



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy



A NATIONAL STUDY OF ASSISTED LIVING FOR THE FRAIL ELDERLY:

REPORT ON IN-DEPTH INTERVIEWS WITH DEVELOPERS

December 1997

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**A NATIONAL STUDY OF ASSISTED LIVING
FOR THE FRAIL ELDERLY:
Report on In-Depth Interviews with Developers**

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EXECUTIVE SUMMARY

This report describes selected trends in the assisted living industry. It is intended to supplement ongoing research being conducted as part of The National Study of Assisted Living. In this supplementary study, detailed interviews were conducted with 29 carefully selected persons from 21 states who are involved in various aspects of the development of assisted living facilities: architects, builders, developers, and consultants to the development industry. This report, the product of the interviews, provides preliminary information concerning barriers to the development of assisted living and future trends in the industry, as well as the potential for assisted living to serve a larger lower income and Medicaid-eligible population.

Key points stressed by those interviewed included the following:

- Policy-makers at all levels will face increasingly difficult decisions with respect to the design, regulation, and financing of assisted living, particularly regarding the extent to which assisted living should provide medical services to the frail elderly.
- The assisted living industry is growing rapidly, and some markets (e.g., high-end markets in many areas) may already be saturated.
- The "assisted living concept," widely discussed but inconsistently defined, is proving more difficult to execute well than many developers had thought; industry shakeouts are anticipated.
- Although a number of developers are working on ways to make assisted living more affordable, this is proving to be a substantial challenge.
- Rising acuity levels, already seen in the industry, will have a major impact on the design and fundamental concept of assisted living in the future.
- There was little agreement among those interviewed regarding how government policies should balance concerns of appropriate consumer protection versus overregulation of this emerging market.

I. PURPOSE OF THE PROJECT

A. Background

"Assisted living" refers to a type of care that combines housing and services in a residential environment and that strives to maximize the individual functioning and autonomy of residents. While assisted living is a concept with relevance for many different groups of individuals requiring assistance with activities of daily living (ADLs), this project focuses on assisted living development and policy issues for the frail elderly population.

The developer interviews are one component of a larger, multiyear project. The National Study of Assisted Living for the Frail Elderly is sponsored by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services (DHHS). Its purpose is to examine the "place" of assisted living in long-term care and the potential for assisted living to address the needs of the frail elderly. The study will also examine the role of assisted living from the perspective of consumers, owners and operators, workers, regulators, developers, investors, and others with a stake in the long-term care system.

The study focuses on such issues as:

- Trends in the supply and demand for assisted living
- Barriers to the development of assisted living
- Scope and status of the regulatory and quality assurance systems for assisted living
- Ways in which the current assisted living industry embodies the principles of consumer choice and autonomy and the extent to which the industry matches the conceptual model of assisted living
- Effect of different models of assisted living on consumer and worker satisfaction, resident length-of-stay, affordability, and its potential substitutability for nursing home care.

The developer interviews, the findings from which are presented in this report, were designed both to provide a context for the larger study and to provide information about emerging trends.

B. Approach to the Developer Interviews

We selected 29 people to interview who have various and often multiple roles in the assisted living industry representing the following:

- Developers and owner/developers involved directly in the development of facilities
- Consultants on development and programming
- Architects.

The developers, consultants, and architects interviewed are not a representative sample in statistical terms, although they do represent a broad sampling from among the various "roles" or professions involved in the development of assisted living. Moreover, they were drawn from geographically diverse areas of the country. First, we compiled a list of members of the Assisted Living Federation of America, separating non-facility members into one of the three groups we sought to interview. Next, we supplemented this list through calls to knowledgeable individuals in the industry, including the major multi-facility systems. After unduplicating the list, so that each individual or organization appeared on the list only once, we divided them into major geographic areas of the country, either in terms of their office location or, if known, the area in which they did most development. We then selected the sample of 29 respondents, seeking at least two respondents from each "role" or professional grouping in each of our geographic areas. As can be seen from the map in Appendix A, some areas of the country have so relatively little development activity that we were not able to achieve this goal. However, we secured representation for most areas in which there is high activity in the development of assisted living projects.

Once selected, we sought respondents' participation in an in-depth interview by telephone. The interviews lasted, on average, 1.5 hours and were conducted during the last quarter of 1996.

The 29 respondents were collectively informed about the industry as it is evolving in at least 21 states, including both urban and rural areas. A list of those interviewed and a map showing the states in which they are working can be found in Appendix A. Additional details about the background of those interviewed is provided in the first part of Section II.

The interviews were organized around five main questions:

1. How did you get involved in the assisted living industry?
2. What, if any, policy barriers do you see affecting the development of assisted living?
3. What are the key trends in this industry? What is changing and what is driving that change?

4. Is there an opportunity for assisted living to serve a larger low-income or Medicaid-eligible population?
5. What information about this industry should be communicated to policy-makers?

II. FINDINGS

A. Overview

The telephone interviews conducted for this project were designed to elicit information about trends and key policy issues relevant to the development of assisted living. As explained in Section I, we sought interviews with a variety of people and organizations involved in the assisted living industry. We interviewed individuals in almost every state and from a number of different occupations (e.g., architects, development consultants). From these interviews, we learned more about the character of assisted living development today as well as the future direction of the industry. We also learned about barriers to the development process and the opportunities for expanding assisted living to serve a larger proportion of lower-income and Medicaid-eligible frail elderly.

B. Background on Respondents

There are multiple roles in the development of assisted living. It appears that there are at least the following roles: developers, consultants, and architects. As noted in Section I, we specifically targeted people in these roles. In earlier research for the National Study of Assisted Living (e.g., the review of the literature of assisted living¹), we learned that assisted living development sometimes involves persons and organizations with multiple roles. This earlier finding was confirmed through preliminary interviews we conducted with three developers and one development consultant. In some cases, developers and operators are from different organizations. In other cases the people who select the site, secure the financing, and supervise the construction of assisted living residences are frequently the very same people who hire the staff, admit new residents, and oversee the day-to-day operations of the facilities.

1. Roles in the Development Process

The development "roles" played by the respondents provided further confirmation of the utility of a more expansive concept of the assisted living development process. Of the 29 individuals interviewed who were involved most directly in the development of assisted living, six defined themselves as only developers. One self-identified as a developer and owner, and 14 others reported themselves to be various combinations of developers, owners, operators, and consultants. All told, more than half the respondents were involved in an extended segment of the assisted living development process. The multiphase involvement in the development process has given them exposure to most

¹ Lewin-VHI. (1995, May). *The National Study of Assisted Living: Review of the Literature*. Prepared for the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Washington, DC: Lewin-VHI, Inc.

of the central issues involved in financing, construction, and operation and thus made them excellent sources of information for this project.

2. Industry Pathways to Assisted Living

The individuals we interviewed came to the assisted living industry through a variety of routes. Through the interviews, we identified five pathways along which individuals typically become involved in the development of assisted living facilities. On the whole, developers are either:

- Former nursing home providers
- Other senior health and housing providers (exclusive of nursing homes)
- Other health and housing providers (e.g., substance abuse rehabilitation)
- Specialized assisted living providers
- Entrepreneurs (most with real estate background).

Of the 21 individuals interviewed whose companies were involved directly in assisted living development, four began developing assisted living residences as their first foray into either health care or housing. Eight others had experience in other areas of senior housing (e.g., independent living and continuing care retirement communities [CCRCs]). Two developers had a background in other types of in-patient health care settings: substance abuse rehabilitation and acute care hospitals. A growing number of nursing facilities (NF) have spun off assisted living units, some as wholly owned entities and others as stand-alone companies; four of the respondents fell into this category. Two others were former NF operators who left the industry. Only one of the developers we interviewed entered the assisted living business with a strong real estate background.

Several respondents reported that large numbers of entrepreneurs and real estate developers have fled the assisted living industry over the past several years. We were told that real estate developers encountered complications with the assisted living product that they had not anticipated. Some noted that success in the assisted living industry requires a commitment to the long-term well-being of residents, an approach thought to be less highly valued by those in the real estate business. As the one respondent with a real estate background readily admitted, "Builders do not know what they are doing when they get involved in assisted living. They think that it is just a real estate 'play,' but they will later find out that it is much more than a real estate venture."

In addition to the developers, we interviewed individuals from three other groups involved indirectly in the assisted living development process: architects, development consultants, and programming consultants. The backgrounds of the respondents from these groups were not as immediately instructive with regard to the future direction of the assisted living industry. It is interesting to note, however, that assisted living consulting is a burgeoning business. The recent emergence of both Karrington Advisory Services and Assisted Living University is an indication of the growing demand from the

provider community for more and better information about site selection, market area analysis, and feasibility.

3. Size of Operations

Respondents' companies varied in size from large, multistate development corporations to small, "mom and pop" operations limited to one or two buildings in a local area. Ten of the 21 developers we interviewed worked for larger companies. Most of these either had already built or were planning to build campuses with assisted living and independent living. A number of them planned to build several different models, including stand-alone buildings for Alzheimer's patients.

The 11 small companies tended to focus their operations on a particular form of assisted living. For example, one company built exclusively for the cognitively impaired frail elderly population. Another respondent indicated that his market niche was high-end buildings featuring state-of-the-art architecture and design features. While most of the small developers owned fewer than five buildings, these buildings did not necessarily have a small number of units. In fact, several of the small developers owned buildings with over 80 units, much higher than the number of units reported by many of the large-scale developers.

C. Findings Based on Four Key Issue Areas

Despite the variation in respondents' backgrounds, there was consistency in their opinions on the issues addressed in the interviews. From a framework of the five questions presented in Section I, the conversations converged around the following four key issue areas:

1. **Policy barriers to the development of assisted living:** a discussion of the federal, state, and local policy issues that may impede the growth of assisted living development
2. **Trends in assisted living:** a discussion of the areas of greatest change in the assisted living industry and the forces driving that change
3. **The potential for assisted living to serve a larger low-income and Medicaid-eligible population:** a discussion of ways in which assisted living may be made more affordable as well as the issues and concerns around Medicaid reimbursement for assisted living
4. **Issues and concepts of particular relevance to policy-makers:** a discussion of the elements of assisted living that developers urged policy-makers to understand.

1. Policy Barriers to the Development of Assisted Living

Most of the people interviewed identified two or more policy-related barriers that they thought either impeded the development process or would soon affect the industry in important ways. A few of the respondents reported that they could not identify a single policy barrier affecting the development of assisted living, and one respondent insisted that policy-making had become more favorable to the assisted living industry in the past several years. On the whole, however, respondents supplied a varied list of policy barriers at the local, state, and federal levels. With the exception of a few anecdotes describing atypical policy problems, the barriers reported were not issues that appear to pose serious threats to the survival of the assisted living industry. Rather, most of them were the focus of ongoing public policy debates that will likely be resolved through negotiations between the provider community and local, state, and federal policy-makers.

As anticipated, few of the policy barriers cited by respondents fell under the purview of the federal government; federal-level barriers were seldom cited as among the most serious issues. In contrast, many respondents offered specific examples of state-based issues, and several also described local-level issues that represented serious challenges to the future growth of the assisted living industry. Many of the decisions affecting the future growth and direction of the industry occurred at the local level, where fire marshals and local planning boards circumscribed some of the critical components of the design of assisted living facilities. It was anticipated that state policy issues would have increasing relevance for the industry as more states developed specific assisted living licensing categories.

The policy barriers reported to us through the course of the interviews fell into the following general categories:

- General barriers, or a lack of a common definition of assisted living and variation in the product
- Federal policy barriers
- State policy barriers
- Local policy barriers.

a. General Barriers: Lack of a Common Definition of Assisted Living and Variation in the Product

Several respondents argued that the most prominent barrier to the development of assisted living derives from the absence of a common policy definition of the product. Policy-makers are reportedly not well-educated about what assisted living is and how assisted living fits into the long-term care continuum and into the fabric of local community institutions.

Defining assisted living along the health care continuum. One of the central problems facing this industry, as explained by respondents, is that policy-makers and

the general public do not understand the various types of senior housing products, including assisted living. As one respondent commented, "The industry throws around terms like 'CCRC' and 'Independent Living' without really fully explaining what those terms mean." Furthermore, we learned in the interviews that these terms may have different meanings across geographic boundaries. As one developer explained, "There is currently no standard across the country in terms of just a common definition for assisted living. This needs to happen so that the industry can mature and gain credibility. But there are barriers to this happening."

The determination of where assisted living begins and ends on the health care continuum is a crucial part of the defining process for this new industry. Confusion about the industry's proper place and relationship to independent living and skilled nursing is a topic raised by a number of the respondents. One of them suggested "We are in the midst of a revolution about this continuum as the whole health care world is changing." He elaborated "Basically, it boils down to 'what is health care?' Traditional elderly housing is definitely not health care. Hospitals and nursing facilities clearly are health care. What about the middle piece--assisted living? Does keeping someone out of a nursing home constitute health care?" This respondent argued "yes." Yet the debate about where assisted living fits on the health care continuum is far from resolved. As another respondent noted, "The debate between the social model and the health care services model is getting tighter."

Because they felt that policy-makers lacked understanding and sensitivity about the core features and philosophy of assisted living, our respondents expressed a concern about the future regulatory environment for assisted living. They argued that overly stringent regulations have emerged in some areas from a lack of understanding of the assisted living product. In other cases, delays in development of assisted living-specific regulations have resulted in governance by board-and-care laws that are inappropriately matched to new assisted living projects.

In contrast to these stories of regulatory mismatch, we heard several stories about states that had successfully designed assisted living regulations that fit the philosophy and development patterns of the industry. A respondent familiar with the regulatory environment in Minnesota explained that policy-makers in that state had been very supportive and encouraging of the assisted living industry. The respondent reported that "the State of Minnesota has recognized assisted living as an alternative to nursing facilities and has decided categorically not to overregulate this industry." Some city governments have been particularly astute in recognizing the potential for assisted living. As one architect working in urban areas stated, "In many cities, policy-makers are recognizing an opportunity to employ residents of public housing projects to care for their aging neighbors either in the older person's own apartment or in a separate building that would be a relatively simple structure. This concept is much like a CCRC because it allows the care to be provided in the older person's home for as long as possible."

Jurisdictional and geographic variation. One respondent argued that standardizing the definitions of assisted living used by states and the federal government would resolve the confusion in assisted living policy. This respondent told us that "What assisted living means to the Feds is based on old concepts which have remained in the policy. For the states, the terms for assisted living vary considerably. Because the regulations fall under different definitions and are interpreted differently, you never know what you're dealing with." The respondent further explained the history of differences between the federal government and state definitions and approaches to assisted living: "The source of this comes from the states making modifications within older concepts such as 'board and care' or 'congregate care.' As each state upgraded its old regulations for assisted living, it came out differently. The Feds, for their part, started out by calling assisted living 'congregate care.'"

The other overarching theme of the respondents' comments regarding general barriers involved the problem of defining assisted living across geographic and legal boundaries. A number of assisted living developers chose to design assisted living models in response to specific state and local regulations. Not only did the multistate developers we interviewed have different models for each state, but they often had unique plans for each particular residence and its intended site. Despite the apparent inefficiencies in design and construction that resulted from this practice, a number of respondents said that the consumer-driven nature of the assisted living industry makes it necessary to design community-specific assisted living residences. As some suggested, even if the laws across geographic boundaries defined assisted living according to a common set of criteria, the needs and preferences of the resident populations vary enough that the product would naturally evolve differently in various places.

Some we interviewed felt that state laws across jurisdictions do not allow them as much latitude as they would like in developing the appropriate facilities. One developer, who builds and operates facilities in a number of western states, explained that geographic variation in assisted living policy has posed a problem for the company's planned expansion:

We have encountered some problems in delivering our 'full program' of services because licensing rules in other states do not allow assisted living facilities to provide a full-range of services. For example, one state where we would like to start developing provides only a minimal level of services. Our company prefers to offer the same set of services in all of its facilities in all states.

It is worth noting that despite these difficulties, this particular developer intends to expand from three states to ten within the next 2 years.

An architect we interviewed advocates the unification of licensing criteria and the development of common definitions of the product across state government bureaucracies. One major reason given for this is that in some cases the licensing rules do not allow for the level of fire code classification required by the building code regulators. In New Jersey, for example, a dispute arose 5 years ago when, as a

respondent reported, "Developers were required to build assisted living facilities to meet I-1 code rather than I-2, even though I-2 was really more appropriate. This occurred because the assisted living facility could not be licensed under I-2 since it was not a nursing facility." As the respondent who reported this anecdote noted, "Through all this confusion you can see the inherent contradictions between the licensing people and the building code people. The building code people often require you to meet a standard that the licensing people will not approve."

b. Federal Policy Barriers

As mentioned, few respondents reported that federal policies seriously impeded the development of assisted living. However, four federal-level issues did emerge from the interviews:

- ADA and FHAA accessibility rules
- FHAA and assisted living discharge protocols
- HUD 232 loan program
- Federal marketing regulations.

ADA and FHAA accessibility rules. Several of our respondents reported that the Americans with Disabilities Act (ADA) and Fair Housing Amendments Act (FHAA), two laws with potentially wide-ranging implications for both the design and operation of assisted living, require further legal interpretation in the context of assisted living. Interviews indicated that there was a great deal of confusion among developers with respect to the universe of applicability of both the ADA and FHAA. In several cases, respondents used the terms "ADA" and "FHAA" interchangeably. However, while both laws reference design and construction specifications for assisted living, they apply to different areas of the building. Moreover, the provisions in the FHAA have implications for facility discharge protocols, an issue not addressed at all in the ADA.

The architects interviewed explained that the ADA applies to the primary structure of an assisted living building. In the public areas (e.g., the entryway, hallways, kitchens, public bathrooms, living rooms), the building must be built according to ADA accessibility specifications. In contrast, the FHAA applies to the private areas (e.g., resident rooms and bathrooms) of an assisted living building. The FHAA may be used to require certain adaptations of a private room to meet the particular needs of a resident. The important distinction to be made between these two laws is that the ADA determines what is to be "accessible" and the FHAA determines what is to be "adaptable."

"The goal of assisted living," reported one architect, "is to create a residential appearance. This is most difficult to achieve in the bathroom. If the facility is to be built to be handicapped-accessible, then the bathroom takes on an institutional look." In addition to such aesthetic concerns, the architects with whom we spoke expressed reservations about the appropriateness of design standards required by the ADA for some assisted living bathrooms. We were told by several architects that the ADA's

bathroom accessibility standard was designed for the "generic population of persons with disabilities." One architect detailed the many areas of potential difficulty for a frail elderly person using a bathroom designed for a more youthful disabled person: "Disabled access assumes wheelchair-accessible, meaning that a wheelchair can get into a bathroom and can be maneuvered around. In addition, the rules assume transferability from wheelchair to toilet and from wheelchair to shower." These movements, particularly the latter, require enormous upper body strength, which this architect believed would be difficult or impossible for almost all frail elderly persons.

Contributing to this difficulty, explained the architects, is that the ADA requires that the grab bars be installed at a height appropriate for the non-elderly. As a result, respondents indicated that it was often nearly impossible for an older person to successfully transfer to the toilet or shower in an ADA-approved bathroom. ADA-approved showers can also pose a hazard to the safety of a frail elderly person due to the prohibition of any protective "lip" to prevent water from spilling out onto the bathroom floor. One architect reported that the State of New Jersey has approved a variance allowing such a lip to serve as a guard against water spillage. With these issues in mind, several of the architects interviewed stated that some of the ADA-approved design rules might be inappropriate in a facility designed for a frail elderly population.

As confusing as the ADA has been for both developers and architects, the FHAA raised even more troubling questions among our respondents. We were informed that many architects were unsure of the implications of the law's requirement for "adaptability"--does the bathroom need to be altered over a specific time period? In what ways must it accommodate a disabled person? At the time of the interviews, those questions had gone largely unanswered.

FHAA and assisted living discharge protocols. Several respondents explained that the FHAA may be used by operators who would like to avoid mandatory transfer to nursing facilities of residents needing more medical services. Two informants indicated that they believed the nursing home industry is promoting these "blue laws" as a backlash against the idea of "aging in place." The laws either prohibited the provision of certain medical services (e.g., medication management) or established mandatory transfer protocols following the use of a certain maximum number of skilled nursing days in assisted living. The FHAA allows assisted living to be defined as a frail elderly person's "medical home," regardless of disability, which could give assisted living providers ammunition in their competition with the nursing home industry and could change the nature of the aging in place debate.

Some developers and operators were not interested in fighting against mandatory discharge rules. In fact, several individuals stated that their companies were only interested in serving a moderately impaired frail elderly population. Companies that either began in the nursing home business or who continued to maintain skilled nursing components tended to favor this viewpoint; however, a few of the developers who were

employed by companies that had only been involved in assisted living development also preferred less frail residents.

Respondents recommended that the U.S. Department of Justice and state Attorney General's offices discuss possible exemptions or adaptations of the ADA to better serve the needs of assisted living residents. With respect to the FHAA, some respondents asserted that there will likely be years of litigation (driven in part by the nursing home industry) to determine the extent to which an assisted living provider may continue to offer services as residents become more frail.

HUD 232 loan program. A second federal-level issue discussed by respondents concerns the U.S. Department of Housing and Urban Development (HUD) 232 loan program. The slow application and approval process for the HUD program has led some developers we interviewed to seek financing elsewhere. In one case, a respondent explained that he had identified a potential site and was awaiting HUD approval when six companies began to make bids on the same piece of property. He had to give up his first right to the property because he knew that it would take at least 2 years to get HUD financing. "By that time," he explained, "it would be too late." According to another respondent, HUD had implemented an expedited application and approval process, but it was not known if this is working well. One respondent reported that even the expedited approval process was very slow.

Respondents indicated that there were no government-sponsored financing programs other than the HUD 232 program and a small tax credit program. Several developers commented that there should be additional public investment in assisted living in the form of federally sponsored tax breaks and tax credits.

Despite these reported problems and concerns, we are not under the impression that the lack of additional federally sponsored financing has been an insurmountable hurdle in the development process. One developer expressed an interesting position on the financing issue: "Just freeing up public money will not guarantee quality assisted living; this is a separate area of concern."

Federal regulations on advertising and marketing to seniors. One marketing consultant reported that policy decisions made by the Clinton Administration last year have changed the way assisted living is now being marketed. He explained that President Clinton approved revised marketing rules for advertising to seniors that focus on nondiscrimination. These rules reportedly apply to all persons 55 or older and require that advertisements for senior housing include the Equal Opportunity Housing symbol. In addition, this respondent indicated that "any photographs of residents have to be representative of the population residing in the community where the facility is or would be located." This consultant reported that those involved in the marketing of assisted living and other senior housing products have found it difficult to comply with these rules, and a few companies have reportedly filed lawsuits. It should be noted, however, that this individual indicated that he believed the rules were not truly inhibiting and that they were actually a good idea.

c. State Policy Barriers

Respondents reported that some of the most vexing policy barriers were found at the state level. Although we were told that fire code barriers often begin as a state-level problem, these issues will be discussed in the section on local policy barriers due to the influence of local fire officials on the rules. The four areas in which respondents reported state-level policy barriers were:

- Licensing regulations and procedures
- Medication management
- Alzheimer's care
- Certificate of Need process.

Licensing regulations and procedures. A large number of respondents reported problems related to state-level licensing rules. In a number of cases, the states where respondents were developing assisted living facilities had no explicit licensing categories for assisted living; they simply applied existing "board and care," "adult home," or "rest home" licensing standards to this new and very different senior housing concept. One respondent reported that his state had written and then discarded new assisted living-specific regulations in favor of existing rest home rules. He reported that the use of older regulations has resulted in a "massive amount" of regulations for assisted living, many of them not unlike nursing home regulations. Another respondent argued that "Some states appear to be simply copying their nursing home regulations and applying them to assisted living." In states where this is the case, respondents said that regulations could make the development of assisted living prohibitively expensive due to stringent staffing and documentation of care requirements. In several cases, developers told us that licensing requirements were so onerous that they had decided to split up their operations: they opted to deliver "home health care" to frail elderly clients residing in "independent living" units that they also own. We discuss the trend of "split operations" later in this section.

Medication management. State prohibitions against providing certain personal care services as assisted living, particularly medication management, was cited by many as one of the most difficult licensing-related policy barriers. Because of such prohibitions in some states, operators reportedly have had difficulty developing programs of care that can adequately meet the needs of the residents. In some states, the regulations allowed only for self-administration of medications by residents; staff were not allowed to assist in any way with opening or administering the medications. This was a particularly troublesome issue, one developer noted, in the case of residents with Alzheimer's disease and other cognitive impairments.

Alzheimer's care. Respondents reported that laws in several states prohibit any entity other than a nursing facility from providing services to persons with Alzheimer's disease--at any stage of the disease. One respondent indicated that he believed these laws were written to protect the nursing home industry from the growth of the assisted

living industry in serving this population. One developer commented that the only policy barrier he had encountered in the entire assisted living industry involves the prohibition against licensing Alzheimer's/dementia units. He explained that in his state, "The regulations do not recognize a capability worthy of care for persons with Alzheimer's." We heard the same story from other developers. One respondent described the potential impact of state regulations that do not address the limited alternatives for people with Alzheimer's or other dementias:

In Alabama, the state forbids assisted living providers from serving Alzheimer's patients. The prohibition kicks in when a person gets really needy. When aging-in-place leads to this in other states with prohibitions, then the facility staff and state workers negotiate over appropriate alternative settings. However, in Alabama, there are very few appropriate alternative settings to turn to. As a result, the state is facing a very big problem in terms of where to place Alzheimer's patients.

One respondent reported that Alabama established a pilot program to determine whether it was appropriate to care for cognitively impaired residents in stand-alone assisted living facilities. One developer commented that a balance should be struck between the operators and the regulators with respect to Alzheimer's care. As he put it, "A higher level of regulation from states is inevitable but not necessarily bad."

Despite the concerns of the developers that licensing regulations represent some of the most serious policy barriers to the development of assisted living, we heard of no developers deciding not to go ahead with a project due to state licensing requirements. The worst licensing problems seemed to be restricted to a few states, most notably New York according to our respondents. Developers, owners, and architects informed us that, although their work in some states is complicated by confining rules, projects in others are virtually regulation-free. Several developers told us that, in general, they believed the industry is still for the most part unregulated. New Jersey was repeatedly cited as a state that is far ahead of its neighbors in the sophistication and sensitivity of its licensing rules. The developers who were working in New Jersey reported that the state has recognized assisted living as an alternative housing opportunity for persons who might otherwise be admitted to a nursing facility. As one architect explained, "New Jersey wanted to ensure that their persons would be able to age in place for as long as possible, and this played a major role in their discussions about how to regulate assisted living."

Certificate of Need (CON). Certificate of Need is a regulatory process employed by some states to prevent oversaturation of local and state health care markets by nursing home and hospital corporations. In a few cases, CON was being applied (or was being considered for application) to the assisted living industry. Because of competition among many operators of facilities for the frail elderly population, there has been a real resistance to the potential growth of assisted living. In some states, a large number of operators of nursing homes and board and care have reportedly formed two powerful and vocal constituencies opposing the growth of assisted living. As one respondent pointed out, "They [operators of nursing homes and homes for the aged]

feel threatened by the assisted living concept which is in stark opposition to their cinder block-constructed drab buildings."

We were told that a group of operators of adult care homes in North Carolina lobbied to include assisted living in that state's CON requirements, but public support for assisted living apparently prevented the group from achieving its goal. However, there reportedly was still a large constituency in North Carolina that opposed assisted living and would push for increased regulation of operations in addition to CON requirements.

d. Local Policy Barriers

Many respondents noted that the bulk of the barriers to development of assisted living arise at the town or community level. Most respondents mentioned at least one of the two major local policy barriers listed below:

- Zoning
- Fire codes.

Zoning. Our respondents argued that one of the biggest challenges to the development of assisted living was the zoning approval process. Respondents reported that in many places there were no zoning categories appropriate for assisted living because it did not fit into any of the existing zoning categories (e.g., single-family housing, multifamily housing, commercial, or hospital zoning classifications). In the absence of a particular zoning designation, developers reported having difficulty convincing zoning boards to allow them to build. They explained that they were often forced to prove to zoning panels and citizen groups that assisted living would not be a detriment to local communities. As one respondent bluntly stated, "Citizens...think it [an assisted living facility] is like an abortion clinic or something. They visualize hundreds of parking spaces being created."

Some of the developers interviewed were of the opinion that the industry could avoid lengthy zoning battles by pushing for the classification of assisted living as "by right" use. Few zoning ordinances accepted assisted living as "by right" use at the time of the interviews. At least one of the respondents had begun the legal process to advocate for the use of the FHAA to define assisted living as "by right." As one exasperated developer explained about his state, "Housing projects are required to develop moderate income components, while assisted living developers must fight to offer housing for the physically challenged." The "by right" use category of the FHAA was just beginning to be used at the time of the interviews, and respondents suggested that the law's appropriate use needed clarification. For example, one respondent inquired, "Should there be a limit on the number of units for a facility using this standard, or could a 130 unit building be built as 'by right?'" Other strategies reportedly used by developers to get around zoning disputes included "conditional use," "special exemptions," and "rezoning."

As one developer explained, the absence of appropriate zoning classifications was not the result of any active movement against the assisted living industry by planning boards and zoning officials. He explained, "The zoning difficulties are often not related to discriminatory or excessive zoning regulations. The problem is that the zoning regulations are open-ended enough that the approval process for a project is really discretionary." We were told that the most important factor determining a zoning authority's acceptance of assisted living was its level of familiarity with the concept of assisted living. Respondents indicated that education of concerned neighbors (i.e., the citizens making zoning objections) and the zoning officials about what assisted living would mean for their communities is the most effective solution to the zoning problems being faced by many developers. When a community was not familiar with assisted living and seems hostile to the idea, said one respondent, "Developers need to explain to citizens that assisted living will not require heavy demand from the city's infrastructure. Seniors do not produce a lot of waste, and they are not heavy users of property."

Several respondents noted that zoning approval for assisted living was particularly difficult to obtain in particular areas. They reported that the entire State of California and the City of Austin, Texas, were particularly difficult places to obtain zoning approval for assisted living, due to stringent land and environmental protection regulations.

Fire codes. Several respondents also mentioned fire codes as an area of difficulty in the development process. Many states and localities were debating whether assisted living should be required to meet institutional (I) or residential (R) construction codes. Although there was some state-level activity with regard to fire code standards, many respondents informed us that fire codes were enforced in local communities. In towns and small communities with assisted living facilities, a local fire official could reportedly make rulings that affect the design and functioning of the buildings.

One architect explained additional complications associated with the building/fire codes. "The [I2] code addresses the need for an indicator light to be illuminated above all resident rooms in case of a fire, with continuous monitoring at a display at a nurse's station." I-2 is the institutional fire code standard currently required for nursing homes; however, assisted living facilities do not have nurses' stations, and thus, at the very design level, do not meet this part of the code.

Many developers were advocating the use of a "lesser use group" or lesser classification so that they could serve residents who are capable of "self-preservation, that is, exiting the building independently within 2 to 3 minutes in an emergency. However, this option would become problematic in the event that acuity levels rose and residents become incapable of self-preservation. A few developers avoided the problem of fire codes by voluntarily building to nursing home or even hospital fire code standards. As one of these developers explained, "In assisted living, it's in everyone's interests to maximize fire safety....It is a mistake to complain about this and try to get around it."

Some developers argued that fire code provisions are inappropriate for dementia residents who tend to wander. Operators would like to have more flexibility in securing areas with cognitively impaired residents. In many places, developers and regulators are currently negotiating ways to make regulations more responsive to the realities of assisted living design and the needs and capabilities of the residents. One developer operating a facility in a large city reported that his company had successfully negotiated variances of the municipal fire code so that the staff could better protect the safety of residents with Alzheimer's disease.

2. Trends in the Assisted Living Industry

In addition to our inquiry regarding policy barriers to the development of assisted living, we invited respondents to comment on key trends they have observed in the industry in recent years. One respondent issued a warning about developing any list of definitive trends. As he noted, "Because there is such a wide range of products calling themselves assisted living, it is almost impossible to do an apples-to-apples comparison....So many different people are doing different things." With this caution in mind, the following is a summary of the comments made by developers, architects, and consultants regarding the future direction of this industry. Trends were reported in three areas:

- Macro-level trends
- Design trends
- Operations trends.

a. Macro-Level Trends

At the macro-level, market forces are shaping the assisted living industry in important ways. Respondents informed us that these forces were generally acting to expand the market penetration of assisted living. The following five macro-level trends were mentioned:

- Continued growth
- Initial public offerings
- The influence of managed care
- Partnerships with nursing homes and hospitals
- The challenge of maintaining consumer-driven quality.

Continued growth. Most respondents commented in some way on the continued dramatic growth in the industry. One midwestern developer reported, "There has been a dramatic increase in the number of assisted living beds in my state." Eight years ago this developer was one of six developer/owners in her entire state; as of 1996 she was one of 55. She argued that this growth was market-driven. Another developer vividly described the growth of the industry with respect to the development community itself:

In terms of the broader industry, assisted living is becoming big business. When I joined, I was one of the first members of ALFAA [now ALFA, the Assisted Living Federation of America]. Our first conference was like a family reunion with a great group of people. At that time, we could all celebrate that we were doing something that the nursing facility providers and the CCRC operators were not doing. It was a very small universe at that time with very little competition.

One respondent argued that the growth trend in assisted living is a harbinger of changes in consumer preferences. He told us, "The growth of the industry is, in itself, an important trend. Old nursing facility operators are getting into the business, but the nursing home medical model is not what people want anymore. They are seeking something that is more residential and more cost-effective. Assisted living represents a change in philosophy."

There was much discussion among those in the industry about the speed with which the growth was occurring. One developer reported, "There has been so much interest in assisted living in all markets; in all communities there are multiple projects on the boards." While oversaturation was reported in all sectors of the market, respondents agreed that the high-income market is becoming more oversaturated because so many developers have pursued the high rentals associated with this population. One respondent explained the differences across the sectors: "There is overbuilding in certain markets, particularly those that tend to be higher income because they are perceived by developers to be the most desirable. In contrast, the middle- and lower-income markets are underbuilt, and the tertiary [i.e., rural] markets are particularly neglected by the industry."

While growth was celebrated by most observers of the industry, some of the people we interviewed expressed reservations about the nature of competition in the industry as some markets reach the saturation point. One person cautioned, "There are a number of markets that have been identified for growth in assisted living. These kinds of predictions lead to much greater competition in the industry and may lead to occupancy problems and financial stresses over time."

One proposed solution to the problem of market oversaturation suggested by some respondents was the inclusion of larger numbers of both low-income and Medicaid-reimbursed populations in assisted living through more affordable design, construction, and operation. In fact, one of the developers stated, "The demographic trends show a great need for affordable assisted living for an increasingly large number of people." This respondent indicated that he believed this to be the great challenge for the industry.

According to many respondents, including additional income tiers in the resident population could counteract some of the effects of competition discussed above. As one developer noted, "The future challenge of the industry will be to use capital/investment and staffing strategies to make assisted living more affordable to a wider range of people while preserving the core residential quality of the product." We discuss the

strategies identified by respondents for making assisted living more affordable in the next section.

Initial public offerings (IPOs). A number of respondents also reported that increasingly large numbers of firms involved in assisted living are becoming publicly traded companies. This trend has been driven, they claimed, by the need among expanding companies for easy access to capital. The best way that they have found to do this was to "go public." At the time of the survey, there were 12 publicly traded assisted living companies, according to one respondent. Some respondents viewed the IPOs as a positive trend for the larger assisted living companies that could use the additional capital for expansion. Others were neutral on the subject, such as one developer who said, "Many operators are going public, making them accountable to stockholders and boards of directors. I am hesitant to say that this trend is bad, because these public offerings were necessary in order to allow the industry to grow." One of the developers declared that going public "is a big mistake;" that it was good for some larger companies but dangerous for the smaller owners. He argued, "Small companies should be accountable to the clients and the families, not to a private board."

The influence of managed care. Worthy of mention, but not yet a full-fledged trend, was the fact that some respondents anticipated the influence of managed care on the assisted living industry. As one developer said, "Managed care is mentioned in all the literature now; it hasn't yet, but it will have a big impact on the industry." Another developer argued, "Even in states that are now resistant, Medicaid reimbursement and managed care will eventually turn to assisted living if only because of the large number of beneficiaries and growing costs." These respondents exhibited interest in the possibility that managed care could affect their industry through market pressures for lower cost and higher quality. They argued that these pressures could provide the industry with the potential for further growth by increasing the accessibility.

A few developers mentioned that they were designing congregate campuses with a wide variety of services (e.g., various types of rehabilitation and therapies) in order to make themselves look more desirable to managed care companies in the future. One development consultant observed a tactical shift on the part of developers in anticipation of competitive managed care contracts in the future. He explained, "The larger providers will go into the metro areas with three to six facilities in order to capture a larger portion of the urban market. They will do this in order to better position themselves to be recipients of managed care contracts. There is a lot of talk about the future influence of managed care on the assisted living industry."

Partnerships with nursing homes and hospitals. There was also evidence from the respondents' reports that the assisted living industry was changing character as it grew. A few respondents noted the trend toward more joint ventures and other relationships established between assisted living developers and owners of hospitals, nursing facilities, and CCRCs. One developer said, "Hospitals, nursing facilities, and CCRCs are adding assisted living within existing buildings, adding a building for assisted living on an existing campus, or converting whole buildings to assisted living."

Another developer explained that the trend of linking assisted living facilities to either hospitals or nursing facilities represents an extension of the long-term care continuum. One other respondent explained the logic behind these linkages: "Nursing facilities and hospitals are moving toward diversification of their businesses. They see assisted living as a cost-effective solution to the problem of people who are not sick enough to be in a nursing home or hospital but who may need some health care services and may later get more sick."

We also learned that a number of nursing home corporations had spun off entire assisted living divisions to break into this market. From the assisted living point of view, as one respondent noted, "Except for the large national companies, most developers are looking beyond just the assisted living component. They are looking at service needs for the aged within the community as a whole." This respondent had observed a great deal of partnering resulting from this trend.

The challenge of maintaining consumer-driven quality. Many respondents emphasized the importance of consumer-driven quality of the assisted living industry, although it was not always clear exactly to what extent consumers are empowered to influence this industry. Almost everyone we interviewed emphasized the importance of addressing assisted living as a consumer-driven phenomenon. As they described it, assisted living grew out of the preferences of the frail elderly for smaller, residential models of senior housing where autonomy and dignity were highly valued. They said the growth of assisted living has been driven by consumer clarification for how this concept should be defined in design and operation.

Respondents suggested that the consumer-driven nature of the assisted living industry made it a prime candidate for market-driven corrections, as opposed to policy-driven corrections, in its service package, quality, and price. One respondent's comments were representative of many on this issue: "It is about time that they [policy-makers] realized that consumers are capable of making decisions about where they want to live; they can go somewhere else if they don't like it." The concept of the frail elderly "voting with their feet" was apparently an appealing one, because it was mentioned by large and small developers alike. Respondents indicated that consumer power in the assisted living market would increase competition and lead to the expansion of services.

b. Design Trends

Because assisted living is not one model but rather a concept of residential housing for the frail elderly that includes many variations, the trends in the design of assisted living facilities reported here may not be representative of the entire industry. The four areas of design trends discussed below are areas in which there had been a great deal of activity and innovation. The four areas in which design trends were reported include:

- Building size
- Building design features
- Resident room design features
- Resident room occupancy issues.

Building size. According to several of our respondents, assisted living facilities in many areas were being built with square footage that was much greater than in the first generation of development. One architect provided an overview of the historical influences on building size in the assisted living industry:

As the business grew, real estate developers started getting involved, but they came from the condo building side, not the "care" side. At that point, individual units began to grow from 350 to over 500 square feet. These newer developers designed and built larger private rooms, but they did not reduce the size of the common rooms. The result was much larger assisted living facilities that require many more staff and which tend to move away from the philosophy of assisted living as defined in the European models with 20 or fewer units. One of the central reasons for the expansion of facility size is the cost of the commercial kitchen. Each commercial kitchen costs about \$100,000, but developers began to amortize that cost over larger and larger numbers of units.

According to others, it appeared that the trend might be turning back to smaller facilities with somewhat smaller resident rooms. As one developer explained, "Some of the newer developers are moving away from the 100+ unit size back down to the 45- to 50-unit range." She said that the "cost creep" associated with larger facilities had led to a downward trend in numbers of units:

It's true that the result is that overhead cannot be spread over as large a number of units, but the environment is so much better with a smaller facility, and it will reduce cost creep in the long run. The reason is that if you open a 120-bed facility with a typical overhead spread, but without a good discharge plan, then the staffing costs will go through the roof as the residents increase [in] acuity levels and staff are having to shuttle around a very large building or series of buildings. Staffing costs will ultimately get out of control.

If there was a trend toward backing away from the larger models, it was, this respondent argued, because the cost savings in amortizing the commercial kitchen and other fixed costs over a larger number of units was more than offset by the enormous increase in costs due to additional staffing needs. This "cost creep" could be dramatic, according to some of the developers we interviewed. In particular, large facilities were generally ill-equipped to respond to the needs of a frail elderly population that was aging in place.

Building design features. Differentiation in building types was also cited as a growing trend in the assisted living industry. Respondents indicated that assisted living may become a niche market with respect to architecture/design and programming to the extent that custom-made assisted living facilities were already being built according to the specifications of a particular local community's preferences.

Another trend reported by several respondents was the growth in the number of segregated dementia/Alzheimer's wings as well as free-standing dementia/Alzheimer's residences. Some developers reported designing facilities for the various types and stages of dementia. However, as one respondent noted, existing building codes did not allow enough flexibility for life safety protections for these residents. Developers reported that they would like to see a more "user-friendly" environment where residents with dementia could be more closely monitored. One architect suggested that a "group home" model might be the best design scheme for Alzheimer's patients residing in assisted living facilities. Although arguments have been made that Alzheimer's patients can be integrated into facilities with residents who do not have cognitive impairments, all of the people interviewed agreed that it was best to isolate the cognitively impaired. As one developer explained, "A debate is raging about whether to 'mix' residents with and without dementia in an assisted living environment. I do not approve of mixing the two populations, but I have observed that both all-dementia units and mixed units are being built. I think it will be interesting to watch what happens with this issue."

Among the CCRC-based assisted living developers, we received reports that special design plans were being developed for the cognitively impaired population. Yet, as one architect suggested, as with many other aspects of assisted living development, the developers approached this problem in a number of different ways. As he reported, "One facility with a large dementia population might design many small dining rooms in order to minimize disruption, while another facility might prefer the more social atmosphere of one large dining hall."

Resident room design issues. Some of our respondents noted another trend for larger resident rooms, in conjunction with the trend for larger overall building square footage. One developer noted, "The trend is toward more apartment-like dwellings because of an increased emphasis on personal space." One respondent, who was both a developer and a consultant, reported that "People are more willing to spend more money on a larger unit." Another developer concurred that the higher monthly rents associated with larger resident and common rooms would be willingly accepted by many residents. In particular, this developer noted an increased demand for dividers that allow for separation between the living and sleeping areas of the resident rooms.

One architect, however, explained that he had observed both increases and decreases in the square footage of resident rooms. According to this architect, there were two models of development that were equally accepted among developers in the assisted living industry at the time of these interviews. The first model was the active management model, which he described as "reminiscent of summer camp." This model was characterized by very small units with very large common areas, intended to encourage socialization among the residents. Others disputed this notion and preferred to build according to the passive management model, which stipulates the design of very large resident rooms and limited common spaces. Advocates of the second model believed that they would be unable to market a small room to people who were used to living in a large home of their own.

In another area of intense debate in assisted living design, the developers contributed comments both for and against the installation of kitchenettes in resident rooms. Some indicated that a number of states required such installations. One respondent argued for the aesthetic value of the kitchenette. According to her, "The kitchenette is important for 'normalcy' from a marketing perspective," and she reported that her research revealed that "Consumers want kitchenettes." She explained that hot plates or ranges could be switched off for cognitively impaired residents but argued that appliances should be placed in the units regardless of whether or not they are ever used.

Others insisted that installation of kitchenettes in apartments where residents will never prepare food was a waste of effort and money. The strong advocate of kitchenette installation argued that the costs of building the kitchenettes is small in relation to overall costs. She explained that in her particular company, "If you get a 30-day earlier occupancy [due to consumer preference for a kitchenette], it recovers the costs." In addition, she explained that her company was not targeting 15 percent return-on-equity as other assisted living developers were; as a result, her company was not as concerned about this type of cost.

We were also told by a number of respondents that designs for studio-style assisted living apartments were becoming more residential. One respondent reported that, "Even in studios, consumers want a separation of the living space and the bedroom space."

Resident room occupancy issues. Occupancy in assisted living resident rooms was a source of further design-related debate among the developers we interviewed. The issue revolved around whether assisted living was fundamentally a single or double occupancy product. One developer said, "Private rooms are increasingly popular because very few people prefer sharing a room." The market reportedly wants assisted living to be a single-occupancy, high-priced product, but one respondent noted that this is probably not the best direction for the industry to go from a policy perspective. This respondent argued that moderate-income residents could only be effectively served in a double-occupancy model, because it is the only cost-effective model for public financing. The perception exists among many of the respondents that the private-pay resident will not rent a bed in a double-occupancy room. As a result, developers and operators may face some difficult choices about how to design "mixed rental" buildings with both upper-income and middle- and lower-income residents.

A countervailing trend noted by some of our respondents was that more couples and related people are moving into double-occupancy rooms in assisted living facilities. Typically, one of the two is more frail and has several ADL needs. In addition, the demand for two-bedroom units was reportedly increasing, leading at least one of the respondents to provide this option.

One consultant we interviewed was promoting the use of "virtual reality" technology to advance the marketing of assisted living and the process of filling up new facilities. He referred to this type of marketing as "preleasing." As one large assisted living company indicated, "[We] want every unit leased before we open the doors." If successful, preleasing could free developers from some of the financing burdens involved in the early stages of the development process.

c. Operations Trends

- Split operations
- On-site ancillary services
- Continued rapid turnover
- Rising acuity levels

Split operations. Although mentioned by only a small number of respondents, some changes in the way that packages of housing and services were being delivered in assisted living may offer insights into future patterns of service delivery in this industry. In some states, because of zoning problems or because of state prohibitions against bundled housing and services in a single location, there was a growing trend of "split" operations. In this model, one company owns and operates an independent living component (i.e., the housing), and another company (that may or may not be owned by the same parties) delivers home health care on a contractual basis to residents of the independent living units. A developer in Maryland followed this pattern, as one respondent explained, and "[He] has avoided zoning problems because the independent living component can be zoned as multifamily housing." Another developer explained that in Wisconsin, "State regulations prohibit assisted living facilities from providing both health care and housing. As a result, operators run senior housing, and separate home health contractors bring in the services."

One respondent argued that this model was particularly advantageous for couples (where one person is frail and the other is not) who were residing together in assisted living. This constituted essentially an "a la carte" version of assisted living, where residents could choose only the care and services that they needed. As stated above, some frustrated developers followed this model not necessarily because they were driven by consumer demand but because zoning and licensure regulations made development of stand-alone assisted living impossible.

Onsite ancillary services. A few respondents reported that some assisted living campuses were expanding on-site ancillary services as part of a trend toward a broader service package. Respondents indicated that the ancillary services most often added to assisted living service packages were occupational and physical therapy. As one respondent explained, "If a hospitalized resident has already paid their month's rent, then they would prefer to move back to their assisted living unit and receive the therapy services on-site." One architect indicated that he has designed a number of independent living facilities with add-on assistance, in other words, "housing with a 'menu' of services." Another architect explained that, "Except for the large national

companies, most developers are looking beyond just the assisted living component. They are looking at service needs for the aged within the community as a whole (e.g., the need for adult day care)." One developer described a campus he was planning: "On the same campus, we will have home health, physical therapy, rehabilitation, and a 60-unit child day care." All of these services would be provided on top of the standard independent living/assisted living services.

Continued rapid turnover. Respondents also reported that resident turnover in assisted living was as rapid as ever. One developer said, "One of the trends we are seeing is greater-than-anticipated turnover. Average resident ages are between 82 and 85, and in that range, residents often experience abrupt health changes or may slip and injure themselves."

The result of annual turnover on the order of 30 to 35 percent (an estimate provided by one respondent) was that greater attention was being paid to the marketing aspect of assisted living development. Those involved in marketing described a number of changes in their approaches. First, a few noted the growing understanding among industry insiders of the need to market almost exclusively to women. Also, race, religion, and class standards in the resident populations in assisted living residences were shifting. One respondent explained, "In the past, 'white, wealthy, and widowed' was the standard. Now we are learning to accommodate different kinds of people but with many of the same needs."

The impact of rising acuity levels. The developers, owners, architects, and consultants we interviewed repeatedly referenced the impact of rising acuity levels on the future of assisted living. According to respondents, acuity levels among assisted living residents have increased dramatically over the last several years and will likely continue to do so. With the expanded use of home health, many frail elderly persons are remaining in their own homes much longer than they have in the past. One developer reported that she used to see 70-year-olds in her company's assisted living residences; today the residents are almost exclusively in their mid-80s. As a result of both the extension of home care and the increasing acuity of assisted living residents, the typical assisted living resident was both older and more frail than those the industry has cared for in the past. A number of respondents admitted that the speed with which their resident populations have become impaired has taken them by surprise. One developer told us that he had observed a "noticeable difference" in acuity levels in just one year. He stated that "Providers need to recognize higher acuity in their financial models and in accounting for increased staffing needs."

One architect explained that acuity levels in continuing care retirement communities (CCRCs) tended to be even higher than those observed in stand-alone assisted living facilities. In the CCRC environment, this respondent indicated, "An operator can provide assistance to persons in the independent living component for a very long time....These residents age in place for an extended period of time and will likely be more frail than persons moving to an assisted living facility directly from their own homes."

As residents' needs change, the character of an assisted living building also changes, according to respondents. When an operator opens up a new facility, residents tend to have fairly low levels of acuity. As these residents begin to develop more complex medical problems, it becomes more difficult for operators to attract more lower-acuity residents. As one developer explained, "The aging-in-place idea is critical to the success of an assisted living facility. It is important for a facility's profitability to have frequent assessments and reassessments of the residents so that the staffing needs can be matched to the increasing acuity levels." The result of the gradual "medicalization" of assisted living facilities is greater cost through additional staff requirements.

The long-term impact of increasing acuity among assisted living residents may be far-reaching, according to the developers and operators interviewed. One developer described the "slow-down" of his planned development expansion due to increasing acuity:

The plans have been slowed because about 3 years ago we began to observe sociological problems among the residents of some facilities. The operators had not made the appropriate preparations for the problems of some residents especially in cases of dementia. The options they faced were kicking these residents out or integrating them with the healthier resident population.

This developer's company sought to preempt this from occurring by following the Assisted Living Services (ALS) model of continuous monitoring of residents to detect and respond to potential problems.

Many respondents discussed the fact that increasing acuity levels and attendant "cost creep" (particularly in the larger facilities) had led to a philosophical conflict between the need for specific discharge protocols and the altruistic character of the industry. As another respondent bluntly put it, "The medical model versus the residential model is a lot of hype." Increasing acuity levels over time make the medical-versus-residential model debate moot, because, as many developers who experienced this first hand indicated, operators do not have as much control as they think in determining the level of medical needs of their resident populations. What operators did have some control over, and this may well create intense internal debate in the industry, was the upgrading of service packages in response to more complex medical problems in the assisted living environment. Some developers were reportedly developing assisted living residences designed expressly to provide higher levels of care.

New Jersey's I-2 building code controversy illustrated much about the great variance in attitudes among providers with respect to how they intended to serve residents with complicated medical needs. In that state, the debate over building codes evolved into a debate about the concept of limiting the extent of care provided in assisted living. Some of the developers in New Jersey were reportedly disappointed that the state chose to limit the provision of care within assisted living. We learned, however, that others in New Jersey and elsewhere never intended for assisted living to become a

laboratory for the concept of aging in place. As one architect explained, "In response, some developers indicated that they did not want to serve a very frail population; they wanted to serve persons up to a certain point and then they would discharge them from their facilities."

What "assisted living" means in terms of the provision of medical services and where assisted living should fit on the long-term care continuum are critical issues with important public-policy implications. As assisted living begins to include a larger Medicaid-subsidized resident population (as we were told by developers who felt it was likely), state policy-makers in particular will be faced with some tough decisions: To what extent will states accept some of the risk in caring for the frail elderly in an environment that has less-stringent life safety requirements and lower staff ratios and staff training requirements? Will the states respond to the consumer-driven nature of this industry and support resident preferences for autonomy and "dignity of risk"? Will states accept the notion that assisted living residents can age in place in facilities with operators who seem willing to provide more medical services over time, or will states definitively classify assisted living by certain acuity level or nursing care limits? How the states answer these questions and how the provider community negotiates an acceptable outcome will likely be an interesting public-private process of policy negotiation.

3. Assisted Living for a Low-Income and Medicaid-Eligible Population

The sponsors of this study expressed a particular interest in learning about the extent to which assisted living may be able to serve a larger lower-income and Medicaid population. We asked respondents a series of questions related to this topic, including questions about how to make assisted living generally more affordable, about the feasibility of Medicaid reimbursement, and about the desirability (from a business perspective) of serving the lower-income and Medicaid populations. The central issues that arose from the interviews included:

- State-level interest
- Feasibility of making assisted living more affordable
- Provider interest
- Possible impacts of changing the industry from an almost exclusively high-end product to a more streamlined, publicly subsidized product.

a. State-Level Interest

A few respondents suggested that state-level financing of assisted living need not require Medicaid reimbursement for all of the costs of assisted living. One respondent noted that, under existing rules, "Patients have to impoverish themselves, and then the state agrees to pay for everything. This creates a situation where a state pays for something that they do not have to." This respondent advocated the expansion of the model currently being promoted in Pennsylvania, where the state agreed only to pick up the cost of the service component of assisted living. The benefit of such a strategy, this

respondent argued, was that a state would have more flexibility to expand eligibility. It was suggested that remaining funds required to pay for the housing component could come from Social Security or earnings on assets. A similar option existed in North Carolina, which had begun reimbursing the personal-care component of assisted living and adult care with Medicaid funds. Several respondents also suggested that rules prohibiting family supplementation for Medicaid-eligibles should be eased.

b. Feasibility

Regarding the willingness of the provider community to consider lower-end models of assisted living, a large number of respondents remarked that assisted living could be developed more affordably and that Medicaid reimbursement for assisted living was feasible. Only a few of the developers expressed concern that costs could not be appreciably reduced. These more pessimistic respondents argued that land, construction, and staffing costs would continue to rise in the foreseeable future, challenging any attempts to achieve cost savings.

Architects provided specific examples of areas in which assisted living could be designed and built for less. All of the architects affirmed that they could design a variety of low-cost assisted living buildings. In addition, more than one developer explained that through aggressive cost containment, assisted living could be made more affordable. As one developer stated, "Someone is going to have to develop truly affordable assisted living in the future." The most frequently mentioned sources of cost savings were:

- Building "reuse" or renovation in place of new construction
- Removal of superficial features that do not add to the quality or safety of a building
- Design of dual occupancy resident rooms
- "Mixed rentals," where private-pay residents subsidize the costs of low-income residents
- Flexibility with regard to licensing and other regulations.

A number of respondents noted that the "bells and whistles" associated with assisted living design features could be removed without threatening the core philosophy of assisted living or the required life safety features. Nearly all of the developers who indicated that assisted living could be made more affordable suggested that the key to cost savings was dual occupancy or semi-private rooms. As one developer commented, "The only way you can serve these populations through assisted living is by designing facilities that are double occupancy rather than single occupancy."

The mixed-rental concept with cross-subsidies of private-pay and Medicaid residents was another frequently suggested option. One developer commented that

"Having the private-pay residents can probably keep you making a profit." Other strategies reportedly being adopted included cross-training of staff (multitasking), cheaper design and construction (one-story wood construction), and building reuse. We were also told that, among the not-for-profit providers, endowments were sometimes made available, which made assisted living affordable for lower-income residents.

Whether or not it is possible to reduce the cost of building and operating assisted living residences, one architect reminded us of the potential for cost savings through the diversion of nursing home residents to assisted living. Even if an assisted living facility was attached to a nursing facility, cost savings could accrue because staffing ratios could be reduced. As the architect explained, "With a rent of \$2,500 per month, the per diem for assisted living could be as low as \$75 [per day] as compared to the \$130 to \$150 for a nursing facility per diem."

c. Provider Interest

A few respondents were banking on the often-cited estimates of large numbers of inappropriately placed nursing home residents to forestall the saturation of the market. As one respondent noted, however, it has been estimated that, of the 25 percent of nursing home residents who might be better served in assisted living, 75 percent could not afford the monthly rents. Developers were cognizant of this fact, and nearly all indicated that they would be willing to take steps to make assisted living more affordable. Many also agreed that they would be interested in accepting Medicaid-eligible frail elderly residents. One developer said, "[The lower-income market] can be a large market from a business standpoint. Granted, you lose some control to the state, but there are many advantages in providing this option to the many low-income persons who cannot afford assisted living."

A few of the developers already accepted Medicaid reimbursement for some portion of the residents in their buildings. One consultant reported that the largest assisted living companies in the country had all expressed an interest in expanding services to the lower-income populations. We were also told that newer entrants to the industry and operators of smaller buildings tended to be more positive than others about the prospects for Medicaid reimbursement. Many respondents reported that it was a responsibility of the industry to serve the lower-income population. The not-for-profit providers, in particular, had historically important missions driving their interest in serving low-income and Medicaid populations.

Although there was some support for Medicaid reimbursement, some developers indicated that they were not interested in serving a Medicaid-reimbursed population. As one respondent stated, "We have determined that, more than ever, we do not want to go into the Medicaid business. As long as the reimbursement rates are kept so low [or]... frozen for a number of years, my company will remain uninterested."

While many respondents were supportive of efforts to expand assisted living to include lower-income residents, many agreed with the suggestion that others in the

industry may not look forward to this prospect. As one respondent noted, "Business is thriving now with all the private-pay dollars and the moderate regulation. After you open the gates to Medicaid, the margins will decline." This might have been a concern for some because, as one developer explained, he expected 40 percent or more gross operating margins for private-pay-only buildings and 20 to 30 percent margins for Medicaid buildings. This respondent argued that even though it was affordable for his company to serve the Medicaid population, his company was holding out for better reimbursement rates. Another developer indicated that he would be more willing to consider accepting Medicaid residents if the federal government offered tax breaks or tax credits.

Two other respondents indicated that the only way that Medicaid reimbursement could work was through the implementation of a voucher program. A voucher system, they explained, could maintain the balance between an operator's responsibility to the consumer and the consumers' ability to walk out with their money if they were dissatisfied with the services provided. This developer warned that "We will kill assisted living if we apply the conventional model of Medicaid reimbursement to this industry."

From our conversations with developers, we concluded that the key decision factor for many operators considering participation in the Medicaid program will be the reimbursement rate. Many of the providers explained that they would like to participate in Medicaid waiver programs but cannot due to the inadequacy of reimbursement rates. The problem was made clear by a California developer who explained that the board and care reimbursement rate was \$700 per month for a single occupancy room and \$1400 per month for the same room with double occupancy. This developer insisted that there was no way to deliver services in assisted living for less than \$1500 per person per month--even with the cost savings strategies discussed above. Unless California designates higher reimbursement rates for assisted living, this developer would be unable to participate and certainly unwilling to offer private rooms to Medicaid recipients. One of the other major concerns voiced was that care for patients with Alzheimer's, at about \$2800 per month, was too expensive for Medicaid reimbursement.

d. Potential Impacts

The major concern among respondents was that state Medicaid programs would be unwilling to reimburse at the private pay rates, even if those rates were still substantially less (sometimes as much as two-thirds less we were told) than nursing home rates. Some states had negotiated what operators considered to be reasonable rates, but other states offered rates so low (e.g., some states were offering to pay only \$20 per day without even factoring in the level of care and the staffing required) that the operators declined to accept Medicaid residents.

In addition, assisted living operators were fearful of the costs associated with the regulations that are likely to be imposed on assisted living facilities providing services to Medicaid beneficiaries. One explained, "There is an immediate cost implication of every regulation imposed." Many argued that, while regulations related to staff training and

safety issues should remain mandatory, other regulations unnecessarily raised the price of assisted living.

According to one respondent, in one state both regulations and costs increased with Medicaid reimbursement. As a supplement to base rates, the state agreed in this situation to reimburse only for medication administration. Because state rules required registered nurse (RN) coverage for this personal care service, the providers in this state (including the respondent) had to contract with an RN to oversee the program. In addition, care staff at the facility had to meet new certification standards. All of these adjustments cost the developer more than the \$150 per month of reimbursement that the state had agreed to pay. A heated debate ensued between the providers and the state, but the providers ultimately lost. The developer expressed frustration with the process and with the lack of influence of the provider community on the outcome.

Some respondents warned that, if more state Medicaid programs begin to reimburse for assisted living, then projects will be built to be profitable at the reimbursement level, and quality will decline as well. However, one developer/operator who currently provides some Medicaid-reimbursed units explained that they limited Medicaid units to 20 percent of one of their buildings. They had developed financial models to make the building profitable, but he explained, "We cannot maintain the building, supply appropriate staff, or control quality to our highest standards."

A marketing consultant expressed the view that two tiers of assisted living would result from efforts to expand the product to more lower-income frail elderly persons. As he described the scenario, "The high-end tier will experience fierce competition for [private-pay] residents, while the low-end tier will have no trouble with fill-up. As a result, this two-tiered phenomenon will require very different marketing strategies." This respondent predicted that in states like Ohio, Missouri, Indiana, and New York, where there are large populations of persons aging in place, lower-end assisted living would experience particularly rapid fill-up.

A number of respondents argued that Medicaid reimbursement for assisted living should be provided for only the truly needy. Respondents predicted that, unless specific state-level action was taken, middle-class elderly persons would "spend down" to become Medicaid eligible. As one developer explained, "[In our state,] older persons can divest themselves of their assets over a two- to three-year period and make themselves Medicaid-eligible through this estate planning process. Given these possibilities, states should monitor very closely the middle-income estate planning phenomenon."

We were also informed about the risk of growing numbers of "bad" operators. One developer suggested, "Anyone willing to accept these low reimbursement rates could theoretically get into the business. Because they would be serving the Medicaid population, they would have no trouble filling such a facility almost instantly and could operate a fairly shaky facility." This respondent urged that state policy-makers watch the

trend of what he described as "Shoddy operators getting the Medicaid reimbursement and not making a real commitment as a provider to do a good job."

4. Important Issues and Concepts for Policy-Makers

At the conclusion of each interview, we provided respondents with an opportunity to help us identify areas in which policy-makers could be better informed about assisted living, as well as the key policy issues that they should consider. The four themes of these closing remarks were the following:

- The industry faces substantial challenges in making the concept work.
- Developers and policy-makers need to work together to make regulations flexible enough so that developers can respond to different needs, preferences, and pocketbooks, although some degree of standardization could be useful.
- Policy-makers should be very cautious about overregulating the industry, striving for the appropriate balance of public (market-oriented) and private approaches to quality assurance.
- There is substantial potential for assisted living to care for a more disabled and sicker population (both as the industry changes and as residents age in place); approaches to financing and quality oversight that recognize this must be developed; the issues are very complex.

a. Substantial Challenges

One challenge faced by the industry is a lack of sophistication regarding the product. As one respondent noted, "Most builders do not know what they are doing when they get involved in assisted living. They think that it is just a real estate 'play,' but they will later find out it is much more than a real estate venture." Moreover, Wall Street has been following this mistaken logic by highly valuing the "pure real estate plays" in the assisted living industry. One respondent noted that Wall Street had the incorrect notion that assisted living developments were guaranteed "get-rich-quick" schemes.

In fact, argued one individual, "this industry is about meeting the needs of seniors for 5, 10, even 20 years." This respondent and others maintained that assisted living companies need to continually alter and update their services. Some of the upgrades that will be required as the industry evolves will be expensive, respondents warn. The 25 to 35 percent profit margins anticipated by many new developers may serve as a strong pressure against acceptance of costly improvements in physical plant and programming, and this pressure should be recognized by policy-makers.

Acceptance of the inherent costs in assisted living may require a paradigm shift, according to some respondents. One of them noted, "[While] policy-makers need to understand the new concept is about freedom and dignity, this has required a mindset

change for [my company] as well, because [it] started out as a nursing home [company]." In this "mindset shift" lies the key to the future of the assisted living industry. As one observer noted:

Sixty to 70 percent of the costs for assisted living are in the staffing, not in the construction costs. If you strip away the extra staffing expense, then the product becomes much more institutional, and the philosophy of assisted living is lost.

Some of our respondents noted that developers need federal assistance in financing this product at lower cost. Policy-makers may wish to consider whether and how this might be feasible.

b. Flexible Regulations, Some Standardization

Several respondents remarked that developers and policy-makers need to work together to make regulations flexible enough so that developers can build facilities that are responsive to different resident populations' needs. "Consumers like flexibility in what they can choose," said one respondent. If residents have more options available, respondents suggested, their needs will be better accommodated. For example, as one respondent noted, "One would design a very different facility for a population with a large percentage of dementia residents as compared to a population with very few dementia residents." Respondents repeatedly commented that policy-makers needed to understand clearly that not all residents are the same and to reflect that understanding in the drafting of regulatory legislation. As one developer noted, "It is important to keep in mind that assisted living is on a continuum from straight housing with one meal to secure housing with three meals to tightly monitored Alzheimer's care....The regulations must be responsive to these different levels."

The developers were of the opinion that there was a tendency among policy-makers to slip into "institutional thinking mode" and to promote building codes that were as strict as those for nursing homes. The developers readily conceded the importance of physical plant features such as fire sprinklers as critical safety requirements for assisted living facilities, but they argued that nurses' stations were neither necessary nor desirable. As one respondent argued, "Lots of building code requirements are really overkill. These things increase the cost of the building, costs which are passed on to the residents. [Some examples of this are] requirements for \$500 smoke dampers in the duct work and some of the ADA space requirements with respect to turning radius [for wheelchair accessibility]."

One roadblock to standardization of regulations is the variance in these regulations across geographic areas. As more than one respondent noted, there was no standard definition of assisted living across the country. Without a common definition of some sort, states will continue to build assisted living residences under building codes that are different from building codes in the rest of the country.

c. Do Not Overregulate, Strive for Balanced Quality Assurance

While virtually everyone cautioned against overregulating this industry, respondents' opinions and perceptions differed regarding how much could and should be left to market forces alone. Some of the comments reported to us on this topic include:

- "Let the market make the determinations about which facilities are good and which are bad. There is enough competition in this industry such that people operating the wrong product are not staying in the business very long."
- "Policy-makers should avoid regulating assisted living more than it is being regulated now. State licensing people are doing a good job of shutting down the bad operators."
- "As it is now, the government is trying to legislate integrity and morality [in the assisted living industry]. In doing so, the price of the product will inevitably increase and will inevitably result in a situation in which lower income people will never be able to afford the product, and the government will have to step in with publicly financed reimbursement. If I put my mother in an assisted living facility and she becomes dissatisfied with the care, then it is my responsibility to remove [her] from the facility."
- "The final version [of assisted living] isn't here. Assisted living is still in the embryonic stage at this point. Overregulation will surely stifle the creativity of the industry."

Despite these concerns about overregulation, most respondents supported some oversight of the industry. As one respondent reported, "In terms of staffing, policy-makers are right to pressure for additional staff and better-trained staff, but they don't need to be heavy-handed about it." A few referenced the ALFA-sponsored accreditation movement. As one individual explained, "ALFA is currently trying to implement industrywide quality assurance regulations for the industry to move forward with immediately....If all operators adopt this set of rules, [the industry] will adapt more easily and at less cost than if similar rules were imposed by state regulators." Others advocated some sort of government involvement in "best-practices" guidelines for assisted living. "Policy-makers should do it through best-practices guidelines. Best-practices guidelines will in fact hurt bad providers."

Many respondents felt that there was substantial potential for assisted living to care for a more disabled and sicker population (both as the industry changes and as residents age in place). However, lack of knowledge among policy-makers may impede this process, according to some respondents. A number of our respondents argued that policy-makers did not fully understand how assisted living fits on the long-term care continuum. As one respondent argued, "policy-makers do not fully understand how assisted living fits between acute care and skilled nursing care. It is easy to show that

30 percent of the residents of an SNF [skilled nursing facility] do not need that level of care." Another explained, "The nursing home industry is really going too far--they 'care people to death.' Eighty percent of the nursing facility population could be better served in some other type of care model."

One respondent argued that policy-makers should recognize the value of assisted living as a potential substitute for nursing facility care. One respondent stated, "policy-makers should recognize the potential substitution of assisted living for nursing facility care would require much more regulation of the industry, because assisted living is not currently equipped to provide the same type and level of services as a nursing facility. In most states, assisted living has already begun to replace intermediate care facilities but not skilled nursing facilities." In the same vein, another respondent argued, "Leave the assisted living industry as regulation free as possible. Only take action when the acuity level goes way up."

The real concern for policy-makers may be the balancing of risks in assisted living. As resident acuity levels rise in assisted living residences, it may become more difficult for policy-makers to navigate between the interests of the government in protecting the personal safety of the frail elderly and the interests of the frail elderly in protecting their dignity and autonomy. One respondent may have captured the issue best:

The biggest problem that everyone has with this industry is also its blessing. When we put an assisted living product on the market, meeting all relevant licensure rules, it is [a more] residential physical plant than the norm for that area. At a certain point, assisted living becomes the norm, and the market pushes it to serve [more disabled people]. At what point does this market-driven thing have to say no? At what point do you define risks--and who absorbs those risks--operators, consumers, the state? This is the most critical [part] of the discussion currently taking place regarding this industry. In a state's mind, they want us [the developers] to expand physical plant and staff to cover increased risk; this costs us a lot of money. From the point of view of the resident, having some risk is important at the outset, [but] with aging in place, families begin to push for greater security and providers are encouraged to take on greater risk. Who bears the burden for expanded risk? What is the most equitable? As needs change, how do we codify our expectations over time?

III. CONCLUSIONS

This report summarizes findings from interviews with 29 individuals involved in the development of assisted living facilities. As part of A National Study of Assisted Living, this report discusses some of the important policy-related issues shaping this industry.

Five key points emerged from our analysis of the interviews:

- Local- and state policy-makers will face additional decisions with respect to the design of assisted living residences as well as the extent to which assisted living should provide medical services to the frail elderly.
- The assisted living industry will continue to grow and may oversaturate certain high-end markets.
- Many developers are working on ways to make assisted living more affordable.
- Rising acuity levels will have a major impact on the design and fundamental concept of assisted living in the future.
- Assisted living is identified as a consumer-driven phenomenon, but the extent to which the market should bear the responsibility for quality assurance is the subject of much debate.

We remind the reader that this report is a summary of a limited number of interviews. This being the case, any trends reported or policy issues described should be taken in their proper context. With additional research and attention to this industry, we may learn about the degree to which the comments of these 29 interviewees represent the opinions and observations of others working in the assisted living industry.

APPENDIX A: INTERVIEW LIST

Charlie Barr
Care Technologies
Atlanta, GA

Alan and Deb Black
Senior Innovations
Minneapolis, MN

Tim Buchanan
Sterling House Corporation
Wichita, KS

Frank L. Conaway
Primelife
Orange, CA

Michael Doyle
CareMatrix
Burlington, MA

Robin Eggert
KKE Architects
Minneapolis, MN

Michael Falcone
Pioneer Development
Company
Syracuse, NY

Scott Ganton
Ganton Retirement
Communities
Jackson, MI

Robert Griffis
Green Briar
Addison, TX

Trish Hall
Beverly Enterprises
Fort Smith, AK

Peggy Kelly
Kelly's Retirement Home
Pierre, SD

Michael Liu
The Architectural Team
Chelsea, MA

Ed McCarthy
Parkside Senior Services
Park Ridge, IL

David Mussleman
Mussleman & Associates
Florence, AL

Linda Neher
Health Resources, Inc.
Tualatin, OR

Edward Novak
Nova-Habitat
Potomac, MD

Scot Park
Karrington Advisory Services
Cleveland, OH

Greg Roderick
Regency Park Living Center
Portland, OR

Gil Rosenthal
Wallace, Roberts, and Todd
Philadelphia, PA

Greg Stevens
Senior LifeChoice Corp.
Sea Girt, NJ

Judy Stevens
Retirement Housing Foundation
Long Beach, CA

Peg Thompson
Thompson, White, & Assoc.
Huntsville, AL

William Vaughn
CareHaven Corp.
Cary, NC

Gary Wade
AdCare Health Systems
Springfield, OH

Whitney Wagner
Beery Rio and Associates
Annandale, VA

Ardith Wahl
Kensington-Bismarck
Bismarck, ND

Tal Widdis
Arden Court, Manor Care
Silver Spring, MD

John Wilcheck
Building Solutions
Trexertown, PA

John Zeisel
Hearthstone Alzheimer's Care
Lexington, MA

Exhibit A.1 illustrates the geographic regions from which our interviewees were drawn. These are the states in which the respondents and their companies or organizations are located. It should be noted, however, that many of the respondents are involved in assisted living in multiple states. As a result, this survey's representation of the assisted living industry is greater than this map would suggest.



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Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

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NATIONAL STUDY OF ASSISTED LIVING FOR THE FRAIL ELDERLY

Reports Available

A National Study of Assisted Living for the Frail Elderly: Discharged Residents Telephone Survey Data Collection and Sampling Report

HTML <http://aspe.hhs.gov/daltcp/reports/drtelesy.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/drtelesy.pdf>

A National Study of Assisted Living for the Frail Elderly: Final Sampling and Weighting Report

HTML <http://aspe.hhs.gov/daltcp/reports/sampweig.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/sampweig.pdf>

A National Study of Assisted Living for the Frail Elderly: Final Summary Report

HTML <http://aspe.hhs.gov/daltcp/reports/finales.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/finales.pdf>

A National Study of Assisted Living for the Frail Elderly: Report on In-Depth Interviews with Developers

Executive Summary <http://aspe.hhs.gov/daltcp/reports/indpthes.htm>
HTML <http://aspe.hhs.gov/daltcp/reports/indepth.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/indepth.pdf>

A National Study of Assisted Living for the Frail Elderly: Results of a National Study of Facilities

Executive Summary <http://aspe.hhs.gov/daltcp/reports/facreses.htm>
HTML <http://aspe.hhs.gov/daltcp/reports/facres.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/facres.pdf>

Assisted Living Policy and Regulation: State Survey

HTML <http://aspe.hhs.gov/daltcp/reports/stasvyes.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/stasvyes.pdf>

Differences Among Services and Policies in High Privacy or High Service Assisted Living Facilities

HTML <http://aspe.hhs.gov/daltcp/reports/alfdiff.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/alfdiff.pdf>

Family Members' Views: What is Quality in Assisted Living Facilities Providing Care to People with Dementia?

HTML <http://aspe.hhs.gov/daltcp/reports/fmviews.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/fmviews.pdf>

Guide to Assisted Living and State Policy

HTML <http://aspe.hhs.gov/daltcp/reports/alspguide.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/alspguide.pdf>

High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey

Executive Summary <http://aspe.hhs.gov/daltcp/reports/hshpes.htm>
HTML <http://aspe.hhs.gov/daltcp/reports/hshp.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/hshp.pdf>

National Study of Assisted Living for the Frail Elderly: Literature Review Update

Abstract HTML <http://aspe.hhs.gov/daltcp/reports/ablitrev.htm>
Abstract PDF <http://aspe.hhs.gov/daltcp/reports/ablitrev.pdf>
HTML <http://aspe.hhs.gov/daltcp/reports/litrev.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/litrev.pdf>

Residents Leaving Assisted Living: Descriptive and Analytic Results from a National Survey

Executive Summary <http://aspe.hhs.gov/daltcp/reports/alresdes.htm>
HTML <http://aspe.hhs.gov/daltcp/reports/alresid.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/alresid.pdf>

State Assisted Living Policy: 1996

Executive Summary <http://aspe.hhs.gov/daltcp/reports/96states.htm>
HTML <http://aspe.hhs.gov/daltcp/reports/96state.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/96state.pdf>

State Assisted Living Policy: 1998

Executive Summary <http://aspe.hhs.gov/daltcp/reports/98states.htm>
HTML <http://aspe.hhs.gov/daltcp/reports/98state.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/98state.pdf>

Instruments Available

Facility Screening Questionnaire

PDF <http://aspe.hhs.gov/daltcp/instruments/FacScQ.pdf>