1997

Quality Assisted Living for Older Adults, A Study of Three Single Family Homes, A Viable Housing Alternative to Institutionalization

Rhonda Lynn Dahlberg

QUALITY ASSISTED LIVING FOR OLDER ADULTS, A STUDY OF THREE SINGLE FAMILY HOMES, A VIABLE HOUSING ALTERNATIVE TO INSTITUTIONALIZATION

Rhonda Lynne Dahlberg, B.S.

Culminating Project Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Art

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ABSTRACT

Long-term care is one of the greatest threats to the financial security of older Americans and their families. People are living longer and because of this many are becoming frail, developing functional impairments and suffering from chronic illnesses. In the past, elderly people did not have many options when health problems made running a household too difficult to manage. It then became necessary to explore other housing alternatives. Previously, nursing homes were the traditional solution for individuals without the family resources to help them stay at home.

Today, new housing options are emerging. These housing options are gaining considerable attention. It is important to consider an alternative housing arrangement for a person who becomes forgetful, incontinent and shows signs of impaired mobility and decreased ability to perform activities of daily living. One housing arrangement that is gaining considerable attention is that of assisted living. Of particular interest is the

viability of a single family home for providing quality assisted living services.

The purpose of this project is to explore assisted living as a viable housing arrangement for promoting optimal health and independence. A discussion on assisted living, regulations and what comprises a good assisted living facility are addressed. In addition, a checklist has been developed and used to study three single family homes that provide assisted living services. Recommendations for establishing a good facility are proposed. Finally, a list of resources is provided for gathering information regarding assisted living.

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DEDICATION

I dedicate this project first and foremost to my father Ronald J. Wolfe who supported me and encouraged me to succeed. I also dedicate this to my mother Muriel D. Wolfe who gave her love and support to me and my children while I was completing the requirements toward a degree of Master of Art from Lindenwood College. Finally, I dedicate this to my three sons Christopher, Matthew and Michael for their patience and understanding regarding the importance of mom completing her homework, too.

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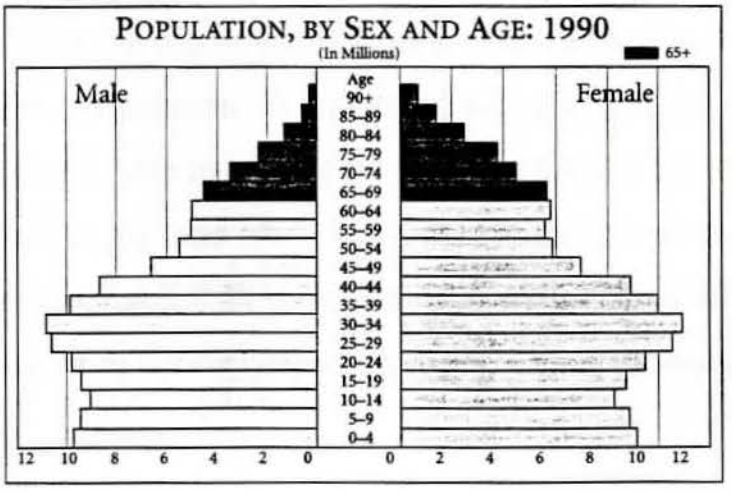
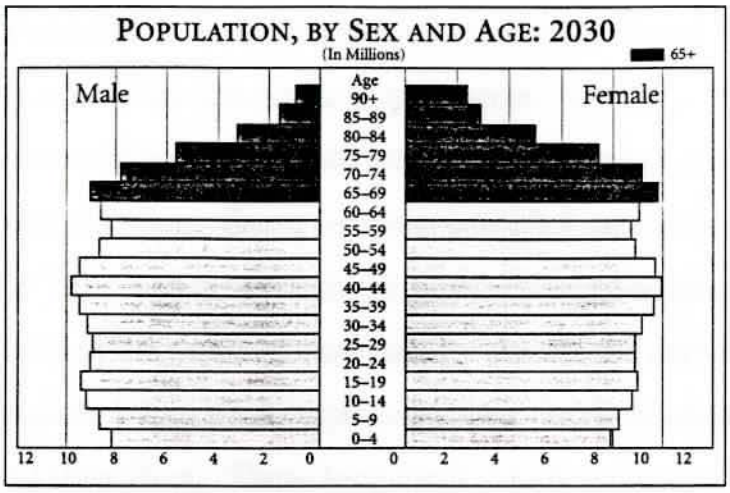
CHAPTER 1
INTRODUCTION

Long-term care involves both non-medical and medical services given along a continuum of care so that individuals can function at a high level and be independent in the community (DeJong 89). The elderly comprise two thirds of the nine to eleven million older Americans who need some type of long-term care (Perspective on Aging, Jan-March 1995, 16). An alarming four to five million people are projected to need nursing home care over the next thirty years. In addition, two to three times as many disabled elderly are likely to be receiving long-term care at home through some combination of formal and informal services (Perspective on Aging, Jan-March 1995, 17). The following two graphs illustrate the growing "over-65" population of the United States.





Sixty-Five Plus in America. U.S. Bureau of the Census, 1991

The number of elderly will dramatically increase over the next few decades from thirty-one million in 1990 to more than seventy million in 2030. In 1995, the "oldest-old" segment of our population was comprised of three million Americans over the age of 85. The projected number of persons age 85 and above in the United States in the year 2030 is 8.1 million (Perspective on Aging, Jan-March 1995, 7).

Age 85 is the age at which a person enters into the "oldest-old" segment of our population. It was noted that at age 85 the average body is no longer able to survive the stress of normal daily life (Wolfe 19). This is also the time when long-term care needs are addressed.

Long-term care is an issue that Americans cannot afford to ignore. Long-term care is defined as the "range of services providing

for the health, personal care, and sociopsychological needs of those whose ability to take care of themselves has been reduced by frailty, chronic illness or other functional impairments" (Osgood 15). The focus of these services is on rehabilitation, maintenance, and/or delay of further deterioration. Some services provided may even enhance the quality of life. These services are geared toward helping the persons receiving the services successfully master the activities required for daily living while improving their personal satisfaction and the quality of their lives. These long-term care needs and desires vary from person to person.

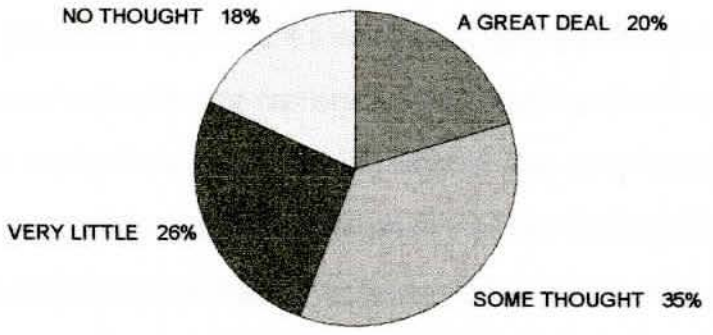
A national telephone survey conducted in 1992 by the American Association of Retired Persons (AARP) shows that when older people think about their domestic arrangements, eighty-five percent of older people surveyed said they wanted to stay in their own homes and never move (3). The ideal situation is "aging in place" (Ivry 77).

Aging in place is defined as "remaining in the same residence where one has spent his or her earlier years (Harris 18). But, if health fails and there is a need to consider future housing arrangements, fifty-one percent of the people surveyed said they would be interested in living in a building that provides meals, transportation, housekeeping services, and social activities (Walser, p. 10). Therefore, the above definition of "aging in place" is not a feasible reality for a good number of frail and impaired elderly persons (Calkins 569). Despite their perhaps declining health status and their decreased ability to perform

activities of daily living, most elderly people want to remain in their homes and never move. As they grow older, however, people are more likely to need supportive and health services to maintain maximum autonomy and a reasonable quality of life (Maddox, p. 15). Thus, the need for long-term care planning exists.

However strong the need may be for long-term care planning, according to the 1992 survey conducted by AARP, fifty-four percent of older Americans have done no or very little planning regarding their housing needs for later years (3). The following chart shows that nearly half of Americans give little or no thought to needing long-term care. If a person is in need of long-term care, it may become a decision that is made in a hurry. If that is the case then a concern might exist regarding the quality of services provided. In addition there might be concern over the environment in which the services are provided in.

TABLE 1
AMERICANS THOUGHTS REGARDING THE NEED FOR LONG-TERM CARE



Source: Perspective on Aging , July-September 1996, 1.

There has been rising concern over the past several years regarding the quality of environments that society has created and what these environments provide for their elderly residents. However it seems to be an accepted fact that providing the quality care that is needed for maintaining all older adults in their homes is both too costly and too hard to regulate. With respect to quality, the government is unable to support the approach of providing home services on a national basis (Ivry 78). Therefore the need exists to bring older people together residentially. This would enable the services to be provided in a more cost effective manner. In addition, other issues such as isolation and loneliness can be addressed. Assisted living is a type of residential housing that addresses these issues. Living in an assisted living environment can delay or eliminate the need to relocate into an institution.

The purpose of this paper is to explore assisted living as a viable alternative to institutionalization. Assisted living is defined and further described in the literature review in Chapter two. In addition, information is provided regarding state and federal regulations. A checklist is provided to use as a tool to evaluate the characteristics to look for in an assisted living facility. The checklist developed has been used to study three single family homes that provide assisted living services to older adults. A summary of the findings is described and recommendations are further delineated for developing a quality

assisted living facility. Appendix A provides a list of resources for gaining information and further knowledge regarding assisted living.

CHAPTER 2
REVIEW OF LITERATURE AND REGULATIONS

There is increased interest in group living arrangements for mentally and physically frail older people because of the economics of health care and the fact that consumers are demanding new choices. A number of factors account for this increased interest.

First, the increase in the eighty-five and over age group is estimated to double in the next twenty years. It has been forecasted that in fifty years, the number of older persons in this age group will be four to seven times what it is now. Second, government agencies estimate that the cost of long-term care may triple in the next twenty-five to thirty years, up to one hundred billion dollars a year in the year 2020. Third, older people who have institutionalized their own parents are refusing to move into nursing homes and are seeking a range of residential care alternatives. Fourth, family members sandwiched between the obligations of children and parents are seeking ways to share caregiving responsibilities with formal service providers thus lessening the informal care burden (Warren 2-3).

The last factor for the increased interest in group living arrangements is that policy makers recognize the growth of nursing homes due to existing funding policy and are realizing that the present funding policy is not a solution consistent with the needs and desires

of older people (Warren 3). Assisted living is one type of group living arrangement that is gaining attention in recent years.

Living in an assisted living environment can delay or eliminate the need to relocate into an institution. To delay the transition to an institution, assisted living arrangements have been developed which provide increased availability of services (Netting & Wilson 268). Due to the physical, social, and organizational environments of assisted living facilities there is more support given towards independence, control, privacy, and autonomy than other care settings, especially nursing homes (Calkins 568).

Because of longevity, frailty, and the chronicity of diseases, the incidence of isolation, loneliness and depression may become more prevalent among the elderly. This, in turn, can cause a further decline in health or an increase in disability and dependency (Osgood 10). This is another strong point for the concept of assisted living and the availability of services.

In the book entitled Aging: It's Complex Management Ronald Cape states that what the elderly patient seeks, almost more than cure, is independence (217). In order to increase your chances of living independently, Cape lists five rules for living into age eighty and beyond. They are regular exercise, diet, mental stimulation, declaration of symptoms and dangers of medications (222). Even when following the five rules throughout one's life, there is no way that an old person can be completely protected from the possibility of

accident or illness (222). There is evidence to support the idea that following the five rules gives one a better chance of living independently in the community as compared to nursing home residents.

A comparative study was completed in 1995 by Paula Grayson, Bernard Lubin and Rodney Van Whitlock and reported in The Journal of Clinical Psychology that cited higher rates of depression and dysphoric mood in nursing home residents as compared with community residents (19). Their findings also revealed that the need appears almost as great for providing adequate social programming and counselling services for assisted living residents as for those who reside in nursing homes (21). Overall, this study showed that proper stimulation and socialization can decrease the incidence of depression and promote healthy psychological aging. If one is unable to live independently in the community, assisted living is one alternative to living in a nursing home.

There is no universally accepted definition of assisted living, although many researchers have proposed the development of one definition for assisted living (Sharpe 16). There are a variety of definitions for assisted living that generally describe a program of care and service that falls between independent living and long-term care (Thornton 30). The outcome of providing an assisted living environment is to promote maximum independence, autonomy, dignity and choice to our frail elderly (Carney 30).

Assisted living is presently known by various other names such as personal care homes, sheltered housing, residential care, homes for the adults, managed care, catered living, board and care, and domiciliary care (Regnier 20). The Assisted Living Facilities Association of America (ALFAA) defines assisted living as: "A special combination of housing and personalized health care designed to respond to the individual needs of those who need help with activities of daily living. Care is provided in a way that promotes maximum independence and dignity for each resident and involves the resident's family, neighbors and friends" (Regnier 2).

Assisted living is designed to serve the growing number of elderly persons who can no longer live independently, but who do not need skilled nursing care (Baker 1). Assisted living is part of a continuum of care spectrum, one that is focused on client needs and desires (Birkett 23). In many cases, assisted living is a combination of "need" for care and a "choice" for a home-like residential environment (Tinsley 9). The need for long-term care is rising.

More than ten million Americans of all ages currently need some type of long-term care to remain in their own homes or in other community-based settings. Questionable is the quality of long-term care received. To address this, the Administration on Aging provided funding for an Institute of Medicine study which started in July of 1995, to last eighteen months. This study was to address the quality of long-term care and to organize and synthesize data already available

(Perspective on Aging, Oct-Dec 1996, 24). Assisted living is a good example of a community-based setting.

Two strong characteristics of a good assisted living facility are that the environment is homelike and the residents are encouraged to be independent and to maintain some sense of control. "The feeling of being in control, of having a say over what happens in one's life, has far-reaching consequences for physical and mental health" (Lowy 138).

A powerful symbol of one's link to self, family and community is that of home (Ivry 77). Assisted living in a home-like environment provides both individual shelter and shared round-the-clock personal care services. People who require such services are growing increasingly frail. They desire to live independently but they need assistance with daily activities such as taking a bath, getting dressed, and eating meals (The Supportive Housing Connection, May 1996). When assistance is needed, there is security and comfort in knowing that a 24-hour live-in care provider is available to help (Lasky 40).

Assisted living is popular due to the fact that dignity can usually be maintained, which is not always the case with institutionalization (Regnier 13). When an older person's level of care changes along the continuum from independence to needing some assistance, assisted living becomes a quality affordable housing alternative. Many older people fear nursing homes and families struggle with guilt as a move to

a nursing home is considered a last step to be made, a place where decline is likely and death may occur (Regnier 13).

The October 1992 issue of The Supportive Housing Connection states that the term assisted living refers to both a philosophy of care and an idea about the character and appearance of the environment. In addition, it cites the criteria that is desirable in a good assisted living facility that fosters support for the mentally and physically frail. The criteria shows that the facility should appear residential in character, be perceived as small in scale and size, provide residential privacy and completeness, foster independence, interdependence, and individuality, focus on health maintenance, physical movement and mental stimulation, support family involvement, maintain connections with the surrounding community, and serve the frail. Due to dementia and other forms of mental illness, it is a challenge to promote the criteria as listed above.

With demented elderly, it is difficult to improve the intellectual impairment, but their total behavior can be improved by providing adequate care in a homelike atmosphere, which may stimulate more appropriate social behavior. Persons suffering from dementia cannot learn a lot of rules and routines. Being flexible, playing the role of facilitator in a calming manner, and humorous therapeutic interaction are necessities of staff-resident relationships to promote autonomy and life-satisfaction (Brink 44).

As the number of frail older persons increases, the demand for housing options will grow. Organizations such as the State Units on Aging (SUAs), Area Agencies on Aging (AAAs), and other aging network organizations all have an important role to play in both developing and supporting housing options for older persons. SUAs are developing models of assisted living, personal care and small group homes. SUA networks in housing are most likely to include aging advocacy organizations, such as AARP or the American Association of Homes for the Aged. In addition, the networks may include state-level agencies, especially social services, housing finance or community development departments. There are also local government adult protective services agencies included in the housing networks. SUA networks in housing are most likely to include public sector organizations rather than non-governmental associations and agencies (Supportive Housing Options, Summer 1992, 3).

The Maryland Office on Aging has a formal state program called the Group Senior Assisted Housing that involves fourteen of nineteen AAAs with 120 state-certified board-and-care/assisted living projects which provide technical assistance, monitoring and quality control, coordination and subsidies (The Supportive Housing Connection, October 1992). The aim of the Maryland Office on Aging is to develop and maintain good assisted living models.

DeJong and his colleagues compared and contrasted three conceptual models of long-term care. They include the informal

support model, the medical model, and the independent model (89). It seems that government has overlooked what is referred to as the independent living model of personal assistance since most long-term care policy has focused primarily on the dependent frail elderly population. What is lacking is that policy makers have not considered the fact that many elderly persons aspire to live independent lives (DeJong 91). Congress needs to distinguish between personal assistance services based on the independent living model and home healthcare based on the medical model. There is confusion because long-term care and homecare are often used interchangeably (DeJong 95).

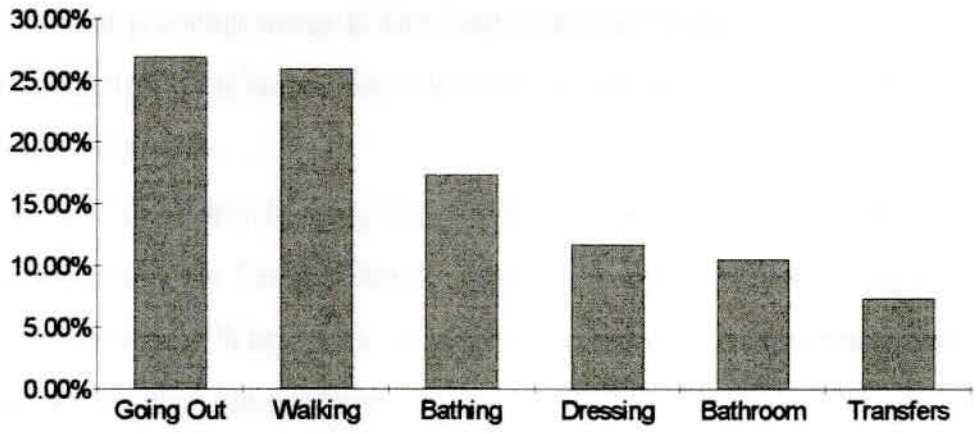
Home-based care has been recognized as a vital component of the health care delivery system (Rabiner 186). Rabiner and his colleagues conducted a study that examined the relationship between participation in and satisfaction with care provided in two home and community-based long-term care case management interventions. They concluded that continued research effort in the health care field by investigating the costs and benefits of health care for elderly Americans will help policy makers determine which long-term care programs enhance quality of care and assist political leaders in making difficult funding decisions (194).

Another study was completed by Vernon L. Greene and his colleagues that showed how community long-term care could reduce nursing home admissions for the frail elderly. Assisted living facilities

are described as "ideal" and "creative" and the most promising emerging model of professionally managed shelter and care that will allow the frail elderly to maintain their independence and dignity. Assisted living is a model of residential long-term care. Personal care services are delivered in a professional manner within a safe housing environment (Binstock 412). Especially great are the personal care needs of those aged 85 and older. For example, forty percent of persons over the age of 85 need assistance with walking. Thirty percent need help with some other normal daily activity (Wolfe 16). The following graph shows what activities the elderly need the most help with. It also shows what percentage of persons need assistance with each particular activity. Providing the needed assistance promotes healthy aging.

TABLE 2

Activities Elderly Need Help With



Source: Census Bureau, Natwest Securities, Alex Brown & Sons.

It has been found that for those elderly to negotiate the terms of their own old age, they needed to live in superior settings and have support of families and staff. Just as important is for this special group of persons to be encouraged to help themselves as much as they are able (Schmidt 253). In addition, social functioning can be prolonged with a combination of physical environment, intellectual challenge, and social supports. Physical environment and programs preserve mobility, continence, and morale (Schmidt 253). Having common space encourages recreational, educational and social activities (Maddox 20). A single family home is the ideal setting to provide this kind of service to our rapidly aging population (Warren 2).

Assisted living can provide a home-like atmosphere which allows residents to maximize their independence and live in a warm and dignified residential setting. Traditional nursing homes have not been able to provide this true home-like atmosphere. And with the cost of nursing home care expected to rise, assisted living could be one of the fastest growing areas of the long-term care industry (Warren 6). In order to provide a home-like atmosphere, the size of the facility needs to be addressed.

Of the thirty to forty thousand residential group living facilities of all types in the United States, approximately two-thirds have less than eight beds (Warren 7). A single family home can provide that small home-like atmosphere.

When converting a small single family residence into an assisted living facility, consider that overhead and operating expenses will be lower and that starting an assisted living facility will only require a minimal amount of capital. It has been recommended that becoming licensed will increase credibility when showing the facility to prospective residents (Warren 13). The single family home conversion will be easier to fill because cost is lower than larger assisted living facilities on a per resident basis. In addition, consider that ninety-five percent of the same services are provided within this single family home environment. Certainly a smaller facility will be more appealing to families (Warren 8).

Since the passage of the Older Americans Act changes in long term care policy have emphasized home care and residential group living arrangements as alternatives to the nursing home. Assisted living is a model of residential long term care where professionally managed and administered services are provided in an effort to keep residents physically and psychologically independent in a residential home-like environment. The term connotes a care philosophy that is resident centered. Its purpose is to keep the older person out of an institution for as long as possible. Although one main component of assisted living is help with activities of daily living, the care philosophy seeks ways to allow the person and/or his family to self manage health care services on an occasional or ongoing basis. In assisted living

facilities, staff members monitor the well-being of residents, and family members are active participants in a loved one's care (Walser 7).

Many times a physically frail older person suffers from more than one chronic ailment. This restricts both his or her mobility and accessibility to care services. The probability is high that this person suffers from such problems as arthritis, hypertension, heart disease, diabetes and/or hearing and visual impairments. In addition to the chronic ailments listed above, a rapid worldwide growth in mental disorders and chronic illness is projected by the year 2000 (Wolfe 17). Assistance with bathing, dressing, medicine supervision, toileting, ambulation, eating and grooming are often needed. However, many times what is not needed is twenty-four hour supervised nursing care. Taking into account what ailment the individual suffers from aids in planning and management of the individual care needs.

Mentally impaired persons are often physically active but experience disorientation, memory lapses, confusion, agitation and frustration. They are frequently experiencing the first stages of dementia and have difficulty comprehending. These persons may easily be confused or lost. But being disoriented and restless, just like being incontinent or disabled by arthritis, is not a good enough reason to be institutionalized.

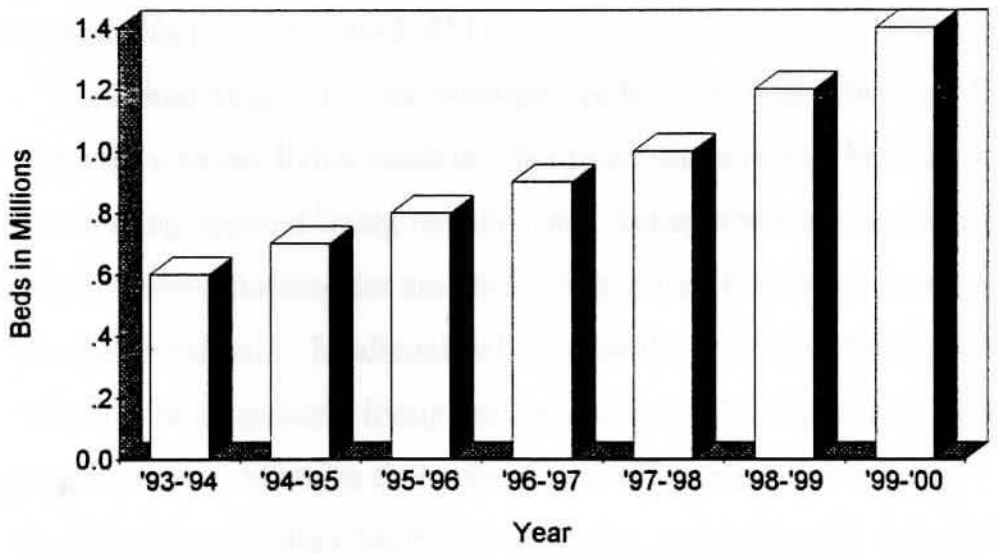
Both the physically and mentally frail are the most common types of persons living in assisted living environments. The typical

assisted living resident is greater than age seventy-five, and usually female (Warren 16). She needs help with activities of daily living.

Assisted living facilities serve older persons in need of some assistance with daily living in the least restrictive setting. The assisted living housing category is a very small percentage of the overall senior-housing market (Bergsman 38). As the population ages, the number of assisted living centers is expected to grow to meet the needs of the elderly. The following chart shows the rising number of assisted living beds estimated in the years to come.

TABLE 3

Estimated Number of Beds in Assisted-Living Complexes



Source: Census Bureau, Natwest Securities, Alex Brown & Sons.

Cost is a factor when detemining the best suited housing arrangement. Generally, nursing home fees range from $2500-$5000 per month. Normally an assisted living facility charges between $1100 and $1700 per month (Warren 16). The fees for assisted living are mostly out-of-pocket expenses. However, some states and local governments provide subsidies for rent or services for low-income persons in need of assisted living services (Tinsley 10). Still, many persons cannot afford the cost of assisted living facilities.

Various financial strategies, which include federally insured reversed mortgages, low-income housing tax credits, federally insured mortgage insurance for assisted living, the financing of assisted living service with Medicaid waivers, more standardized and reliable long-term care insurance products, are all encouraging elderly housing and care options (Binstock 411).

Some long-term care insurance policies provide coverage for stays in assisted living facilities, but most states do not have programs for funding assisted living facility care. Some states are beginning to provide some funding for assisted living, either from state funds or through Medicaid. Medicaid will pay for the cost of services for those who live in an assisted living facility and meet the Medicaid elegibility requirements. In states that subsidize services in assisted living facilities through their Medicaid programs, residents with extremely low income may also qualify for Supplemental Security Income (SSI), which will cover much or all of the room and board cost (Reisacher

23). Eligibility requirements vary from state to state and information regarding eligibility can be obtained through the local welfare office.

Assisted living facilities represent probably the first time that a housing health care product--an environment to care for the frail elderly--has been created without a federal program as the driving force (Lasky 41) Currently most assisted living facilities are privately owned. Assisted living facilities are residential settings. Service plans are developed on an individual basis to meet the needs of each resident. Meals are almost always part of the services provided in assisted living. Autonomy of older persons is to be emphasized and preserved. To be successful, an assisted living facility must be small in size and be residential in character.

There is no federal regulation of assisted living, just as there is no federal regulation of board and care homes. The amount and type of regulation is left up to state governments. The appropriate level of state regulation is a major issue facing the assisted living facility industry (Sharpe 17). The standards and regulations are imposed by the local Health Department and Social Services (Warren 18). Currently, states are doing one of three things. They are either not regulating at all, using one of its existing licensure categories to regulate assisted living, or creating a new licensure type and new regulations specifically for assisted living (Reisacher 21). Oregon and Washington began a widespread movement to encourage assisted living by introducing a special licensing category. According to the

National Academy of State Health Policy, nearly sixty percent of the states have, or are considering, new regulations which apply to assisted living (The Supportive Housing Connection, May 1996).

Given the degree and inconsistency across states and within states, licensure may not be a good indicator of quality or scope of services. A model developed in Oregon required three conditions be met for licensure as an assisted living facility. First, there must be normalization of the environment. Second, an extensive service capacity to facilitate well-being must be in place. And third, a values orientation directed toward enhancing client autonomy must exist (Wilson 1).

The demand for assisted living is greater than the supply. Smaller-sized properties are preferred. In addition, an all-encompassing pricing structure for services is recommended. Many feel there is no need for Federal regulation, but the facility should maintain fire safety and construction standards. It has been stated that regulation is unnecessary for facilities where residents are essentially healthy and require only occasional assistance with their activities of daily living (Sharpe 17). Assisted living accreditation was preferable to regulation "because it is not punitive", yet many feel "regulation is inevitable" (Bruck 13-14). Becoming familiar with individual state regulations is very important.

When investigating assisted living in a particular state, the first thing to do is call the state Department on Aging or the local Area

Agency on Aging to find out whether the state has adopted an approach to assisted living and what that approach is. An assisted living policy may be developing or evolving in a particular state. When contacting the local government agency, identify the name that state uses when referring to assisted living housing. For example, some states refer to assisted living as board and care, RCF I or II or residential care. Appendix A identifies the state and name used within the particular state.

In an assisted living setting, there is far less standardization (Birkett 22). Unlike nursing homes, which must comply with federal Medicare regulations no matter where they are located, assisted living facilities do not operate under a national standard (Walser 6). Because assisted living residences are not bound by the same regulations that govern nursing homes, the opportunity exists to be more flexible and creative with respect to physical environment and delivery of services (Bruck, May 1995, 32). This means that regulations and special requirements vary from state to state.

Licensure also varies from state to state. Most states have a minimum number of residents required before licensure is necessary. Generally, if the facility is home to three or fewer residents, licensure is not required. Without a license, special modifications do not have to be made. These special modifications might include installing an intercom system or installing a sprinkler system (Warren 13).

A licensed facility is required to have an administrator who oversees the day-to-day operation of the facility, protects the safety and physical, mental and emotional health of its residents, assures compliance with standards and regulations set up the state's Department of Social Services, and posts the facility's current business license at all times (Warren 17). In addition, state licensing prohibits assisted living staff from providing medical care (Carney 30).

In a licensed facility, the administrator trains a live-in person on emergency plans for the facility. The live-in must be trained and certified in CPR and first aid (Warren 18). Research shows that the administrator should be a professional person who is knowledgeable about the elderly and can function as a service organizer and provider. Joann Ivry suggests that the roles of a geriatric social worker or other formal service providers can be invaluable and perhaps necessary to facilitate aging in place within an assisted living facility (77).

In 1994, one group within the National Institute of Senior Housing laid the groundwork for establishing a code of ethics for senior housing managers. Another group within the same organization examined tenants' rights in assisted living. Their findings supported the idea that assisted living should be managed by a professional. Their findings also supported the importance of addressing residents' rights and residents should be made aware of their rights in assisted living (1995 Annual Report covering 1994 from the National Council on the Aging, Inc., 6).

Since regulations vary from state to state and this study focuses on single family homes providing assisted living services located in the state of Missouri, Missouri state regulations are described. In Missouri, assisted living falls under the categories of RCF I and RCF II. The small single family homes with a small number of residents falls under the category of RCF I. The regulations for an RCF I facility are described as listed in the 1995 Long-Term Care Facility Regulations and Licensure Law for Residential Care Facilities I and II, Intermediate Care Facilities, and Skilled Nursing Facilities developed by the Department of Social Services and the Division of Aging for the State of Missouri.

An RCF I is defined as "any premises, other than a residential care facility II, intermediate care facility, or SN facility, which is utilized by its owner, operator or manager to provide twenty-four hour care to three or more residents, who are not related within the fourth degree of consanguinity or affinity to the owner, operator, or manager of the facility and who need or are provided with shelter, board, and with protective oversight, which may include storage and distribution or administration of medications and care during a brief short-term illness or recuperation" (ii-iii).

Under the Department of Social Services, Division of Aging, the general licensure fee requirements are $100 for three or more residents but less than twenty-five, $300 for twenty-five to one hundred residents, $600 for one hundred or more residents. The license remains

good for a period of two years (3). Each licensed facility must submit to the Division of Aging on or before the fifteenth day of each month the total number of beds and occupants of the facility (6).

Other Missouri state regulations include that the facility must have one tub or shower per twenty residents, one toilet and lavatory for each six residents, community living and dining areas, fire extinguishers, minimum one per floor, and smoke detectors that are tested monthly (47-50). In addition, there will be adequate ventilation and proper heating and cooling (51).

In additon, there must be one employee at least eighteen years of age on duty at all times. There should be one employee per forty residents and must stay awake. If the facility is licensed for twelve or fewer residents, the employee may sleep during the night hours. If there are twenty or fewer residents, the employee may sleep if there is a sprinkler system (53-54).

Negotiating a normal pathway to safety is an issue discussed in the state regulations book. In an RCF I facility, a resident needs to be physically and mentally capable of negotiating a normal path to safety unassisted or with the use of an assistive device. The facility shall not admit or continue to care for residents whose needs cannot be met. If the necessary services cannot be obtained in or by the facility, the resident shall be promptly referred to appropriate outside resources or transferred to a facility providing the appropriate level of care (54).

On page 55 of the Missouri State Regulations book, other regulations pertinent to an RCF I facility include keeping residents clean, dry and free of offensive body and mouth odor, providing protective oversight twenty-four hours a day, reporting a diagnosed communicable disease to the Division of Aging within seven days, no use of chemical or physical restraints that would limit self-care or the ability to negotiate a path to safety unassisted or with assistive devices, and developing and implementing a safe and effective system of medication control and injections to be administered only by a physician or licensed nurse.

On page 57, food is examined and regulations for an RCF I include the use of pasteurized milk and fluid milk products that meet Grade A quality standards as established by law.

The final issue to be addressed is that of residents' rights. These residents' rights include being told of one's health and medical conditions by a physician, unless medically contraindicated. If there is a legally authorized representative to make health care decisions, that person shall be fully informed under all circumstances. Another right of a resident is that he or she shall be free from mental and physical abuse. In addition, he or she shall be free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time (56).

From the above rules and regulations described, it is clear that establishing an assisted living facility requires the gathering of

information and becoming familiar with local state, perhaps city, and even federal regulations that pertain to a particular type of facility. Knowledge is power so the more one knows about assisted living, the better equipped he or she will be to develop and effectively run a quality facility.

CHAPTER 3
METHOD

SAMPLE

A study was conducted to determine if residential homes can provide needed assisted living services and if these homes are good models for assisted living. The sample for this study was selected from advertisements in a local newspaper located under the heading "elderly care" in the classified section. Advertisements were reviewed weekly for six weeks until a sample was obtained. Only facilities that offered twenty-four hour care were considered.

QUESTIONNAIRE

A checklist of questions for the survey was developed (See Appendix B). Issues addressed by the survey include appearance and size of the facility. It also addressed what services were offered and provided, interaction between staff and resident, if emergency and safety were addressed. The checklist questionnaire also addressed whether the facility was licensed, if the contract was understandable, and if it included residents rights.

INTERVIEWING

The telephone interviewing for this survey was conducted one weekday evening between the hours of 7PM and 9PM. The three facilities contacted are referred to as A, B, and C. The purpose of the

telephone contact was to gather information about the facility, services the facility provides, fees for services, and any other information obtained for seeking out alternatives to nursing home care. The three facilities contacted offered information freely and invited the surveyer to visit the facility at any time. The owners and care providers did not want their names listed in this study but all gave verbal consent to describe their facilities, services and fees.

CHAPTER 4
RESULTS

The results of the telephone interview are discussed in the order of the questions asked. A data table is included at the end of Chapter four.

1. Home-like atmosphere

   Facility A is a two story log cabin home that sits on six acres of land. It includes an observation deck that overlooks a three acre stocked pond. There are first and second floor bedrooms to accomodate a resident's level of mobility. Facility B is a four bedroom three and a half bath split level home located in a nice subvision. Facility C is a three bedroom one bath ranch home where the residents live upstairs and the owner/caregiver and her son live downstairs. All three facilities are residential homes that have not been modified. The owners and providers of care live on the premises. All three facilities have a home-like atmosphere.

2. Size

   All three facilities are single family homes, appear small in size and do not feel overwhelming.

3. Services

   Facility A offers baths three times a week and provides staff to assist with other activities of daily living as needed. Three

home-cooked meals are provided daily and snacks are offered. Laundry and transportation are also provided. Facility B provides all the care and assistance that is needed on a daily basis. This includes three hot cooked meals, transportation, and planned social activities one or two times a month. Each resident is bathed two times a week, nails are trimmed and hair is shampooed. Facility C provides meals, assistance with medications and offers planned activities. All three facilities stated that the monthly fee included all services but the fee would vary depending on the level of care that was needed.

4. Encourage independence

   All three facilities encouraged independence as much as possible and provided assistance with activities of daily living when needed.

5. Emergency call system

   Facilities A and B do not have an emergency call system. Facility C has the resident ring a bell if he or she needs assistance.

6. Encourage family and friends

   All three facilities strongly encourage family assistance and support. Visitation is encouraged and the residents are taken out on a regular basis.

7. Licensure

   None of the facilities are licensed. Facility A did receive a spot

check from the VA since she is housing a veteran. Facility C plans to seek licensure through the Division of Mental Health.

8. Contract

   Facility C is the only facility that has a contract to sign and includes residents rights.

9. Safety

   Facilities A and C address safety and both have smoke detectors and fire extinguishers. In addition, facilities A and C perform monthly storm and fire drills with the residents. Facility B does not address safety at all.

RESULTS OF SURVEY QUESTIONS

		FACILITY		
		A	B	C
	1	YES	YES	YES
	2	YES	YES	YES
Q	3A	YES	YES	YES
U	3B	YES	YES	YES
E	3C	NO	NO	YES
S	4	YES	YES	YES
T	5	NO	NO	YES
I	6	YES	YES	YES
O	7	NO	NO	NO
N	8	NO	NO	YES
	9	YES	NO	YES

The facilities were visited for approximately one hour each on a Saturday afternoon and further described are the appearance and services that are provided.

Facility A is owned and operated by a widow. She strongly encourages family to visit and fish in the pond. She states "This is family care". Friends are welcome at any time. This owner/caregiver is a certified nursing assistant with many years of experience in the long-term care industry. She stresses cleanliness. She has a verbal contract and asks that the resident or a family member notify her by the fifteenth of the month if the resident will be leaving the facility on the first of the next month. The cost for services varies according to the "abilities" of the resident. Typically, the monthly fee totals $1500. This includes "everything" except for Depends or other personal care items that might be needed. The caregiver shops at a local grocery store and plans the meals on a daily basis. No menu is posted. Presently facility A is the home to two persons, a 77 year old male and an 82 year old female. Both suffer from Alzheimers disease. The female resident is prescribed an Alzheimers medication and follows-up with a geriatric specialist at St. Louis University for evaluation and treatment. Facility A can accomodate up to three residents. The caregiver spins wool as a hobby and has discovered that her female resident seems interested and enjoys just sitting at the empty wheel and spinning it. The caregiver states that the county is becoming quite particular with zoning laws and has been told that in order to operate

an assisted living facility, it must be housed on at least five acres of land. This is a beautiful environment. The caregiver seems very knowledgeable about the physical and psychological aspects of aging. She provides the residents with the services they need to maintain good hygiene and nutrition, dignity, and she encourages independence whenever possible.

Facility B is owned by a sixty-five year old widowed registered nurse who recently remarried an eighty-seven year old man. She calls her home an assisted living facility. Presently she cares for one seventy year old female who suffers from "neurological problems and does not like to go out". The caregiver desires to provide assisted living services to one or two elderly persons. Each resident is provided his or her own bedroom and bathroom. Three hot-cooked meals are provided daily and are served at very specific times. The monthly fee for her services depends on the level of care that is needed and begins at $1600 and may be as high as $2000. She insists that family members visit at least five times a year during holidays and on the resident's birthday. This owner is concerned about zoning and regulations and city ordinances that are making it difficult for her to continue to operate her facility. This home is very clean. The resident seems very well taken care of.

Facility C can accomodate up to three residents. The owner/caregiver is a certified nursing assistant and a certified medication assistant. Presently she provides care to a seventy-five year

old diabetic male who requires a pureed diet. Facility C charges a monthly fee depending on the level of care that is needed. She charges $2000 a month if the person suffers from Alzheimers. She also requires a deposit. The family is to provide Depends and pads if needed. In addition, the family is expected to provide all transportation for the resident. This facility has a contract for the resident or family member to sign. It includes residents rights, information about advance directives, an inventory sheet for personal effects, an initial assessment form and care plan form. This caregiver completes monthly summaries on each resident.

LIMITATIONS

The limitations of this study include the small sample size used and that only single family homes were identified. The three homeowners provide the assisted living services in the homes which they reside. Not investigated was why and how the homeowners got started doing this. Facility B owner made mention of "I have bills to pay". This brings thought to whether this is an example of why a person provides assisted living services in a home. Perhaps making money is the motivator rather than providing a much needed service to a special segment of our population. More regulations may become necessary in order to promote a business of service.

The three facilities studied represent clean environments that seem to provide the basic care needs to elderly persons. There is some

concern regarding whether a single family home should be considered an "assisted living facility" if the owner/caregiver occupies the premises. A good facility can be owned by anyone but should be run by a professional who is familiar with geriatrics and gerontology and who possesses a clear understanding of the physical and psychological aspects of aging. Services should be provided by a qualified individual. The examples in this study certainly show that a single family home can support the concept of "aging in place". To promote this concept, recommendations for a good assisted living facility are addressed.

RECOMMENDATIONS

- Provide a home-like atmosphere.
- Provide planned social activities.
- Provide home-cooked meals and snacks.
- Become licensed. Avoid unlicensed facilities.
- Accept persons who are suited for such an environment.
- Provide residents and family with state inspection report.
- Provide a contract and give copies when requested.
- Provide a copy of rules and policies for the facility.
- Offer an all-inclusive monthly fee.
- Address safety. Include residents rights.
- Provide an environment that encourages independence.

After reviewing the recommendations for a good assisted living facility, it is clear that none of the facilities in this study truly qualify as a good facility. It stands to reason that some standardization of care

and services might promote quality if compliance is maintained. However, a negative consequence of standardization is the decreased opportunity to be more flexible and creative with respect to physical environment and delivery of services. Certainly, a challenge before us is to how to effectively meet the housing needs of older adults.

CHAPTER 5
DISCUSSION

To meet the housing needs of the older population, it is vital that public policymakers, advisors and advocates understand the opinions and experiences of older Americans regarding these issues. A challenge before us is how to organize, deliver and pay for long-term are services needed by increasing numbers of frail older persons (Maddox, p. 28).

About three million older persons are in need of long-term care services because of the presence of chronic illness and its disabilities. A goodly number of elderly persons desire to "age in place" but because of frailty, chronic illness, or mental disorders, many elderly persons can no longer live independently in their own homes. The idea that assisted living constitutes a key long-term shelter and care alternative for American elders is indisputable.

As the nation's over 65 population grows, so does the number of alternatives to nursing home care. As recently as a decade ago, a nursing home was the only viable option for an older adult who could no longer take care of himself. Today, assisted living is one of the fastest growing alternatives to nursing home care. Assisted living is a viable alternative to institutionalization. It can be an affordable housing arrangement that would allow a great number of elderly persons to live out their lives in a home-like environment. Surely both

the assisted living concept and the assisted-care business look brighter as more of us become grayer.

With greater consumer demand for alternatives to institutionalization there will most likely be an increase in the development of assisted living as a housing and health care alternative. One problem, however, with increased demand is affordability for all who are in need of this type of housing. Assisted living is often too expensive for low-and moderate-income Americans, since most fees are paid out-of-pocket. Assisted living facilities, whether privately or publicly funded, should be developed under a variety of programs, with nonprofit projects eligible for the Section 202 Capital Grant Program. Eligibility for Medicaid assistance should be expanded to otherwise ineligible low-income frail elderly residents. The National Council on Aging urges that HUD personnel be increased in number and better trained to improve morale, reduce costly backlogs, and expedite the implementation of new legislation, regulations and processing of applications (Perspective on Aging, Jan-March 1995, 26).

The affordability of assisted living can be a problem because generally neither Medicare, Medicaid, nor long-term-care insurance cover assisted living expenses. Government agencies are recognizing the trends pertinent to the elderly and are likely to introduce entitlement programs that allow older people to choose an assisted living setting instead of a nursing home. Public policy, to be truly responsive to new challenges related to aging, must recognize that "the elderly", like other age groups, vary widely in terms of life

experience, needs, resources, and prospects. Just as diverse are the elderly, so are the different housing arrangements for the elderly.

When considering the development of an assisted living facility, it is important to look at size, service and scope of services offered, state regulations, building code restrictions, and zoning and land use restrictions. Offering quality care is the best guarantee against an increase in regulations that may deter innovation.

When properly designed and necessary services are provided, an assisted living facility can be an affordable housing option that can expand and improve opportunities for social interaction and friendships among the residents. In addition, it can increase self-esteem in the later years while preventing or at least postponing costly institutionalization.

Further research is needed in the area of assisted living as a viable option to preventing or postponing institutionalization. Research yields knowledge. Knowledge and creativity are needed so that both private and public financial strategies can be developed. These strategies can help meet the greatest challenge confronting our aging society, that of providing long-term care services to all frail older persons who are in need. Assisted living, especially within the smaller home-like atmosphere, is certainly an area worth exploring further as a viable alternative to meeting the long-term care challenge.

Clearly, it is an exciting time for assisted living housing. The potential exists for enabling frail elders to live a fulfilling and dignified life in a residential environment that stresses independence. Disorientation, restlessness and incontinence are no longer good enough reasons to institutionalize an older frail person.

APPENDIX A

Licensing Categories by State

The following list, broken down by state, identifies some of the names used to identify assisted living in that state. As you can see, almost every state calls assisted living something different. You can use the proper name, for your state, when contacting your local government agencies about getting started in assisted living.

Alabama:	Domiciliary Care Facility
Alaska:	Adult Foster Care Home Group Home Institution for the Care of Dependent Adults
Arizona:	Adult Foster Care Home Personal Care Facility Residential Care Facility Supervisory Care Home
Arkansas:	Residential Care Facility Homes for the Aged
California:	Community Care Facility Residential Facility for the Elderly
Colorado:	Alternative Care Facility Personal Care Boarding Home Residential Care Facility
Connecticut:	Home for Aged and Rest Home Residential Care Home
Delaware:	Rest (residential) Home
District of Columbia:	Community Residential Facility

Florida:	Adult Congregate Living Facility
Georgia:	Congregate Personal Care Home Family Personal Care Home Personal Care Home
Hawaii:	Adult Family Boarding Home Family Care Home Personal Care Home
Idaho:	Residential Care Facility Shelter Home
Illinois:	Sheltered Care Facility
Indiana:	Residential Care Facility
Iowa:	Residential Care Facility
Kansas:	Adult Care Home Adult Family Home Boarding Care Home Intermediate Personal Care Beds
Kentucky:	Personal Care Home Residential Care Home
Louisiana:	Adult Residential Care Facilities
Maine:	Boarding Care Facility Adult Foster Homes
Massachusetts:	Residential Care Facility
Maryland:	Domiciliary Care Program Sheltered Housing for Elderly Sheltered Housing Group Home

Michigan:	Adult Foster Care Home Home for the Aged
Mississippi:	Institution of the Aged and Infirm Personal Care Home
Minnesota:	Adult Foster Care Homes Board and Lodging Home
Missouri:	Residential Care Facility I & II
Montana:	Adult Foster Care Homes Personal Care Facility
Nebraska:	Boarding Home Domiciliary Care Facility Residential Care Facility
Nevada:	Residential Facility for Groups
New Hampshire:	Sheltered Care Facility Shared Home
New Jersey:	Boarding Home Residential Health Care Facility
New Mexico:	Adult Residential Sheltered Care Home Board and Care Home Family Care Home
New York:	Adult Home Enriched Housing Program Family Type Homes for Adults
North Carolina:	Domiciliary Home Family Care Home Home for the Aged

North Dakota:	Boarding Home for Aged and Infirm Foster Care Home for Adults Basic Care Facilities
Ohio:	Adult Family Homes Adult Group Homes Rest Home
Oklahoma:	Residential Care Homes Personal Care Facility
Oregon:	Residential Care Facility Adult Foster Home
Pennsylvania:	Domiciliary Care Home Personal Care Boarding Home
Rhode Island:	Sheltered Care Facility for Adults
South Carolina:	Community Residential Care Facility
South Dakota:	Supervised Personal Care Homes Adult Foster Homes
Tennessee:	Home for the Aged
Texas:	Personal Care Home
Utah:	Residential Care Facility
Vermont:	Residential Care Home
Virginia:	Homes for Adults
Washington:	Boarding Home Adult Family Home
West Virginia:	Personal Care Home

Wisconsin:	Community Based Residential Facility
Wyoming:	Boarding Home

(Source of information is Assisted Living Facilities Association of America (ALFAA), Fairfax, Virginia and the NASLI Dictionary of Terms for Senior Citizens and the Industries that Serve Them, The National Association of Senior Living Industries (NASLI), Annapolis, Maryland).

APPENDIX B

Checklist to Evaluate Characteristics to Look For in an Assisted Living Residence

1. Does the facility have a home-like atmosphere?

2. Does the facility appear small in size and not feel overwhelming?

3. A. Does the facility offer personalized health care services such as bathing, dressing, toileting, taking medications, meals and snacks, housekeeping/laundry, transportation to doctors, shopping, and personal business?
   B. Are these services included in the monthly fee?
   C. Do you pay extra for any of the above services?

4. Does the staff encourage performing tasks yourself with assistance?

5. Is there an emergency call system?

6. Are friends and family close enough to visit and are they encouraged to do so?

7. Is the facility licensed?

8. Is the contract understandable, signed, and include residents' rights?

9. Is safety addressed?

APPENDIX C

Assisted Living Resources

1. National Eldercare Institute on Housing and Supportive Services
   Andrus Gerontology Center
   University of Southern California
   University Park, MC 0191
   Los Angeles, CA 90089-0191

2. Eldercare Locator Service
   1-800-677-1116

3. Assisted Living Facilities Association of America (ALFAA)
   9401 Lee Highway
   Suite 402
   Fairfax, VA 22031
   703-691-8100

4. American Association of Homes and Services for the Aging
   901 E. Street, NW
   Suite 500
   Washington, DC 20004-2037

5. Alzheimer's Association
   919 N. Michigan Ave.
   Suite 1000
   Chicago, IL 60611

6. American Association of Retired Persons
   601 E. Street, NW
   B-4270
   Washington, DC 20049

WORKS CITED

Annual Report covering 1994. The National Council on the Aging, 1995.

Baker, M. (1996, February 26). "Assisted-Living Health Centers Are Making Investors Feel Better." *The Wall Street Journal* section 2, p. 1.

Bergsman, S. (1995). "Senior Housing Is An Old Story: A Market Revives, But Gives Off Warnings of Overheating." *Barrons*, October 16, 38-39.

Binstock, R. (1996). "Shelter and Care For the Elderly Population: Reasons For Cynicism." *The Gerontologist*, Volume 36, Number 3, 410-413.

Birkett, C. (1996). "Moving Into Assisted Living." *Nursing Homes*, February 1996, Volume 45, Number 2, 22-23.

Brink, T.L., PhD. (Ed.) (1990). *Mental Health in the Nursing Home.* New York: The Haworth Press, Inc.

Bruck, L. (1995). "Assisted Living for Alzheimer's Patients." *Nursing Homes,* May 1995, Volume 44, Number 4, 32-33.

Bruck, L. (1996). "Assisted Living Snapshot: 1995." *Nursing Homes*, April 1996, Volume 45, Issue 4, 13-14.

Calkins, M. (1995). "From Aging in Place to Aging in Institutions: Exploring Advances in Environments For

Aging." *The Gerontologist*, August 1995, Volume 35, Number 4, 567-571.

"Can Your Loved Ones Avoid A Nursing Home? The Promise and the Pitfalls of Assisted Living." (1995, October). *Consumer Reports*, Volume 60, Issue 10, 656-659.

Carney, W. (1996). "Aging Trends May Fuel Assisted Living." *Boston Business Journal*, May 31, 1996, Volume 16, Issue 16, 29-30.

Cape, Ronald. (1978). *Aging: Its Complex Management*. Maryland: Harper & Row, Publishers, Inc.

DeJong, G., Batavia, A. and McKnew, L. (1992). "The Independent Living Model of Personal Assistance in National Long-Term-Care Policy." *Generations*, Winter 1992, Volume 16, Issue 1, 89-95.

Grayson, P., Lubin, B. and Whitlock, R. (1995). "Comparison of Depression in the Community-Dwelling and Assisted-Living Elderly." *Journal of Clinical Psychology*, January 1995,Volume 51, Number 1, 18-21.

Greene, V., Lovely, M., Miller, M., and Ondrich, J. (1995). "Reducing Nursing Home Use Through Community Long-Term Care: An Optimization Analysis." *Journal of*

Gerontology: SOCIAL SCIENCES, Volume 50B, Number 4, S259-S268.

Harris, D. (1988). *Dictionary of Gerontology*. Westport, CT: Greenwood Publishing Group.

Ivry, J. (1995). "Aging in Place: The Role of Geriatric Social Work." *The Journal of Contemporary Human Services*, February 1995, Volume 76, Issue 2, 76-85.

Lasky, W. (1995). "Assisted Living: A Brave New World." *Nursing Homes*, July/August 1995, Volume 44, Number 6, 40-41.

Long-term Care Facility Regulations and Licensure Law for Residential Care Facilities I & II, Intermediate Care Facilities, Skilled Nursing Facilities. State of Missouri, Department of Social Services, Division of Aging, 1995.

Lowy, L. (1989). "Independence and Dependence in Aging: A New Balance." *Journal of Gerontological Social Work*, 13, 133-146.

Maddox, G. (1995). "Housing Choices For Older Persons." *Journal of Housing and Community Development*, July 1995, Volume 52, Number 4, 15-21+.

National Council on the Aging. (1995). "Hidden in the Aggregates: Diversity. Older Americans of Today and

Tomorrow." *Perspective on Aging*, January-March 1995, 6-7.

Netting, F. and Wilson, C. (1991). "Accomodation and Relocation Decision Making in Continuing Care Retirement Communities." *Health and Social Work*, 16, 266-273.

Osgood, N., Brant, B., and Lipman, A. (1991). *Suicide Among the Elderly in Long-Term Care Facilities*. New York: Greenwood Press.

Rabiner, D., Mutran, E., and Stearns, S. (1995). "The Effect of Channeling on Home Care Utilization and Satisfaction With Care." *The Gerontologist*, April 1995, Volume 35, Number 2, 186-195.

Regnier, V. and Overton, J. (1992). "Assisted Living." *The Supportive Housing Connection, A Technical Assistance Quarterly From the National Eldercare Institute on Housing and Supportive Services*, October 1992.

Regnier, V. and Overton, J. (1996). "Factors Affecting the Growth of Assisted Living." *The Supportive Housing Connection, A Technical Assistance Quarterly From the National Resource and Policy Center on Housing and Long-Term Care*, May 1996.

Regnier, V., Hamilton, J. and Yatabe, S. (1995). *Assisted Living for the Aged and Frail, Innovations in Design, Management and Financing*. New York: Columbia University Press.

Reisacher, S. and Hornbostel, R. (1995). *A Home Away From Home: A Consumer Guide to Board and Care Homes and Assisted Living Facilities.* Washington, DC: AARP.

Schmidt, M. (1990). *Negotiating A Good Old Age*. San Francisco: Jossey-Bass Publishers.

Sharpe, J. (1996). "Voices From the Industry: Assisted-Living Facilities Add to Seniors' Options." *Indianapolis Business Journal*, January 22, 1996, Volume 16, Issue 45, 16-17.

"Supportive Housing Options." *National Eldercare Institute on Housing and Supportive Services,* Summer 1992, Volume 1, Issue 1, 1-15.

Thornton, P. (1996). "Assisted Living, Marketing the Ten Essentials." *Nursing Homes*, April 1996, Volume 45, Issue 4, 30-59.

Tinsley, R. (1996). "Sizing Up Assisted Living." *Nursing Homes*, April 1996, Volume 45, Issue 4, 9-11.

"Understanding Senior Housing for the 1990's. Surbey of Consumer Preferences, Concerns, and Needs." *American*

Association of Retired Persons.

Walser, N. (1994). "Retirement Living: Picking a Place." *Harvard Health Letter*, January 1994, 9-12.

Warren, M. (1994). *Cash Flow Magic...Renting to Seniors. A Special Report on Adult Congregate Living Facilities.* Virginia: Unified Services Corporation, 1994.

Wilson, K. (1994). *Brown University Long Term Care Quality Letters,* August 15, 1994, Volume 6, Issue 15, 1-3.

Wolfe, J. (1993). *The Coming Health Crisis.* Chicago: The University of Chicago Press.