

## ASSISTED LIVING IN THE UNITED STATES

**Definition and Philosophy of Assisted Living**

States, accrediting organizations, providers, consumer advocates, and researchers use *varying definitions of assisted living*. Most definitions include 24-hour supervision, housekeeping, meal preparation, and assistance with activities of daily living.<sup>1</sup>

Many definitions embrace a *philosophy of assisted living* that includes: meeting a resident's scheduled and unscheduled needs; maximizing a resident's independence, privacy, autonomy, and dignity; minimizing the need for a resident to move when his or her needs change; and providing a homelike environment.<sup>2</sup>

The lack of agreement on a definition makes it difficult to obtain consistent data on assisted living. Studies of assisted living use varying definitions, and some of these definitions include a broader range of residential care settings. Most of the studies referred to in this report use a relatively narrow definition of assisted living, consistent with the philosophy and definition described above.

**Resident Characteristics**

In a 2000 study of assisted living residences (ALRs) that provided high services, high privacy, or both,\* the average age of residents was 85.<sup>3</sup> Women made up 79% of residents, and 99% of residents were White. Assisted living residents needed assistance with an average of 2.3 activities of daily living, compared to an average of 3.8 for nursing home residents.<sup>4</sup> Approximately 52% of assisted living residents had some

form of cognitive impairment. Table 1 shows the proportion of assisted living residents needing assistance with various activities.

**Table 1: Assisted Living Residents' Needs for Assistance**

Need help with medications	86%
Need help with bathing	72%
Need help with dressing	57%
Need help with toileting	41%
Need help with transferring	36%
Need help with eating	23%

Source: National Center for Assisted Living, 2001.

**Length of Stay and Reasons for Leaving**

Estimates of the average length of stay in an ALR range from approximately 2.5 to 3 years.<sup>5</sup> Residents who leave typically do so because they need to move to a nursing home for more care or because of death. A 2000 study found that, among those who moved to another setting, the need for more care was the most commonly cited reason for leaving (see Table 2).<sup>6</sup>

**Table 2: Reasons for Leaving Assisted Living (among residents who left for another setting)**

Needed more care	78%
Location closer to loved ones	14%
Dissatisfied with care	12%
Dissatisfied with price	11%
Other dissatisfaction	11%
Ran out of money	9%
Other/unknown reason	9%

Source: Phillips, et al., 2000. Results total more than 100% because respondents could give more than one answer.

**Costs and Sources of Payment**

An April 2004 review by Health Policy Tracking Services found that estimates of the average cost of assisted living ranged from approximately \$2,100 to \$2,900 a month.<sup>7</sup> In addition, some ALRs may charge an admission fee. Rates vary

\* *High privacy* meant that at least 80 percent of residents' units were private. *High service* ALRs had a full-time RN on staff and provided the following: nursing care if needed, help with at least two activities of daily living, 24-hour staff, housekeeping, and at least two meals a day.

considerably depending on the location of the residence, the type of accommodations (e.g., private or shared room), and the services the resident needs or wants.

Medicaid coverage of assisted living services is increasing gradually. In 2002, Medicaid helped pay for services for approximately 11% of assisted living residents in 41 states.<sup>8</sup> In contrast, Medicaid is the primary source of payment for 58% of nursing home residents.<sup>9</sup>

Assisted living remains primarily private pay. As of 2000, 67% of assisted living residents paid with their own funds and 8% received support from family members.<sup>10</sup> 2% paid with long-term care insurance.

Because of their high cost and lack of public subsidies, ALRs are often unaffordable for persons with low or moderate incomes.

### **Assuring Quality in Assisted Living**

In contrast to nursing homes, no federal quality standards exist for assisted living. Additionally, states vary significantly in their licensing requirements, quality standards, and monitoring and enforcement activities.

Recent media reports have brought attention to quality problems in assisted living, such as inadequately trained staff, too few staff, medication errors, and the admission and retention of individuals who need more care than the residence is equipped to provide.<sup>11</sup> One effort to address quality problems was the establishment of the Assisted Living Workgroup (ALW), formed at the request of the U.S. Senate Special Committee on Aging. In 2003, the ALW issued a report with recommendations for improving quality in assisted living.<sup>12</sup> To continue and expand the work of the ALW, 11 organizations that participated in the ALW have formed an organizing committee to develop a “Center for Excellence in Assisted Living” (CEAL). The CEAL will foster high quality,

affordable assisted living by disseminating research and information and providing technical assistance.<sup>13</sup>

### **Growth of Assisted Living**

ALRs began to appear in the United States in the mid-1980s and have grown rapidly, in spite of concerns about quality problems and affordability. From 1992 to 1998, the number of older persons living in ALRs and other residential care settings greatly increased (from 266,706 to 416,768), while the number in nursing homes declined somewhat (from 1,413,596 to 1,346,119).<sup>14</sup>

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<sup>1</sup> Hawes, C., C. D. Phillips, and M. Rose. *High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey*, November 2000.

<sup>2</sup> Hawes, Phillips, and Rose, 2000.

<sup>3</sup> Hawes, Phillips, and Rose, 2000.

<sup>4</sup> National Center for Assisted Living, *Facts and Trends: The Assisted Living Sourcebook*, 2001.

<sup>5</sup> NCAL, 2001; Hawes, Phillips, and Rose, 2000.

<sup>6</sup> Phillips, C., C. Hawes, K. Spry, and M. Rose, *Residents Leaving Assisted Living: Descriptive and Analytic Results from a National Survey*, 2000.

<sup>7</sup> Tanner, R. “Assisted Living,” 2004.

<sup>8</sup> Mollica, R., *State Assisted Living Policy*, 2002.

<sup>9</sup> O’Brien, El. and R. Elias, *Medicaid and Long-Term Care*, Kaiser Commission on Medicaid and the Uninsured, May 2004.

<sup>10</sup> NCAL, 2001.

<sup>11</sup> Fallis, D. S., “As care declines, cost can be injury, death,” *Washington Post*, May 23, 2004, page A01; Appleby, J., “Good centers keep elderly active, safe,” *USA Today*, May 25, 2004, pg. A11; McCoy, K. and J. Appleby, “Many facilities accept people who are too ill,” *USA Today*, May 27, 2004, p. A06; McCoy, K. and J. Appleby, “Problems with staffing, training can cost lives,” *USA Today*, May 26, 2004, pg B01.

<sup>12</sup> The Assisted Living Workgroup, *Assuring Quality in Assisted Living: Guidelines for Federal and State Policy, State Regulations, and Operations*. Report to the U.S. Senate Special Committee on Aging, April 2003, <http://www.alworkgroup.org/>.

<sup>13</sup> <http://www.theceal.org>

<sup>14</sup> Spillman, B. C., K. Liu, and C. McGilliard, *Trends in Residential Long-Term Care: Use of Nursing Homes and Assisted Living and Characteristics of Facilities and Residents*, November 2002. Data are from the Medicare Current Beneficiary Survey, 1992 through 1998.