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Assisted-Living Regulation Issues: A Business Case for Action or Creative Destruction

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ABSTRACT

This paper examine whether state law regulating assisted-living facilities in United State is sufficient or underdeveloped and inconsistent. As the U.S. population ages, legislatures and courts need to address the growing need to develop comprehensive and consistent law in this area, and the industry must be fast to anticipate threats and changes from all directions. The paper's methodology includes reviewing the statistics that indicate the growing demand for assisted-living facilities and researches and reports variations of regulation regarding assisted-living facilities across the United States. Findings include extensive inconsistencies in regulation exists across the states; and there is a great need for either more uniform industry standards, or for federal regulation if the industry is not willing or able to self-regulate. We also find that regardless of regulation or self-regulation, increasingly demanding and better-informed consumers who have greater access to more information will push the industry to change. The assisted-living industry must find a proper balance between offering a good product and doing so at a reasonable cost – a necessary goal for most businesses.

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1.0 INTRODUCTION

The U.S. Administration on Aging offers some sobering statistics on the maturing of the nation's population. Among its most recent statistics reported in the document "A Prolife of Older Americans: 2014" reported the population aged 65 and over has increased from 35.9 million in 2003 to 44.7 million in 2013 (a 24.7% increase) and is projected to more than double to 98 million in 2060; between 2003 and 2013 the population aged 60 and over increased 30.7% from 48.1 million to 62.8 million. The 85+ population is projected to triple from 6 million in 2013 to 14.6 million in 2040. Also contributing to the growth in the elderly population, persons reaching age 65 have an average life expectancy of an

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additional 19.3 years (20.5 years for females and 17.9 years for males). About 28% (12.5 million) of non-institutionalized older persons live alone (8.8 million women, 3.8 million men). Unfortunately, older people have at least one chronic condition and many have multiple conditions, including hypertension, arthritis, all types of heart disease, any cancer, and diabetes. From a financial perspective, most elderly are not wealthy enough to afford extensive medical bills. The median income of older persons in 2013 was $29,327 for males and $16,301 for females. Over 4.2 million older adults (9.5%) were below the poverty level in 2013.

Assisted-living facilities provide seniors help with some aspects of living, while allowing them to maintain independence and dignity. Seniors need help with a wide range of different life chores: meal preparation, grooming assistance, dressing, supervision, eating, transportation, and medication administration, to name a few. Assisted living includes intermediary steps between living independently and requiring the medical attention provided in a skilled nursing facility.

Regulation and oversight of assisted living takes place primarily at the state level. State regulation of assisted-living facilities is quite variable across the country, and state laws change frequently. In 2012, the most recent year for which data was assembled, 18 states made changes to assisted-living regulations, statutes, or policies; at least nine states made major changes (Polzer, 2013).

Uniform definition and regulation of assisted-living services would facilitate comparability between various assisted-living options and companies, and help to ensure quality care for residents. This paper focuses on some categories of state laws and regulations that are intended to manage care and prevent abuse in assisted-living facilities, as well as licensure requirements regarding the usage of the label "assisted living."

2.0 ASSISTED-LIVING RELATED LITERATURE

2.01 DEFINITIONS OF ASSISTED LIVING

One of the major issues for consumers when investigating and choosing assisted-living options is the lack of a consistent definition for "assisted living." The term covers a range of options from private homes housing several residents to residential-care facilities similar to skilled-nursing homes; from apartment-style living to shared rooms with little or no privacy. The variety of options included in this category complicates the possibility of uniform regulations (Mollica, 2008; Walters, 2012).

While this lack of uniformity is considered a weakness, it could also be a benefit as it allows state and local governments to set standards according to local needs and environments (Mollica, 2008). The flexibility also allows for a greater variety of options available based on the needs of a particular person (Retsinas, 2005). If assisted living is defined too narrowly, regulators would risk eliminating the variety of offerings that allows a resident to pay only for the degree of medical attention needed. Narrow definitions could eliminate affordable options for healthy elderly; on the other hand, it could offer insufficient protections for those who need more extensive medical care, but also less than what a nursing home provides at a higher price.

In reviewing state regulations regarding the definition of "assisted living" and the centers that provide it, state laws tend to categorize them based on one of three factors: (1) retention or admission criteria; (2) living-unit requirements; or (3) service offerings.

In states that use retention/admission criteria to define assisted living, such facilities define the make-up of their residents in terms of health status and diagnoses. Any restrictions on diet, movement, cognitive ability, or related areas are noted before admission. A physician or a registered nurse makes the decision whether to admit the resident or not. There can be laws regarding when a resident must leave the facility due to the inability of it to properly tend to that resident's health or safety needs. Some state laws may

require that there are conditions for dismissal; usually, however, it is up to the institutions to make these conditions known to the residents, as well as to give fair warning as to when the resident must leave.

Some states define assisted-living residences based upon living-unit requirements. For example, North Carolina General Statute § 131D-2 states that an "assisted living residence" means "any group housing and services program for two or more unrelated adults, by whatever name it is called, that 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 or hospice agencies… [and] may allow nursing service exceptions on a case-by-case basis." Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths.

A third category defines "assisted living" residences by the menu of services they offer to residents/patients. For example, Utah Code Annotated § 26-21-2 defines an assisted-living facility in part as "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 department rule to need any of these services." The Utah statute furthers defines these services as including intermittent nursing services, administration of medication, and support services promoting independence and self-sufficiency (sic). Connecticut General Statute § 19a-693 defines assisted living as residential living that includes "nursing services and assistance with activities of daily living provided to residents living within a managed residential community having supportive services that encourage persons primarily fifty-five years of age or older to maintain a maximum level of independence." The common services within these definitions seem to be hotel-type services, personal-care services, and skilled-nursing services.

State laws vary greatly. Alabama, for example, has very detailed laws governing such things as a resident's hair (Alabama State Board of Health, Chapter 420-5-4). In order to maintain the dignity of the individual residents, Washington D.C. has a subsection of the law specifically titled "Dignity." This statute provides that every assisted-living resident has a right to the following:

a. *A safe, clean, comfortable, stimulating, and homelike environment allowing the resident to use personal belongings to the greatest extent possible;*
b. *Control time, space, and lifestyle;*
c. *Free access to visitors of his or her choice;*
d. *To receive and send correspondence without any restrictions;*
e. *To maintain personal possessions to the extent the health, safety, and well-being of others is not disturbed;*
f. *To remain in his or her living unit unless a change corresponds to the uncoerced preference of the resident or conforms to the obligations set forth in the resident's contract respecting discharge and is related to the resident's preference or to transfer conditions stipulated in his or her contract with the ALR;*
g. *To approve his or her roommate whenever possible, if the resident is living in a semi-private unit;*
h. *To attend or not attend religious services of his or her choice;*
i. *To choose activities and schedules consistent with his or her interests, and physical, mental, and psychosocial well-being;*
j. *To interact with members of the community inside and outside the facility and make choices about aspects of his or her life in the facility that are significant to the resident;*
k. *To be free from mental, verbal, emotional, sexual and physical abuse, neglect, involuntary seclusion, and exploitation; and*
l. *To participate in the development, implementation, and review of plans designed to provide services to residents, including the Individualized Service Plan* (D.C. Code § 44-105.03)

In addition to respect for each resident's dignity, assisted-living centers should have written care plans for each resident. Such care plans outline the agreement between the assisted-living facility, the resident, and the resident's family. The plans address how the personnel at the facility will assess and manage the

resident's needs, as well as define how outcomes will be measured and determined when changes in care need to be made (e.g., when a person can no longer care for himself or herself). (Marek; Schneider & Nordheim, 2014) In the increasingly competitive environment of providing services for an ever-growing elderly population, one might think that even in states that do not require written, individualized care plans, assisted-living facilities would provide them as a means of gaining an edge in the marketplace.

What is noteworthy, however, is that, while there are states that do not require written care plans, some of these same states do require written "occupancy plans." Such plans are more like rental agreements between the facilities and the residents, but they do offer provisions for what should happen in circumstances when, among other things, the resident's "health status or behavior constitutes a substantial threat to the health or safety of the [resident], other tenants, or others, including when the [resident] refuses to consent to relocation" (Iowa Code § 231C.5(2)(f)(1)).

For consumers, having adequate information about living arrangements when making decisions for themselves or loved ones is important. The necessity of leaving one's home as a result of being unable to provide complete care for one's self can be traumatic. If before making a decision, the prospective resident and his or her family members are aware of a facility's standard of care – care in screening employees, in making nutritional choices for residents, in meeting its obligations to address the individual needs of each of its residents – there will hopefully be fewer surprises once the resident is settled in to the facility. A written admission agreement can increase the level of such awareness.

2.02 ASSISTED-LIVING FACILITY SERVICES

Assisted-living facilities provide a home to people who need assistance with daily tasks of living. Assisted living is a combination of housing and supportive services to provide a "homelike" environment where the independence, dignity, privacy, and safety of each resident are respected and facilitated. (Lewin-VHI, Inc., 1996) Assisted living offers a more cost-effective solution to individuals who do not need the degree of services offered by nursing facilities. In fact, the 2012 MetLife Survey of Long-Term Care Costs found that the national average for annual nursing home costs was about $90,520 (private room), while the national average for assisted-living costs was less than half that, or about $42,600.

Daily tasks of living include dressing, bathing, and administering medications, receiving and reading mail, paying bills, taking care of personal hygiene, and participating in social functions. In addition to help with daily tasks, assisted-living facilities can provide residents with ongoing health monitoring and provision or arrangement of medical services, including transportation to and from those services as needed (Allen, 1999). Assisted-living facilities vary greatly in the types of services they provide and the residents they serve. The size of the facilities ranges from small independently-owned homes serving a few residents to large corporate-owned homes with many residents. The levels of service vary. Some offer only meals, housekeeping, and limited personal care. Others provide or arrange for a variety of specialized health and related services (Allen, 1999).

Services provided can change over time. A resident of an assisted-living facility may receive a minimal amount of assistance when first there. For instance, many facilities provide a low level of service, including providing optional meals, laundry services, and social activities. But also included in this level of service is a general oversight of a resident's health needs and a response thereto if those needs change. A resident can "age in place" if a facility is able to change the level of service as the resident's need for assistance increases over time. A facility's rules governing discharge can also indicate what conditions must be present for a resident to be recommended for transition to a skilled-nursing facility. Such conditions include the point at which the facility does not provide the level of care required for a resident's health needs. If that point is reached, it is up to the facility to ensure the resident is notified of the discharge.

The laws that govern the area between institutional care and home care have been, and continue to be, developed by individual states. There is a lack of federal policy governing the definition and regulation of

assisted-living facilities, although some people have called for federal regulation of the industry for many years (Bruce, 2006; Edelman, 2007).

3.0 ISSUES IN ASSISTED LIVING

3.01 ABUSE

When looking at how each state attempts to address abuse in the assisted-living setting, it is important to understand the different categories of abuse that exist within this setting. Categories of abuse include, but are not limited to, the following:

- Physical abuse: Physical abuse can include striking a patient or unnecessarily restraining a patient, either physically or with drugs.
- Sexual abuse: Any physical contact of a sexual nature with a patient without that patient's consent. Worthy of emphasis here is that patients with diminished capacity often do not have the legal capacity to give consent.
- Emotional or psychological abuse: According to the National Committee for the Prevention of Elder Abuse (NCPEA), "[p]sychological abuse is the willful infliction of mental or emotional anguish by threat, humiliation, or other verbal or nonverbal conduct" (National Committee for the Prevention of Elder Abuse).
- Neglect: Neglect involves a failure to meet obligations of care for a patient, including proper hygiene, exercise, and nutrition. Neglect can be active (intentionally depriving a patient of care for financial gain).or passive (failing to meet patient care needs "as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources") (National Committee for the Prevention of Elder Abuse).
- Financial exploitation: Financial abuse can include theft, forgery, fraud, and scams targeting the elderly, to name a few.
- Self-neglect: Self-neglect includes patients lying in their own feces, refusing to bathe, allowing food to spoil, ignoring serious medical conditions, and the like.

An increasing number of states are addressing abuse prevention via statutory schemes, probably due to the increased litigation against assisted-living facilities, nursing homes, and, in some instances, the states for failing to properly regulate and prevent abuse. Illinois, for example, has one of the most extensive abuse-prevention statutes. The Illinois Elder Abuse and Neglect Act provides for emergency-response systems to any report of any case of "alleged or suspected abuse or neglect that places an eligible adult at risk of injury or death" (320 ILCS 20/3). The Illinois statute requires that there be personnel available to respond to all complaints of elder abuse or neglect 24 hours a day, 7 days a week. Another state with extensive elder abuse rules is Tennessee. Tennessee's law offers protection from job retaliation for employees who report elder abuse and also makes failure to report abuse a criminal offense (Tenn. Code Ann. § 71-6).

Alabama Code 38-9-7 in part makes it a criminal offense: (a).. . . for any person to abuse, neglect, exploit, or emotionally abuse any protected person. For purposes of this section, residence in a nursing home, mental institution, developmental center for people with an intellectual disability, or other convalescent care facility shall be prima facie evidence that a person is a protected person. Charges of abuse, neglect, exploitation, or emotional abuse may be initiated upon complaints of private individuals, as a result of investigations by social service agencies, or on the direct initiative of law enforcement officials (b).Any person who intentionally abuses or neglects a person in violation of this chapter shall be guilty of a Class B felony if the intentional abuse or neglect causes serious physical injury (c).Any person who recklessly abuses or neglects a person in violation of this chapter shall be guilty of a Class C felony if the reckless abuse or neglect causes serious physical injury (d).Any person who intentionally abuses or neglects a person in violation of this chapter, shall be guilty of a Class C felony if the intentional abuse or neglect causes physical injury. (e).Any person who recklessly abuses or neglects a person in violation of this chapter, shall be guilty of a Class A misdemeanor if the reckless abuse or neglect causes physical injury.

(f). Any person who emotionally abuses a person in violation of this chapter shall be guilty of a Class A misdemeanor…

While Alabama clearly defines various levels of emotional and physical abuse, as well as reckless and intentional abuse, its laws are not as demanding when it comes to reporting abuse as the Illinois and Tennessee statutes are. The Illinois and Tennessee statutes, like many abuse laws across the U.S., require *anyone* who is aware of elder abuse to report it to the appropriate authorities. The Alabama statute, however, places the burden for reporting elder abuse primarily upon medical, long-term care, and law-enforcement personnel (Alabama Code § 38-9-8).

3.02 LICENSING

A facility is usually required to be licensed as an "assisted-living facility" or some other title, such as a "residential-care community." Some states specify which terms can be used by a facility in relation to the nature of its license. A facility is usually licensed by a state's Board of Health, Department of Aging, or Department of Social Services, and any of these agencies serve an oversight function in relation to the facility. Oversight includes an annual renewal of the license being granted only if the facility meets the requirements of the agency involved. These requirements include passing inspections (scheduled and unscheduled) and/or taking corrective action in connection with any reports determining that a facility is not adhering to the assisted-living standards developed by the agency. Complaints must be made to, and registered with, the state, and the states' ombudsmen play key roles by investigating and resolving complaints of residents in assisted-living facilities (Allen, 1999).

3.03 FEDERAL LAW

Some federal law intended to serve broader purposes also happens to apply to assisted-living facilities as well. Federal laws and programs that have some application to assisted-living facilities include the following: Section 202 of the Supportive Housing for the Elderly Act, Elder Justice Act, Home and Community Balanced Incentives Act, Medicare Payment Improvement Act, Money Follows the Person Demonstration Program, Nursing Home Transparency and Improvement Act, Patient Safety and Abuse Prevention Act, Physician Payments Sunshine Act, Retooling the Health Care Workforce for the Aging America Act, and Older Americans Act. All of these laws and programs, with the exception of the Supportive Housing for the Elderly Act and the Older American Act, are part of the Patient Protections and Affordable Care Act. The Supportive Housing for the Elderly Program under the Department of Housing and Urban Development (HUD) is intended to help expand the supply of affordable housing with supportive services for very low-income elderly (HUD, Section 202). The Elder Justice Act, part of the Affordable Care Act, addresses elder abuse (Elder Justice Act). All of these laws offer protections and/or funding for the elderly and can be applied to assisted-living facilities, although most do not specifically mention assisted living.

The Older Americans Act (OAA) includes assisted-living facilities in its definition of "long-term care facility." As a result, this federal statute does offer some protections and regulation of assisted-living facilities. It sets forth a broad set of objectives, the purpose of which is to ensure the well-being of all older citizens. It is "considered to be the major vehicle for the organization and delivery of social and nutritional services" for older individuals and their caregivers. One objective of OAA is "obtaining and maintaining suitable housing, independently selected, designed and located with reference to special needs and available at costs which older citizens can afford." The Act also addresses community-based, long-term care services adequate to appropriately sustain older people in their communities and in their homes (Programs for Older Americans). Community-based services can be supplied in an assisted-living setting.

Another objective of the OAA is for the elderly to enjoy freedom, independence, and the free exercise of individual initiative in planning and managing their own lives; full participation in the planning and operation of community-based services and programs provided for their benefit; and protection against

abuse, neglect, and exploitation (Programs for Older Americans). State laws must encompass all of these objectives, and assisted-living facilities must ensure that policies and practices incorporate this federal law.

While the OAA has done much to ensure a certain level of consistency in regulation regarding social services and nutrition services, there remains concern about a lack of accountability/oversight for assisted-living facilities in connection with licensing, abuse, screening of personnel, financial fraud, and misuse of drugs, neglect, and the potential for discrimination.

4.0 DISCUSSION AND POLICY IMPLICATIONS

Inconsistent regulation of assisted-living facilities results in greater vulnerable for an already-vulnerable population – the elderly. The literature review shows the issues, as well as the lack of consistent and strong state regulation.

4.01 INEVITABLE CHANGE AND REGULATION

Laws and regulations could provide an opportunity in the industry to achieve uniform service and care. This would, in turn, provide high customer satisfaction through the guidance provided on a minimum set of standards that promote the health and living choices of older people in assisted-living facilities. Federal regulation is one possibility; another option would be the development of a uniform code, written by experts in the field that could be adopted in whole or in part by the 50 states (Walters, 2012).

More regulation, however, is not a guarantee of better care and could also damage customer satisfaction if the result is a very restricted environment (Wayne, 2001). Laws and regulations must remain flexible at the same time they help to ensure quality care in the assisted living environment. Some argue that the federal government's involvement in the assisted-living industry would stifle growth and innovation for the assisted-living option, just as aging baby-boomers need more of these facilities. Additionally, regulation and higher standards could result in higher fees for particular resident populations who do not require higher standards of assistance and care (Retsinas, 2005).

4.02 A CASE FOR SELF-REGULATION

Proactive self-regulation by the assisted-living industry could resolve many of these issues. Industries hit by regulation often regret not having addressed oversight themselves and self-regulated activities earlier to prevent Congress's intervention. Flexibility and options decrease as the public and the government become aware, and then alarmed, about issues and problems (Jennings, 2006).

If the assisted-living industry wishes to grow and thrive, proactive self-regulation and customer service/satisfaction, balanced with price, are key elements. Yet change will likely come regardless of actions by the government or the industry itself. In general, consumers are increasingly more discriminating and demanding in purchases of goods and services. They have become accustomed to researching purchases, and, as a result, have more information on price and quality and are able to compare these factors across competitors. The Internet is a useful vehicle for sharing of information and reviews regarding everything from restaurants to travel to dating websites, and assisted living for family or themselves should be no different. Gains in technology that have, in turn, facilitated growth in entrepreneurial spirit that has accelerated new forms of creative destruction will lead to new services that evaluate assisted living or offer more alternatives. One day, there could be an "Uber" or "Airbnb" for assisted-living arrangements, referrals, and reviews.

The ultimate measure of quality in any long-term care facility is customer satisfaction. Health is a very important matter to most everyone, older individuals in particular because of the issues that come with aging. Also important is the ability to lead the life of one's choice. Assisted-living facilities that properly address both of these concerns are the ones that are likely to have high customer satisfaction, both from

the residents and the families, and, as a result, be more likely to experience full capacity and greater profitability.

5.0 CONCLUSION

Federal regulation and oversight of assisted living has the potential to provide a base-line standard of care for residents of assisted-living facilities nationwide, but, conversely, excessive regulation could stifle growth and innovation in assisted living. Industry leaders and business owners should work to develop their own standards for good care that protects the health and welfare of residents, to maintain positive public relations for the industry, to stave off potentially excessive federal regulation, and to effectively address patchwork regulations across the states. This is a prime opportunity for the industry to self-regulate uniform standards. Without this, Congress can – and should – establish minimum uniform standards.

Still, if current state laws, together with industry practices and standards, promote high-quality care and the utmost concern for residents' health and safety needs, uniform federal regulation may not be deemed necessary, or, alternatively, will not be as extensive and restrictive. Some kind of uniform definition and regulation of "assisted living" offers a more predictable setting for consumers, providers, and payers (Shapiro). Regardless of government regulation or industry self-regulation, increasingly informed and demanding consumers will push the industry to improve and find a proper balance between offering a good product at a reasonable cost – a necessary goal for business.

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