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and program recommendations

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Ohio Long-Term Care Research Project

**ASSISTED LIVING
IN OHIO:
POLICY OPTIONS
AND PROGRAM
RECOMMENDATIONS**

**Lawrence J. Weiss
Robert Applebaum**

July 1994



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Prior to coming to Ohio, Dr. Weiss was based in California where he consulted with health organizations and worked at Mount Zion Hospital in San Francisco where he developed and evaluated home- and community-based service systems that integrated acute and long-term care.

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Dr. Weiss has lectured and conducted workshops widely on a variety of topics on health and aging. He has authored several articles including the co-authored book, Managing The Continuum of Care, Aspen Publishers, Inc.; Rockville, Maryland, July, 1987.



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Dr. Applebaum has been a frequent speaker at national and state conferences on long-term care. He has authored numerous articles, monographs and two books on community based long-term care. Dr. Applebaum was also the guest editor of a special issue on Quality Assurance, published in *Generations*, the journal of the American Society on Aging.

Dr. Applebaum has also served as a member of the Ohio Governor's Home and Community Care Council as well as a number of national advisory boards and local agency boards of directors.

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**Assisted Living in Ohio:
Policy Options and Program Recommendations**

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Executive Summary

Reform of the acute health care delivery system has clearly become an issue of critical importance in our nation's capitol. Although health care is certainly a major issue for states as well, it is long-term care reform that appears to be the state agenda item of most immediacy. Faced with ever increasing Medicaid budgets and the continuing growth in the size of the disabled older population, states are overwhelmed with the problems associated with how to finance and deliver long-term care. A number of states, including Ohio, have begun to explore different approaches to providing long-term care, with one strategy, termed assisted living receiving considerable attention. This paper provides policy recommendations to the state on implementation of the assisted living concept.

To assist Ohio in its planning efforts Scripps reviewed both the professional literature and the experience of the states operating or planning assisted living care. This review identified seven care components that we believe need to be considered as assisted living is developed in Ohio. These components include: philosophy, environmental design, services, targeting, financing, linkage to the long-term care system, and regulations.

Philosophy Assisted living is a model of care driven by the principle of consumer autonomy and choice. The model of care assumes that residents should have the ability to choose the type and amount of care received. The resident, when competent, should have the opportunity to structure their long-term care in a manner that they choose. This model represents a substantial paradigm shift in long-term care. Traditional long-term care has adopted a medical patient care model in which the individual is given a more prescriptive regimen of care to follow. Understanding the philosophy underlying assisted living is critical to its success. We recommend that the key state agencies provide information and training in an effort to incorporate these principles into system design and regulatory efforts.

Design The assisted living philosophy of care is based on the premise that the care setting is indeed the resident's home. With features such as private sleeping space, private bath, temperature controls, locking doors, and food preparation areas, assisted living is viewed as an individual's home, in which they receive services. The model of assisted living relies on the principle that the unit is indeed the home of the resident. We recommend that the state agencies involved recognize this principle as development and regulatory issues are considered.

Services Experience indicates that assisted living residents require four major types of services: hotel services, personal care, routine nursing care, and special care. There are some important issues surrounding the provision of these services, such as who should provide such care and the use of a nurse delegation act, that

need to be addressed. However, the most significant issue identified in the services arena involves the resident's ability to choose the type and frequency of services. Thus, if a resident would rather bathe themselves or be helped by a family member, the care provider would respect that choice. As the state moves to develop financing and regulatory mechanisms for assisted living this basic principle of the model will need to be underscored.

Targeting There are several targeting criteria that have been considered as states develop assisted living care. Disability, income level, and age are three key eligibility criteria for policy consideration. In each of these areas there are difficult policy decisions to be made. For example, the disability debate ranges from the perspective that assisted living should be an alternative to nursing home care, to one that considers it a housing alternative for individuals who need some limited assistance. Given the limited state resources we recommend that public dollars be used to facilitate development of care options for highly disabled individuals, in the low and moderate income ranges.

Financing Assisted living has primarily been developed for middle and upper income individuals. However, with almost half of the nation's nursing home bill being paid for by Medicaid, the state role in financing assisted living is an area of critical importance. It is clear that providing an opportunity for low income persons to receive assisted living is essential to developing a system of care. State efforts to obtain a Medicaid waiver for assisted living represent an important step in expanding the assisted living option to low income individuals. Although the waiver allows eligibility for individuals with incomes up to 300% of the Supplemental Security Income program (SSI), the asset limitation (\$1500) results in most applicants having incomes of \$750 or below. With most private development being targeted for individuals with income of \$2,000 per month, the current financing mechanism contains a major gap. We recommend further exploration of construction and service financing mechanisms to address this issue.

Linkage to the long-term care system As assisted living care options become available, questions concerning access and coordination with the long-term care system will need to be addressed. The current system of long-term care has been criticized for a lack of coordination between the various long-term care settings, such as hospitals, nursing homes and home care providers. To address this concern we recommend that the case management model that has been developed for the Medicaid in-home care services be used to manage assisted living residents. Given the recent legislative changes involving pre-admission review for nursing homes, such placement would provide a mechanism for long-term applicants to receive information about a range of long-term care settings.

Regulation As noted assisted living represents a major shift in the way long-term care is delivered. In order for this care option to be successful it will be necessary

for the regulatory paradigm to shift as well. Current efforts to regulate nursing homes have been dominated by concerns about the security of the resident. Autonomy and resident choice, while occasionally mentioned, have not been the central concern. Assisted living is faced with a considerable challenge--balancing autonomy and security. In cases where competent residents choose a care approach that may result in an injury, the regulatory process must understand this delicate balance. We recommend that the state modify its traditional regulatory approach as it develops rules for assisted living care.

Conclusion

Funding concerns associated with long-term care are approaching crisis levels in Ohio and throughout the nation. Projections that indicate the disabled older population will increase by almost 40% by the year 2010 suggest that the state must consider alternatives to the current system of care. Simply increasing the resources currently allocated to long-term care by an additional 40% does not seem to be a feasible state response. Rather it is necessary for Ohio to shift the way care will be provided and financed. Although a number of other changes are required in long-term care policy, the development of assisted living is an important step in changing the way we care. For this care option to be successful the provider and regulatory communities will have to recognize that assisted living represents a considerable shift in how to deliver long-term care.

Introduction

This paper presents the issues associated with Ohio's new Assisted Living legislation including the rationale for decisions on program design and implementation. Ohio passed legislation effective July 1, 1993 establishing Assisted Living as a method of providing long-term care for Ohioans. Assisted Living, established in Section 3726 of the Ohio Revised Code, is defined as a multiple-unit residential facility that provides or arranges for skilled nursing care, supervision, personal care services, homemaker services, physical, occupational or speech therapy, dietary, etc. for one or more individuals who reside in the facility and are not related to the owner. The Assisted Living facility must consist of individual residential units, each of which contains private food preparation area, bathing, washing, and toilet facilities, doors that can lock, and individual temperature controls. The Assisted Living license is to be issued by the Department of Health.

WHY ASSISTED LIVING?

A number of factors have influenced the interest in and development of assisted living. The increasing numbers of disabled older people, a concern that as a nation we have not developed a full array of long-term care service settings, and increasing public long-term care expenditures have all contributed to the heightened interest in assisted living. In addition, home and community-based services have proliferated over the last 10 years, resulting in new modalities of

caring for chronically disabled individuals. Supportive housing has also developed with both public and private independent housing providers who have found that people "age-in-place" and require more supportive personal care services. A final factor influencing the development of assisted living is consumer demand. Through a growing public awareness of a range of long-term care settings, assisted living with its opportunities for shared responsibility and an emphasis on consumer autonomy, has gained popularity. Autonomy, independence and participation in decision-making about one's own life activities and care modalities are important components of assisted living. These components set assisted living philosophically apart from other traditional services and programs that are based more on the medical model of care.

Approach

To examine the policy and program issues of Assisted Living we have drawn both on the program and research literature and the experiences of eight states that have been involved in the development of assisted living.

Over the last year, we have conducted discussion groups, key informant interviews, and discussed policy options and program recommendations with assisted living experts from other states.

COMPONENTS OF ASSISTED LIVING

Our review suggests that there are seven key components to be addressed in exploring the assisted living care setting. These include: The philosophy of operation; Environmental setting; Services provided; Targeting of residents to be served; Methods of financing; Linkage to the long-term care system; Licensing and regulatory requirements.

Philosophy

Assisted living emphasizes home-like living units, privacy, resident choice, independence, shared risk, and shared responsibility. The key components in the design of an assisted living program are making the environment home-like and creating an environment so that the resident maximizes their ability to make choices about their own lives. Such choices include both the nature of the environment and the personal assistance needed. Autonomy and independence are explicit goals of assisted living. Decision-making regarding services is based on reported need and performance. The service plan is negotiated with the resident and then finalized, but perceived as a continuous process that adjusts to individual needs.

The principles of assisted living have been discussed by several authors (Regnier, Hamilton, and Yatabe, 1991; Wilson, 1990; Cohen and Weisman, 1991; Wilson and Kane, 1993). Although the specific program components of assisted living vary, there is a consistent theme that cuts across the literature. As already described, assisted living residents need to have choice and autonomy to the extent possible over the care received. That is operationalized as the ability to control their environment with

such elements as having a separate sleeping area, temperature controls, or a food preparation area. This philosophy is very different from the principles that have traditionally been used in the typical health care setting, such as nursing homes, that emphasize patient compliance and security as dominant care objectives.

The issue of personal health and safety in assisted living needs to be balanced with consumer autonomy, choice and independence. Ohio has taken steps in both maintaining certain health and safety features, like requiring the facility to meet the applicable requirements of the Ohio Basic Building Code and other fire and safety standards while simultaneously attempting to provide personal autonomy and independence (eg. requiring individual unit doors that lock). The main vehicle for dealing with such health and safety issues in the assisted living philosophy is the "negotiated risk contract". In maintaining the spirit of consumer participation and autonomy, each person's service needs are assessed, the resident and support system are educated about the options available, and a plan of care is developed. The plan of care incorporates risks and responsibilities for the consumer, their informal support system, and the provider.

Despite this common philosophy on resident autonomy, there is some variation in state goals toward assisted living. Several states, Massachusetts, Oregon, New York and Washington, identified a goal of reducing or preventing premature institutionalization. Other states, such as Florida, Maine, Maryland, and New Jersey, focused on making services available to older people in less restrictive settings, with a particular emphasis on those individuals aging in place. Ohio's goal is to make

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assisted living available to those individuals who would require institutional care to meet their long-term care needs.

Environmental Design

The setting or environment of assisted living is home-like and features the following:

- ! Individual dwelling units;
- ! Full baths accessible without exit to common corridor;
- ! Food preparation space;
- ! Lockable doors, individual temperature controls, and personal furnishings;
- ! Community space for resident use (e.g. dining rooms, laundry, and living rooms);
- ! Residential approach to construction and community space furnishings.

The above environmental design features maximize the personal and home-like characteristics needed within assisted living. In addition, Ohio Department of Health current draft of the rules specify a minimum of 160 square feet per unit for existing facilities and 220 square feet per unit (excluding the bathroom) for new construction. Other state experience with minimum square foot standards was utilized, taking into account conversion of current assisted living facilities and construction of new buildings. Arriving at a minimum size for an assisted living unit is a subjective endeavor, and it is expected that consumer choice and demand will provide more

influence in provider design than the minimum standards. However, according to some of the other state programs, the rationale for any minimums set need to take into consideration square footage for four distinct areas: sleeping (approximately 80 sq. ft.); food preparation and use (approximately 40 sq. ft.); storage (approximately 20 sq. ft.), and living area (approximately 80 sq. ft.). Each area needs space for functional equipment and mobility (resulting in the need for approximately 220 sq. ft.).

In addition to the individual units, each facility needs to have social gathering places or common useable space as well as a dining area to accommodate at least one-half of the residents. Some assisted living units are designed to maximize the personal individual living space, while others adopt the shared living concept in which greater emphasis is placed on the shared common space. Flexibility and creativity in design should be encouraged, not inhibited.

The size or number of units within an assisted living project is typically not addressed by state policy. In states with extensive development experience (eg. Oregon, Washington) the number of assisted living units range from 40 to 60 units in urban areas, but has been as low as 20 to 25 units in rural areas.

Identifying the optimum size for assisted living is difficult. On one hand there is a concern that a very large setting will be more institutional in its design and operations. Smaller settings may lack the economies of scale necessary for the efficient provision of care. To this point development of facilities ranging from 40 to 60 units appears to be the optimum strategy.

Types of Service

There are four categories of services typically provided in an assisted living environment and are required by Ohio:

- ! Hotel Services: Meals (3 per day, including special diets), housekeeping, transportation, etc.;
- ! Personal care: Assistance in walking, transferring from bed to chair, bathing, and other services affecting functional ability;
- ! Routine Nursing Services: Non-continuous (ie. not 24 hours per day) skilled nursing care (e.g. IV's, skin care);
- ! Special Care: Service coordination, assessment of needs, monitoring individual plan of service and changes in needs, access to specialty providers, and behavioral management.

The intent of Ohio's assisted living program is to provide services to each resident based on individual needs and desires. Services are "unbundled" and delivery is based on the needs of each resident. Each resident's total needs (ie. functional activities of daily living, psychological, social and emotional, as well as the ability to perform instrumental activities of daily living such as housekeeping, meal preparation, and shopping) are assessed upon entry into the program and periodically or as needed thereafter. An individualized service plan is developed and negotiated with the client (and/or client representative) and the provider accordingly.

This process of negotiation involves client participation and results in a signed contract specifying the plan of service between the resident and the provider(s) as to who is responsible for what, including the resident or resident family. This process provides an excellent method for providing the highest quality care with the most client and informal support possible. The result should maximize consumer satisfaction and diminish inappropriate liability.

To coordinate and monitor assisted living services several states have adopted the case management model used in the community-based in-home care setting. The rationale for the use of case management is that it provides the objectivity in determining need, negotiating services, and monitoring outcomes, particularly for those clients receiving public funds. Four arguments have been identified in favor of this approach. First, the services provided need to be authorized for payment, especially if reimbursement depends on the clients level of functioning. Second, managing difficult behavior issues or conflicts between the client and the provider need coordination and monitoring. Third, if the client has no advocate in the negotiation or management of the services and risk, then the case manager could step in with some objectivity to represent the residents best interests. Finally, the case manager serves as an important quality assurance component of the care model.

Arguments against the use of case managers suggest that the costs of such a model are high and take dollars away from direct care provision. Critics of the case management model suggest that there is an overlap between the case managers role and that of the assisted living provider.

Targeting Care to Residents

Most assisted living projects, as in the state of Ohio, have targeted care to residents with impairments in activities of daily living, instrumental activities of daily living, cognitive impairments, and some skilled nursing needs. Assisted living serves a population at some risk of institutionalization, and in fact as reflected in the level of care assessment, will need nursing facility care in order to receive state assistance. The level of frailty within assisted living depends on admission and retention policies, but in more mature models the tenants tend to be more impaired, due to aging-in-place. Based on the Assisted Living Facilities Association of America, the average resident is 85 years old, female, lives in assisted living for 2.5 years, and at entrance, has 2.5 activities of daily living impairments, and about 1/3 are incontinent and/or cognitively impaired.

Our review of state activities in the assisted living arena identified three key targeting factors: level of disability, income, and age.

Level of Disability. A review of the disability criterion identified three variants. Several states, including New York, Oregon, and Washington, require that participants be nursing home eligible. Florida, Massachusetts, and New Jersey require that the resident be at risk of institutionalization. Maine and Maryland also emphasize serving impaired people; however, the nursing home level of care criteria is not used. In an effort to provide care to those individuals that could be placed in nursing homes without other alternatives, Ohio has targeted public resources through Medicaid to nursing home eligible participants.

Income. Income becomes a policy issue as states consider whether and how such care should be supported by public funds. States that decide to provide public reimbursement of this care setting have had to make decisions on financial eligibility of residents. For example, several states utilize the more restrictive Medicaid eligibility criterion for determining eligibility. Several other states, such as Oregon are using the Medicaid waiver program, allowing them to expand eligibility to 300% of the Supplemental Security Income (SSI) rate. Massachusetts targeted individuals with annual incomes below \$15,540. Ohio has decided to target its assisted living program to the 300% of SSI population, the same criteria that is used by the state's PASSPORT program. Since all Ohio Medicaid waiver programs must use the same financial eligibility criteria, this would apply to assisted living clients as well. Therefore, assisted living eligible clients must have incomes at or below 300% of SSI (currently \$1,338 per month) and must meet the resource limits for institutionalized Medicaid recipients. Assisted living clients will also benefit from the special spousal impoverishment rules as do PASSPORT clients and nursing home residents.

Age. The age criterion debate centers on the question of whether assisted living should be designed for aged persons (60 yrs. of age or older), or whether it should be designed for chronically disabled individuals, regardless of their age. Several states such as Maryland, Maine, and Massachusetts specifically directed assisted living to individuals age 60 or above. Other states focused extensively on impairment level and while the majority of residents are over age 75, no specific age requirements are used. Using age as an eligibility criterion has sparked some intense debate.

On one hand some have argued that disability is the factor that influences the need for long-term care, rather than age. Thus, arguing for an age neutral policy. The counter argument suggests that chronically disabled older people have very different needs than the younger disabled population, particularly those with developmental disabilities, chronic mental illness, or chemical abuse problems. Physically disabled individuals have also raised some concerns about this model of care, expressing an interest in using a self directed attendant care model in which they hire and train care providers. Ohio has chosen to provide assisted living to persons who are 60 plus years of age.

Financing

Private rates for assisted living range from \$900 to \$3,000 a month for room, board, and services. Many factors enter into the cost including building design, development costs, service packages, and amenities. Many financing mechanisms and strategies have been used by different states, primarily because there is not one single source of financing for both the housing component and the service component. Most states have used a combination of Medicaid and private pay to fund assisted living. This multiple funding is essential because the room and board component of assisted living is not Medicaid reimbursable. New York, Massachusetts, Oregon, and Washington offer tax-exempt or low-interest bond financing to not-for-profits and Medicaid 2176 or 1915(c) waivers (Home and community based services) to cover services. Maine and Maryland have used Older Americans Act monies, along with resident contributions, and have been in process of incorporating Medicaid waivers. Several states use the residents' SSI payment

to cover room and board. Clearly, states have used different strategies to pool funds to create assisted living.

Because a large proportion of long-term care has been funded by individuals and their families, the assisted living model attempts to build on the resources in place in the long-term care system. However, for assisted living to be available to the majority of older people, the way it is developed needs to be altered. Current marketing attempts for assisted living have focused on the population of the older people age 75 and above, that have incomes of \$25,000 or higher a year. This includes about 20% of the potential population. To develop assisted living as a viable option for a larger proportion of the older population alternative methods of developing and financing assisted living need to be identified. The major challenge is to make assisted living available for the majority of older people that have incomes under \$25,000 per year. A strategy that relies on a range of funding approaches and sources has been developed by Ohio.

A strategy for funding the lowest income group has been developed by the state that combines the principles of the Optional State Subsidy (OSS) program, which provides an income subsidy so that disabled persons can live in a group setting, and the Home and Community-Based Care Medicaid waiver program. Using this combination of a state-funded program and the ability to increase income eligibility under a Medicaid waiver Ohio has increased the accessibility of assisted living to this low-income group. Under this approach the OSS-like component is used to pay the individual's room and board costs, and the Medicaid waiver would be used to fund the services.

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The financing plan also proposes that assisted living participants be entitled to retain the first \$847 of income each month, similar to the state's PASSPORT clients. The reasoning is that as in the PASSPORT program participants need to keep enough income to pay for housing, food costs, and other incidentals. In addition, it is proposed that the standard for room and board be set at \$700 per month, paid to the assisted living facility. Any short fall by the assisted living participant will be supplemented with state funds, just as in the standard used for determining eligibility for OSS in rest homes.

One problem that still persists in the Ohio design is the Medicaid asset limitation of \$1,500 imposed on those assisted living participants who qualify for state help. The assisted living waiver will allow individuals with incomes up to 300% of SSI to receive Medicaid service dollars. The asset limit of Medicaid however, remains unchanged. Although there are many older Ohioans that could be eligible based on the higher income category, most of these individuals remain ineligible because of the asset limits. It is recommended that assisted living be designed to serve a balance of residents, especially those who spend down to Medicaid eligibility, rather than targeting specifically to any one income group.

In order to deal with the issue of allocating limited resources to those in need, the state has proposed the following priorities for Medicaid waiver enrollment of those persons who meet all the other Assisted Living criteria:

- ! Persons referred by the state's Adult Protective Services program

- ! Assisted Living residents who spend down
- ! Hospital discharges
- ! Persons in the Ohio State Supplement Program who need more care
- ! Nursing home residents who want to relocate
- ! Community residents

Linkage to the long-term care system

One of the major problems of long-term care is the lack of coordination between different services and providers. The linkages between home care, adult care facilities, rest homes, and nursing homes have been limited. The development of assisted living needs to recognize this fragmentation, and hopefully not add to the problem. Using the home and community-based waiver has two advantages: (1) It provides a funding source that allows low-income persons a mechanism to have assisted living funded through public dollars; and, (2) The PASSPORT case management component incorporates assisted living within a total long-term care system structure. It is proposed that the case management approach, although in modified form, would be used to arrange and monitor assisted living. The assisted living option would be integrated with the home care and nursing home settings to create a range of care locations. This creates the opportunity for a system of care that has not existed.

Licensing and Regulation

C.O.N. The Certificate of Need (C.O.N.) is designed to restrict or control

development and growth of a product (ie. nursing home or hospital beds). A C.O.N. strategy has been identified as important in areas that have access to categorical entitlement programs such as Medicaid and Medicare. Under these programs all eligible individuals covered could receive care and thus it was deemed important by some theorists to restrict supply. A C.O.N. program for assisted living, where few public funds are involved, would serve simply to drive up the cost to private pay residents. Growth and development of affordable assisted living as an alternative needs to be fostered. There is no evidence to suggest that the C.O.N. process in assisted living would have beneficial effects for the citizens of Ohio.

Nurse Practice Act. Ohio is currently exploring regulatory changes in other areas that are of importance to the development of assisted living. For example, modifications to the nurse practice act are integral to offering assisted living at a cost-effective rate. Assisted living providers have estimated that requiring nurses to distribute daily medication could add as much as \$10 per day to the cost of resident care. Although nurse supervision of medication distribution is critical, appropriate delegation of tasks is important in controlling the cost of assisted living.

Other Issues. In addition to determining the regulatory standards of care there are a series of other issues that have been identified. For example, how would efforts to regulate assisted living be integrated with the service delivery components, such as case management? How would the paradigm shift towards increased autonomy and independence with a more disabled population impact the current regulations for other residential care facilities? In order to address

these and other critical issues, assisted living was legislated and regulated separately from the other modes of care such as rest home, adult care homes, and nursing homes. It is critical that the state, the provider community, and consumers work collaboratively to develop a regulatory effort that balances consumer safety and autonomy. It is important that rules and regulations developed by the Ohio Department of Health recognize that assisted living is a different model of delivering long-term care.

Summary

Ohio is developing a new alternative long-term care service termed assisted living. Assisted living provides a new paradigm of care that emphasizes consumer autonomy, independence and participation. In the process of determining the detailed rules and guidelines for implementation, Ohio has to be aware of the delicate balance between promoting resident autonomy and regulations that ensure consumer safety. Regulation for health care and particularly institutional long-term care have been dominated by safety concerns. For assisted living to be successful, a model must be created in which concerns about consumer safety are balanced with resident autonomy. To create this balance regulators, providers, consumers and their families will have to re-think the way we deliver long-term care.

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