

Assisted Living: Now and in the Future

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The Growth and Evolution of Assisted Living

- From ACLF to AL (role of ECC)—common philosophy, multiple types
- 1985-2005 – (800,000 to 1,000,000 residents aging in place under conditions of autonomy, choice, dignity and privacy in a homelike environment; 65,000-70,000 in Florida; 13,000 state-supported); 90% private-pay
- Changing regulations (less restrictive)—ECC license

Growth and Evolution (cont'd)

- Assistive Services Program (now Medicaid match on OSS)
- Assisted Living Medicaid Waiver—slow growth, available in 45 states (4,000 beds in FL)
- Florida Diversion Program—heavily dependent on AL (800-1,000 PMPM)
- AL growth has reduced NH use—how much?

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

- The AL research base is growing (Hawes, Zimmerman, Kane, Hedrick, Morgan, Ekhardt, Salmon)
- 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 average a month)—less impaired on average than NH residents

What Do We Know (cont'd)

- No one type (small or large) appears to be generally superior in terms of resident satisfaction
- Outcomes, however, may vary—Medical services (RN) and well-developed dementia care units may help *retention* and support aging in place
- Resident satisfaction is generally high (Hawes, Zimmerman), 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
- This may be especially true for those without caregivers and those with dementia (mild to serious)

Policy Implications of What We Know

- Expand publicly supported AL at a substantial and predictable annual rate through the assisted services and waiver programs and keep rates competitive (10,000 more slots by 2010).
- AL is the most underdeveloped part of the publicly supported LTC system and has the potential to be its most cost-effective component as the number of frail elderly without caregivers grows
- The greatest AL challenge is availability for the less affluent, not its regulatory structure

Policy Implications (cont'd)

- There is no evidence at this point that AL regulations generally need tightening. 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 are fine and should be adopted
- Physical plant and environmental design—homelike, interior/exterior, private rooms
- Training—Alzheimer's care training is good and may need to be extended. More focus on AL philosophy
- Nurse delegation—cost containment and sufficient quality
- Quality of life criteria (regulatory focus)—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)—quality of life advantages for some residents.