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Good afternoon, Senator Grassley and members of the Committee. Thank you for the opportunity to testify before the Committee and for the extraordinary care and attention the Committee has shown over the last year, indeed over the last three decades, to the well-being of the nation's elders and particularly to issues related to long-term care.

My name is Catherine Hawes, and I am a Senior Research Scientist at the Myers Research Institute at Menorah Park Center for the Aging in Cleveland, Ohio. Twenty-three years ago, I started my career in aging and long-term care as an investigator for this Committee, so I feel especially honored to be here today as a witness.

I am here to discuss research findings from *A National Study of Assisted Living for the Frail Elderly*. I have submitted written testimony and the Executive Summary of a report from this study that present somewhat greater detail on the main points I will make today.

I am the principal investigator and project director for this study, which is being conducted for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE). Additional support for this project has been provided by the Administration on Aging, the National Institute for Aging, the Alzheimer's Association, and the American Association of Retired Persons. ASPE and AARP funded the survey and data analysis that serve as the basis for my testimony; however, my testimony today represents my views alone and does not necessarily represent the views or opinions of DHHS/ASPE, AARP, or Menorah Park.

Recently, project staff completed a telephone survey of a nationally representative sample of assisted living facilities. Project staff surveyed a sample of 2,945 places thought to be assisted living facilities in 34 states. For those places that met study eligibility criteria, project staff conducted a more in-depth survey of the administrators or their designees. ⁽¹⁾

Because of our sample design, we are able to provide a description of the assisted living industry, nationwide, as of early 1998. Over the course of the next year, the study will report on site visits to a sample of assisted living facilities and in-depth interviews with residents, family members, staff and administrators. In addition, project staff will conduct follow-up telephone interviews with all residents who have left the facility within eight months of the original interview. If the resident is deceased, we will interview the next-of-kin.

The main goals of the telephone survey were:

- To provide an estimate of the number of assisted living facilities nationwide;
- To describe the characteristics of the assisted living industry,
- To examine the degree to which the current supply of assisted living facilities (ALFs) matches the philosophical principles of assisted living; and
- To determine whether assisted living is affordable for low and moderate-income older persons.

One of the questions I hear repeated by consumers and state policy-makers alike is "*what is assisted living?*" Some of the national statistics from our 1998 survey may help answer this question. For example, we found:

- An estimated 11,500 facilities that met our definition of assisted living, with approximately 650,000 beds.
- The average facility had 57 beds.
- The average facility occupancy rate was 84%.
- 54% of the ALFs were free-standing; 46% were situated on a campus offering multiple levels of care, such as nursing home care, congregate care, or independent living in addition to assisted living.
- The average length of time in business was 15 years, but more than half the industry had been in business for 10 years or less.
- Nearly all ALFs either provided or arranged a number of basic services, including housekeeping, three meals a day, 24-hour staff, medication reminders, and assistance with bathing and dressing.
- About nine out of ten (88%) facilities offer assistance with medications.
- About three-quarters of the ALFs offered to arrange or provide therapies (74%) and some care or monitoring by a licensed nurse (80%).
- 40 percent of the facilities had a full-time registered nurse (RN) on staff.

What these general, descriptive statistics mask is the tremendous variation across the country among places known as assisted living facilities. Any attempt to understand assisted living is hindered by the lack of a common definition of assisted living.

As Dr. Mollica has shown in several of his reports, there is no consensus among state policy-makers about the appropriate regulatory model for assisted living. Similarly, in the market-place, there is no consensus about what assisted living is. Indeed, we found enormous diversity in the size, accommodations, services, staffing, policies on admission and retention, and price among places that called themselves assisted living. Essentially, we identified four different types of ALFs based on their mix of services and privacy.

The most common type of assisted living facility cannot be easily distinguished from traditional board and care homes. A significant proportion of resident rooms were shared rather than private, and such facilities offered little beyond assistance with medications, bathing, or dressing. In about half the ALFs described by this model, there was at least one room shared by three or more people. This model, which we define as minimal or low service/low privacy, represented 58 percent of all the places that described themselves as assisted living.

Another ALF type offers a high degree of privacy in accommodations but low services, a sort of "cruise ship" model of assisted living. In this model, more than 80 percent of the accommodations were private. However, these facilities would have had a difficult time helping residents age in place, since they had no RN on staff and most were unwilling or unable to provide or arrange nursing care for residents. Only 19% of the ALFs in this model would provide or arrange nursing care and retain a resident who needed such care. This ALF type comprised 18 percent of all ALFs nationwide.

A third type of ALF is one we describe as high service/low privacy. In such facilities, two-thirds of the accommodations were in single rooms rather than apartments, and fewer than 80 percent of the rooms were private. However, all such facilities had a full-time RN on staff and about half the facilities (53%) were willing to provide or arrange nursing care, as needed, and retain residents who needed such care. This was also the ALF type that had the most expansive admission and retention criteria and the highest resident acuity. For example, such facilities were more likely to retain residents who needed assistance with transfers in or out of bed or a wheelchair and residents who needed nursing care. Compared to the other ALF types, they also had a much higher proportion of residents who received assistance with three or more activities of daily living (ADLs), such as help with locomotion or using the toilet, as well as bathing and dressing. An estimated 12 percent of the ALFs across the country were in this category.

A fourth type of ALF offered high service and high privacy. Only 11 percent of all ALFs fell into this category. While resident accommodations were almost evenly split between single rooms and apartments, nearly all the accommodations

were private. In addition, 41 percent of the high service/high privacy ALFs offered to arrange or provide nursing care and retain residents who needed such care. All had an RN on staff.

Having described ALFs, our next question was whether the current supply of assisted living facilities matched the philosophical principles of assisted living. One philosophical tenet is that residents should have control of their personal environment, often defined, at least partially, in terms of privacy. Certainly, on average, ALF residents had more privacy than residents of board and care and nursing homes. But not all ALFs provided an environment consistent with the principle of privacy.

- Three-quarters of resident accommodations were private; 2 percent were in ward-type rooms that housed three or more residents; and the remainder were semi-private.
- Thirty-five percent of all bathrooms were shared; thus some residents have private rooms but share bathrooms.

In the Oregon model, apartments were also considered an essential ingredient of assisted living; however, nationwide, only 48 percent of all resident accommodations were in apartments; 52 percent were in single rooms.

Another philosophical tenet of assisted living is that services should be available to meet residents' scheduled and unscheduled needs. The answer to whether the current supply of ALFs meets this principle is not yet clear. However, it appears that both facility policies and, in some states, licensure policies limit the ability of ALFs in general to meet the health needs of residents. For example, we asked administrators about their willingness to address a temporary need for nursing care. Slightly more than half the facility administrators (52%) reported that they would provide such care with a registered nurse (RN) or licensed vocational nurse (LVN) from the facility staff. Twenty-five percent reported that they would help the resident arrange for such care with an external agency, such as a home health provider. But slightly more than one in five ALFs (21%) reported that they did not provide or arrange any services by an RN or LVN/LPN. Further, while most facilities would provide or arrange nursing care for a period of 14 or fewer days, only 28% of the ALFs nationwide would retain a resident who needed such care or monitoring for more than 14 days.

We also wanted to know whether residents would be able to "age-in-place," another key element of the philosophy of assisted living. We found that there was a limit to the amount of aging in place that could occur in most ALFs, if aging was accompanied by decline in the resident's physical and cognitive functioning. Nine out of ten administrators reported a willingness to serve residents with modest physical limitations, such as needing help with bathing, dressing, or medications. In addition, 69 percent said they would retain residents who used a wheelchair to get around, while 62 percent would retain a resident who needed help from another person with walking or using a wheelchair.

At the same time, this meant that 31 percent of the ALFs would not retain a resident who eventually needed to use a wheelchair to get around, and 38 percent would not retain a resident who needed any assistance from another person to walk. The majority of ALFs (54%) would not retain a resident whose health declined to the point at which he or she needed assistance with transfers in and out of bed, a chair, or wheelchair. Most facility administrators also reported they would not retain residents with moderate to severe cognitive impairment (55%), and 76 percent were unwilling to retain a resident who exhibited any challenging behaviors, such as wandering. Thus, while most assisted living facilities were willing to admit residents in the early stage of Alzheimer's disease or related dementias, most would not retain such residents as their level of cognitive impairment increased or if they developed a behavioral symptom.

A final issue we wished to explore was whether assisted living was affordable. The most common monthly price was between \$1000 and \$1999 or between \$12,000 and \$24,000 per year. However, it is important to note that the average monthly price was held down by the presence of a very large number of ALFs that offered minimal or low privacy and services. The most common monthly price for ALFs offering either high service or high privacy was approximately \$1,800 per month or almost \$22,000 per year. Moreover, the basic monthly price did not cover all the monthly expenses in many assisted living facilities, which often impose additional charges for such services as transportation, personal laundry, special diets, and medication administration. Thus, the total cost for residents can be higher than the basic monthly price.

When we examined the price of assisted living and compare it to the income of the elderly, it was clear that most ALFs were not affordable for low and moderate income elderly. In 1997, nearly two-thirds of persons aged 75 and older (64%) had annual incomes below \$15,000 and could not have afforded the most common ALF rate (\$1458 per month/\$17,496 per year) charged by low service/low privacy ALFs. High service (\$22,068) and high privacy (\$21,252) ALFs, at an average cost of

about \$22,000, would have been unaffordable for more than four out of five people aged 75 and older.

The implications of these findings for consumers and policy-makers are significant.

- Because of the substantial differences among places known as assisted living facilities, consumers need to be sophisticated shoppers. They need to understand their own or their relative's current needs and to anticipate the likely trajectory of those needs over time.
- Consumers and their families should be aware that the promise of aging in place in an ALF is not unlimited. For a substantial number of residents, the move to assisted living will entail a subsequent move to another type of health or personal care facility.
- In order to facilitate appropriate consumer decision-making, ALFs must provide accurate, comprehensive and comprehensible information to consumers about the staffing, services, and charges, as well as explicit information about their retention policies.
- With the exception of a very few cases, assisted living, particularly in facilities offering any type of private accommodations or high services, is largely not affordable for moderate and low-income elderly.
- Policy-makers should beware the assumption that ALFs are substitutes for nursing homes. ALF admission and retention policies, their level and type of staffing, and their unwillingness or inability to address problems common among nursing home residents, such as behavioral symptoms, moderate to severe cognitive impairment, and the need for on-going nursing care or oversight limit their ability to serve the same population.

1. ¹ To be eligible for the study, a place had to meet the following criteria: (1) Serve a mainly elderly clientele; (2) Have more than 10 beds; AND either (3a) Be a facility that holds itself out to be "assisted living" OR (3b) Be a facility that provided at least the following services: 24 hour staff, housekeeping, at least 2 meals a day, and help with at least two of the following: medications, bathing or dressing.