in general, although wages in private assisted living facilities may approach those in other care settings. Many financial models presume low wages to be viable and it may be a task to attract qualified staff at these low wages (Kane, 1990. AAHA/E&Y, 1989). Finally, a fundamental question yet to be fully examined is how much of and what types of training are required.

Potential staffing limitations, for example, the inability to compete with facilities offering higher salaries and the lack of training opportunities for existing staff are a major concern in the assisted living industry (Moon, 1989). There are several options with regard to minimizing them. While increasing salaries is always an attractive option it is not always feasible and recruitment and retention studies related to the nursing profession in particular, note that non-compensation issues may be equally or more important.

Cross staffing (utilizing one person to perform many different functions that otherwise might be performed by more than one type of professional; e.g., having a case manager perform office administrative functions, or a nurses aid perform housekeeping tasks) is another option. For example, in 202 facilities, the managers are not uncommonly responsible for providing case-management services (often performed by social workers) in addition to providing day-to-day oversight for facility operations (Gayda and Heumann, 1989). Housekeepers may be responsible for assisting with meal services in addition to cleaning units. Cross staffing provides flexibility that is particularly important to smaller facilities. In addition, job diversity can enhance job satisfaction. Enhanced opportunities for staff to attend training opportunities; e.g., national conferences, is another option. These conferences might be sponsored by national assisted living facility associations, the gerontologic societies, etc. A strategy typically employed by hospitals to enhance staffing is affiliating with local **training** programs. On finishing training, trainees often opt to work where they trained. Assisted living facilities might provide structured training opportunities such as externships in their facilities to provide exposure to their facilities. And **finally**, another option is to seek out collaborative opportunities with other organizations to consider shared staffing arrangements. For example, two organizations can pool resources to recruit a case manager that neither one alone could afford or has the case load to justify a full-time position.

## X. RESEARCH QUESTIONS (CHAPTERS I-IV)

It is difficult to articulate a research agenda on the questions, "what is assisted living?" and "for whom is assisted living appropriate?" since assisted living is a dynamic and evolving concept. In the ASPE/NASHP meeting on assisted living for the frail elderly, panelists were reluctant to recommend research designed to arrive at a concrete definition, since doing so could thwart innovation. As assisted living develops, many panelists stressed that research should be more descriptive, focusing on the range of assisted living settings, the breadth of services offered, staffing patterns, and the types of people currently residing in assisted living facilities. A general definition of assisted living could emerge from the results of such descriptive studies.

Panelists also suggested that a descriptive study of a sample of private assisted living developers on design, rates, policies, services, staffing, and related factors would yield useful findings.

The types of "descriptive" research questions that might be pursued include:

1. **Services and Staffing**: What range of services are offered in different types of assisted living settings? Who is responsible for providing (or arranging for the provision of) these services? What limitations are there in provision of certain services (e.g., staffing; cost; regulations)? How do these services compare to those provided in nursing homes? How are assisted living facilities staffed? What are the levels of professionalism of staff, and how do they function?
2. **Eligibility**: How is eligibility for assisted living determined? Who makes that determination? Do eligibility requirements differ between public versus private facilities?
3. **Environmental Design**: What range of design features typify assisted living? What housing modifications are required to make assisted living serve highly disabled people? Could nursing homes, board and care homes, or **congregate** housing sites be converted into assisted living facilities? If so, what modifications would be required?
4. **Public vs. Private Sector**: Are there fundamental differences between public and private-sector approaches to assisted living in terms of services, environmental design; philosophy, discharge policies, and other factors?

5. Resident Characteristics: How many frail elderly currently reside in “assisted living” facilities? What are the characteristics of these tenants in terms of ADL/cognitive impairment, income/assets, informal supports, health status, and medical care needs? What are these characteristics upon entry, how do they change as tenants “age in place,” and what are the measures upon discharge? How do these tenants compare with nursing home residents on the same measures?
6. Utilization Patterns: Using a longitudinal research design, what services are consumed by assisted living tenants over time? Across what settings (e.g., hospital emergency rooms) are the services consumed? Who provides or arranges for the provision of services (e.g., facility, case manager, outside agency, family, etc.)? What percentage of tenants consume what percentage of services over time (e.g., are there a small number of tenants with long lengths of stay who consume a disproportionate amount of services, or are services consumed evenly across a population with similar lengths of stay?)?
7. Residence and Relocation: Where did people live before residing in assisted living? Why do they choose to live in assisted living versus other settings? How long do they stay? How many people leave assisted living voluntarily and how many involuntarily (e.g., because of discharge policies)? Where do they move?
8. Need/Demand: How many frail elderly people need assisted living (e.g., those residing in the community and/or in nursing homes)? What are appropriate measures of need? For those determined to need assisted living, how are their needs met and how does this differ from nursing home care? What is the projected demand for assisted living (especially as the baby boom generation comes of age)? How does assisted living fit in with what is known about what the elderly and their families want in the way of long term care?



## CHAPTER V THE EFFECTIVENESS AND COST OF ASSISTED LIVING

### I. INTRODUCTION

Why has assisted living emerged as an important living alternative for the frail elderly in the view of so many policy officials, advocates, and consumers? The answer resides, in part, in the belief that assisted living represents an autonomy-enhancing, home-like environment preferred by the frail elderly, while at the same time it provides a level of care difficult to deliver in homes or apartments. Assisted living is also thought to be a cost-effective alternative to nursing home care. Although these beliefs are often grounded in sound logic, professional experience, and in some cases empirical research, it is important to explore underlying **assumptions** and elucidate areas of uncertainty. Rigorously examining these assumptions can help assisted living develop as a viable housing alternative for the frail elderly while it is still in its formative stages. Policy makers may also avoid some of the pitfalls experienced in other areas of long term care. To this end, this chapter reviews available research on the following three general questions:

- **Do the frail elderly prefer assisted living to nursing homes?**

Little research exists on the preferences of frail elderly for assisted living. Existing research does suggest that they do prefer these settings to nursing homes. Moreover, elderly people overwhelmingly prefer to stay in their own homes, or reside in congregate living arrangements, over living in nursing homes. Whether these findings extend to assisted living facilities will depend, in part, on whether the needs of the frail elderly can be met without creating an “institutional” assisted living environment.

- **Does assisted’ living improve the quality of life and produce better “outcomes” for the frail elderly?**

important’ outcomes to measure for assisted living include life satisfaction, nursing home placement, functional capacity, health outcomes, and caregiver satisfaction. Limited research suggests that the frail elderly residing in assisted living settings are happier than nursing home residents, may avoid institutional placement (but the empirical evidence is weak on this point), and caregivers of assisted living tenants also exhibit higher levels of satisfaction. Limited and

preliminary research suggests some improvement in health and functioning for assisted living residents. In contrast, evidence from the home and community-based care literature suggests that there are few, if any, differences in **functioning or health outcomes** between community and nursing **home dwelling frail elders**. This literature also questions whether community-based care serves as a substitute for nursing home care and can successfully avert nursing home placement. The extent to which these findings apply in the assisted living context is an open question, especially since home and community based care tells us nothing about the role of the environment in facilitating health outcomes and improved functions.

- **Does assisted living cost less than nursing home care?**

Again, the assisted living literature is sparse, but the limited evidence points to some cost savings as assisted living is substituted for nursing home care. In **contrast**, a comparably well developed body of literature indicates that home and community-based care does not reduce aggregate costs since it is difficult to target those frail elders who are truly "at risk" of nursing home placement, and because the costs of home/community care for a dependent population can approach **nursing** home costs. Assisted living facilities, however, may be able to achieve economies of scale impossible to achieve for individuals living in their homes and some states have been more successful at "targeting" frail elderly most likely to use a nursing home. The applicability of the home and community-based care literature is therefore an open question.

These three questions are discussed in greater detail below.

## **II. DO THE ELDERLY PREFER ASSISTED LIVING?**

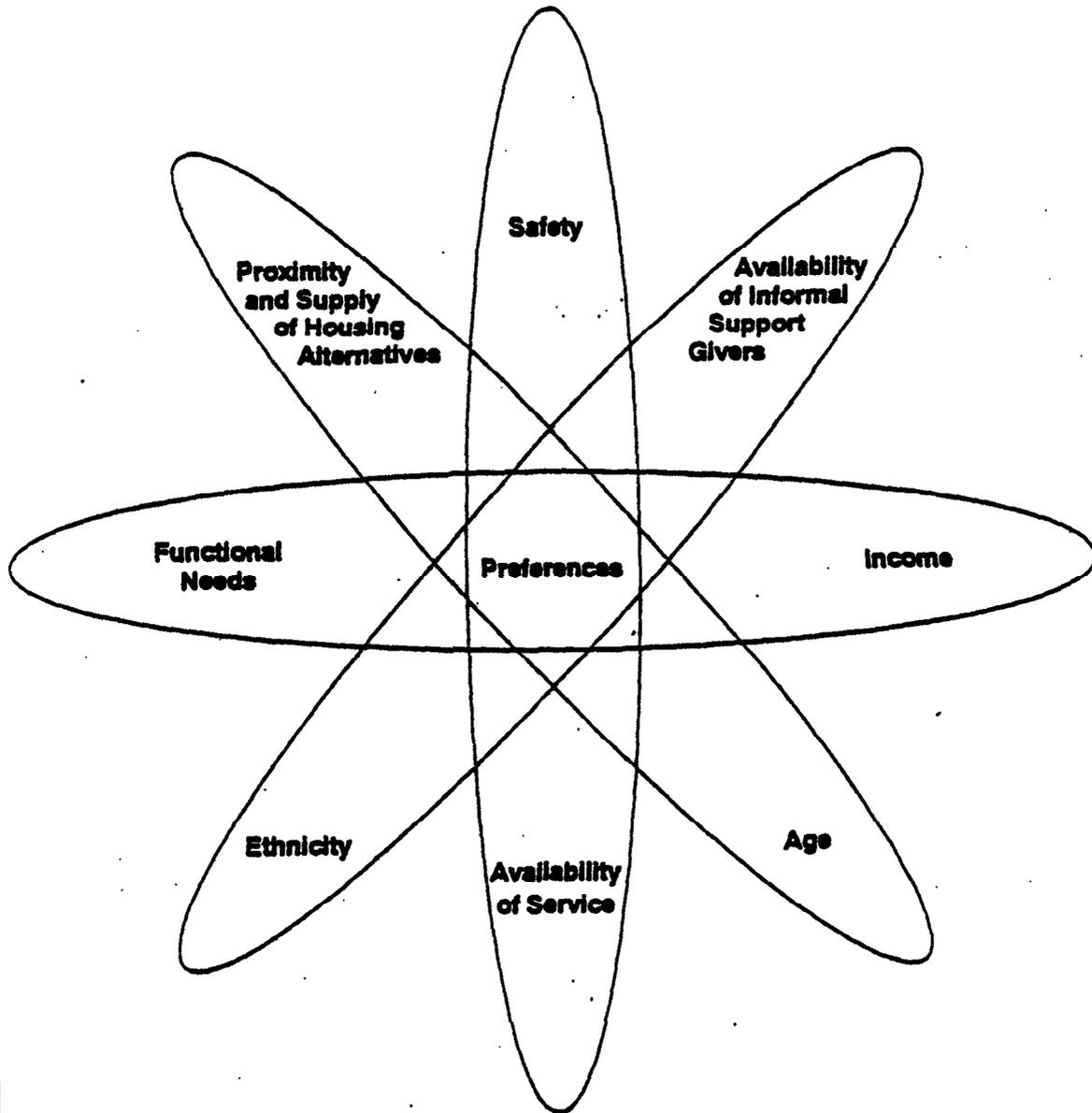
Understanding the frail elderly's preferences for living situations is an exceedingly complex and individualized phenomenon. Overall, research from the assisted living, congregate **housing**, and home/community-based care literature suggests that the frail elderly prefer living in assisted living settings over nursing homes. Evidence from each of these bodies of literature is reviewed in this section.

### **A. Preference for Assisted Living Settings**

We were able to identify little research which directly assessed whether the frail elderly prefer assisted living over other housing alternatives. At the outset, it is important to note that

# Exhibit V-1

## SCHMATIC OF FACTORS INFLUENCING PREFERENCES



the frail elderly represents a heterogeneous group, coming from diverse ethnic, socioeconomic, and familial backgrounds. The array of factors that can influence housing preferences, depicted in Exhibit V-I, reflects the complexity of this issue. In research on the choices elders make about living arrangements, for example, Wilson (1992) found that the elderly who chose to live in assisted living facilities did so because of their desire to live in an environment with supportive services which also had a warm atmosphere and flexibility in daily schedules. In contrast, elderly people with extremely severe impairments were more likely to opt for placement in nursing homes. Consistent with Exhibit V-I, these findings suggest that frail elderly (and their families) base their preferences, in part, on the level of health care needs and their perception about whether assisted living can meet those needs. By the same token, it is also important to recognize that the factors depicted in Exhibit V-I should be viewed as interrelated. Thus, health factors alone are unlikely to determine a person's preferences. Instead, health' status, in combination with such factors as income, family status, regulations, and the perception of housing management about care capabilities, all influence preferences and choices.

#### B. Preference for **Home and (Non-Residential) Community Care**

While little research currently exists about preferences for assisted living facilities per se, a comparatively well developed body of literature documents the elderly's preferences for home and (non-residential) community-based care over nursing homes.<sup>1</sup> All else being equal, the overwhelming majority of the frail elderly prefer to live in their own homes over other long term care alternatives (Varady, 1984; Tell, 1987; Beland, 1987). When asked what they would do if they became sick or disabled for a long time, the majority (66 percent) of the 1,240 elderly respondents in the McAuley and Bliesner (1985) study replied that they would prefer to live at home with a relative caring for them over going to a nursing home, adult day care center, or the home of a relative. Overall, elderly people prefer not to live in their children's homes, both to maintain their autonomy and to avoid being a burden.

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<sup>1</sup> As used in this synthesis, the term home and-community-based care refers to the frail elderly living either in their own homes or in settings that are not organized to provide services or assistance. Excluded from this definition are board and care homes, congregate apartments, and "residential" related settings.

This research asked people about their preferences hypothetically, while they were still living at home at a time when assistance was not needed. Other studies have suggested that some elderly people needing assistance actually improved their living conditions when they moved from home to a congregate living arrangement. In an evaluation of the FmHA-AoA Demonstration Program of Congregate Housing in Rural Areas, for example, Cronin, Drury, and Gragg (1983) found that over half of surveyed residents reported a decrease in their “housing burden” after moving into a congregate living complex from their homes or other living arrangements. Indeed, the potential downside of home living for the frail elderly has also been documented. Mutschler (1992) found that frail elders living **at home are more likely** to be socially isolated than their peers living in congregate living arrangements.

### C. **Preferences for Certain Environmental Design Features Among the Elderly**

One fundamental challenge faced by proponents of assisted living is to create a “home-like” environment for a frail and often disabled clientele while avoiding the trap of replicating an institutional environment such as a nursing home. This challenge applies not only to architectural design, but also to regulatory aspects of minimum structural requirements. One often overlooked step in this design and regulation formation process is accounting for the design preferences of the elderly themselves. Assisted living has the unique opportunity to avoid this **pitfall** by soliciting, where possible, the preferences of the frail elderly in designing and regulating assisted living settings.

Fortunately, there is a growing body of environmental gerontological research assessing preferences for living environments. While it is beyond the scope of this synthesis to review in a comprehensive way this research, a recent **article** by Penny Brennan, Rudolf Moos, and Sonne Lemke (1988) is a good example of the value of this research. Brennan and colleagues surveyed 799 people on their design preferences. Surveyed subjects were nursing home residents, **elderly** people living in congregate settings, community dwellers, nursing **home** staff, congregate apartment staff, and experts. Preferences (and their importance) were measured in the areas of social-recreational aids (e.g., library area, visitor parking lounge seating, etc.), prosthetic aids (e.g., bathroom handrails, access to public phones, etc.), orientational aids (e.g., clocks, color coded hallways, etc.), and safety features

(e.g., nonskid surfaces, smoke detectors, etc.). One important finding was that significant differences emerged between what the **elderly** viewed as important versus what **experts** prioritized. For example, while 95 percent of experts thought it important to have lift bars next to toilets, only 52 percent of apartment residents agreed. Likewise, 86 percent of experts viewed having public phones accessible to wheelchairs as very important or essential, while only 42 percent of apartment residents ranked this item as a top concern. Without overstating the point, design features such as grab bars can influence the extent to which an assisted living facility takes on the characteristics of an “institutional” environment. As suggested by Wilson (1992), one important design feature might be to make grab bars in bathrooms optional. In sum, the preferences of the frail elderly can help guide the development of assisted living and should represent an important component of designing these settings.<sup>2</sup> Of course, designers of assisted living facilities must adhere to minimum structural requirements, relating to the physical environment, such as fire safety codes, licensure regulations and recent legislative mandates of the Americans with Disabilities Act (ADA) and the Fair Housing Act.

#### D. **Summary**

This brief review of the literature confirms the common sense notion that the frail elderly prefer their own homes and “home-like” settings to institutional environments such as nursing homes. It follows that assisted living facilities could likewise be more desirable. The extent to which these findings extend to assisted living will depend on whether environments can be developed which successfully preserve a “homelike” atmosphere and avoid the aspects of institutional environments that the frail elderly (and their families) find objectionable. As assisted living develops into a more widely available option for the frail elderly, researchers should measure carefully the array of factors that influence preferences for this housing setting. For their part, policy makers should ensure, where possible, that

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<sup>2</sup> **Additional research that might be helpful on this point includes (Moos and Lemke 1980, Regnier and Geluicks, 1981; Geluicks and Duisl, 1982; Lawton, 1986; Moos et al., 1987 and Nasar and Forokhpot, 1985).** In addition, Rosalie Kane and colleagues recently completed very important **work on what aspects of nursing home life residents find most important** (Kane, 1989). This work could also provide valuable information to those planning assisted living environments.

funded programs incorporate these design features so that environments can be designed with consumer preferences in mind. Of course, policy makers should also consider options to make nursing homes themselves more “homelike.”

### **III. DOES ASSISTED LIVING IMPROVE OUTCOMES AND THE QUALITY OF LIFE FOR THE FRAIL ELDERLY?**

Assisted living has emerged as an important housing alternative for the frail elderly based, in significant part, on perceptions about its capacity to produce desired outcomes (relative to the capacity of other settings such as nursing homes or home care to achieve these outcomes). In particular, it is believed that assisted living can improve life satisfaction among the frail elderly, avert or postpone nursing home placement by facilitating “aging in place,” improve or maintain functional capacity, improve health outcomes, and improve life satisfaction of caregivers. **This section** examines each of these issues, drawing heavily on the home and community-based care literature in the absence of detailed empirical work on assisted living.

#### **A. Is life satisfaction and “quality of life” higher in assisted living settings than in nursing homes or other housing alternatives?**

To the extent assisted living achieves its objective of providing needed services in a non-institutional, home-like environment, it makes intuitive sense that tenants should be happier in these settings. What limited research exists does suggest that tenants of assisted living facilities are satisfied and have a higher quality of life compared with their peers living in nursing homes. Evidence from the home care literature likewise **confirms** that **community-**based living arrangements by and large result in higher life satisfaction and quality of life for the frail elderly than do institutional living arrangements.

##### **1. Evidence from the Assisted Living Literature**

In one of the few studies to examine assisted living in depth, Rosalie Kane and colleagues evaluated two assisted living complexes started as demonstration projects in Oregon in 1988. While much of their analysis was descriptive, and the results based on two facilities only, they found that “**the** appeal of assisted living to Medicaid clients” was obvious, in large part because of access to private rooms, an option virtually unavailable to program

recipients in nursing homes. In their view, this factor alone can contribute substantially to increased life satisfaction.

Sherwood, et. al., evaluated Pennsylvania's "Domiciliary Care Program" in 1983 and also reported positive results on quality of life measures. This program offered supplemental payments and services to board and care facilities housing frail elderly people<sup>3</sup> incapable of independent living but who did not require nursing home care. The program assigned case managers the responsibility for client assessment, service coordination, and related case management functions as well as the responsibility to monitor facility care provision. In this sense, the services provided bear substantial resemblance to those available in assisted living facilities. Overall, results suggested that the program resulted in self-reported improved living conditions for the frail elderly (as measured by relationships, privacy, environmental satisfaction, and related variables). Program participants also were' more integrated into the community than they were prior to the intervention, although over time they had reduced contacts with their community-based friends.

## 2. Evidence from the Congregate Housing Literature

Evidence from the congregate housing literature confirms the belief that assisted living can improve the quality of life for frail elders. A study of the quality of life in Massachusetts' congregate living facilities found that a significant portion of residents previously living in nursing homes felt that their quality of life was higher in their new living arrangement:

*"These congregate residents overwhelmingly reported that moving into congregate (housing) improved their quality of life. They regained control of their money, their food, their own affairs, and their daily routine. Congregate living provides them with the-freedom to come and go and buy what they want" (Nenno, Nachison, and Andersdn, 1986, quoting: Heumann, f.n.9)...The quality of life advantages of congregate housing are not just limited to the freedom and independence gained when moving from long-term care. Studies also report advantages to elderly who former/y lived alone. The combination of security and companionship is the primary gain reported by elderly entering congregate housing from lonely isolated environments. The provision of security and companionship often results in renewed independence, strength and self-confidence." (Heumann, et. al., 1985)*

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<sup>3</sup> The study also included mentally ill and mentally retarded residents.

Evaluations of the Congregate Housing and Services Program (CHSP) conducted by Sylvia Sherwood and colleagues in 1985<sup>4</sup> also examined improvements in life satisfaction and quality of life for program participants. Overall, the CHSP program improved the quality of life for elders living in congregate housing, though the results were not overwhelmingly positive (Struyk, p. 68, citing Sherwood, 1985). Quality of life was measured in four areas: functional, psychological, tenant satisfaction, and social. The research compared a sample of frail CHSP residents (n=324) with a sample of comparable non-CHSP congregate living residents (n=259) in each quality of life domain. In the psychological quality of life domain, no significant differences were found between experimental and control groups on concerns about health status or attitudes about aging, but significant differences did emerge with respect to self-satisfaction (as measured by the Zung Self-Satisfaction Index) (Sherwood, 1985): on average, CHSP congregate dwellers were more satisfied than their peers. In the tenant satisfaction domain, no significant differences emerged, although CHSP residents were somewhat more likely to be satisfied with the services they received. Finally, the CHSP program had neither positive nor deleterious effects in the social activities domain: residents from both samples had, on average, the same number of social contacts and scored the same on loneliness measures (Sherwood, 1985).

One concern with assisted living or any supportive services environment for the elderly is the effect on the cognitively intact, more independent tenants, of living in proximity to an increasingly frail and often cognitively impaired population. Intuitively, one might expect that housing frail elderly together with tenants exhibiting a range of disabilities runs the risk of having negative morale effects on the tenant population as a whole. One study examining

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<sup>4</sup> Newman and Struyk (1990) described the CHSP program as follows: "The federal CHSP program has operated in 60 public housing and Section 202 projects, with about 1,800 persons receiving support services under the program... Participation is supposed to be limited to people who genuinely need the services. The service bundle has consisted of a mandatory component of twice-a-day meals and options under which services are tailored to the **individual** resident's needs. To participate in the program, each applicant's needs are assessed by a Progressional Assessment Committee and determined to be sufficient to warrant such care. Possibly the most distinctive characteristic of the program is that funding for both housing assistance and support **services** comes from the Department of Housing and Urban Development (HUD), thus solving the often difficult problem of patching together funding for support services at the local level." (p. 439).

this issue concluded that elders who moved into a supportive housing environment with frail elders did not have a lower life satisfaction than their peers living in a more independent environment (Gutman, 1978). In fact, the tenants living in the supportive housing environment fared better on measures of social activity and morale. According to Gutman, “these findings should help to allay the fears of those concerned that the well-elderly might find it depressing to be among those less competent and that the availability of on-site meals, housekeeping and nursing services, and recreation might foster dependency and/or disengagement from the broader community” (p. 592). Consistent with these findings, other research has found that elderly people living in age-concentrated housing had a “larger number of friends, more active friendships, and slightly better morale” than their peers living in more age-integrated environments (Hinrichsen, 1985).

### 3. **Evidence from the Home and (Non-Residential) Community-Based Care Literature**

Finally, a related body of literature has examined life satisfaction and “quality of life” among the frail elderly receiving care in their own homes or community. As discussed above, when asked in advance, the elderly would prefer to stay in their homes over other living arrangements. Other research has examined life satisfaction in home care settings among the frail elderly eligible for nursing home care. Peter Kemper and colleagues reviewed the results of 16 Medicare and Medicaid demonstration projects that provided case-managed community care to impaired elderly populations (Kemper et. al., 1988).<sup>5</sup> Their analysis evaluated a number of variables, including recipient satisfaction with service arrangements and life satisfaction/morale. In a review and synthesis of these demonstrations, Kemper concluded that, overall, the frail elderly receiving home care had higher levels of social interaction, were generally more satisfied with care, and generally scored better on global measures of psychological well-being and life satisfaction (although in some cases the differences on life satisfaction were not statistically significant) than their peers not receiving the services. Commenting on some of the same research, Weissert concluded that, although the interventions may not have saved money or improved health outcomes, “patients (in some studies) who received **community** care showed higher contentment or global life satisfaction

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<sup>5</sup> One well known demonstration project was known as “Channeling” in which elderly ‘at risk’ of **nursing home placement were randomly assigned** to receive case management services, increased financial **assistance** for home services, and the home **services** themselves. Results of this experiment are reported in Health Services Research, 23(1) (April 1988).

levels than those who did not receive community care....This result is encouraging and suggests that case-managed community care, delivered as it was in (the Channelling demonstration project), **does** have a beneficial effect upon patient contentment” (Weissert, 1985, p. 429).

Other researchers have commented that “there is widespread agreement in studies on community-based programs that these programs are effective in improving or maintaining health, mental functioning, life satisfaction, and social activities (Oktay and Pauly, 1988, citing Goherty, Segal, & Hicks, 1978).

#### 4. **Implications for Assisted Living**

Taken collectively, these results largely validate professional experience and common sense: life satisfaction and “quality of life” is higher for frail elderly residing in non-institutional, home-like environments. Though research is limited, it follows that assisted living settings have potential to improve the quality of life for the frail elderly. Future research needs to monitor this issue carefully. In particular, designers of assisted living facilities should ‘account for the array of environmental factors that influence satisfaction with housing. The **fundamental challenge** for proponents of assisted living will be to create environments that have the characteristics of home, while being able to serve an increasingly frail and dependent population outside **an** institution.

#### **B. Does assisted living improve the functional capacity and health of the frail elderly? Does assisted living at least prevent decline as compared with nursing homes?**

Another **perceived** benefit of assisted living over institutional alternatives is its potential to improve the functional capacity and health of participants. The prevailing belief that nursing homes discourage independence and functional improvement among the frail elderly has prompted advocates and ‘policy makers to explore alternatives **such as assisted living**. These alternatives often have the expressed philosophy of creating environments that avoid institutional characteristics thought to induce dependence and decline. The limited assisted literature on this issue is encouraging: preliminary findings suggest that independence and health does improve in assisted living facilities relative to nursing homes.

As with other issues in assisted living, however, the evidence is limited, and it is instructive to draw on the experience of more rigorous research conducted in the areas of community-based and congregate care. Here, the evidence is more equivocal. While health and overall functioning appear to be better in community-based care (controlling for confounding variables), the differences are small and often statistically insignificant. Before drawing firm conclusions, it is clear that more research needs to be conducted in the assisted living arena.

1. **Assisted Living Literature suggests some improvement in health and functional outcomes.**

**Oregon:** As discussed in greater detail above, Oregon developed an assisted living program for the frail elderly in an effort to foster alternatives to nursing home care. Pursuant to a federal Medicaid waiver, the state assessed every Medicaid-funded nursing home resident to determine whether alternative placements — including assisted living — were more appropriate. Kane, et. al., (1990) conducted an evaluation of Oregon’s program by examining in detail two assisted living facilities on a variety of measures, including outcomes and quality. Two important findings from this work emerged. First, there were significant similarities between patient characteristics in the assisted living facilities and nursing homes: “Overall, more than 1/3 of the Medicaid clients were dependent in 1 to 6 of the measured ADLs (behavior, eating, continence, mobility, bathing, and dressing). This proportion doubled for the clients with an immediate prior or recent nursing facility stay” (Kane, et. al., 1990, p. 131). Second, assisted living appeared to improve the physical, mental, and functional capacity of assisted living residents, many **of whom were previously living in nursing homes**. As described by Kane:

*“Both anecdotal and **statistical** analysis indicated an improvement in client outcomes, particularly in mobility, orientation, use of physical restraints (which are not used at all at Regency Park), and stability of placement. Direct statistical analysis of functional change was measured on the 6 composite ADL scores and on the 8 separate scales on which the behavior ADL was derived (Wilson, Ladd, and Saslow, 1988). The composite **mobility/ADL** score showed improvement at the .05 level and the orientation **scale** within the behavior ADL showed improvement at the .01 level. In addition to improved mobility an (sic) orientation, restraints were **not used** and the discharge data on the 30 clients placed during the first 14 months showed **overall** increased lengths of stay” (pp. 131-l 32).*

**Pennsylvania's Domiciliary Care Experiment:** Pennsylvania's domiciliary care program supplemented traditional board and care home services with case management services and financial support. Sherwood and colleagues evaluated this program in 1983 on a number of variables, including improvements in functional status and psychological health. Their limited findings suggest that the psychological health of elderly program participants (self-reported and test results) was better than that of the control group for the study period. Overall, the domiciliary care program did not appear to have significant effects on physical functioning (Sherwood, et. al., 1983).

**Hawaii's Adult Foster Care Program:** Though not formally designated an "assisted care" program, Hawaii implemented an adult foster care program designed to provide services to the frail elderly in non-institutional settings. The Hawaii program, funded by a three-year Medicaid waiver, referred frail elderly eligible for SNF/ICF care from an acute care hospital to a foster family. The foster family was responsible for 24-hour supervision, transportation to community and medical programs, assistance with ADLs, and monitoring of medications. Program staff provided case management services. In many respects, the scope of services and mode of operation bore resemblance to assisted living, which makes comparisons on outcome measures instructive.

Results from this demonstration were generally positive, but not overwhelmingly so. As compared with nursing home patients, the adult foster care frail elderly showed some improvement in activities of daily living, but fared the same in most measures of functional capacity:

*"The results suggest that supervised foster family care is associated with equal maintenance of bathing, dressing, toileting, transfer, continence, and feeding skills along with greater improvement in mobility and patient anxiety... than nursing home care of a selected group of comparable ICF patients. Caregivers observed additional positive outcomes for foster family patients, such as greater likelihood of patient interactions with children, nicknames, tasks, and saying they liked placement" (Braun, et. al., 1986, p.522).*

**Summary of Assisted Care Literature:** Clearly, more research needs to be done in the assisted living context to answer the question whether such settings can help improve (or

prevent further deterioration) of the functional capacity and health condition of the frail elderly. On balance, existing evidence is promising. The potential of assisted living to achieve improve outcomes may be facilitated by incorporating the experience gained from the areas of home/community-based care and congregate housing. The following section presents an overview of findings from research conducted on this topic.

2. The **Home and Community-Based Care Literature** reports **little, if any, improvements.**

The extensive literature examining the effects of home and community-based care demonstration projects on the frail elderly has extensively measured the “outcomes” that such programs can produce. As noted above, both Kemper and colleagues (1987) and Weissert and colleagues (1988) have conducted extensive syntheses of these demonstration projects. Drawing on the collective wisdom of these works, we can understand with some certainty the impact of home and community-based care on the functional capacity and health status of the frail elderly.

One important goal of most demonstrations was to improve outcomes, especially to the extent that the widely believed pejorative effects of nursing home placement (i.e., increased dependence and functional decline) could be ameliorated through community-based care. Overall, the results were quite disappointing. With few exceptions, the demonstration projects did not increase longevity, improve functional status, or have a detectable effect on health status for community dwelling frail elderly as compared with their nursing home counterparts or their peers residing in the community. Weissert, et. al., (1988) summarized these results:

*"Survival and mental functioning may have sometimes been positively affected by the receipt of community care, but not by much and evidence was tenuous. Effects on physical functioning have been extensively measured, and although little effect was found in the aggregate — except perhaps a negative one — treatment members in some subgroups may have benefitted, compared to controls. Patients who were young-old, minimally disabled, and socially supported may have benefitted. But others got worse: the o/d-o/d, the severely dependent, and socially deprived patients may have become more dependent and functioned less well when given community care. These subgroup findings are tentative, however, due to small sample sizes and some conflicting results" (p.365).*

It bears reemphasis that community care appears to have improved life satisfaction and quality of life in most demonstrations (Weissert, et. al., 1988; Kemper, et. al., 1987).

3. **The Congregate Housing Literature is consistent with the community-based literature;**

As described in greater detail in Chapter VII above, the Congregate Housing Services Program (CHSP) added to traditional HUD Section 202 congregate housing projects supplemental services such as meals, personal assistance, and social support. The intent of the program, among other goals, was to prevent or postpone nursing home placement and to improve the quality of residents' lives. In evaluating the program, Sylvia Sherwood and colleagues assessed whether CHSP participants fared better on functional health measures than did their peers in non-CHSP sponsored congregate housing arrangements. As summarized by Struyk, results showed no differences between the two groups on mortality or other "quality/outcome" measures:

*"Quality of life measures examined included mobility, ability to perform daily activities, and **ability** to care oneself. There were no differences between the experimental and control groups on these measures" (p.215).<sup>6</sup>*

4. **Summary and Implications for Assisted Living**

While results **from** the home and community-based care literature **are** disappointing with respect to improvements in functional status and other health outcomes, some evidence exists to suggest that assisted living still has potential to improve outcomes for the frail elderly. Kane's finding that use of restraints dropped significantly for assisted living tenants is particularly encouraging and should provide impetus for more interventions and research along these lines. The focus of inquiry should turn from whether such settings can positively influence outcomes, to an **inquiry** regarding what design characteristics and service packages do and do not work to **foster independence**, functional improvement, and related desirable outcomes. In particular, future research needs to elucidate why certain types of interventions do **not** work, rather **than** measuring the fact that they do not.

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<sup>6</sup> **The Evaluation of the FmHA-AoA Demonstration Program of Congregate Housing in Rural Areas did not evaluate health or functional outcomes.**

c. Does assisted living increase **life satisfaction and “quality of life” for caregivers of the frail elderly?**

Though beyond the scope of this synthesis to discuss in depth the issue of caregiver burden, it belabors the obvious to state that one potential benefit of assisted living is that it may relieve family members and other informal caregivers of a tremendous and sometimes debilitating burden. On the other hand, from a public policy perspective, fiscally-minded policy makers may be concerned about substituting assisted living for informal care that is not an undue burden on the caregiver and that would be given in the absence of assisted living. Though a burgeoning literature on caregiver burden is emerging (Boersh-Supan, et al. 1990; Greene, 1983; Kemper, 1989; Soldo, 1983; Zedlewski, 1989), comparatively little research has been done on whether assisted living can relieve some of this burden. The existing research does suggest that assisted living has the potential of relieving caregiver burden to some extent.

Weissert and colleagues (1988), for example, reviewed eight studies which measured the effect of community-based care on caregivers of the frail elderly. All but one of these studies documented a positive effect, with four results (all from randomized clinical trials) achieving statistical significance. The positive impact of community-based care was documented in the following areas: reduction in collateral and household stress; increase in household morale; increase in caretaker satisfaction with patient care; and increase in caretaker satisfaction (Weissert, et. al., 1988, Table 15). In contrast, the Congregate Housing Services Program (CHSP) discussed at length above did not find substantial reductions in caregiver measures. There were no differences between experimental and control subjects in the areas of family interactions, the extent to which CHSP services relieved family and friends from having to provide help to the frail elderly, and the extent to which informal caregivers reduced the amount they worried about their frail loved ones (Sherwood. et. al., 1985, p. 136).

Clearly, more research needs to be conducted on this important issue. The extent to which these limited findings apply to assisted living will depend on the target population various programs serve.<sup>7</sup> States providing assisted living to current nursing home residents cannot expect to reduce caregiver burden measurably. except to the extent informal caregivers may feel better “psychologically” about their loved ones residing in a more home-

like environment. On the other hand, states providing assisted living to frail elders living in the community and receiving a substantial amount of informal support might expect to see reductions in caregiver burden. As with many assisted living issues, the meritorious public policy of easing caregiver strain must be balanced against the potential of increased costs of substituting formal for currently provided informal care.

**D. Does assisted living prevent and/or delay nursing home placement for the frail elderly?**

As with many issues discussed in this synthesis, no rigorously designed study has assessed the extent to which assisted living, per se, prevents or postpones nursing home placement. Many policy makers believe that assisted living can substitute for nursing home care. This steadfast belief is based, in part, on extensive state experience and decades of trend data on institutional living Situations of the elderly population. On the first point, Oregon and other states have demonstrated that programs targeted at the frail elderly population at risk of nursing home placement can both prevent people from entering a nursing home and place current residents in non-institutional, “assisted living” settings. On the second point, we know from historical experience that many frail elderly lived in non-institutional settings before the advent of Medicare and Medicaid, suggesting that non-nursing home substitutes (such as they were) can exist (see Chapter III). More recent state experiences also suggest that non-institutional residential substitutes to nursing home care do exist.

In stark contrast, however, evidence from the home and (non-residential) community-based care and congregate housing literatures gives some reason to question intuitive arguments. This literature suggests “that it is extremely difficult to identify prospectively those frail elderly most likely to need nursing home care. Without being able to target the truly “at risk” population, these studies have found that it is difficult to substitute community-based alternatives for nursing home care. On its face, this evidence seems to flatly contradict the belief that viable substitutes for nursing home care can be developed. In this regard, it may be intuitive for U.S. policy makers to look overseas for ideas and innovations. Though beyond the scope of this synthesis to examine international trends, interested readers should consult Pegnier, forthcoming, for a discussion of assisted living models in Northern Europe.

How can these two competing theories be reconciled **for assisted living**? This section presents a framework that attempts to explain areas of differences, and to posit that the two competing views can coexist. In short, the explanation resides in the way the “at risk” nursing home population is defined, the extent to which this population can be identified, and the policies that a state might pursue to develop alternatives to institutionalization. In the end, we conclude that in fact assisted living does have the potential to serve as a substitute for nursing home care.

1. **Literature Review**

- a. **Studies of Home and (Non-Residential) Community-Based Care suggest that it is difficult to substitute community for nursing home care, unless programs are carefully targeted.**

Since the 1970s, numerous home and community-based service interventions have been initiated, many of which have been formally evaluated using either randomized or quasi-experimental designs. Reviews of these evaluations have summarized intervention components, targeting criteria, research designs, and outcomes (Kemper, Applebaum, and Harrigan (1987); Weissert, Cready, and Pawelak (1988); Capitman (1986)). The primary goal of home and community-based interventions has been to improve quality and reduce costs through the substitution of home and community-based services, such as case management, chore, companion, and adult **day** care services, for nursing home care.

Evaluation findings indicate, however, that the reduction **in nursing home use achieved through these interventions was small and largely insignificant because the level of nursing home use among control groups was quite low**. In other words, most frail elderly do not ever use nursing home care. For example, Weissert et. al., report that nursing home admission rates for the control groups in different studies ranged from 5.6 to 58.6 percent, with 70 percent of the studies reviewed in the article having control group nursing home admission rates of less than 25 percent.. As articulated by Weissert et. al. (1988), and Kemper et. al. (1988), the fundamental issue is one of targeting: home and community-based care (including assisted living) can serve as a substitute for nursing home care only if those frail elderly truly “at risk” of nursing home placement can be identified, and services appropriately targeted for them. Because most of the demonstrations which have been formally evaluated were unable to target effectively, “there (was) no evidence that any of the demonstrations reduced nursing home use after the first year“ (Kemper. et. al.. 1988).

One demonstration project did show significant reductions in nursing home use following the intervention. The South Carolina program was unlike the other demonstrations in that it used a preadmission screening program to identify potential nursing home users, Findings from this program evaluation have led researchers to conclude that effective targeting of services to potential nursing home entrants can be accomplished with the use of preadmission screening. According to Kemper, et. al. (1987), “by identifying clients ‘at the nursing home door’ and requiring nursing home eligibility under Medicaid, South Carolina appears to have identified the intended target population and reduced its nursing home use” (p. 93).

In addition to results from the South Carolina demonstration, evidence from a special subgroup of Channeling Demonstration participants lends further support to the conclusion that careful program targeting can, produce demonstrably successful results.

The National **Channeling** Demonstration is widely regarded as the premiere test of the thesis that home and community-based services can prevent and/or delay nursing home use and hence save money. In this randomly-controlled and relatively large (N=6,326) study, it was found that “reductions in nursing home use among the treatment group were neither large nor, generally, statistically significant” (Wooldridge and Schore, 1988). However, “An exception was for the small group of persons **who were** in a nursing home at enrollment, for whom large reductions in nursing home use were found (Wooldridge and Schore, 1988).

The results from the analysis of that Channeling subgroup are generally not included in reviews of the literature on the effectiveness of home and community-based services (e.g., Kemper, Applebaum, and Harrigan, 1987) and have been somewhat overwhelmed by findings from the many studies involving persons with relatively little true risk of institutionalization. The Channeling subsample targeted for program interventions while they were waiting for nursing home placement or actually in a nursing home (and certified as ready for discharge within three months) was quite small (2-3 percent of the total), in part “because channeling staff generally felt that by the time individuals’ had decided to apply for institutional care, it was difficult to reverse the decision” (Applebaum, 1987). Similarly, at the conclusion of the Channeling Demonstration, key federal officials involved in the projects noted that “there

appears to be no straightforward way to target community resources on what has come to be known as the “but for” long-term care group — persons who would enter institutions but for their access to community services” (Harahan, Hamm, and Fallon, 1987).

Since that time, however, researchers have developed better screening tools (e.g., “Inst-Risk II”, described in Chapter II), and some states have implemented home- and community-based programs targeted via nursing home pre-admission screening programs (e.g., Minnesota), or — in the case of Oregon — have actually gone into nursing homes to find those persons “inappropriately placed”. Thus, some contemporary programs to prevent or delay institutionalization with alternative services may well be effective (as advocates and some state officials assert), despite the skepticism of those familiar with research from an earlier period.

**b. Studies of “Residential-Type Facilities” support the experience of the community-based studies.**

A limited number of studies have examined the extent to which residential-type facilities (e.g., congregate apartments or board and care homes with supplemental services) can work to delay or prevent institutionalization. Overall, the evidence is mixed. Some research suggests that these settings can prevent premature nursing home placement if the appropriate type and scope of services are provided. Others question this finding and suggest that it is difficult to avert or delay nursing home placement for many of the same reasons specified in the home and community-based care literature.

**Pennsylvania’s Domiciliary Care Experiment:** Sylvia Sherwood and John Morris’ evaluation of the Pennsylvania Domiciliary Care Program is the only formal evaluation we were able to identify looking at the impact of assisted living on nursing home use. Though not formally designated as “assisted living,” the Pennsylvania program supplemented care provided in existing board and care homes with case management services and financial support, which resulted in a service setting similar to assisted living as conceptualized in this synthesis.

After implementation of this program, results showed that the domiciliary care patients spent significantly fewer days in non-community settings (e.g., nursing homes) than did their

counterparts not receiving the treatment. For example, the experimental group (n=20) experienced only 61 days in hospitals and long term care settings as compared with 258 days for the control group (n=20). Significantly, these effects were even more pronounced for the **deinstitutionalized** elderly; i.e., those placed in the domiciliary care program from nursing homes and other long term care settings. As already discussed, it is critical to be able to identify in advance those frail elderly most likely to be at risk of nursing home care if assisted living is to be an effective substitute for nursing home care. Developing assisted living options for those already institutionalized provides perhaps the strongest assurance that the target population is most at risk.

**Congregate Housing Literature:** Since their inception in the late 1970s, it was hoped that congregate housing would make it possible for the frail elderly to avoid nursing home placement for as long as **possible**. (Sherwood, 1985; Struyk, 1989). Overall, the experience from congregate housing indicates that the level of services provided in these settings does not avert institutionalization, although nursing home placement could be delayed for certain types of residents. Additionally, the types of residents most often admitted to congregate housing settings may not include the frail **elderly** most likely to be at risk for nursing home placement.

**Evidence from the CHSP Program:** The Congregate Housing Services Program (CHSP) was a demonstration project designed to help the frail elderly avoid premature institutional placement by providing supplemental services in HUD-financed public housing projects (Sherwood, 1985). The services included on-site meal service twice a day, seven days a week, **housekeeping/chore** assistance, personal assistance, transportation, escort, and social services. Sherwood (1985) conducted a comprehensive evaluation of the CHSP program in 41 sites **nationwide**, including the impact of the intervention on institutional placement rates. In general, after one year of operation, there was no significant difference in institutionalization rates between frail elderly receiving CHSP services and those who lived in comparable congregate settings without the services. There was a difference between experiments and controls after two years of program operation in the rate of temporary institutionalization: 1.5 percent of those receiving the CHSP service had at least one institutional placement while 23 percent of those not participating in CHSP were

institutionalized at least once. As Sherwood pointed out, however, “it is important to recognize that an institutional placement is not synonymous with permanent residency. For those sample member who were alive (after 2 years), as many as 92 percent of the experimental and 88 percent of the Controls resided in a community setting“ (Sherwood, 1985, p. 133).

While these findings are disappointing in that they suggest CHSP did not achieve its primary objective of delaying or averting institutional placement, several explanations have been offered for these results. First, eligibility for CHSP was not limited to frail elderly determined to be “at risk” of nursing home placement. Thus, as was the case in many community care studies, services might not have been targeted at a population that was likely to move to a nursing home in any event. Likewise, many of the control group residents lived in environments which provided a rich array of services, further dampening any observed differences in institutional placement rates with residents receiving CHSP services. Third, the core service in CHSP was provision of meals. According to Newman and Struyk (1990), many residents neither needed nor wanted the meal service. Thus, such services should not be expected to affect institutional placement rates. Fourth, the comparison group was Section 202 housing projects which often provide meals; this may have further dampened observable effects of the intervention. Finally, Sherwood (1985) and Newman and Struyk (1990) suggest that the observation period may have been too short, and that greater differences between experimental and control groups may have emerged over time as the CHSP program began to serve a more disabled and “at risk” clientele.

**Evidence from the FmHA-AoA Congregate Housing Demonstration Program:**

Evidence from the FmHA-AoA Congregate Housing Demonstration is much less comprehensive than information from the CHSP demonstration, but reports similar results. The FmHA-AoA program, like the CHSP demonstration, provided supplemental services in congregate housing projects to elderly residents in rural areas. One of the purposes of the demonstration was to promote “aging in place,” and to avert premature institutionalization. Unfortunately, available data did not permit detailed analysis of the issue. Evaluators had the following to say about the program’s impact on institutional placement:

*"When it comes to drawing conclusions about the potential of congregate housing as an alternative to institutionalization, we are severely constrained by both the limitations placed on the study design and the time frame for observations. There are some preliminary indications, mostly anecdotal, that congregate housing may current/y be an alternative to institutionalization for a small number of tenants. It appears, however, that congregate housing cannot cope with tenants, especially those living alone, whose mental and/or physical condition necessitates fairly constant supervision, nor do we believe it is intended to do so" (p. 266 FHA),*

2. **State Experiences suggest that Assisted Living and community-based alternatives can replace nursing home care for some frail elderly.**

Oregon: Though no formal evaluation has been conducted of Oregon's experience with assisted living, anecdotal evidence, statements from state officials, and logic suggests that assisted living may serve as a substitute for nursing home care in the state. Oregon's assisted living and adult foster care programs have been described in detail by Kane and colleagues (1990), Mollica and colleagues (1992) and others. One important purpose of Oregon's assisted living and foster care programs is to reduce the use of nursing home care. To this end, Oregon actively sought to place current nursing home residents in assisted living settings, as well as prevent community dwelling frail elders from entering nursing homes. One possible indicator of success in this regard are supply trends for nursing home beds in Oregon. In contrast to many other states, Oregon's supply of nursing home beds has remained relatively constant since 1979. In 1978 there were 14,653 nursing home beds in Oregon, in 1989 the number fell to 12,381, and in 1992 the number of beds was 14,963 (Mollica, 1992, p. 5). **The** ratio of beds per 1000 elderly population has actually decreased substantially from 50.9 in 1978 to 39.2 in 1989. While it is impossible to attribute causality to these trends, it is reasonable to speculate that one factor contributing to this reduction may be the development of assisted living settings and other home/community-based alternatives as viable substitutes. Another factor could be the scope and intensity of services available in Oregon's assisted living facilities. One might also hypothesize, consistent with Sherwood's evaluation of Pennsylvania, that assisted living apparently substituted for nursing home care in part because Oregon was able to identify frail elderly truly "at risk" of nursing home placement by targeting (among others) current nursing home residents. Indeed, under a Medicaid waiver, Oregon "evaluated every Medicaid-funded client receiving care in a nursing

home to see whether they could be served in a less restrictive environment” (Kane, et. al., 1990).

### 3. **Implications for Assisted Living**

State experience, limited research, and common sense strongly suggest that assisted living may have potential to act as a substitute for nursing home care, contrary evidence from projects notwithstanding. One key factor to consider is the issue of targeting: assisted living may emerge as a substitute for nursing home care if the at risk population can be identified and targeted; e.g., by **deinstitutionalizing** current nursing home residents (as in Oregon and Pennsylvania) or by using preadmission screening programs as a referral source (as in South Carolina). A second key issue is nursing home bed supply. Experience of several states suggests that constraining supply of nursing home beds and allocating more resources to non-institutional alternatives may have the effect of inducing substitution of non-nursing home for nursing home care. A third factor is the scope and intensity of services provided in assisted living settings. As discussed above, some evidence suggests that this substitution can positively affect life satisfaction and functioning among the frail elderly. Whether such substitution translates into cost savings is an issue we turn to next.

## IV. **DOES ASSISTED LIVING COST LESS THAN NURSING HOME CARE?**

Formal research on the cost of assisted living and related facilities, compared to nursing home care generally favors the former: however the research is fundamentally inconclusive with respect to the key issue of whether (and under what conditions) the development of assisted living facilities as an alternative to nursing home care can actually save states and the nation money. These issues are discussed **below**.

### **A. Overview of the Literature**

Advocates of assisted living argue that assisted living is a desirable option in part because it costs less than nursing home care; therefore, significant cost savings could be **achieved by placing** many otherwise nursing home eligible residents in these lower cost

facilities. Estimates of cost savings are as high as 35 percent. Several studies have reported lower costs for assisted living facilities (Ruchlin, et. al., 1983; Heumann. 1991). Taken as a whole, these studies are generally inconclusive for a variety of reasons: including the following.

- **The cost savings achieved through assisted living may be offset by concomitant increases in nursing home costs.** Average nursing home costs per resident are calculated by averaging the costs of a range of residents • from those who are fairly independent to those who require extensive staff time. In moving lighter care patients to assisted living facilities, the service intensity and related average cost of nursing residents will increase. How those costs will increase in comparison to the cost savings achieved through assisted living is not clear.
- **Most of the comparative studies that do exist do not standardize comparison groups by important factors that contribute to costs such as age, degree of functional disability, etc.** For example, skilled nursing facilities tend to have older and more disabled populations that do assisted living facilities. More accurate analyses require controlling for the major factors that account for differences in cost.
- **Differences in cost accounting across facilities can lead to inaccurate comparisons.** For example, in **CCRCs** overhead may be allocated equally across units, resulting in an artificially low overhead rate for an assisted living facility particularly if the CCRC is primarily composed of independent units. There may be differences in the types of costs included. For example, one facility may include marketing costs in calculations while another does not.
- **Costs calculations for individuals living in assisted living facilities often do not include out-of-pocket costs for services not rendered by the facility.** Not all assisted living facilities designated as such provide a comprehensive

range of personal care services (bathing, dressing and feeding). Residents may elect to pay out-of-pocket for those services.

**B. Some Necessary Conditions for Assisted Living to be at Least “Cost Neutral”**

In the absence of well-controlled studies comparing nursing home costs versus assisted living costs, it is helpful to consider the circumstances required for assisted living to be at least cost neutral. First, it should be noted that if the comparative cost advantage of assisted living, relative to nursing homes, is a function of the fact that lighter care nursing home residents cost less than others in that setting (and hence cost less than the average nursing home resident, when served in assisted living), it follows that moving all of the people with lighter care needs into assisted living will raise the average cost of nursing homes, and total costs will *theoretically* stay the same.

The theoretical cost neutrality of assisted living, under the above scenario, ignores the probability of rather high transition costs to a new system in which assisted living facility beds outnumber nursing facility beds. Thus, as a practical matter, for assisted living to be at least cost neutral in the shorter run, it would need to be able to serve persons with identical needs at lower cost than in a nursing facility.

There are several reasons why assisted living could cost more than nursing home care. These include the cost of private rooms, more space, more amenities, and transportation costs (and extra overhead) for purchased services (e.g., RN visits). For assisted living to be cost-saving, those potentially cost-increasing features of the concept would have to be more than offset by such things as: lower costs associated with a lesser “regulatory burden”, the use of less-costly staff, the elimination of certain activities such as daily charting and routine monitoring, or the price-constraining effect of competition in a less-regulated environment. Such competition, however, presumes relatively free entry into the market and the absence of the types of supply controls (e.g., CON) that most states have found necessary to control public spending for nursing home care.

There are a variety of related “cost” issues that researchers and policy makers should consider including, who should be required to bear the costs of assisted living; what is the

role of private equity versus public subsidization: to what extent can the public sector provide the same scope of services to public assistance recipients?

## V. RESEARCH QUESTIONS ON COST AND EFFECTIVENESS (CHAPTER V)

Though a substantial amount of research has been conducted on the cost and effectiveness of congregate housing and home and community-based care for the elderly, comparatively little research exists on assisted living, per se. In evaluating cost and effectiveness, it is important for researchers to identify clearly what aspects of assisted living are being tested, since assisted living means different things to different people. With this preface in mind, a range of research questions arise with respect to the issue of what assisted living is intended to achieve and how successful it is in meeting its goals:

### A. Cost

1. Overall Costs: What are the costs of assisted living when housing and services are disaggregated? Is there substantial variation between regions? What accounts for variations in costs (e.g., services, housing costs, staff, level of patient disability, etc.)?
2. Cost Comparisons with Nursing Homes: How do the costs of assisted living compare with nursing homes, controlling for differences in patient characteristics, accounting practices, tenant copayment obligations, and related factors? Are potential cost savings achieved through assisted living offset by concomitant increases in nursing home costs? Are the cost increasing aspects of assisted living (e.g., private rooms, more space, more amenities, transportation costs, etc.) offset by potential cost-saving aspects (e.g., reduced "regulatory burden," less costly staff, effects of competitive pricing, etc.)?
3. Costs across care settings: What are aggregate costs when acute care utilization costs are included? How does this compare with similar statistics for nursing home residents?
4. Affordability: How many elderly people can afford assisted living? How fast do (would) these people spend down their assets when paying for assisted living?
5. Expenditure Patterns: What are expenditure patterns in assisted living facilities (for public and private providers)? How do providers allocate their funds (e.g., between tenant care, administration, debt service, etc.)?

6. Cost and Quality Trade-Offs: What are the trade-offs between cost and quality in assisted living? How can these trade-offs be quantified in econometric models which also capture consumer preferences on their willingness to make trade-offs?

## **B. Effectiveness**

1. Preferences: How many frail elderly would choose assisted living (over other settings) if options were available? Why do people choose assisted living over nursing homes, home care, or congregate living (i.e., what aspects of assisted living do they find preferable: homelike atmosphere: private rooms: services; etc.)? What are the barriers to residing in assisted living (e.g., limited supply: cost; regulatory; service limitations: etc.). What factors influence private payors to choose assisted living?
2. Substitution with Nursing Home Care: To what extent is assisted living a substitute for nursing home care? Controlling for patient characteristics and other variables, does assisted living prevent or postpone nursing home placement for a segment of the frail elderly population? What factors are most important in preventing or postponing nursing home placement? For what types of elderly people is assisted living not a substitute for nursing homes? Are there differences between public and private sector experiences? For how many current nursing home residents is assisted living appropriate?
3. Outcomes: As compared with peers in different settings (e.g., home, congregate housing, foster care, nursing homes, etc.) how do assisted living tenants fare on various outcomes (e.g., functional status, independence, health outcomes, satisfaction, etc.)? To what extent are outcomes attributable specifically to assisted living? What aspects of assisted living are most important in achieving specified outcomes?

## CHAPTER VI ISSUES IN REGULATING ASSISTED LIVING

This chapter considers the myriad of assisted living regulatory issues faced by policy makers, researchers, consumers, and providers. The chapter has two parts. Part One raises basic theoretical and practical reasons why regulation of assisted living is an important and challenging question, and describes some general regulatory approaches. Part Two addresses specific regulatory issues that arise in assisted living. How some of these issues manifest themselves in particular states is discussed in Chapter VIII.

### I. WHY IS REGULATION AN IMPORTANT ISSUE IN ASSISTED LIVING?

#### A. **Introduction: Overriding Themes and Lessons Learned from Regulating Nursing Homes**

The scope and manner of regulation can directly influence care practices of providers and the quality of life for frail elders. Since assisted living is still in its formative stages of development, policy makers may want to tread carefully in formulating a regulatory approach so as not to prevent providers from developing innovative practices and to avoid infringing on the autonomy and independence of the frail elderly. The appropriate scope, content, and approach of assisted living regulation is an open question. On one hand, since assisted living seeks to serve **a highly disabled, vulnerable** population, strong regulations may be needed to ensure safety and guarantee provider compliance with minimum quality standards. These regulations could take the form of new standards specifically crafted for assisted living or, as some advocate, existing board and care licensure requirements as applied to assisted living facilities (Coleman and **Fairbanks**, 1991). On the other hand, extensive regulation of assisted

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living could subvert provider innovation, infringe upon tenant autonomy, and lead inexorably to creation of an “institutional” environment. Accordingly, a more “free market” orientation which relies on consumer choice could be another regulatory option.

Despite disagreement about approach, few thoughtful analysts advocate a nursing home regulatory framework for assisted living. The widely held perception is that our system of monitoring quality in nursing homes, recent improvements notwithstanding, is heavily influenced by a “medical model” which may be of limited applicability to many frail elders. Experts have pointed out that regulations neither identify accurately poor care practices nor effectively encourage providers to deliver care likely to produce positive outcomes (IOM, 1966). Instead, the concern has been that, in response to regulations reflecting a medical bent, providers have created “mini-hospitals,” which are thought to be insensitive to the social and psychological needs of the frail elderly. Moreover, the “medical model” is not just a care typology; it is also a building typology.

In some respects, development of assisted living alternatives can be seen as a direct response to this phenomenon. Assisted living suggests a “social” (as opposed to “medical”) model. Since it rejects institutional atmospheres and instead is premised on creating home-like environments where tenants are encouraged to exercise independence and autonomy,<sup>7</sup> proponents of this setting understandably reject out of hand regulatory approaches akin to those applied in nursing homes.

Still, there is much to be learned from experiences with regulating nursing homes. Understanding why policy makers adopted a medical model of regulation can help to avoid similar pitfalls in crafting a regulatory approach for assisted living. Some analysts have posited, for example, that the pervasiveness and medical orientation of nursing home regulation arose in response to a legitimate social need: appallingly poor quality nursing facilities unable to provide even basic medical and custodial care (Caplow, 1976). Not surprisingly, these conditions affected the **poor most** directly; In response, public subsidies (e.g., Medicare and Medicaid) were allocated to care for people in nursing homes, on condition that providers receiving public monies maintain clean, sanitary environments with the capacity to treat a range of medical problems. A related factor influencing this regulatory

orientation was the notion that aging was a treatable medical condition. Thus was spawned a pervasive and medically-oriented regulatory approach for nursing homes that continues in many respects to this day. In some ways, this approach has worked remarkably well to solve the problem it was 'originally designed to address: few nursing homes presently have unclean, unsafe, or unsanitary environments, and the poor have access to "acceptable" levels of quality care. Nor can nursing homes be widely criticized for lacking the capacity to treat (or refer to have treated) medical problems faced by the frail elderly.'

## **B. Tensions inherent in regulating assisted living**

In the view of many analysts, the main concerns with nursing homes, simply stated for the **purposes** of this synthesis, are that regulations have gone too far in the direction of "medicalizing" **nursing** homes, that well-intentioned paternalistic regulations have acted to infringe upon resident **autonomy/independence**, and that "safety" has taken precedence over free choice, thereby precluding both providers and residents from voluntarily assuming "risk." What emerges is a series of seemingly irreconcilable tensions that those regulating nursing homes (and related care settings) have struggled with for years. These same tensions may be helpful in developing a regulatory approach for assisted living. These tensions include:

- Medical Model vs. Social Model
- Paternalism/Beneficence vs. Frail **Elderly's** Autonomy
- Safety vs. Risk.

Assisted living has **developed**, in part, as a reaction against a perceived pendulum swing in care of the frail elderly towards the left side of these tensions: i.e., towards medically-oriented regulations, paternalism, and safety. Indeed, assisted living favors a social over medical model, strives to facilitate tenant choice, autonomy, and independence, and is willing to sacrifice (up to a point) safety for the "dignity of risk." Acknowledging these tensions prospectively, before regulatory approaches are cast in stone, may help policy makers avoid letting the pendulum swing too far in either direction. While most would agree that assisted living should not walk down the same **regulatory** road as nursing homes, it may also be that

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<sup>1</sup> **Whether nursing homes are effective at fulfilling this mandate is beyond the scope of this synthesis to discuss.**

lessons from history should not be ignored. As discussed in the following section, viewing the regulatory tensions as being able to coexist (rather than as being irreconcilable) may help in structuring a regulatory approach for assisted living that meets the needs of the frail elderly.

### C. Resolution of Regulatory Tensions: An Individual and Contextual Orientation

Taken at face value, it would seem that the regulatory tensions articulated above are irreconcilable. The “medical model” historically adopted by nursing homes would seem at odds with a social model which focuses more on emotional well-being, individual choice, and restoration of function. This tension between a medical and social model is often played out in the tension between paternalism and autonomy, sometimes termed “medical paternalism.” As defined by Perry and Appelgate (1985), medical paternalism is the. “interference by physicians or other health care providers in the life or decisions of an individual when that interference is independent of the individual’s wishes but is for his benefit” (p.353). This notion of paternalism could be extended to the state (and federal government) in its capacity as protector of publicly funded beneficiaries against poor providers and in its capacity of assuring quality care. Interpreted positively, paternalism invokes providers to optimize patients’ well-being. Yet it implicitly denotes supersession of patients’ wishes, presumably because the provider’s judgment is in some way superior (Altman and Parmelee, 1991). Finally, primary concern with safety features for the frail elderly — e.g., restricting movement in certain areas of a facility to prevent falls or confusion — seemingly contradicts assisted living’s notion of permitting tenants to assume “risk”, in the name of independence and autonomy. Historically, the balance between these tensions (for some legitimate reasons) has been skewed towards medical **interventions**, paternalism, and safety for the frail elderly. Implicit in development of assisted living options is a rejection of this history. Viewing these tensions as contradictory can **reasonably** lead to a rejection of regulatory approaches that foster continuation of this skewed approach. Yet, it may also be true that for certain frail elderly individuals, in certain situations, at certain times, a medical orientation may be appropriate, paternalistic **interventions** indicated, and safety concerns primary, **just** as the opposite may be **true** for another frail elder.

These three factors — individual needs, situational/contextual factors, and time — are

vital in thinking about any regulatory approach for assisted living. Rather than viewing the polar opposites of the tensions as incompatible, it is also possible to view them as complementary, depending on the situation. **Thus**, for some frail elderly living in assisted living, a social model of care may be most appropriate at the beginning of their tenancy. As their physical, social, and/or cognitive condition changes over time, however, more paternalistic and medical interventions may be needed to facilitate the person's ability to "age in place." Likewise, some frail elders living in assisted living may have neither the ability (e.g., through cognitive decline) nor the desire to make certain decisions for themselves. Just as decisions to act independently and care for oneself must be respected as an autonomous act, so too should abdication of decisionmaking responsibility be viewed as an exercise of autonomy. Of 'course, the family's role must also be accounted for in this analysis.

The challenge for policy makers is to structure a regulatory approach for assisted living which at the same time recognizes the pitfalls of traditional regulatory orientations skewed towards medicalism, paternalism, and safety while acknowledging the potential problems of letting the pendulum swing to far in the opposite direction. Recognizing the primacy of individual differences, situational factors, and changing circumstances over time for the frail elderly, suggests that assisted living may not have to fully resolve tensions between a medical and social model, paternalism and autonomy, or safety and risk. Instead, viewing these tensions as points on a spectrum dictated by individual needs and preferences, setting, and time suggests a flexible regulatory approach which elevates neither end of the tensions over the other. Operationallizing this into a concrete regulatory approach will be a continuing challenge for assisted living.

#### **D. What are Some Approaches to Regulating Assisted Living?**

To resolve these complex issues by recommending a single regulatory approach for assisted living would be ingenuous. Instead, this section provides a brief **overview** of some approaches for regulating assisted living, ranging from a free market approach' to a model based on nursing homes.

##### **1. Free Market Approach**

At one end of the regulatory spectrum is the "free market" approach. Though it is

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common to characterize this approach as consisting of no government regulation, in fact existing regulatory mechanisms will always be present in housing and health care, even if specific regulations are not developed explicitly for settings such as assisted living. For example, licensing of health care providers provides some government assurance that care delivered by these professionals conforms to a socially defined level of acceptability. Likewise, housing codes presumably ensure minimum compliance with fire and safety standards. Of course, general housing codes may not be tailored closely enough to account for the needs of a frail elderly population. The free market approach would argue, however, that developers, in an effort to attract business, would make sure that the physical plant is designed to account for these features.

At root, the free market regulatory approach is premised on the notion that consumers will provide the incentive for providers to supply quality goods through exercise of their buying power. In this regard, it values consumer and provider autonomy above the need for government's (paternalistic) protection of program recipients. In the context of assisted living, the frail elderly and their families would ensure quality through demanding care only from those facilities that successfully captured the philosophy of assisted living by creating a home-like, high quality environment. The advantage of this approach is that it encourages providers to innovate in developing assisted living alternatives, and these innovations in a competitive environment would ideally reflect consumer preferences. It also places primary emphasis on autonomy and individualism.

Potential concerns with a free market approach relate to the ability of the frail elderly (and their families) to exert market power to influence assisted living development and operations. The problem may be further complicated if assisted living is more heavily subsidized with public funds than it currently is. Expenditure of public funds usually requires some level of regulatory oversight.

## **2. Nursing Home Regulatory Model**

At the other end of the regulatory spectrum is the nursing home regulatory model. In this approach, nearly every aspect of development, financing, operations, and performance is extensively regulated by federal and state governments. As described in great detail by the Institute of Medicine (1986), the focal points of regulation have moved from regulating

structural aspects of quality (physical plant, safety, etc.), to process indicators (the mode of delivering care), and more recently to outcome measures (does the care provided result in positive outcomes for residents). While it is beyond the scope of this synthesis to discuss in detail nursing home regulation, the potential advantage of such an approach is that providers are carefully monitored to ensure that residents receive the care that they need, that the treatment is administered properly, and that the care results in acceptable outcomes. Of course, the system has been widely criticized as failing to achieve these objectives.

The disadvantages of this regulatory approach are too numerous to list and are discussed in detail elsewhere in this synthesis. In the context of assisted living, however, it has already been noted that such pervasive regulation can subvert provider innovation, inhibit patient autonomy, and create an environment where providers **structure** operations simply to conform to regulations, not necessarily to provide the best care. As noted above, few people advocate a nursing home regulatory model for assisted living.

### 3. Use Existing Licensure Standards to Regulate

In between the free market and nursing home approaches are a variety of alternatives. One alternative is to apply existing regulations to assisted living. Two obvious candidates emerge for assisted living, state regulations on Continuing Care Retirement Communities (**CCRCs**) and regulations on Board and Care Homes. CCRC regulations may not provide a useful regulatory framework since these regulations typically monitor only financial aspects of facility operations (unless a part of the facility is certified for Medicare or Medicaid) (Coleman and Fairbanks, 1991). Board and Care licensure laws could apply to assisted living, and some commentators advocate their use (e.g., Coleman and Fairbanks, 1991). The potential advantage of **this** approach is that many aspects of operations and quality could be regulated to ensure patient protection and safety. The ABA Model Board and Care Act enumerates detailed **regulatory** guidelines in the following areas: size, resident care plans, admissions/discharge policies, residents rights, staff qualifications, physical environment, medication administration, staff training, licensure application rules, and related areas. The disadvantages of this approach, discussed more fully below, include a historical failure to monitor effectively quality in board and care homes. Congressional hearings have repeatedly documented deficiencies in this area (Special Committee on Aging and Select Committee on Aging, U.S. Congress, 1989). In addition, board **and care** licensure requirements relating to

restrictions on services that can be provided (e.g., **medications**) and physical environment may run counter to assisted living philosophy.

4. **Regulate the Values of Assisted Living, the Capabilities of Providers to Deliver Care, but not the actual processes or outcomes of care.**

Another approach between a free market and nursing home regulatory approach is to develop regulations designed to ensure that providers adhere to basic principles underlying assisted living, but avoid generating comprehensive regulations pertaining to processes and outcomes of care. Under this general approach, providers might be required to demonstrate, as a condition of licensure and on an ongoing basis, their **capacity** to provide a prescribed level of care. As described in greater detail in Chapter VIII (State Experiences with Assisted Living), Oregon's assisted living regulations have certain aspects of this approach. For example, regulations require that each tenant have a private room, consistent with the philosophy that the environment should be as home-like as possible and respect individual privacy. In addition, regulations require that staffing be adequate to provide needed care. Yet, no specific staffing ratios are mandated, affording the provider considerable flexibility in structuring operations and care delivery systems.\*

The advantages of such a regulatory approach are obvious. States communicate through regulations their expectations about what assisted living should look like, but afford considerable latitude to providers to structure their operations in accordance with innovative care practices and the **needs** and preferences of individual tenants. On the other hand, enforcement under this type of system is difficult. Developing standards on assisted living philosophy that are both clear and enforceable is challenging. Moreover, experiences with nursing homes suggest that regulatory requirements that do not, at some level, address outcomes, may be weak in their ability to guarantee a minimum level of quality.

5. **Regulate certain aspects of structure, process, and outcome, focusing on those aspects where linkages among the three are strongest.**

A final **approach** regulates only those aspects of operations most directly related to "quality" (as defined by policy makers) and tenant well-being, leaving unregulated

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\* It should also be noted that Oregon does regulate some outcomes relating to treatment efficacy.

facets of assisted living for which proper care practices and outcomes are unknown, or where provider innovation and tenant autonomy are to be encouraged. Donabedian's (1972) trilogy of structural, process, and outcome aspects of quality provides a useful framework. Some proponents of assisted living argue that certain fundamental aspects of quality are important for that setting. In Oregon, for example, the State decided that tenants should have a private room (structural domain). Other states have regulations pertaining to what services may be provided only under the supervision of nursing personnel or their designates (process domain). Finally, most policy makers agree that only in rare circumstances should the frail elderly be physically or chemically restrained (outcome domain). A regulatory approach might be crafted where those aspects of quality a state decides are most directly linked to the philosophy of assisted living (including tenant autonomy) and tenant **well-being** are regulated, but the myriad of other aspects of care and facility operations are not.

For example, regulations could specify that all assisted living facilities must provide rooms with certain requirements relating to size, safety, privacy and related design features. But regulations might not be so specific as to inhibit provider innovation in creating a home-like environment or precluding a tenant from modifying a room (within reason) to make a suitable environment for herself. Likewise, it may be important to require that staff be available 24 hours a day in an assisted living setting. Staff performance is an important process indicator of quality. But it may inhibit provider innovation and infringe upon patient autonomy to require specific staffing ratios and prescribe staff qualifications beyond those necessary to provide certain types of care.

Beyond simply deciding which aspects of structure, process, and outcome to regulate, policy makers might also focus on those aspects of each that are most strongly linked to the other, for it is the connections between structure, process, and outcome that lead to good quality care. Ideally, the linkages between structure, process, and outcome should be established before any **aspect** of each is used as a measure of quality (Donabedian, 1988, p. 1745). For example, a valued outcome in assisted living is freedom from restraints, and the ability of even cognitively impaired tenants to act autonomously within the limits of their capabilities. For safety reasons, it has historically been a challenge in assisted living and nursing settings to permit patients who wander to walk freely. Thus, patients were (and are)

restrained or placed in locked wards. Some innovative approaches, however, have been developed that might facilitate this outcome for assisted living. Sections of a facility could be designed with natural barriers to discourage wandering without creating an institutional or oppressive environment. Regulations could require these types of designs, without being too prescriptive. Another important related question is the extent to which cognitively impaired tenants should be segregated from, or integrated with, cognitively intact tenants. This question has ramifications for design, staffing, and virtually all aspects of assisted living operations. Likewise, regulations could require sufficient staff to supervise patients who wander (without prescribing ratios or staff training). In this simple example, the linkages between environmental design (structure), the role of staff (process), and the valued outcome (freedom from restraints and autonomy) are strong and may be facilitated by regulation. At the same time, providers could be afforded considerable latitude in design, staffing, and how to achieve this and other outcomes.

#### **6. Summary of Regulatory Approaches**

The most appropriate regulatory approach will depend, in part, on what a state's assisted living goals are, and how the various stakeholders believe those goals can be achieved. This section has attempted to identify some overarching theoretical issues involved in regulating assisted living and outlined general approaches that policy makers might consider. Ultimately, regulatory approaches may emerge from the myriad of practical issues that face assisted living, which we turn to next.

## **II. PART TWO: WHAT ARE SOME MAJOR REGULATORY ISSUES IN ASSISTED LIVING**

This section raises some specific regulatory issues that assisted living policy makers currently face. The issues discussed in this section represent examples of some major issues and are not meant to be exclusive of the range of regulatory challenges in the field. Our intent is to raise the issues, not to provide definitive answers. How some of these issues (and others) arise and are dealt with in particular states is discussed in Chapter VIII.

A. Do Board and Care Licensure Laws Apply to Assisted Living? Should They?

According to the American Bar Association, board and care is defined as a “publicly or privately operated residence that provides personal assistance, lodging and meals to two or more adults who are unrelated to the licensee or administrator” (Coleman and Fairbanks, 1991, p. 522). So defined, it is clear that many state board and care licensure laws would apply to assisted living facilities.

Whether these laws should apply is a more complicated issue. Some argue that board and care licensure requirements should apply, especially as the private sector becomes more active in the assisted living market and is otherwise unregulated (Coleman and Fairbanks, 1991). There are; however, downsides to applying board and care regulations to assisted living. As discussed in Chapter VIII,, some board and care statutes limit the services that can be provided to residents (e.g., medication administration). If assisted living is to achieve its goal of fostering aging in place, then regulations would have to be modified to reflect this goal. In addition, enforcement of quality standards in board and care homes has been lax, as documented by Congressional hearings. One reason for this is the lack of federal jurisdiction over assisted living settings that do not receive federal funds. As discussed in Chapter IV, the Keys amendment attempted to force states to adopt quality standards in board and care homes through tying provider compliance with receipt of SSI payments, the major source of funding for many facilities. Unfortunately, this enforcement mechanism has proven ineffective, in part because the sanction ultimately falls on the SSI recipient who is entitled to receive their payment.

In the end, many board and care regulations may be transferable to assisted living, but others would need to be modified or abandoned to fit the philosophy of assisted living. These complexities have caused many to question whether board and care regulations should apply to assisted living at all.

**B. What role (if any) should the federal government play in regulating Assisted Living?**

A related concern is the role of the federal government in regulating assisted living. Since many current “public” assisted living projects are funded through Medicaid waivers, the federal government has had the authority to regulate at least those projects. On balance, the federal government has afforded states broad latitude to implement assisted living programs in accordance with local needs and variation. A recent interim final rule implementing Section 1915(d) waivers, however, suggests the type of concerns that some states might have with an increasing federal role. The rule specifies the requirements states must meet to receive federal matching funds for the waivers (financing options for assisted living, including Medicaid Waivers, are discussed in detail in Chapter VII). Among other provisions, the rule requires that all facilities providing services (and receiving federal funds) under the waiver must meet applicable state board and care licensure requirements. As discussed in the previous section, these requirements may run counter to a state’s goals for assisted living.

**C. Should Regulatory approaches change as assisted living becomes more heavily publicly-subsidized?**

One issue raised by a researcher interviewed for this synthesis relates to the scope and nature of regulation as assisted living evolves into a public-subsidized program attracting for-profit industry. The private sector has shown increasing interest in assisted living settings, and many for-profit corporations already have well-developed living arrangements for the frail elderly who can afford more expensive settings. Indeed, some of the most innovative assisted living settings have been developed and managed by private companies. Besides these private developments, many other assisted living settings are funded by demonstration projects. Assuming results from these demonstration projects convince policy makers to expand access to assisted living arrangements to the Medicaid-eligible frail elderly population, a dramatic growth in the for-profit assisted living industry could occur (not unlike what happened in the nursing home industry). Non-interventive regulatory strategies might work quite well in demonstration projects run by carefully selected providers committed to the principles of assisted living. The concern is that as the market is opened to the broader for-

profit community (through public funding), more extensive regulations will be needed to ensure quality. On the other hand, regulations should not inhibit innovation or subvert consumer influence. While no easy answer exists, this is an **issue** that requires careful consideration.

D. How **can “risk” be regulated in assisted living? Should risk be regulated?**

Some proponents of assisted living suggest that both providers and the frail elderly should be permitted to take “risk” in assisted living. For the frail elderly, assumption of risk might mean being able to choose activities or make care decisions that others may not view to be in their best interests or that pose safety concerns. For providers, assumption of **risk** might mean being free of regulatory pressures to protect the safety of tenants in all circumstances (even if certain frail elders do not want to be protected). **The rationale** for this assisted living value is grounded in notions of autonomy. Returning to the tension between paternalism and autonomy discussed above, many analysts believe that our approach to providing care to the frail elderly has been skewed in favor of paternalism and beneficence, resulting in highly regulated environments designed to protect the safety, but not necessarily the autonomy, of program recipients. In the words of Richard Ladd: “Safety is the most important value for regulators. It’s the quality of life that should count most, not safety. In pursuing quality of life, I’m willing to take a lot of risk” (Mollica et., al. 1992).

On its face, this concern would seem to argue for limited regulation to permit tenants to exercise choice, and providers to craft and administer an environment that facilitates autonomy (as they do in their own homes). On the other hand, as suggested by **Lawton** (1982) and others (See Altman and Parmelee, **1991**), **risk** per se may not be the valued outcome. Rather, a **congruence** between risk and the individual’s **willingness** and **ability** to assume that risk might be the appropriate end. Thus, those frail elders residing in assisted living who want to assume risk — and have the cognitive capacity to assume risk — perhaps should be guaranteed the right to make choices by regulation. By the same token, there may be frail elders who do not want to assume risk but who seek assisted living because of its promise of safety and security. Likewise, there will undoubtedly **be frail** elders in assisted living settings who are cognitively impaired and unable to assume certain kinds of risk. From a regulatory perspective, then, one focus should perhaps be on the **process** of determining

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when, and for whom, risk is appropriate. Regulations could require, for example, that tenants be given the opportunity to assume risk, that providers or state **representatives have** discussed the consequences of the assumption of risk, and that the tenant understands the consequences of the decision. In many respects, this process is similar to the legal doctrine of informed consent, which has been extensively discussed as applied to the frail, cognitively impaired, elderly (See Altman, Smyer and Parmelee, 1992). Indeed, Wilson (1992) has written extensively about the notion of “negotiated risk”, a contractual approach to specifying appropriate care that can supplant traditional regulations.

From the provider’s perspective, Kane and colleagues (1990) suggest that if tenants are able to take risk, regulations might have to afford some legal insulation to providers in the event of injury. In the absence of such protection, providers may be reluctant to participate in shared decision making and mutual **assumption** of risk. Of course, ‘regulations should also be clear about provider responsibilities in informing frail elders about the consequences of risk, and facilitating autonomy where possible.

#### **E. Should the supply of assisted living facilities be regulated?**

Supply of nursing home beds is often carefully controlled by states through licensing and certificate of need laws. The purposes of this regulation are to monitor quality (through licensing only qualified providers), access (through bed supply), and cost. Whether the supply of assisted living needs to be extensively regulated is an open question, but one which policy makers should carefully consider for at least two reasons. First, through careful review of provider applications states may be able to discern whether applicants are committed to the philosophy of assisted living, and the extent to which they are capable of providing care in conformance with the stated goals.

Second, assisted living might be viewed as an integral part of an interrelated long term care system, where changes in supply of one setting affects other components of the system. Thus, rapid expansion of assisted living may dramatically affect nursing home occupancy rates. Indeed, reduction in nursing home bed supply might be an explicit state goal, as it was in Oregon. On the other hand, state **officials** may want to monitor this issue closely to the

extent rapid reductions in nursing home occupancy forces some nursing homes to close, potentially creating an access problem for those in need of institutional care. This potential problem may be especially relevant in rural areas, where nursing home occupancy might already be low. In addition, to the extent assisted living attracts a less disabled elderly clientele, heavier care patients could be left in nursing homes, potentially increasing overall costs of care in that setting.

Mendelson and Arnold recently summarized the role of CON in addressing quality and access issues in long term care:

*“States also use CON to address **long-term** care access and quality concerns. For example, many states require that new nursing homes locate themselves in **underserved** areas, or plan to treat a given percentage of indigent patients. States have also used CON to encourage development of alternative delivery systems and improve nursing home quality. For example, Ohio is currently using **CON** to reduce the institutional bias in long-term **care**, and encourage the development of **community-based** services, including adult day care, respite care, and support for **caregivers**. New York has changed CON criteria through the **rulemaking** process to encourage the submission of **CONs** for **AIDS** beds. Many states review an applicant’s **licensure** record, and New York does this both in and out of state.”*

Policy makers should consider these issues as assisted living develops as a housing option for the frail elderly.

**F. Should there be different regulations for the cognitively impaired frail elderly?**

Assisted living philosophy, as articulated by some of its leading proponents (e.g., Wilson, 1992), is premised (in part) on the notion of elder autonomy, independence, and shared decision making between providers, consumers, and their proxies. Many frail elders in assisted living settings have or will develop cognitive impairments that call into question their ability to engage in autonomous decision making. Historically, elderly people with even mild impairments were deemed incompetent to make any decisions (See, Altman and Parmelee, 1991). This approach has been widely rejected, and it is increasingly recognized that even cognitively impaired elderly people can, with appropriate interventions and therapies, exercise some judgment and make their preferences known (Altman, Smyer, and Parmelee, 1992). Nonetheless, cognitively impaired people may require more protection against abuse than

their cognitively intact peers. Indeed, psychological research suggests that an incongruity between the environmental demands placed on an elderly individual, and their “competence” to function within that environment, can cause pathology (Lawton, 1982). From a regulatory perspective, this suggests that cognitively impaired assisted living tenants might require more “paternalistic” protection than other frail elderly tenants, or more active efforts should be made to involve “surrogate decisionmakers” in the process.

**G. To what extent can (should) “aging in place” be regulated?**

Another important hallmark of assisted living is its promise of facilitating “aging in place” of frail elders. To some, assisted living’s success is measured by its ability to prevent the frail elderly from having to move to a nursing home. From a regulatory perspective, one important issue relates to the circumstances under which a frail tenant is too disabled to continue residing in the assisted living setting. The answer to this obviously depends on a range of regulatory issues, including what services may or may not be provided outside the institution. A fundamental regulatory issue, however, relates to discharge policies, or what regulations have to say about when a provider may or may not transfer a resident to another care setting. In a review of discharge policies of congregate living centers, Sheehan (1986) found that these policies were not established and varied from complex to complex, and individual to individual. As noted above, this issue may not be of concern in demonstration projects committed to the idea of aging in place. As the market for assisted living opens, however, policy makers might be concerned about providers inclined to discharge difficult tenants in need of care, both for administrative and cost reasons. In the end, this is an issue that requires careful consideration.

**H. Should marketing and advertising be regulated?**

A related regulatory consideration involves the marketing of assisted living to the frail elderly by providers. Coleman and Fairbanks (1991) raise the concern that some providers market a broad range of services in their assisted living facilities to attract “independent” elderly tenants. When these tenants age in place and require more assistance, they sometimes find that marketed services are unavailable and they are asked to move to a

higher care setting. Coleman and Fairbanks (1991) suggest that regulating marketing practices, admission agreements, and discharge policies (as described above) might help address this potential problem.

### **I. Who Should Regulate?**

A final regulatory concern is who should regulate assisted living. Several possible entities exist: housing authorities, Medicaid agencies, social services agencies, consumer advocates, or state aging agencies, to mention a few. The most appropriate regulatory entity (and the level of regulation) depends critically on what the state hopes to achieve. If a state seeks to ensure certain physical design requirements are met but feels that care practices should be left to provider discretion, then perhaps the housing authority should have primary regulatory responsibility. On the other hand, as noted above, prescriptive design regulations can inhibit provider innovation in creating a homelike environment. Perhaps the most important consideration, however, is the potentially detrimental 'effects of having multiple regulatory authorities' which may not coordinate the substance and process of regulations. This is an important issue for policy makers to consider in deciding whether and how to regulate assisted living.

### **III. CONCLUSION**

No simple solutions exist to the complex problem of regulating assisted living. This chapter has outlined some basic theoretical and practical issues to consider in crafting regulatory approaches. Chapter VIII discusses how some of these issues have arisen in specific states, and how policy makers have chosen to address them. At least two important points emerge from this discussion. First, assisted living has the unique opportunity to structure a regulatory approach with the benefit of hindsight, drawing on ~~the~~ extensive and well documented history of nursing home regulation. Second, given the goals of assisted living, many analysts believe that a hallmark of regulation in this area should be flexibility, where the needs and preferences of frail elders can be recognized and effectuated, and providers have some degree of latitude to develop innovations within established guidelines. The challenge for assisted living is in being able to translate these principles into workable

regulations.

#### IV. RESEARCH QUESTIONS (CHAPTER VI)

The scope and manner of regulating assisted living gives rise to a host of philosophical, political, economic, and ethical issues which are important to address, but difficult to translate into a research agenda. One meaningful role for researchers is to conduct research designed to produce objective information about the effect of regulations on the cost, quality, and operation of assisted living. Such information can help policymakers begin to resolve some of the complex issues raised in this chapter. In this vein, researchers might consider some of the following questions:

1. **Current Regulatory Approaches:** How do states currently regulate assisted living? How consistent are these regulations with the philosophy and intent of assisted living? What aspects of existing nursing home regulations are inconsistent with assisted living? Are there differences when assisted living is regulated by health agencies versus social services agencies? Are there differences in “outcomes” with different regulatory approaches (e.g., avoiding nursing home placement: tenant independence/ autonomy; functional status; health status; life satisfaction; etc.)?
2. **Indeopendence and Autonomy:** To what extent do regulations restrict or protect tenant independence and autonomy? To what extent do regulations conflict with state “patients’ rights” statutes?
3. **Cost of Regulation:** How much do regulations contribute to the costs of assisted living (for providers, **payors**, and tenants)? For example, do the costs of assisted living in states with different regulatory approaches vary? (controlling for factors such as wage differences, real estate values, services, and a variety of regional factors).
4. **Safetv and Risk:** To what extent can tenant “safety” be minimally regulated without unduly jeopardizing tenant well-being? For example, small scale safety studies could examine under what circumstances tenants can be permitted to take “risks” without getting injured.
5. **Professional Delegation and Staffing:** To what extent do existing regulations permit non-professionals to provide care (e.g., medication administration) in assisted living? What are the effects of such regulations (e.g., nurse delegation acts) on cost, quality, and outcomes in assisted living? For example, studies on “practice patterns” could examine optimal staffing ratios, appropriate staff (and cross-staff) functions, and the effects of professional “delegation” on cost,

quality, and outcomes.

6. **Admission and Discharge Policies:** What are the regulatory criteria for accepting tenants into assisted living? What do regulations say about discharge policies as tenants “age in place” and become more disabled?
7. **Environmental Design:** To what extent do regulations restrict innovative environmental design of assisted living facilities? How can these regulations be changed without compromising tenant safety?
8. **Advertising:** In evaluating whether to regulate advertising, are consumer perceptions about assisted living (e.g., regarding available services) consistent with reality? Is the content of advertising consistent with facility policies (e.g., discharge policies)?
9. **Cognitively Impaired Frail Elders:** How can independence and autonomy for cognitively impaired tenants be facilitated through regulations (if at all)? For example, to what extent can “negotiated risk” be implemented through contractual means without unduly jeopardizing tenant safety?
10. **Federal Regulations:** What aspects of federal regulations apply to assisted living (e.g., board and care regulations)? How do these regulations inhibit or facilitate assisted living operations (e.g., how might the Americans with Disabilities Act and the Fair Housing Act amendments impact assisted living)?
11. **Competitive Regulatory Approach:** To what extent can competitive market forces facilitate assisted living goals (cost containment, quality, access, independence, autonomy)?



## CHAPTER VII PUBLIC FINANCING

### I. INTRODUCTION

Compared to the private sector, public programs have played a limited role in financing the development of assisted living for the frail elderly, but over the past several decades a variety of programs to support housing with services have been developed. Financing has included resources to fund both housing (the construction of new units and rental assistance in existing units) and services. Three major trends have occurred with regard to this financing. First, over time resources have shifted from producing new housing units to increasing support for rental assistance in existing housing. In the late 1960s, a congressional committee saw the country's primary housing problem to be the lack of adequate housing for low-income families. The commission proposed a major housing construction and rehabilitation program to consist of six million units for low income families. A Reagan commission in the 1980s, found that the quality of housing had steadily improved due to earlier investments in new housing. The commission considered the new problem to be the lack of affordability of housing that was readily available and recommended cuts to the numbers of new units funded. Due to the fact that housing assistance is provided through multi-year contracts the impact of these cuts is only now being felt (U.S. Code Congressional and Administrative News, 1991). A second major trend in the housing industry, as evidenced by new programs authorized by the National Affordable Housing Act of 1990 and the earlier Congregate Housing Services programs is efforts to combine bricks and mortar financing with services financing. These programs have largely been in the domain of the Department of Housing and Urban Development (HUD). HUD has considered human services to be in the domain of other agencies and has traditionally avoided responsibility for even small supportive services programs (Tilson, 1990; U.S. Code Congressional and Administrative News, 1991). And finally, as evidenced by the new HOME initiatives, the third trend is for Congress to encourage partnerships between the federal government and states to develop housing — partnerships where the federal government sets broader policy direction and relies on states to develop solutions tailored to their local needs.

In this chapter, we examine public financing that can potentially be used for assisted living by addressing the following topics:

- **Federal programs that can increase the supply of assisted living units by directly financing the construction of new facilities.** The federal government has been a major generator of publicly funded housing through the Department of Housing and Urban Development (202 and public housing authority programs) and through Farmers Home Administration funding. The percentage of frail elderly served across these facilities and the services provided within them vary widely across facilities; however, in the aggregate approximately 40 percent of all federally assisted units are estimated to be occupied by the elderly (Special Committee on Aging, United States Senate, 1991). This funding has traditionally focussed on the housing and not the services components of these facilities.
- **Federal programs that can promote the construction of new units by providing incentives for other investors to fund units.** The mainstays of the types of federal incentives designed to generate investments in low-income housing by other investors are federal mortgage insurance, tax-exempt bonds, and more recently low income tax credits. These incentives are available to both the for-profit and non-profit sectors,
- **Federal programs that can promote assisted living by paying rental subsidies directly to low income households.** In addition to providing project based housing assistance, the federal government provides rental subsidies directly to households. These subsidies are in the form of rental certificates which are limited to the difference between 30 percent of the tenants income and fair market rent as set by HUD, and more recently rental vouchers which, unlike rental certificates, allow tenants to pay any excess between 30 percent of income and fair market rents out-of-pocket. Housing vouchers are intended to provide tenants with more flexibility in their choice of housing arrangements.
- **Traditional sources of federal/state funding that can be used to provide services in housing for the elderly.** Traditional sources which have been used to finance services in elderly housing include Medicare, Medicaid, Social Services Block Grants, the Older Americans Act, and the Supplemental Security Income Program. Medicare and Medicaid in particular largely have been limited to funding medical models of care in institutional settings.
- **Options for financing additional home and community-based services in assisted living settings under Medicaid waivers and new optimal services provisions.** It is frequently said that the availability of Medicaid to pay for nursing home care and limited public funds for community-based care creates a "bias" toward institutionalization. Partly in response to those concerns, Congress amended the Social Security Act (which governs state options under Medicaid) to expand states' ability to pay for home and community care. The federal government has authorized a selective expansion of Medicaid services

to the frail elderly in the community under Medicaid Home and Community Based Service Waivers.

- **Federal programs designed to integrate financing for housing and services.** A major criticism of policies for funding assisted living is that historically disparate funding sources for housing and service have created a fragmented delivery system that does not optimally address the needs of the frail elderly. Recently, more coordinated programs (albeit limited in scope) have been developed to begin to address these concerns. One of the earlier programs was the congregate housing services program; more recently, the National Affordable Housing Act of 1990 has generated combined housing/services initiatives as well.
- **Additional ways in which states finance assisted living.** States rely on a variety of sources to finance assisted living that include: state general revenue appropriations, state-levied fees or trust funds, and state general obligation bonds.

This chapter focuses on the major sources of public financing. In addition to these resources, funding is available through a myriad of other programs. These programs are usually available to the broader population and are not specifically targeted to the elderly. An extensive listing of the programs available through 1988 has been developed (Pynoos, 1988). Examples of the additional programs that can be used to provide resources to the frail elderly in supportive housing include funding through a succession of acts for supportive care for veterans in the community.

## **II. FEDERAL PROGRAMS THAT CAN POTENTIALLY INCREASE THE SUPPLY OF ASSISTED LIVING UNITS BY DIRECTLY FINANCING THE CONSTRUCTION AND OPERATION OF FACILITIES.**

The federal government commits substantial resources to directly fund the construction of new housing and the rehabilitation of existing houses. The two primary direct funding sources are the Department of Housing and Urban Development (through its 202 funds and Public and Indian Housing Authority funds) and the Farmers Home Administration. As illustrated in Exhibit VII.1, federal policy has shifted in favor of providing assistance for existing housing stock over construction of new housing in an effort to contain the rising housing costs as a result of a Reagan Commission report that considered the problem in the

**EXHIBIT VII.1**

**FEDERAL ASSISTANCE TO RENTERS IN EXISTING HOUSING  
AS COMPARED TO ASSISTANCE IN NEW UNITS  
1977-1 992**

(Households in thousands)

<b>ASSISTED RENTERS</b>			
<b>Beginning of fiscal year</b>	<b>Existing housing</b>	<b>New construction</b>	<b>Total assisted renters</b>
1977	268	1,825	2,092
1970	423	1,977	2,400
1979	602	2,052	2,654
1980	707	2,189	2,895
1981	820	2,379	3,012
1982	844	2,559	3,210
1983	955	2,702	3,443
1984	1,086	2,836	3,700
1985	1,180	2,931	3,887
1986	1,253	2,986	3,998
1987	1,366	3,047	4,175
1988	1,446	3,085	4,296
1989	1,534	3,117	4,402
1990	1,616	3,141	4,515
1991	1,678	3,180	4,613
1992	1,721	3,204	4,680

**Source:** Congressional Budget Office based on mimeographed data provided by the Department of Housing and Urban Development and the Farmers Home Administration.

80s to be the lack of affordability for an adequate existing stock of housing in addition to efforts to contain rising housing costs (U.S. Code Congressional and Administrative News, 1991; 1992 Green Book).

The incremental number of public housing units reserved is included in Exhibit VII.2. This exhibit also illustrates the decrease in funding for new units over time.

### **A. Housing and Urban Development (HUD) Programs**

The two primary housing programs financed through HUD are Section 202 and Public and Indian Housing Authority funds. While Section 202 has historically only served the elderly and disabled, and since 1990, exclusively serves the elderly for new projects, the Indian Housing Authority serves a broader population of low income individuals. In addition, the numbers of frail elderly served by these projects, as defined by individuals needing assistance in one or more ADLs, has not specifically been quantified.

#### **1. HUD 202 Program**

Section 202 housing has in many ways been the flagship of HUD's construction-oriented programs. It is said to have had relatively few management problems, almost no defaults, and being judged by its residents as very high quality (Pynoos, 1984).<sup>1</sup> Originally, 202 funds were in the form of direct low interest loans to non-profit organizations and section 8 rental subsidies to develop affordable housing for low income individuals. More recently these resources have been in the form of capital advances and rental assistance contracts. In addition, new provisions allow for limited funding for case management and services for frail elderly residents.

Income eligibility standards have become more restrictive over time and the average age of residents in 202 facilities is increasing. In those facilities built before 1974, 35 percent of the residents are over 80 (Gayda, 1989). With the shift in federal resources from new

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<sup>1</sup> A 1988 report by the House Subcommittee on Aging did identify a number of problems with regard to Section 202 as housing for the frail elderly. The report noted, among other things, that severe limitations in Section 202 construction costs have resulted in cutbacks that had reduced communal spaces, reduced average space per unit, reduced space for personal care service delivery, etc.. which make these spaces less conducive alternatives for housing the frail elderly.

**EXHIBIT VII.2**  
**PUBLIC HOUSING**

<b>INCREMENTAL NUMBER OF UNITS RESERVED</b>			
	<b>Section 202*</b>	<b>Public Housing</b>	<b>Indian Housing</b>
1980	92,763	31,834	4,893
1981	73,861	33,242	3,128
1982	27,527	8,944	3,192
1983	15,588	240	5,200
1984	14,488	5,212	2,762
1985	12,639	5,448	2,178
1986	11,515	3,993	2,078
1987	12,550	6,130	3,671
1988	11,264	7,791	2,864
1989	9,173	5,246	1,478
1990	7,281	293	1,677
1991	N/A	11,569	2,518
Estimate 1992	13,964	6,477	2,960
Estimate 1993	4,542	N/A	N/A

\* New and substantial rehabilitation

SOURCE: Department of Housing and Urban Development; February 12, 1992 (mimeographed table)

construction to existing housing stock, the number of new 202 units funded each year has decreased over time. Currently a total of just over 200,000 units are funded under the 202 program.

a. **Funding**

In Fiscal Year 1991, 202 funding was allocated for 9,389 units: \$550 million for capital advances and \$264 million for project rental assistance. Capital advances cover the cost of constructing new facilities or rehabilitating existing facilities, the cost of congregate space (not to exceed 10 percent of the total facility), the cost of special design features in individual units required to meet the needs of the elderly, the cost of the land, and the cost of movable equipment necessary to the basic operation of the housing (Federal Register, June 12, 1991). Capital advances are based on per unit limits of \$29,500 for efficiencies and \$33,816 for one bedroom units in buildings with elevators. Limits can be adjusted where necessary by “high cost factors” used by other HUD programs. Capital advances do not have to be repaid as long as the units that receive 202 funding continue to be used for low income individuals for at least 40 years.

Rental subsidies in 202 housing are provided through contract rental assistance that HUD provides to developers. This assistance is based on the difference between the rent paid by the tenant and facility’s operating expenses for those low income units. Contract rental assistance for new units replaces Section 8 assistance which is based on the difference between local fair market rent and the tenant’s contribution. While tying rental assistance to actual operating expenses may provide opportunities for some facilities to receive increases in their reimbursement, the aggregate impact of this new system on expenditures is not clear. New capital and operating reimbursement schemes were designed to overcome constraints the prior system imposed on construction costs and operating costs and overly bureaucratic approval processes which hindered the development of new facilities (US. Code Congressional and Administrative News, 1991). Tenant rents are also a source of funding for 202 housing, The 1983 Housing Act increased tenants rents in 202 housing from 25 percent to 30 percent of adjusted income (Gayda, 1989).

b. **Eligibility**

Over time the limits on income eligibility to qualify for 202 housing have become increasingly stringent. With the linkage to the 1974 Housing Act, 20 percent of 202

occupants were required to have incomes below 80 percent of the median area income (though virtually 100 percent of occupants met this criteria). The 1983 Housing Act limited eligibility to residents with incomes below 50 percent of the median area income.

### C. Services

Until recently, federal funding for 202 housing has excluded funding for services. Services have been covered primarily by tenant incomes. Services may include housekeeping, transportation, meals, personal care; no medical services can be provided by facility. One of the major differences in new and old 202 funding provisions is coverage for services. In the 1992 provisions, case management services were included in operating expense as long as at least 50 percent of the occupants of the facility are frail. (The threshold has yet to be determined for FY 93.) In addition, 202 payments will include an addition: \$15 per resident per month to cover the cost of services for residents in facilities targeted for the frail (defined as more than three ADL impairments). As described later in this paper other programs (e.g., Project Retrofit and the Congregate Housing Services Program) have expanded services funded in 202 facilities (U.S. Code Congressional and Administrative News, 1991) as well.

## 2. Public Housing

Public Housing is the oldest and **largest** federal program designed to fund housing for low income individuals. 387,000 elderly are estimated to live in public housing, about half of these in projects designed specifically for the elderly. One-third of the elderly in a survey of 100 of the largest facilities were over 75 years old and three-fourths of these individuals lived alone (U.S. Congressional Code and Administrative News, 1991). Like 202 housing, the services provided across facilities vary widely and are largely funded and coordinated by outside agencies and organizations rather than by the operators of the facilities themselves. By the mid-50s, public housing **increasingly** was occupied by poor and predominately black families. Around that time legislative changes provided incentives for elderly participation (e.g., since older persons were deemed eligible and financial assistance was increased for public housing designed specifically for the elderly) and **since then public housing for the elderly has proliferated** (Pynoos, 1984).

**a. Funding**

Federally-financed public housing is operated by state chartered and local housing authorities. Housing authorities are authorized to lease or buy low-income housing. They are also authorized to issue notes and bonds to finance projects. While the federal government provides capital funds for housing authorities, the federal government has also contributed funds towards operating expenses. Operating expenses were originally to be met by tenants' rents which have not kept pace with increases in operating expenses (Special Committee on Aging, United States Senate, 1991).

**b. Eligibility/Services**

Public housing is targeted to households with incomes under 50 percent of area median incomes. Services, when they are available, are funded by tenant incomes and other sources as discussed later in this chapter.

**B. Farmers Home administration (FmHA)**

Like the HUD 202 program, the FmHA program includes direct loans to promote the construction of units targeted to low income populations. These loans are made to state or local public agencies, consumer cooperatives, individuals, trusts and associations. They are generally targeted to towns with populations less than 10,000, but may be targeted to towns with populations between 10,000 and 20,000 if they are not adjacent to an MSA. Of the 4.3 million people living in rural communities, some 2 million are estimated to live in substandard housing and there is a backlog of requests for FmHA housing (U.S. Code Congressional and Administrative News, 1990).

**1. Funding**

The federal government may provide public agencies with construction or rehabilitation loans for the entire amount, others must provide three percent equity. Loans may be used to build, purchase, or renovate existing facilities. Units must include kitchens and bathrooms, be close to service providers and shopping, have central dining rooms and emergency call systems. Tenants pay 30 percent of their income for rent in projects participating in rental assistance program.

## 2. Eligibility

Eligibility is limited to those 62 and older with income eligibility related to area median income.

## 3. Services

FmHA facilities are required to provide at least one meal per day, transportation, routine housekeeping, personal care, recreation and social activities. In addition the service package must be affordable to low and moderate income residents. Projects may not serve anyone who needs continuous medical or institutional care.

### c. Other Federally Funded Programs

Other more flexible federal source of funding for housing are the Community Development Block Grant programs and the new HOME program authorized by the 1990 National Affordable Housing Act. While not specific to the elderly, these programs are an additional source of housing financing.

#### 1. The **Community Development Block Grant Program**

The primary purpose of HUD's **Community Development Block Grant Program (CDBG)** is neighborhood revitalization and community development. Entitlement communities develop their own program and funding priorities. This revitalization and development may include housing activities that benefit low and moderate income people. In fact, 70 percent of the funding is to be targeted to low and moderate income residents. CDBG funds are primarily used in conjunction with funds from several other housing programs to guarantee affordability. The primary advantage of these grants are that they are a highly flexible source of funding; nonetheless, many types of projects compete with frail elderly housing projects for these funds (U.S. Department of Housing and Urban Development, 1989-1990).

#### 2. The **HOME Program**

The **HOME program** was authorized by Title II of the National Affordable Housing Act of 1990 to provide funding for states and local governments to make affordable housing available to low income individuals. The funding available is for new construction, rehabilitation acquisition, and rental assistance. A major purpose of the HOME program was to respond to criticism that HUD's programs are not as responsive as they might be to varying local needs. The HOME program delegates authority to local jurisdictions to develop

detailed housing strategies for their respective areas and funds programs based on those identified priorities,

**a. Funding for the HOME Program**

In FY 1992 \$1.5 billion was set aside for the HOME Program (Federal Register: Jan., 1992). The program requires matching funds (25 percent for rental assistance and rehabilitation funds, 33 percent for substantial rehabilitation, and 50 percent for new construction) to encourage partnerships across funding sources and providers. The HOME program is not specific to the frail elderly (Special Committee on Aging, United States Senate, 1991). It should be noted that HOME matching requirements have been changed by the new housing act, just signed into law.

**b. Eligibility for the HOME Program**

The program specifies that uses are to be targeted to assisting low- and very low income families. For rental housing, at least 90 percent of funds must be used for families with incomes no higher than 60 percent of median and the rest at no higher than 80 percent of median,

**D. Issues/problems Related to Direct Federal Funding of Housing**

Several issues/problems arise in projects that receive direct federal funding; the National Affordable Housing Act of 1990 represents an attempt to deal with many of these issues.

- **Demand may exceed supply.** Even with increasingly stringent eligibility requirements demand for directly funded federal housing may exceed supply. A 1988 survey of 202 facilities reveals that an **average** of 10 individuals are on each 202 facility's waiting list (Gayda, 1989). With **the shift** in emphasis from new construction to existing housing it is unlikely that this apparent shortage will be alleviated.
- **Limits on construction and operating costs.** While the basic methodology for calculating federal subsidies represents a shift from direct loans to capital advances and from Section 8 rental assistance to rental assistance contracts, the basic concern remains that reimbursement is insufficient for facilities to provide the types of space and services required for an increasingly frail population.

- **Only non-profits are eligible.** The funding available for developing 202 housing, albeit limited, is **targeted** to non-profits. At issue is what impact expanding eligibility to for-profits would have on the development of 202 units.
- **Impact of more integrated housing and services funding.** Integrated housing and services funding streams would increase accessibility to services and decrease service fragmentation. HUD's CHSP program and 1990 **National Housing Act** programs are steps in that direction: in addition to new 202 funding for services (albeit limited) and case management: How to better integrate disparate housing and service funding streams in facilities directly funded by the federal government remains an issue.

### III. FEDERAL PROGRAMS THAT CAN PROMOTE **THE** CONSTRUCTION OF NEW UNITS BY PROVIDING INCENTIVES FOR OTHER INVESTORS TO FUND UNITS.

A variety of federal programs encourages other investors to develop housing by providing federal mortgage insurance, tax-exempt bonds, and tax-credits. As explained in the next section, section 8 is a program that includes rental housing certificates and vouchers which are provided to tenants of low income housing.

#### A. **Federal Mortgage Insurance**

The two major types of federally insured mortgages are Section 232 and 236 mortgage insurance. Unlike the 202 program, which is characterized by direct federal funding, federal mortgage insurance programs encourages other lenders to make loans to those interested in developing low income housing. Federal mortgage insurance is often used as credit enhancement for tax-exempt bond financing. Half of the tenants projected to be affected are elderly, and 70 percent of the tenants have incomes below 50 percent of the median area incomes (U.S. Code Congressional and Administrative. News, 1991).

A major issue addressed by the National Affordable Housing Act is the impending loss of hundreds of thousands of federally assisted units under the old 221 (d) program as well **as** the loss of federally assisted units since Section 236 stopped financing projects years ago. Experts estimate that prepayment clauses that allow owners to prepay 40-year mortgages after 20 years and end the low income use of the housing risk the loss of 250,000 units

during the next 15 years with most of the losses occurring between 1991 and 1995. The National Affordable Housing Act creates incentives for owners to maintain units for low-income individuals.

### **Section 232 Mortgage insurance**

Section 232 mortgage insurance was originally intended to promote the construction of nursing home and intermediate care facilities. In 1983 the program was expanded to include board and care homes as well. The mortgage insurance program is available to both not-for-profit and proprietary facilities.

Facilities insured under this program are not restricted by income limits or limits on rents or charges. HUD looks at comparable facilities in the area to make sure that rents charged are reasonable. The subsidies therefore allow developers to focus on low or moderate income elderly but developers are not required to do so. Facilities with federally insured mortgages are prohibited from charging admission or entrance fees (Early, 1988).

Facilities insured under these programs must have full-service kitchens if individual apartments do not have kitchens. There are per-unit cost guidelines that make it difficult to cover single occupancy units with kitchens and baths. Facilities subsidized through this mortgage insurance must provide continuous protective oversight (24 hours/day). Additional services can include but are not limited to housekeeping, laundry, supervision of nutrition or medication and assistance with daily living.

### **B. Tax Exempt Bonds**

Tax exempt bonds are another way that the federal government attempts to encourage the financing of housing. Through tax exempt bonds, investors can obtain favorable financing terms for up to 100 percent of all site and development costs from state and local government authorities. In addition, debt amortization schedules can be tailored to meet the cash flow requirements of the project. Investors are willing to buy them at below-market interest rates because the interest they earn is tax-exempt. Eligibility for tax exempt bonds varies from authority to authority, Community-based development of assisted living through use of tax exempt bonds may be difficult because of high financing costs. Because of the

sizable fees associated with bond financing, it may be better to pursue conventional financing for smaller loan amounts (Early, 1988).

### C. **Low Income Housing Tax Credits (LITC)**

Section 252 of the Tax Reform Act of 1986 introduced a tax credit for owners of certain low income housing projects to address a growing concern that existing subsidies were not successfully addressing the housing needs of low to moderate income individuals (Blatter, 1988). LITCs were viewed as a way to overcome existing limitations on tax-exempt financing which were not viewed as well targeted to low income individuals (individuals with incomes at 80 percent of mean area incomes were eligible) and because other programs had been cut, doing away with the tax advantages of providing rental assistance. In addition, beyond minimal requirements for number of units to be occupied by low income individuals, developers using tax-exempt financing did not have incentives to develop the number of units beyond those minimal requirements: the subsidy did not increase according to the number of low income units set aside. In addition, facilities were required to maintain the low income units for only ten years. And finally, there were no limitations on the amount of rent that low to moderate income individuals were required to pay as a percentage of their total income. The LITC program sought to address those limitations (Blatter, 1988).

LITCs are tax credits, or foregone revenues administered by states. Annual funds and state appropriations are capped. The states have some flexibility in setting targeting goals and requirements for developing tax credits. The maximum amount of the credit depends on the percentage of qualifying residents in the facility. Government allocations to the LITC program are included in Exhibit V11.3.

To qualify for low income tax credits, investors must set aside 20 percent or more of the units for individuals whose gross incomes are no more than 50 percent of the area median income or set aside 40 percent or more of the units for individuals whose incomes are not greater than 60 percent of area median gross income. Units are not counted towards the set aside if the tenant occupying the unit pays more than 30 percent of his or her income

towards rents (Blatter, 1988). The actual amount of the tax credit depends on the number of units set aside for low income residents.

In 1987 when the Act was new, state allocations were not completely used as investors were less familiar with the LITC option. Since that time allocations have been more widely used and many states have reached their allocation limits.

#### D. Issues/Problems

Incentives for other investors to fund projects (which could include assisted living) are often combined to achieve favorable financing; nonetheless, these incentives have generated the following concerns:

- Targeting — Concerns are expressed that these programs could be better targeted to the low income elderly.
- Prepayment — There are concerns that prepayment clauses place existing low income unit set asides at risk. More recent legislation has attempted to minimize these risks.

**EXHIBIT VII.3**

**LOW-INCOME HOUSING TAX CREDIT AUTHORITY: 1987 TO 1991**

<b>YEAR</b>	<b>AUTHORITY</b>
1987	\$306,000,000
1988	304,000,000
1989	314,230,800
1990	317,674,678
1991	314,351,540

SOURCE: ACF Report and NCSHA Tables (mimeograph document provided by the Department of Housing and Urban Development)

#### **IV. FEDERAL PROGRAMS THAT CAN PROMOTE ASSISTED LIVING BY PAYING RENTAL SUBSIDIES DIRECTLY TO LOW INCOME HOUSEHOLDS.**

There are two primary forms of Section 8 rental assistance. There is assistance tied to projects, which is the type used for 202 housing where the landlord receives the rental assistance directly. And there is household assistance where the tenants themselves receive the supplements and are free to use them in different types of projects. The two mainstays of household subsidies are Section 8 housing rental certificates and housing vouchers. This section describes those household based subsidies. As explained in the introduction to this chapter, funding for rental assistance has increased over time as compared to funding for new construction.

##### **A. Section 8 Rental Housing Certificates**

The traditional form of household based assistance has been rental certificates, The amount of this assistance is limited to the difference between the tenant's contribution of 30 percent of his or her income and the fair market area rental rate (U.S. Code Congressional and Administrative News, 1991). Eligible individuals include those whose incomes do not exceed 50 percent of the median income for the area (U.S. Department of Housing and Urban Development, 1989-1990) The new Section 202, however, use project rental assistance contracts (PRACs), instead of Section 8.

##### **B. Housing Vouchers**

The National Affordable Housing Act of 1990 makes vouchers the other primary vehicle for household rental assistance than housing certificates which are more flexible in terms of where they can be used. (In Fiscal Year 1993 appropriation is almost equally divided between certificates and vouchers.) The Section 8 housing voucher program is intended to provide assisted families with a greater range of choice in living facilities by permitting families to rent units beyond the fair market rents in houses of their own choosing (U.S. Department of Housing and Urban Development, 1989-1990). Like Section 8 rental certificates, families

whose incomes do not exceed 50 percent of median area incomes are eligible for this program.

### C. Issues/Problems

Even with the shift to vouchers there is still concern about the availability of housing for their use and the ability of low-income elderly to afford costs exceeding the amount of the subsidies. Newer provisions to periodically review the extent to which low income individuals incur cost beyond the value of the vouchers seek to address these concerns (U.S. Code and Congressional News Act, 1991).

## V. TRADITIONAL SOURCES OF FEDERAL/STATE FUNDING THAT CAN BE USED TO PROVIDE SERVICES IN' HOUSING FOR THE ELDERLY.

Medicare and Medicaid — two key sources of financing for long-term care services — are fundamentally health insurance programs, The cost of needed or desired services provided outside institutional settings; and/or those services of a less medical nature (e.g., help with activities such as bathing and meal preparation), are largely incurred as out-of-pocket expenses which are often beyond the reach of low and moderate income individuals who are not in institutional settings. Over the last decade, Congress has developed programs, albeit limited in scope, explicitly targeted to expanding services for the frail elderly in non-institutional settings. In this section, we describe the traditional funding streams, in the next section we describe the newer expanded sources of funding.

The traditional sources of public funding available for services in community settings (e.g., outside of certified nursing homes) include:

- Medicare
- Medicaid
- **Social Services Block Grants**
- Older Americans Act
- Supplementary Security Income Program

**EXHIBIT VII.4.  
FEDERAL SUPPORT FOR SERVICES FOR THE FRAIL ELDERLY**

Type of Residence	Sources of Federal Assistance						
	Case Management	Personal Care	Chore Services	Home Health	Transportation	Meals	RN Services
Private Residence • Family • Family alone	(H) (I)	(D) (E) (G) (H) (I) (O)	(D) (E) (G) (H) (I)	(A) (B)	(I)	(H)	(A)(B)
Assisted Living Facility (non-Public)		(G) (J) (K) (O)	(G) (J) (K)	(A) (B)	(I)	(H)	(A)(B)
Board and Care Home	(G)	(G) (J) (K) (O)	(G) (J) (K)	(A) (B)	(I)	(H)	(A)(B)
CCRC	(I)	(I) (O)	(I)	(A) (B)	(I)	(H)	(A) (B)
Public Housing Authority	(I) (L) (M)	(I) (J) (K) (O)	(I) (J) (K)	(A) (B)	(I)	(H)	(A)(B)
Section 202. Elderly Housing	(I) (L) (M)	(I) (J) (K) (O)	(I) (J) (K)	(A) (B)	(I)	(H)	(A)(B)
Section 8. Rental Housing	(L)	(I) (J) (K) (O)	(I) (J) (K)	(A) (B)	(I)		(A)(B)

**CODE:**

(A) Medicare: home health	(G) Medicaid: 4711
(B) Medicaid: home health	(H) OAA
(C) Medicaid: nursing home	(I) SSBG
(D) Medicaid: personal care	(J) SSI
(E) Medicaid: 2176	(L) CHSP
(F) Medicaid: 1915(d)	

**SOURCE:** Adapted from mimeographed document provided by ASPE.

Exhibit VII.4 provides a summary of the services funded by these various sources. in addition to those funded under the newer Home and Community Based waivers.

#### **A. Medicare**

The primary Medicare services that benefit the elderly in assisted living facilities are home health services provided under both Medicare Part A and Medicare Part B. A total of \$4.8 billion was spent on Medicare Part A and Medicare Part B home health services in 1991, 4.2 percent of total Medicare expenditures during that year. Home health services include coverage for persons who need skilled nursing care, physical therapy, and speech therapy on an intermittent basis (Green Book, 1991). To be eligible, persons must be homebound. Medicare also covers hospice care for those deemed to be terminally ill. Medicare does not cover the personal care services required for those with functional impairments in their ADLs, unless the person also needs “skilled nursing.”

#### **B. Medicaid**

Medicaid is a source for financing assisted living for the frail elderly. Traditionally, Medicaid coverage has been **modelled** along the medical model of care: e.g., targeted to the elderly in institutions and to physician payments. In addition, limited home care coverage has been available that has been used to provide supportive services to the elderly in public and other low income housing. Services require a physician’s order as part of a plan of care that is frequently reviewed by a physician. Home health services include three mandatory services (part-time nursing, home health aide, and medical supplies and equipment) and one optional service (**physical** therapy, occupational therapy, and speech pathology and audiology services). In addition, states may elect to cover a broad range of services that benefit the elderly, from dentures to prescription drugs to case management services (Medicaid Source Book, 1988).

### C. **Social Services Block Grants**

One of the purposes of **Social Services Block Grants (SSBG)** is to provide for community-based care, home-based care or less intensive care. The current and future total funding limits for these grants are capped at \$2.7 billion. Funds are allocated to states based on their population: 47 states currently use from one to 50 percent of their funding for services for the elderly. Typical service provided under these grants are homemaker, companionship, and home maintenance services. SSBG monies may not be used for medical care, construction, major capital improvements, or room and board. The elderly often do not receive priority under block grants because of other state priorities. These supportive service funds, like those provided by the Older Americans Act and the Supplemental Security Income Program, are targeted to the low income elderly and therefore are common sources of funding for the elderly living in Section 202 housing.

### D. **Older Americans Act**

Title III of the **Older Americans Act (OAA)** received \$859 million in total appropriations in 1989. OAA funds are allocated to states based on the percentage of their populations over 60. OAA funds are dispensed through local area agencies on aging which use the funds to supporting congregate and home-delivered meals programs, among other things.

In addition, some states (e.g., Oregon) pool all dollars, including OAA funds, for services.

### E. **Supplemental Security Income Program**

The **Supplemental Security Income (SSI) Program** through Title XVI of the Social Security Act provides minimum income levels for aged, blind and disabled persons. Those eligible may use SSI funds to pay rent or purchase services. The rate of participation in SSI of those elderly in public housing was about 62.5 percent in 1987. The relatively high rate of participation may partly be attributed to more linkages, formal and informal, between the procedures used to enroll in public housing and SSI enrollment (Lewin-ICF, 1988).

States are allowed to supplement the federally-mandated minimum SSI payments. Many states target SSI supplements to low-income elderly in residential care facilities (Meiners, 1988). All but 7 of 50 states have federal or state administered supplementation which is specifically directed at covering the additional cost of housing in a protective, supervised environment, and there is wide variability in what states allow (1992 Green Book). However, the number of persons receiving assistance through this mechanism is small, about 320,000 SSI recipients.

**vi. OPTIONS FOR FINANCING ADDITIONAL HOME AND COMMUNITY-BASED SERVICES (INCLUDING THOSE IN ASSISTED LIVING FACILITIES) UNDER MEDICAID WAIVERS AND NEW OPTIMAL SERVICES PROVISIONS.**

Medicaid Home and Community-Based Medicaid waivers (2176 and 1915(d)) and Section 4711 have provided funding for additional services in an effort to expand services to the community elderly said to be at risk of institutionalization. These services include: case management services, adult day care, respite care, and personal care. Demonstration waivers related to home and community care have also been authorized under section 1115(a) of the Social Security Act. These programs are limited in the populations they serve and most frail elderly rely on services provided by family and friends and/or funded by other sources.

**A. Home and Community-Based Waivers**

The two key home and community based Medicaid waivers designed to target individuals who are otherwise nursing home eligible, are the 2176 and 1915(d) waiver. These waivers are described in more detail below. Once granted, they are in effect for three years and are renewable for five years (Federal Register, June 30, 1992). A summary of the funding for home and community based Medicaid waivers between 1984 and 1991 is included in Exhibit VII.5.

**1. Section 2176 Waiver'**

The Section 2176 Home and Community-Based Services Medicaid waiver represents a major initiative to expand eligibility for Medicaid services beyond certain income limitations

**EXHIBIT VII.5.**

**MEDICAID HOME AND COMMUNITY BASED WAIVERS  
FISCAL YEARS 1984 TO 1991**

<b>YEAR</b>	<b>TOTAL COMPUTABLE</b>	<b>FEDERAL SHARE</b>	<b>STATE SHARE</b>
<b>1984</b>	\$ 168,627,211	\$ 86,826,567	\$ 71500, 644
<b>1985</b>	270,847,517	151,144,820	119,752,697
<b>1986</b>	364,768,646	207,469,770	157,298,376
<b>1987</b>	451,061,130	263,914,563	188,146,562
<b>1988</b>	632,858,917	358,491,580	274,367,337
<b>1989</b>	934,468,062	537,271,063	397,146,999
<b>1990</b>	1,246,721,569	710,139,972	536,587,597
<b>1991</b>	1,606,904,181	918,245,054	688,659,127
<b>TOTAL</b>	<b>\$5,675,937,233</b>	<b>\$3,242,497,394</b>	<b>\$2,433,459,939</b>

Source: Medicaid Financial Management Reports

and service restrictions to those who are nursing home eligible or otherwise said to be at risk of institutionalization. It waives statewideness criteria for Medicaid services and allows services to be provided to the otherwise nursing home eligible frail elderly in the community without requiring that those services also be provided to all Medicaid eligible populations. A major condition of participation of the program is that the number of people served under the waiver can not exceed the number that would otherwise be cared for in a nursing home; therefore, for states with limited nursing home the demand for waiver services may exceed potential caps on those services. In addition, expenditures under this waiver can not exceed per capita expenditures that the state estimates would have been made if the waiver had not been granted (U.S. Code, 1989).

**a. Services**

Coverage for room and board is excluded under this waiver which is only applicable to services. The seven categories of services that are eligible under this waiver are case management services, homemaker services, home health aide services, personal care services, adult day health services, respite care services, in addition to other services that contribute to the health and well-being of individuals and their ability to reside in a community based setting (as long as states identify and define such services) .

**b. Eligibility**

Recipients must be nursing home eligible or at high risk of institutionalization, but not necessarily elderly. The waiver allows states to provide **medicaid** services to those who would otherwise be ineligible for Medicaid; in other words, states can develop new eligibility standards for these individuals (as high as 300 percent of state's SSI standard). In addition, the spouse's income may be excluded in determining eligibility (U.S. Code, 1989).

**c. Issue/Problem**

A major issue with regard to the waiver is that states are limited to the number of nursing home beds vacant in determining how many residents are eligible to receive community-based services under the waiver. This is more problematic for those states with high nursing home occupancy rates. Section 1915(d) described below is designed to overcome that limitation.

**2. 1915(d) Waivers**

Like 2176 waivers 1915(d) waivers are designed to provide community services to nursing home eligible individuals or individuals at high risk of institutionalization. Unlike 2176

applicants under 1915(d) do not have to prove budget neutrality; however states funded under this waiver must agree to caps on the growth of total long term care expenditures over time. The cap on costs for increases in total long-term care expenditures for states electing this waiver is seven percent until 1991 and based on market basket increases thereafter, Also unlike the 2176 waiver, this waiver is limited to services for the elderly. At this time, Oregon is said to be the only state to have applied for a 1915(d) waiver.

a. **Eligibility**

Unlike the 2176 waiver, 1915(d) is restricted to those over 65. Otherwise services and eligibility requirements are similar (Federal Register, 1992).

b. **Issues/Problems**

While the 1915(d) waiver overcomes caps on the numbers of community residents that can be served based on the empty nursing home bed formula, states opting for this waiver potentially incur significant liability to the extent that their total long-term care expenditures exceed the caps in annual increases in expenditures.

3. **Section 1115 Waiver Authority**

Section 1115(a) of the Social Security Act provides the authority to conduct demonstration projects that may include but are not limited to community based services to the frail elderly. These demonstrations are different from waiver programs in several respects. Because they are granted for research purposes they usually include a formal research or experimental methodology and provide for an individual evaluation. States do not automatically qualify for these waivers as they may, for example, for 2176 waivers by automatically meeting established conditions (Medicaid Yellow Book, 1988). There are several different active projects under this waiver authority. The On Lok demonstration project is one example. The On Lok demonstration is a social healthcare maintenance demonstration that includes coverage for long-term care in the coverage package.

B. **Section 4711 of the 1990 Omnibus Reconciliation Act**

Section 4711 was developed in part in response to states' concerns regarding the lengthy and cumbersome procedures associated with the 2176 waiver. Because Section 4711 allows for home and community care optimal Medicaid services under a states plan, administrative obligations associated with the waiver process are theoretically less onerous.

The application process is less complicated: e.g., budget neutrality does not have to be proven, and the cumbersome evaluation, reporting and reapplication processes associated with waivers are avoided (Medicaid Yellow Book, 1988). Nonetheless, 4711 has its own inherent limitations. Eligibility criteria are more restrictive than those under the 2176 waiver and federal reimbursement streams may be less predictable. In addition, under Section 4711 states do not have the flexibility that there is under 2176 to raise income eligibility: nonetheless, 2176 may be attractive to those state that may be near the maximum number of residents who can be served under 2176 waivers.

1. **Funding**

The funds allocated nationally to the program are capped at \$40 million for FY 91, \$70 million for FY 1992; \$130 million for FY 1993, \$160 million for FY 1994, and \$180 million for FY 1995. What each state receives under Section 4711 is capped at that state's proportion of the population over 65 as compared to all other states participating in Section 4711. This ruling makes Section 4711 inherently risky for states which may find their share of potential funding drop unpredictably during any one year as new states enter the program during that year (State Policy).

2. **Eligibility**

Eligibility under Section 4711 may be more restrictive than that under the 2176 waiver. Eligibility is limited to elders that require substantial assistance with at least two of three ADLs (toileting, transferring, and eating); or to elders with Alzheimer's Disease who cannot perform two of five ADLs (bathing, dressing, toileting, transferring or eating), or who are so cognitively impaired that they require constant supervision. States may further limit eligibility.

3. **Issues/Problems**

Several issues have been raised by Mollica and his colleagues (1992) with respect to the 4711 program. They note that while 4711 may be a good alternative for states near their limits under the 2176 waiver, although it is cumbersome to run the two programs simultaneously. In addition, they point out that the program lacks the flexibility in terms of income eligibility provided by 2176, and that the formula for calculating annual state specific appropriations makes 4711 inherently risky.

## **VIII. FEDERAL PROGRAMS DESIGNED TO INTEGRATE FINANCING FOR HOUSING AND SERVICES.**

Previous sections presented overviews of federal financing of housing services (largely through HUD) and of federal financing for services in supportive housing (largely through Medicaid). Recent trends have been to integrate housing and services financing through new initiatives such as the Congregate Housing Services program, HOPE for elderly independence, and Project Retrofit. These programs are all quite small.

### **A. Congregate Housing Services Program**

The **Congregate Housing Services Program (CHSP)**, is one of the first federal efforts to integrate funding for housing and services for the frail elderly. The CHSP was first authorized in 1978 as a demonstration project funded through HUD and was upgraded to a permanent program in 1987. While originally targeted for HUD-financed public housing, and Section 202 eligibility was expanded to include other federal housing as well (Section 8, Sections 221 and 236 housing, etc.).

#### **1. Funding**

The CHSP is still limited in scope; in 1990 CHSP served 1,800 persons in 33 states, utilizing \$5.9 million in appropriations. HUD provides 40 percent of the funding for the program, the rest is provided through third party matches and fees. Resident fees cover 10 percent of the service costs and fees for meals range between 10 and 20 percent of the resident's income. Funding can be used to retrofit existing buildings, to create and rehabilitate congregate space, improve management capacity, and provide supportive services (Gayda, 1989). (Due to the limited appropriations, HUD is not currently implementing the provision offunding retrofit and rehabilitation.) CHSP contracts are limited to five years and are renewable.

#### **2. Eligibility**

In addition, to be eligible for 202 funding those served in CHSP facilities must have three or more ADL impairments.

### **3. Services**

CHSP funds reimburse for case management homemaker services, personal care, meals, health screening and other preventive medical services and other medical and social services that contribute to the well-being of individuals and their ability to remain in the community.

#### **B. HOPE for Elderly Independence**

HOPE for Elderly Independence is a demonstration grant started in September of 1992 to determine whether or not supportive services prevent or delay institutionalization. Through HUD, public and indian housing authorities receive 40 percent of the total costs of providing supportive services under this demonstration project linked with five year housing vouchers. An RAP has recently been issued- to evaluate the success/impact of this demonstration.

##### **1. Funding**

Through HOPE for Elderly Independence, PHAs and IHAs in FY 1992 competes for a total of 1,257 rental vouchers and \$10 million in supportive services grants. HUD provides 40 percent of the cost, PHAs and IHAs provide 50 percent and participants pay 10 percent. Each applicant for these funds is limited to a total of 10 percent of total supportive services funds available and 144 units. Service which can be funded under this program include assistance with bathing, dressing, toileting, and mobility, case management, and other services essential to achieving and maintaining independent living. This program will help answer the question of whether services tied to housing assistance can help frail elderly remain in their homes.

##### **2. Eligibility**

The frail elderly needing assistance in at least three ADLs, who are not receiving housing assistance, and who have incomes of less than 50 percent of the median area income are eligible. The frail elderly are not required to live in a specific unit but PHA/IHAs may require that live within a certain geographic area to ensure that services can be provided.

## IX. ADDITIONAL WAYS THAT STATES FINANCE ASSISTED LIVING.

States rely heavily on a combination of sources for financing long-term care services. States opt for state-only financing (even though that option may be at the expense of receiving federal matching funds) to:

- Develop programs that provide services that would not be funded under current Medicaid provisions.
- Avoid the regulatory requirements of the waiver programs and the risk inherent in the funding streams of Section 4711.
- Develop state organizational authority for the new programs outside of existing state Medicaid infrastructures.
- And finally, state-only funds allow states to expand coverage to those individuals who would otherwise be ineligible for coverage under Medicaid (Etheredge, 1988).

Interest in state funded housing options has increased dramatically; before 1980 only 44 state-funded housing programs existed, from 1980 to 1987 the states created 112 programs.. State funded housing options have increased in large part in response to cut-backs in federally funded housing (Sidor, 1988). There is competition for state housing funds from many special needs groups (e.g., the homeless); therefore, resources ultimately available to the frail elderly may be limited in any specific state.

The proportion of state only funding as compared to the use of federal matching funds varies across states. In a study of six states (Arkansas, Illinois, Maine, Maryland, Oregon, and Wisconsin), only two of the states used Medicaid funds for more than half of their total spending (Etheredge, 1988).

State resources for state-only funding of housing and supportive services targeted to low-income populations are generated primarily through state general revenue appropriations, state-levied fees or trust funds, and state general obligation bonds. Programs targeted to low income households and involve local governments, nonprofit developers, community-based

organizations, and private limited-profit developers (Sidor, 1988).<sup>2</sup> More detail on state specific programs and recent initiatives is provided in Chapter VIII.

## X. SUMMARY

In summary, the major trends in federal financing of supportive housing have included:

- **Increasing integration of financing** for housing and services through limited expansions in HUD programs.
- Expansion of Medicaid targeted to cover services to selected elderly in the community at high risk of institutionalization.
- Increased funding for housing which makes space more affordable and amenable to the provision of congregate services.
- Programs that are increasingly specific to local and often unique development and operating needs.

While these trends over the last few years represent significant shifts to a more integrated and broader system of coverage of supportive housing, programs are still limited by shortages in funding.

## XI. RESEARCH QUESTIONS (CHAPTER VII)

Many research questions related to financing assisted living are embedded in the questions presented in preceding chapters since financing bears so directly on all facets of assisted living operations. Some additional research questions are presented below:

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<sup>2</sup> **Of particular interest is a demonstration program funded by the Robert Wood Johnson Foundation. Under these demonstrations, states combined contributions totalling \$4 million with \$1 million in housing finance agency funds, \$2.5 million in development funds, and \$300,000 in tenant contributions in addition to other resources to add service packages to state Housing Finance Agency financed housing developments for the elderly. Funds were directed to ten states who participated in the demonstrations. Services under the demonstration were designed to promote aging in place by funding case managers and services based on resident surveys of actual need..**

1. Funding Source: How does the funding source (e.g., Medicaid, private funds, etc.) shape the appearance, physical plant, operations, services, costs, and clientele of assisted living facilities?
2. Payment Options: What are the pros and cons of various ways for the frail elderly to pay for assisted living (e.g., voucher programs; tax credits; Medicaid payment; etc.) Should “spend-down” provisions apply?
3. National Health Policy: If there is a home care benefit in national health policy, how might assisted living fit in? Should assisted living be considered a public good to which frail elderly of all income levels are entitled, or should it be considered a luxury, available only to those willing and able to pay?
4. HUD Funding: What barriers currently exist to broad scale HUD funding of assisted living (e.g., service limitations)? What modifications would have to be made to remove these barriers? What are the pros and cons of relying on HUD funds for expansion of assisted living?
5. Medicaid Funding: -What aspects of Medicaid funding facilitate or inhibit development of assisted living options? What are the pros and cons of using Medicaid funds (e.g., Medicaid waivers) for assisted living?
6. Incentives: How do different financing options create incentives or disincentives for frail elderly seeking assisted living? For example, could heavy public financing create incentives for some frail elderly and disincentives for others?



## CHAPTER VIII STATE EXPERIENCES

### I. INTRODUCTION

Many states have under development or are currently considering assisted living programs for the frail elderly. Different states have different goals in pursuing assisted living as a housing alternative: cost savings by reducing nursing home care; promoting independence among the frail elderly; improving health and psychosocial outcomes; and the range of other assisted living goals discussed in this synthesis. Several recent works have described in detail state programs in assisted living. In addition, a number of ongoing projects sponsored by the federal government (ASPE) and private organizations (AARP) are further examining assisted living programs on the state level. Exhibit VIII.1 summarizes the substance and status of these **evaluations**. These projects provide a detailed view of the philosophy, structure, and operations of state assisted living programs.

Rather than replicate this extensive work, this chapter attempts to identify some major issues faced by states in developing assisted living for the frail elderly, and how various states have addressed these issues. The analysis attempts to identify how states have tried different approaches to address the same issue. As such, this chapter is not intended to be a comprehensive review of state experiences with assisted living, nor does it provide a detailed description of state programs,

The chapter is divided into two parts. Part One highlights some of the important challenges faced by states considering assisted living for the frail elderly, reviews how various states have dealt with these issues, and discusses the pros and cons of these approaches. Part Two presents a more detailed summary of assisted living programs in Oregon, New York, Florida, Washington state, Maryland, New Jersey, Maine, Rhode Island, Connecticut, and New Hampshire. The information presented in this chapter was obtained through a review of the literature, interviews with state officials, interviews with experts in the field, and documents received from states.

**EXHIBIT VIII.1**

<b>STUDIES FOCUSING ON STATE ASSISTED LIVING PROGRAMS</b>			
<b>Source</b>	<b>Year</b>	<b>States Examined</b>	<b>Focus Areas</b>
Cook (AHCA)	Forthcoming	ME, OR, MS	Ongoing attempt to draft a set of standards for establishing regulations for assisted living.
Halbrook (Coopers & Lybrand for ALFA)	Forthcoming	Matrix of States	Ongoing comprehensive study of Assisted Living: focus on industry growth and related issues.
Hawes (AARP)	Forthcoming 12/1992	All	National Summary and state-by-state review of licensure, enforcement, and payment policies.
Hawes (Research Triangle Institute)	Forthcoming	Matrix of States	Ongoing examination of effect of state regulations on quality in board and care homes.
Justice et. al. (National Association of State Units on Aging (NASUA))	1988	AR, IL, MD, OR, WI	Comprehensive overview of Assisted Living: focus on State and Local Roles in Organization, and Funding.
Kane et. al. (University of Minnesota)	1990	OR	Recommendations for applying Oregon's programs to other states.
Kane and Wilson (AARP)	Forthcoming 12/1992	WA, OR, CA, AZ, KS, TX, PA, MN, FL, NC, NJ, NY, CO, MA	Ongoing study aimed at producing descriptive overview of developments in assisted living and board and care in United States, including regulation issues.
Mollica et. al. (National Academy for State Health Policy)	1992	FL, MA, NY, OR, WA	Comprehensive overview of Assisted Living: focus on quality assurance, funding, services, and policy implications.
Newcomer and Blum (Institute for Health and Aging)	Forthcoming	CA	Ongoing comprehensive multi-pan study of residential care facilities.
Schless (National Multihousing Council)	Forthcoming	Matrix of States	Ongoing study of Assisted Living with focus on regulatory issues.
Struyk (Urban Institute)	1989	MD, MA, NY, OR	State Integrated Housing/Service Programs. Models of Federal/State Cooperation.
Tiven et. al. (Council of States Housing Agencies and NASUA)	1987	Matrix of 38 States	Overview of Elderly Housing Initiatives: focus on services, funding, planning, and access.

Part One addresses the following questions:

- **Should states develop assisted living programs by investing in new assisted living facility stock, or by supplementing services available in existing settings that provide some level of care (e.g., board and care homes or congregate living apartments)?**

The answer depends on which segment of the frail elderly population the state intends to serve, how quickly the state wants to implement its program, cost containment considerations, and the availability of existing facilities that can be used, or adapted for use, for assisted living purposes.

- **How should a state fund its assisted living program? Through Federal Medicaid Waivers? Through Use of State Funds Only? What are the pros and cons of different funding mechanisms?**

The answer depends on how much a state needs federal matching funds, the degree of flexibility the state needs (i.e., freedom from federal restrictions), a state's cost containment goals, and funding stability issues.

- **How should states approach regulation of assisted living? What are regulations intended to achieve?**

The answer depends, in large measure, on the philosophy of assisted living the state wants to advance. The benefits of regulation (assuring quality of care) must be balanced against the risk of overregulation; i.e., inadvertently creating an "institutional" environment and infringing on the frail elderly's autonomy and independence.

- **How much should a state aggressively develop assisted living for the frail elderly as compared with state subsidized programs for other groups (such as the developmentally disabled, or children)?**

The answer depends on political and equity issues peculiar to each state. Fundamentally, states must decide how to allocate limited state funds between worthy recipients. If state officials believe assisted living can save money as compared to current long term care alternatives (e.g., nursing homes), the allocation decision might be easier to make.

- **Should states consolidate assisted living programs into a single agency, combining funding, programmatic, and regulatory functions?**

Some states have found consolidation of financing, regulatory, and programmatic functions into a single agency to be more efficient from economic and operations perspectives.

- **Should states control the supply of assisted living facilities through regulatory means?**

Some states view assisted living as an integral part of the continuum of their long term care system. As such, they have chosen to monitor supply through traditional regulatory means (e.g., licensing).

## **II. PART ONE: MAJOR ISSUES FACED BY STATES IN DEVELOPING ASSISTED LIVING PROGRAMS**

- A. **Should states develop assisted living programs by investing in new assisted living facility stock or by supplementing services available in existing facilities that provide some level of care (e.g., congregate housing, board and care homes)?**

As noted by Mollica (1992); states considering assisted living programs face the threshold question of how to start the program: states can expand services in existing settings serving the elderly (e.g., congregate apartments) or states can construct new assisted living facilities specifically designed to house the frail elderly. Which route a state takes depends, in part, on characteristics of the target population, the maturity of existing housing resources, how expeditiously the state wants to implement the assisted living program, and cost **considerations**.

On the targeting issue, a state might want to serve the frail elderly currently residing in nursing homes. This population may require a level of service that would be difficult to provide in existing housing sites with supplementary services. Some states, like Oregon, have **accordingly** decided to build new assisted living facilities with the capacity to serve a very frail population.

How a state proceeds may also depend on the degree to which existing programs are developed. States which currently subsidize little or no services for the frail elderly and do not have a large stock of elderly housing may choose to invest in new facilities specifically designed to meet the needs of the frail elderly. In contrast, other states have well developed networks of elderly housing sites. These states may conclude, for timing and cost considerations, to upgrade the level of care and services available in one or more types of

existing facilities (e.g., congregate housing, adult foster homes, boarding homes, or downsized nursing homes).

In the end, States may decide to pursue both methods of system development simultaneously, by adding new facilities reserved for frail elders while supplementing the services available in existing facilities. A discussion of how various states have responded follows.

1. **The answer depends, in part, on what segment of the frail elderly population the state wants to target.**

Oregon is a good example of how a state can choose its method of providing assisted living based, in part, on what population of frail elders the state wants ultimately to serve, Oregon's assisted living program was created in response to the rising cost and increasing budgetary burden of nursing home care, and to create a more positive, non-institutional environment for elders who could not live alone.<sup>1</sup> This program was intended to place current Medicaid-funded nursing home residents into assisted living units, Assisted living facilities, it was argued, could meet the medical and psychosocial needs of residents in an environment that would simultaneously improve the patients' quality of life and reduce overall expenditures. To meet the needs of this relatively frail population, the range and level of services available in Oregon's assisted living **facilities** needed to be high. While Oregon has promoted conversion and upgrade (and several projects have actually done so), Oregon has primarily concentrated resources on investing in new facilities that could be designed specifically to meet the needs of this frail elderly population, due in part to a lack of enough suitable existing facilities that could be upgraded to such high standards at significantly lower cost. Some states may likewise find it infeasible (and uneconomical) to upgrade existing facilities to a level where they can meet the needs of a population primarily drawn out of nursing homes.

In contrast, the state of Connecticut targets a more independent elderly population through its existing supply of facilities. These facilities, called "congregate housing", were introduced in the 1970s as a response to the rising population of elderly in Connecticut, the

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<sup>1</sup> It should be noted that Oregon's demonstration program was initially developed as private pay — currently three-fourths of the tenants are private pay.

increasingly popular belief in the-benefits of aging in place, and the rising cost of nursing home care. Congregate housing facilities offer limited congregate meals, housekeeping and security, but no personal or medical services (this would require the homes to be licensed or certified which is beyond the scope of the program). A state official expressed concern about the limited population that can benefit from the services available in congregate housing. This official argued that by providing some level of personal and/or medical care services, the population which could be served would increase, resulting in a decrease in overall expenditures on the frail elderly, and an improved quality of life for this population. In the end, Connecticut's assisted living program consists of a plan to supplement services in existing housing settings. As such, they are serving a different population of frail elderly than is Oregon.

2. **Some states with existing well-developed elderly housing alternatives have chosen to supplement these settings with additional services** to meet the needs of the frail elderly.

Florida is an example of a state currently in the process of expanding the service delivery capability in existing elderly housing sites. Presently, Florida's network of elderly housing consists of two models: Adult Congregate Living Facilities (functional since 1975, offering some personal services) and Adult Foster Homes (which began operation in the 1960s as part of a movement to **deinstitutionalize** mental patients, offering limited personal services). Recent legislation which went into effect in October 1992, has called for the creation of a new licensure category called Extended Congregate Care (ECC) that allows existing facilities to expand the scope and nature of services they can provide. According to state officials interviewed for this synthesis, this new regulatory initiative resulted from the recognition that assisted living could serve as an alternative to nursing home care if certain regulatory restrictions were addressed. Under the new ECC license, homes that previously could only provide personal services will now be permitted to offer nursing services, and assistance with up to three **ADLs**. The license also specifies that staff administrators in each facility must take six hours of preservice training, thereby both upgrading the skills of existing staff, and adding nursing **staff**.

Washington state chose a similar path to expand the services that the state could offer the frail elderly in existing **elderly housing**. **Since 1991, frail elderly living in participating boarding homes have been able to access nursing services (including assessment,**

monitoring, medication administration, stage one skin care, therapy, and temporary bed care made possible by the addition of an LPN or RN on duty eight hours a day), personal services (such as laundry, housekeeping, incontinence care, and assistance with ADLs), case management, and residents must be provided with private lockable rooms and bathrooms (which are not standard for other residents in state subsidized boarding houses). In at least one respect, Washington's method of expanding the availability of services in existing housing differs from Florida's: facilities do not obtain additional licenses, but rather respond to state RFPs through which they enter into an agreement with the state regarding the type, scope, and provision of services to program recipients. The agreement is codified and enforced through contractual means. A state official interviewed for this synthesis stressed that Washington chose this method of developing their assisted living program in hopes that it would allow for a very fast and efficient development of the program. The results indicate success: within a 12-month period, the program grew from one facility to 165 units in 12 buildings. In addition, the state chose to use RFPs to rigorously assess the financial viability of applicants to convince the legislature that assisted living should be supported as a long-term program.

3. **Some states seeking to serve a highly disabled frail population have chosen to develop new assisted living facilities.**

Oregon, in contrast, chose to develop their system of assisted living by creating a new facility stock, that is, by building new assisted living facilities specifically designed to meet the needs of a frail elderly population while maintaining independence, autonomy, and a "home-like" environment. One reason for this choice was a lack of suitable existing alternatives to serve a highly disabled population. This program began in 1984 with the construction of new 'hotel style' facilities that would house only frail elders. All projects have been funded privately or through a 1976 bond which was passed for elderly housing. After 1988 this bond gave priority to assisted living projects because of the joint review process between the housing agency and SDS (Mollica et. al., 1992). In some other states where large buildings are used for assisted living programs, absolute or relative limits are put on the number of frail residents who can participate in the program in an attempt to prevent an institutional atmosphere. For example, in addition to other regulations intended to encourage a noninstitutional setting, Maryland allows no more than 20 percent of residents in Multifamily buildings to participate in their assisted living program. However, since Oregon's facilities are

specifically designed to serve the needs of the frail elderly, the participating buildings are reserved for the population they can best serve. Their safeguards against creating an institutional atmosphere do not lie in quotas, but in building design (with private apartments and regulations designed to ensure a 'homelike' setting).

Through a series of demonstration projects and Medicaid waivers (discussed more fully in Part Two of this chapter), Oregon has expanded the number of assisted living units available for frail Medicaid recipients: by December 1991, 748 apartments in 15 buildings had been licensed for assisted living (Wilson, 1990) and today it has reached about 1,200 units in 22 buildings (Wilson). As described by Mollica, et. al. (1992), and others, the program has fared well both in terms of meeting the needs of a frail population in a non-institutional setting and on cost measures.<sup>2</sup>

**B. How should a state fund its assisted living program? Through Federal Medicaid Waivers? Through use of state funds only? What are the pros and cons of different funding mechanisms?**

The range of funding mechanisms for assisted living is discussed in greater detail in Chapter VII.' This section provides examples of how some states have funded their assisted living programs. **The** focus is on how various funding options can facilitate or inhibit implementing the state's objectives in pursuing assisted living, and the extent to which the needs of the target population can be served.

States have secured funding for their assisted living programs from a variety of sources. Which funding source is best depends to a large degree upon who the state wants the funds to subsidize. Some states seek funding through Medicaid waivers to leverage federal financial participation.' Others rely primarily on state funds to retain flexibility. In forging a balance between state/federal funding, states may consider the following issues:

**Federal Funding:** Federal funding can be accessed by obtaining one or several Medicaid waivers. These waivers allow states to divert federal Medicaid funds normally reserved for subsidizing patients in nursing homes to Medicaid eligible frail elderly in other state programs that provide services in non-

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<sup>2</sup> Keren Brown Wilson notes that the problem, per se, has not been demand (or success) but equity financing.

institutional **settings**. However, states must accept federal restrictions in exchange for federal money. For example, Medicaid Waivers may place caps on overall reimbursement or the number of Medicaid eligibles who can be served, leaving the state responsible for the difference between overall expenditures on care for Medicaid eligible elders and the imposed cap on Federal subsidies. In addition, a state may find that the frail elders targeted for assisted living under the state program do not meet Medicaid eligibility criteria, thereby necessitating an undesired change in the target population. In the end, States must consider if a Medicaid waiver will assist or restrict them in delivering services to the population they seek to target.

- **State Funding:** Due to the restrictions discussed above, some states choose to rely primarily on state funding sources. There are also drawbacks to this approach. For example, states may find that restrictions in overall budgets will decrease the total amount that any one person can be subsidized. Those of the lowest incomes may not be able to afford participation, and may be forced to wait until they become both financially and medically eligible for Medicaid, at which point their only option may be nursing home care. In addition, if only state funds are used, assisted living programs may be more susceptible to state **budgetary cuts**. This possibility can be a barrier to attracting investors in assisted living facilities.
- **Balancing State and Federal Dollars:** Many states fall somewhere in between, that is, accessing both federal and state sources of funding.
- **Cost Containment:** How a state structures its funding and reimbursement system will reflect, to some degree, the importance placed on reducing the overall cost burden of long term care for the frail elderly.
- **Funding Stability:** The perceived stability of funding sources is a critical factor in attracting investors to participate in the development/initiation of assisted living program and in assuring continuity of care for the frail elderly.

Discussion of how various states have balanced their funding sources in light of these concerns follows.

#### **1. Examples of States Relying Primarily on Federal Funding**

Since 1984, when Oregon received the first Medicaid 2176 waiver to subsidize state expenditures on home and community-based services, interest in Medicaid waivers has increased rapidly. Today 47 states receive 2176 waivers, which allow these states to use federal Medicaid funds to provide program recipients with services in settings other than **nursing homes**. For states (such as Oregon) which have developed assisted living programs in an attempt to move nursing home residents into a more independent and non institutional **atmosphere**, **Medicaid waivers may** be viewed as a desirable source of funding. Oregon is

currently the only state that also receives a 1915(d) waiver. This waiver is “limited to persons 65 years and older, and caps the amount of funds spent on long term care for institutional and community services. In exchange for a fixed level of federal reimbursement, the state has the flexibility to cover services similar to the 2176 waiver.” (Mollica, 1992). Oregon’s use of this waiver rests on the belief that the need for nursing home funding would fall relative to the need for funding of their rapidly expanding assisted living program, resulting in an absolute reduction in expenditures on elders who are both financially and medically eligible for Medicaid. The state was willing to accept a fixed level of reimbursement in exchange for the ability to divert more federal funds to assisted living. Overall, Oregon has decided to expand its assisted living capacity by leveraging federal Medicaid funds.

## 2. **Examples of States Relying Primarily on State Funding**

Our discussions with other states, however, revealed that some choose to rely primarily on state funding sources in order to avoid the restrictions often accompanying federal funds. Maryland, for example, has explicitly chosen not to pursue a 2176 waiver. “State officials are unanimous in their reasons for rejecting the waiver approach. They note that Maryland wants to see community-based care services grow substantially. With limits on the number of people that can be served by waiver programs and limits on total expenditures. Maryland feels that expansion will be more substantial and reliable if it comes about by encouraging greater use of Medicaid personal care services and adult day care provided under the state plan.” (Justice, 1988)

In electing not to obtain a Medicaid waiver, however, Maryland is restricting its flow of funds for assisting living. Limited overall funding in Maryland has resulted in a \$550 cap on assisted living subsidies available to any one individual, and a state official interviewed for this synthesis expressed concern that those with the lowest incomes cannot afford to participate. In addition, the “Impact Statement on Housing Budget Reductions” for 1992, issued by Maryland’s Office on Aging, reports that approximately 31 percent of offices in 115 certified group homes have expressed concerns about their ability to continue operating in the future as a result of lack of subsidies for seniors who request their services. As a result, approximately 10 percent of homes are in danger of going out of business. Thus, Maryland’s enhanced flexibility, made possible by their using only state funds (and existing services

under the Medicaid program), is accompanied by program constraints in the form of budgetary restrictions,

### 3. **Combining Funding Streams: Balancing State and Federal Dollars**

Other states have elected to combine both state and federal dollars to advance their assisted living programs. One example is Florida, which attempted to balance the conflict between its need for federal funding and its reluctance to accept restrictive Medicaid financial eligibility criteria. Florida applied for and received a Medicaid COPS waiver, which is a Title XIX **waivered** program serving nursing home eligible persons in their homes or at **community-based** sites. According to a state official interviewed for this synthesis, this waiver, obtained for Florida's Community Care Program (which provides home based care to nursing home eligible seniors), was kept "transparent" to providers and participating elders. That is, the state did not impose Medicaid financial eligibility requirements on participants in their **Community Care Program**, but rather retrospectively reviewed all Community Care participants and matched up those **who** fulfilled Medicaid eligibility requirements with Medicaid funds, Medicaid funds were filtered through the state (were not given directly to providers) and therefore the waiver was transparent to all but the state. However, according to the official we interviewed, this method of distributing Medicaid funds in Florida is no longer exercised because the Health Care Financing Administration and the federal Department of Health and Human Services determined that the Medicaid waiver dollars were to go directly to the provider to bring Florida into conformity with other states.

How states have approached combining funding sources was summarized by **Mollica** (1992):

*"Medicaid waiver programs and state community based care programs financed through **general** revenues' are most amenable to assisted living. Modifications to the Medicaid income eligibility guidelines and SSI payment standards offer options for states to increase eligibility and gain access to private, mixed income projects. Most states rely on Medicaid to pay for services. Florida, Oregon and Washington will utilize their home and community based care waivers to pay for services. New York, which does not have a waiver for its elder/y recipients, will provide a flat **capitation** payment for state p/an **services** provided in assisted living facilities. The supportive services, which are required by regulation (housekeeping, limited personal care, laundry, **activities**), are covered by a higher SSI payment rate. States can develop programs with state general revenues to divert elders with incomes near but above Medicaid levels and avoid the costs for those who would spend down if admitted to a nursing facility."*

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4. **The Amount of Expenditures Depends on the State's Cost Containment Goals**

States also differ in how heavily they weigh the importance of cost containment in developing assisted living alternatives to institutionalization. For example, Maine's cap on reimbursement for their highest level of assisted living is \$2300, the same cap placed on nursing home care. This implies that state officials have weighed heavily the importance of improving the quality of life and the projected benefits of facilitating aging in place for their target population (those at risk of going into a nursing home): they are willing to pay as much for community-based care as for nursing home care.<sup>3</sup>

In contrast, New York officials interviewed for this synthesis report that the need to reduce gross expenditures on nursing home care is the main reason why New York is currently developing a new assisted living program for the frail elderly. Therefore, the state has placed a cap on assisted living expenditures for an individual at 50 percent of the cost of nursing home care for a patient with similar needs.

5. **The Sources of Funding a State Chooses May Depend on the Importance Placed on Funding Stability**

A final consideration is the importance a state places on the stability of funding sources for its assisted living program, both from the perspective of program planners and from the perspective of investors. Maryland state officials report that the lack of a long term funding commitment from the state has been a barrier to attracting facilities to participate. Whether a state chooses to develop a new facility stock or supplement services available in existing facilities, how easily investors **will be attracted (and therefore how quickly the program can grow) will depend to a significant degree on the perceived stability of funding.**

How investors perceive the stability of overall funding will be influenced, in turn, by the ratio of federal to state funds. State funds may be viewed as less stable. Investors may lack confidence in the stability of assisted living programs because of widespread state budget crises. Programs funded by Medicaid dollars, in contrast, may be viewed as more insulated

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<sup>3</sup> In **practice, the average cost of assisted living care** in Maine is \$822, substantially below the cost of nursing **home care**. The high cap, however, is reflective of the state's philosophy regarding the importance of promoting non-institutional care.

from states' financial situations, especially since many states are loathe to sacrifice federal matching funds.<sup>4</sup>

**C. How much should a state aggressively develop assisted living for the frail elderly as compared with state programs for other groups (e.g., children, or the developmentally disabled)?**

In developing assisted living programs, states are explicitly committing limited state resources to meet the needs and improve the quality of life of a targeted population, the frail elderly. Although some would argue that increased use of Assisted Living as an option for the frail elderly may result in overall cost savings, according to some state officials interviewed for this synthesis, an unintended byproduct of funds being targeted to subsidize these programs has been a concurrent decrease in resources available to people with similar needs but in different age categories. For example, a Maine official told us that 80 percent of state funds allocated to the physically or mentally impaired goes to the elderly; this leaves only 20 percent for the non-senior population. While states supplement services in existing state subsidized facilities to the frail elderly, non-seniors with similar needs, perhaps even in the same facilities, cannot obtain these newly available resources.

A related regulatory issue concerns equal treatment of public assistance recipients living in the same housing setting. Many states have “upgraded” structural requirements for assisted living units for the frail elderly by, for example, requiring private rooms or kitchenettes. These regulations often stipulate that participating facilities can receive funding only if these “higher” requirements are met. Yet non-elderly tenants do not have access to these luxuries, which may cause problems in some states.

In the end, these difficult equity issues involve complex policy decisions that must be made at the state level. The issues are especially challenging in the current era of limited resources and fiscal austerity.

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<sup>4</sup> On the other hand, the perceived stability of Medicaid funds may be viewed by some providers as irrelevant if the rates are not adequate for the services, or if the regulatory climate is unsatisfactory.

**D. How should states approach regulation of assisted living? What are regulations intended to achieve?**

Broader regulatory issues are discussed in greater detail in Chapter VI. This section raises some basic issues faced by states in developing and regulating assisted living. A fundamental aspect of this issue is that states use regulations as a tool through which to achieve their philosophical goals and to implement choices for assisted living for the frail elderly. As such, the type and scope of regulation that will best promote the environment and quality of care the state ultimately wants to achieve is inherently state idiosyncratic, and depends in large measure on how clearly a state articulates its philosophy and goals.

Unfortunately, the appropriate nature and scope of regulations can not be derived from a simple formula. Several studies are currently ongoing to review the nature and scope of state regulations applied to assisted living which will provide for the first time detailed insight into the issue (see Exhibit VIII.1). Any attempt to determine the scope and content on assisted living regulations is fraught with philosophical, legal, operational, cost, and administrative complexities. Many of these issues are discussed more fully in Chapter VI. This section draws upon state experiences in regulating assisted living. In particular, based on our review of existing analyses and interviews with state officials, we raise some fundamental regulatory issues faced by states, and discuss how states have handled these challenges differently. These issues include:

- **Facility Environment:** Regulations pertaining to structural requirements risk inadvertently creating an institutional environment.
- **Quality/Regulation Linkages:** The scope and content of regulation needed to ensure quality is difficult to discern. Some states attempt to maintain a certain level of quality by creating staffing and service availability standards and by introducing mechanisms through which the state can monitor the quality of care delivered. A basic issue is how flexible the standards are to permit provider innovation and preserve tenant independence.
- **Conflicting and Multiple Regulations:** Some states build assisted living programs by supplementing the services already available in existing state subsidized housing. Some states have found regulations pertaining to these existing settings inconsistent with the state's vision of assisted living. For example, certain desired assisted living services may be beyond the scope of licensure in existing facilities. Some states have addressed this concern by

allowing facilities to apply for new 'assisted living' licenses or amending state practice acts.

In designing regulatory schemes, states may find the need to address some or all of these concerns. A discussion of how specific states have approached regulating assisted living, as well as evaluations of their successes and shortcomings, follows.

**1. Regulating the Assisted Living Physical Environment without creating an institutional atmosphere.**

The physical design of assisted living facilities is often reflective of a state's goals and priorities in its assisted living program. It may also be a harbinger of a program's success. As discussed in Chapter V, a major justification for assisted living is its potential for providing an independent, "home-like" environment for the frail elderly as a substitute for the institutional environment of nursing homes. To this end, many states design regulations that are intended to preclude an institutional atmosphere and to encourage a home-like environment. Proscriptive regulations inevitably run the risk of mandating safety features that could create an institutional atmosphere. States have handled this problem differently, which is the focus of this section.

Washington state, for example, mandates that the design of all state subsidized assisted living facilities for the frail elderly be designed around what state officials have termed a "social model", described as "the assumption that all individuals should have a right to live independently with respect for their privacy and dignity, free from restraints," (Assisted Living Project Summary Document, 1992). Specific regulatory requirements include minimum common space areas such as activity rooms, lounges, dining rooms, and laundry areas.

To achieve the same end, other states have included small homes (similar to boarding houses) among participant's options in modes of assisted living, where additional services are provided in a home-like setting. One example is Maryland's Group Home Model, where elderly home-owners provide space and services for frail elders in their residences in exchange for funding. Although there are advantages to smaller homes for the purposes of assisted living, there are also benefits to supporting assisted living units in larger buildings. For example, it may be more efficient to make capital-related investments in larger facilities, because the services could potentially reach more people in need, and the cost of care per

resident could decrease due to economies of scale. In addition, larger facilities often contain apartments, as opposed to private/semi-private rooms, which states may view as desirable for encouraging residents to remain as independent as possible.

Herein lies the challenge for state policy makers. Assisted living may be most economically and operationally provided in larger facilities, but many state officials and experts with whom we spoke expressed concern about the risks of creating institutional atmospheres in these larger complexes: Some state policy makers argue that a large facility housing predominantly frail elderly residents would necessarily take on an institutional atmosphere. The larger the facility, the larger this fear seems to be. States have attempted to counteract this potential problem in a variety of ways. Oregon's assisted living facilities house frail elderly residents exclusively, but have managed to maintain a non-institutional atmosphere through regulating building design and decoration. Keren Brown Wilson, the gerontologist who conducted the design and implementation of Oregon's program, cites a "Homelike environment" as one of the five main principles essential to quality long term care:

*"This principle generates a sense of family, community and belonging where one feels comfortable and secure. The programs allow the patient to keep furnishing and personal belongings that are comfortable and comforting, opportunities to become emotionally attached to a place and the people assisted with it; and the creation of a setting that invokes memories and feelings of being at home."*  
(Wilson, 1992)

Other states have limited the absolute or relative number of frail elderly assisted living participants that can reside in any one facility. For example, in Maryland's larger participating facilities, no more than 20 percent of a building's total residents may participate in the program. An evaluation of New York's programs that provide additional services to the frail elderly in state subsidized housing found that randomly scattering units in large buildings was successful in achieving an integrated atmosphere (Struyk, 1989). The study also concluded that program participants did not feel stigmatized in their buildings.

In designing new facilities (or for that matter in setting eligibility requirements for existing facilities) states often grapple with the question of whether they should prioritize the independence associated with individual, fully equipped apartments, over the ability to serve

more people with less funds in smaller single private/semi-private rooms that would encourage the use of common space and social activity. Oregon program founders, for example, “have a strong commitment to maintaining even the most frail elderly participants in independent units, with their own kitchens, bedrooms and baths.” (Struyk, 1989) While other states mandate private space, they may not necessarily require full apartments, but rather design individual living space in “efficiency style” apartments. For example, Washington state requires private lockable rooms with private bathrooms, kitchenettes, and emergency response **systems**.

In addition, some states have different regulatory requirements for different models of housing. For example, in New Jersey, Class C Boarding Houses (which provide supplemental services to frail elderly residents) must provide each **subsidized participant** with a private apartment. In **contrast**, \*participants housed in New Jersey’s Residential Health Care Facilities (geared to seniors with a slightly higher level of frailty, and providing more services than Class C Boarding Houses) only require semi-private or private rooms and baths. Maryland has a similar two-tiered facility system: participating facilities that are the equivalent of large apartment buildings must provide private apartments, while smaller “group homes” need only supply private and semi-private rooms.

Finally, some states may find it necessary to include regulatory mechanisms designed to ensure safety, due to the high level of frailty of many participating residents. Oregon, for example, has implemented a program that targets elders with high levels of frailty while simultaneously encouraging each resident to exercise as much individuality as possible (including regulations requiring independent apartments). Struyk (1992) notes that, “this commitment, combined with the high levels of participant frailty (and often mental dysfunction), would seem to necessitate extensive physical modifications to any building before the program could be implemented. They **include** grab bars, wheelchair-accessible showers, pull cords, and stoves that have timers or can be disconnected.” Of course, mandating such “safety” features in physical plant design runs the risk of creating an “institutional” atmosphere. This inherent tension is discussed more fully in Chapter VI.

## 2. Establishing Quality/Regulation Linkages

States regulate their assisted living facilities in many areas: some are regulated in terms of what services they can provide, how they should be provided, where they should be provided, and by what level of staff. On the one hand, states find it necessary to safeguard against pervasive regulation that inhibits provider innovation, increases costs, and infringes upon tenant independence and autonomy. On the other hand, regulations are often seen as necessary to ensure the provision of a certain level and quality of care. The level of services provided varies significantly among states. How various states have addressed these complex regulatory issues is discussed in this section.

### a. Services

The level and range of assisted living services required by state regulations may depend upon the population the state is targeting. For example, Oregon's target population is frail elders **eligible** for **nursing** home care. In fact, many assisted living tenants were transferred out of Oregon nursing homes. Therefore, Oregon's assisted living regulations call for a high level of both personal and nursing services in assisted living facilities for the frail elderly. Assisted living facilities must demonstrate the **capacity** to provide a range of nursing services, including injection, catheter care, wound care, and health status monitoring and assessment (Mollica, 1992).<sup>5</sup> Oregon engaged in extensive rulemaking to draft a comprehensive set of regulations specifically for assisted living. At the other extreme, Connecticut assisted living settings offer no personal or medical services. The provision of these types of services was not permitted under licensure regulations of the facilities in which assisted living units were to be housed. According to state officials interviewed for this synthesis, creation of a new licensure category was beyond the scope of the program.

Washington state experienced similar service restriction problems in designing its assisted living program. **State** officials had originally envisioned that assisted living facilities would be responsible for treating stage 2 and 3 decubitus ulcers (bedsores) and changing sterile dressings. However, assisted living units were to be located in boarding homes, and health department **staff concluded** that such services were beyond the scope of boarding

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<sup>5</sup> Oregon has utilized home health extensively, both in order to counteract limits in ability to provide services and due to a desire to avoid regulation.

home licenses. To deal with this problem, residents may arrange for such services to be provided by certified home health agencies. As noted by Mollica (1992), the extent to which such services can be provided by independent agencies in assisted living facilities will depend, in part, on state licensure rules and the rules of specific facilities. In some instances, the comprehensive services that home dwelling frail elders may contract for through home health agencies may not be permissible in subsidized apartments. The medication administration issue is a particularly complex one. Some states have dealt with this by creating flexible guidelines permitting unlicensed staff to facilitate medication administration. Massachusetts is one such state:

*“Unlicensed personnel may supervise the administration of medication. This supervision includes: reminding residents to take medication, opening bottle caps for residents, opening prepackaged medication for residents, reading the medication labels, observing residents while they take medication, checking the self-administered dosage against the label, reassuring residents that they have obtained and are taking the dosage as prescribed, and immediately reporting noticeable changes in the condition of a resident to the resident’s physician.”* (Mollica, 1992).

States also have different approaches to the regulation of meals. While some states mandate that all participants in a facility eat together in common dining areas to promote social activities, other states specifically mandate the provision of individual cooking facilities to allow residents to exercise the maximum level of independence possible. For example, Maryland regulations pertaining to Multi-Family Housing not only make three meals per day available in all assisted living facilities, but require that participating residents attend congregate meals. If the health of a resident will not allow him/her to attend congregate meals, provisions are made to deliver meals to the resident’s room for a maximum of two weeks. If, after two weeks, the resident is unable to attend meals, this presumably could be an indication that the resident is no longer capable of living in that setting.

#### b. **Staffing**

The extent to which staffing levels and staff training is regulated in assisted living is an important issue confronted by many states. In the nursing home model, staff to patient ratios, hours of staff coverage, and staff training and heavily regulated as a mechanism to assure quality care. The assumption, safe within limits, is that a disabled elderly population cannot receive quality care without access to adequate staffing. As a result, the model we (as a

society) have chosen for nursing homes has a medical orientation, partially reflected in staffing regulations. The orientation in assisted living is intended to be different. While many tenants present the same constellation of physical and mental problems observed in nursing homes, much care in assisted living is non-medical in nature and does not require particular staffing configurations. Indeed, state officials interviewed for this synthesis expressed the concern that proliferation of nurse staffing regulations not only can (unnecessarily) increase costs, but can also contribute to an institutional environment in contradiction to assisted living philosophy.

States have dealt with this issue in a variety of ways. Oregon, for example, requires that an assisted living facility demonstrate the capacity to provide sufficient care to tenants, but does not prescribe specific staffing levels. Instead, providers may decide for themselves what staffing levels and types of staff are required to provide care in conformance with regulations. As noted by **Mollica (1992)**, one (of many) advantages of this approach is that providers are not constrained to assign staff to specific functions. Instead, each staff can take responsibility for the total care of the patient, especially in terms of doing what is necessary to facilitate autonomy and independence.

As a facility is required to provide services of a higher and more skilled nature, it may become necessary to raise the skill level of staff so that the services may be delivered. Florida, like Oregon, does not require specific staffing levels. Florida does have certain staff training requirements. Eligible Extended Congregate Care (ECC) facilities in Florida (their newest and most far reaching licensure category for assisted living facilities) must provide nursing services! and enroll administrators and supervisors in preservices training by the state. According to one state official interviewed for this synthesis, these modifications were implemented because of increasing concern about the capability of staff in Adult Congregate Care Facilities and Adult Foster Homes: under the prior regulations they were only required to be at least 18 years old with a high school diploma. The training requirement was therefore added to ensure that staff and administrators had some understanding of how to care for frail elderly residents. Oregon also requires preservices training, specifically in the “philosophy” of assisted living.

One way in which some states have attempted to meet the needs of the frail elderly without adding skilled nursing staff, or creating a new licensure category, has been to require 24-hour supervision. A typical requirement is that someone be on site 24 hours a day who would be responsible for securing medical assistance in case of emergency. For example, Maryland's Group Homes (state subsidized facilities which house frail elderly assisted living participants) are required to provide **24-hour** supervision: the supervisors are often caregivers who are elderly people themselves. In contrast, their Multi-Family facilities (which also house frail elderly assisted living participants, but usually those with slightly lesser needs) do not require staff to be on site 24 hours a day.

In some states, a lack of in house skilled staff is compensated for by contracting for additional services with outside sources. Use of external contractors work best for tenants who are self-directing in care, whose service needs are temporary or episodic, and where the assisted living provider and the external agency work closely together. To facilitate coordination, many states, such as Maryland, have a Resident Service Coordinator on staff, who is responsible for ensuring that program participants receive the services they need. Many states with strong existing community-based support services have also found that Resident Service Coordinators are useful in helping frail elders in assisted living units access external resources.

An additional barrier that state officials have encountered in regulating staffing is that certain needed services can only be provided under law by skilled nursing staff. Hiring a more highly skilled (and more expensive) staff may require more resources than the state can afford, especially in light of nursing shortages and since all of the skills and expertise of licensed nurses are not needed. Oregon addressed this problem by amending the state practice act to permit non-R.N.s to provide certain services (e.g., medication administration) which formerly could only be administered by registered nurses.

### **c. Quality Incentive Payments**

Oregon is the only state we identified which has attempted to link quality assurance initiatives with reimbursement in assisted living. As described by Kane, et. al. (1990), Oregon's reimbursement scheme has one component based on "expected outcomes":

*"This component allows for special payments to be made, above the established 5-tier payment schedule, when targeted outcomes in functioning are achieved. These incentives are hoped to be seen as a 'carrot' to get people to come out of nursing homes" (pp. 133-1 34).*

Oregon recently decided, however, to discontinue these quality incentive payments. Providers felt the amount involved was not worth the cost and felt that the existing banded payment rates and consumer-provider focus of service delivery make it unnecessary (Keren Brown Wilson, correspondence). Several states recently examined by Lewin-ICF have attempted to link reimbursement with quality in **nursing** homes, with mixed success (e.g., Illinois, Michigan, Massachusetts, Florida, Washington).

The extent to which such quality incentive payments improve "quality" in assisted living is an open question meriting further research.

### **d. Mechanisms for monitoring the quality of care provided**

The techniques for regulating quality care in nursing homes are extensive, entailing periodic and annual surveys by inspectors. This mode of regulation may be inappropriate for assisted living facilities, since it runs the risk of overburdening providers, subverting provider innovation, infringing upon tenant autonomy, and creating an institutional atmosphere. As Mollica (1992) summarized:

*"Assisted living offers an opportunity to alter the approach used to assure quality care in long term care settings. Historically, nursing facilities have been regulated and surveyed to ensure appropriate utilization, adequate capacity based upon fixed standards and outcomes as measured by predetermined results. This posture has generated a **defensive operational** mode in which the prevailing response is to follow the letter of regulations. Regulations intended to represent minimum standards often become **a ceiling for achievement...** Unfortunate/y, while this approach usually has a temporary positive effect on providers, it has also has led to impersonal, sterile environments, in which fear of negative outcomes acts to restrict resident autonomy and to increase cost."*

In an attempt to address this concern, Oregon introduced a strong case management component into their assisted living program for the frail elderly. While participating facilities

must show that they are capable of meeting all of the regulations in order to be licensed, and the state bi-annually conducts a one-day, two-page survey, primary responsibility for overseeing the facilities' operation is not left to state surveyors (as would normally occur in a state subsidized institution). Rather, each facility has a case manager similar to resident service coordinators in some states (such as Maryland). The case manager's primary function is to ensure that residents are receiving the services they need, at an acceptable level of quality. But the role of case manager goes one step beyond that of most resident service coordinators: they are also responsible for ensuring that the facility's operation is meeting the intended philosophical goals and needs of the frail elderly in assisted living.<sup>6</sup>

In addition, Florida has enacted statutory **provisions** to ensure that regulations of assisted living facilities do not stifle provider innovation. The Adult Congregate Living Facilities Act (August 1992) states, "Regulations shall be flexible to allow facilities to adopt policies which enable residents to age **in place** when resources are available to meet their needs and accommodate their preferences."

Ultimate resolution of this issue is difficult. On the one hand, most would agree that the scope and nature of quality monitoring in assisted living should not approach that of nursing homes. On the other hand, quality must be monitored in some way, especially as assisted living moves from its current status as a combination of high priced, privately subsidized facilities (where the market can regulate quality) and demonstration projects (run largely by well-intentioned proponents of assisted living), to a for-profit status where public funds are paying private providers to deliver care to program recipients. As assisted living evolves, states may consider more extensive quality monitoring systems.

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<sup>6</sup> Oregon is currently considering following up on a sample of discharges to assure appropriateness as another method of ensuring quality. In addition, it should be noted that the state does retain the ability to impose the same criminal and civil sanctions as they have for nursing homes. The experiences of Oregon have led the state to pursue a policy closer ongoing monitoring, a consultative model, and heavy training (Keren Brown Wilson, correspondence).

### **3. Conflicting and Multiple Regulations**

A final regulatory issue relates to the uncertainty and ambiguity about what regulations apply to assisted living in certain states. Some states have found that despite a desire to expand the spectrum of services offered in assisted living facilities, their ability to do so is restricted by preexisting regulations promulgated for other care settings (e.g., board and care homes). Some states have responded by creating new licensure categories that would allow facilities to supplement the current services provided. Florida, for example, has just added a new licensure category for which facilities can apply. This license would allow participating facilities to provide assistance with up to 3 ADLs (whereas before 1 + personal services, but no nursing services, were allowed); would allow the administration of medication/treatments by an authorized licensed practitioner (before only the supervision of self-administered medication was permitted); and requires staff administrators and supervisors to take at least six hours of preservice training. In addition, as discussed previously, implementation of the Americans with Disabilities Act and Fair Housing Act Amendments may impose further regulatory requirements on assisted living facilities in all states.

#### **E. Should states consolidate oversight and regulation of assisted living programs into a single agency?**

Some states have been addressing the needs of the frail elderly for well over a decade, and have continually expanded the population of frail elders that can be served by supplementing service availability in existing facilities, creating new licensure categories, creating community-based programs to supplement services available in state subsidized facilities, and through a variety of other methods. One result of building assisted living in steps can be a fragmented system with different agencies at different levels of government overseeing both the allocation of funding and the development of regulatory guidelines.

Florida's range of programs which address the needs of frail elderly by providing some form of assisted living illustrates how a state system of care for the frail elderly can be fragmented. Florida's system consists of four major programs: Community Care, Adult Congregate Living Facilities (ACLFs), Adult Foster Care, and Extended Congregate Care (ECC). ACLFs and Adult Foster Care facilities house frail elders with similar characteristics.

and both provide room and board, limited personal services, but no medical services, While ACLFs have targeted frail elders since the program's inception in 1975, Adult Foster Homes were initially intended to facilitate the deinstitutionalization of patients from mental hospitals. Although the population served in Adult Foster Homes has evolved to closely resemble the population in ACLFs, the two programs are governed by separate regulations, reflecting the different populations and needs they were created to address. The ECC program allows either ACLFs or Adult Foster Homes to obtain additional licenses that would allow the provision of nursing services, and those homes which obtain ECC licenses are then subject to an additional set of regulations. Finally, the Community Care Program, which was created to allow elders eligible for nursing home care to age in place by subsidizing home-based services, is subject to both state and local agency regulations. The state allocates funding to local agencies, who then must provide case management and two other services in their community, as well as determine eligibility requirements for who can access community services and funds for in-home"care within the agency's jurisdiction.

In the short term, developing a system of programs and services to meet the needs of the frail elderly in steps, as Florida did, is not necessarily negative, since it may allow states to implement new initiatives (and supplement old ones) to meet the needs of the frail elderly expeditiously. However, negative side effects may include a duplication of efforts, and/or conflicting regulations which are ultimately aimed at reaching conflicting goals. For these reasons, some states have decided to consolidate agency oversight: the state of Florida is currently in the process of creating a new Department of Elder Affairs in reaction to such concerns, In addition, the Report on Board and Health Reform by the New Jersey Department of 'the Public Advocate (April 1990) made the following recommendations:

*"First, the current structure of the regulatory system should be overhauled to more effectively coordinate licensing, inspections, service delivery and the investigation of complaints of abuse and neglect from residents. Second, board and care facilities should be reclassified so that facilities which house residents with similar needs can provide comparable services and receive a standardized SSI rate."*

Oregon has consolidated its state agencies that address the needs of the aged, and some argue that this has been a necessary precondition to the development of Oregon's unique initiatives in concepts of assisted living. As Dr. Rosalie Kane concluded:

*"Although not every state can or wishes to completely reorganize its existing administrative configuration to mimic the consolidated aging system found in Oregon, administrative cooperation among the Medicaid agency, the State Unit on Aging, and other aging services agencies would at least alleviate some of the problems inherent in a fragmented system. Discussions should take place toward that end. If funds can be pooled and if access to, monitoring of, and payment to nursing homes, home care programs, and creative living situations can all be consolidated, it is easier to design innovative combinations and to make system changes."*

**F. Should states control the supply of assisted living facilities through regulatory means?**

Mollica et. al. (1992), elucidate a potential budgetary and health planning concern with expanding assisted living capacity without accounting for the broader consequences in the context of the overall long term care system. On the one hand, the addition of assisted living units could result in an increase in case-mix in nursing homes (that is nursing home beds would generally be made available to patients needing a higher level of care). This is generally considered a positive indirect outcome of assisted living programs. However, at the same time, those patients who ordinarily would have been placed in nursing homes would now be cared for, at the state's expense, in assisted living units. In sum, "states may be concerned that a new supply of long term care services would increase the total number of people served at the state's expense," (Mollica, 1992).

Oregon has attempted to keep a handle on costs by maintaining some control over the supply of residential care alternatives: that is, by expanding the availability of space in the most cost efficient alternatives in long term care (i.e., assisted living facilities), Oregon hopes that elders will be attracted to the advantages of assisted living, causing occupancy rates in nursing homes to simultaneously fall. In fact, the number of Medicaid recipients in nursing homes in Oregon has fallen from 8,400 to 7,640 between 1981 and 1992. In addition, the number of beds per 1,000 in both Oregon and Washington has declined.

Massachusetts also tried to control long term care occupancy through policy initiatives, although their approach was different. By raising the eligibility requirements of nursing home admission while simultaneously increasing the availability of assisted living units, Massachusetts hopes to stimulate a shift in patterns of nursing home and assisted living facility utilization.

At the same time, states must be careful in reducing nursing home occupancy (through substitution with assisted living or otherwise) in regions where bed availability is already constrained (e.g., in rural areas). Nursing homes with chronically low occupancy may be forced to close. If there is an insufficient supply of beds in that region, those in need of nursing home care may not be able to obtain it. In short, states should view development of assisted living alternatives in the context of its overall long term care system and pursuant to a rational health planning process.

### III. PART TWO: DESCRIPTION OF STATE PROGRAMS

This section presents an overview of selected state assisted living programs. The states include: Oregon, New York, Florida, Washington state, Maryland, New Jersey, Maine, Rhode Island, Connecticut, and New Hampshire. As shown in Exhibit VIII.8 above, several completed and ongoing projects have described in detail the content, philosophy, operation, and results of these state assisted living programs. Accordingly, this synthesis does not attempt to provide a comprehensive description, but provides enough background for the reader to gain an understanding of the fundamental aspects of the various assisted living programs.

#### A. OREGON

##### 1. Program Overview

Oregon's Assisted Living program has received extensive national attention of late due to the various innovations in assisted living which were created by Oregon policy makers, and were tested in this program. Extensive research and evaluations have been conducted on

this program in particular. Rather than attempt to review the results of these studies and evaluations comprehensively, this abstract of Oregon's Assisted Living program attempts to touch upon the program's major themes. For more comprehensive discussions, see "Assisted Living: A Model of Supportive Housing" (Wilson, 1992) or "Concepts in Community Living: Assisted Living Program" (Wilson, 1992), or Mollica, et. al. (1992).

Oregon began its Assisted Living Program in 1987/88 (following a demonstration project that began in 1984) to provide a high level of community support to frail elders in an environment resembling a residential home as closely as possible, while at the same time fostering as much independence as possible. Furthermore, the broad range and level of services offered makes Oregon's Assisted Living Program for the frail elderly unique compared to other states. "A key goal in developing the program has been to provide services up to and including the availability of 16 hours a day of licensed nursing<sup>7</sup> so that even the frailest elderly participants may not only age in place but even finish their lives without having to move to a different setting. The program is unique in the high level of frailty that it is designed to handle, and it embodies a more medically oriented model than most other supportive services programs," (Struyk, 1989). Emphasis is on ensuring residents the right to privacy, choice, **dignity**, and individuality. Care is provided, but a prevailing philosophy is that too much care can lead to premature dependency. Managed risk and shared philosophy (e.g., in looking at "**bad**" outcomes, the skill shown in developing and implementing a managed risk contract is weighed heavily by the state) are strong components of the program (Keren Brown Wilson, correspondence).

## 2. Program Description

The assisted living facilities were designed and built as elderly housing, hotel style. The Oregon Senior and Disabled Services Division (SDSD) has stimulated the construction of nearly 1000 assisted living units in 21 licensed facilities ranging in size from 15 to 105 units. The state's residential care facilities operate about 4000 beds of which 1,000 are subsidized by state programs (Mollica et. al., 1992). (In addition to the **newly constructed facilities, many**

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<sup>7</sup> **Actually, nursing services must be available 24 hours a day, typically through the Nurse Delegation Act. with a licensed nurse on-call all the time (Keren Brown Wilson, correspondence).**

of Oregon's Adult Foster Homes<sup>8</sup> (which began operation in 1981 as the state's first attempt to address the needs of the frail elderly) have evolved into assisted living models.)

Features of the assisted living program are briefly outlined below:

- The state currently subsidizes the tenants of 17 assisted living facilities! with an average of 40 residents per facility.
- Most residents are at least 80 years old, with the mean age of program participants at 85. The majority are women, 40 percent experience incontinence and 65 percent are cognitively impaired (Struyk, 1989). Eligibility is not restricted to private pay patients.
- The program targets those meeting Medicaid skilled criteria (however, assisted living cannot serve those who need continuous care). In fact, about half came from a licensed nursing facility.
- All residents in each facility participate, and there is no attempt to avoid an institutional atmosphere by limiting the number or percentage of frail elders in each building (or the level of frailty) (Struyk, 1992). Each room is equipped with kitchens and doors can be locked.
- The model designs and implementation were conducted by Keren Brown Wilson, a gerontologist, in 1985. As policy makers and their constituencies became less tolerant of the fact that the long existing long-term care system in place was intrusive, expensive and overly focused on safety at the expense of quality and other issues, a heightened interest in an alternative model of care developed. Adult foster care mitigated some problems, but there was still a gap for people who required night time care.
- Services provided include meals, opportunities for social interaction, housekeeping, laundry, transportation, assistance with ADLs (including bathing, dressing, eating, bowel and bladder management, personal hygiene and special approaches for behavior management), medication management, and nursing services (such as injection, catheter care, wound care, health status monitoring and assessment, and planning and reviewing the direct and ancillary services for supporting resident independence) (Mollica et. al.. 1992).
- A 24-hour professional staff must be available to provide care and service as needed.

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<sup>8</sup> Oregon's Foster Care is a type of supportive housing, and has remained distinct from assisted living from a regulatory perspective.

Because the program is financed using Medicaid waivers (see below) all eligible applicants must be both financially eligible **for Medicaid, and medically eligible** for placement in a **nursing facility**. **However, Assisted Living Facilities cannot serve frail elders who require 24-hour nursing care or monitoring.**

### 3. **Elaboration on Areas of Interest**

#### a. **Funding**

Oregon has recently received national attention for their initiatives in attempting alternative methods of financing and delivering services. Oregon is currently the only state to receive a 1915(d) Medicaid waiver, and was the first to receive 2176 waivers (which 47 states have now). 2176 allow states to provide support services and services that are not part of the state plan to nursing home eligible Medicaid recipients. "The 1915(d) waiver is limited to persons **65** and older and caps the amount of funds spent on long term care for institutional and community services. In exchange for a fixed level of federal reimbursement, the state has the flexibility to cover services similar to the 1915(c) waiver," (Mollica et. al., 1992). Medicaid pays assisted living facilities in Oregon **75 percent of the nursing** home reimbursement level, and 25 percent of the facilities are populated by Medicaid beneficiaries. In addition, monthly payments are provided by the Senior and Disabled Services Division to cover services. Service costs range from **\$497** to **\$1,425** and the state contributes an average of \$891 per month. Residents usually contribute \$445 per month toward room and board (the SSI standard in Oregon is \$423.70 a month, and any income above that and below \$1,266 — the maximum income at which a person is Medicaid eligible) is applied to the cost of services, while the remaining \$423.70 is retained **to pay for room and board (Mollica et. al., 1992).** **Construction of new facilities were financed either privately or through the Oregon Housing Finance Agency. Four projects have been submitted for HUD funding (Mollica et. al., 1992).**

#### b. **Concerns**

**A state official we interviewed articulated that the main concern of the state is ensuring that assisted living meets the spirit of what its supposed to do. This official stressed that the maintenance of the privacy and dignity of residents is a necessary condition** for success. In addition, this official articulated a concern about the continued availability of Medicaid funds, the future of which appears uncertain in light of growing budgetary constraints.

### **c. Evaluation Results**

The following are the result of an evaluation of the 1987 Demonstration Project, as articulated by Rosalie Kane and colleagues (1990):

- Results showed significant overlap in patient characteristics with nursing home patients.
- Anecdotal and statistical analysis indicated improved client outcomes, particularly in mobility, orientation, use of restraints, and stability of placement.
- Cost to the state was 80 percent of area nursing home rate, and 20 percent more than average foster home rate.
- Result of evaluation was the full implementation of the Assisted Living Program.

## **B. NEW YORK**

### **1. Program Overview**

Based on legislation passed in 1991, the New York Departments of Social Service and Health are developing a new Assisted Living Program for the frail elderly. This program aims to combine and enrich the existing state programs which currently serve the state's population of elders who are in need of some level of assistance, but are not yet ready for nursing care. By expanding upon current programs (including Adult Care Facilities, and Enriched Housing Programs, and a program which provides home care services to individuals who are medically eligible for placement in a nursing facility), New York hopes to serve elderly people in non institutional residential settings, who previously would have been placed in a nursing home. This program is being implemented because of the belief that providing supplemental services in the state's existing facility stock will be a low cost alternative both to developing new facilities and to caring for these same people in nursing homes. "The Assisted Living Program is designed to serve as an alternative to nursing **home placement for individuals who historically** have been admitted to nursing facilities for reasons that are primarily social, rather than medical in nature. The target population for the Assisted Living Program includes those individuals who would be classified in the 'health related' categories of the nursing facility Resource Utilization Groups. .. The Assisted Living Program was jointly developed by the Departments of Health and the Department of Social Services. The primary **goals of both departments in this effort is to develop a less restrictive and lower cost**

residential setting that can serve people who don't need the highly structured, highly medical environment of a nursing facility.” (Department of Social Services Program Applicant Information.)

## 2. Program Description

A 4,200-bed target has been established; and the number of facilities that will ultimately participate is unknown, although well over 200 responses to a request for interested proprietors have already been received. Adult Care facilities and Enriched Housing Program facilities can expand their programs in one of two ways: either by obtaining a license to provide expanded services, or by contracting with an existing home care agency or certified home health agency to provide added personal care and professional services. According to one state official, the supplemental **services will include:**

- Three meals per day
- Nursing, Home Health Aides, and Therapies (PT, OT, Speech)
- Medical supplies and equipment for which no prior approval is required
- Adult Day Health Care
- Space for congregate meals
- Personal services
- Supervision including Emergency Response Systems

The Assisted Living Program targets those elderly who can no longer live independently, and yet do not require full nursing care. People who need continual nursing or medical care, anyone chronically bedfast or chairfast, or anyone who is cognitively, physically or mentally impaired to a point where safety is compromised are not eligible to participate. The new Assisted Living Program attempts to expand the eligible population by offering more comprehensive as well as more skilled services in existing state subscribed housing. State officials **hope that** in addition to the direct benefits the state's frail elderly will receive, those in need of a higher level of care will also benefit (from the increased space available in Nursing Homes). One state official we interviewed stressed that the congregate living space would not be categorized as “Nursing Facilities”, allowing fairly independent elders to move out of full nursing **care**.

Before the Assisted Living Program was created in New York, Enriched Housing was the state's most far reaching attempt at assisted congregate living for the frail elderly, The Enriched Housing Program was started in 1978 in existing state subsidized housing. Additional services provided in Enriched Housing facilities include one daily meal, housekeeping, personal care (such as limited assistance with dressing, bathing and grooming), case management, and other personal services. The regulations for Enriched Housing Facilities are fairly comprehensive, including detailed regulations on everything from physical plant, to nutrition, to specific guidelines on resident supervision and assistance in administering medication. The regulatory system for Enriched Housing will be an important factor in the development of the state's assisted living program, since many of the assisted living facilities will be Enriched Housing facilities with additional licenses, but where Enriched Housing regulations are still in effect.

3. **Elaboration on Areas of Interest**

a. **Funding/Assessments/Concerns**

In accordance with New York's focus on cost containment, the cost per resident is **capitated** on a daily basis at fifty percent of what nursing care would cost for a nursing-home resident with similar needs. It is estimated that the program will save a projected \$61.8 million annually based on a supply of 4,200 assisted living units (Discussion Paper: National Academy for State Health Policy). Funding would be comprised of a combination of SSI payments (which would subsidize room and board costs) and Medicaid Title XIX funding (covering medical expenditures). One state official we interviewed saw cost containment as the main impetus driving the program's implementation. This state official contends that the reimbursement level would be high enough to allow reinvestment on the part of providers, which would **eventually** result in the addition of **new** facilities to the stock of available assisted living housing.

b. **Evaluation Results**

The following are the results of a DSS-sponsored evaluation of the Enriched Housing Program conducted in 1982. While outdated, the results can still be useful in identifying possible problems in the early stages of any similar assisted living program's implementation. The results were summarized by Struyk (1989) as follows:

- A high level of unmet service needs of participants before joining the program was found, The Enriched Housing Program was found to be effective in meeting those needs, particularly with ADLs.

- Program coordinators reported that program participants did not feel stigmatized in their buildings. The study concluded that randomly scattering units was successful in achieving an integrated atmosphere.
- One difficulty in expanding the program was with encouraging housing managers of existing state subsidized housing stock to implement the program. Many felt that if residents needed additional services, they should move out.

## C. FLORIDA

### 1. Program Overview

Pursuant to regulations issued by the Florida Department of Health and Rehabilitative Services in August 1992 which creates a new licensure category for state subsidized housing, some existing state subsidized facilities which provide limited services to the frail elderly have obtained additional licenses that will allow them to provide nursing services. These facilities are called Extended Congregate Care (ECC) Facilities, and the state anticipates that they will expand the scope of assisted living and the population it can serve in Florida substantially. ECC facilities must “promote privacy and independence, and provide opportunities and encouragement for residents to make personal choices and decisions.”

The ECC program will build upon two of Florida’s existing programs that offer services to the frail elderly, Adult Congregate Living Facilities and Adult Foster Homes. Florida’s third program, Community Care, utilizes a Medicaid Community Based Waiver to subsidize the cost of services for the frail elderly in their homes.

### 2. Program Description

ECCs add the following features to Adult Foster Care Homes and Adult Congregate Living Facilities:

- ECC facilities may provide assistance with up to 3 ADLs, and nursing services under the standard and limited nursing services licenses.
- Facilities must provide the following services: promotion of normal elimination, administration of medications/treatments prescribed by an authorized licensed practitioner; and transportation and escort services for health-related appointments.
- The ECC supervisor and Boarding Home Administrator for each facility must take six hours of preservice training. Staff must include a registered nurse.

licensed practical nurse or advanced registered nurse practitioner on staff or by contract.

- ECC residents may not be kept if he/she is bedridden for 14 consecutive days, needs 24 hour nursing supervision, has four or more ADLs, has a cognitive impairment disallowing simple decision making, requires treatment for a stage 3 or 4 pressure ulcer, is a danger to self or others, or is in a medically unstable condition. (Rajecki, 1992)

As stated, this program builds upon two of Florida's existing programs to assist the frail elderly: Adult Congregate Living Facilities (ACLFs) and Adult Foster Homes. ACLFs have been functional in Florida since 1975, and the program has grown to include 1500 facilities (most of which are small) serving approximately 50,000 people a year. Features include:

- Room and Board
- 1+ Personal Services
- Supervision of self administered medication (or if an ECC, then administration of medication)
- Mostly private pay patients

The Adult Foster Care program began in the 1960s with the intention of deinstitutionalizing patients from Mental Hospitals. However, over time the program has evolved to focus almost exclusively on serving the elderly and has expanded to include 500 facilities with a maximum of 3 residents per facility. Features include:

- Room and Board
- Personal Services
- No Medical Services Provided
- Mostly state subsidized patients

**Eligibility** is determined on a case by case basis by state case workers for those seeking state subsidies (no restrictions for private pay patients). Residents must be at least 18 years old, they cannot require 24 hour nursing care, and do not have to be frail (they can be fully independent and seek participation for purely social reasons).

in addition to ECC facilities, ACLFs, and Adult Foster Homes, Florida has a community-based program, entitled Community Care, which uses a Medicaid Community Based (COPs) Waiver to subsidize in-home services for the frail elderly.

### **3. Elaboration on Areas of Interest**

#### **a. Agency Oversight**

Currently three separate agencies participate in the oversight of Florida's Programs that provide services to frail elders. Due to the conflicts which this may cause (as outlined in Part One of this chapter), the state is currently in the process of consolidating agency oversight of assisted living programs. Currently, the department of Health and Rehabilitative Services oversees rules, policies and training; the Department of Elder Affairs supplements the DH&RS with placements; and the Agency for Health Care Administration is responsible for licensing and inspections.

#### **b. Funding**

The residential services programs (ACLFs and Adult Foster Homes) receive approximately \$19 million in state subsidies annually. They do not receive Home and Community Medicaid Waivers, although according to one state official we interviewed, the state is currently attempting to obtain one. The Department of Health and Rehabilitative Services plans to develop a service rate for ECC that will be based on 50 percent of the Nursing Home Rate for a patient with similar characteristics. The rate would be paid through a Medicaid Home and Community Based 2176 Waiver (this new payment methodology has to be approved in the legislature's next session before it can be implemented) (Mollica et. al., 1992). State subsidies are available to those with incomes under **\$575/month** (the cost of one month's care in either type of facility). Residents are expected to contribute as much of their income as they can up to \$575 per month (most of which comes from SSI), retaining \$43 per month for personal expenses, with the remainder subsidized by state general revenues.

As mentioned, the Community Care program is financed with a Medicaid Community Based (COPs) waiver. This waiver was kept "transparent" to providers and participating elders. That is, the state did **not** impose Medicaid financial eligibility requirements on participants in their Community Care program, but rather retrospectively reviewed all Community Care participants and matched up those who fulfilled Medicaid eligibility requirements with Medicaid funds. Medicaid funds were filtered through the state (were not given directly to providers) and therefore the waiver was transparent to all but the state. However, this method of distributing Medicaid funds in Florida is no longer exercised. The Health Care Financing Administration and the federal Department of Health and Human

Services determined that the Medicaid Waiver dollars were to go directly to the provider. to bring Florida into conformity with other states.

c. **Concerns**

Current concerns include the adequacy of funding (including the need for a Medicaid Waiver to subsidize state funding of ACLFs and Adult Foster Homes), and the need to increase the administrative and training requirements for program administrators and staff. Currently the only requirement is a High School diploma, and one state official with the Office of Aging and Adult Services, stressed the need to professionalize the program's staff.

D. WASHINGTON STATE

1. **Program Overview**

According to a state official in the Department of Social and Health Services, the Washington State's Assisted Living Project "require[s] a change in philosophy by [state staff], residents, families, community agencies, health professionals, providers, communities, providers and the Legislature. The Assisted Living project and the Assisted Living Concept can and should be able to reduce our dependence on Nursing Facilities. Residents will be able to receive a more personal and individualized service in a more homelike environment," (Assisted Living Project summary document). As stated in the RFP, "The purpose of Assisted Living Services is to promote the availability of services for elderly and disabled persons in a home-like environment enhancing the dignity, independence, individuality, privacy, choice and decision making ability of the resident... There is an assumption that each person has a right to live independently, have his/her privacy and dignity respected, and be free from restraints."

According to one state official, a recognition of the need for state guidance in coordinating, assisting, and supplementing the private sector's growing investment in housing that provides some level of assistance to the frail elderly was the original impetus for Washington's state involvement in assisted living. The assisted living program in Washington State began as a demonstration project in October of 1990, and consisted of only one facility until July of 1991, at which time the state legislature granted authority (approved funding) to expand the program to 180 units. By July of 1992, the program had expanded to include 165 units in 12 buildings. Since the program's inception, RFP and Boarding House contract

negotiation has allowed assisted living to be quickly introduced in existing state facilities. This Assisted Living Program aims to serve those residents who require more care than regular Congregate Care Facility services, but less care than provided in a Nursing Facility.

## 2. Program Description

Instead of creating new legislation and regulations for the development of a new facility stock, supplemental services were added to existing state subsidized facilities. One state official we interviewed stressed that this method of developing an assisted living program has allowed a very fast and efficient development of the program. The state subsidies have funded the addition of the following features in state subsidized homes:

- Case management.
- Private lockable rooms with private bathrooms (which is not standard in state subsidized boarding homes), kitchens, and an emergency response system.
- An LPN or RN on duty 8 hours/day, with a nurse on site or on call 24 hours/day (which is necessary due to existing restrictions on medication administration).
- Personal services such as laundry, housekeeping, behavior management, incontinence care, and assistance with ADLs and IADLs except positioning (Mollica et. al., 1992).
- Available nursing services include: assessment, monitoring, medication administration, stage one skin care, and temporary bed care. Therapy is also available as needed.
- Homes developed around a social (as opposed to medical) model, including access to common areas such as activity rooms, lounges, dining room and laundry facilities.
- Ancillary services such as beauty shop, banking and transportation.

The extent of services which could be made available in assisted living units were somewhat restricted by regulations on the Boarding Homes in which the Assisted Living Units have been introduced. These regulations are fairly comprehensive, and include provisions for some services which must be 'available, and some which can not be provided. For example, there are detailed regulations on which types of residents are to receive what extent of supervision (assistance) in administering medication. "The initial guidelines allowed assisted living facilities to be responsible for ensuring the provision of additional skilled nursing services (catheter care, stage 2-3 skin care and changing sterile dressings.) Health department staff

concluded that such care was beyond the scope of a boarding home license. However, residents may still receive such services in assisted living and facility staff may help residents arrange such services with certified home health agencies. The facility is not now responsible for such care. The distinction reflects concerns among regulators and providers over the model," (Mollica et. al., 1992).

Regulations for physical plant of boarding homes are also comprehensive, detailing everything from stairways and guardrails to toiletry requirements in bathrooms. These regulations may be seen as a barrier to achieving the non-institutional and individual character which Assisted Living Units are intended to achieve. In an attempt to counteract this and to encourage resident individuality, facilities must have written procedures to document staff efforts to involve residents in their care (Mollica et. al., 1992).

### 3; **Elaboration on Areas of Interest**

#### a. **Eligibility and Funding**

The program will not serve elders who need continual nursing or medical care, anyone chronically bedfast or chair-fast, or anyone who is cognitively, physically or mentally impaired to a point where safety is compromised (Discussion Paper, National Academy for State Health Policy). Admission criteria are further restricted because the program is funded through a Medicaid COPS waiver (which is a Title XIX **waivered** program serving nursing home eligible persons in their homes or at community-based sites), and therefore, recipients of funds must meet Medicaid requirements. Therefore, the state subsidized homes have impacted a relatively narrowly defined population of the frail elderly: those who are Medicaid eligible, are eligible for nursing home level of care, are likely to be institutionalized in the near future, and who require assistance with **ADLs**. One state official we interviewed indicated that the population **which** the Assisted Living Facilities are available to serve is further limited by the fact that current Boarding Home regulations restrict the types of services which can be provided in Boarding Homes. Therefore, many elders who meet the COPS funding requirements may find **that** boarding houses do not provide sufficient services to meet their needs. In an attempt to address more frail elders, the Aging and Adult Services Administration has made a proposal to add 600 assisted living units under Title XIX Personal Care for the next Biennium (as well as 180 units under the **COPs** Program), thereby expanding the absolute number of elders that can be served.

Presently, the program's bi-annual budget is \$3.5 million. Individuals contribute their income less the CPI of \$38.84 per month, and the maximum subsidy for any individual is \$1066.

#### b. Evaluation Results

The following are the results of an evaluation of the Washington State pilot project for Assisted Living (Heritage House), which was conducted in 1991/92 by Keren Brown Wilson.

- Residents were generally found to be very frail, considerably impaired, and could "clearly be classified as nursing home eligible."
- Assisted Living residents were at significant risk of institutionalization. Compared to nursing home residents, assisted living residents were generally younger and more likely to have lived in an independent living arrangement prior to admission. Thirty-eight percent relocated from Nursing Homes.
- Cost for assisted living was fixed by a state contract at \$40/day. The average nursing facility cost for the period averaged \$75/day. The actual costs for assisted living facilities were \$47.12/day. Compared to nursing facilities, nursing costs in assisted living facilities were \$18.72 less per day. In contrast, the property cost per day was significantly higher in assisted living facilities than in nursing facilities (\$4.36 versus \$2.40 per day).
- The evaluation made the following recommendations: Private space was essential (unless double rooms were requested); private baths and cooking capacity should be provided; physical design of facilities should allow maximum accessibility; homelike residential equipment and furnishings should be used; and the program should be developed by using RFPs.

### E. MARYLAND

#### 1. Program Overview

Maryland's senior assisted housing program (entitled Sheltered Housing Program) was established in 1976 by the Maryland General Assembly, under the auspices of the Maryland Office on Aging, "in response to growing concern over the inappropriate use of nursing homes by the elderly," (Maryland Office on Aging Multi-Family Assisted Housing Summary). According to one state official we interviewed, this program was the first state sponsored **congregate** living program, preceding even the development of the HUD congregate living model. The program **was** instituted to provide alternative care and housing options for those at risk of institutionalization before nursing home care becomes necessary. The program was

created both to help frail elders maintain as much independence as possible before, and as a response to the rapidly increasing cost of Nursing Home Care,

## 2. **Program Description**

The program serves close to 2000 elders in 130 group homes and 40 participating apartment buildings. The facilities are public and assisted housing as well as private apartment buildings. The program is operated in two different types of facilities! Multifamily Housing and the Group Home Model. These two models target slightly different populations, and the services which they offer differ slightly as well:

### **Multifamily Housing:**

- Three meals/day, at least two of which are in a congregate setting. If resident's health requires it, meals may be delivered to participant's apartment for a maximum of two weeks.
- Personal services provided include laundry, housekeeping, one hour of assistance per week with bathing, grooming and dressing, and transportation.
- Individual apartments 'with kitchenette.
- Resident Service Coordinator in each facility.
- Targets elders who are still capable of being highly independent.
- Offered in senior citizen apartment buildings which are primarily federally subsidized (HUD) and may be operated by public housing authorities, non-profit organizations, or private management companies.
- Multifamily Housing is available in large apartment buildings. To prevent an institutional atmosphere, no more than 20 percent of a building's total residents may participate in the program (with exceptions permitted on a case by case basis). A minimum of 10 participating residents per facility is needed for the program to be economically efficient (Struyk, 1989).
- Eligible applicants are at least 62 years old; physically or mentally impaired; in need of services such as meals and housekeeping; need assistance with activities of daily living; and are determined by the provider, through an evaluation of the applicant's functional ability, to be both in need of the level of care available in the facility and capable of functioning in the facility. One or more of these requirements may be waived for a variety of reasons, including special consideration for age, health, family relationship, or emergency situations that may place **the applicant** for services at risk of institutionalization.

### Group Home Model:

- Three daily meals.
- Personal care such as grooming, bathing, dressing, and laundry as needed; and the delivery of meals to the resident's room for a limited period, when the health of the resident requires it.
- **24-hour** supervision by elderly caregivers, who usually own and supervise the home.
- Resident Service Coordinator in each facility.
- Single family homes, former convents, and converted school buildings make up most of the group home facility stock (Struyk, 1989). Facilities for 4 to 15 residents may be certified by the Maryland Office on Aging as a Group Senior Assisted Housing Facility provided all applicable local requirements have been satisfied, such as zoning, housing, life safety, and health codes. In addition to meeting state wide-standards, the facility must be consistent with the plans and objectives of **the area** agency on aging in the jurisdiction for which the facility is proposed. These regulations vary by jurisdiction.
- Private and semi-private rooms: no apartments.
- Geared to the elder individual who requires more help in daily functioning. Individuals may be frail but not ill and should be ambulatory.
- Eligible applicants are at least 62 years old; physically or mentally impaired; in need of support services such as meals and housekeeping; in need of temporary or periodic assistance with **ADLs**; and free of infectious communicable diseases, as evidenced by a physician's statements. Applicants who do not meet all of these criteria may be accepted if the Office on Aging determines that the applicant is at risk of institutionalization, or needs special consideration for age, health, family relationship, and emergency situations.

Essentially, both models have the same basic admission criteria: participants must be 62 years of age or older, with 1 + **ADLs**, but do not need constant medical or nursing care. Of the more than 900 current residents of the Office on Aging certified group homes, 88 (almost 10 percent) were transferred to the group home from a nursing home (Impact Statement on Housing Budget Reductions). Maryland regulations require that participants be 'physically or mentally impaired', defined as a "condition which inhibits a person's ability to perform one or more activities of daily living" (Struyk, 1989). Responsibility for the assisted living programs are divided among three state agencies: The Department of Health and Mental Hygiene, The Department of Human Resources, and the Office on Aging.

### **3. Elaboration on Areas of Interest**

#### **a. Funding/Assessments**

The program is subsidized by federal, state, and county dollars. Individual residents will only be subsidized if their income falls below 60 percent of the state's median income, and if they pass the assets test (with a limit at \$20,000). Social Security is the income of most, and the individual keeps \$92, with the rest going to the caregiver. There is a \$550 cap on subsidies for any one individual, and therefore a major concern is that those with very low incomes cannot participate.

Program subsidies come from both federal and state sources. At the Federal level, HUD funding subsidizes rent, Title III of the Older Americans Act subsidizes nutrition, and In Home Aides Services are funded from the Social Services Block Grant. The state budget allocates \$3,000,000 to the program from state general funds. This state subsidy is annually renewed, and the lack of a long term commitment is a barrier to attracting providers to build new facilities. As a result of recent Maryland budget cuts, the Office on Aging has reduced its expenditures on the Senior Assisted Housing Program by \$267,746 since the start of FY '91. As a result, a number of senior apartment projects, many of which have significant elder populations have had to indefinitely delay or cancel the implementation of a Senior Assisted Housing Program. The Office on Aging expects to have 44 fewer subsidized slots in the Group Home Model by the end of FY 1992. (Impact Statement on Housing Budget Reductions).

While 47 states now receive a Medicaid 2176 waiver, "Maryland has made an explicit choice not to pursue a 2176 waiver to serve the elderly (they are already administering a waiver program for the developmentally disabled population). State officials are unanimous in their reasons for rejecting the waiver approach. They note that Maryland wants to see community-based care services grow substantially. With limits on the number of people that can be served by waiver programs and limits on total expenditures, Maryland feels that expansion will be more substantial and reliable if it comes about by encouraging greater use of Medicaid personal care services and' adult day care provided under the state plan" (Justice, 1988).

b. **Concerns**

According to one state official, the budgetary concerns mentioned above are the program's most important problems. She also indicated that while there are no major program changes envisioned for the near future, a need to increase the flexibility of services provided in the Multi Family Model (to increase utilization possibilities) is recognized, and this problem is being addressed.

c. **Evaluation Results**

We are aware of no formal evaluations conducted on the systemic level, or that were designed to determine the program's effectiveness in meeting their original goals or the needs of its target population as a group. However, two other evaluation sources (a state document highlighting the impact of recent budget cuts and a Project Report on the Sheltered Housing Screening Instrument which completed a pretest and description of 75 residents) revealed the following observations:

- Of 900 current residents in group homes 88 were transferred from Nursing Homes.
- Approximately 30 percent of offices in **115** certified group homes have expressed concerns about their ability to continue operating in the future as a result of lack of subsidies for low-income seniors who request their services.
- About **10 percent** of homes are in danger of going out of business. If 10 go under in **FY 1992**, 80 fewer beds will be available.
- The **ADLs** and **IADLs** which the highest percentages of residents required assistance with were bathing (35 percent), getting in and out of bed or a chair (27 percent), shopping (65 percent), housework (51 percent), laundry (47 percent), and meals (42 percent).

**F. NEW JERSEY**

**1. Program Overview**

As a result of New Jersey's new State Health Plan, published this year, which called for increased attention to assisted living in the state of New Jersey, the concept of "assisted living" will be formalized, defined, and explicitly addressed for the first time in the state's history. However, although no official "assisted living" program is currently in place in New Jersey, the state **has been directly addressing and attempting to meet the housing needs of**

the frail elderly since 1981. At that time a state legislated Congregate Housing Services Program was passed, which called for the provision of supplemental services in existing state subsidized facilities that housed many elder residents. The Congregate Housing Program was implemented to allow this elderly population to 'age in place' for an extended period of time.

## 2. Program Description

Sixty of the state's 450 subsidized housing facilities offer extended services to the elderly, which are organized by a resident service coordinator in each facility. The program's \$1.85 million annual budget enables participating facilities to provide elder residents with one congregate meal per day, 2-4 hours of housekeeping per week, and some personal assistance (e.g., certified aides provide personal care such as assistance with bathing, and aides who are not certified help with other tasks such as shopping).

At the same time, two other forms of 'assisted living' were being developed in the state: Class C Boarding Houses and Residential Health Care Facilities (RHCFs). Class C Boarding Houses were developed in the same manner as Congregate Living (by adding supplemental services to existing state subsidized facilities). RHCFs were facilities specifically designed to address the needs of the frail elderly population. Although different services are available in these two types of assisted living, they attract roughly the same type of person.

Program features include:

### **Class C Boarding Houses**

- Limited personal services (such as assistance with as bathing or dressing), the extent of which are determined on a facility specific basis. However, state regulations for Class C Boarding homes limit the kinds and amounts of personal/medical care that can be offered.
- Monitoring of self-administered medications.
- Assistance in financial management.
- Private apartments.
- Security in the larger facilities.
- Licensed and 'regulated by the Department of Community Affairs.

## Residential Health Care Facilities

- Health maintenance and monitoring services under the direction of a professional nurse.
- Expanded and defined personal services: including laundry, 3 meals per day, recreational activities, and one hour of personal care per resident day.
- A minimum of 12 minutes of Nursing Care per resident week.
- Supervised administering of medication,
- Semi-private or private rooms and baths.
- Licensed and regulated by the Department of Health.

Boarding homes served a population of approximately 2,612 persons in 1990, while 11,200 persons were residents in **RHCFs**. Seventy-five percent of residents were elderly, 25 percent were at least 80, 50 percent suffered from mental illnesses, and 50 percent of residents received SSI.

As mentioned, New Jersey's new state health plan devotes a chapter to discussing other long term care alternatives to nursing home care which will be considered in New Jersey. In addition to elder foster care, the plan proposed a formal 'assisted living' program which would be modeled after Oregon's assisted living program in terms of the physical plant and philosophy, but without the degree of case management which has been established in Oregon. A committee is now debating over what exactly an assisted living facility will look like in New Jersey. According to a state official we interviewed, several goals for the facilities in the new program have been agreed upon:

- To establish a home like environment (some think at least an apartment with a kitchenette, while others contend that a room with a lock is sufficient):
- Three hot meals per day, housekeeping and laundry; and
- A flexibility in the amount of personal care a resident would receive, allowing elders to age in place until acuity care was needed.

While goals are largely agreed upon, the form which facilities would take is not yet decided. Three models of facility development are being considered:

- Building new facilities with units having some semblance to private home (at least private rooms with locks on doors, if not apartments with kitchenettes). The facility operation would allow maximum personal flexibility and choice of services for the individual resident. This model would be designed to encourage and attempt to facilitate individual choice and competence, as well as family involvement, while keeping the facilities as noninstitutional in character as possible.
- Upgrading the level of care and services available in Class C Boarding Houses and Resident Health Care Facilities. This model would allow the frail elderly already in these facilities to age in place for an extended period of time. These upgraded homes would be called Comprehensive Personal Care Homes.
- Upgrading the level of care and services available in the facilities already participating in the Congregate Housing Services Program. State officials are now attempting to obtain a Medicaid waiver that would subsidize two additional meals per day, nursing services, and increased personal care in the Congregate Facilities.

### 3 . **Elaboration-on Areas of interest**

#### a. **Funding**

Most of the state subsidized housing for the elderly is currently funded by Casino revenues. In order to expand the availability and scope of services, a Medicaid waiver **needs to be obtained**. The expanded services would therefore target those who both eligible for nursing care and eligible for Medicare. The Assisted Living Program's impact on middle-lower income elderly who cannot presently afford congregate housing, Class C Boarding Houses, or Residential Nursing Care Facilities and are not Medicaid eligible would be limited.

#### b. **Evaluation Results**

The Report on Board and Health Reform by the New Jersey Department of the Public Advocate, April 1991, found the following:

- *“First, the current structure of the regulatory system should be overhauled to **more** effective/y coordinate licensing, inspections, service delivery and the investigation of complaints of abuse and neglect from residents;*
- *“Second, board and care facilities should be reclassified so that facilities which house residents with similar needs can provide comparable services and receive a standardized SSI rate;*
- *“Third, the state supplement to the SSI rate of reimbursement to these facilities should be restructured to enable recipients to receive an appropriate level of care and service;*

- *“Finally, a program to construct new board and care facilities should be implemented, with an emphasis on developing small, community-based living arrangements.”*

The evaluation also found that, “Board and care homes provide housing for our State’s most vulnerable citizens, a population that has a critical need for intense social and rehabilitative services. Yet boarding homes and RHCs are simply unable to provide the requisite care and services to residents because of an inadequate level of reimbursement through the SSI program. As the recent studies clearly indicate, those housed in board and care homes are often no better off than they were in state hospitals or other institutions. Indeed, these facilities now operate as mini-institutions for the frail and disabled. There is wide agreement that it would be far superior for most residents to be afforded rehabilitation and social services in the context of small group homes and supervised apartment operated by non-profit organizations. Small, community-based living arrangements offer a normalized **setting, intensive supervision by trained staff and rehabilitation plans that allow residents an** opportunity to realize their full potential. Accordingly, along with the restructuring of the state SSI supplement, a comprehensive program to develop these alternate housing options should be implemented to address the severe shortage of appropriate community placements.”

This evaluation was the catalyst for New Jersey’s decision to implement changes in their assisted living programs.

## G. MAINE

### 1. Program Overview

Maine’s efforts to address the needs of the frail elderly began in 1980 as a direct result of concerns expressed by constituents at the Governors Bi-Annual Conference on Aging. These elders wanted to see some state funds for allocated to senior citizens diverted to the care of the frail elderly. As a result, Maine’s **Home Based Care program, which provides** additional services to the frail elderly in their homes, was instituted in 1982; and a Medicaid 2176 Waiver was obtained in 1985 to subsidize community-based service programs. Since that time, a congregate housing program has also been developed to meet the needs of the

most independent of the frail elderly population. One state official we interviewed placed the three programs along a continuum of care for Maine's elder population:

Congregate Housing → Home Based → Medicaid Waiver Program → Nursing Home

## 2. Program Description

Congregate Housing Facilities consist of those housing units that were already state subsidized, with owners who were willing to bring their buildings into compliance with Congregate Housing Facility regulations (for example, some needed to upgrade kitchens and congregate dining areas). There are presently approximately 20 sites, housing 250-300 elders per year. Congregate Housing features include:

- Case Management (including functional and financial assessments)
- Home health services (which are not defined) to assist a consumer with medical or health needs (Bureau of Elder and Adult Services Policy Manual).
- One meal per day
- Assistance with heavy cleaning
- Transportation (according to interviews — not in regulations)
- **Personal Care** (according to interviews — not in regulations)

The next level of care is provided in home based care. To qualify, an elder must be 'at risk of going into a Nursing Home' and must meet a minimum functional score. This program subsidized anywhere from 500 to 700 elders per year, depending upon the funding available and the needs of the population served at any one time. The third, Community Based, is an extension of Home Based Care (providing additional services to the same population) is funded with a Medicaid Waiver (and therefore participants must meet Medicaid eligibility requirements) and is run by local agencies. In-Home and Community Support Services for Elderly and Other Adults is a state funded program to provide long term care services to assist eligible consumers to avoid or delay inappropriate institutionalization. In this program, supplementary services to those standard in Congregate Housing are available, including:

- Personal Care Assistance (services which are required by an adult with long term care needs to achieve greater physical independence, which may be consumer directed). These include, but are not limited to assistance with

routine bodily functions, such as bowel or bladder care; dressing; preparation and consumption of food; moving in and out of bed; routine bathing; ambulation; incidental household tasks essential to the activities of daily living and to the maintenance of a client's health and safety within his or her own home setting; and any other similar activity of daily living. (Bureau of Elder and Adult Services Policy Manual).

The state scores each elder requesting state subsidies based on their ability to function independently and that individual's access to other sources of funding (see below for additional information on funding). In order to qualify for congregate housing, an applicant must be a tenant in a Congregate Housing site approved for BEAS funding: be at least 60 years old; receive a minimum score of twelve on the functional assessment (which one state official described as the equivalent of 2-3 ADLs and/or IADLs, or fewer ADLs/IADLs with significant mental disabilities); and lack enough income, access to other public services, or support from informal sources to get needed help (BEAS Policy Manual).

### 3. **Elaboration. on Areas of Interest**

#### a. **Funding**

State expenditures in FY 1992 on Congregate Housing were \$568,000; \$3.7 million on Home Based Care; and \$2.1 million on the Medicaid Waiver Program (\$5.6 million with federal funding). Costs per individual were \$320 per month for Congregate Housing, \$401 for Home Based Care, and \$822 for the Medicaid Waiver Program. Individuals who meet medical criteria for Congregate Housing or Home Based Care contribute five percent of their income, plus three percent of their assets over \$8,000. Those utilizing the Medicaid Waiver contribute a copayment equivalent to the difference between their personal income and 125 percent of the poverty level.

#### b. **Concerns**

Some concern was expressed by state officials over Maine's funding methods. Only 20 percent of the state's appropriated funding goes to the mentally disabled, with the rest used to subsidize the state's elderly population. In addition, it was noted that the assessment tools should be fine tuned, so that reimbursement would reflect more appropriately an individual's financial needs. While the cap for Congregate Housing subsidies is at \$589/month, the cap for both Home Based Care and the Medicaid Waiver Program is \$2300/month (the state cap on per patient month nursing home subsidies). This may be viewed as an insufficient incentive to use Home Based Care or the Medicaid Waiver Program as a cost efficient alternative to Nursing Home Care.

## H. RHODE ISLAND

### 1. Program Overview

Rhode Island's assisted living program for the frail elderly is somewhat unique in that it is not run by the government. Although set up by an act of legislature, Rhode Island Housing and Mortgage Corporation (RIH) is a publicly owned entity which acts as the catalyst to carry out state programs and ideas. RIH's housing initiatives are financed by state monies filtered through RIH, including the operation of the state's section 8 housing program. While the corporation does not look to **become** a part of the Department of Health and Human Services, there is a concerted effort to coordinate efforts and avoid the duplication of services. In addition, although the state has input within the corporation, they do not have control: Rhode Island Housing is not the state's finance administration, but several state officials are mandated to sit on the RIH Board of Directors, the body which determines future direction and goals of state **assisted housing**.

*"It is a belief of the Foundations Program that a decrease in a person's ability to accomplish activities of daily living should not be reason to subject that person to an institutional setting. As such, the program intends to facilitate a person's right to 'age in place'. There are elderly persons who fall into the category of 'frail'. They are neither well enough to be independent in all of their functions, nor ill (hospitalized or institutionalized) enough to require nursing home care. .. The Foundations Program intends to bridge that gap with support enough to allow seniors to maintain their present living arrangements. It is estimated that 20-30 percent of the residents currently living in subsidized housing fall into the gap area. The Foundations Program will neither create a dependence among residents on supportive services nor an independence among residents from family and friends. The Foundations Program will provide balance to a person's daily activities."* ("Rhode Island Housing's Foundations of Senior Health Program: A Planning Document, March 1991").

### 2. Program Description

Rhode Island Housing 'implemented its Resident Services Program in November of 1986 in some of its existing developments to meet the needs the facilities' increasing population of elderly with diminished capacity. Over the years the Corporation has funded the development of, and oversees the management of 85 rental housing developments designated as elderly housing, which house elderly, disabled and handicapped persons.

(Background Information, Resident Services, Foundations of Senior Health Program.)

Program features include:

- Resident Services Coordinators provide residents with information and referral services (for social programs) and informal counseling.
- Other subsidized services include transportation to community events and meals.

### 3. **Elaboration on Areas of Interest**

Funding comes from federal, state, and private sources. The state's section 8 housing program, which RIH operates, receives HUD funding. At the state level, service partnerships with State Human Service Agencies constitute another source of funding, as do Municipal Tax Exemptions. And from the private sector, the RIH Trust for Supportive Services, established by an action of RIH's Board of Commissioner's, contributes \$75,000 per year to the program. It subsidizes individuals on a sliding scale depending upon their personal income (100 percent for those with incomes under \$550, 70 percent for incomes from \$550-999. and 60 percent for incomes above \$1000).

## I. **CONNECTICUT**

### 1. **Program Overview and Description**

According to one state official we interviewed with Connecticut's Department on Aging, "Assisted Living" is a fleeting and ambivalent term in Connecticut, and as a result the housing continuum has a gap in statutory based "real assisted living". What Connecticut does offer, however, is 'Congregate Housing' — a concept introduced in their state in the 1970s. This state subsidized elderly rental housing has the following features:

- 'No personal or medical services — this would require the homes to be licensed or certified, which is beyond the scope of the program;
- One hot meal per day, and one hour of housekeeping per week;
- Security systems in facilities.

The program was started in order to improve the availability and affordability of housing for the elderly in response to several concerns, including the population growth of elders in Connecticut who, it was felt, should be enabled to age in place: and the high and rapidly rising cost of nursing home care.

The program provides an alternative housing option to people 72 years or older who are not yet ready for nursing home care and can basically function independently, but do not want to live on their own,

## 2. **Elaboration on Areas of Interest**

### a. **Funding**

The rentals are state subsidized. and individual contributions can not exceed 30 percent of one's personal income. A state statute provides funds for subsidizing services, and also provides funding for the construction of new facilities (whose operations the state then oversees). The state's Rental Assistance Program (RAP) subsidizes the rents of individuals on a sliding scale. According to a state official with the Elderly Division of the Department of Housing, this triple subsidy, and the cost structuring in general, is a point of contention. While the cost of congregate living is believed to make sense on an individual basis, when compared to the cost,of nursing home care, the population which the program currently serves is seen as too **limited** and small to have a substantial impact on overall cost. One state official we interviewed argued that if the program were expanded to 'true assisted living' (Le., providing some level of personal or medical care), it could serve a much larger population, which could in turn reduce gross expenditures. Instead, the current program offers a limited spectrum of services (**which** might be more efficiently utilized on a community wide, rather than facility specific, level) to a small population with a rapid rate of turnover. In addition, the costs of renting a unit in this program is high when compared to living in one's own home and utilizing community resources. Therefore, for the past several years Connecticut has had trouble renting units.

### b. **New Initiatives**

A state official with the Department on Aging elaborated on state attempts to address these concerns. 'A two year grant allowed the DOH, the Connecticut Housing Finance Department and the University of Connecticut to collaboratively assess the probable benefit of adding "resident service coordinators" (RSCs) to the program. The analysis, which will be published in October, contends that the **RSCs** could be useful for among the following reasons:

- A major challenge in Connecticut's congregate living facilities is finding ways to ensure that residents have access to the services which they need and are available in the community (since they are not available in individual facilities).

The RSC would be responsible for bringing the services to the elderly or bringing the elderly to the services.

- The increased access to services which many frail elderly require, but are unavailable in the current assisted living program, would expand the population who could benefit from congregate housing. This would allow more of Connecticut's elderly population to age in place, and remain independent for a longer period of time.

Hence, a state official we interviewed contends that while the congregate housing program in Connecticut can realistically only serve those elderly with less than two ADLs, and therefore does not meet the needs of all those it was designed to serve, the addition of an RSC would expand the current program sufficiently to provide relief for a much larger portion of the frail elderly population.

## J. NEW HAMPSHIRE

### 1. Program Overview and Description

According to one state official we interviewed with the Department of Social Services/Division of Elderly and Adult Services, the state's only current attempt to address the needs of the frail elderly is the subsidization of congregate housing facilities which offer no personal or medical services; only a "community setting" for those who do not desire to live alone. The program was originally implemented in order to promote, "dignified life for elders in the state." This state official is currently working with the Housing Finance Authority to expand the services available to those in subsidized housing. However, supplemental services are purchased by DEAS from individuals or agencies: "The Division of Elderly and Adult Services- (DEAS) assists elderly and incapacitated adults by providing them a variety of social services" (Item 200, p. 9, Elderly and Adult Services Program Manual). These services include:

- Transportation
- Noon meal
- Referral/Information services and Case Management
- Adult Group Home Day Care, Adult In-Home Care, and Respite Care.

Services are provided in three different-program settings: Adult In-Home, Adult Protection, and Adult Alternate Living. Each program is associated with a specific goal, as follows:

### **Adult In-Home Program**

- Consists of coordinated social services aimed at maintaining and enhancing the ability of elderly/incapacitated adults to live safely in their own homes.
- For adults in independent living situations, achieving or maintaining self-sufficiency, preventing institutionalization, or preventing abuse, neglect or exploitation.

### **Adult Protection Program**

- Consists of coordinated social services aimed at safeguarding elderly/incapacitated adults who are found to be abused, neglected or exploited.
- Goals include remedying abuse, neglect or exploitation of elderly/incapacitated adults who are unable to protect their own interests.

### **Adult Alternate Living Program**

- Consists of coordinated social services aimed at assisting in the location/arrangement of shared home/nursing home placements for elderly/incapacitated adults, assisting such adults during placement, or helping such adults transfer to a different facility/form of care when appropriate.
- **Assisting in locating and/or arranging** for alternate placement for elderly/incapacitated adults, maintaining such adults during placement or assisting in the transfer to a different facility/form of care when appropriate.

#### **2. Elaboration on Areas of Interest**

##### **a. Assessments/Concerns**

According to the "Needs Assessment Survey of New Hampshire's Elderly", submitted for the State Committee on Aging (February, 1992), "It is assumed that the state's overall housing needs for individuals over the age of 60 will eventually center around the provision of supportive services. These are services which can be provided outside the institutional setting and allow individuals to remain independent. Currently, the state's housing plan, which is in the process of being written, is going to focus on congregate housing or housing which can offer a **certain** level of service provision."

Informally, an evaluation, offered by one state official involved in the Needs Assessment Survey of the program is mixed, and this official believes that success varies with the personal financial situation of each participant. While this official believes that those at

financial extremes are well served, middle income elders are trapped in 'income testing' which makes utilization of the program and its services difficult.

**b. Funding**

**New** Hampshire provides state funding (to supplement HUD funding) for congregate living facilities which are modeled after the federal CHCP program. Of the 160,000 elders in the state, 10,000 live in these units. The total budget of the program is \$14,000,000, with funding coming from the Social Security Block Grant (Title XIX), Title III of the Older Americans Act, and some straight state funding. In addition the social services purchased by the DEAS which are described above are funded by federal monies under Title XX of the Social Security Act and also by state funds (Elderly and Adult Services Program Manual).

**APPENDIX A**  
**OVERVIEW MATRIX OF BOARD AND CARE FACILITIES BY STATE**



	LICENSING AGENCY	LICENSE CATEGORY	TYPE OF FACILITIES WITHIN THE LICENSE CATEGORY
ALABAMA	• Department of Public Health Division of Licensing and Certification	Domiciliary Care Facility	Small Group Institutional Personal Care
	• Department of Mental Health and Mental Retardation Office of Non-Institutional Certification	Community Program (certified)	Foster Home Group Home Residential Care Home Supervised Community Living Home Semi-Independent Living Facility
	• Department of Human Resources Division of Adult Services	Adult Foster Home	Adult Foster Home
ALASKA	• Department of Health and Social Services Division of Family and Youth Services	Adult Residential Care Facility	Adult Residential Care Facility
		Adult Foster Home	Adult Foster Home
ARIZONA	• Department of Health Services Division of Emergency Medical Services and Health Care Facilities Office of Health Care Licensure	Supervisory Care Home	Supervisory Care Home
		Residential Care Home	Residential Care Home
		Adult Foster Care Home	Adult Foster Care Home
ARIZONA	• Department of Economic Security Division of Developmental Disabilities	Residential Facility	Residential Facility
		State-Operated Program	Group Home Apartment Cluster
		Behavioral Health Residential Facility	Behavioral Health Residential Facility
ARIZONA	• Department of Health Services Community Behavioral Health Licensure	Behavioral Health Residential Facility	Behavioral Health Residential Facility
		Behavioral Health Residential Facility	Behavioral Health Residential Facility
ARKANSAS	• Department of Human Services Division of Economic and Medical Services Office of Long-Term Care	Residential Care Facility	Residential Care Facility
		Community Program	Community Program
CALIFORNIA	• Department of Social Services Community Care Licensure	Residential Care Facility	Adult Residential Facilities Residential Care Facilities for the Elderly
		Personal Care Boarding Home	Personal Care Boarding Home
COLORADO	• Department of Health Division of Health Facilities Regulation	Habilitation Residential Service	Adult Residential Service Moderate Supervision Group Home Specialized Group Home
		Non-Facility Based Program	Non-Facility Based Program
		Host Home	Host Home

	LICENSING AGENCY	LICENSE CATEGORY	TYPE OF FACILITIES WITHIN THE LICENSURE CATEGORY
CONNECTICUT	• Department of Health Services Division of Hospital and Medical Core	Residential Home	Home for the Aged Family Core Home
	• Department of Mental Retardation Division of Quality Assurance	Community Living Arrangement	Group Home Semi-Independent living
		State-Operated Program Community Training Home	Community Living Arrangement Community Training Home
DELAWARE	• Department of Health and Social Services Division of Public Health Office of Health Facilities Licensing and Certification	Residential Facility	Rest (Residential) Home Rest (Family Care) Home Neighborhood Home
DISTRICT OF COLUMBIA	• Department of Consumer and Regulatory Affairs Services Facility Regulatory Administration	Community-Based Residential Facility	Community Residence Facility
FLORIDA	• Department of Health & Rehabilitative Services Office of Licensure and Certification ACIF Unit	Adult Congregate Living Facility	Adult Congregate Living Facility
	• Department of Health & Rehabilitative Services Office of Regulation and Health Facilities	Residential Treatment Facility for the Mentally Ill	Level 1 (Group Home) Level 2 (Group Home) Level 3 (Cluster Apartments) Level 4 (Semi-Independent Living) Level 5 (Semi-Independent Living)
	• Department of Health & Rehabilitative Services Office of Aging and Adult Services	Adult Foster Home	Adult Foster Home
	• Department of Health & Rehabilitative Services Office of Developmental Services Program	Residential Home	Foster Care Home Group Home Residential Habilitation Center
GEORGIA	• Department of Human Resources Environmental Section PCH Program Unit	Personal Care Home	Family Personal Care Homes Group Personal Care Homes Congregate Personal Care Homes
HAWAII	• Department of Health Division of Medical Health Services Hospital and Medical Facilities Branch	Adult Residential Care Home	Adult Residential Care Home
IDAHO	• Department of Health and Welfare Bureau of Facility Standards	Residential Care Home	Residential Care Home
		Adult Foster Care Home	Adult Foster Care Home

	LICENSING AGENCY	LICENSE CATEGORY	TYPE OF FACILITIES WITHIN THE LICENSURE CATEGORY
ILLINOIS	<ul style="list-style-type: none"> <li>Department of Public Health Office of Health Regulations Division of Health Care Facilities and Programs Standards Development Section</li> </ul>	Shelter Care Facility	Shelter Care Facility
		Community Living Facility	Community living Facility
	<ul style="list-style-type: none"> <li>Department of Mental Health and Developmental Disabilities Division of Developmental Disabilities</li> </ul>	Community-Based Facility	Community Residential Alternative Home Individual Program Specialized Home Placement
		Community Integrated Living Arrangement	Community Integrated Living Arrangement
INDIANA	<ul style="list-style-type: none"> <li>Board of Health Bureau of Quality Assurance Division of Health Facilities</li> <li>Department of Mental Health Division of Residential Services</li> </ul>	Residential Care Facility	Residential Care Facility
		Community Residential Facility Alternative Family Care Home for Adults	Community Residential Facility & motive Family Care Home for Adults
IOWA	<ul style="list-style-type: none"> <li>Department of Inspections and Appeals Division of Health Facilities</li> <li>Department of Human Services Division of Mental Health, Mental Retardation and Developmental Disabilities Standards and Accreditation Section</li> </ul>	Residential Care Facility	Residential Care Facility
		Community Supervised Apartment Living Arrangement	Community Supervised Apartment Living Arrangement
	<ul style="list-style-type: none"> <li>Department of Human Services Division of Social Services Bureau of Alternative Living Services</li> </ul>	Family Life Home	Family Life Home
KANSAS	<ul style="list-style-type: none"> <li>Department of Health and Environment Bureau of Adult and Child Care Facilities</li> <li>Department of Social and Rehab Services Commission on Adult Services</li> </ul>	Adult Care Home	Personal Care Home Boarding Care Home
		Resident Care Facility Community Living Program	Resident Care Facility Group Home
KENTUCKY	<ul style="list-style-type: none"> <li>Cabinet for Human Resources Department of Health Services Division of Licensing and Regulation</li> </ul>	Residential Care Home	Family Care Home Personal Care Home Group Care Home
LOUISIANA	<ul style="list-style-type: none"> <li>Department of Health and Hospitals Health Standards Division</li> </ul>	Child Residential Facilities	Community Homes Group Homes Residential Homes
		Adult Residential Facilities	Adult Residential Facilities Supervised Independent Living
	<ul style="list-style-type: none"> <li>Office of Mental Retardation Substitute Family Care</li> </ul>	Adult Foster Care Home	Adult Foster Care Home

	LICENSING AGENCY	LICENSE CATEGORY	TYPE OF FACILITIES WITHIN THE LICENSE CATEGORY
MAINE	• Department of Human Services Division of Residential Care	facilities	Adult Foster Homes Boarding Care Facilities
	• Bureau of Mental Health	Facilities for the Mentally Ill	Halfway House Group Homes Boarding Homes
MARYLAND	• Department of Health and Mental Hygiene Office of Licensing and Certification Programs	Facilities	Domiciliary Care Homes Group Homes for the Mentally Disabled Alternative living Units Independent family Core Group Homes Residential Rehabilitation Programs Psychiatric Group House
	• Office on Aging	Group Senior Assisted Housing	Group Senior Assisted Housing for the Elderly
	• Department of Human Resources Office of Adult Services	Certified Adult Residential Environment Homes	CARE Homes
MASSACHUSETTS	• Department of Public Health Division of Health Care Quality	Long-Term Care Facilities	Resident Care Facilities - Level IV Community Support Facilities
	• Department of Mental Retardation Licensing Division	Community Residential Facilities	Community Residence Services Staffed Apartment Cooperative Apartment Alternative Programs
	• Department of Mental Health Licensing Division	Adult Community Mental Health Programs	Community Residence Limited Group Residence Apartment Program Limited Apartment Program Alternative Living Program
MICHIGAN	• Department of Public Health Bureau of Health Facilities	Homes for the Aged	Homes for the Aged
	• Department of Social Services Bureau of Regulatory Services	Adult Foster Care Facilities	Small Home Small Group Home Large Group Home Congregate
MINNESOTA	• Department of Health Division of Health Resources	Boarding Care Homes Supervised Living Facilities	Boarding Care Home Supervised Living Facility
	• Department of Human Services	Adult Foster Care Homes	Adult Foster Care Homes

	LICENSING AGENCY	LICENSE CATEGORY	TYPE OF FACILITIES WITHIN THE LICENSURE CATEGORY
MISSISSIPPI	<ul style="list-style-type: none"> <li>• Department of Health Health Facility Licensing</li> <li>• Department of Mental Health Division of Accreditation and Licensure</li> </ul>	<p>Personal Care Homes</p> <p>Community Residential Programs</p>	<p>Personal Care Homes</p> <p>Group Homes</p>
MISSOURI	<ul style="list-style-type: none"> <li>• Department of Social Services Division of Aging - Licensure Unit</li> <li>• Department of Mental Health Bureau of Licensure</li> </ul>	<p>Residential Facilities</p> <p>Mental Health Facilities</p>	<p>Residential Care Facility I Residential Care Facility II</p> <p>Residential Care Center Group Care Home (MR/DD) MI Group Home (Adult) MR Foster Care Home MI Foster Care Home (Adult) MI Group Home Semi-Independent Apartment Living</p>
MONTANA	<ul style="list-style-type: none"> <li>• Department of Health &amp; Environmental Services Licensing and Certification</li> <li>• Department of Family Services</li> </ul>	<p>Personal Care Facilities</p> <p>Homes</p>	<p>Personal Care Facilities</p> <p>Adult Foster Family Care Home Community Homes for the Developmentally Disabled Community Homes for the Physically Disabled</p>
NEBRASKA	<ul style="list-style-type: none"> <li>• Department of Health Health Facilities Standards</li> <li>• Department of Social Services Medical Services Division</li> </ul>	<p>Facilities</p> <p>Adult Family Homes</p>	<p>Residential Facilities Domiciliary Facilities Centers for the Developmentally Disabled Mental Health Centers</p> <p>Adult Family Homes</p>
NEVADA	<ul style="list-style-type: none"> <li>• State Division of Health Bureau of Regulatory Services</li> </ul>	<p>Residential Facilities for Groups</p>	<p>Facilities with Seven or More Residents Facilities with Less Than Seven Residents</p>
NEW HAMPSHIRE	<ul style="list-style-type: none"> <li>• Division of Public Health Services Bureau of Health Facilities Administration</li> <li>• Department of Mental Health and Developmental Services</li> </ul>	<p>Sheltered Care Facilities</p> <p>Shared Homes</p> <p>Community Residences</p>	<p>Sheltered Care Facilities/Shared Homes Sheltered Care Facilities/Community Residences Community Residences Shared Homes</p> <p>Community Residences</p>

NEW JERSEY	LICENSING AGENCY	LICENSE CATEGORY	TYPE OF FACILITIES WITHIN THE LICENSURE CATEGORY
	<ul style="list-style-type: none"> <li>Department of Community Affairs Bureau of Rooming and Boarding House</li> </ul>	Boarding Homes	Type C Type D
	<ul style="list-style-type: none"> <li>Department of Health Bureau of Health Facilities</li> </ul>	Residential Health Care Facilities	Residential Health Care Facilities
	<ul style="list-style-type: none"> <li>Department of Human Services Division of Developmental Disabilities</li> </ul>	Community Residences	Family Core Homes Group Homes Skill Development Homes Provider Agency Apartments
	<ul style="list-style-type: none"> <li>Division of Mental Health and Hospitals Bureau of Licensing and Inspection</li> </ul>	Community Residences	Group Homes Family Care Homes
NEW MEXICO	<ul style="list-style-type: none"> <li>Health and Environment Department Health Facilities &amp; Occupational Licensing</li> </ul>	Shelter Care	Adult Residential Shelter Care Community Residential facility for Adult DD Residential Treatment Homes
		Boarding Home	Board and Care Home Family Core Home
NEW YORK	<ul style="list-style-type: none"> <li>Department of Social Services Division of Adult Services</li> </ul>	Adult Care Facilities	Adult Home Enriched Housing Program Family-type Home Residence for Adults
	<ul style="list-style-type: none"> <li>Department of Mental Health Residential Services</li> </ul>	Community Residences	Supervised Living Intensive Supported Program
	<ul style="list-style-type: none"> <li>Department of Mental Retardation</li> </ul>	Community Residences	Family Care Home Supervised Community Residences Intensive Supported Program
NORTH CAROLINA	<ul style="list-style-type: none"> <li>Department of Human Resources Division of Facility Services</li> </ul>	Domiciliary Homes	Family Care Homes Homes for the Aged and Disabled
		Group Homes	Group Home for MR/DD w/ Behavioral Disorders Group Homes for MR/DD Adults Psychosocial Rehab Facilities for Chronically MI Group Homes for Adult and Elderly MI Alternative Family Living Supervised Independent Living
		Group Homes	
NORTH DAKOTA	<ul style="list-style-type: none"> <li>Health and Laboratories Department Health Facilities Division</li> </ul>	Basic Care Facilities	Basic Care Facilities
	<ul style="list-style-type: none"> <li>Department of Human Services Developmental Disabilities Division</li> </ul>	Congregate Care Facilities Semi-Independent Living Programs	Congregate Care Facilities Minimally Supervised Living Arrangements Supported Living Arrangements
	<ul style="list-style-type: none"> <li>Department of Human Services Division of Mental Health Services</li> </ul>	Community Residential Services Semi-Independent Living Programs	Community Residential Services Supportive Living

	LICENSING AGENCY	LICENSE CATEGORY	TYPE OF FACILITIES WITHIN THE LICENSURE CATEGORY
OHIO	• Department of Health Licensing Division	Rest Home	Rest Homes Homes for the Aged - Rest Home Component
	• Department of Human Services Licensing Division	Group Home	Adult Foster Care Facilities or Adult Group Homes
	• Department of Mental Retardation and Developmental Disabilities Licensing Division	Community Facilities and Developmental Centers	Foster Family Homes Family Homes Group Homes Specialized Care Semi-Independent Living
	• Department of Mental Health Licensing Division	Semi-Independent Living Programs  Residential Care Facility for the Mentally Ill	Type A Facilities Type B Facilities Type C Facilities Type D Facilities
OKLAHOMA	• Health Department Long Term Care Division/ Medical Facilities Services	Residential Care Home	Residential Care Home
	• Health Department Licensure and Certification Division	Group Homes for Developmentally Disabled and Physically Handicapped Adults	Class I Group Home Class II Group Home
	• Department of Mental Health and Substance Abuse Services	Semi-Independent Living Programs	Supervised Apartments
	• Human Services Department Developmental Disabilities Services	Foster Homes	Foster Homes
OREGON	• Department of Human Resources Mental Retardation and Developmental Disabilities Services	Residential Facility Adult Non-Relative Foster Homes	Residential Facility Adult Non-Relative Foster Homes
	• Department of Human Resources Mental Health Division	Community Residential Care Facility Adult Residential Care Facility  Adult Foster Home Semi-Independent Living Programs	Community Residential Care Facility Homes Centers  Semi-Independent Living Facilities
	• Department of Human Resources Senior and Disabled Services	Residential Care Facility	Residential Care Home Residential car. Center Adult Foster Home Relative Foster Home

	LICENSING AGENCY	LICENSE CATEGORY	TYPE OF FACILITIES WITHIN THE LICENSURE CATEGORY
PENNSYLVANIA	• Department of Public Welfare Office of Social Programs Division of Personal Care Homes	Personal Care Board Homes	Personal Care Board Homes
	• Department of Public Welfare Office of Mental Retardation	Community Residential Services Family Living Facility Semi-Independent Living Programs	Small Large Family Living Facility Minimal Supervision Facilities Semi-Independent living Facilities
	• Department of Public Welfare Office of Mental Health	Community Residential Rehabilitation Facility	Community Residential Rehabilitation Services (CRRS) Full-care CRRS for Adults Partial Care CRRS
RHODE ISLAND	• Department of Health Division of Facilities Regulation	Sheltered Care Facility	Sheltered Care Facility for Adults
	• Department of Mental Health, Retardation and Hospitals Office of Licensure and Standards	Community Residences	Mental Health Facilities and Programs Mental Retardation Facilities and Programs Group Home Apartments Semi-Independent Living Apartments
SOUTH CAROLINA	• Department of Health and Environmental Control Division of Health Licensing	Semi-Independent Living Programs Community Residential Care Facilities	Community Residential Care Facilities
	• Department of Mental Retardation	Supervised Apartments	Independent Living Supervised Living Program (SLP I) Supervised Living Program (SLP II)
SOUTH DAKOTA	• Department of Social Services Adult Services and Aging	Adult Foster Homes Supervised Living Facility	Adult Foster Homes Supervised Living Facilities
	• Department of Human Services Developmental Disabilities and Mental Health Office	Residential Facilities Foster Homes Semi-Independent Living Programs	Community Residential Facilities Community Group Residential Facilities Foster Homes Supervised Apartments Supervised Apartment Facilities Uncertified Apartment Living Arrangements Group Homes
TENNESSEE	• Department of Health and Environment Division of Health Care Facilities	Homes for the Aged	Homes for the Aged
	• Department of Mental Health and Mental Retardation Licensure Office	Residential Facilities Semi-Independent Living Programs Group Homes	Residential Habilitation Facilities Supportive Living Facilities Boarding Home Facilities Supported Semi-Independent Living Level II Group Home Level III Group Home Level IV Group Home
TEXAS	• Department of Health Quality Standards Division	Personal Care Home Custodial Care Homes	Personal Care Home Type A Personal Care Home Type B Custodial Care Homes
	• Department of Human Services Licensing Division	Adult Foster Care	Adult Foster Care Homes
	• Texas Department of Mental Health and Mental Retardation	Community Residential Programs	Group Homes Apartment Living

	LICENSING AGENCY	LICENSE CATEGORY	TYPE OF FACILITIES WITHIN THE LICENSURE CATEGORY
UTAH	• Department of Health Bureau of Health Facility Licensure	Residential Care Facilities	Residential Care Facilities
	• Department of Social Services Office of Licensing	Facilities	Adult Foster Care Group Homes Residential Support Programs Residential Treatment Programs
VERMONT	• Department of Rehabilitation and Aging Division of Licensing and Protection	Residential Care Homes	Level III Residential Care Home Level IV Residential Care Home
	• Community Mental Health and Mental Retardation Agencies	Semi-Independent Living Programs Group Homes	Supervised Apartments Group Homes
VIRGINIA	• Department of Social Services Division of Licensure and Certification	Homes for Adults	Homes for Adults
	• Department of Mental Health, Mental Retardation and Substance Abuse Services Office of Licensure	Residential Facilities Supported Residential Programs	Residential Facilities Supervised Apartments Supported Independent Living Settings
WASHINGTON	• Department of Social and Health Services	Boarding Homes Semi-Independent Living Programs	Boarding Homes Community Tenant Support Providers
WEST VIRGINIA	• Department of Health Personal Care Homes Division	Personal Care Homes Adult Group Homes	Personal Care Homes Family Adult Group Homes Non-Family Adult Group Homes Group Residential Facilities Registered Unlicensed Personal Care Homes
		Group Residential Facilities Registered Unlicensed Personal Care Homes	
WISCONSIN	• Department of Health and Social Services Division of Community Services	Community Based Residential Facilities	Small Medium Large
		Semi-Independent Living Programs	Supported Living Arrangements Supervised Apartments
WYOMING	• Department of Health and Social Services Division of Health and Medical Services	Boarding Homes	Boarding Homes
	• Department of Health and Social Services Division of Mental Health	Adult Foster Homes Semi-Independent Living Programs	Adult Foster Homes Independent Living Apartments Independent Living Complex



**APPENDIX B**

**LIST OF PARTICIPANTS FOR THE ASPE/NASHP MEETING ON  
ASSISTED LIVING FOR THE FRAIL ELDERLY**

**November 20, 1992**



## **LIST OF PARTICIPANTS**

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**BIBLIOGRAPHY**



## BIBLIOGRAPHY

- Advisory Council of Social Security. The Financing and Delivery of Long-Term Care Services: A Review of Current Problems and Potential Solutions. Washington, D.C.: December 1991.
- Altman, Irwin., M. Powell Lawton and J. F. Wohlwill. Elderly Persons and the Environment. 7 New York: Plenum Press, 1984.
- Altman, William M. and Patricia A. Parmelee. "Discrimination Based on Age: The Special Case of Institutionalized Aged." Handbook of Psychology and the Law. New York: Springer-Verlag, 1991.
- Altman, William M., et. al. "Autonomy, Competence and Informed Consent in Long Term Care: Legal and Psychological Perspectives." Villanova Law Review (April 1992).
- American Association of Homes for the Aging and Ernst and Young. Continuing Care Retirement Communities: An Industry in Action, Analysis and Demographic Trends. Washington, D.C: AAHA, 1989.
- American Association of Retired Persons. Understanding Senior Housing for the 1990s. Washington, D.C.: AARP, 1990.
- American Council of Life Insurance, Health Insurance Association of America. Health Care and Finances: A Guide for Adult Children and Their Parents. Washington, D.C.: American Council of Life Insurance Association of America, Health Insurance Association of America, 1987
- Anderson, E.A., A. Chen and R. C. Hula. "Housing Strategies for the Elderly: Beyond the Ecological Model." Journal of Housing for the Elderly 2 (1984): 47-60.
- Applebaum, R. "The Evaluation of the National Long Term Care Demonstration: 9. The Effect of Channeling on Mortality, Functioning, and Well-Being." Health Services Research 23(1) (April 1988): 143-160.
- Assistant Comptroller General of the United States. An Aging Society: Meeting the Needs of the Elderly While Responding to Rising Federal Costs. (HRD-86-135), Washington, D.C.: U.S. General Accounting Office, September 1986.
- Assisted Living Association of America. Fact Sheet : Assisted Living. Virginia: ALFAA, 1991.
- Baker, P. and M. Prince. " Supportive Housing Preferences Among the Elderly." in Homes Not Houses: Options in Housing for the Elderly, ed. L. Pastalan. New York: The Haworth Press, 1990.
- Banton, J. and A. Luui. "New Coinsurance Programs for Nursing Homes and Assisted Living Facilities." Contemporary Long Term Care 12(5) (April 1989): 30-33.

- Barney, K.F. "From Ellis Island to Assisted Living: Meeting the Needs of the Older Adults from Diverse Cultures." American Journal of Occupational Therapy 45(7) (July 1991): 586-93.
- Bear, M. "Use of Adult Congregate Living Facilities: Impact on Network Characteristics on Health Severity and Time of Entry." Adult Foster Care Journal 2(3) (Fall 1988): 158-1 75.
- Beland, F. "The Decision of Elderly Persons to Leave Their Homes." The Gerontoloaist 24(2) (1984): 179-1 85.
- Benedict, R., "Integrating Housing and Services for Older People." in Conoreate Housino For Older People: An Uraent Need, A Growina Demand, eds. W. Donahue, M. Thompson and D. Curren. Washington, D.C.: U.S. Government Printing Office, 1977.
- Benjamin, A. and R. Newcomer. "Board and Care Housing: An Analysis of State Differences." Research on Aging 8:3 (1986).
- Berg, S., et al. "Institutional and Hospital-Based Long-Term Alternatives," The Gerontologist 28(16) (1988): 825-9.
- Bernstein, J. "Who Leaves - Who Stays: Residency Policy In Housing for the Elderly." The Gerontoloaist 22 (1982): 305-313.
- Bishop, C.E. "Containing Costs for Lifetime Long-Term Care Coverage: Use of Nursing Care in Continuing Care Retirement Communities." Advances in Health Economics and Health Services Research (September 1988): 149-1 62.
- Bishop, C.E., "Features of Lower Cost Continuing Care Retirement Communities: Learning from a Cost Analysis." in Optimizing Housing for the Elderly: Homes Not Houses, ed. L. Pastalan. New York: The Hayworth Press, 1990.
- Bishop, C. E. "Living Arrangement Choices of Elderly Singles: Effects of Income and Disability." Health Care Financing Review 7(3) (Spring 1986): 65-73.
- Blanford, A., Chappell, N., and Horne, J. "Can the Elderly Be Differentiated by Housing Alternatives?" in Homes not Houses: Optimiting Housing for the Elderly, ed. L. Pastalan. 35-51. The Hayworth Press, 1990.
- Blatter, A.Z. and E. Marty-Nelson. "An Overview of the Low-Income Housing Tax Credit." in Zoning and Planning Law Handbook ed. Mark S. Dennison. 445-468. New York: Clark, Boardman Company, Ltd., 1989.
- Bonfield, T., "Elder Care: Dealing with a Dilemma." Cincinnati Business Courier 7(42) (Febuary 25th 1991): 2,3.
- Borra, Pier C. "Assisted Living: A Timely Alternative." Provider 12 (December 1986): 14-1 7.
- Bowe, J. "Drawing a Bead on Assisted Living." Contemporary Long Term Care 13 (46) (July 1990): 47.

- Braun, K.L. and C. L. Rose. "The Hawaii Geriatric Foster Care Experiment: Impact Evaluation and Cost Analysis." The Gerontoloaist 26 (May 1986): 516-524.
- Brennan, Penny L., Rudolph H. Moos and Sonne Lemke. "Preferences of Older Adults and Experts for Physical and Architectural Features of Group Living Facilities." The Gerontologist (1988): 84-97.
- Brock, K. "Elderly Population Up, but Nursing Home Beds Go Empty." The Business Journal - Portland 7(18) (July 2, 1990): s.1,4.
- Brockett, Ralph G. "Issues in Promoting Adult Foster Care as an Option to Institutionalization." Journal of Housina for the Elderly 29(1) (Spring 1984): 51-61.
- Brothers, Sharon and Jorgenson, Roger H. "Senior Assisted Living : A Hospital Niche?" Health Care Strategic Manaaement (December 1989):1 8-18.
- Brown, Randall S. "The Evaluation of the National Long Term Care Demonstration: 2. Estimation Methodology." Health Services Research 23(1): 23-50.
- Buland, Francois, "Living Arrangements Preferences Among Elderly People." The Gerontoloaist 27(6) (1987): 797-803.
- Butterfield, D. and S. Weidemann, "Housing Satisfaction for the Elderly." in Housina the Aaed: Desian Directives and Policy Considerations, eds. V. Regnier and J. Pynoos. 133-1 52. Elsvier: New York. 1987.
- Capitman, John A. "Present and Future Roles of HUD Programs in Board and Care Financing." in Preserving Independence. Supporting Needs, eds. Marilyn Moon, et al. 77-92. AARP, Public Policy Institute, 1989.
- Cargano, George G. and Peter Kemper. "The Evaluation of the National Long Term Care Demonstration: 1. An Overview of the Channeling Demonstration and Its Evaluation." Health Services Research 23(1) (April 1988): 1-22.
- Carp, F.M. "Importance of Improved Living Environment on Health and Life Expectancy." The Gerontoloaist 17 (1977): 242-248.
- Carp, F.M. and D. L Christensen. "Technical Environmental Assesment Predictors of Residential Satisfaction." Research on Aaing. 8(2) (1986): 269-287.
- Carp, F.M. "User Evaluation of Housing for the Elderly." The Gerontologist 16 (1976): 102-1 11.
- Chairman of the Subcommittee on Health and Long-Term Care, House. Select Committee on Aging. Board and Care Homes in America: A National Traaedv, 101-1 17. Washington, D.C.: US. Government Printing Office, March 1989.

- Chairman of the Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging. The 1988 National Survey of Section 202 Housing for the Elderly and Handicapped 101-736. Washington, D.C.: U.S. Government Printing Office, December 1, 1989.
- Chambliss, B. Creating Assisted Living Housing, Denver, Colorado: Association of Homes and Services for the Aging, 1987.
- Chen, Alexander. "Paying for Board and Care." in Preserving Independence. Supporting Needs, eds. Marilyn Moon, et al. 61-76. AARP, Public Policy Institute, 1989.
- Christianson, Jon B. "The Evaluation of the National Long Term Care Demonstration: 6. The Effect of Channeling on Informal Caregiving." Health Services Research 23(1): 99-118.
- Clements, J. "Retirement Complexes Hit Chilly Economy in NE." Boston Business Journal 11(32) (September 30 1991): s1:6.
- Cohen, E. "The Elderly Mystique: Constraints on the Autonomy of the Elderly with Disabilities." The Gerontologist 28 (1988): 24-31.
- Cole, R. "Class, Culture and Coercion." Generations Issue on "Coercive Placement of Elders: Protection or Choice?" (Summer 1987): 9-15.
- Coleman, Nancy and Joan Fairbanks. "Licensing and New Board and Care for the Elderly." St. Louis University Public Law Review 10 (1991): 521-530.
- Commission on California State Government. Community Residential Care in California: Community Care as a Long Term Care Service. Sacramento CA: Commission on California State Government Organization and Economy, 1983.
- Congressional Research Services. Medicaid Source Book: Background Data and Analysis. For the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives. Washington, D.C.: U.S. Government Printing Office, November 1988.
- Conley, Ronald W. "Federal Policies in Board and Care." in Preserving Independence. Supporting Needs, eds. Marilyn Moon, et al. 41-60.
- Connerly, E. "Housing Trust Funds: New Resources for Low-Income Housing." Journal of Housing 47 (1990): 2.
- Corson, Walter, Thomas-Grannemann and Nancy Holden. "The Evaluation of the National Long Term Care Demonstration: 5. Formal Community Services under Channeling." Health Services Research 23(1) (April 1988): 83-98.

- Cranston and Gonzales. "National Affordable Housing Act" in the United States Code Congressional and Administrative News, 101 st Congress-Second Session 1990. 8. Legislative History: Public Laws 101-625 to 101-650. St. Paul Minnesota: West Publishing co., 1990.
- Cronin, R.C., Drury, M.J. and F.E. Gragg. An Evaluation of the FmHA-AoA Demonstration Proaram of Congregate Housing in Rural Areas, Final Report. Washington, D.C.: American Institutes for Research, 1983.
- DeReus, M. Servina the Elderly: Securing Financing. San Francisco, California: Backen, Arrigoni & Ross, Inc., 1987.
- Department of Housing and Urban Development. Proarams of HUD. HUD-214-PA(17) Washington, D.C.: HUD, October 1989.
- Department of Housing and Urban Development, Office of Assistant Secretary for Housing. "Part **232**- Mortgage Insurance for Nursing Homes, intermediate Care Facilities, and Board and Care Homes." Code of Federal Reaulations 24 (April 1992): **541-571**.
- Department of Housing and Urban Development, Office of Assistant Secretary for Community Planning and Development. "Section 312 Rehabilitation Loan Program, Announcement of Funding Awards for Loans Exceeding \$200,000." Federal Reaister 57(29) (February 12 1992): 5164-5.
- Department of Housing and Urban Development. "Supportive Housing for the Elderly." Federal Renister 56(113) (June 12 1991): 27104-2711 Q.
- Dill, Ann E. P. "The Case of George Sellers: A Safe Plan." Generations. Issue on "Coercive Placement of Elders: Protection or Choice? (Summer 1987): 48-53.
- Dittmar, Nancy. "Facility and Resident Characteristics of Board and Care Homes for the Elderly." in Preservino Independence Supporting Needs, eds. Marilyn Moon, et al. AARP, Public Policy Institute, 1989.
- Dittmar, N., G. Smith, J. Bell, C. Jones and D. Manzanares. Board and Care for Elderly and Mentally Disabled Populations: Final Report. Vol. 1. Denver: Denver Research Institute, Social Systems Research and Evaluation Division, University of Denver, 1983.
- Dluhy, Milan J. The Demographics of Older America: A Data Sourcebook. North Miami, Florida: Florida International University, October 1987.
- Dobkin, Leah. The Board and Care Svstem: A Regulatory Jungle. Washington, D.C. : AARP, Consumer Affairs Department, 1989.
- Dobkin, Leah. "If You Build it, They May Not Come." Generations. (Spring 1992).

- Donabedian, Avedis. "Quality and Cost: Choices and Responsibility." Inquiry 25 (Spring 1988): 173-190.
- Dubler, Nancy Neveloff. "Introduction." Generations Issue on "Coercive Placement of Elders: Protection or Choice?" (September 1987): 6-8.
- Early, Mary Ellen K. "Housing for the Elderly Financing Options." Journal of Housing for the Elderly 5(1) (1988): 51-66.
- Edwards, J. "Housing Elderly Promises Profits," Arizona Business Gazette. 90(38) September 1991: S1: 1.
- Evans, Dennis A., et al. "Prevalence of Alzheimer Disease in a Community Population of Older Persons." Journal of American Medical Association 262(18) (November 1984).
- Feder, Judith, William Scanlon, Jennifer Edwards and Jody Hoffman. "Board and Care: Problem or Solution?" in Preserving Independence Supporting Needs, eds. Marilyn Moon, et al. 27-40. AARP, Public Policy Institute, 1989.
- Florida State Department of Health and Rehabilitative Services: Deputy Secretary for Programs. Community Care for the Elderly Summary Report: FY 1985-1986 to FY 1989-1990. Tallahassee, FL. June, 1991.
- Florida State Department of Health and Rehabilitative Services. Adult Congregate Living Facilities Program Description. Tallahassee, FL. September, 1992.
- Florida State Department of Health and Rehabilitative Services. Adult Congregate Living Facilities Rule and Law: Chapter 10A-5, F.A.C. and Chapter 400, Part II, Florida Statutes. Tallahassee, FL. October, 1992.
- Florida State Department of Health and Rehabilitative Services: Office of Evaluation and Management Review. Adult Congregate Living Facilities Rate Study. Tallahassee, FL.
- Forrest, Richard and Mary Forrest. Retirement Living: A Guide to Housing Alternatives. New York: Facts on File, 1991.
- Friedman, Emily. Health Care for the Aged: What's Being Done? What Should Be Done? Chicago: Society for Healthcare Planning and Marketing of the American Hospital Association, 1988.
- Fulton J.P., S. Katz, S.S. Jack and G.E. Hendershot. "Physical Functioning of the Aged United States, 1984." Vital and Health Statistics. 10(167) DHHD Pub. No.(PHS) 89-1595. Washington D.C.: U.S. Government Printing Office, March 1989.
- Gaberlavage, G. Social Services to Older Persons under the Social Services Block Grant. Washington, D.C.: Public Policy Institute, American Association of Retired Persons, 1987.

- Gayda, K. and L. Heumann. The 1988 National Survey of Section 202 Housing for the Elderly and Handicapped. House Select Committee on Aging, Subcommittee on Housing and Consumer Interests Comm. Pub. No. 101-736. Washington, D.C. : U.S. Government Printing Office, 1989.
- Gelwicks, L. E. and M. B. Dwight. "Programming for Alternative and Future Models." in Congregate Housing for Older People: A Solution for the 1980's, eds. R.D. Chellis, J. F. Seagle and B. M. Seagle. Lexington, Massachusetts: Lexington Books, 1982.
- General Accounting Office. Lona Term Care Needs: Projected Needs of the Aaina Baby Boom Generation. HRD-91-86. Report to the Honorable William S. Cohen, Special Committee on Aging, U.S. Senate, 1991.
- Gillespie, Ann E. and Katrinka S. Sloan. Housing Options for Older Adults. ABC-CLIO, 1990.
- Gonzales, Cdmmittee on Banking, Finance and Urban Affairs. Housing and Community Development Act 1990.101459. Washington, D.C.: US. Government Printing Office, June 21 1991.
- Goodman, John, "Residential Care Communities Integrating Residents Needs," Provider, 17(1): 47-48, January 1991.
- Govoni, S. J.. "Nursing Homes Come of Age." Financial World. 154 16(3) (June 26, 1985).
- Guggenheim, J. "Alternate Financing." Journal of Housing 45: (April 1988).
- Guggenheim, J. "Using Tax Credits: Financing Rehabilitation." Journal of Housing 45 (April 1988): 189-1 91.
- Gutman, Gloria M. "Issues and Findings Related to Multi-Level **Accomodation** for Seniors." Journal of Gerontology 33(4): (1978): 592-600.
- Halbrook, Al. "Financing Senior Living and Long-term Care Developments." Health Care Outlook (Coopers and Lybrand newsletter) (Winter 1992).
- Hancock, Judith Ann. Housing the Elderly. New Jersey: The Center for Urban Policy Research, 1987.
- Harless, Sandy D. "The Medicaid Home and Community Care Options Act: How will it Affect the Assisted Living Industry?" Retirement Housing Report 5 (7) (March 1991): 5-7.
- Harrington, Charlene, Steve Preston and Susan Koch Madden. "Revised Trends in States' Nursing Home Capacity." Health Affairs 11(2) (Summer 1992): 170-1 80.
- Hartwigsen, G., "The Appeal of the Life Care Facility to the Older Widow." Journal of Housing for the Elderly 2(4)(1984/85): 63-75.

- Harvell, Zed and Townsend, Aleon, "Health Vulnerability and Services Need Among the Aged." in The Vulnerable Aged,
- Health Care Finance Administration, DHHS. "Medicaid Program: Home and Community-Based Services Waivers for Individuals 65 or older." Federal Register 57(126) (June 30 1992): 29142-29154.
- Hegyvary, Sue, "Academic-Corporation Long-Term Partnership to Improve Nursing Homes." 40(4) (July 8, 1991): 40-45.
- Hendrickson, Michael C., "Assisted Living: An Emerging Focus in an Expanding Market: Assisted Living Represents a Strategic Interaction of the Long Term Care and Retirement Home Industries." Contemporary Long Term Care, 11 (July 1988): 20-23.
- Hendrickson, Michael C., "Assisted Living: Responsibilities to Contemporary Seniors Needs and Desires," Contemporary Long Term Care, 11(9) (September 1988): 116.
- Hendrickson, Michael C. "Assisted Living: An Emerging Focus in An Expanding Market," Contemporary Long Term Care 11 (July 1988).
- Heumann, L. "Assisting the Frail Elderly Living in Subsidized Housing for the Independent Elderly: A Profile of the Management and its Supportive Priorities." The Gerontologist 28(5) (1988):625-31.
- Heumann, L. A Cost Comparison of Congregate Housing and Long-Term Care Facilities in Mid-West. Urbana, Illinois: University of Illinois, Housing Research and Development Program, 1985.
- Heumann, L. "A Cost Comparison of Congregate Housing and Long Term Care Facilities for Elderly Residents With Comparable Support Needs in 1985 and 1990." in L. Pastalan, ed. Homes not Houses: Optimizing Housing for the Elderly. The Hayworth Press, 1991.
- Heumann, L. Housing for the Elderly: Policy Formulation in Europe and North America. London: St. Martin Press, 1982.
- Heumann, L. The Retention and Transfer of Frail Elderly Living in Independent Housing. Urbana, Illinois: University of Illinois, Housing Research and Development Program, 1987.
- Hing, Ester, "Use of Nursing Homes by the Elderly: Preliminary Data from the 1985 National Nursing Home Survey," Advance Data from Vital and Health Statistics, No.1 35,DHHS,(PHS) 87-1250. Hyattsville,MD: National Center for Health Statistics, May 14, 1987
- Hing, Ester, E. Sekscenski, and G. Strahan. "The National Nursing Home Survey; 1985 Summary for the United States." Vital and Health Statistics 13(97). DHHS Pub. No. (PHS) 89-1 758. Washington, D.C.: US. Government Printing Office, January 1989.

- Hing, Ester, "Nursing- Home Utilization by Current Residents: United States **1985.**" Vital and Health Statistics, 13(102) DHHS Pub No. (PHS) 89-1763. Washington, D.C.: U.S. Government Printing Office, October 1989.
- Hinrichsen, Gregory A. "The Impact of Age-Concentrated, Publicly Assisted Housing on Older People's Social and Emotional Well-Being." Journal of Gerontology 40(6) (1985): 758-760.
- Hoglund, David. Housing for the Elderly: Privacy and Independence in Environments for the Aging. New York: Van Nostrand Reinhold Company, 1985.
- Holshauser, W. and F. Waltman. Aging in Place: The Demographics and Service Needs of Elders in Urban Public Housing. Boston: Citizens Housing and Planning Association, 1988
- Hopkins, Paula. "Enforcement of the Rights of Residents of Board and Care **Homes.**" in Preserving Independence, Supporting Needs, eds. Marilyn Moon, et al. AARP, Public Policy Institute, 1989.
- Housing and Community Development Act of 1990, Committee on Banking, Finance and Urban Affairs, House of Representatives, Report 101-559, 1990.
- Houston, Lois E. "Rural Congregate 'Housing.'" Generations (Spring 1985): 36-8.
- Howell, C. "Home: Source of Meaning in Elder's Lives." Generations (Spring 1985): 58-61.
- Hurd, M., "Research on the Elderly : Retirement and Consumption and Savings," Journal of Economic Literature, 28 (June 1990): 565-637.
- Huttman, Elizabeth D., Housing and Social Services for the Elderly. New York: Praeger Publications, 1977.
- Jordan, H., "Retirement Housing Market is Promising but Challenging." New Hampshire Business Review, 12(15) (September 1990): s2, 1A.
- Justice, Diane, et al. State Long-Term Care Reform. Washington, D.C.: National Governor's Association, Center for Policy Research, 1988.
- Kallen, B. "The Age-old Question." Forbes, 138: 244(3) (November 1986).
- Kalymun, M., "Assisted Living With Residents in Mind." Contemporary Long Term Care 13: (January 1990) :25,28-29.
- Kalymun, Mary., "Toward a Definition of Assisted Living". Journal of Housing for The Elderly 7 (January 1990): 97-1 31.
- Kane, et al. Adult Foster Care in Oregon: Evaluation. A Report to the Oregon Department of Human Resources, Senior Services Division. Minneapolis, Minnesota: University of Minnesota Division of Health Services Research and Policy. School of Public Health. May 1989.

- Kane, R., et al. Meshina Services with Housing: Lessons From Adult Foster Care and Assisted Living in Orean. Minneapolis, Minesota: University of Minnesota Care Decisions Research Center, 1990.
- Kapp, M.B. "Decision Making by and for Nursing Home Residents." Clinics in Geriatric Medicine 4(3) (1988): 667-679.
- Kapp, M.B. "Forcing Service on At-Risk Older Adults: When Doing Good is Not So Good." Social Work in Healthcare 13(4) (1988): 1-13.
- Keegan, J. and C. Naczas. Needs Assessment Survey of New Hampshire's Elderly. Submitted to New Hampshire Department of Health and Human Services Division of Elderly and Adult Services. State Committee on Aging, February 20, 1990.
- Kemper, Peter. "Case Management Agency Systems of Administering Long-Term Care: Evidence from the Channeling Demonstration." The Gerontologist 30(6) (1990): 817-824.
- Kemper, Peter, "The Evaluation of the National Long-Term Care Demonstration: Final Report." HHS-100-80-0157. Prepared for DHHS. Princeton: Mathematica Policy Research, 1986.
- Kemper, Peter, "The Evaluation of the National Long-Term Care Demonstration: Overview of the Findings." Health Services Research, 23(1) (April 1988): 161-176.
- Kemper, Peter, Robert Applebaum Margaret Harrigan. "Community Care Demonstrations: What Have We Learned?" Health Care Financing Review 8(4) (Summer 1987): 87-100.
- Klaasen, Paul. Notes from Conference Sponsored by the National Academy for State Health Policy and the Bigel Institute, "Building Assisted Living Into Public Long Term Care Programs." April 15, 1992.
- Korcok, M., "Assisted Living: Developing an Alternative to Nursing Homes," Canadian Medical Association Journal, 137: 843-5, November 1, 1987.
- Kotranski, Lynne and Joan Halbert. Philadelphia's Elderly: Their Health and Social Status, Utilization and Access to Services. Philadelphia: Philadelphia Health Management Corporation, May 1986.
- Kurneth, A. M. "The Four A's' of Marketing Senior Living Facilities." Contemporary Long Term Care (November 1987): 114-118.
- Kurneth, A.M., "Insurancing Assisted Living." Contemporary Long Term Care, 12 (October 1989): 54,68,71.
- Ladd, Richard C., Robert Mollica and Barbara Ryther. Discussion Paper On: Building Assisted Living Into Public Long Term Care Policy. Prepared for the National Academy for State Health Policy's Public Policy Seminar on Assisted Living: Washington! DC: April 15 1992.

- Landesman, S. "Preventing "Institutionalization" in the Community." in , Community Residences for People with Developmental Disabilities: Here to Stay. eds. M. Janicki, et al Paul Brooks Publishing Company: Baltimore, 1988
- Lane, T.S. and J. D. Feins. "Are the Elderly Overhoused? Definitions of Space Utilization and Policy Implications." The Gerontologist, 25(3) (1985):243-250.
- Lansperg, Susan. "Supportive Services in Senior Housing: New Partnerships Between Housing Sponsors and Residents." The Gerontologist, (Spring 1992).
- Laventhol & Horwath. Retirement Housing Industry, 1988. Philadelphia, Pennsylvania: Laventhol & Horwath, 1989.
- Lawton, M.P. "A Multidimensional View of Quality of Life in frail Elders," in The Concept and Measurement of Quality of Life in the Frail Elderly. San Diego: Academic Press, 1991.
- Lawton, M.P. "Housing the Elderly: Residential Quality and Residential Satisfaction." Research on Aging 2(3) (September 1980): 309-328.
- Lawton, P. and J. Weeden. "Introduction." Generations 9: (Spring 1985): 4-8.
- Lawton, P. Environment and Aging. Monterey, California: Brooks/Cole Publishing Co., 1980.
- Lawton, P. "The Elderly in Context: Perspectives from Environmental Psychology and Gerontology," Environment and Behavior, 17(4): 501-519, July 1985.
- Lawton, P., M. Greenbaum, and B. Liebowitz. "The Lifespan of Housing Environments for the Aging." The Gerontologist 20(1) (1980): 58-64.
- Lawton, P., Miriam Moss and Miriam Grimes. "The Changing Service Needs of Older Tenants In Planned Housing." The Gerontologist 25(3) (1987): 258-264.
- Lawton, P. "Three Functions of the Residential Environment." Journal of Housing for the Elderly 5(1) (1987): 35-48.
- Lawton, P., "Vulnerability and Socioenvironmental Factors." in The Vulnerable Aged, eds. Z. Harvel, P. Ehrlich, R. Hubbard. New York: Springer Publishing Company, 1990.
- Leak, S., "State Housing with Services Programs : New Initiatives, Striking Diversity." Long-Term Care Advances 3(2) (1991): 2-7.
- Lemke, S. and R.H. Moos. "Measuring the Social Climate of Congregate Residences for Older People: The Sheltered Care Environment Scale." Psychology and Aging (1987): 20-29.
- Lemke, S. and R.H. Moos. "Ownership and Quality of Care in Residential Facilities for the Elderly." The Gerontologist 29 (1989): 209-215.

- Lemke, S and Moos, R.H. "Quality of Residential Settings for the Elderly." Journal of Gerontology, 41: (1986): 268-276.
- Lewin-ICF and James Bell Associates. Descriptions of and Supplemental Information on Board and Care Homes Included in the Update of the National Health Provider Inventory. Washington, D.C. : Health & Sciences International Company. Report submitted to the Assistant Secretary of Planning and Evaluation, DHHS, August 8, 1990.
- Lewin-ICF. Elderly Persons Eligible for and Participating in the Supplemental Security Income (SSI) Program: Estimate for 1975-2020. Report prepared for the Assistant Secretary of Planning and Evaluation, DHHS, June 1989.
- Liu, K., Manton, K. and Liu, N.M., "Home Care Expenses for the Disabled Elderly," Health Care Financia Review, 7(2) (1985): 51-58.
- Long-Term Care National Resource Center at UCLA/USC. Assisted Living Resource Guide. Los Angeles, California: The Hayworth Press, 1989.
- Longino, Charles F. "Who Are the Oldest Americans?" The Gerontologist 28(4) (1988).
- Macken, C. "A Profile of Functionally Impaired Older Persons." Health Care Financia Review 7(4) (1986) ,33-49.
- Maine Department of Health and Human Services/Bureau of Elder and Adult Services, Bureau of Elder and Adult Services Policy Manual. Augusta, Maine. July, 1992.
- Manard, Barbara B., Ralph E. Woehle and James .M. Heilman. Better Homes for the Old. Lexington, Massachussets: Lexington Books, 1977.
- Manard, Barbara B., et al. Old Age Institutions. Lexington, Massachussets: Lexington Books, 1975.
- Manton, Kenneth G. "A Longitudinal Study of Functional Change and Mortality in the United States." Journal of Gerontology 43(5) (1988): S153-S161.
- Marshall, Victor W. Aaina in Canada. Ontario: Fitzhenry & Whiteside, 1980.
- Maryland Office on Aging. Group Sheltered Housing for the Elderly. Baltimore, MD. October, 1987.
- Maryland Office on Aging. Impact Statement on Housina Budoet Reductions. Baltimore, MD. November, 1991.
- Maryland Office on Aging. Multi-Familv Senior Assisted Housino for the Elderly/Authority: Article 70B. 4, Annotated Code of Maryland. Baltimore, MD.

- Maryland Office on Aging. Preliminary Tables Describing Selected Characteristics of 75 Sheltered Housing Residents. Prepared by Department of Epidemiology & Preventive Medicine: University of Maryland School of Medicine. December 1982.
- Maryland Office on Aging. Summary Document: Group Senior Assisted Housing. Baltimore, MD. October, 1989.
- Maryland Office on Aging. Summary Document: Multi-Family Senior Assisted Housing. Baltimore, MD. October, 1989.
- McCauley, William J. and Rosemary Blieszner. "Selection of Long Term Care Arrangements by Older Community Residents." The Gerontologist **25(2)** (1985): 188-193.
- McCain, John M. "Adult Foster Care: Old Wine in a New Glass." Adult Foster Care Journal **1(1)** (Spring 1987): 21-41.
- Medical Care and Research Foundation. Providing New Directions. New Hope in Board and Care: Practical Guidelines for Establishing and Operating Small Assisted Living Facilities for the Elderly. Denver, Colorado: Medical Care and Research Foundation, 1988.
- Meiners, M. "Financing Long-Term Care in Residential Environments." in Aging in Place, ed., David Tilson. 209-40. Illinois: Scott, Foresman and Company: Illinois: 1990.
- Meisel, Bert. "A Look at Assisted Living." The Spectrum (June 1987).
- Mendelson, D.N. and Judy Arnold. "Certificate of Need Revisited." Journal of State Government (forthcoming)
- Merill, J. and M. Hunt. "Aging in Place : A Dilemma for Retirement Housing Administrators," The Journal of Applied Gerontology **9** (1990): 60-76.
- Miller, Judith Ann and Wilson, Keren Brown, Concepts in Community Living: Assisted Living Program, Portland, Oregon. Newbury Park, California: Sage Publications, 1991.
- Mitchell, J. "Senior Housing Industry in Perspective." Contemporary Long Term Care **11** (July 1989): **56,58,76.**
- Mollica, R., J. Moltenbrey and J. Dionne. Guidelines for the Planning and Management of State-Funded Congregate Housing for the Elders. Boston: Executive Office of Elder Affairs, 1987.
- Mollica, Robert L., Richard C. Ladd, Susan Dietsche, Keren Brown Wilson and Barbara S. Ryther. Building Assisted Living for the Elderly into Public Long Term Care Policy: A Technical Guide for States. The Center for Vulnerable Populations, September 1992.
- Moon, Marilyn, George Gaberlavage and Sandra Newman, eds. Preserving Independence. Supporting Needs. AARP, Public Policy Institute, 1989.

- Moore, J., "Positioning Assisted Living For the 1990s." Contemporary Long-Term Care 14: (November 1991): 20,82.
- Mor, Vincent, S. Sherwood and C. Gutkin. "A National Study of Residential Care for the Aged." The Gerontologist 26 (August 1986): 405-417.
- Morris, J., et al. "Aging in Place: A Longitudinal Example", in Aging in Place: Supporting the Frail Elderly in a Residential Environment. ed., David Tilson. 25-52. Illinois: Scott, Foreman and Company, 1990..
- Morris, John N. and Shirley A. Morris. "Aging in Place: The Role of Formal Human Services." Generations (Spring 1992): 41-48.
- Morris, J., et al. "Institutional Risk II: An Approach to Forecasting Relative Risk of Future Institutional Placement." Health Services Research 23(4) (1988): 511-536.
- Mullen, A.J. "The Assisted Living Industry: An Assessment." Retirement Housing Report. (January 1991).
- Murtaugh, C., Kemper, P., Spillman, B., "The Risk of Nursing Home Use in Later Life," Medical Care, 28(10) October 1990.
- Mutschler, Pyyllis H. "Where Elders Live." Generations (Spring 1992): 7-14.
- Nachison, Jerold S. "Who Pays?" Generations (Spring 1985): 34-6.
- Namazi, K., K. Eckert, E. Kahana and S. Lyons. "Psychological Well-being of Elderly Board and Care Home Residents." The Gerontologist 29 (1989): 511-516.
- Nenno, M. K., Nachison, J. S. and Anderson, E., "Support Services for the Frail Elderly or Handicapped Persons Living in Government-Assisted Housing: A Public Policy Whose Time Has Come." Public Law Forum 5 (1986): 69-84.
- Nenno, M.K. and G. S. Coyler. "Trust Funds: New Trends in Housing and Finance." Journal of Housing 46(1) (January/February 1989): 23-27.
- Netting, F. Ellen, Cindy C. Wilson and Nancy Coleman. Assisted Living: New Term, Old Concept? Paper presented at the Gerontological Society of America's Annual Scientific Program. San Francisco, California, November 26, 1991.
- Newcomer, R., Sue S. Roderick, Steven Preston. Assisted Living and Nursing Unit Use Among Continuing Care Retirement Community Residents. Presented at the annual meeting of the American Association of Homes for the Aged, Boston, 1992.
- Newcomer, R. and Steven Preston. Relationships Between Acute Care and Nursing Unit Use in Two Continuing Care Retirement Communities. Institute-for Health and Aging, University of California: 1992.

- New Hampshire Division of Elderly and Adult Services. Administrative Hearing Rules (He-E 200). November 1990.
- New Hampshire Division of Elderly and Adult Services. Adult Protection Program Policy Manual. November 1990.
- New Hampshire Division of Elderly and Adult Services. Adult Protection Program Rules (He-E 700). November 1990.
- New Hampshire Division of Elderly and Adult Services. Rules on Division of Elderly and Adult Services Files (He-E300). October 1990.
- New Hampshire Division of Elderly and Adult Services. State Plan: October 1, 1991 to September 30, 1995.
- New Jersey Department of Community Affairs. Bureau of Rooming and Boarding House Standards: Rooming and Boarding House Act of 1979: Regulations Governing Rooming and Boarding Houses and Related Statutes. Trenton, NJ. September, 1991 .
- New Jersey Department of Community Affairs/Division on Aging. Glossary of Housing Options for Senior Citizens. Trenton NJ.
- New Jersey Department of the Public Advocate. Report on Board and Care Reform. Trenton, NJ. April, 1991.
- New York State. Assisted Living Program Application. Albany, NY.
- New York State. Assisted Living Program (Statutory Authority: Public Health Law 3614 (6) and 3612 (5)). Albany, NY.
- New York State Department of Social Services/Department of Health. Assisted Living Program Application Process. Albany, NY.
- New York State Department of Social Services/Department of Health. Assisted Living Program Information for Applicants. Albany, NY. August 1992.
- Newcomer, R. and R. Stone. "Board and Care Housing: Expansion and Improvement Needed." Generations (Spring 1985): 39-41.
- Newcomer, R. J. and Leslie A. Grant. "Residential Care Facilities: Understanding Their Role and Improving Their Effectiveness", in Aging in Place: Supporting the Frail Elderly in Residential Environments, ed. David Tilson. 101-124. Illinois: Scott, Foresman and Company, 1990.
- Newman, Sandra and **Raymond Struyk**. "Housing and Supportive Services: Federal Policy for the Frail Elderly and the Chronically Mentally Ill." in Building Foundations, eds., Denise DiPasquale and Langley Keyes. New York: University Press, 1990.

- Newman, Sandra. "The Frail Elderly in the Community: An Overview of Characteristics", in Ageing in Place: Supporting the Frail Elderly in a Residential Environment, ed., David Tilson. 3-24. Illinois: Scott, Foresman and Company, 1990.
- Newman, Sandra. "The Bounds of Success: What is Quality in Board and Care Homes?" in Preserving Independence, Supporting Needs, eds. Marilyn Moon, et al. AARP, Public Policy Institute, 1989.
- Newman, S. "The Shape of Things to Come." Generations (September 1985): 14-17.
- O'Bryant, S.L. "The Value of Home to Older Persons: Relationship to Housing Satisfaction." Research on Ageing 4(3): (September 1982): 349-363.
- Okta, J. S. and A. H. Palley. "The Frail Elderly and the Promise of Foster Care." Adult Foster Care Journal. 2(1) (Spring 1988): 8-25.
- Parkoff, Barbara, Adding Services to Existing Housing. Washington, D.C.: Council of State Housing Agencies, National Association of State Units on Aging, 1987.
- Parr, Joyce, Sara Green and Cdrinne Behncke. "What People Want, Why They Move and What Happens After They Move: A Summary of Research in Retirement Housing." Journal of Housing for the Elderly 5(1): (1988): 7-34.
- Pastalan, Leon A. "Designing a Humane Environment for the Frail Elderly", in Ageing in Place: Supporting the Frail Elderly in a Residential Environment, ed. David Tilson. 273-286. Illinois: Scott, Foreman and Company: 1990.
- Pastalan, Leon A. Optimizing Housing for the Elderly: Homes Not Houses. New York: The Hayworth Press, Inc, 1990.
- The Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care. A Call For Action Final Report. 101-1 14. Washington, D.C.: U.S. Government Printing Office, September 1990.
- Perry, C.B. and W.B. Applegate, "Medical Paternalism and Patient Self-Determination." Journal of the American Geriatrics Society, 33: 353-359.
- Phillips, Barbara R., Peter Kemper, Robert Applebaum. "The Evaluation of the National Long Term Care Demonstration: 4. Case Management under Channeling." Health Services Research 23(1) (April 1988): 6782.
- Phillips, D. R., "Privatizing Residential Care for Elderly People: the Geographics of Developments in Devon, England." Social Science and Medicine 26(1) (1988): 37-47.
- Plasschaert, Gary. "Assisted Living Boom Forces Developers to Carefully Scrutinize Project Planning." Today's Nursing Home 10 (1989): 1,24-26,39-40.
- Poulin, J.E. "Age Segregation and the Interpersonal Involvement and Morale of the Aged." The

Gerontologist 24(3): (1984): 266-269.

Prince, M., " Supportive Housing Preferences Among the Elderly," in Homes Not Houses : Options in Housing for the Elderly, ed. L. Pastalan. New York: The Haworth Press, 1990.

Pring, Catherine G. and Fern C. Portnoy. "A Foundation's Role: Developing a Continuum of Housing Programs." Generations (Spring 1985): 56-7.

Pristic, S. "Assisted Living in the Spotlight: New Association Eyes Expanded Medicaid Funding." Contemporary Long-Term Care 14(2) (February 1991): 40,42.

Prosper, Vera. A Review of Congregate Housing in the United States. New York: New York State Office of the Aging, 1987.

The Providence Journal "Real Estate Hybrid, Assisted Living, a Boon for Elderly". (1989): G-1, G-2, 2.

Pynoos, J. "Options for Mid-Upper-Income Elders: Continuum of Care Retirement Communities." Generations (Spring 1985): 31-4.

Pynoos, J. "Public Policy and Aging 'in Place' - Identifying the Problems and Potential solutions" Ageing in Place: Supporting the Frail Elderly in a Residential Environment, ed. David Tilson. 167-208. Illinois: Scott. Foreman and Company, 1990..

Quinn, Joan and Cheryl M. Whitman. "Elderly Living in the Community: Challenges and Opportunities." 5(1) (1988): 83-92.

Quirk, D.A. "An Agenda for the Nineties and Beyond: Aging Policy and the Older Americans Act After 25 Years." Generations, 15(3) 23(4), (Summer-Fall 1991).

Rajecki, R. "Balancing on Assisted Living Budget." Contemporary Long Term Care 14(3) (March 1991) :30-32,82.

Rajecki, R. "Charting a New Course in Alzheimer's Care." Contemporary Long Term Care 15(8) (August 1992): 40-44.

Rajecki, Ron. "New Regs Promote Aging in Place." Contemporary Long Term Care (September 1992) : 46."

Raschko, B. Housing Interiors for the Disabled and Elderly. New York: Van Nostrand Reinhold Company, 1982..

Ravel, Sally. Retirement Living: A Guide to the Best Residences in Northern California. Berkeley, California: Conari Press, 1990.

Reddick, J. "The Interdependence of Health and Housing for the Elderly," Journal of Housing For the Elderly, 2(4): 77-82, Winter 1984/85.

- Redfoot, D. and G. Gaberlavage. "Housing for Older Americans: Sustaining the Dream". Generations, 15 (1991): 35-38.
- Redfoot, D. "Getting Housing and Services Together for Older People: A Change in the Conversation." Long Term Care Advances 2(3), Duke University Center for the Study of Aging and Human Development (1991): 2-7.
- Regnier, V., J. Hamilton, and S. Yatabe. Best Practices in Assisted Living. Los Angeles, California: National Elder Care Center on Housing and Support Services, Andrus Gerontology Center, University of Southern California, May 1991.
- Regnier, V. and J. Pynoos. Housing the Aged: Design Directives and Policy Considerations New York: Elsevier, 1987.
- Regnier, Victor. New Concepts in Assisted Living: Design Innovation from the United States and Northern Europe. AIA, Van Nostrand-Reinhold, New York, forthcoming.
- Reichstein, K. and L. Begofsky. "Domiciliary Care Facilities for adults: An Analysis of State Regulations." Research on Aging 5(1) (1983): 25-43.
- Reisacher, Sally. "Quality of Care: Operation and Management Issues." in Preserving Independence, Supporting Needs, eds. Marilyn Moon, et al. AARP, Public Policy Institute, 1989.
- Reilly, Thomas W., et. al. "Trends in Medicaid Payments and Utilization, 1975-1989." Health Care Financing Review (1990 Annual Supplement).
- Reschovsky, James D. "Present and Future Roles of HUD Programs in Board and Care Financing." in Preserving Independence, Supporting Needs, eds. Marilyn Moon, et al. 93-108. AARP, Public Policy Institute, 1989.
- Retsinas, Joan. "Triggers to Nursing Home Placement." Geriatric Nursing (September/October, 1991).
- Rhode Island Housing. Foundations of Senior Health Program: Quarterly Report for the Period Ending. October 31, 1991.
- Rhode Island Housing. Foundations of Senior Health Program: Quarterly Report for the Period Ending January 31, 1991.
- Rhode Island Housing. Foundations of Senior Health Program: A Planning Document. March 1991.
- Rhode Island Housing. Foundations of Senior Health Program: Resident Assessment Tool.
- Rhode Island Housing. Foundations of Senior Health Program: Resident Service Coordinators' Manual. March 1991.

- Rhode Island Housing. The Foundations of Senior Health Program: Annual Progress Report, Year 3. Submitted to the Robert Wood Johnson Foundation, Grant #15926. November, 1991.
- Rhode Island Housing. Market Analysis for Supportive Services in Housing Developments for the Elderly. August, 1989.
- Rivlin, A. and J. Wiener., et al. Carina For the Disabled Elderly: Who Will Play? Washington, D.C.: The Brookings Institution, 1988.
- Roderick, G. A. "Congregate Care Provider Sizes up Assisted Living." Contemporary Long Term Care 14(3): (March 1991): 28,81.
- Roistacher, Elizabeth A. "A Modest Proposal: Housing Vouchers as Refundable Tax Credits," in Housing America's Poor, ed., Peter D. Satins. 162-174. North Carolina: University of North Carolina Press, 1987.
- Rowland, Diane, et al. Defining the Functionally Impaired Elderly Population. #8808 Washington, D.C.: AARP, The Public Policy Institute, November 1988.
- Ruchlin, H., et al. Expenditures for Institutional and Community-Based Services by a Cross-Section of Elderly Living in the Community. Boston: Hebrew Rehabilitation Center for the Aged, 1987.
- Ruchlin, H. Analysis of CCRC Operating Costs. Boston: Department of Social Gerontological Research, Hebrew Rehabilitation Center for the Aged, 1988.
- Ruchlin, H. "The Pennsylvania Domiciliary Care Experiment: II. Cost Benefit Implications." The American Journal of Public Health
- Salins, Peter D. Housing America's Poor. Chapel Hill, North Carolina: University of North Carolina Press, 1987.
- Scanlon, William J. "Possible Reforms for Financing Long-Term Care." Journal of Economic Perspectives, 6(3) (Summer 1992): 43-58.
- Schneider, Mary Jo, Diane D. Chapman, and Donald E. Voth. "Senior Center Participation: A Two Stage Approach to Impact Evaluation." The Gerontologist 25(2) (1985): 194-200.
- Sedies, Harry L. Assisted Living Summary Document. Aging and Adult Services Administration Department of Social and Health Services. Olympia, Washington, August 12, 1992.
- Seip, David E. "Assisted Living Comes of Age." Contemporary Long Term Care, 14(3) (March 1991) : 24-78.
- Seip, David E. "Assisted Living Facilities Survey: A Sneak Preview," Contemporary Long-Term Care 12(12) (October 1989): 30-32.

- Seip, David E. "Assisted Living: The Industry is Coming of Age," Contemporary Long Term Care, 12(6) (May 1989): 24-6.
- Seip, David E. "Building Awareness of Assisted Living," Contemporary Long Term Care, 12(5) (April 1989): 22-24.
- Seip, David E. "Design Principles Bind Diverse Industry," Contemporary Long Term Care, 14(1): (January 1991): 24,95.
- Seip, David E. "First National Assisted Living Industry Survey." Contemporary Long Term Care 12(7): (June 1989): 69-70.
- Seip, David E. "Free-standing Assisted Living Trends." Contemporary Long-Term Care 12(20) (December 1989): 22-23.
- Seip, David E. "A New Address for an Aging Resident," Contemporary Long Term Care, 12(10): (September 1989).
- Seip, David E. "Hot Concepts in the Retirement Living Industry: A Look At 10 of the Most Progressive ideas in the Senior Housing Marketplace," Contemporary Long-Term Care, 10(8) (August 1987): 28-31.
- Seip, David E. "The Retirement Housing Industry Plainly Defined: Standardization of Terms Can help Explain Concepts in Senior Living Market." Contemporary Long-Term Care, 10(11) (November 1987): 32,33.
- Seip, David E. "Specializing in Assisted Living Facilities: Bridging the Gap Between Retirement Housing and Nursing Homes." Contemporary Long-Term Care (October 1987): 32-33.
- Seip, David E. "Specializing in Assisted Facility." Contemporary Long Term Care, 10(9) (September 1987): 34-36.
- Seip, David E. The Survival Handbook for Developers of Assisted Living. Boca Raton, Florida: The Seip Group Inc., 1990.
- Seip, David E. "Tallying the First National Assisted Living Survey." Contemporary Long-Term Care 10 (November 1989): 28, 30, 32-33.
- Sekscenski, ES. "Discharges From Nursing Homes: 1985 National Nursing Home Survey." Vital and Health Statistics. 13(103) DHHS Pub No. (PHS) 89-600251. Washington D.C.: U.S. Government Printing Office, March 1990.
- Select Committee on Aging, U.S. House of Representatives. Dignity, Independence, and Cost-Effectiveness: The Success of the Conaegate Housing Services Program. Testimony to Subcommittee on Housing and Consumer Interest. Washington, D.C.: U.S. Government Printing Office, 1988..

- Select Committee on an Aging, U.S. House of Representatives. Society Institute of Medicine and National Research Council. The Social and Built Environment in and Older Society. Washington, D.C.: National Academy Press, 1988.
- Select Committee on Aging. Subcommittee on Human Services, U.S. House of Representatives. Meeting the Needs of the Frail Elderly: Hearina Before the Subcommittee on Human Services of the Select Committee on Aaina, House of Representatives, March 5th. FL 1990.
- Shapiro, E. and Tate R., "Who is Really at Risk of Institutionalization?" The Gerontoloaist, **28(2)**: 237-45, 1988,
- Shashaty, A. (1989) "Housing Options for the Elderly." Good Housekeeping, 208: **166(1)**, February.
- Sheehan, N.W. "Aging of tenants: Termination Policy in Public Sector Housing. "The Gerontoloaist" 26: (1986): **505-509**.
- Sheehan, N., "Informal support among the elderly in public senior housing." The Gerontoloaist, 26, 171-175, 1986.
- Sheehan, Nancy H. and Wisensale, Steven K., "Aging in Place : Discharge Policies and Procedures Concerning Frailty Among Senior Housing Tenants," Journal of Gerontological Studies, **16(1/2)**: 109-1 23, **1991**.
- Sherwood, Sylvia. Executive Summary for the Evaluation of the Conaeate Housina Services Proaram. HC-5373. Boston: Department of Social Gerontological Research, Hebrew Rehabilitation Center for the Aged, April 1985.
- Sherwood, S., et. al. "CCRCs an Option For Aging in Place", in Aging in Place: Suoportina the Frail Elderly in Residential Environments, ed., David Tilson. pp. 125-1 65. Glenview, Illinois: Scott, **Foresman** and Company, 1990.
- Sherwood, Sylvia and John N. Morris. 'The Pennsylvania's Domilliary Care Experiment: I. Impact on Quality of Life.'" American Journal of Public Health
- Shikles, Janet L. Nursina Homes. Admission Problems for Medicaid Recipients and Attempts to Solve Them. HRD-90-135. Washington, D.C.: US. General Accounting Office, September 1990.
- Sidor, J. State Housing Initiatives : The 1988 Compendium. Washington, D.C.: Council of State Community Care Agencies,1 988.
- Silverstone, B. and Horowitz, A."Aging in Palce: The Role of Families." Generations (Spring 1992).
- Sirrocco, A. "Nursing and Related Care Homes, As Reported from the 1980 NMFI Survey." Vital and Health Statistics 14(29) DHHS Pub. No.(PHS) 84-1 824. Washington, D.C.: U.S. Government Printing Office, December 1983.

- Skinner, John H. "Aging in Place: The Experience of African American and Other Minority Elders." Generations (Spring 1992).
- Smith, D.G., and Karras, T. L., "Creating Interiors for a Changing Clientelle," Provider, 14(9) (September 1988): 20-23.
- Special Committee on Aging, U.S. Senate. Aging America: Trends and Projections Series 101 E. Washington, D.C.: U.S. Government Printing Office, 1989.
- Special Committee on Aging, U.S. Senate. Developments in Aging: 1991, Volume I. 102-261. Washington, D.C.: US. Government Printing Office, February 28, 1991.
- Special Committee on Aging, U.S. Senate. Developments in Aging: 1991, Volume 2-Appendixes. 102-261. Washington, D.C.: U.S. Government Printing Office, February 28, 1991.
- Special Committee on Aging, U.S. Senate and Select Committee on Aging, U.S. House of Representatives. Board and Care: A Failure in Public Policy. 101-714. Washington, D.C.: U.S. Government Printing Office, 1989.
- Special Committee on Aging, US. Senate. AARP, The Federal Council on the Aging and the U.S. Administration on Aging. Aging America: Trends and Projections, 1991 Edition. 91-28001. Washington, D.C.: U.S. Department of Health and Human Services, 1991.
- Spence, A. and J. M. Wiener. "Nursing Home Length of Stay Patterns: Results from the 1985 National Nursing Home Survey." The Gerontologist, 30(11) (1990).
- Spring, Julia. "Applying Due Process Safeguards." Generations Issue on "Coercive Placement of Elders: Protection or Choice?" (Spring 1987): 32-39.
- Stark, A.J., Gutman, G.M. and Brothers, K. "Reliability of Level Care Decisions in a Long-Term Care Program." Journal of Community, 8(2) (1982): 102-109.
- Stegman, Michael A. Housing Finance and Public Policy. New York: Van Nostrand Reinhold Company, 1986.
- Stephens, M.A.P. and M.D. Bernstein. "Social Support and Well-being among residents of planned housing." The Gerontologist 24 (1984): 144-148.
- Stone, R. et al. "Caregivers of the Frail Elderly: A National Profile" The Gerontologist 27 (1987): 616-626.
- Strahan, Genevieve and Barbara J. Burns. "Mental Illness in Nursing Homes: United States, 1985." Vital and Health Statistics 13(105) DHHS Pub. No.(PHS) 91-1766. Washington D.C.: U.S. Government Printing Office, February 1991.
- Strahan, Genevieve. "Trends in Nursing and Related Care Homes and Hospitals, United States Selected Years 1969- 1980." Vital and Health Statistics 14(30) DHHS Pub. No.(PHS) 84-1825. Washington. D.C.: U.S. Government Printing Office, March 1984.

- State of Connecticut Department on Aging. Connecticut State Plan on Aging: October 1, 1991 Thru September 30, 1995. Presented to: Administration On Aging Department of Health and Human Services.
- State of Connecticut Department on Aging. Reputations: Congregate Housing Pilot Program. December 1989.
- Streib, G. "Congregate Housing: People, Places, Policies", in Aging in Place: Supporting the Frail Elderly in a Residential Environment, ed., David Tilson. 75-100. Illinois: Scott, Foresman and Company, 1990.
- Streib, G. "The Frail Elderly: Research Dilemmas and Research Opportunities." The Gerontologist 23 (1983): 40-44.
- Struyk, R., D. Page and S. Newman, et al. Providing Supportive Services to the Frail Elderly in Federally Assisted Housing. (Report 89-2). Washington, D.C.: The Urban Institute Press, 1989.
- Struyk, R., M. Turner, and M. Ueno. Future U.S. Housing Policy: Meeting the Demographic Challenge. Washington, D.C.: Urban Institute Press: 1986.
- Stutts, P. "Consultants to Developers: Get in Touch with Needs of Elderly." Arizona Business Gazette 88(17) (1987): sl.
- Tancredi, Laurence R. "The Mental Status Examination." Generations Issue on "Coercive Placement of Elders: Protection or Choice?" (Summer 1987): 24-31.
- Tell, E., S. Wallack and M. Cohen, M. "Assessing the Elderly's Preferences for Lifecare Retirement Options." The Gerontologist 27(4): (1987): 503-509.
- Tell, E., S. Wallack, M. Cohen. "New Directions for Life Care: An Industry in Transition." Milibank Memorial Fund Quarterly 67(4) (1987): 551-75.
- Tell, J., et al. "Assessing the Elderly's Preferences for Lifecare Retirement Options." The Gerontologist 27(4) (1987): 503-9.
- Thielen, R., M. Tiven, M. and M. Parkoff. Adding Services to Existing Housing. Washington, D.C.: Council of State Housing Agencies and National Association of State Units on Aging, 1987.
- Thornton, Craig, Shari Miller Dunstan and Peter Kemper. "The Evaluation of the National Long Term Care Demonstration: 8. The Effect of Channeling on Health and Long-Term Care Costs," Health Services Research 23(1): 129-142.
- Tilson, David., ed. Aging in Place: Supporting Frail Elderly in a Residential Environment. Glenview Illinois: Scott, Foresman and Co., 1990.

- Timko, Christine and Rudolph H. Moos. "A Typology of Social Climate in Group Residence Facilities for Older People." Journal of Gerontology 46(3) (May 1991): S160-169.
- Tiven, M. and B. Ryther. State Initiatives in Elderly Housing: What's New What's Tried and True. Washington, D.C.: Council of State Housing Agencies and National Association of State Units on Aging, December, 1986.
- Tiven, M. and B. Ryther Adding Services to Existing Housing Washington, D.C.: National Association of State Units Aging and Council of State Housing Agencies, 1988.
- Topical Law Reports. Chicago, Illinois: Commerce Clearing House, Inc., 1990.
- Townsend, A. and Z. Havel, "The Vulnerability and Service Need Among the Aged." in The Vulnerable Aged, eds. Z. Harvel, P. Ehrlich, R. Hubbard. New York: Springer Publishing Company, 1990.
- Traska, N.R. "Life Care Undergoing Changes in Delivery, Settings, and Ownership." Hospitals. 59(5) (1985): 75-77.
- Vandevanter, Peter. Retirement Communities. Virginia: EPM Publications, Inc., 1991.
- Varady, David P. "Determinants of Interest in Senior Citizen Housing Among Elderly People." The Gerontologist 24(4): (1984): 392-395.
- Waldo, Daniel R., et. al. "Health Expenditure by Age Group, 1977 and 1987." Health Care Financing Review 10(4) (1989).
- Washington State Department of Health. Boarding Homes: Licensing Law/Regulations. Olympia, Washington, July, 1991.
- Washington State Department of Social and Health Services/Aging and Adult Services. Request for Proposal No. 1200-85553 for Assisted Living.
- Watzke, James, and Bryan Kemp. "Safety for Older Adults: The Role of Technology and the Home Environment." Topics in Geriatric Rehabilitation 7(4) (June 1992): 9-21.
- Weal, F., and F. Weal. Housing for the Elderly: Options and Design. New York: Nichols Publishing, 1988.
- Weissert, William G. "The National Channeling Demonstration: What We Knew, Know Now, and Still Need to Know." Health Services Research 28(1): 175-197.
- Weissert, William G. "A New Policy Agenda for Home Care." Health Affairs (Summer 1991): 66-77.
- Weissert, William G. "Seven Reasons Why it Is So Difficult To Make Community-Based Long-Term Care Cost-Effective." Health Services Research 20(4) (October 1985): 423-433.

- Weissert, W.G. and C.M. Cready. "Determinants of Hospital-to-Nursing Home Placement Delays: A Pilot Study." Health Services Research 23(5) (December 1988): 619-647.
- Weissert, W.G. and C. M. Cready. "The Past and Future of Home-and Community-based Long-Term Care." The Milbank Quarterly 66(2) (1988): 309-386.
- Weissert, W.G. and C. M. Cready. "Toward a Model for Improved Targetting of Aged at Risk of Institutionalization." Health Services Research 24(4) (1989): 485-509.
- Welch, P., V. Parker and J. Zeisel. Independence Through Interdependence. Boston: Department of Elder Affairs, Commonwealth of Massachusetts, 1984.
- Wiener, J., et al., "Private Long-Term Care Insurance, Cost, Coverage, and Restrictions," The Gerontologist, 27(4) (April 1987): 487-493.
- Wilkenson, R.G., et al., "Housing: Must the Crisis Worsen," Perspectives on Aging, 17(4) (July/August 1988): 6-22.
- Wilner, M. "Refining the Assisted Living Model to Include Persons with Limited Incomes and Smaller Resident Populations." Portland, Oregon: Milestone Management, 1988.
- Wilson, K. "Beyond Loving Care". Paper presented for the Oregon Gerontological Society: Portland, Oregon, 1988.
- Wilson, K. and D. Rankos. "Assisted Living: New Hope for Long-Term Care." Paper presented at the Gerontological Society of America: San Francisco, California.
- Wilson, K., "Assisted Living: The Merger of Housing and Long Term Services," Long Term Care Advances, North Carolina: Duke University Center for the Study of Aging and Human Development. (1), 4, 1990.
- Wilson, K. "Assisted Living: A Model of Supportive Housing." Journal of the American Geriatrics Society (Fall 1992).
- Wilson, K. and M. DeShane. Executive Summary: Implementation of Assisted Living in the State of Washington. Program Review for Aging and Adult Services. Portland, Oregon: Concepts in Community Living, February 1992.
- Wilson, K. and M. DeShane. Implications of Assisted Living in the State of Washington. Program Review for Aging and Adult Services. Portland, Oregon: Concepts in Community Living, February 1992.
- Wilson, K. and M. DeShane. Narrative Data for the Report: Implementation of Assisted Living in the State of Washington. Program Review for Aging and Adult Services. Portland, Oregon: Concepts in Community Living, February 1992.
- Wilson, K. and M. DeShane. Technical Appendices/Supplemental Data for the Report: Implementation of Assisted Living in the State of Washington. Program Review for Aging

- and Adult Services. Portland, Oregon: Concepts in Community Living, February 1992.
- Winklevoss, H.E. and Powell, A. Continuing Care Retirement Communities: An Empirical, Financial, and Legal Analysis. Illinois: Irwin, 1984.
- Winograd, Carol H., et al., "Screening for Frailty; Criteria and Predictors of Outcomes." Journal of the American Geriatrics, **39(8)**: (August 1991).
- Wolfe, D. Serving the Ageless Market: Strategies for Selling to the Fifty-Plus Market. New York: McGraw Hill, Inc, 1990.
- Wooldridge, Judith and Jennifer Schore. "The Evaluation of the National Long Term Care Demonstration: 7. The Effect of Channeling on the Use of Nursing Homes, Hospitals, and Other Medical Services." Health Services Research **23(1)** (April 1988): 119-128.
- Zedlewski, S., et al. "Supportive Services in Senior Housing: Lessons from the Robert Wood Johnson Foundation Demonstration." **Waltham**, Massachusetts : Paper prepared by The Policy Center on Aging, The Heller School, Brandeis University, 1991.
- Zedlewski, S. R. Barnes, M. Burt, T. McBride and J. Meyer. The Needs of the Elderly in the 21st Century. Washington, D.C.: The Urban Institute, 1990.