U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

ASSISTED LIVING POLICY AND REGULATIONS:

STATE SURVEY

April 1995

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contracts #HHS-100-94-0024 and #HHS-100-98-0013 between HHS's ASPE/DALTCP and the Research Triangle Institute. Additional funding was provided by American Association of Retired Persons, the Administration on Aging, the National Institute on Aging, and the Alzheimer's Association. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Gavin Kennedy, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. His e-mail address is: Gavin.Kennedy@hhs.gov.

ASSISTED LIVING POLICY AND REGULATIONS:
State Survey

Robert L. Mollica, Ed.D.

National Academy for State Health Policy

April 1995

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
#HHS-100-94-0024 and #HHS-100-98-0013

This report was prepared for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation under contract number HHS-100-94-0024, with partial support from a grant to the National Long-Term Care Resource Center from the U.S. Administration on Aging.

TABLE OF CONTENTS

LIST OF TABLES

I. INTRODUCTION

In 1992, The Academy published "Building Assisted Living For The Elderly Into Public Policy: A Guide For States" to help state policy makers examine an emerging concept for providing residential, home-like settings for elders. The Guide examined the confusion surrounding the use of the term "assisted living" and the principles that are associated with assisted living as distinct from board and care, residential care, personal care homes and other terms. The Guide also described policy initiatives in five states: Florida, Massachusetts, New York, Oregon, and Washington and the financing sources for housing construction and operation and services. Since 1992, a number of states have issued regulations, are presently developing regulations or have initiated a study process to consider assisted living as a separate category. As the trend continues, the use of the term assisted living still brings confusion and variations in definition and meaning among states.

This report is intended to update information provided in the original guide and to describe policies in all states that can be identified as licensing or providing assisted living. In addition, it seeks to differentiate assisted living from board and care and similar types of care.

State Surveys

In July 1994, the Academy conducted two brief surveys to identify state activity in assisted living. The first survey focused on licensing and service delivery while the second dealt with housing financing. The regulation/services survey was designed to identify states that have promulgated or are developing or considering assisted living policies or regulations. The survey was sent to the Health, Aging and Medicaid Agencies in each state. States were asked to submit copies of their most recent statutes, regulations, or draft regulations/policies. The survey was intended to gather initial information and to identify states that would receive follow up calls to learn more about the specifics of their program.

The survey did not offer a definition of assisted living. Instead, the survey sought to identify states that indicated, using their own frame of reference, that they have an assisted living program or licensure category. Eighty six respondents from 48 states answered the survey: Aging, 32; Medicaid, 32; Health, 22. Responses to the question "does your state have an assisted living model, program or category" sometimes brought conflicting answers from respondents in the same state. The conflict resulted from varying perceptions about the question and possibly a lack of knowledge about programs outside their own agency. The question was intentionally worded to gather information about how state agency staff thought assisted living is defined. Follow up calls were made to states that responded positively to the question. Many people view the term assisted living generically and considered residential care, personal care

homes and other variations as assisted living. Others indicated that they needed a definition before they could answer.

Based on follow up interviews and analysis of regulations and legislation, 19 states either have legislation authorizing assisted living, a licensure category, or an assisted living service program. Reports and recommendations have been issued in three states (**Idaho, Indiana and North Carolina**). Legislation that would repeal or modify existing program authority is pending in **Florida (modify), New York (repeal) and Ohio (repeal and substitute a service program for a licensure category)**, while legislation to establish assisted living authority is pending in **Hawaii, Montana and Wisconsin**. Finally, interagency work groups or task forces are operating in five states to develop policy (**Illinois, Louisiana, Michigan, Oklahoma and Vermont**). As this report was finished, two states, **Maine and Utah**, were finalizing their regulations.

Because of the overlap between assisted living and other forms of supportive housing, we asked respondents if the state's assisted living program or category differed from board and care or equivalent programs (personal care homes, rest homes, residential care facilities, etc.).[1] An analysis of state policies found that assisted living and board and care models were the same in five states (**Alabama, Rhode Island, South Dakota, Virginia and Wyoming**).

The second survey was mailed to Housing Finance Agencies and asked if the state HFA had financed assisted living projects in the last five years or, if not, whether the HFA had plans to do so in the future. The response rate was much lower -- only 15 states. Nine states indicated that they provided financing for assisted living or planned to do so and 6 state HFAs said they did not. Confusion about the definition may be present here as well since several of the state answering affirmatively do not have an assisted living category or program. However, HFAs provide financing for private sector facilities that either are not required to be licensed or use the term "assisted living" rather than the term specified as a licensure category. The survey also asked HFAs to identify the sources of financing (tax exempt bonds, tax credits, HUD loans). Analysis of the HFA survey is continuing.

[1] Throughout the study, board and care is used generically to refer to models such as adult homes, residential care facilities, personal care homes and other terms. States regulations generally allow multiple occupancy bedrooms with shared lavatories and bathrooms.

II. FINDINGS

In order to bridge the gap between states which explicitly use the term "assisted living" and states that do not, we have developed a working framework which delineates several components found in state policy that may be used to differentiate assisted living from board and care models. We are developing a matrix that identifies the components in each state. As a result, some states that use the term assisted living may not in fact meet the framework (**Alabama, Rhode Island, South Dakota, Wyoming**) and others that do not use the term may be included (**Florida**). Florida uses the term adult congregate living facility and extended congregate care although legislation is pending that would change the term to assisted living.

Defining Assisted Living

In developing our approach to assisted living, we struggled with a starting point. No one in the long term care field enters a discussion about assisted living without a frame of reference. For many, it's the nursing home and for others a housing setting. We pictured three buildings standing side by side, a single family home, an apartment building and an assisted living site (we prefer to avoid using the term "facility" but have been unable to avoid it). Within each building, an individual with chronic but stable health conditions and dependencies in activities of daily living lives. The person living in their own home can receive skilled nursing care, personal care and a host of other services. Relatives can perform tasks that only a licensed professional can perform if the caregiver were not related. Except in relation to local building codes, government agencies do not consider the condition of the structure. Subject to a rental agreement, a similar person living in an elderly housing project can receive a full range of ADL and nursing services from certified home health agencies and other community providers. If the housing entity provides or arranges for services, and the cost of the service is included in the rent, a license would be needed in most states. For reasons related to the preferences of the housing owner or management company, rental agreements may not allow someone who is incontinent, forgetful or exhibits aggressive behaviors to reside in the project. However, these conditions are not a function of the government's regulation of the building.

When the person moves from their single family home or apartment to a building in which all the residents receive services, a totally different government perspective and regulatory requirements take over. Until the advent of assisted living, policy makers and regulators tended to focus not only on the organization providing the actual service and the credentials of the direct care staff, but on the building itself apart from the application of local and state building and fire codes. While a person may live at home with skilled nursing needs, extensive ADL needs and unstable medical conditions, regulations often will not allow the same person to receive care in other settings. In apartments, assisted living and other settings, government regulation focuses on both

the person's conditions and service needs, the source of care and the source of payment. Licensed facilities may be prevented from providing skilled nursing services but the resident may receive the very same care from an outside agency! These incongruities highlight the contradictions of many regulatory policies and provide a sound basis for re-examining how states license, regulate and finance long term care for their citizens.

This perspective leads to consideration of assisted living as a service, rather than service in a particular setting, but, if so, how then would it differ from home care or in-home services? The value of the assisted living trend is its emphasis on two factors: residential settings, which raises a debate over whether multiple occupancy bedrooms and shared baths should be considered residential, and autonomy, dignity, privacy, independence and choice.

We have approached assisted living as a home setting in which services are provided. Boundaries can be drawn around the conditions and needs that can be met -- how much skilled nursing can be provided, what types of health conditions can be treated -- the types of living environments or structures which define the setting, and the philosophy or goals that differentiate assisted living from other models of care. We have not developed a definition, per se, but instead have identified factors which we believe constitute assisted living in state models.

Developing a definition that would be accepted nationally is unlikely. States have historically retained the authority to license service providers and, despite similarities, each state has developed definitions and requirements to meet their own circumstances. Unlike its approach to nursing homes, the federal government has not developed a strict definition of assisted living since it is only reimbursed as a Medicaid waiver service.

A range of definitions have been developed by national associations, states and the US Health Care Finance Administration (HCFA). The definitions have different sources and purposes. Definitions can be found in state law, regulations, Medicaid waiver programs and even provider contracts. They can be used to set licensure standards and requirements and to describe purchasing expectations. A few states use their definition to set purchasing standards (**Minnesota, Texas**) for the services that will be reimbursed and they also set requirements for the housing in which people who receive such services can reside. This approach does not affect the state's licensure categories and instead sets parameters that differentiate among providers in a licensure category.

Policy makers, providers and consumers would benefit from a commonly understood meaning for the term "assisted living." Regulations is five states (**Alabama, Rhode Island, South Dakota, Virginia and Wyoming**) use the term for their licensure category but it used to describe a board and care model. Some states use the board and care regulations as the basis of their assisted living program and require higher standards for the living unit or allow a higher level of services to be provided to

residents who need some skilled services. **Florida** does not use the term but differentiates Extended Congregate Care from the basic level of service in adult care homes. Assisted living providers in **Washington** must have a boarding home license but must offer apartment style units to participate in the state's program. **Maine's** draft regulations use the term assisted living but define it as a service which essentially renames existing programs.

Definitions from the Assisted Living Facilities Association of America and the American Seniors Housing Association (ASHA) emphasize the service focus and the resident's prominent role. Definitions or frameworks developed by associations usually do not deal with or define the nature of the housing component. The ASHA definition makes reference to residential surroundings but does not describe what constitutes residential surroundings. The National Association of Residential Care Facilities considers that the definition of assisted living is interchangeable with residential care, foster homes, board and care homes, sheltered care homes and other terms. They believe that board and care carries a negative meaning and assisted living has emerged as a market and public relations oriented strategy.

The Health Care Financing Administration's definition serves a narrower purpose than a state licensing requirement. It was developed to help states define the services which are reimbursed through the Medicaid waiver program.

A potential paradigm ...

After examining definitions and models from these sources, we have offer a path for arriving at a standard understanding of assisted living. Consumers, advocates and policy makers feel the term "facility" conveys an institutional environment that is contrary to the goals of their program. They consider assisted living as someone's home with all the meaning "home" implies (bedroom, living room, bathroom, kitchen, control, belongings). Yet referring to assisted living as "home" is also confusing. The recently passed statute in **Massachusetts** uses the term "assisted living residence." Perhaps we need to create a term that has no other meaning. We would give it meaning for at least a segment of the assisted living market or in states that have defined assisted living as a purpose-built building with apartments. Otherwise tenants in conventional elderly housing buildings would refer to the building differently depending upon whether they were independent and did not receive any service or if they participated in the state's assisted living program.

As the field evolves, it is likely that we may need several terms that differentiate the settings in which assisted living is found. We may need one term for apartment style buildings in which all residents receive services and have sought tenancy in the building because of their service needs. We may need another term to describe services provided to some but not all residents in elderly housing buildings. This housing with supportive services model meets the needs of people as they age in place. Still another term is needed to describe modifications to the existing or historical board and care

licensure category of facilities as they serve residents with higher needs for personal care and routine nursing services. Models that identify assisted living as a service that can be provided in a range of residential/institutional settings create a further conflict. Assisted living, as it first emerged in state policy, conveyed a combination of a service package (emphasizing personal care and nursing services) provided in a home-like setting. Many of the settings were covered by the state's board and care license but offered an environment that exceeded minimum standards and emphasized privacy. Yet the emphasis on apartment style units conflicts with emerging concepts concerning models to serve people with Alzheimers' Disease assisted living. Studies have found that 29% to 42% of the residents in assisted living settings have cognitive impairments.[2] Hyde contends that "best practices" in dementia care show that shared rather than private units are more successful serving people with dementia.

An examination and analysis of licensure categories alone is not sufficient to develop a clearer understanding of assisted living since several states have defined assisted living through their service systems, most notably the Medicaid Home and Community Based Services Waiver program. These efforts in Minnesota and Texas have led to adoption of apartment criteria for participants to qualify to receive assisted living services under a waiver and for providers to participate in the program. Recipients in conventional elderly housing projects can receive similar services in their apartment and many waivers allow personal care, home health aide and skilled services to be delivered to residents in licensed board and care facilities.

Based on the patterns of state policy, it may be possible to differentiate services from the setting in which services are received. The service component can be called "in-home" services which recognizes that wherever a person lives is their home although some might not consider their setting their "home" but rather a place they have to live. If services are defined by a separate term, then assisted living can refer to a building with apartment-like settings, in which all residents live in order to take advantage of the services which are provided. This approach allows settings which are licensed as board and care but do not provide single occupancy units to retain a separate and distinct meaning. Buildings currently licensed as board and care which do offer single occupancy units would be licensed or certified under the new category of assisted living. Apartments in elderly housing projects would not be called assisted living.

While this approach may appeal to those who are not involved in a state's program or who do not operate assisted living or board and care facilities, it is unlikely that any state would modify their program after many months, often several years, of work, negotiation and compromise to develop their definition or program. As such, this section is perhaps an academic exercise that may have relevance to states that are now defining their program and it may help people in states with an existing assisted living definition or program place their policy in the broader context of assisted living and identify similarities and differences with other models.

---

[2] Hyde, Joan. *Serving People with Dementia: Toward Appropriate Regulation of Assisted Living and Residential Care Settings*. Publication pending. University of Massachusetts-Boston.

State flexibility means variation in approach. People who prefer a standard definition will be satisfied if the final definition is consistent with their approach. The other alternative is to develop a definition that is broad, flexible and encompasses a range of models such as the ALFAA definition. The quest to develop a standard definition becomes a circular exercise guaranteed to end in frustration! For policy makers who seek a standard, acceptable definition, readily understood by all, the need will pass once your state has arrived at its own definition. Unfortunately, based on the experience of states that have persevered through the process, it is time consuming, labor intensive, requires skills in listening, negotiation and compromise. A matrix which summarizes the components we have identified in state programs and policies will be included in the next report.

III. COMPARING STATE MODELS

States have defined assisted living as a program approach in a new model of housing and services (**Arizona, Massachusetts, Ohio, Oregon, and Washington**), a service in an apartment setting (**Connecticut, Minnesota, North Dakota, Wisconsin (draft)**), and a service model in multiple settings (**Alaska, Florida, Maine, Maryland, New Jersey, Utah, Texas**). In **New Jersey**, assisted living services can be provided to residents in personal care homes, free standing assisted living facilities or conventional elderly housing developments. Extended congregate care can be provided in **Florida** to residents in a wide range of settings: any building or buildings, section of a building, or distinct part of a building, residence, private home, boarding home, home for the aged, or other place... " **Connecticut** licenses assisted living as a service but limits its provision to managed residential communities which can be purpose-built facilities or conventional elderly housing. The pending definition in **Maine** proposes a definition of "assisted living services provider" which means a provider of assisted living services licensed either as a residential care facility, certified as congregate housing services or licensed as a home health agency. **Maine's** statute (Chapter 661 of the Acts of 1994) requires that the definition include a range of services from in-home assistance to facility based care which varies the levels of regulation depending upon the level of care provided.

State definitions use a number of common terms to define their program although many key program requirements are found elsewhere in regulations or statute. For example, the definition of the housing unit is not contained in the definition of assisted living in **Connecticut, Massachusetts or Oregon** while it is included in the definition used by **New Jersey** and **Ohio**.

A few states have separated licensing of the housing from service provision. **Connecticut, Minnesota, New Jersey, and North Dakota** have created requirements for the provision of services and do not add new licensing requirements as part of the assisted living designation. **Massachusetts and Wisconsin (draft)** provide for certification rather than licensing of assisted living facilities. **Minnesota** defines assisted living as a service through their Medicaid Home and Community Based Services (HCBS) Waiver programs and requires that units must consist of individual apartments. **Texas**, which has also created assisted living through a Medicaid HCBS waiver, allows assisted living to be provided in apartments and non-apartment settings.

A proposal in **North Carolina** takes a variation of the same approach. This proposal addresses the residences in which services are provided. It would define assisted living residences as "any group housing and service program for two or more unrelated adults, by whatever name it is called, which makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care agencies." The draft policy does not affect the unit requirements and instead allows personal care and nursing services "to the extent allowed under Medicare home health regulations" to

be delivered in two settings multi-unit independent housing and adult care homes. Multi-unit independent housing sites can arrange for the delivery of services by a licensed home care agency. Residents would have a choice of provider and housing managers must register with a state agency. This supportive housing model provides in-home services to frail tenants in conventional elderly housing. Services are provided by management in the second category, adult care homes or adult family care homes which are subject to state licensure.

Virginia's regulations define assisted living as "a level of service provided by an adult care residence for adults who may have physical or mental impairments and require at least a moderate (2 or more ADL impairments) level of assistance with activities of daily living." Facilities must describe the characteristics of the people served and program components and services that will be provided.

The confusion around the use of the term is further complicated when comparing similar programs by states that do not use the term assisted living but, when asked on the survey if they have assisted living, respond affirmatively. **Missouri** is a good example. The state licenses residential care facilities and reimburses for personal care and advanced personal care through Medicaid. Prior to Medicaid payment, facilities also provided personal care. SSI covered room and board and state payments covered the service component. Though the term "assisted living" is not used, the program resembles the program in **Virginia**, which has issued draft regulations using the term "assisted living." Personal care is provided by a home health agency, an in-home services provider or residential care facility. Personal care is available to recipients who need an institutional level of care who have chronic, stable conditions that can be safely maintained at home. Services include bathing, dressing, hair care, oral hygiene, nail care, assistance with toileting, walking, transfers, meal preparation, light housework and other tasks. Advanced personal care covers assistance for persons with altered body functions who have a catheter, or ostomy, require bowel and bladder routines, range of motion exercises, skin care and other tasks. The RCF licensure regulations allow up to four beds per room and require 1 tub/shower per 20 residents and 1 toilet/lavatory for every 6 residents. These requirements are typical of many board and care type regulations.

While confusion about the definition of assisted living continues to frustrate policy makers, providers, developers and consumers, we have assumed that it differs from board and care, and it is possible to identify characteristics that differentiate assisted living from board and care models. An examination of state policies suggests that several variables can be used to compare assisted living models. The variables include: the characteristics of the living unit, range of services provided or arranged by the facility, the health, functional and cognitive status of the residents and the philosophy used to guide the model. Assisted living can be identified by one or more of the following components of the above categories:

The living unit

- Individual apartments with kitchenettes or cooking capacity or individual rooms in a homelike setting, shared by consent.
- Attached bathrooms.
- Lockable doors.
- Resident controlled heat.

Services provided or arranged

- Service package that includes some nursing services.
- Service capacity is available to meet unscheduled needs.
- Flexible staffing requirements.

Health, functional and cognitive status

- Admission criteria that allow people with nursing needs to be served.

Philosophy

- A philosophy that emphasizes resident independence, dignity, privacy and participation in developing the plan of care and service delivery.

State policy makers begin their efforts to define assisted living for specific programmatic reasons. As residents in board and care settings become frailer and exhibit increased needs for health services, regulations have been amended to allow a higher level of service to be provided and admission/retention guidelines are relaxed to prevent further pressure to increase the supply of nursing home beds (**South Dakota, Virginia**).

Aging-in-place also affects residents in conventional elderly housing buildings. A number of states have adopted assisted living policies to provide services to allow elders living in public housing to remain. Policy makers are also concerned about people who need a more structured and supervised setting, but do not require extensive 24 hour nursing care. This group must move from their single family home or apartment because of the lack of 24 hour staffing to respond to needs that arise during the evening when caregivers or service provider staff are not available. Until recently, the only choice was a nursing home. Several states have developed assisted living as a residential model which allows a person who must move an alternative to a nursing home. These programs set standards that are more residential and home-like than board and care facilities. Finally, states have seen similarities in the service needs of residents in multiple settings and have focused on the service-rich nature of assisted living rather than the setting in which services are provided.

As a result, state models can be grouped into three general categories:

- board and care/institutional,
- a new housing and services model
- a service model.

Service models can be subdivided into models that allow assisted living services to be delivered in multiple settings and those in which services are delivered only in apartment settings. Table 1 presents state assisted living policies by the type of model. State models were developed to meet defined needs in different settings. A state's policy may address needs in more than one setting. The upgraded board and care approach recognizes that residents are aging-in-place and need more care to prevent a move to a nursing home. State policies have allowed these facilities to admit and retain people who need ADL assistance and some nursing services. Mutually exclusive level of care criteria can blur and people who would qualify for admission to a nursing home might be retained. The model retains the minimum requirements for the building and units (usually bedrooms with shared bathrooms and tub/shower areas).

The "services in multiple settings" model also addresses aging-in-place in both board and care and larger elderly housing projects. Residents in both settings are aging-in-place. A higher level of service may be available in settings which were previously licensed as board and care. In addition, similar services are provided in a supportive housing program to residents in conventional elderly housing. In these settings, some tenants may be totally independent and do not receive assisted living services while others require assistance with IADLs, ADLs and health care needs. This model includes settings which may be licensed and others which are not. States representing this approach include **Alaska, Florida, Maine, Maryland, New York, North Carolina (proposed), Utah and Texas**.

Maryland provides assisted living services through its Medicaid Home and Community Based Waiver. The waiver was developed to support elderly (62 or older) residents in 150 small group homes and conventional apartment buildings, called Senior Assisted Housing, throughout the state. Projects are primarily federally subsidized. The program is administered by the Office on Aging through contracts with housing management companies or other community organizations to deliver services.

The service delivery model licenses or contracts with the agency providing assisted living services that may be provided in housing settings. **Connecticut, Minnesota, New Jersey, North Dakota and Wisconsin** (draft) are examples of this approach although the basis of the program differs. **Connecticut's** program is contained in an assisted living regulation while **Minnesota's and North Dakota's** programs are defined through a Medicaid HCBS waiver program. Regardless of the basis, local and state building codes or existing licensure rules sometimes govern the physical structure and new regulations focus on the services provided.

States which separate the housing and service components provide greater flexibility, encourage aging-in-place and recognize important realities in the fragmentation of funding sources and the existing supply of "housing" types. However, these approaches do not address the institutional character of board and care programs, nor are they intended to do so. Yet, approaches that focus on services do address one of the limitations in board and care models that specifically exclude residents who require the level of care provided in a nursing home. It recognizes that residents in board and care facilities throughout the country may require more care than is allowed through original licensure guidelines. Though many states allow services to be delivered by community organizations, the "assisted living as a service" model can respond to the important dynamics in the resident characteristics of board and care facilities. In other settings (non-board and care), it is also a useful way to minimize state licensing, focus on meeting service needs and allow residential building codes to address the housing structure.

TABLE 1. Models in States Using the Term "Assisted Living"

New Housing and Services Model	Service Model		Institutional Model
	Multiple Settings	Apartment Setting	
Arizona	Alaska	Connecticut	Alabama
Hawaii[4]	Florida	Minnesota*	Rhode Island
Massachusetts	Maine[5]	New Jersey[2]	South Dakota
Ohio[1]	Maryland	North Dakota	Virginia
Oregon	New York	Wisconsin[3]	Wyoming
Washington	North Carolina[4]		
	Oklahoma[4]		
	Utah[5]		
	Texas*		

* Created through Medicaid Home and Community Based Waiver Services Programs.

1. Based on existing law. Legislation is pending that would change the model from a licensure category to a Medicaid program.
2. New Jersey provides services in multiple settings but each unit participating in the assisted living services program must meet apartment standards.
3. Recommendation from a task force report. Legislation is pending.
4. Based on tentative recommendations from a task force.
5. Proposed rules.

Units

Apartments are required in **Arizona, Connecticut, Minnesota, North Dakota, Oregon, Washington and Wisconsin**. **Arizona, Oregon and Washington** require 220 square feet per unit, excluding bathrooms. **New Jersey's** regulations require that all units include 150 square of usable floor area, plus an additional 80 square feet for each additional occupant. Unlike most rules that allow for multiple occupancy, **New Jersey** requires that each unit include a bathroom with sink, toilet, bathtub and/or shower, a kitchenette that includes a refrigerator, cabinet for food storage, sink, and outlets for small electrical appliances (eg., microwave, two burner cook top, toaster oven). This

policy would provide assisted living services in facilities licensed as board and care but which meet a higher standard for living units. Residents or family members may request that cooking appliances may be removed if it is unsafe. In addition, residents may elect to bring their own appliances if they meet code requirements.

Ohio's draft rules also required single occupancy units, unless shared by choice, with private cooking, bathing, washing and toilet facilities, lockable doors, temperature controls and sprinkler equipment. Buildings in **Massachusetts, New Jersey, Ohio, and Oregon** also had to meet local building codes.

The opportunity to prepare a meal or snack is an important variable in determining whether a unit is home-like. While many residents may be too impaired to prepare their own meal, operators reports that family members and friends often fix meals for residents when they visit and the presence of a kitchenette adds to the residential ambiance even for people who do not prepare their own meals from time to time. All residences must provide a kitchenette or access to cooking capacity (kitchen, microwave) in **Arizona, Connecticut, Massachusetts, Oregon, Ohio, Minnesota and Wisconsin**.

Alaska's policy does not specify requirements for units although shared rooms are allowed and the policy is flexible to accommodate small group homes facilities which are likely in such a rural state. **Florida** requires private rooms, apartments, or semi-private rooms. If shared rooms are offered, there must be no less than one bathroom for every four persons. **Massachusetts** allows single and double occupancy units with lockable doors. New construction must include private baths for each unit. Existing buildings may provide private half baths and one bathing facility for every three units.

Two types of units are allowed in **New York**. Enriched housing models (conventional housing) must provide single occupancy apartment units, unless shared by agreement, with full bathroom, living and dining space and equipment for preparing and storing food. Adult care homes offer single or double occupancy bedrooms and must have 1 toilet for every six residents and 1 tub/shower for every ten residents. **Texas** also allows several occupancy types including assisted living apartments with 220 square feet or 160 square if the building is being remodeled to participate in the assisted living program; residential care apartments (double occupancy, bedroom, kitchen and bathroom with 350 square feet); and residential care non-apartments (double occupancy, 16 or fewer units).

The institutional model is predominantly a shared model. Residents share bedrooms, although many states limit occupancy to two persons per room, bathrooms and tub/shower rooms. **Alabama** requires bedrooms with 80 square feet for single occupancy and 130 square feet for double units. If sitting areas are included, the square footage requirements are 160 for single rooms and 200 square feet for double rooms. **Virginia's** existing adult care residence rules allow single rooms (100 square feet) and

multiple occupancy (80 square feet per occupant) with toilet and wash basins for every seven residents and a bath tub for every ten residents.

Tenant Policy

Two distinctions are drawn concerning tenant policy. State licensure rules often set parameters on who may be served in an assisted living residence, however, state reimbursement policies may set different criteria for residents that will be reimbursed in assisted living. In fact, most states, except **Massachusetts**, limit their reimbursement to tenants that meet the level of care criteria for placement in a nursing home.

While many states have defined the characteristics of tenants who may be served, a draft report from an advisory group in Wisconsin has recommended that services be limited to 28 hours a week as a means of assuring that tenants would not be discharged prematurely. The limit exceeds the average hours of service provided to participants in the state's home care program.

A few states have modeled tenant policies on the definition of Medicare skilled services. Anyone needing services beyond the Medicare definition for a period that exceeds the definition are not consider appropriate for assisted living. The definition has been equated with a judgement about safety and the level of care that can safely be provided in a homelike setting. However, Medicare definitions have been developed for reimbursement purposes and do not define the line between care that can be delivered at home and care that should be provided in a nursing home.

Florida developed precise rules for admission and continued residency. New residents must be able to perform ADLs with supervision or assistance; do not require 24 hour nursing supervision; are capable of taking their own medication or may require administration of medication and the residence has licensed staff to provide the service; do not have bed sores or stage 2, 3, or 4 pressure ulcers, are able to participate in social activities; capable of self-preservation; is not bedridden; nonviolent; and does not require 24 hour mental health care.

The criteria for continued residency do not allow residents to be retained if they develop a need for 24 hour supervision; become bedridden for more than 14 days, become totally dependent in 4 or more ADLs (exceptions for quadraplegics, paraplegics and victims of muscular dystrophy, multiple sclerosis and other neuro-muscular diseases if the resident is able to communicate their needs and do not require assistance with complex medical problems). Residents may stay if they develop stage 2 pressure sores but must be relocated for stage 3 and 4 pressure sores. Residents who are medically unstable, become a danger to self or others or experience cognitive decline to prevent simple decision making may not be retained.

This lengthy list of resident conditions which may and may not be treated may be replaced by using the Medicare skilled nursing definition to establish the admission and retention policy.

New Jersey has developed the broadest tenant policy by allowing, but not requiring, care for people who require 24 hour, seven day a week nursing supervision, are bedridden longer than 14 days, consistently and totally dependent in four or more ADLs, have cognitive decline that interferes with simple decisions, require treatment of stage three or four pressure sores or multiple stage two sores, are a danger to self or others or has a medically unstable condition and/or special health problems. The admission agreement has to specify if the residence will retain residents with one or more of these characteristics and the additional costs which may be charged.

Alabama, which has a board and care model, does not allow residents to be served in assisted living who require the level of care provided in a nursing home. **Rhode Island**, another board and care model, allows people who need nursing assistance to be served, but does not allow people needing skilled care to be served.

The **Virginia** requirements offer flexibility for adult care residences to develop a service program that reflects their market segment and the service needs of the market. The regulations do set some parameters on who may admitted and retained. ACRs may not serve people who are ventilator dependent, have dermal ulcers (III and IV), receive intravenous therapy, or require continuous nursing care.

Services

The extent of service provision has been a key component of assisted living policy. Mutually exclusive resident policies, which prohibit anyone needing a nursing home level of services from being served in board and care, are being revised. State policy makers are focusing on the level of care that can be provided in a person's single family home or apartment and allowing the delivery of similar services in assisted living settings. Drawing the line has been controversial. Some nursing home operators see assisted living as competition for their "patients" and oppose rules which allow skilled nursing services to be delivered outside the home or nursing home setting.

Most states require an assessment and the development of a plan of care that determines what services will be provided, by whom and when. Residents often have a prominent role in determining what they will receive from the residence and what tasks they will do for themselves.

The key factor in assisted living policies is the extent of skilled nursing services. **Connecticut** allows client teaching, wellness counseling, health promotion and disease prevention, medication administration and skilled services to clients with chronic but stable conditions.

Florida developed specific regulations in response to complaints from the nursing home industry that listed the services that may be provided and those that could not be provided. Facilities may provide limited nursing services (eg., medication administration and supervision of self-administration, applying heat, passive range of motion exercises, ice caps, urine tests, routine dressings that do not require packing or irrigation and others), intermittent nursing services (eg., change of colostomy bag and related care, catheter care, administration of oxygen, routine care of an amputation or fracture, prophylactic and palliative skin care).

Facilities in **Florida** may not provide oral or nasopharyngeal auctioning, assistance with tube feeding, monitoring of blood gasses, intermittent positive pressure breathing therapy, intensive rehabilitation services for a stroke or fracture or treatment of surgical incisions which are not clean and free from infection and any treatment requiring 24 hour nursing supervision. **Washington** has developed a list of skilled services that may and may not be delivered by licensed nurses and unlicensed staff. Nursing services are differentiated by licensure category. RNs or LPNs may provide insertion of catheters, nursing assessments, and glucometer readings. Unlicensed staff may provide the following under supervision of an RN or LPN: stage one skin care, routine ostomy care, enema, catheter care, and wound care. Changes in the nurse practice are pending in the legislature which would greater delegation.

Oregon's policy allow a wide range of delegation under which nurses must train unlicensed staff for each resident receiving delegated services.

Legislation in **Massachusetts**, as in other states, does not allow twenty four hour nursing services. However, skilled services may only be provided by a certified home health agency on a part time or intermittent basis not to exceed 90 days in a one year period. Medical conditions requiring services on a periodic, scheduled basis are also allowed. In addition, residents may "engage or contract with any licensed health care professional and providers to obtain necessary health care services ... to the same extent available to persons residing in private homes." The **Massachusetts** statute only allows skilled nursing services to be provided by a certified home health agency. As a result, although regulations have not been issued, registered nurses, if hired by an assisted living facility, presumably, would not be allowed to deliver skilled care. **Ohio's** pending policy will limit skilled services to 120 days with exceptions for diets, dressing changes and medication administration.

The **Massachusetts** statute specifies a minimum level of personal care services that must be provided (bathing, dressing, ambulation) and requires that tenant agreements include the services which will be provided and those which will not be provided. Facilities certified under the law may offer a broader range of personal care services. **Alaska's** regulations also require that tenant contracts spell out the services and accommodations that will be provided which reflects the diversity of providers and varied availability of service providers in the state. Intermittent nursing services are allowed to residents who do not require 24 hour nursing care and supervision and tasks approved by the Board of Nursing may be delegated to unlicensed staff. **Arizona** also

allows intermittent home health (nursing, home health aide, supplies, equipment and therapies) in its demonstration program.

Because of its funding source, **New York** allows for skilled nursing, home health aide and therapies. Regular Medicaid state plan services have been included in a capitated rate to include the full range of Medicaid long term care services that can be delivered in the home.

A concept paper in **Idaho** would require personal care (eating, bathing, dressing, toileting and walking), three meals a day in a common dinning room, housekeeping, transportation, medication management, social and recreational activities and laundry services. **Maryland's** policy includes a similar list but adds 24 hour on-site supervision in group homes but not in the Senior Assisted Housing setting. Skilled nursing is not included in **Idaho and Maryland**. In **Utah**, which has a similar list of services, facilities must arrange for necessary medical and dental care although medication administration of prescription drugs is allowed. **Maine's** pending policy only specifies skilled services when they are provided by a licensed home health agency.

Financing and Reimbursement

States have developed a number of methodologies to set rates for subsidized residents. **Oregon** uses a five tiered methodology for reimbursing providers based on the type and degree of impairments (See table). Arizona has developed three rate classes based on the needs of the resident. **Ohio** is also planning to use a rate structure with five tiers ranging from $200 to $1400 a month that vary based on the number and type of ADL impairments, skilled nursing needs and behavior needs. The room and board payment is likely to be $700 a month. The service rate was developed after consultation by the Department of Aging with assisted living providers. **North Dakota** uses a rate classification system that is derived from a point system that measures a person's level of service need.

Flat rates are used in **Massachusetts, Texas and Washington**. **Massachusetts** uses two sources of financing to pay for assisted living. Medicaid state plan services are available to reimburse for Medicaid recipients and a special program (Managed Care in Housing) funded with general revenues is available for elders who are not eligible for Medicaid is administered by the Executive Office of Elder Affairs. The service payment is $33.70 per day for Medicaid recipients and the Managed Care in Housing program rate is $817 a month. The financing sources were developed prior to passage of the assisted living legislation and the program represents an approach that combines two approaches: services in elderly housing and purpose built assisted living sites. **Massachusetts**, with its higher development costs, is the only states that has set a separate SSI payment for assisted living of $920 a month which is considerably higher than the Community standard (the payment for an aged person living alone in the community) and the board and care standard. The increased rate reflects the higher real estate and development costs in the state and provides access for Medicaid

recipients to market rate and mixed income developments. However, legislation creating an assisted living certification program also Suspended use of the higher rate until the Medical Assistance Division completes a report showing the projected demand and costs to the state. The report was Submitted to the legislature on March 1, 1995 and concluded that a higher payment standard would save $2389 per participant for a total savings of $239,800 in FY 95 rising to savings of $4.8 million in FY 99 as the supply of assisted living residences for low income residents increases.

TABLE 2. Oregon Service Priority Categories and Payment Rates

Impairment Level	Service Priority	Rate
Level V	Service priority A or priority B and dependent in the behavior ADL.	$1586
Level IV	Service priority B or priority C with assistance required in the behavior ADL.	$1283
Level III	Service priority C or priority D with assistance required in the behavior ADL.	$978
Level II	Service priority D or priority E with assistance required in the behavior ADL.	$736
Level I	Service priority E or F or priority G with assistance required in the behavior ADL.	$553

Texas varies its rate by the number of occupants. Single occupancy assisted living apartments receive $29.39 a day for services. Residential care units receive $22.96 a day for double occupancy. The SSI rate for room and board is $11.88 a day for all settings.

Washington uses a flat per them rate which is $47.37 a day for 1995 consisting of $27.06 for services and $20.31 for room and board. However, **Washington** is planning to develop a new rate structure that includes three payment rates for low, moderate and high service needs based on ADLs.

Several states have modeled their reimbursement rates on their case mix system for paying nursing homes. In **New York**, the service reimbursement is set at 50% of the resident's Resource Utilization Group (RUG) which would have been paid in a nursing home. The state has created RUG rates for 16 geographic areas of the state. The reimbursement category is determined through a joint assessment by the Assisted Living Program and the designated home health agency or long term home health care program. The assessment and the RUG category are reviewed by the Department of Social Services district office. The residential services (room, board and some personal care) is covered by SSI which also varies by region. In 1992, the SSI rates were $827 to $857 a month.

Rates in **Minnesota** are negotiated between the client and the provider with caps based on the client's case mix classification. Service rates under the Alternative Care program, a state funded program for people who do not meet the Medicaid eligibility criteria, cannot exceed the state's share of the average monthly nursing home payment. The client pays for room and board (raw food costs only -- meal preparation is covered as a service). The costs services in addition to assisted living services may not exceed

75% of the average nursing home payment for the case mix classification. Under the HCBS waiver, rates for assisted living services are also capped at the state share of the average nursing home payment and the total costs, including skilled nursing and home health aide, cannot exceed 100% of the average cost for the client's case mix classification.

TABLE 3. Ohio Assisted Living Waiver Service Levels (Proposed)	
Service Level	**Minimum Waiver Service Needs**
One	• Assistance with 2 secondary ADLs
Two	• Assist with 1 primary ADL & 1 secondary ADL; or • Level one + medication administration; or • Level one + behavior management; or • Level one + plus unstable medical condition; or, • Level one + daily skilled nursing services not covered under the state Medicaid Plan
Three	• Assist with 4 ADLs (any type); or • Assist with 3 ADLs (including 1 primary ADL) plus medication administration; or • Level two plus behavior management; or • Level two plus unstable medical condition; or • Assist with 3 ADLs (including one primary ADL) plus daily skilled nursing services not covered under the state Medicaid Plan.
Four	• Assist with 5 ADLs (any); or • Assist with 4 ADLs (any) plus medication administration; or • Level three plus behavior management; or • Level three plus unstable medical condition; or • Assist with 4 ADLs (any) plus daily skilled nursing services not covered under the state Medicaid Plan.
Five	• Assist with 5 ADLs plus medication administration AND daily skilled nursing services not covered under that state Medicaid Plan; or • Level four plus behavior management; or • Level four plus unstable medical condition.

The statewide maximum FY 94 rates for elderly recipients ranged from $565 a month to $1330 a month depending upon the case mix classification. Rates in a particular county could be higher or lower than the averages. Rates for participants with physical disabilities ranged from $597 to $1361. These rates are in effect in 1995 (see table).

Proposed legislation in **Wisconsin** will cap rates at 85% of the nursing facility rate. It is assumed that counties will have flexibility to negotiate rates with providers within the overall cap set by the state agency.

TABLE 4. Minnesota Case Mix Categories and Average Rate Limits			
Category	**Rate**		**Description**
	Elderly	**Disabled**	
A	$565	$597	Up to 3 ADL dependencies[1]
B	$638	$671	3 ADLs + behavior
C	$722	$755	3 ADLs + special nursing care
D	$798	$831	4-6 ADLs
E	$876	$9090	4-6 ADLs + behavior
F	$881	$914	4-6 ADLs + special nursing care
G	$948	$980	7-8 ADLs
H	$1073	$1105	7-8 ADLs + behavior
I	$1117	$1150	7-8 + needs total or partial help eating (observation for choking, tube or IV feeding and inappropriate behavior)
J	$1186	$1218	7-8 + total help eating (as above) or severe neuro-muscular diagnosis or behavior problems
K	$1330	$1363	7-8 + special nursing
1. ADLs include bathing, dressing, grooming, eating, bed mobility, transferring, walking and toileting.			

Medications and Staffing

Nearly all states allow assistance with self-administration of medications or administration of medications by licensed nurses. The predominant provisions for staffing require that facilities provide an adequate number and type of staff necessary to fulfill the service needs of residents as required by plans of care. A few states require ratios of awake or on-site staff but the clear trend substitutes flexible staffing plans and schedules for specific staffing ratios.

States Developing Policy Options

The trend among states to develop assisted living continues. As frequently as states move from study, analysis and recommendations to passing legislation and issuing regulations, other states have begun their own initiatives. Assisted living has attracted interest in a number of states that have created a process to examine options and make recommendations. In **Ohio**, a task force was created to re-examine legislation passed in 1993 and draft regulations developed to implement the legislation. Language was added to the state budget bill in 1994 that halted implementation. As the process for developing the regulations proceeded, segments of the assisted living and nursing home industries expressed concerns about the model and the direction of the regulations. A special committee consisting of 6 legislators, 4 state agencies, 4 provider groups (3 nursing home and 1 assisted living), the Area Agency on Aging Association, the Ombudsman Association, AARP and a taxpayer group was created to review the program.

The task force was created to address opposition to Chapter 3726 and the proposed regulations dealing with the unit requirements, the level of services provided

in assisted living and the medical conditions of tenants. While a formal consensus report was not submitted, the governor's budget included several proposals contained in the draft report. The budget bill would repeal the assisted living statute and create a new category of residential care facility to replace the current rest home classification. Residential care facilities would be able to provide up to 120 days of skilled nursing services with exceptions for special diets, medication administration and dressing changes. In addition, the **Ohio** Department on Aging would be authorized to create an assisted living program, funded through a Medicaid HCBS waiver, that is likely to use the rules developed for the licensure category.

A task force consisting of state agencies, consumers, nursing home associations, and assisted living providers has been meeting in **Delaware** to recommend a policy. Requirements for self-preservation has been a contested issue. The task force has considered private apartments, elderly housing and residential care as settings for the provision of assisted living. **Louisiana** state officials have begun drafting an assisted living policy statement. A meeting with Aging, Health and Medicaid staff was held to initiate discussion of the primary elements of the policy statement. Monthly meetings between staff of the Governor's Office on Aging, the Department of Health and Hospitals (Medicaid) and the Department of Social Services (regulations) have been held. It is anticipated that the Department of Health and Hospitals will submit a Medicaid Home and Community Based Services waiver to fund two pilot assisted living projects. Licensing rules are being drafted with a projected effective date of July 1, 1995.

In **Hawaii** the 1994 legislative session assed House Concurrent resolution 377 which directed the formation of a task force to study and make recommendations on assisted living. A 7 member legislative task force that includes three state agencies and provider groups has been meeting weekly. The task force is chaired the Gerontology Administrator of the Child and Family Services agency which is a large social services agency. The group organized a conference on assisted living in the fall of 1994 and presented a report to the legislature which has resulted in several bills being filed. Members made site visits to facilities in Oregon and Washington. The report recommended adoption of a common definition of assisted living to mean "a special combination of housing, personalized supportive services and health care designed to respond to individual needs. Assisted living promotes choice, responsibility, independence, privacy, dignity and individuality and encourages the involvement of a resident's family and friends. The setting within an assisted living facility is usually a private studio apartment and bath."

The state faces constraints due to high land costs and must examine the use of existing housing capacity rather than new construction to implement a new model. The report recommends that counties be encouraged to modify their land use policies to support assisted living and that state loans and bonds be made available a favorable interest rates to stimulate development.

Legislation authorizing development of assisted living regulations and authorizing funding through a Medicaid waiver is pending before the state legislature which meets

until the end of April. The legislature is expected to pass a bill directing the development of assisted living regulations modeled after the Oregon and Washington programs and another bill providing for nurse delegation in a range of settings (nursing home, hospitals, assisted living and others). Another bill is expected to pass that provides mortgage insurance through the state housing finance agency for non-profit agencies which develop assisted living programs.

A resolution directing the Department of Human Resources to study and report to the legislature on the feasibility of developing a Medicaid Home and Community Based Services waiver for assisted living. In addition, **Hawaii** is implementing an 1115 demonstration waiver, called Health QUEST, that provides health care for Medicaid recipients and uninsured residents with incomes below 300% of the poverty level through managed care plans. Planning has begun to expand the waiver to SSI recipients and to include long term care in the service package. The work group is interested in including assisted living as part of the benefit package. Implementation is not expected until 1999 to allow ample time for implementation of the current waiver.

A seven member Residential Care Council examined assisted living options for 18 months in **Idaho**. A change in administrations and lack of funding limited the scope of the work. A concept paper was issued which may serve as the basis for legislation that was expected to be filed by the Assisted Living and Residential Care Associations. A legislative task force was created in **Indiana** to make recommendations on assisted living. After a series of hearings, a report was issued but no action has been taken to develop a formal proposal.

In **Michigan**, the Long Term Care Working Group, appointed by Governor Engler, is developing administrative rules for assisted living. Officials from the Office of Services to the Aging, Public Health, Mental Health, the Department of Social Services (Medicaid) and the State Housing Authority are members of the Working Group. Draft rules are being developed for review by the Working Group at their January, 1995 meeting.

Legislation consolidating the licensing of personal care homes, retirement homes, adult foster care and adult day care under a broader residential care category will be filed with the **Montana** legislature for consideration during the 1995 session. Another proposal will provide funding for 50 slots for Medicaid waiver participants in residential care homes that are comparable to assisted living.

The **Oklahoma** Aging Services Division organized a task force to study assisted living in the spring of 1994 which included representatives of both aging and people with disabilities, providers and others. The task force developed a broad definition that considered assisted living as a service available in multiple settings 24 hours a day for unscheduled needs. The group also identified a philosophy to guide their work that emphasized privacy, dignity, and resident involvement in the assessment and care planning process. Committees were formed to focus on the housing environment, services to be provided, clients to be served and funding sources. Legislation was

drafted and circulated for comment that would have replaced the current residential care licensure category with a new assisted living category. The task force is refining the legislative proposal based on reactions from affected groups. The task force is addressing issues dealing the level of care that can be provided outside a nursing home, the role for residential care facilities, financing for low income residents, and the appropriate models for serving people with dementia versus people with disabilities who prefer an independent living model.

State agencies in **Texas** have formed a task force to build on their Medicaid waiver program and develop a more formalized licensure policy on assisted living.

The **Vermont** Department of Aging and Disabilities convened a working group to consider options for developing assisted living models. The group recommended conducting pilot projects to gain experience with several approaches, including the supportive or congregate housing services model in which frail residents in conventional elderly housing buildings receive services. This approach would be comparable to **Maryland's** model. The **Vermont** Department of Aging and Disability has subsequently created an advisory group to assist with the development of the state's Medicaid home and Community Based Services Waiver renewal. A subcommittee has been formed to deal with assisted living and the renewal application may contain a proposal to add assisted living as a service as Minnesota and Texas have done. The governor's proposed 1996 budget included funds to implement an assisted living demonstration program through a Medicaid HCBS waiver.

The policy development process need not begin with public officials. In **Illinois**, The Center for Eldercare Choices (a Foundation formed by the Illinois Association of Homes and Services for the Aging, the Life Services Network of Illinois) initiated a statewide, two day summit on assisted living in October 1994. Thirty three policy leaders (legislators, state agency officials, housing and service providers) were invited to examine issues around residential alternatives to develop a framework for working on an assisted living proposal for the state. The session reviewed background information on assisted living and created a coalition to guide policy development.

The group identified seven elements of assisted living: risk, services, choice, cost, home, internal community and external community and phrases which describe each area (see appendix). A matrix presenting the strengths and weaknesses, opportunities and threats posed by assisted living was devised as well as a plan with 6 options for action. Three options were considered a priority, and task forces were established. The three priorities identified were: to develop a definition of assisted living, to create strategies for identifying and educating stakeholders, and to study and recommend provisions for legislative and regulatory oversight. One year timetables were established for each task force.

Interest in the work of the task forces has attracted the attention of other interest groups around the state. Subsequently, membership of the task forces was extended well beyond the original summit participants.

Assisted Living at a Glance: Comparing State Models

Assisted Living At A Glance: Status of State Activities		
State	**Status**	**Model**
Alabama	Multiple categories are licensed based on size.	Institutional model.
Alaska	Statute passed in 1994. Draft regulations were issued in January 1995.	Board & Care/housing model.
Arizona	Demonstration program operating.	New housing & services model.
Connecticut	Regulations were effective in December 1994. Licensure process implemented.	Licensed as a service in settings meeting certain requirements.
Florida	Regulations issued in 1992. Regulatory and legislative amendments are pending. An HCBS waiver has been approved to serve Medicaid recipients.	Service model in multiple settings.
Hawaii	A task force has been formed to pursue assisted living. Legislation directing the development of assisted living regulations modeled after Oregon & Washington, nurse delegation regulations and a study of Medicaid HCBS waiver options is expected to pass this session of the legislature.	New housing and services model.
Idaho	Concept paper has been developed by the residential Care Council. Bills are pending in the legislature.	
Illinois	Early phases of development through an initiative of the Illinois affiliate of the American Association of Homes and Services of the Aging.	
Indiana	Study completed in 1994. No follow up activity to date.	
Louisiana	Draft regulations are being prepared as a cooperative effort by the Aging, Health and Medicaid Departments.	
Maine	New regulations are effective in April, 1995 that re-classify current programs.	Service model in public housing and residential care settings.
Maryland	Service model in elderly housing and small group homes.	Service in multiple settings model.
Massachusetts	Legislation creating an assisted living certification process was signed in January 1995. Regulations being drafted. Certification process created for settings meeting specified criteria. Financing for services and housing (SSI) are available for purpose built and conventional elderly housing projects.	New Housing & service model.
Michigan	The Department on Aging chairs a work group charged with developing recommendations.	
Minnesota	Assisted living has been implemented as a Medicaid HCBS service.	Licensed as a service in settings meeting certain requirements.
Montana	Legislation creating an assisted living category is pending.	
New Jersey	Regulations creating a new licensure category were implemented. 3 facilities have been licensed and 35 applications are pending.	Service in multiple settings model.
New York	Contracts with 63 projects and 3500 units have been approved. An RFP for 700 units in New York City is being issued. Budget proposal may repeal the program.	Board &Care and housing model.
North Carolina	A report and recommendations was submitted March 1st. A January 1996 effective date is expected for new assisted living guidelines.	
North Dakota	Assisted living services are funded through the state's Medicaid waivers and two state funded service programs.	Service model in apartment settings.

Assisted Living At A Glance: Status of State Activities		
State	**Status**	**Model**
Ohio	Legislation was passed in 1993. Regulations implementing the bill were postponed pending review by a special committee in 1994. Legislation repealing the statute, and authorizing funding for development of an assisted living Medicaid waiver has been requested by the governor. Further direction from the legislature is expected.	New housing and service model.
Oklahoma	A task force has been created to review and develop assisted living recommendations. A draft bill has been circulated and is being revised by the task force.	Service model.
Oregon	Program rules operational. Supply continues to expand.	New housing and service model.
Rhode Island	About 45 Residential care and assisted living facilities are licensed. Newer buildings offer units with private bath.	Institutional model.
South Dakota	Assisted living category exists in statute. Limited services allowed.	Institutional model.
Texas	Assisted living has been added to the Medicaid HCBS waiver.	Licensed as a service in settings meeting certain requirements.
Utah	Program rules have been approved; rules governing the buildings to be reviewed by state board in March. An amendment to the HCBS waiver will be submitted in May 1995 to add assisted living.	Covers apartment style units and models with single/double occupancy rooms with shared lavatories & baths.
Vermont	Department of Aging & Disability is developing a program as part of the process to renew their Medicaid HCBS waiver. An advisory group has been established with a subcommittee on assisted living.	
Virginia	Regulations allowing assisted living services in adult care residences are pending. Expected to be effective in July, 1995.	Institutional model.
Washington	A demonstration program has been expended to 35 facilities and 1200 units. Further expansion approved. Draft rules have been developed based on the demonstration experience.	New housing and service model.
Wisconsin	Legislation permitting development of assisted living and providing funding for a Medicaid HCBS program was submitted as part of the governor's budget. Action is expected to be completed by the end of June 1995.	New housing and services model under HCBS.
Wyoming	Regulations upgrading board & care rules were issued. New rules allow skilled nursing and medication administration.	Institutional model.

TABLE 5. Comparison of State Models According to Characteristics of Assisted Living								
State	**Apartments Required**	**Bathroom Attached**	**Lockable Doors**	**Double Occupancy**	**Admissions[1]**	**Service Package[2]**	**Staffing**	**Philosophy[3]**
Arizona	X	X	X		X	X	X	X
New Jersey	X	X	X		X	X	X	X
Ohio (pending)	X	X	X		X	X	X	X
Oregon	X	X	X		X	X	X	X
Connecticut	X	X	X		X	X	X	X
Wisconsin (draft)	X	X	X		X	X	X	X
Washington	X	X	X		X	X	X	X
Massachusetts	X	X	X	X	X	X	X	
Minnesota	X	X	X		X	X		
New York	X[4]		X	X[5]	X	X	X	
Texas	X	X	X		X	X		
North Dakota	X	X	X		X	X		
Utah			X	X	X	X	X	X
Florida			X	X	X	X	X	X
Virginia					X	X	X	X
Alaska					X	X	X	
Alabama				X				
Rhode Island				X				

1. Regulations allow tenants who require nursing facility level of care or skilled services.
2. Services regulations allow provision of some skilled nursing service although the extent of skilled services may vary.
3. Philosophy: means a policy that emphasizes resident autonomy, privacy, choice and participation in decisions.
4. In "Enriched Housing" settins.
5. In Adult Home settings.

TABLE 6. Components of State Assisted Living Programs									
Component	**AL**	**AK**	**AZ**	**CN**	**FL**	**MD**	**MA**	**MN**	**NJ**
Authority									
Facility license	X	X			X				
Services license				X	X			X	X
Certification			X	X[3]			X		
Medicaid Contracts						X		X	
Residential									
Apartments			X	X	X	X	X	X	X
Private room w/bath							X		
Private BR, shared bath	X				X	X	X[4]		
Multiple occupancy	X[8]	X			X[8]	X			
Access to cooking				X			X		
Lockable doors			X	X	X		X	X	
Tenant policy	E	C	C	B	C	--	B	B	A
24 hour on-site staff		X	X	?	X				X
Nursing services	X	45 days[2]	X	X	X[5]		90 days[2]		
Staffing pattern	Ratio	Care plans	Care plans	Ratio & Care plans	Care plans		Proposed by residence		
Medicaid Financing		X	X		X	X	X	X	X[6]
Reimbursement	Market	2 Levels	Three classes	Market	Flat	Subsidy caps	Per diem	Case mix with caps[9]	
Resident focus[1]			X		X				X

TABLE 6 (*continued*)										
Component	**NY**	**ND**	**OH**	**OR**	**RI**	**TX**	**UT**	**VA**	**WA**	**WI**
Authority										
Facility license	X		X	X	X			X	X	
Services license	X									
Certification										
Medicaid Contracts		X				X				X
Residential										
Apartments	X[10]	X	X	X		X	X		X	X
Private room w/bath										
Private BR, shared bath										
Multiple occupancy	X[10]				X[8]		X	X		
Access to cooking										
Lockable doors	X	X	X	X					X	X
Tenant policy	C	D	B	B	E	--	B	C	C	A
24 hour on-site staff	X[11]			X			X			
Nursing services	X	X	120 days[2]			X			X	X
Staffing pattern	Plans of care	Plans of care							Plans of care	X
Medicaid Financing	X	X	X[6]	X		X	X[6]		X	X[6]
Reimbursement	Case mix[9]	Multiple	5 tiers	5 tiers	Market	Per diem		Flat rate	Per diem	Tiers[7]
Resident focus1			X	X			X	X	X	

TABLE KEY:

1. Resident focus eg., promote self-direction, independence, autonomy, dignity, choice, privacy.
2. With exceptions allowed to 120 skilled limit.
3. The housing setting is certified.
4. Existing buildings must have private half bath and many share bathing facilities.
5. Regulations specify services that may and may not be provided.
6. Medicaid waiver under consideration.
7. Tiered rates will be developed to reflect resident needs.
8. Bedrooms may be shared by no more than two people.
9. Based on nursing home case mix methodology.

TENANT POLICY KEY:

A. Meet nursing home criteria, may have extensive nursing needs.
B. Stable medical conditions, must not need 24 nursing supervision.
C. Nursing home eligible with specific conditions included or excluded.
D. Needs assistance with ADLs.
E. Do not allow nursing home eligible residents.

Definitions

Associations

Assisted Living Facilities Association of America

A special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help with activities of daily living and instrumental activities of daily living. Supportive service are available 24 hours a day, to meet scheduled and unscheduled needs, in a way

that promotes maximum dignity and independence for each resident and involves the resident's family, neighbors and friends.

American Association of Homes and Services for the Aging

Assisted living is a philosophy/program which combines and coordinates housing, personal and health-related services needed to help an individual maintain maximum independence and choice.

American Seniors Housing Association

A coordinated array of personal care, health services and other supportive services available 24 hours per day, to residents who have been assessed to need these services. Assisted living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity and residential surroundings.

National Association of Residential Care Facilities

Residential care facility means a home or facility of any size, operated for profit or not for profit, which undertakes through its owner/s or management to provide food, housing and support with activities of daily living and/or protective care for two or more adult residents not related to the owner or administrator. Residential care homes are also know as assisted living facilities, foster homes, board and care homes, sheltered care homes, etc.

National Association of State Units on Aging

NASUA subscribes to a definition of assisted living which acknowledges the deep desire of America's elders to reside in their own homes or in a homelike environment. Accordingly, the Association views assisted living as referring to a homelike congregate residence providing individual living units where appropriate supportive services are provided through individualized service plans. Assisted living is first and foremost a home in which residents' independence and individuality are supported and in which their privacy and right to self-expression are respected. Contributing to its appeal is an emphasis placed upon maximum autonomy, costs which appear to be lower than those for nursing home and a track record of a high degree of consumer satisfaction.

The position paper discusses several principles which include homelike environment, foster resident capabilities, honor the right of resident's to age in place, provide individualized supportive services which are developed with the full participation of informed residents, offer resident full disclosure and ensure that resident's rights are protected.

Federal Agencies

US Health Care Financing Administration (for Medicaid Home and Community Based Services Waivers). HCFA developed a definition of assisted living for states to use in their Home and Community Based Services Waiver programs (2176 waivers). The definition states:

> Assisted Living. Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, provided in a licensed community care facility, in connection with residing in the facility. This service includes 24 hours on site response staff to meet scheduled or unpredictable needs and to provide supervision of safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.
>
> Care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms as well as bedrooms. Living units may be locked at the discretion of the client except when a physician or mental health professional has certified in writing that the client is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with the fire code). Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). Routines of care provision and service delivery must be client-driven to the maximum extent possible.
>
> Assisted living services may also include (check all that apply):
>
> - Home health care
> - Physical therapy
> - Occupational therapy
> - Speech therapy
> - Medication administration
> - Intermittent skilled nursing services
> - Transportation specified in the plan of care
> - Other (specify)
>
> However, nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24 hour skilled nursing care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

HUD (232 Program)

Assisted living facility means a public facility, proprietary facility, or facility of a private nonprofit corporation that is used for the care of the frail elderly, and that:

1. Is licensed and regulated by the state or if there is no state law providing for such licensing and regulation by the state, by the municipality or other political subdivision in which the facility is located;

2. Makes available to residents supportive services to assist the residents in carrying out activities of daily living such as bathing, dressing, eating, getting in and out of bed or chairs, walking, going outdoors, using the toilet, doing laundry, preparing meals, shopping for personal items, obtaining and taking medications, managing money, using the telephone, or performing light or heavy housework, and which may make available to residents home health care services such as nursing and therapy.;

3. Provide separate dwelling units for residents, each of which may contain a full kitchen or bathroom, and includes common rooms and other facilities appropriate for the provision of supportive services to residents of the facility.

Long Term Care Insurance Policies

AMEX Life Assurance Company

Assisted care facility is a duly licensed facility with the primary purpose of providing continuous care and services to support needs resulting from inability to perform activities of daily living or cognitive impairment to at least ten resident inpatients. There must be a trained employee available at all times to provide that care; and the facility must have established procedures for overseeing the administration of medications. (The policy covers 80% of the daily maximum benefit for room and board and services in facilities that meet this definition).

UNUM

An assisted living facility is:

- an institution that is licensed by the appropriate licensing agency (if licensing is required) to primarily engage executive Director providing ongoing care and services to a minimum of 10 inpatients in one location and operates under state licensing laws and any other laws that apply; or
- any other institution that meets all of the following tests:
    - provides 24 hour a day care, custodial services and personal care assistance to support needs resulting from a loss of functional capacity or cognitive impairment;

- has an employee on duty at all times who is awake, trained and ready to provide care;
- provides three meals day, including special dietary requirements;
- operates under applicable state licensing laws and any other laws that apply;
- has formal arrangements for the services of doctor or nurse to furnish medical care in the event of an emergency;
- is authorized to administer medication to patients on the order of a doctor; and;
- is not, other than incidentally, a home for the mentally retarded, the mentally ill, the blind or deaf, a hotel or a home for alcoholics or drug abusers; or
- a similar institution approved by UNUM.

John Hancock (Group Products)

A facility which is licensed to provide residential care specifically to persons with dementia, including but not limited to Alzheimer's Disease.

If the jurisdiction in which the facility operates does not license such facilities, then it must: be operated pursuant to law; and meet all of the following standards.

- Its primary function must be to provide residential care to persons with dementia.
- It must have a consulting physician to review the medical condition of residents. The physician must conduct an assessment of each resident prior to admission and ongoing assessment of each resident at least every 60 days to monitor problem behaviors and medical conditions.
- It must be a separate facility or a distinct part of another facility.
- It has established procedures for obtaining appropriate aid in the event of a medical emergency.

AEGON Insurance Group

A facility that is engaged primarily in priding ongoing care and related services to at least 10 inpatients in one location and meets all of the following criteria:

1. It provides 24 hour a day care and service sufficient to support needs resulting from inability to perform activities of daily living or cognitive impairment;

2. Has an awake, trained and ready to respond employee on duty at all times to provide that care;

3. Provides three meals a day and accommodates special dietary needs;

4. Is licensed by the appropriate licensing agency (if any) to provide such care;

5. Has formal agreements for the services of a doctor or nurse to furnish medical care in case of emergency; and

6. Has appropriate methods and procedures for handling and administering drugs and biologicals.

States

Alaska

Residential facilities operated in the state that serve three or more adults who are not related to the owner of the facility by blood or marriage by providing housing and food service to its residents and providing or obtaining or offering to provide or obtain for its residents assistance with (a) activities of daily living, (b) personal assistance or a combination of services under (a) or (b).

Arizona

Supportive residential living center: a center that provides or coordinates supportive residential living services on a 24 hour basis in residential units. Facilities shall be capable of providing or coordinating home and community based services on a twenty four hour basis for support of resident independence in a residential setting.

Connecticut

Assisted living services means nursing services and assistance with activities of daily living provided to clients living within a managed residential community having supportive services that encourage clients primarily age 55 or older to maintain a maximum level of independence. Routine household services may be provided as assisted living services by the assisted living services agency or by the managed residential community as defined in subsection (a)(13). These services provide an alternative for elderly persons who require some help or aid with activities of daily living as described in subsection (a)(4) or nursing service in order to remain in their private residential units within the managed residential community.

Florida

Adult congregate living facility, hereinafter referred to as facility, means any building or buildings, section of a building, or distinct part of a building, residence, private home, boarding home, home for the aged, or other place, whether operated for profit or not, which undertakes through its ownership or management to provide, for a period exceeding 24 hours, housing, food service, and one or more personal services for four or more adults, not related to the owner or administrator by blood or marriage, who require such services; or to provide extended congregate care, limited nursing services, or limited mental health services for fewer than four adults

is within the meaning of this definition if it formally or informally advertises to or solicits the public for residents or referrals and holds itself out to the public to be an establishment which regularly provides such services.

Massachusetts

Any entity ... which provides room and board and provides, directly by employees ... Or through arrangements with another organization, assistance with activities of daily living for three or more adult residents who are not related. ... And collects payment or third party reimbursements from or on behalf of residents to pay for the provision of assistance with ADLs or arranges for same.

Maine

Assisted Living Services: personalized supportive services provided to functionally and/or mentally impaired adults that assist them in living in the residential environment of their choice and take into consideration their formal and informal support network.

Assisted living services provider: a provider of assisted living services certified by the Department as a Congregate Housing Services Program, a residential care facility or as a home health agency.

Maryland

Assisted living services include "a structured supportive environment in a home-like setting and personal care and chore services (help with IADLs, ADLs, routine housekeeping, menu planning, shopping, meal preparation, 24 hour supervision, assistance with medication administration, recreational and social activities of a non-therapeutic nature, assisting with transportation arrangements, and helping participants access medical care. The program also covers purchase of assistive equipment, environmental modifications, environmental assessment and behavior consultation.

Minnesota

Individualized home care aide tasks or home management tasks provided to a client of a residential center in their living units, and provided either by management of the residential center or by providers under contract with the management.

New Jersey

A coordinated array of supportive and health services, available 24 hours per day, to residents who have been assessed to need these services, including residents who require formal long term care. Assisted living promotes resident self direction and

participation in decisions that emphasize independence, individuality, privacy, dignity and home-like surroundings.

Assisted living residence: a facility which is licensed by the department of health to provide apartment style housing and congregate dining and to assure that assisted living services are available when needed... Apartment units offer at a minimum one unfurnished room, a private bathroom, a kitchenette and a lockable door on the unit entrance.

North Carolina (draft)

Any group housing and services program for two or more adults, by whatever name it is called, which makes available, at a minimum, one meal per day and housekeeping service and provides personal care service directly or through a formal written agreement with one or more licensed home care agencies. Nursing services provided to an individual in assisted living residence may not exceed those allowed under Medicare home health regulations.

Ohio

A multiple unit residential facility that provides or arranges for skilled nursing care for one or more individuals who reside in the facility and are not related to the owner or operator ...

Must consist of assisted living units, each of which contains private cooking, bathing, washing and toilet facilities; has doors that can be locked and individual temperature controls; is equipped with automatic sprinkler equipment and is maintained for single occupancy except in cases in which two residents choose to share a unit.

Oregon

A program approach, within a physical structure, which provides or coordinates a range of services, available on a 24 hour basis, for support of resident independence in a residential setting. Assisted living promotes resident self direction and participation in decisions that emphasize choice, dignity, privacy, individuality and home-like surroundings.

Utah

A residential facility with a home like setting that provides an array of coordinated supportive personal and health care services, available 24 hours per day to residents who have been assessed under division rule to need any of these services. Each resident shall have a service based on the assessment which may include intermittent nursing care, administration of medications, support service promoting residents' independence and self-sufficiency.

Rhode Island

Residential care and assisted living facility. Publicly or privately operated residences that provide personal assistance lodging, and meals to two or more adults who are unrelated ... Residential care facilities include sheltered care homes and board and care residences or any other entity by any other name providing the above services which meet the definition of residential care and assisted living facility.

Washington

(Draft) A combination of housing, health services and assistance with personal care,rn provided by a licensed boarding home in accordance with the department's contract. The assisted living facility shall design and provide services in response to each resident's individual need, emphasizing and promoting the resident's independence and dignity. The assisted living facility shall develop and implement individualized service plans based upon the individual resident's needs and choices, and shall, whenever possible include the resident's family, friends and support system in the service planning process. To the extent possible the resident shall always be included in service negotiations.

(Contract) A coordinated array of personal care, health services and other supportive services available 24 hours per day to residents who have been assessed to need these services. Assisted living promotes resident self direction and participation in decisions that emphasize independence, individuality, privacy, choice and residential surroundings.

Wisconsin (proposed)

A place where five or more adults reside that entirely consists of independent apartments, each of which has an individual lockable entrance and exit and individual separate kitchen, bathroom, sleeping and living areas, and that to a person who residents in the place provides not more than 28 hours per week of services that are supportive, personal and nursing services.

IV. STATE SUMMARIES

This section contains summaries of policies and regulations in each state that response to our survey indicated that they operate an assisted living program. The summary begins with a general presentation of their policy and the context in which it has been developed. In addition, the regulations are summarized as they relate to the definition of assisted living, requirements for the living unit, admission policy, services provided, medication, and staffing.

ALABAMA

General Policy Approach

The state has a licensure category for assisted living but does not differentiate assisted living from board and care. In 1994, the state Commission on Aging organized a series of forums on long term care, held a statewide summit on long term care and formed a Policy Development Council to make recommendations for the reform of the state's long term care system. During the forums and the statewide summit, several nursing home administrators, consumers and others testified to the need for an assisted living program that expanded the range of services that could be provided in assisted living and changes the admission policy to allow people who meet the nursing home level of care criteria to be served in assisted living. However, a new administration and the announcement of a substantial Medicaid deficit are likely to effect the policy process and the environment for expanding services.

The regulations license three categories of facilities. Congregate assisted living facilities serve 17 or more adults, group assisted living facilities serve 4-16 adults and family assisted living facilities serve 2-3 adults.

Unit Requirements

The regulations do not require separate living and sleeping quarters. Private bedrooms without sitting areas must provide 80 square feet and double rooms 130 square feet. If sitting areas are included, private rooms must be 160 square feet and double rooms 200 square feet. Bath tubs or showers must be available for every 8 beds, and lavatories and toilers for every six beds. Lockable doors are permitted.

Tenant Policy

The regulations provide that assisted living facilities may serve persons "who are not in need of hospital or nursing home care." Facilities may not serve anyone with chronic health conditions requiring extensive nursing care and/or daily medication supervision, persons requiring daily professional observation or the exercise of professional judgement by staff. People who need assistance from more than one person to evacuate a building, show severe symptoms of senility, require restraint or treatment for addiction of alcohol or drugs may not be admitted or retained.

Services

Assisted living facilities must provide personal care for bathing, oral hygiene, hair care and nail care. Facilities may provide for general observation and may arrange or assist residents to obtain medical attention or nursing services when needed. Home health may be provided by a certified agency as long as residents receiving home health services do not require hospital or nursing home care.

Financing

Other than SSI, no public financing is available for assisted living.

Medication

Assistance is limited to reminders, reading container labels to the resident, checking the dosage, opening containers. Registered nurses are allowed to administer medications for residents who do not require acute, continuous or extensive medical or nursing care.

Staffing

The regulations require at least 1 staff member per 6 residents 24 hours a day and personal care staff to meet the needs of residents.

ALASKA

General Policy Approach

In 1994 the Alaska legislature passed a law to encourage the development of assisted living homes to provide a homelike environment for older and persons with a mental or physical disability needing assistance with activities of daily living. The law promotes resident participation in the community, recognizes the resident's right and responsibility to evaluate and make choices concerning the services to be provided. The law provides for licensing assisted living homes for elders, people with dementia, and people with physical, mental or developmental disabilities. The Department of Health and Social Services will license homes for people with mental or developmental disabilities and the Department of Administration will license homes for older people, people with dementia and people with physical disabilities. The agencies are allowed to issue regulations setting additional requirements or standards.

The law is effective January 1, 1995. Draft regulations have been prepared and were issued for comment in February. The regulations set minimal requirements which will be defined in more detail in policies and procedures which will be developed and issued during the first year of the program as experience during the transition is gained. State officials expect that most providers will be small and personal care, RN assessment and oversight will be arranged or contracted from other organizations.

Fees are charged for a license. A base fee of $100 is charged for facilities of 3-5 residents and $250 for 6 and larger. In addition, applicants must pay $50 per resident for each resident over 2. Holders of residential care facility and adult foster care licenses may convert to an assisted living license.

Definition

The law creates "Chapter 33. Assisted Living Homes" to emphasize that assisted living serves as the resident's home. The statute applies to residential facilities serving three or more adults who are not related to the owner of the residence by blood or marriage that provide housing, food service, and provide, obtain or offer to provide assistance with activities of daily living, personal assistance (help with IADLs, obtaining supportive services [recreational, leisure, transportation, social, legal, et.al.], being aware of the resident's whereabouts when traveling in the community, and monitoring activities) or a combination of ADL assistance and personal assistance.

Unit Requirements

No requirements are specified for the type of unit. Shared rooms are allowed. Facilities must meet life safety code requirements applicable for buildings its size.

Tenant Policy

The home and each resident must sign a residential service contract that describes the services and accommodations to be provided, rates, the rights, duties and obligations of the resident, and the policies and procedures for terminating the contract. Residents who have exceeded the 45 consecutive day limit for receiving 24 hour skilled nursing (see below) may continue to live at the home if the home and the resident or resident's representative have consulted with the resident's physician, discussed the consequences and risks and a revised plan without 24 hour nursing has been reviewed by a registered nurse. Terminally ill residents may continue to reside in the residence if a physician certifies that the person's needs are being met.

Services

Each resident must have a plan of care developed within 30 days of move-in that identifies strengths and weaknesses performing ADLs, physical disabilities and impairments, preferences for roommates, living environment, food, recreation, religious affiliation and other factors. The plan also identifies the ADLs with which the resident needs help, how help will be provided by the home or other agencies, and health needs and how they will be addressed. The plan must also identify the resident's reasonable wants and how those will be addressed. If health related services are provided or arranged, the evaluation must be done quarterly. If no health services are provided, an annual evaluation is required. Assisted living homes may provide intermittent nursing services to residents who do not require 24 hour care and supervision. Intermittent nursing tasks may be delegated to staff who are not licensed as a nurse for tasks designated by the board of nursing. 24 hour skilled care may be provided for not more than 45 consecutive days.

Financing

When the regulations are finalized, rates will be adjusted to reflect the level of care and regional variations across the state. Rates will be comparable to current rates for residential care I and II which in the Anchorage area are 38.44 a day for Level I and $48.44 for Level II. The level II rate in the Northwest region is $80.64 a day.

Medications

"Home staff persons" may provide medication reminders, reading labels, observing a resident while taking medication, checking self-administered dosage against the label, reassuring the resident that the dosage is correct, and directing/guiding the hand of a resident at the resident's request.

Staffing

Homes must have the type and number of staff needed to operate the home and must develop a staffing plan that is appropriate to provide services required by resident care plans.

ARIZONA

General Policy Approach

Chapter 163 (1993) authorized the Director of Health Services to certify centers for the delivery of home and community based services. The law views supportive residential living services as in-home services. Participation is capped at 100 "members" at any point in time until September 30, 1995. An additional 100 members may be served after October 1, 1995. The pilot supportive residential living (assisted living) project operates in Maricopa County. Although the statute and regulations do not use the term assisted living, the pilot operates according to the principles of assisted living. Providers submit a statement that demonstrates their knowledge and commitment to the philosophy of supportive residential living.

Three facilities have been certified with 18, 28 and 54 units.

Data concerning resident satisfaction, number of residents, length of stay, level of care, emergency room utilization, urgent care visits, days of hospitalization, average days and cost, average daily cost of supportive residential living, service levels, demographic information, functional information, and medical information must be reported by sites. A one year report on resident satisfaction will be issued in March 1995. An evaluation will be submitted to the Governor's Long Term Care Committee by December 1995 and a full report is due to the legislature in 1996 when a decision will be made to expand the program statewide or terminate the demonstration.

The residence must meet local building and fire codes based on construction and occupancy.

Unit Requirements

Each unit must be constructed as a private apartment with living and sleeping space, kitchen area, bathroom and storage areas with a minimum of 220 square feet, excluding the bathroom. Units must have individually keyed locks and resident temperature controls. Kitchen areas must have a sink, refrigerator, cooking appliance that can be disconnected or removed, space for food preparation and storage space for utensils and supplies.

Tenant Policy

Projects cannot serve anyone who needs continuous nursing services, cannot direct care, needs continuous therapeutic intervention to sustain life and is violent toward self or others. In addition, non-Medicaid (ALTCS) residents cannot require more than one person to assist with ambulation, transfer from bed, chair or toilet or other ADLs, is unable to self-propel a wheelchair or cannot get out of bed more than three hours a day.

Resident agreements include the terms of occupancy, a statement of the services provided, services that are available for an additional cost, monthly fees and expenses, deposit and refund policies, termination procedures, copies of the rules and resident rights.

Services

Prior to move in, an interdisciplinary team conducts an assessment and develops a plan with the resident or their representative that identifies the services needed, the person responsible for providing the service, method and frequency of services, measurable resident goals and the person responsible for assisting the resident in an emergency.

The statute allows intermittent home health (nursing, aide, medical supplies, equipment or appliances and therapies), homemaker, personal care, medically necessary transportation and meals.

Financing

Rates have been negotiated with each project within guidelines specified in the waiver. Program administrators used rates set for adult foster care, nursing facilities, the Oregon assisted living program and the Arizona HCBS program as guidelines in working with centers. Administrators also consider the package of services provided and ask each residence to propose a unit rate. Three classes of rates are negotiated based on the level of care: intermediate, low skill and high skilled. The SSI payment rate is $446 a month of which $391.10 is paid to the residence to cover room and board charges and $66.90 is retained by the resident.

Arizona Payment Rates		
Class I	**Class II**	**Class III**
44.00 - 45.51	49.00 - 50.76	55.00 - 63.51

Medications

Facilities must have policies and procedures governing the procurement, administration, storing and disposal of medications. Staff may supervise self-administration by opening bottle caps, reading labels, checking the dosage and observing the resident taking the medication. Medications which cannot be self-administered must be administered by an RN or "as otherwise permitted." The phrase as otherwise permitted was included to accommodate any future statutory changes in the state's nurse practice act. Medication organizers can be prepared a month in advance by an RN or family members.

Staffing

The center manager may employ or contract with staff for supportive services, supervision, food service, housekeeping and maintenance, social and activity programs and general supervision. At least one staff must be awake and on-duty. An RN must be available to provide nursing service specified in each plan of care. No staff ratios are included in the regulations and centers are required to have sufficient personnel available to provide services identified in resident care plans.

Managers must receive 20 hours of continuing education credit each year. Staff are required to receive an orientation from the center and complete a 16 hour training program, approved by the county within 60 days of their employment as well as 20 hours of in-service training a year.

CONNECTICUT

General Policy Approach

Assisted living regulations were issued by the Health Department and approved by the Legislative Review Committee in December, 1994. The regulations take a unique approach by allowing "managed residential communities" (MRCs) to offer assisted living services through assisted living services agencies (ALSAs). MRCs may obtain a license to also serve as an ALSA.

The regulations focus on the licensing of agencies to provide services rather than the building and services as an entity. MRCs have to notify the health department of their intention to provide assisted living services. The ALSA, either the MRC or another agency, must be licensed by the Department of Public Health and Addiction Services to provide services. The MRC is not licensed by the Department of Public Health and Addiction services. MRCs must show evidence of compliance with local zoning ordinances and building codes.

Definition

Assisted living services: nursing services and assistance with ADLs provided to clients living within a managed group living environment having supportive services that encourage clients primarily age 55 or older to maintain a maximum level of independence. Routine household services may be provided as assisted living services or by the managed residential community. These services provide an alternative for elderly persons who require some help or aid with ADLs and/or nursing services.

Unit Requirements

To qualify as a managed residential community and a setting in which assisted living services may be provided, units are defined as a living environment belonging to a tenant(s) that includes a full bathroom within the unit including water closet, lavatory, tub or shower bathing unit and access to facilities and equipment for the preparation and storage of food.

Tenant Policy

Each agency will develop its own admission criteria but the regulations do not allow the agencies to impose unreasonable restrictions and screen out people whose needs may be met by the agency. Assisted living services may be provided to residents with chronic and stable health, mental health and cognitive conditions as determined by a physician or health care practitioner.

Services

Services may only be provided by organizations licensed as an assisted living services agency. Nursing services are listed in the regulations and include client teaching, wellness counseling, health promotion and disease prevention, medication administration and delegation of supervision of self-administered medications and provision of care and services to clients whose conditions are chronic and stable.

Registered nurses may also perform quarterly assessments, coordination, orientation, training and supervision of aides.

Financing

The Health and Education Facilities Authority provides loans for the development of assisted living settings. As yet, no specific program has been developed to subsidize services for low income residents of assisted living.

Medications

The regulations allow for administration of medications by licensed staff. Assisted living aides may supervise the self-administration of medications which includes reminding, verifying, and opening the package.

Staffing

ALSAs must have at least 1 RN and an on-site supervisor 20 hours a week for every 10 or fewer RNs and aides and a full time supervisor for every 20 RNs and aides. A sufficient number of aides must be available to meet residents' needs. All aides must be certified Nurses Aides or Home Health Aides and complete 10 hours of orientation and one hour of in-service training every 2 months.

Twenty four awake staff are not required since the needs will vary among managed residential communities. However, 24 hour staffing could be required if indicated by resident plans of care. An RN must be available on-call 24 hours a day.

FLORIDA

General Approach

Legislation was passed in 1991 that authorized the delivery of Extended Congregate Care (ECC) in Adult Congregate Living Facilities (ACLFs) to promote the availability of appropriate services for elderly and disabled persons in the least restrictive and most homelike environment to encourage the development of facilities which promote dignity, individuality, privacy and decision-making ability. The law specifies that regulations governing these facilities shall be sufficiently flexible to allow facilities to adopt policies which enable residents to age in place when resources are available to meet their needs and accommodate their preferences. ACLFs may provide extended congregate care to residents.

Providers must receive ACLF and ECC licenses. The ECC license sets higher requirements for units and services than the ACLF license alone.

Both the authorizing statute and the regulations include a philosophy that emphasizes resident autonomy. Facilities with both licenses must provide opportunities for residents to make personal decisions and choices, and to participate in developing a care plan. The residence must also develop policies which allow residents to age-in-place, maximize independence, dignity, choice and decision-making.

Legislation changing the name of the ACLF program to assisted living is pending before the state legislature. A number of other legislative proposals are pending that would extend the range of allowable services, require a test for administrators, set requirements for specialized Alzheimers' programs, and increase fire safety requirements (require sprinklers). Amendments to the regulations, which were initially promulgated in 1992, were published January 31, 1995. The revised regulations are expected to be effective by May 1995.

Approximately 1800 facilities are licensed as ACLFs of which 120 have an ECC or limited nursing service license and are eligible to participate in the state's assisted living Medicaid waiver program.

Definition

"Adult congregate care facility means any building or buildings, section of a building or distinct part of a building, residence, private home, boarding home, home for the aged or other place, whether operated for profit or not, which undertakes to provide through its ownership or management, for a period exceeding 24 hours, housing, food service, and one or more personal services for four or more adults, not related to the owner or administrator by blood or marriage, who require such services; or to provide extended congregate care, limited nursing services, or limited mental health services."

"Extended congregate care license: a specialized license which is issued to facilities which have met the basic licensure provisions of (ACLFs).

Unit Requirements

ACLFs providing extended congregate care must provide private rooms or apartments, or semi-private room or apartment shared with a roommate of choice, with a lockable entry door. Facilities that provide shared bathrooms must have one bathroom shared by no more than four residents.

Tenant Policy

Admission The regulations for "admissions" are very detailed. New residents must be able to perform ADLs with supervision or assistance; do not require 24 hour nursing supervision; are capable of taking their own medication or may require administration of medication and the facility has licensed staff to provide the service; do not have bed sores or stage 2, 3, or 4 pressure ulcers, are able to participate in social activities; capable of self-preservation; is not bedridden; non-violent; and does not require 24 hour mental health care.

Continued residency Additional criteria affect continued residency. Residents may not be retained if they develop a need for 24 hour supervision; become bedridden for more than 14 days, become totally dependent in 4 or more ADLs (exceptions for quadraplegics, paraplegics and victims of muscular dystrophy, multiple sclerosis and other neuro-muscular diseases if the resident is able to communicate their needs and do not require assistance with complex medical problems). Residents may stay if they develop stage 2 pressure sores but must be relocated for stage 3 and 4 pressure sores. Residents who are medically unstable, become a danger to self or others or experience cognitive decline to prevent simple decision making may not be retained.

This lengthy list of resident conditions which may and may not be treated may be replaced by using the Medicare skilled nursing definition to establish the admission and retention policy.

The original law emphasized aging-in-place and the regulations included a requirement that residents must reside in the facility 90 days prior to the need for ECC services. This prevented people from moving in to an ACLF who needed the services upon move in. Modifications to the requirement are pending in the legislature.

To receive services under the Medicaid waiver, tenants must be 60 years of ago or older and meet one of the following criteria:

- Require assistance with 4 or more ADLs or three ADLs plus supervision or administration of medications;
- Require total help with 1 or more ADLs;

- Have a diagnosis of Alzheimer's Disease or another type of dementia and require assistance with 2 or more ADLs;
- Have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard ACLF;
- Are Medicaid eligible, awaiting discharge from a nursing home but cannot return to a private residence because of a need for supervision, personal care, periodic nursing services or a combination of the three.

Services

The facility must describe the personal, supportive and nursing services to be made available. Facilities may provide limited nursing services (eg., medication administration and supervision of self-administration, applying heat, passive range of motion exercises, ice caps, urine tests, routine dressings that do not require packing or irrigation and others), intermittent nursing services (eg., change of colostomy bag and related care, catheter care, administration of oxygen, routine care of an amputation or fracture, prophylactic and palliative skin care); counseling emotional support, networking, assistance securing social and leisure services, shopping, escort, companionship, family support, information and referral, transportation assistance developing and implementing self-directed activities. In addition, facilities are to provide ongoing medical and social evaluation, dietary management, and medication administration.

Facilities **may not** provide oral or nasopharyngeal auctioning, assistance with tube feeding, monitoring of blood gasses, intermittent positive pressure breathing therapy, intensive rehabilitation services for a stroke or fracture or treatment of surgical incisions which are not clean and free from infection and any treatment requiring 24 hour nursing supervision.

The Medicaid waiver includes the following services for recipients in ECC settings: personal care, homemaker, attendant and companion, medication administration and oversight, therapeutic social and recreational programming, physical, occupational and speech therapy, intermittent nursing services, specialized medical supplies, specialized approaches for behavior management for people with dementia, emergency call systems and case management.

Financing

A total of $2.3 million was approved in 1994 for 220 Medicaid Home and Community Based Services Waiver slots as a pilot program. The SSI benefit is $586 a month. The program reimburses providers $750 a month for services for a total payment of $1336 less the personal needs allowance. An evaluation of the program will be done to examine levels of need and developed a tiered rating system as appropriate.

To be eligible for the program, recipients must be an SSI recipient, have income under 300% of the federal SSI benefit or, for aged and disabled applicants, have income under 90% of the federal poverty level.

Medications

Medications may be administered by staff within the scope of their license.

Staffing

Facilities are allowed to establish their own staffing plan based on the amount and type of services needed by residents and reflected in resident plans of care. Certified nursing assistants and certified home health aides must receive training in the concepts and requirements of extended congregate care.

HAWAII

General Approach

A multi-member task force was created by House Concurrent Resolution 377 to make recommendations and assisted living and to explore the use of Medicaid waivers to support low income residents in assisted living. The report was issued in December 1994 and legislation implementing some of the recommendations was filed for consideration by the legislature in 1995. Members of the task force made site visits to facilities in Oregon and Washington. The report recommended that the Department of Health be authorized to develop regulations to establish an assisted living program.

Definition

The report recommended that assisted living be defined as a special combination of housing, personalized supportive services, and health care designed to respond to individual needs. Assisted living promotes choice, responsibility, independence, privacy, dignity and individuality and encourages the involvement of a resident's family and friends. The setting within an assisted living facility is usually a private studio apartment and bath.

Unit

The definition emphasizes but would not require that units be configured as apartments.

Services

Not described.

Financing

The report suggested that land policies should be reviewed and modification of zoning requirements made to allow existing housing stock to be used. State loans and bonds would be made available to at favorable interest rates to stimulate development. The report recommended consideration of providing a higher level of service in residential care facilities as a means of maximizing existing buildings to meet new needs.

Medication

The nurse practice act should be modified to allow medication management by designated staff.

Staffing

Not addressed.

IDAHO

General Approach

A concept paper has been prepared by the Idaho Residential Care Council that outlines a policy for assisted living. The draft paper states that assisted living serves people who need assistance with ADLs but not skilled nursing care. Assisted living promotes independence and dignity for each resident in a home like atmosphere rather than a medical atmosphere.

The paper envisions assisted living as providing care that is less intensive than nursing home care and more services than are available in independent housing. Licensing would be done in a manner that does not remove independence and choice from the resident.

Definition

Not developed yet.

Unit

Not addressed.

Services

The concept paper calls for providing assistance with eating, bathing, dressing, toileting and walking; three meals a day in a common dining room; housekeeping services; transportation; emergency call system for each resident; medication management by licensed CNAs; social and recreational activities; and personal laundry services.

The paper recommends development of a point system to charge for services in addition to the monthly rent which charges residents only for the services they use.

Financing

Not addressed.

Medication

Not addressed.

Staffing

Not addressed.

INDIANA

General Approach

The state legislature called for a study of assisted living during the summer of 1994. The Interim Study Committee on Health Care and Licensure Issues held five meetings and received public testimony. The Committee report, issued November 1994, included a proposed definition for assisted living. A motion to file le islation authorizing creation of a program based on Oregon and draft regulations in Ohio received a 5-4 vote but required 7 affirmative votes to be adopted as a recommendation of the Committee.

Definition

Proposed: a program approach, within a physical structure, which provides or coordinates a range of social and health care services for five or more individuals, available on a 24 hour basis, for support of resident independence in a residential setting. Assisted living promotes resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and home-like surroundings. (Approved 9-0).

Unit Requirements

Not addressed.

Tenant Policy

Not addressed.

Services

Not addressed.

Financing

Not addressed.

Medications

Not addressed.

Staffing

Not addressed.

MAINE

General Approach

Chapter 661 of the Acts 1994 directed that state agencies develop a definition of assisted living that includes a range of services from in-home assistance to facility based care but that excludes supported living program operated by the Department of Mental Health and Mental Retardation; recognizes different levels of care with appropriate levels of regulation and provides necessary protection for consumers without unduly restricting choice. The Bureau of Elder and Adult Services (BEAS) has published a proposed policy with an effective date of April 1, 1995. The service based approach will license providers of service and limits which organizations may be licensed to provide assisted living services. Any organization offering assisted living services must be licensed under one of three categories identified in the regulations. The new policy does not make changes in current programs or licensure categories and simply alter the terms that can be applied to current programs as well as introduce a set of principles.

The five principles described in the regulations are:

- Assisted living services are personalized and based on the needs and values of the consumer. This means the consumer is involved in decision-making, is informed of risks and has the right to fail.
- Assisted living services foster independence.
- Assisted living services recognize and respect the dignity and rights of the consumer.
- Assisted living services offer the consumer a choice of services and lifestyle.
- Assisted living services respect the privacy of the consumer.

Further regulations are to be developed by the Department of Human Services to implement consumer protection standards related to provider fitness, service contracts and leases, promotion of consumer rights and a grievance process, scope of practice and minimum safeguards for life safety, food service and sanitation and the minimum standards for accommodations and the environment.

Definition

Assisted Living Services: personalized supportive services provided to functionally and/or mentally impaired adults that assist them in living in the residential environment of their choice and take into consideration their formal and informal support network.

Assisted living services provider: a provider of assisted living services certified by the Department as a Congregate Housing Services Program, a residential care facility or as a home health agency.

Unit Requirements

Not specified. May be the subject of further regulations.

Tenant Policy

Not specified.

Services

The regulations do not revise the scope of services provided by residential care facilities, congregate housing services programs and home health agencies. Each provider category provides a different set of services.

Congregate housing services: care management services, housekeeping services, personal care assistance, transportation and at least one meal a day available to consumers in a multiunit residential building.

Residential care services: personal supervision, protection from environmental hazards, assistance with activities of daily living, administration of medications, diversional or motivational activities, diet care and nursing services.

Home health services: in-home provision of professional nursing services, physical and/or occupational therapy speech pathology, medical social work, nutritionist services and the supervised services of licensed practical nurses, home health aides and/or certified nurse assistants providing treatment and rehabilitation for illness or disability, aimed at restoring or maintaining independent functioning.

Financing

Assisted living would be financed through existing program. No new sources of funding are provided.

Medications

No changes are made from current practice.

Staffing

No changes are made from current practice.

MARYLAND

General Approach

There are several housing with supportive services programs that operate in the state. In 1976, the Office on Aging began the Sheltered Housing program, a support services program for frail elderly residents in HUD subsidized senior apartment buildings. In 1986, Sheltered Housing (now known as Senior Assisted Housing) was expanded to group homes for the elderly which provides services to 4-15 residents in a group setting. In 1993, the Office on Aging was approved for Medicaid Home and Community Based Services Waiver to serve resident in Group Senior Assisted Housing (GSAH) facilities.

The Department of Health and Hygiene regulates large facilities serving 16 or more residents in non-apartment settings. While this category is regulated as domiciliary care, some facilities advertize themselves as assisted living. Some private market apartment models that offer support services operate without state regulation. State agencies are currently reviewing the array of models to determine how assisted living should be defined and regulated.

Definition

Senior Assisted Housing is a residential program that combines housing and support services for seniors, who are at least 62 years old, who need daily help with activities of daily living in order to remain in the community.

Units

The multi-family SAH program operates in 43 senior apartment buildings throughout the state, serving over 900 people. There are over 1400 residents living in 175 certified GSAH facilities. Group facilities offer private or semi-private bedrooms and residents share common areas of the home. Many group home residents (about half) have some form of dementia. Although some group facilities have been developed in former convents, school buildings or newly constructed buildings, most facilities are developed using existing housing stock. The conditions of participation require that buildings meet all state and local laws governing the physical plant, including fire accessibility and safety standards. To offer assisted living services, providers must be certified annually by the Maryland Office on Aging.

Services

Required services include daily meals, housekeeping, laundry and assistance with personal care. The group home model also requires 24-hour on site supervision. Optional services include assistance with medication administration, recreational and social activities of a non-therapeutic nature, assisting with transportation arrangements,

and helping participants access medical care. Under the Medicaid waiver, services in group homes have been augmented to include environmental modifications, assistive equipment and behavior consultation services, and Senior Center Plus, a social day care program.

The Medicaid waiver component of the program is unique in that it provides support for environmental modifications. The program will pay two thirds of the modification costs and the assisted living provider pays the remaining third. Reimbursement for assistive equipment must be pre-authorized by the Area Agency on Aging case manager and approved by the state Office on Aging. Reimbursement for assistive equipment is limited to $1000 per participant during a 12 month period and reimbursement for environmental modifications is limited to $3000 per participant over a lifetime. Assistive equipment and environmental modifications reimbursements are divided among the participants affected.

Financing

In both models, eligible low income residents may be subsidized through state general funds. Subsidies are provided on a sliding scale based on income. In the group home program, services for nursing home eligible residents may also be covered under the Office on Aging's Medicaid waiver.

Service providers determine the cost of care in both models. In the multi-family model, the average monthly fee for services is $474, with an average monthly subsidy of $151 per resident. Rates for group homes range from $1000 to $2500 a month. The state subsidy is capped at $550 a month in non-waiver group homes. Participants pay the difference between the state subsidy and the monthly fee. The monthly fee is capped at $1200 for residents determined eligible under the GSAH Medicaid waiver. Waiver eligible residents pay 20% of the monthly fee for room and board.

Medication assistance

The Medicaid waiver allows approved providers, under the supervision of a registered nurse, to administer medications to waiver clients. Only persons who have successfully completed medication management training provided by the Office on Aging may administer medications. A registered nurse, under contract with the Area Agency on Aging, is required to monitor Medicaid approved homes at least every 45 days to assure that medications are administered properly.

Staffing

In both SAH models staff must be adequate to provide the required services. Under the Medicaid waiver at least 1 staff person must be on duty at all times for every 8 residents. Providers may be a physician, nurse or persons with three years of applicable experience.

MASSACHUSETTS

General Approach

Chapter 354 (Acts of 1994) was signed into law in early January 1995 and creates a process for the certification of assisted living facilities by the Executive Office of Elder Affairs. The law provides that the regulations "shall be sufficiently flexible to allow assisted living residences to adopt policies and methods of operation which enable residents to age-in-place." To be certified, residences must submit information such as the number of units and number of residents per unit, location of units, common spaces and egress by floor; base fees to be charged; services to be offered and arrangement for delivering care; number of staff to be employed and other information required by the Executive Office of Elder Affairs. The process does not require licensing or review of the building which must comply with state and local building codes. The buildings are considered residential use for applying codes.

Throughout the state, 42 assisted living residences (1636 units) are operating, 24 residences (1321 units) are under development. All 66 residences expect to become certified under the new legislation. The Massachusetts Housing Finance Agency (MHFA) and the Massachusetts Industrial Finance Agency (MIFA) provide loans for assisted living. The MHFA "Elder CHOICE program is designed to support development of appropriate housing and ADL assistance for frail elders. The agency's RFP says that assisted living offers a supportive residential environments which maximizes the ability of elders to live independently and reduces the need for costly institutionalization. The Medicaid Group Adult Foster Care program has certified 7 programs and 8 more applications are expected to be approved.

Definition

Assisted living residence, any entity, however organized, whether conducted for profit or not for profit, which meets all of the following criteria:

> Provides room and board; provides, directly by employees of the entity or through arrangements with another organization which the entity may or may not control or own, assistance with activities of daily living for three or more adults residents who are not related by consanguinity of affinity to their care provider and; collects payments or third party reimbursements from or on behalf of residents to pay for the provision of assistance with the activities of daily living.

Unit Requirements

Units must be single or double occupancy with lockable doors. New construction must provide for private baths. Existing buildings may qualify if they provide private half baths and one bathing facility for every three units. All residences must provide a kitchenette in each unit or access to cooking capacity. The Secretary of Elder Affairs is

authorized to waive the requirements for bathrooms and bathing facilities when determined to meet public necessity and to prevent undue economic hardship as long as the residence provides a homelike environment and promotes privacy, dignity, choice, individuality and independence.

Tenant Policy

The statute does not allow people needing 24 hour skilled nursing supervision to be admitted or retained in an assisted living residence. To qualify for reimbursement under the Medicaid Group Adult Foster Care program, tenants must require daily assistance with at least one ADL and assistance with managing medications as documented by a physician and a nursing assessment; be at risk of requiring nursing home placement; have been discharged from a nursing home; be chronically disabled; and require 24 hour supervision.

Services

Chapter 354 requires that residences all provide or arrange for opportunities for socialization and access to community resources; assistance with ADLs identified in a plan of care (at a minimum residences must offer support for bathing, dressing and ambulation); up to three meals daily; housekeeping; self-administered medication management; laundry; and the ability to respond to urgent or emergency needs.

Twenty four hour nursing services are not allowed. Skilled services may only be provided by a certified home health agency on a part time or intermittent basis not to exceed 90 days in a one year period. Medical conditions requiring services on a periodic, scheduled basis are also allowed. In addition, residents may "engage or contract with any licensed health care professional and providers to obtain necessary health care services ... to the same extent available to persons residing in private homes."

The MHFA Elder CHOICE program requires, at a minimum, personal care (assistance with bathing, dressing, continence, ambulation, toileting, eating and transfers); housekeeping and maintenance, laundry, medical monitoring and transportation, up to 3 meals a day, 24 emergency response and service coordination and case management.

Financing

The Massachusetts Housing Finance Agency and the Massachusetts Industrial Finance Agency provide loans for the construction of assisted living projects.

Services for low income tenants are Subsidized through Medicaid and the Executive Office of Elder Affairs. The Medicaid Group Adult Foster Care provides an average of $33.70 per day for services and administrative costs. The Elder Affairs program provides $817 a month.

Chapter 354 suspends approval of further SSI applications for the higher payment standard for assisted living residents pending a study of the economic affect of the program. The study has been completed and submitted to the legislature for further consideration. The study concluded that Medicaid saves $2,398 (average savings weighted by income) a year per recipient through the GAFC program and the SSI assisted living payment compared to nursing home costs. Based on terminations in the GAFC program, the study estimated that nursing home admission would be delayed an average of 8 months for 29% of the participants, avoided entirely for 31% of the participants who would die and another 39% who may return to another community option.

The state had received approval from the Social Security Administration for a separate payment standard of $920 a month for single individuals in assisted living. The regular community payment standard for an aged person living alone is approximately $550 a month. The higher standard was approved to provide a more realistic level of support for room and board which cannot be reimbursed by Medicaid for low income recipients.

Medications

Residence staff are allowed to remind residents to take medications, open containers, open prepackaged medications, reading the label, observe, check dosage against the label and reassure residents that the proper dosage has been taken.

Staffing

No staffing specific guidelines are included concerning the type and number of staff. However, the residence must maintain an ability to provide timely assistance to residents and to respond to urgent or emergency needs through on site staffing, personal emergency response or other means. Under draft regulations, all staff and contracted providers must receive a 6 hour orientation which includes the philosophy of independent living, resident bill of rights, abuse, safety and emergency measures, communicable diseases, communication skills, the aging process and resident health and related problems. Staff providing personal must complete an additional 54 hour training Course that includes 20 hours of personal care and 34 hours of general training. The personal care component must be taught by an RN. Personal care staff will be reviewed twice a year by a qualified nurse.

MINNESOTA

General Policy Approach

The Minnesota statute covers home care services which include nursing, personal care, therapies, nutritional services, home management and others which are delivered in a place of residence. The state has implemented an assisted living program through its state funded Alternative Care (AC) program and the Medicaid Home and Community Based Services Waiver program. Licensing is provided through regulations governing home care providers.

The Alternative Care Program serves nursing home eligible residents whose income exceeds Medicaid eligibility levels but who would spend down to Medicaid levels within six months if admitted to a nursing home. The HCBS waiver covers aged and disabled Medicaid recipients who meet the nursing home criteria.

Definition

Assisted living services are defined in the home care regulations as individualized home care aide tasks or home management tasks provided to clients of a residential center in their living units, and provided either by the management of the residential center or by providers under contract with the management. Individualized means chosen and designed specifically for each client's needs, rather than provided or offered to all clients regardless of their illness, disability or physical condition. Residential centers are defined as a building or complex of buildings in which clients rent or own distinct living units. Five classes of home care may be licensed including class E, assisted living license which covers the provision of "assisted living services to residents of a residential center."

The state's Medicaid waiver defines assisted living services as "up to 24 hour oversight and supervision, supportive services, home care aide tasks and individualized home management tasks provided to residents of a residential center living in their own units/apartments with a full kitchen and bathroom. A full kitchen includes a conventional stove with an oven, refrigerator, food preparation counter space and a kitchen utensil storage compartment. Supportive services include socialization (when socialization is part of the plan of care, has specific goals and outcomes established and is not diversional or recreational in nature), assisting clients in setting up meetings and appointments, and providing transportation (when provided by the residential center only). Individuals receiving assisted living services will not receive both homemaking and personal care services and assisted living services. Individualized means that services are chosen and designed specifically for each resident's need, rather than provided or offered to all residents regardless of their illness, disabilities or physical conditions.

Unit Requirements

The assisted living policies under the waiver require full apartments with kitchens.

Tenant Policy

Participants for the AC and Medicaid waiver programs must be screened by the county preadmission screening team and must meet the nursing home level of care criteria. Most residents fall into case mix categories A through D (see table).

Services

The regulations allow the provision of assisted living services which include home care aide and home management tasks provided to clients of a residential center within living units and provided by management or by providers under contract with the center. Home care aide tasks are differentiated from home health aide and include assisting with dressing, oral hygiene, hair care, grooming and bathing, if the client is ambulatory and has no serious illness or infectious disease, preparing modified diets, medication reminders, household chores in the presence of technically sophisticated medical equipment or episodes of acute illness of infectious disease.

The Medicaid waiver defines services as "supportive services include socialization (when socialization is part of the plan of care, has specific goals and outcomes established and is not diversional or recreational in nature), assisting clients in setting up meetings and appointments, and providing transportation (when provided by the residential center only). Individuals receiving assisted living services will not receive both homemaking and personal care and assisted living services. Individualized means that services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illness, disabilities or physical conditions.

Under the AC and Waiver programs, residents may also receive home health and skilled nursing which are reimbursed separately from the payment for assisted living services.

Financing

Rates are negotiated between the client and the provider with limits based on the client's case mix classification. Service rates under the AC program cannot exceed the state's share of the average monthly nursing home payment. The client pays for room and board (raw food costs only - meal preparation is covered as a service). The cost of services in addition to assisted living services may not exceed 75% of the average nursing home payment for the case mix classification. Under the HCBS waiver, rates for assisted living services are also capped at the state share of the average nursing home

payment and the total costs, including skilled nursing and home health aide, cannot exceed 100% of the average cost for the client's case mix classification.

Statewide maximum FY 94 rates for elderly recipients ranged from $565 a month to $1330 a month depending upon the case mix classification. Rates in a particular county could be higher or lower than the averages. Rates for participants with physical disabilities ranged from $597 to $1361. These rates are in effect in 1995 (see table).

Medications

Assistance with self-administration is allowed.

Staffing

The Department of Health's standards for home care services licenses do not apply to the building itself.

Minnesota Case Mix Categories and Average Rate Limits

Category	Rate		Description
	Elderly	Disabled	
A	$565	$597	Up to 3 ADL dependencies[1]
B	$638	$671	3 ADLs + behavior
C	$722	$755	3 ADLs + special nursing care
D	$798	$831	4-6 ADLs
E	$876	$9090	4-6 ADLs + behavior
F	$881	$914	4-6 ADLs + special nursing care
G	$948	$980	7-8 ADLs
H	$1073	$1105	7-8 ADLs + behavior
I	$1117	$1150	7-8 + needs total or partial help eating (observation for choking, tube or IV feeding and inappropriate behavior)
J	$1186	$1218	7-8 + total help eating (as above) or severe neuro-muscular diagnosis or behavior problems
K	$1330	$1363	7-8 + special nursing

1. ADLs include bathing, dressing, grooming, eating, bed mobility, transferring, walking and toileting.

NEW JERSEY

General Policy Approach

Regulations took effect in December 1993 governing the provision of assisted living services in assisted living residences and comprehensive personal care homes. The regulations are intended to promote aging in place in homelike, apartment style settings for frail elders. The purpose section of the regulations describes the goals of assisted living to "maintain independence, individuality, privacy, dignity" in an environment that "promotes resident self direction and personal decision making while protecting health and safety."

State policy makers intended to allow the provision of assisted living in a range of settings, including conventional elderly housing projects. Because of conflicts between HUD policy and state licensure, the regulations do not apply to conventional housing. Any facility requiring a license is considered a medical facility under HUD rules and therefore ineligible for HUD subsidies. New Jersey has received a demonstration grant from the Administration on Aging to implement an assisted living service model from which appropriate standards can be developed.

As of February, 1995, 3 facilities have been licensed and 15 proposal were pending.

Definition

Assisted living "means a coordinated array of supportive personal and health services, available 24 hours per day to residents who have been assessed to need these services, including residents who require formal long term care. Assisted living promotes resident self direction and participation in decisions that emphasize independence, individuality, privacy, dignity and homelike surroundings."

Unit Requirements

The regulations define an assisted living residence as "a facility which is licensed by the Department of Health to provide apartment-style housing and congregate dining and to assure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor." Each unit must offer one unfurnished room (minimum 150 square feet of clear and useable floor area), private bathroom, a kitchenette and a lockable door on the unit entrance. The kitchenette must include a small refrigerator, cabinet for food storage, sink, and space with outlets suitable for cooking appliances such as a microwave, cook top or toaster oven." An additional 80 square feet of floor space must be provided in for each additional person occupying a unit.

Tenant Policy

Assisted living is not appropriate for people who are not capable of responding to their environment, expressing volition, interacting or demonstrating independent activity. Each resident receives an assessment and a care plan by a registered nurse. The residence may, but is not required to, care for people who require 24 hours, seven day a week nursing supervision, are bedridden longer than 14 days, consistently and totally dependent in four or more ADLs, have cognitive decline that interferes with simple decisions, require treatment of stage three or four pressure sores or multiple stage two sores, are a danger to self or others or has a medically unstable condition and/or special health problems. The admission agreement has to specify if the facility will retain residents with one or more of these characteristics and the additional costs which may be charged.

Services

The residence must provide or coordinate services. The minimum service capacity must include personal care, nursing, pharmacy, dining, activities, recreation, and social work services to meet the individual needs of residents.

Financing

State officials are examining options for financing assisted living for low income residents.

Medications

Residences are allowed to provide supervision of and assistance with self-administration of medications and administration by trained and supervised personnel.

Staffing

The regulations require at least one awake staff member and one additional staff at night and sufficient staffing to provide the services indicated by the assessments of resident needs. A registered nurse must be available on staff or on call 24 hours a day. Administrators must either be licensed as a nursing home administrator or complete an assisted living training course approved by the Department of Human Service or equivalent training approved by the Department of Health within one year of their employment as an administrator. In addition they must complete 10 hours of continuing education a year. Personal care assistants must complete a nurses aide training course, a homemaker-home health aide training program or equivalent training approved by the Department of Health.

NEW YORK

General Approach

In 1991, the state legislature created an assisted living program (ALP) and authorized contracting for 4200 units. Since the program substitutes for nursing home beds, the nursing home bed need formula was reduced by an equivalent amount. By 1994, 63 projects totalling 3500 units had been approved through a state contracting process. Fourteen sites are operational. An RFP process has been implemented for 700 units in New York City. The budget submitted by Governor Pataki would repeal the program as part of a proposed Medicaid savings plan.

The state approaches assisted living as a service option in existing housing. Assisted living programs must hold a licensed as an adult home or enriched housing program (which address housing) and a license as a licensed home care services agency or a certified home health agency or a long term home health care agency (which address service delivery).

Oversight is spread among a number of state agencies. The Department of Health reviews licenses for licensed home care agencies and the Department of Social Services licenses adult homes and enriched housing.

Adult homes and enriched housing programs are both licensed under the state's adult care facility regulations. Both models serve five or more people and provide long term residential care, room, board, housekeeping, personal care and supervision. Adult homes represent the state's board and care model while enriched housing programs operate in community integrated settings resembling independent housing units.

Definition

Assisted Living Program (ALP): An entity which is approved to operate pursuant to section 485.6(n) of this Title, and which is established and operated for the purpose of providing long term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible adults unrelated to the operator.

Unit

Adult homes provide single or double occupancy bedrooms and have 1 toilet and lavatory for every six residents and 1 tub/shower for every 10 residents.

Enriched housing programs must provide single occupancy units, unless shared by agreement, and each unit must include a full bathroom, living and dining space, sleeping area and equipment for storing and preparing food. Shared units must provide for toilets, lavatory, shower or tub shared by not more than 3 residents.

Tenant Policy

To receive state reimbursement, tenants must be assessed by a physician to need nursing home care. Participants must have stable medical conditions and are able to assure self-preservation in an emergency. Operators may not serve anyone requiring continual nursing or medical care; is chronically bedfast or chairfast and requires lifting equipment or two person assist for transfer; or is cognitively, physically or medically impaired to a degree which endangers the safety of the resident or other residents.

Services

Adult homes and enriched housing programs can provide supervision, personal care, case management, activities and food service under their adult care facilities license. To operate as an assisted living program, additional services and licenses are needed. The facility may seek a license to provide nursing care and therapies or they may contract with a home health agency or a long term home health care program.

The capitation rate covers personal care, home health aide, personal emergency response, nursing services, physical therapy, occupational therapy, speech therapy, medical supplies that do not require prior authorization and adult day health care, if needed.

A care plan is jointly developed by the ALP and the CHAA/LTHHP which reflects physician's orders and the assessment process.

Financing

Subsidies are available for Medicaid recipients. The service reimbursement is set at 50% of the resident's Resource Utilization Group (RUG) which would have been paid in a nursing home. The state has created RUG rates for 16 geographic areas of the state. There are two groups of RUGs, one for health related services and another for skilled services. Payments based on RUGs for ALP residents (50% of the amount paid in a nursing home) for the four health related categories range from $51.04 to $66.54 a day in New York City to $31.07 to $39.53 in northern rural areas of the state. The rate for skilled nursing RUGs range from$ 74.57 to $104.88 a day in New York City to $43.85 to $60.35 in northern rural areas.

The reimbursement category is determined through a joint assessment by the Assisted Living Program and the designated home health agency or long term home health care program. The assessment and the RUG category are reviewed by the Department of Social Services district office. The residential services (room, board and some personal care) is covered by SSI which also varies by region. In 1994, the SSI rates were $881 in New York City, Nassau, Suffolk and Westchester counties and $851 in the rest of the state.

Medication

Assistance with self-administration is allowed including prompting, identifying the medication for the resident, bringing the medication to the resident, opening containers, positioning the resident, disposing of used supplies and storing the medication.

Staffing

Adult homes must have a case manager and staffing that is sufficient to provide the care needed by residents. Staff providing personal care must complete a home health aide training course or other examination approved by the Department of Health. Adult home staff must provide 3.5 hours of service staff time per resident per week for personal care, 1 hour per resident per week for housekeeping and 2 hours of food service time per resident per week.

Enriched housing programs must staff to provide a total of 6 hours per resident per week for housekeeping, personal care and food service which can be allocated based on aggregate resident needs.

NORTH CAROLINA

General Approach

A 31 member "Steering Team" has made recommendations to the Secretary of the Department of Human Resources that would establish assisted living as an umbrella concept that includes a variety of models in two basic categories -- multi-unit independent housing and adult care homes, including family care homes. The Team included state and county agencies, advocacy groups, nursing home, housing and adult care home providers, legislators and others. The group met 9 times between August 1993 and January 1995 and five subcommittees were formed that met regularly between meetings. The Team established four goals for the model:

- assure that adults of all ages and adults with disabilities receive high quality care and services;
- protect individuals' safety and well-being;
- reserve individual rights and dignity; and
- allows diversity in service delivery models.

Quality of care would be assured through the development of outcome measures rather than rules that rely on structure and process. The report supports passage of legislation creating an assisted living program in 1995 and the development of regulations to implement the legislation by 1996.

Definition

The Team's recommendation would define assisted living "as any group housing and services program for two or more unrelated adults, by whatever name it is called, which makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care agencies. Nursing services provided to an individual in an assisted living resident may not exceed those allowed under Medicare home health regulations.

Unit Requirements

Settings in which services are delivered may include selfcontained apartment unit or single or shared room units with private or area baths. Residential building codes would apply to adult care homes serving 6 or fewer residents and institutional codes to adult care homes service more than 6 residents.

Tenant Policy

Multi-unit independent models serve residents that are independent enough to arrange for the provision of their personal care and will not require 24 hour supervision. Adult care homes will service a population that is more mentally or physically dependent needing 24 hour supervision and assistance with personal needs.

Services

In multi-unit housing, one to three meals would be served and no resident monitoring or supervision would be provided by staff of the housing provider. In adult care homes, three meals would be provided in adult care homes. Personal care would be provided in both settings as well as nursing services that do not exceed the Medicare definition.

The mental health system would provide services to personal with developmental disabilities and mental health condition in adult care homes.

Financing

The report recommended that the Division of Medical Assistance investigate the use of funds to reimburse for personal care and that the personal needs allowance either be increased or that personal care supplies be included in the standard rate.

Medication

Not addressed in the report.

Staffing

Not addressed in the report.

NORTH DAKOTA

General Approach

Assisted living is viewed as a service in an apartment setting. The state reimburses assisted living through its Medicaid Home and Community Based Services Waiver and state funded service programs. Licensing is not required however, the public welfare statute contains a definition of assisted living. While only one provider participates in the programs, state officials note that interest from other potential providers has increased. The current site is a mixed population site funded by HUD for people with mobility impairments. The state assisted living programs provides services to residents in fifteen of the twenty apartments.

Definition

An environment where a person lives in an apartment like unit and receives services on a twenty four hour basis to accommodate the person's needs and abilities and maintain as much independence as possible.

Unit Requirements

An apartment setting is required.

Tenant Policy

Participants in the service programs must have needs that can be met through the program. To qualify for services, residents must have impairments in 4 ADLs or impairments in 5 IADLs totalling 8 points (see below) or 6 points if the person lives alone.

Services

The program provides environmental and personal services to participants.

Financing

The state has four sources of financing: an HCBS waiver for the aged, blind and disabled, an HCBS waiver for people with traumatic brain injuries, and two state funded programs - service payment for elderly and disabled and the exceptional service payment for the elderly and disabled. The programs pay providers a rate based on the care needs of the resident. The maximum rate is $50 a day. A point system is used to convert unmet service functional needs to a rate (see table). The total points are multiplied by a factor of 8 to obtain a monthly payment rate.

Medications

The state's nurse practice act allows assistance with self-administration but not the direct administration except by licensed staff. No separate requirement outside the nurse practice act are included.

Staffing

Must be able to deliver the necessary services required by plans of care.

North Dakota Point System			
Activity		**Value**	
Taking Medication	1	Foot Care	10
Temp\Pulse\Resp\BP	1	Nail Care	10
Managing Money	1	Change Dressings	10
Communication	1	Apply Elastic Bandage	10
Shopping	6	Care of Prosthetic	10
Housework	6	Medical Gases	10
Laundry	6	Meal Preparation	20
Mobility	6	Exercise	20
Transportation	6	Water Bath/Heat	20
Bathing	15	Ostomy Care	20
Teeth/mouth care	15	Bowel Program	20
Dress/undress	15	Indwelling Catheter	20
Toileting	15	Bronchial Drainage	20
Transfer	10	Feeding/eating	20
Continence	15	Supervision Level I	15
Eye Care	10	Supervision Level II	30
Skin Care	10		

OHIO

General Approach

In July 1993, chapter 3726 was signed that created an assisted living program. In April 1994 the Department of Health issued draft regulations and a Medicaid Home and Community Based Services Waiver proposal was submitted to HCFA. Implementation of the program was planned for July 1, 1994. As the process for developing the regulations proceeded, segments of the assisted living and nursing home industries expressed concerns about the model and the direction of the regulations. An amendment was passed that delayed the effective date of regulations pending a review by a special committee consisting of 6 legislators, 4 state agencies 4 provider groups (3 nursing home and 1 assisted living), the Area Agency on Aging Association, the Ombudsman Association, AARP and a taxpayer group.

The task force was created to address opposition to Chapter 3726 and the proposed regulations dealing with the unit requirements, the level of services provided in assisted living and the medical conditions of tenants. While a formal consensus report was not submitted, the governor's budget included several proposals contained in the draft report. The budget bill would repeal the assisted living statute and create a new category of residential care facility to replace the current rest home classification. Residential care facilities would be able to provide up to 120 days of skilled nursing services with exceptions for special diets, medication administration and dressing changes.

The current statute describes a licensing role for the Department of Health to regulate the services provided, and general requirements for the living unit. The policy focuses on the services rather than the setting which must comply with local building codes.

Definition

Chapter 3726 defines an assisted living facility as "a multiple unit residential facility, other than ... that provides or arranges for skilled nursing care for one or more individuals who reside in the facility and are not related to the owner or operator of the facility or his spouse as a parent, grandparent, child, sibling, niece, nephew or child of an aunt or uncle."

Unit Requirements

The current law specifies that the facility must consist of single occupancy units (unless shared by choice) containing private cooking, bathing, washing, and toilet facilities, has doors that can be locked and individual temperature controls, is equipped with automatic sprinkler equipment. The facility must be approved by the local building department rather than the Health Department.

Tenant Policy

Assisted living facilities may not admit anyone who requires skilled nursing care on a 24 hour a day basis or retain a resident for a period longer than is necessary to complete an appropriate transfer. Residents requiring 24 hours of care for more than 30 days, or have medically complex needs requiring constant nursing supervision, assessment, planning or intervention or require direct supervision of licensed nursing personnel may not be served.

The statute allows facilities to serve residents requiring skilled care for up to 120 days. Exceptions to the 120 day limit allow residents receive dressing changes, special diets and medication administration.

Services

The law provides that an assisted living facility must provide or arrange for services needed or requested be the resident such as skilled nursing care, supervision, personal care services including assistance with self-administration of medications, homemaker services, therapies and other services specified by the Director of the Department of Health. A home and community based services waiver application was submitted, and later withdrawn, to HCFA to finance services for Medicaid recipients. The governor's budget includes funding for waiver services. A new waiver will be submitted following adoption of the budget recommendation.

Financing

The budget proposal includes $4.4 million for the Department of Aging to develop an assisted living program through a Medicaid Home and Community Based Services waiver and to subsidize room and board payments. The Department of Aging has developed a five tiered system for determining the level of reimbursement (see table). Rates will range from $200 to $1400 a month. A residential State Supplement of $700 a month will be paid to cover room and board costs.

Medications

Non-licensed staff may assist with self-administration. Activities include reminders, observing, handing medications to the resident, verifying the resident's name on the label, removing oral or topical medications from containers, applying medication upon request, placing containers with medication to the mouth of the resident.

Staffing

At least 1 staff member must be on-site at all times. In addition, sufficient staff time must be available to meeting a timely manner the residents' care, supervisory and emotional needs and reasonable requests for service, including ongoing supervision of

residents with increased emotional needs or presenting behaviors that cause problems for the resident or other residents and to properly provide dietary, housekeeping, laundry and facility maintenance services and recreational activities. An RN, LPN or physician must be on duty when medications are being administered. Staff may be shared with other licensed facilities in the same building or in the same lot as long as staffing requirements for all facilities are met.

Ohio Assisted Living Waiver Service Levels	
Service Level	**Minimum Waiver Service Needs**
One	• Assistance with 2 secondary ADLs
Two	• Assist with 1 primary ADL & 1 secondary ADL; or • Level one + medication administration; or • Level one + behavior management; or • Level one + plus unstable medical condition; or • Level one + daily skilled nursing services not covered under the state Medicaid Plan
Three	• Assist with 4 ADLs (any type); or • Assist with 3 ADLs (including 1 primary ADL) plus medication administration; or • Level two plus behavior management; or • Level two plus unstable medical condition; or • Assist with 3 ADLs (including one primary ADL) plus daily skilled nursing services not covered under the state Medicaid Plan.
Four	• Assist with 5 ADLs (any); or • Assist with 4 ADLs (any) plus medication administration; or • Level three plus behavior management; or • Level three plus unstable medical condition; or • Assist with 4 ADLs (any) plus daily skilled nursing services not covered under the state Medicaid Plan.
Five	• Assist with 5 ADLs plus medication administration AND daily skilled nursing services not covered under the state Medicaid Plan; or • Level four plus behavior management; or • Level four plus unstable medical condition.

OREGON

General Approach

The state has adopted assisted living regulations and policies which encourage the use of the arrangement to substitute for nursing homes and to offer home-like environments which enhance dignity, independence, individuality, privacy, choice and decision making. Facilities are required to have written policies and procedures which describe how they will operationalize these principles.

Definition

"Assisted living means a program approach, within a physical structure, which provides or coordinates a range of services, available on a 24 hour basis, for support of resident independence in a residential setting. Assisted living promotes resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and home-like surroundings."

Unit Requirements

Each unit must provide 220 square feet of space, not including a private bathroom. Units in pre-existing structures may provide 180 square feet. Units must have kitchen with a sink, refrigerator, cooking appliance and space for food preparation and storage, individual heat controls, lockable doors and a phone jack. Buildings must meet applicable zoning and building codes.

Tenant Policy

The regulations specify "move out" criteria that allow residents to choose to remain their living environment despite functional decline. Facilities may ask residents to leave if the resident's behavior poses an imminent danger to self or others, if the facility cannot meet the resident's needs or services are not available, non-payment or the resident has a documented pattern of non-compliance with agreements necessary for assisted living.

Services

An interdisciplinary team conducts an assessment with each resident and develop a plan that responds to their needs. Services include assistance with ADLs, nursing assessment, health monitoring, routine nursing tasks, medication assistance, housekeeping, three meals a day, laundry, and opportunities for socialization that utilizes community resources.

Each facility must also have the capability to provide or arrange for medical and social transportation, ancillary services for medically related care, barber/beauty

services, social/recreational, hospice, home health and maintenance of a personal financial account for residents.

Financing

The state provides five levels of payment for Medicaid recipients residing in assisted living settings. Residents must meet the nursing home level of care criteria. The levels are assigned based on a service priority score determined through an assessment (see table below). ADLs include eating/nutrition, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder control and behavior.

Service priority ratings are assigned based on the number and type of impairments in ADLs. Service priority A is assigned to people who are dependent in 3-6 ADLs; priority B dependent in 1-2 ADLs (see table).

Oregon Service Priority Categories and Payment Rates		
Impairment Level	**Service Priority**	**Rate**
Level V	Service priority A or priority B and dependent in the behavior ADL.	$1586
Level IV	Service priority B or priority C with assistance required in the behavior ADL.	$1283
Level III	Service priority C or priority D with assistance required in the behavior ADL.	$978
Level II	Service priority D or priority E with assistance required in the behavior ADL.	$736
Level I	Service priority E or F or priority G with assistance required in the behavior ADL.	$553

Medications

The regulations allow residents to keep medications in their unit if they are capable of self-administration. Facilities are allowed to administer medications and they must have medication administration policies and procedures which assure all administered medications are reviewed every 90 days.

Staffing

The regulations do not specify staffing requirements. Each facility must have sufficient staff to deliver the services specified in resident plans of care.

Service Priority Categories	
Category	**Impairments**
A	Dependent in 3-6 ADLs
B	Dependent in 1-2 ADLs
C	Requires assistance in 4-6 ADLs
D	Requires assistance in 3 critical ADLs
E	Requires assistance in 2 critical ADLs
F	Requires assistance in 3 ADLs
G	Requires assistance with 1 critical ADL and meets conditions of at least 1 other essential factor or requires assistance with 1 critical ADL and 1 less critical ADL.
NOTE: critical ADLs are bowel and bladder control, eating/nutrition, behavior/cognition; less critical ADLs are dressing/grooming, bathing/personal hygiene, mobility.	

RHODE ISLAND

General Approach

The state's regulations use the term "residential care and assisted living facilities." Only 45 homes are licensed and about half were previously licensed as ICFs. The program is equivalent to board and care.

Definition

Rhode Island regulations define "residential care and assisted living facility means a publicly or privately operated residence that provides personal assistance lodging and meals to two or more adults who are unrelated to the licensee or administrator, excluding however, any privately operated establishment or facility licensed pursuant to" other statutes.

Unit Requirements

The regulations allow double occupancy. Older homes have shared baths while newer buildings provide private baths in each unit.

Tenant Policy

Two levels of licensing are allowed. Level I cares for residents who are capable of self-preservation, take their own medications and are ambulatory. Level II residents are not capable of self-preservation, need nursing assistance to take medications and require assistance with personal hygiene. Residents needing skilled care cannot be served.

Services

The regulations define personal assistance as 24 hour adult staffing of the home, and of one or more of the following services, as required by the resident or as reasonably requested by the resident, including: assisting the resident with personal needs; self administration of medication, or administration of medications by appropriately licensed staff, assisting in arranging for supportive services, monitoring activities, reasonable recreational, social and personal services. Homes cannot provide skilled care.

Medication

RNs must administer medications and monitor health conditions. Unlicensed staff may only remind residents to take their medications and observe, Staff must have 4 hours of training by an RN regarding policies and procedures and have passed an exam based on the training.

Staffing

Must be sufficient to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being of the residents, according to appropriate level of licensing.

TEXAS

General Approach

Assisted living services are included in the state's Medicaid Home and Community Based Services waiver program.

Definition

Assisted living/residential care services provide a 24 hour living arrangement for persons who, because of a physical or mental limitation, are unable to continue independent functioning in their homes. Services are provided in personal care facilities licensed by the Texas Department of Human Services (DHS). In effect the rules recognize 3 types of units provided in licensed personal care facilities. Nursing facility waiver participants are responsible or their room and board costs and, if applicable, copayment for assisted living/residential care services.

Unit Requirements

The program guidelines differentiate between assisted living apartments, residential care apartments and residential care non-apartments. Assisted living apartments must provide each participant a separate living unit to guarantee their privacy, dignity and independence. Units must include individual living and sleeping areas, a kitchen, bathroom and adequate storage. Units must provide 220 square feet, excluding bath, but units in remodeled buildings may provide 160 square feet. Double occupancy units may be provided if requested.

Residential care apartments must be double occupancy with a connected bedroom, kitchen, and bathroom area providing a minimum of 350 square per client. Indoor common space used by residents may be counted in the square footage requirement. Kitchens must be equipped with a sink, refrigerator, cooking appliance (stove, microwave, built-in surface unit) that can be removed or disconnected and space for food preparation.

Residential care non-apartments is a licensed personal care facility which do not meet either of the above definitions. These units may be double occupancy units in free standing buildings that have 16 or less beds.

Tenant Policy

Not stated.

Services

Services that must be available provided include personal care, administration of medications, home management (housekeeping), escort, 24 hour supervision, social and recreational activities and transportation.

Financing

The Medicaid waiver provides $29.39 a day for services in single occupancy assisted living apartments, $22.96 a day for double occupancy residential care apartments and $18.99 a day for residential care non-apartments. The SSI payment for room and board is $11.88 a day.

Medications

The waiver rules allow the direct administration of all medications or the assistance with or supervision of medication.

Staffing

Not described.

UTAH

General Approach

The state's regulations establish assisted living as a place of residence where elderly and disabled persons can receive 24 hour individualized personal and health related services to help maintain maximum independence, choice, dignity, privacy, and individuality in a home-like environment. The rules provide for 3 levels of license: large facilities, 15 or more residents; small facilities 6-16 residents; and limited capacity facilities, up to 5 residents.

Program rules have been approved and rules for construction of assisted living facilities were approved March 17th and were expected to be effective by July, 1995.

Definition

HB 201, which was passed during the 1994 legislative session, defines assisted living as "a residential facility with a homelike setting that provides an array of coordinated supportive personal and health care service, available 24 hours per day, to residents who have been assessed under division rule to need any of these services. Each resident shall have a service plan based on the assessment, which may include: specified services of intermittent nursing care, administration of medication, and supportive services promoting residents' independence and self-sufficiency.

Unit Requirements

A residential living unit means a one or two bedroom unit which may also include a bathroom and additional living space. A maximum of two residents may occupy a resident living unit. Additional living space means a living room, dining space and kitchen facilities, or a combination of these facilities, in a resident living unit. Units must have lockable doors and tenants must have a key.

Facilities providing only bedrooms must provide a toilet and lavatory for every four residents and a bathtub or shower for every 10 residents. Occupancy units without additional living space must be a minimum of 120 square feet for single occupancy units and 200 square feet for double occupancy units. Bedrooms in units that do provide additional living space must be at least 100 square feet for single units and 160 square feet for double units.

Tenant Policy

Facilities may not serve anyone who requires inpatient hospital care or 24 hour continual nursing care that will last more than 15 calendar days or people who cannot evacuate without physical assistance of one person. Written acceptance, retention and transfer policies are required of each facility. Facilities may not accept anyone who is

suicidal, assaultive or a danger to self or others, has active tuberculosis or other communicable disease that cannot be adequately treated at the facility or on an outpatient basis or may be transmitted to other residents through general daily living.

Physician's statements are required that document the resident's ability to function in the facility and describing the following information: whether the resident's health condition is stable, free from communicable disease, allergies, diets, current prescribed medications with dose, route, time of administration and assistance required, physical or mental limitations and activity restrictions.

The rules allow pets to be kept if permitted by local ordinances.

Services

Facilities must provide personal care, food service, housekeeping, laundry, maintenance, activity programs, medication administration and assistance with self-administration and arrange for necessary medical and dental care.

Financing

The state plans to amend its Medicaid Home and Community Based Services Waiver in May to add assisted living as a service. Rates for the program have not been developed.

Medications

Facilities are allowed to provide medication administration by licensed staff and assistance with self-medication by unlicensed staff (opening containers, reading instructions, checking dosage against the label, reassuring the resident that the correct dosage was taken and reminding residents that a prescription needs to be refilled.

Staffing

Direct care staff are required on-site 24 hours a day to meet resident needs as determined by assessments and service plans.

VIRGINIA

General Approach

The state is revising its adult care residence (ACR) regulations to include assisted living which is described as a service in ACRs rather than a setting or a building. The summary is based on the draft regulations dated 6/94. The regulations are expected to be finalized and implemented by July, 1995. A Medicaid HCBS waiver will be sought to provide funding for Medicaid recipients when the regulations are finalized.

Definition

Assisted living means a level of service provided by an adult care residence for adults who may physical or mental impairment, and require at least a moderate level of assistance with activities of daily living. Moderate level of assistance means dependency in two or more ADLs.

Unit Requirements

The regulations do not change the unit requirements. ACRs may offer single rooms (minimum 100 square feet for newer buildings) or multiple occupancy rooms (80 square feet per occupant). Facilities must provide one toilet and wash basin for every seven people and one bath tub for every ten people.

Tenant Policy

ACRs cannot admit or retain residents with the following conditions or needs:

- Ventilator dependent
- Dermal ulcers (III or IV)
- Intravenous therapy or injections directly into the vein.
- Airborne infectious disease in a communicable state.
- Psychotropic medications without an appropriate diagnosis and treatment plan.
- Nasogastric tubes/gastric tubes.
- Individuals who present a danger to themselves or others.
- Individuals requiring continuous nursing care.
- Individuals whose physician certifies that placement is no longer appropriate.
- Individuals who require maximum physical assistance as documented by an assessment.
- Individuals whose health care needs cannot be met in the specific ACR.

Public residents must have an assessment completed by a case manager. Assessments for private pay residents may be completed by a case manager, an independent private physician, or an employee of the facility who meets the

qualifications of a case manager and assessments by facility workers must be signed by an independent physician.

Services

The policy offers ACRs the flexibility to develop a program and service plan that meets the following criteria:

- Meet physical, mental, emotional and psycho-social needs,
- Provide protection guidance and supervision;
- Promote a sense of security and self worth; and
- Meet the objectives of the service plan.

Each facility develops a written program description for prospective residents that describes the population to be served and the program components and services available. Facilities are permitted but are not required to offer all services as long as they have services that are appropriate for the needs of residents.

Financing

A service rate of $180 a month to cover personal care services is anticipated. Nursing care would not be covered in the rate.

Medications

Self-administration of medications is allowed although assistance with self-administration is not described in the regulations. Medication administration is permitted when licensed staff are available or a medication training program approved by the board of nursing has been completed.

Staffing

Staffing patterns must be appropriate to deliver the services required by the residents as described in the plans of care.

WASHINGTON

General Approach

The state initiated its assisted living program as a pilot effort in 1 site in 1989. A larger demonstration began in July, 1991. Thirty five facilities, representing 1200 units had signed contracts as of January 1995 and contracts with 14 facilities, with approximately 800 units, were pending. Of the 1200 units, 300 are occupied by Medicaid recipients. The Department of Aging and Adult Services has budgetary authorization to contract for 1030 state funded units. Contracting for new units for Medicaid recipients requires adding capacity through new construction or contracting with existing facilities whose availability varies with resident turn over rates. State policy limits the percentage of units that they will contract for in a facility.

Based on demonstration experience, the Department of Aging and Adult Services has developed draft regulations codifying its contract requirements. Proposed regulations will establish contract requirements. Until regulations are issued, the program requirements are contained in "Assisted Living Facility and Service Contract" between the state agency and facilities which must be licensed under the boarding home rules. The regulations are expected to be finalized by June, 1995.

Definition

"Assisted living means a coordinated array of personal care, health services and other supportive services available 24 hours per day to residents who have been assessed to need these services. Assisted living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, choice and residential surroundings."

Unit Requirements

The contract requires that facilities provide a home-like environment enhancing the dignity, independence, individuality, privacy, choice and decision-making ability of residents. In addition to meeting boarding homes rules, the contract requires that units are private, personally furnished apartments with an accessible shower, kitchen area, lockable door and mail box. Units must be at least 220 square feet and include an interactive communication unit or an emergency response system monitored 24 hours a day. Kitchens must have a refrigerator and a microwave oven or a two burner stove. Each unit must be wired for television and telephone service. Homes built and occupied prior to July 1, 1993 may provide a community kitchen rather than kitchens within each unit. Existing facilities must provide a minimum of 180 square feet.

Tenant Policy

Residents may be required to move when their needs exceeds the services provided through the contract with the state agency; the resident places themself or others at an unreasonable risk; the resident has failed to make proper payments for services; or the resident requires a level of nursing care that is exceeds what is allowed by the boarding home license.

Services

Facilities must develop a negotiated service plan. Services include personal care, nursing services, social services, consultation (dietician, pharmacist), social/recreational activities, 3 meals, housekeeping and laundry. Nursing services are differentiated by licensure category. RNs or LPNs may provide insertion of catheters, nursing assessments, and glucometer readings. Unlicensed staff may provide the following under supervision of an RN or LPN: stage one skin care, routine ostomy care, enema, catheter care, and wound care. Unlicensed staff may provide assistance with transfer, mobility, hygiene and incontinence.

Financing

Currently, the reimbursement rate for Medicaid recipients who meet the nursing home level of care criteria is $47.37 a day that includes the SSI payment for room and board of $20.31 a day and a Medicaid payment of $27.06 for services. The Aging and Adult Services Division is considering a tiered rate structure with three levels for light, moderate and heavy care. The levels will reflect number and type of ADL impairments and the extent to which mental health and dementia issues affect the intensity of service delivery.

Medications

Medication administration is covered under the boarding homes rules. The boarding home rules allow for reminders, assistance with self-administration and administration of medications by licensed staff. Changes in the nurse practice act to allow nurse delegation is pending in the legislature.

Staffing

RNs or LPNs are required to be available on site 5 hours a day, 7 days a week and on call 24 hours a day to provide services listed in the negotiated service agreements. Other staff must be sufficient to deliver services identified in service agreements. New staff must receive 5 hours of training and monthly in-service on assisted living values and principles.

WISCONSIN

General Approach

An Assisted Living Advisory Committee developed a draft report in 1994 which described an assisted living model for Wisconsin. The governor has submitted legislation as part of the budget proposal to permit development of assisted living facilities in the state. In the proposed budget legislation, assisted living facilities would be unregulated unless they serve Medicaid recipients, in which case, they would have to be certified by the state. If passed, rules implementing the legislation would be submitted by December 1, 1995 to the Department of Administration and to the joint legislative council by January 1, 1996. The program would be effective in July 1996. The Department is likely to use the recommendations of the advisory committee as a basis for developing the certification requirements for facilities seeking reimbursement for Medicaid recipients.

The draft report emphasized a philosophy that is the basis of the long term care system called RESPECT (relationships, empowerment to make choice, services to meet individual needs, physical and mental health services, enhancement of participant reputation, community and family participation and tools for independence).

Definition

The budget legislation defines assisted living as a place where five or more adults reside that entirely consists of independent apartments, each of which has an individual lockable entrance and exit and individual separate kitchen, bathroom, sleeping and living areas, and that to a person who residents in the place provides not more than 28 hours per week of services that are supportive, personal and nursing services.

Unit Requirements

As stated in the definition, the proposal will require individual apartments.

Tenant Policy

State funding would be provided to Medicaid recipients who meet the nursing home level of care criteria through the Medicaid Community Options Program Waiver (COP-W) and the Community Integration Program (CIP). CIP funding is only available when nursing home beds are closed and funding is transferred to provide community care to replace the closed capacity. The legislation addresses the type of resident who may be served through the 28 hour per week cap on services. Tenants needing more care could not be supported in assisted living. The regulations that will be developed following passage of the bill may address the types of residents who may be served as opposed to the amount of reimbursement that will be provided for Medicaid tenants.

The advisory committee report set the 28 hour threshold as the minimum service need before a facility could discharge a resident although facilities choose to serve residents requiring more than 28 hours of service.

The draft report from the advisory committee recommended that facilities be allowed, but not required to, deny admission to people with chronically unstable medical conditions which require the availability of a nurse 24 hours a day; residents who are unable to recognize danger; residents who require hands on assistance with eating or swallowing; require two person transfer; are incontinent and cannot self-manage or control their incontinence through a reasonable schedule of reminders and/or toileting assistance; ventilator dependent; and other conditions. Facilities may care for people with such conditions if they are adequately staffed to do so.

Services

The budget legislation sets a limit of 28 hours a week for supportive nursing and personal care services. However, the advisory committee concluded that assisted living residents may require more care than people in the community and the threshold was devised to prevent facilities from discharging residents prematurely. The threshold was developed based on an analysis of the amount of care required by participants in the state's Community Options (Medicaid Waiver) program and the Community Integration Program and reflects a higher level of care than the average community client. Rules defining supportive services and nursing services will be developed for purposes of reimbursement.

The draft report recommended the following as required services: housekeeping, laundry, three meals a day, personal care, assistance with transferring, mobility assistance, provide or arrange of transportation, nursing assessment, evaluation and supervision, medical administration and monitoring, nursing care sufficient to meet resident needs within parameters of discharge criteria, social and recreational services, psycho-social support/intervention, behavior symptom management, opportunities for community activities, personal emergency response, information and referral and arrangement of other services (financial management, therapy, counseling).

Financing

The bill limits state reimbursement to 85% of the average statewide Medicaid nursing home rate. Rates would be established each year by July 1st. The Department of Health and Social Services would be responsible for developing the rates which have to be approved by the Department of Administration. State officials are planning to develop a tiered rate structure that reflects varying service needs. Facilities would be reimbursed as waiver slots are available.

Medications

The draft report would have allowed assistance with self-administration and administration of medications by appropriate staff.

Staffing

The draft report would require that providers submit staffing plans which would be approved by the Department of Health and Social Services. Minimum standards would require 24 awake staff, full time administrator/manager, sufficient staff to meet resident needs as identified in plans of care, licensed or certified staff to provide or arrange for nursing, dietary evaluation and services and pharmaceutical services. Cross training of staff to provide personal care, basic nursing care, cooking, laundry, housekeeping and other services would be encouraged.

WYOMING

General Approach

In 1992, the Director of the Department of Health formed a task force to determine how board and care homes can be established as low cost options in the continuum of care for the elderly. The task force reviewed who qualifies, current and future needs, existing and potential resources and cost reimbursement options. The task force included state agencies including the housing agency, ombudsman, consumer advocacy (AARP), home health agencies, not-for-profit nursing homes, board and care homes, and domiciliary care homes. The group's report was issued in October, 1992. In 1993, the legislature passed a definition of assisted living that allowed limited nursing care to be provided. Regulations were effective in October 1994 that re-name and modify the board and care licensure category. Board and care facilities can also be licensed as an assisted living facility in order to provide limited skilled nursing services and medication administration.

Definition

The statute defines assisted living as "a dwelling operated by any person, firm or corporation engaged in providing limited nursing care, personal care and boarding home care, but not habilitative care, for persons not related to the owner of the facility." Boarding home care means a dwelling or rooming house operated by any person, firm or corporation engaged in the business of operating a home for the purpose of letting rooms for rent and providing meals and personal daily living care, but not habilitative or nursing care, or personal not related to the owner.

Unit Requirements

A maximum of 2 people may share a bedroom. Bedrooms include toilets and sinks. One tub and shower rooms are required for every 10 residents.

Tenant Policy

The regulations now allow residents who need limited nursing to be served. Previously, residents needing skilled nursing had to transfer to a nursing facility. However, residents who wander or need wound care, stage II skin care, are incontinent or need total assistance with bathing and dressing, continuous assistance with transfer and mobility may not be served.

Services

The facility must describe the services provided and the charges for services. Facilities must provide meals, housekeeping, personal and other laundry service, assistance with transportation, assistance obtaining medical, dental and optometric care

and social services, partial assistance with personal care, limited assistance with dressing, minor non-sterile dressing changes, stage I skin care, infrequent assistance with mobility, cuing for ADLs with visually impaired residents and intermittently confused and/or agitated residents requiring occasional reminders to time, place and person, care for residents who care for their own catheter/ostomy without assistance, care for residents who are incontinent but care for themselves, RN assessments and medication review, and 24 hour supervision.

Services that may not be provided in assisted living include continuous assistance with transfer and mobility, care for residents who cannot feed themselves independently, total assistance with bathing or dressing, provision of catheter or ostomy care, care of residents who is on continuous oxygen if monitoring is required, residents whose medical condition requires more than 7 days bedrest, residents who wander, stage 11 skin care and beyond, wound care, incontinence care.

Financing

The task force report recommended that the Wyoming Department of Commerce be authorized to make loans to finance the development, remodeling and construction of board and care and/or assisted living facilities in underserved communities. No subsidies are available for low income residents.

Medications

The new regulations allow assistance with self-administration which includes but is not limited to reminders, removing from containers, assistance with removing caps, and observing the resident take the medication.

NATIONAL STUDY OF ASSISTED LIVING FOR THE FRAIL ELDERLY

Reports Available

A National Study of Assisted Living for the Frail Elderly: Discharged Residents Telephone Survey Data Collection and Sampling Report

HTML	http://aspe.hhs.gov/daltcp/reports/drtelesy.htm
PDF	http://aspe.hhs.gov/daltcp/reports/drtelesy.pdf

A National Study of Assisted Living for the Frail Elderly: Final Sampling and Weighting Report

HTML	http://aspe.hhs.gov/daltcp/reports/sampweig.htm
PDF	http://aspe.hhs.gov/daltcp/reports/sampweig.pdf

A National Study of Assisted Living for the Frail Elderly: Final Summary Report

HTML	http://aspe.hhs.gov/daltcp/reports/finales.htm
PDF	http://aspe.hhs.gov/daltcp/reports/finales.pdf

A National Study of Assisted Living for the Frail Elderly: Report on In-Depth Interviews with Developers

Executive Summary	http://aspe.hhs.gov/daltcp/reports/indpthes.htm
HTML	http://aspe.hhs.gov/daltcp/reports/indepth.htm
PDF	http://aspe.hhs.gov/daltcp/reports/indepth.pdf

A National Study of Assisted Living for the Frail Elderly: Results of a National Study of Facilities

Executive Summary	http://aspe.hhs.gov/daltcp/reports/facreses.htm
HTML	http://aspe.hhs.gov/daltcp/reports/facres.htm
PDF	http://aspe.hhs.gov/daltcp/reports/facres.pdf

Assisted Living Policy and Regulation: State Survey

HTML	http://aspe.hhs.gov/daltcp/reports/stasvyes.htm
PDF	http://aspe.hhs.gov/daltcp/reports/stasvyes.pdf

Differences Among Services and Policies in High Privacy or High Service Assisted Living Facilities

HTML	http://aspe.hhs.gov/daltcp/reports/alfdiff.htm
PDF	http://aspe.hhs.gov/daltcp/reports/alfdiff.pdf

Family Members' Views: What is Quality in Assisted Living Facilities Providing Care to People with Dementia?

HTML	http://aspe.hhs.gov/daltcp/reports/fmviews.htm
PDF	http://aspe.hhs.gov/daltcp/reports/fmviews.pdf

Guide to Assisted Living and State Policy

HTML	http://aspe.hhs.gov/daltcp/reports/alspguide.htm
PDF	http://aspe.hhs.gov/daltcp/reports/alspguide.pdf

High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey

Executive Summary	http://aspe.hhs.gov/daltcp/reports/hshpes.htm
HTML	http://aspe.hhs.gov/daltcp/reports/hshp.htm
PDF	http://aspe.hhs.gov/daltcp/reports/hshp.pdf

National Study of Assisted Living for the Frail Elderly: Literature Review Update

Abstract HTML	http://aspe.hhs.gov/daltcp/reports/ablitrev.htm
Abstract PDF	http://aspe.hhs.gov/daltcp/reports/ablitrev.pdf
HTML	http://aspe.hhs.gov/daltcp/reports/litrev.htm
PDF	http://aspe.hhs.gov/daltcp/reports/litrev.pdf

Residents Leaving Assisted Living: Descriptive and Analytic Results from a National Survey

Executive Summary	http://aspe.hhs.gov/daltcp/reports/alresdes.htm
HTML	http://aspe.hhs.gov/daltcp/reports/alresid.htm
PDF	http://aspe.hhs.gov/daltcp/reports/alresid.pdf

State Assisted Living Policy: 1996

Executive Summary	http://aspe.hhs.gov/daltcp/reports/96states.htm
HTML	http://aspe.hhs.gov/daltcp/reports/96state.htm
PDF	http://aspe.hhs.gov/daltcp/reports/96state.pdf

State Assisted Living Policy: 1998

Executive Summary	http://aspe.hhs.gov/daltcp/reports/98states.htm
HTML	http://aspe.hhs.gov/daltcp/reports/98state.htm
PDF	http://aspe.hhs.gov/daltcp/reports/98state.pdf

Instruments Available

Facility Screening Questionnaire

PDF	http://aspe.hhs.gov/daltcp/instruments/FacScQ.pdf