Part 4: Aging in Place

Lisa Rill, Ph.D.

As discussed in the previous paper, the original vision for assisted living was largely a product of a philosophical commitment to the commonly recognized quality of life values of autonomy and choice, social engagement, privacy and dignity, and to the deep preference of most impaired persons to "age in place" in the least restrictive environment. 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.

As Golant illustrates in his book, "Aging in the Right Place" (2015), experts on aging and older adults do not always agree on what constitutes as great places to live. This is because the experts focus on the "objective anatomy of places" (p. 10) and the older adults are guided by their "emotional anatomy of places" (p. 13). The objective anatomy measures the quality of residential environments using scientific and emotion-free methods, and the experts often impose their own value judgments in the assessment. Emotional anatomy is the recognition of the older adults subjective view of their world, including their thoughts on what they consider to be favorable and unfavorable living arrangements.

These two different worldviews complicate generalizations about where older adults can successfully age in place and which factors are most important for this to happen. Golant (2015) suggests we should be open to both perspectives. However, many of the recent studies rely on the objective anatomy measures to rate the quality of older

peoples residences. Therefore, 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 provide “residential comfort” and “residential mastery” emotional experiences (p. 18).

Residential comfort emotional experiences represent “whether older people feel that their residential settings are pleasurable, comfortable, enjoyable, and memorable places as well as free of hassles” (p. 27). Expressions of these feelings inform us which older adults are actively engaged and have a high quality of life. This is, however, an individual experience. In other words, one type of residence can generate different feelings, in that it can appeal to one person but not another.

An example of a way to achieve residential comfort in assisted living was illustrated in the previous paper. The rapid growth of ALFs reflects the fact that many aging individuals are willing to pay substantially to receive the services they need in an environment that supports their autonomy. Many residents are able to remain in the ALF until they die, which reflects their desire to “age in place” to the maximum extent possible.

Residential mastery emotional experiences denote “whether older people occupy residential settings in which they feel competent and in control” (p. 29). Feelings of competence depend on the individual’s physical and cognitive health, interpersonal relationships, and residential settings. Residents feel in control when they can spend time as they want, achieve environmental privacy, have trusting human relationships, and financial security.

As discussed in the previous paper, an example of a way to achieve residential mastery in assisted living is through privacy. Privacy is virtually a necessary, if not always sufficient, condition for the effective exercise of autonomy and for maintaining interpersonal relationships. Privacy for many people is an essential resource in maintaining a modicum of control over one's personal space and time and in achieving a sense of self-efficacy and dignity, which are fundamental components of identity (Polivka and Salmon 2003).

Overall, 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 (subjective) and those who are trying to help them (objective), 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. This is also true for when professionals consider how to improve long-term care settings in the future. Of course, the most difficult part is the fact that the aging population is a heterogeneous group; thus, care must be taken when developing "best practices" for aging in place.

Aging in Place in Residential Care Communities[1]

In the section on "Regulating Small Facilities" in the earlier paper, it was recommended that policies, financing, and regulatory strategies should reflect the support for the different forms of assisted living and the need to provide the consumers with as

[1] Residential care communities includes assisted living communities and other residential care communities (e.g., personal care homes, adult care homes, board care homes, adult foster care)

many options as possible to choose from, as long as they are consistent with the values of the assisted living philosophy and basic safety requirements. Golant's model of residential normalcy supports this recommendation and could potentially change the focus of the discussion from one that debates which facility size (small vs. large) is better, to which type of facility is the best fit depending on the "residential comfort" and "residential mastery" of the individual. But first, in order to make an informed and appropriate decision for placement, the aging individual and family members must be aware of the diversity of ALFs across their different sizes.

The National Center for Health Statistics (NCHS) published multiple reports on the most current national estimates of residential care community operating characteristics and selected characteristics of current residents, and compared them by community bed size.[2] The first report provides a brief profile of the operating characteristics found in the residential care communities in 2014 (Caffrey, Harris-Kojetin, and Sengupta 2015). They found that the majority (63%) of residential care communities had 4-25 beds but only housed 17 percent of the residents, yet communities with more than 50 beds accounted for only 24 percent and housed most (68%) of residents. Eighty-seven percent of smaller communities were for-profit compared with 76 percent of larger communities. Chain affiliation was more common as community size increased (47% for 4-25 beds, 74% for 50+ beds).

[2] The reports provide results for three sizes of communities (4-25, 25-50, and 50+ beds). This paper only presents the finding for smallest and largest communities. For more detailed results, please refer to the original reports.

Table 1: Residential Care Communities and Residents by Bed Size (%)

Bed Size	Communities	Residents
4-25	63	17
50+	24	68

Table 2: For-profit and Chain-affiliated Communities by Bed Size (%)

Bed Size	For-profit	Chain-affiliated
4-25	87	47
50+	76	74

Communities with 50 plus beds offered more (67%) disease-specific programs for residents with Alzheimer's disease and other dementias, compared to 56 percent with 4-25 beds. However, communities with 4-25 beds offered more diabetes (61% vs. 56%), cardiovascular disease (56% vs. 46%), and depression-specific programming (52% vs. 42%) compared with communities with more than 50 beds.

Table 3: Disease Specific Programs by Bed Size (%)

Bed Size	Alzheimer's Disease/Dementia	Diabetes	Cardiovascular Disease	Depression
4-25	56	61	56	52
50+	67	56	46	42

The second report presents national estimates of selected characteristics of current residents in 2014 (Sengupta, Harris-Kojetin, and Caffrey 2015). They found that the majority (53%) of residents in communities of both sizes were aged 85 and over.

Table 4: Age distribution of Residents by Bed Size (%)

Bed Size	Under age 65	65-74 years old	75-84 years old	85+ years old
4-25	15	13	26	47
50+	5	10	31	54

A higher percentage of residents in 4-25 bed communities were living with Alzheimer's disease or other dementias (47% vs. 37%) and depression (27% vs. 22%). Yet a higher percentage of residents in the larger communities had cardiovascular disease (46%) compared with residents in smaller communities (43%). The diagnosis of diabetes we very close in both types of communities (18% in small, 17% in large). These findings are interesting because, as presented in the first report, the larger communities offered more disease-specific programs for residents with Alzheimer's disease and other dementias, yet the smaller communities were more likely to have residents with Alzheimer's disease/dementia. In addition, communities with 4-25 beds offered more cardiovascular disease-specific program, yet the 50 plus bed communities were more likely to have residents with the disease. The small communities also provided more programs for depression, yet had a higher percent of residents with depression when compared to larger communities. Therefore, it seems that the program needs to be re-evaluated.

Table 5: Selected Diagnosed Medical Conditions among Residents by Bed Size (%)

Bed Size	Cardiovascular Disease Diagnosis	Alzheimer's Disease/Dementia Diagnosis	Depression Diagnosis	Diabetes Diagnosis
4-25	43	47	27	18
50+	46	37	22	17

The percentages of residents needing assistance with all ADLs were considerably higher in the smaller communities compared to the larger communities (bathing 77% vs. 58%, dressing 58% vs. 45%, toileting 50% vs. 37%, transferring 39% vs. 28%, walking 40% vs. 27% and eating 34% vs. 17%). The percentage of residents receiving Medicaid decreased with increasing bed size. Twenty-three percent of residents in communities with 4-25 beds had some services paid for by Medicaid, compared with 13 percent in communities with 50 plus beds. The percentage of residents that had fallen in the past 90 days increased with increasing community bed size, from 11 percent of residents in communities with 4-25 beds to 24 percent in communities with more than 50 beds.

Table 6: Need for Assistance with ADLs among Residents by Bed Size (%)

Bed Size	Bathing	Walking	Dressing	Toileting	Transferring	Eating
4-25	77	40	58	50	39	34
50+	58	27	45	37	28	17

Table 7: MCD Coverage in last 30 days & Falls in last 90 days by Bed Size (%)

Bed Size	MCD coverage in last 30 days	Falls in last 90 days
4-25	23	11
50+	13	24

Overall, the resident population living in smaller residential care communities differed from the resident population living in larger communities in a variety of sociodemographic, functional and health status, and service utilization characteristics. Therefore, it is up to the aging individual and family members to decide which community size will provide the best fit for achieving residential normalcy and have the greatest chance to age in place.

Comparison of Select State-level and National Estimates

If the individual and family have decided that a residential care community is the best fit for achieving residential normalcy and ability to age in place, they then must select the optimal size of the community in which they want to live. This section provides a description of ten state-level estimates covering all of the variables discussed above.[3] These variables include the following: bed size, ownership, chain affiliation, programs offered for specific diseases, resident characteristics, Medicaid coverage, select disease diagnoses, ADL assistance, and falls in the past 90 days. The purpose of this information is to give the reader an indication of what the average community provides in certain states.

Table 1: Operating Characteristics of Residential Care Communities (%)

State	4-25 beds	50+ beds	For-profit ownership	Chain-affiliated
All RCCs	63	24	82	56
Alaska	92	8	88	57
California	83	17	90	57
Colorado	64	36	85	73
Connecticut	65	35	50	26
Florida	67	33	85	48
Minnesota	52	48	65	60
Oregon	75	25	87	43
Vermont	57	43	85	44
Washington	78	22	89	52
Wisconsin	73	27	80	75

[3] This paper only presents the findings for ten states: MN, WA, OR, CO, AK, VT, WI, CA, CT, FL. For more detailed results, please refer to the original reports (Caffrey, et al. 2015, and Sengupta et al. 2015).

Table 2: Specific Disease Programs offered in Residential Care Communities (%)

State	Alzheimer's Disease/Dementia	Diabetes	Cardiovascular Disease	Depression
All RCCs	58	58	52	48
Alaska	69	70	66	40
California	58	61	57	54
Colorado	56	51	50	46
Connecticut	32	44	39	39
Florida	58	56	51	46
Minnesota	65	50	46	41
Oregon	59	66	59	56
Vermont	49	48	44	43
Washington	65	66	55	55
Wisconsin	59	63	55	54

Table 3: Resident Characteristics in Residential Care Communities (%)

State	Under age 65	65-74 years old	75-84 years old	85+ years old
All RCCs	7	10	30	53
Alaska	14	18	31	38
California	4	12	30	53
Colorado	8	10	25	57
Connecticut	33	16	18	34
Florida	4	9	31	55
Minnesota	6	8	27	58
Oregon	7	11	27	55
Vermont	6	11	31	52
Washington	9	10	30	52
Wisconsin	14	12	29	44

Table 4: Disease Diagnosis in Residential Care Communities (%)

State	Alzheimer's Disease/Dementia Diagnosis	Depression Diagnosis	Cardiovascular Disease Diagnosis	Diabetes Diagnosis
All RCCs	40	23	46	17
Alaska	46	21	30	18
California	40	20	39	14
Colorado	43	28	50	15
Connecticut	22	30	35	24
Florida	40	16	46	15
Minnesota	39	28	47	14
Oregon	47	26	43	18
Vermont	37	33	52	16
Washington	34	22	33	15
Wisconsin	38	30	47	19

Table 5: Assistance with all ADLs in Residential Care Communities (%)

State	Bathing	Walking	Dressing	Toileting	Transferring	Eating
All RCCs	62	29	47	39	30	20
Alaska	70	42	59	57	40	45
California	69	38	57	51	38	24
Colorado	63	23	47	32	19	18
Connecticut	38	19	13	12	9	8
Florida	62	36	49	41	33	17
Minnesota	60	26	43	37	26	24
Oregon	63	30	51	47	38	30
Vermont	72	27	45	34	21	21
Washington	55	32	42	36	29	21
Wisconsin	69	23	46	36	30	20

Table 6: LTC MCD Coverage in past 30 days & Falls in last 90 days in RCCs (%)

State	**LTC MCD Coverage in past 30 days**	**Falls in last 90 days**
All RCCs	15	21
Alaska	43	19
California	3	13
Colorado	21	22
Connecticut	79	10
Florida	14	17
Minnesota	20	18
Oregon	40	23
Vermont	39	19
Washington	23	16
Wisconsin	21	17

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