Assisted living and nursing homes: Apples and oranges?

Based upon the work of:
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Developed by Ashlie D. West, MSW Student
Why did we move away from skilled nursing facilities?

- Combined impact of the growing numbers of older adults,
- A shortage of nursing beds,
- Increasing costs of nursing care,
- The better overall health of new cohorts of older adults, and
- The dissatisfaction with nursing home (NH) care (Bishop, 1999; Borra, 1986; Korock, 1987)
Filling the gap

- Congregate housing – first attempt; failed
- Continuing care retirement communities and NHs learned from congregate housing’s mistake and broadened their continuum of care
- Assisted living (AL) facilities – provided an “invisible support system” in a residential setting (Sullivan, 1998)
The assisted living debate

- NHs are threatened by their increasing market share
- ALs are not subject to the same licensing restrictions and guidelines as NHs
- There is no single accepted definition of AL nor guidelines for how to operationally distinguish it from other forms of care (Lewin-VHI, Inc., 1996)
- The lack of longstanding AL state regulations and federal oversight has allowed significant variability in the characteristics of the facilities and residents served (Assisted Living Quality Coalition, 1998; Frytak et al., 2001; Hawes, Lux, et al., 1995; Mitchell & Kemp, 2000; Wilson, 1996)
Current study goals

- To describe the current state of AL care and residents in comparison with NH care and residents;
- To identify differences between different types of AL care and residents; and
- To consider how differences in AL case-mix reflect differences in care provision and/or consumer preference
Sample

- Data used from a multistage cluster sample of residential care/assisted living (RC/AL) facilities and NHs in Florida, Maryland, New Jersey, and North Carolina.
- 233 long-term care facilities and 2,078 AL residents participated in the Collaborative Studies of Long-Term Care (CS-LTC) – spanning across the spectrum of licensed AL and NH care.
- 3 types of RC/AL facilities – 1) fewer than 16 beds; 2) facilities with 16 or more bed of the traditional board-and-care type; and 3) new model facilities.
- Nursing homes were also included.
Facilities across the states

<table>
<thead>
<tr>
<th>State</th>
<th>RC/AL Beds</th>
<th>New-model Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>49,800</td>
<td>14,314</td>
</tr>
<tr>
<td>Maryland</td>
<td>4,708</td>
<td>1,858</td>
</tr>
<tr>
<td>North Carolina</td>
<td>15,012</td>
<td>5,514</td>
</tr>
</tbody>
</table>

Total of 2,500 facilities – 1,216 (49%) are small, 877 (35%) are traditional, and 407 (16%) are new-model.
Sampling region for each state

- Each region must contain at least 15% of the state’s RC/AL facilities of each type;
- Each region must include both urban and rural areas;
- When compared with the entire state, the region must fall within 30% of the state mean on 8 measures that characterize the county population by race, age, income, and employment status, and prevalence of primary care physicians, hospitals, and NH beds.

A total of 233 facilities were recruited from October 1997 to November 1998 (113 small, and 40 from each of the other 3 types).
Differences between participating and nonparticipating facilities

- Nonparticipating RC/AL facilities have more owners working more hours in the facility, more rate levels, and a slightly less impaired resident population.

- No differences in reference to proprietary status; affiliation with other long-term care facilities; facility size, age, or occupancy rate; and resident age, race, or ethnicity.

- Nonparticipating NHs have a higher occupancy rate than participating NHs and less resident impairment.
Facility-level measures

- Demographic – facility size, age, and profit status
- 6 measures from the *Policy and Program Information Form* of the Multiphasic Environmental Assessment Procedure (Moos & Lemke, 1996)
- 4 measures that summarize admission policies and estimate the range of available services
- These 10 process of care measures are organized by the following domains:
  - Requirements for the residents,
  - Individual freedom and institutional order, and
  - Provision of services and activities.
Resident-level measures

- Resident demographics – age, race, gender, marital status, and medical conditions
- Minimum Data Set ADL Self-Performance Index (MDS-ADL; Morris, Fries, & Morris, 1999) – need for assistance in ADLs
- Mini-Mental State Examination (Folstein, Folstein, & McHugh, 1975)
- Minimum Data Set Cognition Scale (MDS-COGS; Hartmaier, Sloane, Guess, & Koch, 1994)
- Cohen-Mansfield Agitation Inventory (Cohen-Mansfield, 1986)
Analyses

- Descriptive statistics across facility type
- Multivariate analyses examined differences in 10 process of care measures between RC/AL facilities with less than 16 beds; traditional RC/AL with 16 or more beds; new model RC/AL; and NHs
- Generalized estimating equation models determined differences in resident case-mix across RC/AL facilities using data for 2,078 residents
Results – Description of facilities

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Small RC/AL (n=113)</th>
<th>Traditional (n=40)</th>
<th>New-model (n=40)</th>
<th>NH (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed size</td>
<td>8.9 (3.6)</td>
<td>45.8 (36.7)</td>
<td>65.1 (43.1)</td>
<td>115.8 (50.8)</td>
</tr>
<tr>
<td>Facility age</td>
<td>12.8 (13.4)</td>
<td>23.0 (16.4)*</td>
<td>5.3 (3.0)</td>
<td>24.1 (15.1)</td>
</tr>
<tr>
<td>For-profit</td>
<td>92%</td>
<td>67%</td>
<td>73%</td>
<td>58%</td>
</tr>
</tbody>
</table>

* One facility had been in operation for 148 years and was excluded from the calculation; the facility in operation for the next longest time had been open for 80 years
### Requirements for residents

<table>
<thead>
<tr>
<th>Characteristic</th>
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<th>New-model (n=40)</th>
<th>NH (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance of Problem Behaviors</td>
<td>30.6</td>
<td>41.8</td>
<td>34.9</td>
<td>42.3</td>
</tr>
<tr>
<td>Admission Policies (ADLs)</td>
<td>61.4</td>
<td>51.9</td>
<td>72.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Admission Policies (all)</td>
<td>72.5</td>
<td>70.0</td>
<td>75.1</td>
<td>94.7</td>
</tr>
</tbody>
</table>

Note: All range from 0 – 100.
### Individual freedom and institutional order

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Small RC/AL (n=113)</th>
<th>Traditional (n=40)</th>
<th>New-model (n=40)</th>
<th>NH (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Choice</td>
<td>44.7</td>
<td>52.8</td>
<td>63.4</td>
<td>51.3</td>
</tr>
<tr>
<td>Policy Clarity</td>
<td>47.9</td>
<td>69.9</td>
<td>78.1</td>
<td>81.7</td>
</tr>
<tr>
<td>Provision of Privacy</td>
<td>47.9</td>
<td>64.3</td>
<td>74.9</td>
<td>41.7</td>
</tr>
<tr>
<td>Resident Control</td>
<td>21.3</td>
<td>37.6</td>
<td>38.6</td>
<td>41.6</td>
</tr>
</tbody>
</table>

*Note: All range from 0 – 100.*
Provision of services and activities

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Small RC/AL (n=113)</th>
<th>Traditional (n=40)</th>
<th>New-model (n=40)</th>
<th>NH (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Services</td>
<td>51.2</td>
<td>75.1</td>
<td>77.1</td>
<td>86.4</td>
</tr>
<tr>
<td>Social / Recreational Services</td>
<td>41.4</td>
<td>61.4</td>
<td>66.7</td>
<td>72.3</td>
</tr>
<tr>
<td>Services (All)</td>
<td>51.0</td>
<td>68.3</td>
<td>69.1</td>
<td>77.2</td>
</tr>
</tbody>
</table>

Note: All range from 0 – 100.
### Description of residents (Percent)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Small RC/AL (n=665)</th>
<th>Traditional (n=648)</th>
<th>New-model (n=765)</th>
<th>NH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 85+</td>
<td>46</td>
<td>57</td>
<td>52</td>
<td>49</td>
</tr>
<tr>
<td>White</td>
<td>85</td>
<td>92</td>
<td>95</td>
<td>89</td>
</tr>
<tr>
<td>Female</td>
<td>76</td>
<td>77</td>
<td>75</td>
<td>72</td>
</tr>
<tr>
<td>Married</td>
<td>10</td>
<td>10</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>Heart Condition</td>
<td>38</td>
<td>48</td>
<td>49</td>
<td>48</td>
</tr>
<tr>
<td>ADL Impaired</td>
<td>37</td>
<td>15</td>
<td>25</td>
<td>83</td>
</tr>
<tr>
<td>Cognitive Impaired</td>
<td>42</td>
<td>23</td>
<td>35</td>
<td>51</td>
</tr>
<tr>
<td>Behavioral Imp.</td>
<td>49</td>
<td>37</td>
<td>39</td>
<td>30</td>
</tr>
</tbody>
</table>
1. Residents in traditional facilities differed significantly from those in smaller facilities:

- Race (92% White, compared with 83% White),
- Percentage with a heart condition (48% vs. 38%),
- Functional impairment (mean MDS-ADL score 3.0 vs. 6.1), and
- Cognitive impairment (mean MDS-COGS score 2.1 vs. 3.2)
Case-mix of RC/AL residents by facility characteristics (cont.)

2. Residents in facilities that provided more privacy are more often:
   - White (94% vs. 84%);
   - Female (79% vs. 72%);
   - Older (85.2 years vs. 82.7 years)
   - With a heart condition (50% vs. 39%); and
   - Scored lower in functional, cognitive, and behavioral impairments.
Discussion

- New-model facilities score higher than small facilities across all domains of individual freedom and institutional order.
- Smaller homes are outperformed by larger homes on many objective measures of structure and process.
- NHs score significantly lower on the provision of privacy than all RC/AL facility types and lower on policy choice than do new-model facilities.
- New-model facilities score higher than traditional facilities in both privacy and policy choice.
Discussion (cont.)

- Residents in RC/AL facilities are functionally impaired, however less so than those in NHs; cognitive impairment is also less than in NHs.
- Behavioral problems are more prevalent in RC/AL than in NHs (as reported in this study).
- ADL, cognitive and behavioral impairments are highest in younger facilities (less than 5 yrs old) and those that are for-profit.
- Facilities with higher rates of resident impairment have more lenient admission policies, provide less privacy, and less resident control.
Discussion (cont.)

In only one instance (NH admission policies) are 100% of items endorsed, and within the individual freedom and institutional order domain, only 21-78% of items within any area are endorsed.

Among all CS-LTC facilities under study, nonprofit facilities score higher than for-profit facilities in reference to policy choice, clarity, and provision of privacy, and they have more restricted admission policies.
Final revelations

- NHs do not differ from traditional and new-model RC/AL facilities in the provision of social/recreational services, policy clarity, and resident control. NHs are significantly different from smaller RC/AL facilities in these same 3 areas, and in all cases score higher than smaller RC/AL facilities.

- Overall, it appears that RC/AL and NH populations are becoming increasingly similar (Hawes, Mor, et al., 1995).

- Given the similarities in case-mix and service provision, the degree to which RC/AL differentiates itself from NH care requires that conditions allow for differences. The degree to which RC/AL substitutes for NH care is in large part dependent on both the degree to which Medicaid programs will pay for RC/AL as an alternative to NH care and the extent to which research demonstrates differences in outcomes between the two settings (Zimmerman, Sloane, & Eckert, 2001).
References


Additional references cited in the article and this presentation:

References


References (cont.)


