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# ASSISTED LIVING: TRENDS IN COST AND STAFFING

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## ABSTRACT

Assisted living communities (ALFs), which provide a community for residents who require assistance throughout their day, is an important part of the long-term care system in the US. Trained individuals assist residents with activities known as Activities of Daily Living (ADL). The costs of ALFs are paid either out of pocket, by Medicaid or by Long-Term Care Insurance (LTCI). Medicare does not pay for ALFs.

Monthly costs of ALFs have increased over the past five years on an average of 4.1%. The major reason for this cost increase is probably the increased healthcare needs of the baby boomers generation, but an increase in Alzheimer's disease may also be a factor.

## INTRODUCTION

Assisted living, also known as residential care, has been one of the fastest growing portions of the long-term care system in the United States (US) over the past several decades. From 1990 to 2002 the number of Assisted Living Facilities (ALFs) has more than doubled in capacity and accommodated more than one million residents (Smith and Feng, 2012). Between 2010 and 2050 the US is projected to experience growth in the older population partly due to the baby boomers, a group which is expected to more than double in size during this time period (Vincent and Velkoff, 2010).

According to the Assisted Living Federation of America (ALFA), assisted living is a long term care option that combines housing, support services and healthcare as needed (ALFA, 2013a), which notes that assisted living is designed for individuals who require assistance with everyday activities, also known as Activities of Daily Living (ADL). Examples of ADLs include dressing, eating, bathing and transferring (Bercovitz, et al, 2011). Approximately 38% of residents receive assistance with three or more ADLs (Caffrey et al, 2012).

Residents living in ALFs are more independent in comparison to nursing home residents. ALFs provide apartment style living to their residents which gives them a sense of self-sufficiency and privacy. Also, individuals moving into an ALF usually come directly from their own homes, so a transition to an apartment is much easier for them. Assisted living has been designed to allow residents dignity, privacy, autonomy, independence, choice and safety (AHCA, 2008).

ALFs can vary in size from smaller facilities with 4 to 10 beds to extra-large facilities with more than 100 beds (Park-Lee et al, 2011). The AHCA has pointed out that size of the facility is not as important as the services provided to the residents. About 82% of facilities are privately owned for profit and only 18% were private, nonprofit facilities (Park-Lee et al, 2011).

In 2007, the US had 1,046,631 total beds available in ALFs; by 2010 the number of such beds had risen nearly 18% to 1,233,690 (Mollica, Houser and Ujavari, 2012). The market for ALFs has grown partly due to consumer needs - people requiring assistance with ADL's preferred to be cared for in ALF because it resembled a homelike setting (Stevenson and Grabowski, 2012).

In 2010 the median Length of Stay (LOS) for residents in ALFs facilities was 671 days, with an estimated monthly cost of \$3165 (Caffrey et al., 2012). Most residents have been diagnosed with a chronic condition; e.g., hypertension, osteoporosis, diabetes, depression, arthritis, Alzheimer's and dementia (ALFA, 2013). The ALFA has classified resident characteristics in ALFs as 54% aged 85 or older, predominantly female, and 42% as having Alzheimer's and dementia (ALFA, 2013b).

Individuals in ALFs require skilled care from trained professionals such as nurses, social workers, pharmacists, dieticians, physical therapists, occupational therapists, certified nurse assistants and nursing aides; the staff providing care has to be available 24 hours a day 7 days a week to meet the needs of the residents (AHRQ, 2006). Approximately 40% of all ALFs provided some skilled care (NHPPF, 2013). These facilities also employ other job positions such as administrators, marketing directors, housekeepers, dining staff, maintenance workers and activity coordinators.

The purpose of this literature review was to analyze the future and trends of ALFs in the US to determine if it has an impact on cost and number of trained professionals required to staff these facilities.

### TRENDS IN COSTS ASSOCIATED WITH ASSISTED LIVING

The mean costs associated with ALFs in the US rose steadily between 2004 and 2011, as seen in the Table, below. The monthly costs rose from \$2,524 in 2004 to \$3,500 in 2014. In 2006, the average monthly cost was \$2,968 in relation to \$2,969 in 2007 (MMMI, 2007). Then in 2010 the cost was \$3,293 per month for a resident in comparison to \$3,477 per month for an AFL for 2011 (MMMI, 2011). From 2010 to 2011 there was a calculated difference of \$184 per month increase which is a 5.3% increase. Between 2004 and 2011, the costs associated with assisted living facilities increased by 27.4%.

Table 1: Monthly Assisted Living Costs including Highest and Lowest Costs in United States: 2004-2014

Author, Year	Study Design	Mean Monthly Cost of Assisted Living (\$) (year over year % increase)	State with Highest Monthly Cost (\$)*	State with Lowest Monthly Cost (\$)*
MetLife Mature Market Institute, 2004	MetLife market survey of assisted living costs	\$2,524	Connecticut (\$4,327)	Florida (\$1,340)
MetLife Mature Market Institute, 2005	MetLife market survey of assisted living costs	\$2,905 (9.3%)		
MetLife Mature Market Institute, 2006	MetLife market survey of assisted living costs	\$2,968 (2.1%)	New Jersey (\$5,197)	North Dakota (\$1,742)
MetLife Mature Market Institute, 2007	MetLife market survey of assisted living cost	\$2,969 (0.0%)	Washington, DC (\$5,031)	Indiana (\$1,963)
MetLife Mature Market Institute, 2010	MetLife market survey of long-term care costs	\$3,293 (9.8%)	Washington, DC (5,231)	Arkansas (\$2,073)
MetLife Mature Market Institute, 2011	MetLife market survey of long-term care costs	\$3,477 (5.3%)	Washington, DC (\$5,757)	Arkansas (\$2,156)

\*Data was not supplied by state in 2005

The costs associated with ALFs are not only associated with number and type of services required by each resident, but are also associated with the geographic region in which a facility is located (AHCA, 2013). Ten years prior to this study the state with the highest monthly cost was Connecticut where the mean cost of providing services in a ALF was \$4,327 per month, but that same year the costs of providing ALF services was only \$1,340 in Miami, Florida (MMMI, 2004). In 2014, costs associated with ALFs in Washington DC averaged \$6,890 per month, while the average costs in Georgia and Missouri were \$2,500 per month (GLIC, 2014). The range of costs associated with ALFs in 2004 were \$1,340 to \$4,327; this range of average costs rose almost continuously until in 2014 was \$2,500 to \$6,890. This is a difference of \$1,160 from 2004-2014 for the lowest monthly costs and \$2,563 dollars for the highest monthly costs. These costs and cost ranges exclude services such as bathing assistance, dressing assistance

and medication management which is an extra cost to residents (MMMI, 2012), so actual, out-of-pocket costs to ALF residents are actually higher than reported in the Table, because these additional services are hardly optional for most residents of ALFs.

### **FINANCIAL ASSISTANCE AVAILABLE FOR RESIDENTS OF ALFs**

Most people believe that Medicare covers most long-term care services (“Highmark”, 2006), but this is incorrect (O’Connell, 2014; Shelton, 2014); Medicare pays only for skilled nursing facilities for the first 100 days (ALFA, 2013c).

Medicaid is the major payer associated with ALFs in the US and between 2002 and 2009 the number of Medicaid participants increased by 43.9% (AHCA, 2009). However, the vast majority of the costs associated with ALFs are paid by the resident and his or her family (Marak, 2014). In order to qualify for Medicaid, residents of ALFs must first virtually exhaust their assets to reach the Medicaid resource limit. Many enter an ALF as a “private pay” patient, paying for their care out of their own pocket and then apply for Medicaid when they have spent down their savings to the point that they meet Medicaid’s eligibility guidelines (Dickey, 2014).

Individuals may purchase Long Term Care Insurance (LTCI) to help pay for ALFs. The ALFA has suggested that LTCI is one of the best ways for an individual to afford to pay privately for ALFs, noting that experts suggest consumers should be looking for LTCI at age 40 and should have purchased it by age 50 (ALFA, 2013c). However, despite the fact that it is estimated that forty percent (70%) of the population over 65 will require long-term care services during their lifetime (HHS, 2014), the public typically avoids any discussion of long-term care, because of the “fear and denial” associated with envisioning themselves in such a facility (Chiappelli, Koepke and Cherry, 2005). Those fears, and pre-existing health conditions which preclude insurers from issuing long-term care policies, combine to make private insurance for LTC “relatively uncommon” (Baer and O’Brien, 2010, p. 1).

### **Concerns with Staffing in ALFs**

Each state has different regulations concerning staff at ALFs (ALFA, 2014a). The ALFA posts information regarding each state’s assisted living regulations on staffing requirements through their website. For example, the state of Kentucky has defined that staffing shall be sufficient in number and qualification to meet the 24 hour schedule and unscheduled needs of its residents and the services provided, but Pennsylvania ALFs are required to have enough staff to provide at least one hour of daily care to each resident needing personal care and two hours of assistance for patients who are immobile (Carlson, 2005). It was also reported that there are 18 states that set minimum staffing ratios; for example, Georgia and Mississippi require minimum staff to resident ratios of 1:15 during the day and 1:25 at night, while Alabama requires at least 1:8 staff to resident ratio during the day, 1:12 during the evening shift and 1:16 during the late night shift for specialty care ALF (Carlson, 2005). According to the US Government Accounting Office, consumers looking for ALFs need to check to see if the facility provides 24 hour service to care for the residents (GAO, 2004).

In 2012 there were approximately 58,500 paid long term care providers that served eight million people in the US with the largest share of direct care workers as certified nursing assistants, personal care aides and home health aides. About two thirds of these providers provided care in residential settings such as nursing homes and assisted living facilities, and 19.2% or 143,600 full time equivalent nurses worked in residential care. The total average nursing hours for registered nurses, licensed practical nurses and aides per resident at a facility was 2.6 hours per day. The average nursing hours for licensed staff members was only 0.5 hours per resident, thus aides did the majority of the work in these facilities (Harris-Kojetin et al., 2013).

The retention rate for nurses in ALFs in 2011 was 73%. This retention rate were defined and calculated by dividing the total number of employees who had worked in ALF for 12 months or longer by the total number of current employees. The vacancy rate for nurses in ALFs in 2011 was 3%, and was calculated by dividing the total vacant positions by total number of established positions. The turnover rate for nurses in ALFs in 2011 was high at 29%; this rate was calculated by dividing the total number of terminations by the total number of employees (AHCA, 2012).

### **DISCUSSION**

The purpose of this research was to examine the future trends in ALF's in the US and determine if they might have an impact on costs. WE also examined the number of trained professionals required to staff an ALF. The results suggest that costs will continue to increase over time and there are limitations on information concerning staffing in ALFs.

Individuals are growing older and living longer in today's society. In the US, the group of individuals aged 65 and older is rapidly growing and it's projected to increase to 80 million by the year 2040 (Guo and Castillo, 2012). The baby boomer generation is a contributing factor to the increase. The number of individuals aged 85 and older will also continue to increase to 14 million by 2040 (Guo and Castillo, 2012). Thus, ALFs are anticipated to continue to be an important component of the long-term care industry and the need for them is expected to increase due to the growth in the older population and its subsequent increasing need for healthcare of all kinds.

In regards to costs associated for residents in ALFs, the evidence demonstrates that the monthly costs have increased incrementally each year from 2004 to 2014. The states with the highest and lowest monthly costs from 2004-2014 has also increased each year. Absent some major change in the payor system, the rise in costs of ALFs is anticipated to be an ever increasing barrier to the use of these facilities. Because assisted living costs vary widely in the US, as long as many individuals and families pay for ALFs out-of-pocket it is very important for consumers to compare prices of ALFs. It could be advantageous for individuals to go to a geographic location where ALF costs would be lower.

Size does matter in regards to costs with ALFs: increased spending for assisted living is associated with increased size of the facility. The smaller ALF's tend to offer fewer services to their residents in comparison to larger ALFs that tend to offer more services. These additional services are not included in the base price and can become a financial burden to the residents who need them.

Another possible cause to increased spending is the health status of the resident in the ALF. If the resident exhibits a complex health condition he/she will require additional assistance during the day which will cost more. For example, patients with Alzheimer's disease and dementia require additional care that patients not having these conditions will pay more for their care. By the year 2050, there are estimated to be approximately 16 million Americans with Alzheimer's disease; cost of care for these individuals is estimated to be \$1.2 trillion dollars (ALFA, 2014b). ALFs may have Special Care Units (SCUs) for individuals who may have Alzheimer's disease or a related dementia diagnosis (ALFA, 2013d). The ALFA suggest that these SCUs are staffed with trained professionals who are able to better care for these individuals and are housed in a special wing with additional security for the residents. These SCUs come at an added cost to the resident.

The costs of assisted living will continue to be financed either privately or federally through Medicaid. Private LTCI plays a very limited role in covering long-term care costs because of the high premiums associated with individuals purchasing (Ujvari, 2012). Medicaid will remain the primary payer for ALFs unless a change occurs in government regulations of healthcare.

This study could be limited by the amount of information found on assisted living. There is no national data on ALFs according to one study found (Stevenson and Grabowski, 2012). ALFs are regulated by each state and information regarding each state is vague in regards to the number of individuals working. Instead, each state gives staffing ratios for ALFs which does not give an accurate illustration of the number of employees in each ALF.

Further research should be conducted to help determine if there will be adequate staffing available to residents in ALFs in order to keep up with the demand of people aging in the US. There could be problems if there is not enough staff to adequately care for residents in ALF's. If there is inadequate staffing at these facilities it could cause quality of care issues and increased LOS contributing to increased spending by either the federal government or the resident of the ALF.

## CONCLUSIONS

The results suggest that costs associated with ALFs have the potential to continue to increase over the next several years based on the growth of the baby boomer population, larger sized ALFs and the increase in number of

individuals with chronic health conditions. Therefore it is imperative to keep costs of ALFs down to consumers requiring care in these facilities, otherwise individuals will seek alternative forms of living such as in home care, adult day care and nursing homes.

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