The Place of Assisted Living in Long-Term Care and Related Service Systems

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Purpose: The purpose of this article is to describe how assisted living (AL) fits with other long-term-care services. Design and Methods: We analyzed the evolution of AL, including the populations served, the services offered, and federal and state policies that create various incentives or disincentives for using AL to replace other forms of care such as nursing home care or home care. Results: Provider models that have emerged include independent senior housing with services, freestanding AL, nursing home expansion, and continuing care retirement communities. Some integrated health systems have also built AL into their array of services. Federal and state policy rules for financing and programs also shape AL, and states vary in how deliberately they try to create an array of options with specific roles for AL. Among state policies reviewed are reimbursement and rate-setting policies, admission and discharge criteria, and nurse practice policies that permit or prohibit various nursing tasks to be delegated in AL settings. Recent initiatives to increase flexible home care, such as nursing home transition programs, cash and counseling, and money-follows-the-person initiatives may influence the way AL emerges in a particular state. Implications: There is no single easy answer about the role of AL. To understand the current role and decide how to shape the future of AL, researchers need information systems that track the transitions individuals make during their long-term-care experiences along with information about the case-mix characteristics and service needs of the clientele.

Key Words: Senior housing, Housing with services

One of the issues that is subject to much debate among policy makers, providers, consumers, and researchers is where assisted living fits within the continuum of health, long-term care, and related service systems. Drawing upon the limited empirical research in this area, the current status of provider models, and our own experience in developing and analyzing the evolution of assisted living policy at the state and national levels, we attempt to address the place of assisted living in the service system for elders and other people with disabilities. We begin by describing the population that assisted living is serving and how that has changed over time. We then describe changes in service delivery over time and discuss varying formulations of how both the provider and consumer perspectives view the place of assisted living, including transitions between and across settings. We follow this with a review of how federal and state policy shapes the current role of assisted living in the continuum, with a special focus on incentives and disincentives for substituting assisted living for other forms of care, such as nursing homes and home care. We conclude with some recommendations for a research agenda, including questions that need to be addressed and methodological issues that emerge.

Whom Does Assisted Living Serve?

One of the ways to assess the place of assisted living in the service continuum is to examine the characteristics of assisted living residents and how they have changed over time. Based on our review of the literature over the past decade, we provide in this section an overview of the health and functional status and service needs of the assisted living population. Given the fact that researchers have used a variety of definitions in studying assisted living, as well as different samples and different methods, readers should be aware that we may be comparing apples and oranges (Zimmerman et al., 2003) and should interpret our findings with caution.

Hawes, Rose, and Phillips (1999) developed a
nationally representative sample of assisted living facilities that had 11 or more beds and that either self-identified as an assisted living provider or offered at least a basic level of service, including 24-hr staff oversight, housekeeping, at least two meals a day, and personal assistance (i.e., help with at least two of the following: managing medication, bathing, or dressing). The researchers identified approximately 2 out of 5 facilities as either high privacy or high service, a proxy for facilities representing the assisted living philosophy. Almost 4 out of 5 of the residents in these facilities were totally independent in all activities of daily living (ADLs), 13% needed help with one or two ADLs, and 8% needed help with three or more ADLs. These findings indicate that the assisted living population is significantly less impaired than the nursing home population, of which only 3% are totally independent and 75% need assistance with three or more ADLs (Gabrel & Jones, 2000).

Among all facilities in this study, only 44% had policies that would admit individuals who needed assistance with transfers and 47% would admit people with moderate cognitive impairment. Almost 3 in 4, furthermore, would not retain residents who needed nursing care for more than 2 weeks. Together, the residents’ functional status and the admission policies of the facilities suggest that, on average, these organizations do not substitute for nursing homes.

Spillman, Liu, and McGilliard (2002) analyzed data from the National Medicare Beneficiaries Survey to examine changes in the assisted living resident population between 1992 and 1998. This study employed a much broader definition than the one mentioned previously, including in the sample all individuals reportedly living in retirement homes, domiciliary or personal care homes, continuing care retirement communities (CCRCs), or any facility that called itself assisted living. These researchers observed a shift to an older population in assisted living over time. At both points in time, assisted living residents were healthier than the nursing home population, but there was also evidence that assisted living facilities were accepting less healthy people over time and that residents were also aging in place. The longitudinal analysis revealed an increase in the proportion of residents with significant functional disability (those needing assistance with three or more ADLs) from 35% in 1992 to more than half of the residents in 1998. It is interesting to note that the level of disability was much higher in this study than in the one conducted by Hawes and colleagues (1999), probably due to definitional and methodological differences. These changes in the functional status of the assisted living population over time suggest that, at least for a subgroup of residents, assisted living has become a potential substitute for the nursing home.

### Assisted Living Services

Another way to assess the role that assisted living plays in the service continuum is to examine the array and level of service offered by or allowed in these facilities. Spillman and colleagues (2002) found little change in the array of services offered by nursing homes between 1992 and 1998. In contrast, they found a significant increase in the number and types of services available in assisted living over time. In particular, nearly all residents had access to supervision with medications and help with bathing in 1998. They concluded, “Assisted living residents also were more likely to have a package of services at least nominally similar to that offered in nursing homes in 1998, including a large increase in routine availability of nursing or other medical care” (p. 18). This finding is consistent with the data reported by Hawes and colleagues (1999) that 92% of the facilities in their sample provided medication reminders, 79% had care or monitoring provided by a licensed practical nurse or a registered nurse, and 40% employed a full-time registered nurse.

An analysis by Phillips and colleagues (2003) provides more insights into the importance of services, particularly nursing services, in deterring nursing home placement. They found that more than three quarters of those leaving assisted living between the baseline data collection in 1998 and the 7-month follow-up interview did so because they needed more care. Individuals who were more physically or cognitively impaired were at greater risk than their less impaired peers of moving from assisted living to a nursing home. The presence of a full-time registered nurse, however, significantly reduced the odds of individuals moving to a nursing home. The researchers concluded that assisted living has the potential to substitute for a nursing home “…if they provide some of the nursing services one would expect in a nursing home” (p. 695).

### Consumer and Provider Perspectives on Where Assisted Living Fits

By virtue of differences in the preferences and financial statuses of older adults and their families, consumers help to determine where assisted living fits within the continuum. Some view assisted living as a residential and care alternative for when they can no longer live independently in their own home or apartment, but they do not necessarily see it as the last stop on the continuum. Others consider assisted living as their final destination before death, with no intention of ever being placed in a nursing home. Phillips, Hawes, Spry, and Rose (2000) found that just more than 98% of the residents in their national sample of assisted living facilities expected to live there for as long as they wished. From their perspective, the nursing home was never going to be an option. In reality, however, 1 in 5 residents...
interviewed at baseline had left the facility during the 7 months prior to the follow-up. Only 7% had died; 3 out of 5 of the remaining discharges went to more service-rich environments, primarily nursing homes.

Providers play a major role in determining where assisted living fits within the health care and long-term-care system. Although assisted living organizations are increasingly subjected to state regulatory requirements, providers still have much control over who can be admitted to their facilities and when they should be discharged. They also determine the availability of services (either provided in house or through contract) and the nature and quality of the residential environment, including the degree of autonomy and choice afforded the residents. Providers also make important decisions about whether to be free standing or part of a larger long-term-care or health system.

**Provider Models of Assisted Living**

Providers have developed assisted living programs in a range of settings including independent living apartments (market rate and low income) that allow people to age in place; intentional, purpose-built, freestanding assisted living; nursing home/assisted living complexes (either within the same facility or on a campus); and CCRCs that provide housing and services across the full continuum.

**Independent Housing With Services Model**

An increasing number of independent senior housing providers—market rate and publicly subsidized for low-income tenants—recognize that their residents are aging in place (Gibler, 2003). In addition, the average age of individuals entering this type of housing option has increased substantially over the past decade (Heumann, 2004). Many apartment complexes, furthermore, have experienced a graying of their resident population, as older residents have aged in place and younger individuals and families have moved out. Building managers and service coordinators hired by the property often face the dilemma of how to continue to house residents who have escalating needs for supportive services, personal care, and some type of coordination with the health care system.

Findings from a series of regional workshops with stakeholders involved in linking affordable senior housing with services indicated that housing providers had mixed views about the role of independent apartments in helping their elderly tenants remain in the community and delay or avoid transfers to nursing homes (Harahan et al., 2006). Some expressed the view that housing providers should only be responsible for the traditional housing functions (leasing, collecting rents, maintaining the physical plant). Others expressed a strong commitment to helping the residents living in their properties to remain in “their own homes” for as long as possible, including providing or linking with the necessary health-related services and hospice care.

Housing sponsors/managers who oversee market-rate apartments and who are interested in assisting their elderly residents to age in place may help to arrange for services and allow their residents to purchase home care and personal care privately. Some have created home care/personal care subsidiaries to serve their residents and the surrounding community and have also established onsite adult day care programs. A growing number of low-income senior housing providers have also developed—either directly or in partnership with local service agencies—formal service programs for their residents (see Golant, 2003; Harahan et al., 2006; Milbank Memorial Fund and Council of Large Public Housing Authorities, 2006; Pynoos, Liebig, Alley, & Nishita, 2004; Wilden & Redfoot, 2002, for detailed reviews). Although they take a variety of forms, overall these arrangements are characterized by a low-cost or subsidized residential setting, a significant proportion of frail or disabled elders among the resident population, and access to a coordinated program of health-related and supportive services (Stone, Harahan, & Sanders, in press). Most of these housing properties are not licensed as formal assisted living providers.

To facilitate formal service linkages, many property managers or housing sponsors employ a full- or part-time service coordinator—often funded by grants from the U.S. Department of Housing and Urban Development (HUD)—whose role is to help residents identify needs, link them to community service providers, and monitor and assist residents with accessing needed services. The primary focus of these service coordinators is to identify supportive services needs (e.g., housekeeping, transportation, meals, socialization) and to create the appropriate service linkages. Some service coordination, however, goes beyond basic information/referral and linkages by offering older residents who are aging in place or those who are frail at entry a formal, structured assessment of their functional and health status and their service needs. Residents who are found to be disabled and who have unmet needs are offered a formal plan of services (e.g., personal response systems, housekeeping, personal care, medication management) that is coordinated and monitored by property staff in collaboration with community services providers. A variety of sources fund these services, including the Medicaid home- and community-based services (HCBS) waiver and personal care programs, the Older Americans Act funds, municipal and philanthropic funds, property refinancing, and out-of-pocket payments on a sliding scale.

A number of housing providers have developed a more comprehensive, integrated program of
supportive and health-related services linked to publicly subsidized housing. They achieve this integration through formal, purposeful collaboration among one or more low-income housing organizations, neighborhood health care providers (clinics, hospitals), and aging services agencies (Harahan et al., 2006; Pynoos et al., 2004). The availability of adult day health care, either co-located or in close proximity to the housing property, is often a key resource for making this strategy workable.

Some low-income senior housing providers have recognized the increasing health-related needs of their aging residents and have hired nurses as service coordinators to provide health education, monitoring of basic vital signs like blood pressure, and informal coordination with the residents' physicians. One chronic care management model—often referred to as the *house calls program*—is being used in a number of low-income and market-rate senior housing facilities (Yaggy et al., 2006). The typical primary care provider is a physician-led team that includes a geriatric nurse practitioner, a social worker, and others depending on the condition and needs of the resident. These teams have arrangements with service coordinators or property managers to make house calls to chronically disabled older adults who have multiple chronic conditions such as diabetes or congestive heart failure and who find it difficult or impossible to go to a doctor's office or a clinic. The teams provide intensive chronic disease management (often using electronic health records and telemedicine), conduct environmental scans of the residents' apartments, and link residents with appropriate community resources. House call providers are reimbursed on a fee-for-service basis, but the coordination with the housing provider's service coordinator and the linkages with community resources essentially turn the independent housing provider into a comprehensive health- and long-term-care model with the housing unit as the hub.

**Freestanding Market-Rate Assisted Living**

Freestanding assisted living facilities have proliferated across the country over the past 20 years. Developers—primarily for profit—have marketed this residential option to older adults and their families as the place to go when one can no longer live independently in one's own home. One national study of assisted living, conducted in 1998, found that freestanding facilities composed 54% of the industry and housed an estimated 44% of assisted living residents (Hawes, Rose, & Phillips, 1999). Much of this development, however, has remained cost prohibitive for older people with limited incomes. A 2004 review, for example, found that the average monthly cost of assisted living ranged from approximately $2,100 to $2,900. This report, furthermore, indicated that in 2000, 75% of residents paid for assisted living with their own funds or with support from family members (Wright, 2004).

Although not explicit in most marketing materials, provider policies and behavior suggest that most of these organizations view assisted living as a discrete residential/service modality between the individual home and nursing home. Personal care, medication reminders, and some more substantial nursing care may be provided in house or through contracts with outside organizations. A subset of these providers, however, have developed specific programs for people with dementia and, depending on the specific services offered, may be considered as alternatives to nursing home placement rather than a step in between one's own home and the nursing home.

**Freestanding Low-Income Assisted Living**

The availability of intentionally built, freestanding assisted living for people with low or modest incomes is much more limited. The Coming Home Program, a national demonstration funded by the Robert Wood Johnson Foundation, represents one effort to make this option available to low-income seniors (Jenkins, Carder, & Maher, 2004). This demonstration's definition of assisted living explicitly excluded the development of projects that offered only "light care" programs as a pre-nursing home service. The demonstration defined an affordable project, furthermore, as a property that makes 25% or more of its units and services available to persons using Medicaid to pay for the services and Supplemental Security Income-level incomes to pay for the rent. This initiative, therefore, was specifically designed to offer an affordable alternative to nursing home placement. As of 2004, the project had fostered public–private partnerships resulting in 31 operational affordable assisted living properties with another 73 in development.

Connecticut's Assisted Living Demonstration Project, created by state legislation in 1999, authorized three state agencies to jointly develop up to 300 units of affordable assisted living for moderate- and low-income seniors (Sheehan & Oakes, 2004). At least 40% of the units were required to serve households making less than 50% of the area median income. As of November 2006, four sites were operational.

The creation of intentionally built, freestanding affordable assisted living faces significant challenges. These include the need for sufficient subsidy programs to help cover both the real estate and services costs of the program; and the requirement that state agencies, typically not used to working together, create workable partnerships. Predevelopment loan programs are also critical to encourage and enable organizations, particularly nonprofits, to pursue an assisted living project. Given these challenges and the fact that the Coming Home and Connecticut programs have produced relatively few
operational sites over the past 15 years, the viability of freestanding affordable assisted living remains unclear.

**Nursing Home Expansion Into Assisted Living**

Increasing consumer interest in and demand for assisted living, dropping occupancy rates, and market competition have forced many nursing home providers to explore expansion into assisted living. Some nursing home operators have transformed one or more of the facility’s floors or wings into assisted living. Others have built an assisted living complex either on a campus or in close proximity to the nursing home. It is important to note that freestanding, private-pay assisted living facilities make up less than half of the projects.

From the provider perspective, assisted living is not designed to address aging in place but rather is primarily as a tool for diversification, marketing, and financial survival. As Golant (2004) noted, conflicting data on the admission and retention policies of multilevel facilities leave researchers unsure about whether assisted living residences in multilevel facilities are more likely to admit and retain impaired elders who need nursing care (Hawes et al., 1999) or less likely to do so. Nonetheless, nursing home expansion into the assisted living business provides some consumers who can no longer live independently in their own homes and who have sufficient financial resources with the opportunity to move into a residential care environment that fits between the home and the nursing home. Although they may not ever intend to go to a nursing home, these individuals have the security of knowing that this higher level of care is right nearby.

**CCRCs**

CCRCs were developed in the mid-1970s to address the demands and preferences of middle- to high-income individuals for a continuum of residential and service options that would be able to meet their needs as they aged and potentially became more disabled over time. Developers built campuses that included independent living apartments and cottages, facilities to meet more intensive service needs (precursors to assisted living), and nursing homes. Most also included a physician- or nurse-staffed clinic and home care services. Individuals purchased a life care contract in which they sold their homes and paid a huge entrance fee and monthly fees with the guarantee that they would be fully taken care of in the event of debilitating illness or disability. Thirty years later, CCRCs still exist and continue to be built, although most do not offer the life care contract but rather provide a residential and care continuum on a pay-as-you-go basis. These organizations are almost exclusively private pay, although many cross-subsidize residents who have spent down resources over time because of deteriorating health.

This model explicitly recognizes assisted living as a residential and care setting designed to meet the needs of individuals who can no longer live independently but who are not in need of skilled nursing care. Although there has been little empirical evidence about transition decisions within CCRCs, the conventional wisdom and anecdotes suggest that most residents living in the independent apartments are initially loathe to move to this setting. Many, however, ultimately do make the transition. Furthermore, some residents who are placed in the skilled nursing center within a CCRC return to the assisted living part of the campus when their condition is stabilized. A select few may also move into assisted living for a short period of time before returning to their apartment or cottage. In these instances, assisted living is seen as respite rather than the next step on the long-term-care continuum.

For some residents, assisted living is the last stop on the continuum. CCRC operators are, for example, increasingly bringing hospice services into this setting to allow the residents to die with dignity without having to enter the skilled nursing center. At the same time, a growing trend in CCRCs is for consumers to demand that they receive assisted living services in their independent apartments or cottages, thereby obviating the need to move to either the assisted living or skilled nursing sections of the campus. Given the aging in place that has occurred in many CCRCs over the past decade and the increased age of admission to the independent living part of the campus, it will be interesting to see what role assisted living will play in the evolution of the CCRC over time. Will it become the “new nursing home,” or will it become obsolete as residents demand that services be provided in independent living?

**Comprehensive Health- and Long-Term-Care Models**

A number of vertically integrated hospital and health care systems include assisted living as part of their repertoire of services. Organizations such as the Eddy—part of the Northeast Health system in Troy, New York—have developed assisted living in an attempt to better coordinate the services of elderly and disabled persons in their community. Assisted living is viewed primarily as a residential setting for individuals who need personal care and oversight but not skilled nursing care. Because all parts of the health- and long-term-care system are administratively integrated, the Eddy has the opportunity to effectively manage the transitions between hospital and assisted living and to make efforts to avoid nursing home placement following a hospital discharge. It is important to note, however, that comprehensive hospital, health-, and long-term-care
systems that achieve administrative integration do not always achieve good service integration. Where care management is not really occurring, assisted living becomes just another production center in the system rather than a true part of the continuum.

The Role of Public Policy

Although providers and consumers drive the market for assisted living, federal and state policy makers have a substantial voice in shaping the role of assisted living in the long-term-care and support system. Payment rules and incentives, state planning and licensing laws, quality oversight processes, and state long-term-care policy goals provide incentives and disincentives for making assisted living a substitute for other forms of care, such as nursing homes and home care. Sometimes federal and state policy incentives collide, making predictions of where assisted living will fall into the service mix even more complicated.

Federal Role

The current federal policy role is more modest than the states’ role in developing assisted living policy, but it has major consequences. Congressional hearings and federal reports on quality oversight of assisted living raise questions about the acuity levels of residents and the extent to which these residents should receive protections that their counterparts in nursing homes do (U.S. General Accounting Office, 1997, 1999; U.S. Senate Special Committee on Aging, 2003). The tone of these deliberations suggests that federal policy makers view assisted living more like nursing home care than home care. This bias is evident in the lack of attention to assisted living in the U.S. General Accounting Office (2003) report on quality oversight of assisted living in Medicaid HCBS waiver programs, and the lack of attention to assisted living in the Centers for Medicare & Medicaid Services (CMS) HCBS quality framework (Stanton, 2004).

Federal payment rules play a critical role in the relative placements of nursing home, assisted living, and home care. We offer a few examples here. Federal Medicaid rules permit payment for room and board in nursing homes but not in assisted living or other residential options (Mollica, 2001). The effort to use HUD vouchers for supported housing, including assisted living, has been a small but welcome incentive to help consumers find affordable assisted living (HUD, 2000). In 2000, HUD created the Assisted Living Conversion Program, which provides grants to federally subsidized senior housing providers to convert one or more floors in their buildings to licensed assisted living. Providers may not use HUD funds for services, and applicants must demonstrate commitments from other funding sources, such as Medicaid waivers, to support assisted living services. To date, the provider participation rate has been much lower than expected. Between 2000 and 2005, the Assisted Living Conversion Program supported the conversion of only 2,318 units. Experts have attributed this low participation rate to lack of knowledge on the part of providers, inadequate technical assistance, and the concern expressed by a number of providers that becoming licensed as an assisted living provider would subject them to undue regulatory oversight and liability problems (Harahan, Sanders & Stone, 2006).

Federal rules mandate that all states must make nursing home care an entitlement for all Medicaid beneficiaries who “need” such care, and federal regulations then permit states to determine how to define and measure that need (Mollica & Reinhard, 2005). Within this policy framework, consumers do not have equal access to nursing home care under Medicaid around the country. As just one example, people who would be eligible for nursing home level of care in Oregon would not be eligible for that level of care in Maine because Maine “tightened” its nursing home eligibility criteria in the late 1990s (Gianopoulos, 2002). The federal Medicaid HCBS waiver policy adds another level of complexity. First, each state must determine under which functional criteria (i.e., ADLs, cognitive scores, and the like) a financially eligible person can enter a nursing home. Then each state can choose if and how to waive the rules to let that person choose nursing home alternatives, including care in one’s home or in an assisted living facility. All but a handful of states now have an assisted living HCBS waiver, but consumers are far more likely to be able to choose assisted living, adult foster care, or home care in a well-developed nursing home alternative state like Oregon than they are in Indiana, which is in the early stages of developing both assisted living and adult foster care.

States’ Roles

To a large extent, states determine where assisted living fits into a long-term service system. Their long-term-care policy goals may explicitly envision a role for assisted living and home care as nursing home alternatives (Kane, Kane, & Ladd, 1998; Reinhard & Fahey, 2003). Through their regulatory authority, states can determine the extent to which older adults can age in place in assisted living. Through their planning regulations, such as certificate of need and moratorium laws and rules, states can control the number of nursing homes, assisted living facilities, residential services, home health agencies, and other health care providers (Harrington, Anzaldo, Burdin, Kitchener, & Miller, 2003). Through their Medicaid payment policies, states can also exert a strong influence on the choices...
that publicly financed residents can make among nursing homes, assisted living, other residential settings, and in-home services (Stone, 2006). It is within these parameters that assisted living providers carve out the place (or places) of assisted living in the repertoire of long-term-care services. Of course, by choosing assisted living over nursing homes or home care, consumers who have the resources to make choices have the final word.

The influence of states’ regulations in shaping assisted living is profound and continually evolving (Bentley, Sabo, & Waye, 2003; Mollica, 1995, 1998, 2000, 2002; Mollica & Johnson-LaMarche, 2005). Crafted through negotiations with the provider community and the public, states can explicitly define the overlap between assisted living and nursing home care. Political forces in each state will determine the final outcome at any given time. The differences between efforts in New Jersey and Maryland in the 1990s demonstrate this interplay.

First developed in 1993, New Jersey’s regulations attempted to operationalize the aging in place philosophy by mandating that within 3 years of opening their doors, every assisted living provider must be able to document that at least 20% of its residents are nursing home level of care. Nursing home providers in that state agreed to this provision in part because several of the most influential nursing home leaders in the 1990s had visited Oregon and accepted the premise that a more social model of care was appropriate for many frail older adults who might otherwise be served in nursing homes. These leaders encouraged their nursing home colleagues to enter the assisted living arena themselves. Diversification was the theme.

Maryland adopted assisted living regulations about 5 years after New Jersey and took the opposite approach. Instead of mandating that at least 20% of an assisted living facility must provide a nursing home level of care, Maryland mandated that no more than 20% of the residents can require this level of care. The nursing home industry negotiated this provision, and the State agreed (Firth & Dorlester, 1998).

There is no documentation that these regulatory mandates are enforced, but in both cases, the State’s policy intent is expressed in writing. New Jersey actively seeks a nursing home substitution model, grounded in research that suggests that 10% to 35% of people living in nursing homes might be served in residential care facilities (Newcomer et al., 2001). Like Oregon, providers can determine how far they want to go in providing a nursing home level of care as long as they staff up to meet the higher level of needs. The interplay between state regulations and providers’ business goals permits, at least in theory, a range of choices for both private-pay and publicly supported consumers and an evolution of assisted living as the consumer market demands. Maryland’s policy appears to be more conservative.

States have several policy levers to address the overlaps among home care, assisted living, and nursing home care. We have already mentioned rules defining nursing home level of care and the use of Medicaid waivers. Admission/discharge criteria and levels of licensure are others (Mollica, 2002). States like Idaho, Maryland, Arkansas, and Vermont, among others, have two or more levels of licensed facilities; in these states, the location of assisted living within the health and social service continuum varies. Admission and discharge criteria specifically limit the extent to which a consumer can stay in assisted living. For example, in Tennessee, a person who needs gastrostomy tube feedings or a Foley catheter cannot be admitted to an assisted living facility and will most likely need to find a nursing home or enough support to stay at home. The same person can be admitted and stay in assisted living in Hawaii. And in many states, personal care attendants could provide this support at home (either one’s own home or a residential care alternative) under personal care Medicaid waiver or state plan services; that is, if the state’s Nurse Practice Act and regulations permit personal care attendants or other unlicensed assistive personnel to perform these care tasks (Reinhard, 2001).

One of the most common consumer care needs is medication administration, and in many states, the fit of assisted living in the repertoire of long-term-care and support services is restricted due to rules and regulations from different state agencies and interpretation of those rules related to medications. A recent national study of state Nurse Practice Acts and interpretations by state boards of nursing executives found that states are almost evenly divided on the issue of delegating medication administration to unlicensed assistive personnel in assisted living: 22 states permit nurses to delegate at least oral medication administration to unlicensed assistive personnel and 24 states do not, with the remaining 4 providing missing or contradictory information (Reinhard, Young, Kane, & Quinn, 2006). Providers in states that mandate the hiring of registered nurses and licensed practical nurses to administer medications face workforce shortages and higher costs that ultimately affect consumers’ ability to choose different long-term-care options.

Another factor that affects consumers’ ability to choose long-term-care options, and therefore the place that assisted living fits in the service mix, is states’ payment policies. As stated earlier, most states now include assisted living in their set of Medicaid HCBS waivers. However, only a few states make extensive use of this capacity. In 2002, only 121,000 Medicaid beneficiaries benefited from an assisted living waiver program (Mollica & Johnson-LaMarche, 2005). Swan and Newcomer (2000) noted that states’ reimbursement levels may be too low to stimulate an adequate supply of assisted living beds.
for low-income persons. The limited scope of public support for assisted living facilities in most states constrains access for low-income people to assisted living facilities as a nursing home alternative (Borrayo, Salmon, Polivka, & Dunlop, 2002). As noted previously, many assisted living providers prefer the private-pay market and are reluctant to become Medicaid providers because they fear more regulatory oversight and low reimbursements. Uptake was slow in New Jersey until the assisted living market became more saturated and occupancy rates were falling. Indiana is having a similar experience trying to attract providers in the early stages of its assisted living development.

A state’s overall long-term-care financing strategy can go beyond waivers and help fuel the overlap among assisted living, nursing home, and home care. Both Oregon and Washington have “global” long-term-care budgets that permit more flexible movement of dollars to support people in settings of their choice (Hendrickson & Reinhard, 2004). The Texas legislature enacted appropriations language that allows money to follow the person out of a nursing home into the community, including assisted living and individuals’ homes. From September 2001 to November, 2006, approximately 12,400 people transitioned out of nursing homes. Data for the current 5,053 clients enrolled in services indicate that 1,397 reside in assisted living, 1,127 live alone, 2,300 live with other family members, 1,037 are in their own homes, 41 are in adult foster care, 2 are in intermediate care facilities, and the remaining have gone to live with other clients (153) or the living arrangements are unknown (33) (THHSC, 2007). These data suggest that there is substantial overlap in the settings in which persons who are nursing home eligible receive their care.

CMS has been encouraging states since the mid-1990s to develop and sustain nursing home transition programs to bring people out of nursing homes into the community (Reinhard & Farnham, 2006). Since 2001, CMS has funded 27 states to develop these programs and another 9 states to pursue a money-follows-the-person strategy. The 2005 Deficit Reduction Act that authorized a 5-year, $1.8 billion Money Follows the Person Demonstration did not include assisted living settings. Nonetheless, as states aggressively explore ways to divert and relocate consumers from nursing homes, the role of assisted living as an alternative setting for both residence and service delivery is likely to grow.

Finally, states’ interest in consumer direction is growing. Three states piloted the Cash & Counseling program that permits consumers to purchase their own services, and preliminary research has indicated that consumers with high levels of disability are able to live in their homes and communities and direct their own workers (Mahoney, Simon-Rusinowitz, Loughlin, Desmond, & Squillace, 2004). The Robert Wood Johnson Foundation, the U.S. Administration on Aging, and the Office of the Assistant Secretary for Planning and Evaluation funded 11 more states in July 2004. As more states attempt to expand their HCBS waivers to provide more financial flexibility to consumers, it will be interesting to see how many consumers choose assisted living as the next step in the care continuum when they can no longer remain in their own homes or as an alternative to nursing home placement.

Conclusions

The answer to the question of where assisted living fits in the health- and long-term-care continuum is “it depends.” A variety of factors, including consumer preferences and demands; provider interest, motivation, and service delivery and care management practices; and federal and state payment and regulatory policies all help to define and shape the nature of the role of assisted living in the continuum of care. Privately paying individuals and their families may view assisted living as the next and last step on the continuum, but this option cannot substitute for nursing home care if the requisite services are not available when they are needed. It is difficult to see how assisted living can become a viable alternative to nursing home placement for a large proportion of low-income individuals without reimbursement that adequately covers the room and board costs as well as the service costs in this setting. Oregon’s and Washington’s global budgets for long-term care have provided the opportunity for widespread substitution of assisted living for nursing home placement in these two states. At the same time, nursing home coverage remains an entitlement, and the availability of assisted living services depends on the generosity of Medicaid waivers, state plan options, and state-only funds.

Consumers and their families need more information about the potential and limits of assisted living in order to set realistic expectations about where this setting fits within the continuum. Consumer education efforts in this area are minimal, and many individuals paying high monthly rates are not clear about the services and supports to which they are entitled. There is a fledgling assisted living consumer movement, but educational materials are limited, primarily because of the dearth of information and data available to develop the tools. Although there have been significant recent efforts to require providers to fully disclose their admission and discharge policies, unwritten practices continue to limit the accessibility of some who view assisted living as the stage following living independently at home (e.g., people who are mildly cognitively impaired, who must use a wheelchair, or who have intermittent incontinence) and discharge others who need a higher level of care but could remain in
assisted living with good medication management, supervision, and some nursing services.

To understand the role of assisted living in the continuum, there is a pressing need for information systems that track the transitions that individuals make across settings, including one’s private home or apartment, assisted living, nursing home, and hospital. It is also important to have better information about resident characteristics in assisted living and how they change over time relative to those of individuals remaining in their own homes or residing in nursing homes. Furthermore, it is essential that researchers have more detailed information about the range of services that are provided in assisted living settings and utilization patterns adjusted for case mix. Given the conflicting findings on assisted living in multilevel facilities, it is important to distinguish freestanding from multilevel assisted living facilities, along with many of the beds and other potential intervening variables. Finally, scholars need research that helps us to better understand the relative importance of the various factors identified here in determining the fit of assisted living in the long-term-care continuum and the implications of various policy and practice changes on the position of assisted living in the future.

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