

The Assisted Living Alternative: What Is It; Are Changes Needed?

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What Is Assisted Living and Why Was It Created?

- From nursing home to formal in-home services (1975-1990) and the emerging focus on accommodating consumer preferences and values
- From congregate housing to housing with services (adult foster care and multiple forms of assisted living)—adapting the in-home care rationale to congregate housing (accommodating consumer preferences and values)—1985 to present
- The values framework for AL—the values of autonomy, privacy, dignity and homelike environment first emerged with in-house LTC, but have been more explicitly articulated in AL as part of the argument for resisting excessive (nursing home-oriented) regulations

The Growth and Evolution of Assisted Living

- From congregate care to assisted living—common philosophy, multiple types
- Growth of AL from 1985-2005—800,000 to 1,000,000 residents now reside in AL and many (most) are aging in place under conditions of relative autonomy, choice, dignity and privacy in a homelike environment
- Changing regulations—less restrictive admission/retention criteria have helped the growth of the AL population

Growth and Evolution (cont'd)

- Assisted Living Medicaid Waiver—
available in 45 states but growth in number
of publicly supported residents has been
slow
- AL growth has helped reduce NH use—
from 1.7 to 1.4 million NH population
- This impact has occurred mostly within the
private-pay population

What Do We Know About Who's in AL, Quality of Services and Achievement of AL Values

- The AL research base is growing (Hawes, Golant Zimmerman, Kane, Hedrick, Morgan, Ekhart, Salmon, and Hyde)
- AL serves a wide range of residents (physical and cognitive impairments, age) in a wide range of facility types and costs (\$1,200 to \$5,000—\$2,500-\$3,000 average a month) vs \$5,500 to \$6,000 for NHs—significantly less impaired on average than NH residents, but with a large overlap population

What Do We Know (cont'd)

- No one type (small or large) appears to be generally superior in terms of currently available outcome data—small facilities are more homelike, but large, purpose-built facilities offer more health care services and privacy
- Variance in services provided and associated outcomes may have significant implications for consumers and require trade offs—Medical services (RN) and well-developed dementia care units may help *retention* and support aging in place (Hawes)
- Resident satisfaction is generally high (Hawes, Zimmerman, Hedrick), possibly highest in small, more familial facilities, including foster homes (Hedrick-Washington)

What Do We Know (cont'd)

- AL may be a better environment for achieving autonomy (sense of control) and maintaining dignity and increasing consumer satisfaction than either NHs or in-home programs (Salmon)
- This may be especially true for those without caregivers and those with dementia (mild to serious)

Policy Implications

- AL isn't perfect, but there is no evidence at this point that AL regulations should be made qualitatively more restrictive. May need more extensive disclosure requirements and dementia care unit specifications, but:
 - Admission, retention criteria and staffing levels (as needed) should be kept or even made more flexible and person-oriented.
 - Negotiated risk should be supported and monitored (choice and autonomy)

Policy Implications (cont'd)

- Dementia care—the AL Workgroup guidelines (2003) are sound and should be adopted
- Physical plant and environmental design—homelike, interior/exterior, private rooms (a controversial, but critical issue from the perspective of AL values—privacy and autonomy)
- Training—Alzheimer's care training is increasingly necessary. More focus on AL philosophy
- Nurse delegation—helps contain costs without sacrificing quality
- Quality of life criteria—regulatory priority should be given to all the soft stuff (enjoyment, meaningful activity, relationships, dignity, privacy, autonomy/choice, individuality (sense of identity), spiritual well-being)

Policy Implications (cont'd)

- Use case managers to monitor and ensure quality of life and care—keep caseloads at or below 40:1.
- Extend consumer direction to AL—consistent with AL philosophy (resident control)
- Maintain/enhance the variety and diversity of AL—no one type (size, services) is ideal for all residents (Zimmerman, 2005). This will require a concerted effort to preserve a role for the small facility
- Expand the Adult Foster (Family Care) Home Program (Oregon, Washington-Hedrick)—availability (inexpensive) and quality of life advantages for some residents

Policy Implications of What We Know

- The greatest AL challenge is availability for the less affluent, not its regulatory structure
- Expand publicly supported AL at a substantial and predictable annual rate through the Medicaid waiver programs and keep rates competitive
- AL is arguably the most underdeveloped part of the publicly supported LTC system and has the potential to be a cost-effective component as the number of frail elderly without caregivers grows
- The future of AL for the more seriously impaired (NH profile) and medically complex is still unclear and could be substantially influenced by the evolution of negotiated risk legal arrangements
- Furthermore, an effective balance between the values of AL and aging in place may not be achievable beyond a critical mass of service needs—potential limits of a hybrid model