

# *Assisted Living Facilities*

## *Challenges and Concerns*

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### *Introduction*

**T**he notion of the “ideal” assisted living model is based on a continuing commitment to **autonomy and choice, social engagement, privacy and dignity, and aging in place in an affordable, homelike and least restrictive environment.** Over the past two decades, assisted living has become the fastest growing sector of long-term care, and with rapid growth comes many challenges. This issue brief presents some of the challenges that the ALFs face with particular focus on ALFs for the less affluent, function-focused care in ALFs, and aging in place.

### *ALFs for the Less Affluent – Availability and Affordability*

It is commonly known that the growing problem with assisted living is the lack of access for the less affluent aging population who require public support, have limited access to community resources, and want to avoid ending up in a nursing home. For many of these people, assisted living offers the optimal long-term care setting for not only receiving the physical care they need, but also for achieving a quality of life that may not be available in their own homes. This section discusses the reasons behind the lack of availability and

affordability of ALFs for lower-income individuals.

### **Availability**

Although historically the demand for long term care came from individuals relying heavily on public assistance, as middle and higher income individuals have shown greater interest in these care communities more options have become available to assist them with their increasing functional dependency (Coe and Boyle 2013). In a study by Stevenson and Grabowski (2010), data was collected on county-level ALF supply throughout the United States. They found that, when compared to areas with fewer choices for ALFs, counties with multiple options tend to have greater educational attainment (19.9% versus 13.8%), higher median household income (\$43,034 versus \$35,379), higher median home values (\$98,541 versus \$69,560), and a lower proportion of minorities (12.8% versus 17.1%).

Assisted living has the potential to serve as a cost-effective substitute for nursing home care for some people. Yet, to date, states have been cautious in expanding Medicaid coverage for services in ALFs. Unlike care delivered in nursing homes, Medicaid does not pay for Medicaid supported residents’ room-and-board

expenses in ALFs, which potentially creates a major barrier to access.

Policymakers are concerned about the so-called “woodwork effect” likely associated with offering people an array of long-term care services, especially attractive options such as ALFs (Stevenson and Grabowski 2010). There are, however, many states with small programs under which Medicaid pays for personal care and medical services in ALFs (Stevenson and Grabowski 2010). Some larger private-pay, for-profit ALFs allocate a small number of their units to low-income older persons, but few residents receive these public supports (Golant 2008). For example, in 2011, the Florida Legislature created the Statewide Medicaid Managed Care (SMMC) LTC program. Medicaid recipients who are enrolled in the SMMC LTC program receive long-term care services from a managed care plan. Assisted living facilities are included in the list of managed care plan services. The plans cover services only and excludes medications, doctor’s visits or other healthcare related services.

Overall, the government’s role in ALFs will inevitably evolve as Medicaid and other public payers invest more in this area. Therefore, it is important to evaluate the changing demands in long-term care use and the assets available to pay for that care, which will have an impact on the future costs for Medicaid and availability of

ALFs to lower income individuals (Coe and Boyle 2013).

### **Affordability**

In the ALFA survey of AL residents (2013), the two factors with the lowest ratings are the overall value for the dollar spent on assisted living (47% satisfied) and the cost associated with living in your assisted living community (36% satisfied). According to the 2015 Glenworth cost of care report, the national median monthly rate for an ALF is \$3,600 (a 2.86% increase from the previous year). The Residents Financial Survey (RFS) shows that one quarter to one third of the respondents have a total income of at least \$3,500 a month and approximately 26 percent of the self-reported total net worth of residents is less than \$50,000 (Coe and Wu 2014). If the residents’ total income tends to be equal to or less than the monthly cost for an ALF and they have a low total net worth, the question then becomes, who pays for their housing and what income sources are used to pay the bills? The answers can be useful when it comes to figuring out the best ways to expand access to lower income individuals.

The RFS found that only 21 percent of ALF residents pay *all* expenses from their current income, with an additional 26 percent stating that *most* expenses are covered by their current income (Coe and Wu 2012b). Among those residents with *most* expenses covered by their current income, 86 percent spend their

savings and assets to pay for housing and care, and 19 percent receive help from family (Coe and Wu 2012b).

According to the RFS, the top four income sources are Social Security (97%), pension/annuity (59%), interest from bank accounts (44%), and interest from stocks/bonds (33%) (Coe and Wu 2014). In terms of assets, 85 percent have a checking/savings account, 35 percent have brokerage/stocks/bonds, 24 percent have a house/property/land, and 17 percent have a 410(k)/IRA (Coe and Wu 2012c). Means-tested government programs (Medicaid, SSI, food stamps, HUD rental assistance) have the lowest percentages of use. Of these programs, Medicaid coverage has the highest (8%) reported use from the ALF residents (Coe and Wu 2014).

Overall, the RFS findings illustrate that most ALF residents are mid- to high- income, which explains the relatively high self-reported monthly incomes. Less than 10 percent of the sample is living with incomes below the poverty line (Coe and Wu 2014). Individuals overwhelmingly report that they pay for their own services, with very few relying on family or government programs for assistance.

### *Function-Focused Person-Centered Care in ALFs*

As the number of individuals entering ALFs continues to rise, so too does our need to better understand the associations between

physical activity and health-related outcomes such as function and disability (Hall and McAuley 2011). There is ample evidence that physical activity among older adults is a key factor to aging successfully (Resnick, Galik, and Boltz 2013). However, multiple studies illustrate that many ALF residents are inactive and have limited opportunities to engage in physical activity.

A major contributor to this lack of physical activity comes from the expectations of residents and families regarding the care provided by the direct support staff. They believe that monthly payments ensure that the staff will provide the service rather than encourage the resident to participate in their own care, such as walking, dressing, or bathing (Resnick, Galik, and Vigne 2014). That belief, along with other barriers, has led to a culture of care that focuses on providing care *for* (bathing or dressing an individual) as opposed to *with* (providing verbal cueing) the residents (Resnick, et al. 2009, 2011). This type of protective care decreases physical activity, facilitates functional decline, increases the chance of falls, and contributes to disability (Resnick, Galik, and Boltz 2013).

Function-focused care (FFC) is a model of care that helps optimize and maintain the residents' functional abilities and increases time spent in physical activities (Resnick and Galik 2013). Implementation of FFC includes four components: assessment of the environment

and policies/procedures of the facility; education of the interdisciplinary team, residents, and family; development of FFC goals for the resident; and mentoring and motivating the caregivers (Resnick et al. 2011; Resnick, Galik, and Vigne 2014). Each component is applied sequentially and the process continues until all parts become a routine part of care.

Overall, the FFC model of care has shown benefits for residents in various settings with evidence of improving or limiting the negative impact that sedentary behavior has on the residents in terms of contributing to de-conditioning, pressure ulcers, falls, infections, and exacerbation of underlying comorbidities (Resnick and Galik 2013). This approach not only provides more personalized care, but also improves quality of life by enabling residents to remain in their ALF rather than be transferred to a nursing home or acute care setting (Resnick et al. 2011).

### *Aging in Place*

The rapid growth of ALFs as a long-term care option reflects the fact that these facilities are able to provide services needed to age in place in an environment, which supports autonomy, dignity, and privacy. However, this is not a suitable or desirable option for everyone.

Golant (2015) introduced a new emotion-based theoretical model called “residential normalcy” as a way to identify older adults who are living in desirable or congruent places that satisfies

their needs and goals. More specifically, older adults achieve residential normalcy when their living arrangements meet the largely emotional needs of “residential comfort” and “residential mastery” (p. 18).

Positive residential comfort emotional experiences occur when “older people feel that their residential settings are pleasurable, comfortable, enjoyable, and memorable places as well as free of hassles” (p. 27). Residential mastery emotional experiences occur when “older people occupy residential settings in which they feel competent and in control” (p. 29). In the best-case scenario, older people will have both residential comfort and mastery emotional experiences, and thus, have achieved residential normalcy. What makes this difficult to attain is often the difference in views regarding quality living arrangements between the older person and those who are trying to help them, even when they have the best intentions. Therefore, when evaluating whether or not an ALF is appropriate for an older individual, both perspectives need to be taken into consideration and reaching residential normalcy should be the main objective.

### *AL Quality: The Regulatory Challenge*

Everyone has the right to quality care in the least restrictive environment. Access to, and choice of appropriate services and living arrangements is essential to the quality of care and quality of life for aging individuals (IOM

2001). Today, more and more aging adults are interested in assisted living when they can no longer live in their home because it can provide them with the care they need in a homelike environment while still maintaining autonomy, social engagement, privacy, and dignity. However, accessibility to assisted living facilities is not uniformly available across the aging population. A move towards meaningful person-centered care for all will require changes in consumer and provider attitudes, policies, and organizational management. A greater legislative focus on promoting assisted living for the growing population of older adults is needed to effectively address the issues discussed in this brief.



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