Slide 1

This presentation discusses the emergence of assisted living facilities from nursing homes, and the differences between the provisions of care. The study presented describes the current state of residential care/assisted living (RC/AL) care and residents in skilled nursing homes (NHs). The authors identify different types of RC/AL facilities and their residents, and how the variation in case-mix reflects differences in service provision. This lecture is appropriate for students concentrating on the aging population, specifically in HBSE and policy courses.

Slide 2

Review the slide.

Slide 3

Review the slide.

Note: Failure of congregate housing - an overestimation of demand and an underestimation of the level of care needed by residents. Continuing care retirement communities and larger NHs developed the first stand-alone assisted living facility that was modeled after Dutch residential settings and could provide the invisible care needed. The success of this concept drew investment from a number of larger NH chains that saw the opportunity to use AL as a feeder for their nursing level of care, into which residents could be transferred as impairment increased. However, the market pressured stand-alone ALs to provide higher levels of care to enable aging-in-place (Mollica, 2001b; Sullivan, 1998); in which case facilities opted to avoid NH transfer and provided outside home health care or physical therapy (Thompson & Marianaccio, 1997).

Slide 4

Review the slides.

Note: To sum this up, one form of AL is not necessarily similar to another, nor is the distinction between AL and NH care and residents evident as this form of care has evolved. The thought that AL is a distinct stop along a continuum of care merits questioning; AL may be best considered a discrete node that provides services to residents similar to those in NHs and in a similar fashion.
Note: The CS-LTC defined RC/AL broadly as facilities of discrete portions of facilities licensed by the state at a non-nursing home level of care, which provide room, board, 24-hour oversight, and assistance with activities of daily living (ADLs; Kane & Wilson, 1993). Because the term “assisted living” has come to be used as both a generic and specific term, the CS-LTC refers to its sample of facilities as RC/AL facilities to indicate the broad inclusion of facility types and to avoid confusion about nomenclature.

Note: New-model RC/AL homes include those that have 16 or more beds, built after Jan. 1, 1987, and 1 or more of the following: multiple private pay rates, 20% or more of the residents requiring transfer assistance, 25% or more of the residents are incontinent daily, and/or a nurse (RN or LPN) is on duty 24 hours a day.

Note: It is important to remember that the definition of new-model is a research construction only, permitting clarity and uniformity in data collection and interpretation.

Note: The numbers of beds per 1,000 elderly persons by state are: Florida - 18, North Carolina - 16, New Jersey - 10, and Maryland - 8. Maryland has the fewest RC/AL beds and new-model beds.

Note: A purposive sample of counties was selected to increase efficiency in data collection. Within each region, facilities were randomly selected from a stratified list of all licensed RC/AL facilities and NHs. The sample of new-model facilities was identified by random numbering all facilities with ≥ 16 beds and calling them to determine if they met eligibility criteria and would participate. The study aimed to include an equal number of residents from each type of facility; this goal dictated that more small RC/AL facilities be enrolled than other facilities, because they house fewer residents.
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Review the slide.

Note: Among eligible facilities, the overall recruitment rate was 59%.

Note: There are no differences between participating NHs and nonparticipating NHs in reference to proprietary status; affiliation with other long-term care facilities; facility age, multiple rate levels, or size; and resident age, race, or ethnicity.

Note: RC/AL and NH residents were eligible to participate if they were 65 years or older. NH residents needed to meet additional eligibility criteria hypothesized to reflect current or future cohorts of RC/AL residents - therefore, they are inappropriate for comparison in the present analyses, and such comparative data will be derived from national samples reported elsewhere. Further details about the CS-LTC sampling and data collection procedures are available elsewhere - Zimmerman, Sloane, Eckert, Buie, 2001).

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Note: Data sources for the CS-LTC used in these analyses included interviews with facility administrators, care providers, and residents.

Note:
- Requirements for residents - the degree to which facilities accept 16 problem behaviors; admission policies related to 7 ADLs; and overall admission policies related to 24 resident characteristics.
- Individual freedom and institutional order - policy choice, the extent to which residents can individualize 19 routines; resident control, the degree to which residents can influence 27 policies; policy clarity, the extent to which mechanisms are in place to define/communicate expectation in 10 areas; and the amount of privacy available in 10 areas.
- Provision of services and activities - prevalence and accessibility of 10 health services; the availability of 13 social/recreational activities; and the overall provision of 20 health and supportive services.
Each of the 10 measures result in an aggregate score ranging from 0% to 100%, with higher scores indicating endorsement of more items.

Note: Because 6 of the measures are replicates of extensively tested measures with established reliability and validity (Moos & Lemke, 1996), the study did not re-examine these properties. For the 4 new measures, Cronback’s alpha was used to assess internal consistency, ranging from .74 to .84 for the measures - indicating good internal reliability.
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Note: to assess functional, cognitive, and behavioral status the following tools were use
- Minimum Data Set ADL Self-Performance Index - rates dependency over the last 7 days in bed mobility, eating, locomotion, transfer, toileting, dressing, and personal hygiene, with scores ranging from 0 (independence/no assistance) to 4 (total dependence)
- Mini-Mental State Examination
- Minimum Data Set Cognition Scale - a ten-point measure of cognition on which scores of 2 or greater indicate impairment and scores of 5 or more indicate severe impairment
- Cohen-Mansfield Agitation Inventory - behavioral problems measured using the short (14-item) scale that identifies the frequency of reported agitated behaviors over the last 2 weeks.

Slide 12

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Slide 13

Review the slide.

Note: Take notice of the following findings:
- NHs, on average, were approximately twice as large as traditional and new-model RC/AL (115.8 vs. 45.8 and 65.1 beds);
- NHs were as old as traditional facilities (24.1 yrs vs. 23.0 yrs) and twice as old as smaller RC/AL facilities (12.8 yrs); and
- The majority of all facilities were for-profit, although the percentage of for-profit NHs in the CS-LTC sample was somewhat less than national figures (58% vs. 67%; Gabrel & Jones, 2000).

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Note: Take notice of the following findings:
- NHs were more likely than RC/AL facilities to admit impaired residents, both overall and specific to those with ADL impairments.
- Differences in policies allowing residents with problem behaviors were less marked.
- Variation within RC/AL facilities was minimal and inconsistent; traditional facilities appeared more accepting of problem behaviors (endorsing 42% vs.
31%-35% of items), and new-model facilities were more accepting of ADL impairment (endorsing 73% vs. 52%-61% of items).

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Note: Point out the following:
- All RC/AL facilities scored higher than NHs on the provision of privacy, but NHs scored similarly to larger RC/AL facilities (i.e. traditional and new-model) in policy choice, clarity, and resident control;
- There was a consistent trend of new-models scoring highest and smaller facilities scoring the lowest;
- The greatest disparity among RC/AL facilities was in privacy and policy clarity, where there was a difference of 27-30 percentage points between smaller and new-model facilities.
- NHs were significantly less restrictive than RC/AL in all measures (except acceptance of problem behaviors by traditional facilities);
- NHs scored approximately 5-18 percentage points higher on acceptance of problem behavior, 33-46 points higher on ADL admission policies, and 24-26 points higher on all admission policies than RC/AL facilities.

**Slide 16**

Review the slide.

Note: Point out the following:
- There was a consistent ordering in the provision of services and activities, with NHs having the highest scores, followed in order by new-model, traditional, and smaller RC/AL facilities;
- The differences between new-model and traditional were not marked, however, and ranged from 1 to 6 percentage points;
- NHs scored significantly higher than all RC/AL facility types in the provision of health and overall services, and higher than smaller facilities in the provision of social/recreational services;
- The largest differences were in comparison with smaller facilities (ranging from 25% to 35%), and there was only a 9-12 point difference between NHs and traditional and new-model facilities;
- Also, new-model facilities again scored significantly higher than smaller facilities across all measures, but did not differ from traditional facilities.

Note: In addition to the differences between NHs and RC/AL and within the RC/AL types, it is worth noting that NHs scored higher than new-models across every indicator except policy choice and privacy, and that new-model facilities scored higher than both small and traditional RC/AL facilities on all indicators other than acceptance of problem behavior.
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Note: Information pertaining to the NH residents (obtained from Krauss & Altman, 1998) is from national statistics. The CS-LTC sample of NH residents was a selected sample and does not permit comparison. Also, the best medical data available for comparison on a national level were heart conditions, considered as a good indicator of a prevalent and chronic health condition.

Note: Pay particular attention to the following points:
- The demographic characteristics of RC/AL and NH residents were similar: 46%-57% were aged 85 and older;
- 85-95% were White;
- 72-77% were female;
- 10-17% were married; and
- 38-49% had a heart condition.
- Markedly more NH residents were impaired in ADLs (83% vs. 15-37% in RC/AL), but differences in the percentage with cognitive impairment (51% vs. 23-42%) and behavioral problems (30% vs. 37-49%) were less extreme.
- Within RC/AL facility types, smaller facilities consistently housed the most impaired residents, and traditional facilities consistently housed the least impaired.

Slides 18 and 19

Prior to reviewing the slides, inform the class: For these analyses, bedsize for facilities ≥ 16 beds was cut at the median (60 beds), facility age was cut at the first and third quartiles (5 and 15 years), and the process of care measures were cut at their respective median.

Slide 20

Review the slide.

Note: Processes of care as practiced in NHs differ in expected and unexpected ways from RC/AL. For example, it is to be expected that NHs would be more encompassing in their admission policies than RC/AL facilities because NHs primarily exist to serve people with severe medical and disability problems (Krauss & Altman, 1998). It is also to be expected that NHs would provide more health and overall services to meet the needs of these residents. The similarities between NHs and traditional and new-model RC/AL facilities may speak to improvements that have been made in the philosophy of NH care, and that may increasingly blur distinctions between RC/AL and NHs.

Note: Differences in privacy are not unexpected, given the expense of NH care and the greater incapacitation of some of the residents. In relation to policy choice, it is evident
that new-model facilities present the AL tenets of maximizing autonomy and independence and emphasizing individual’s rights to make decision regarding their own care (Assisted Living Quality Coalition, 1998; Wilson, 1996) to a degree that sets them apart from other RC/AL care.

**Slide 21**

Review the slide.

Note: Such findings may indicate a difference in both admission and discharge policies, selection on the part of prospective residents, or a matching of facility policies and resources to resident need.

**Slide 22**

Review the slide.

**Slide 23**

Review the slide.

Discussion questions: What are the implications for social workers in the aging field? How will this information help social workers in direct practice, community practice, and policy?

**Slides 24, 25, and 26**

Reference information for article and information cited in the article and slides.