

How California's Assisted Living System Falls Short In Addressing Resident's Health Care Needs

The Problem: A False Choice Between Community Living and Access to Health-Related Services

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California's assisted living regulatory system was created in the 1980s on the assumption that assisted living residents did not need on-site health-related services. Now, however, California's assisted living facilities house many residents with significant needs for ongoing health care and health-related services.

This change in the assisted living population is not unique to California and, in response, many states have changed their assisted living models to incorporate an increased focus on health care. California has not done so, in part based on the explanation that assisted living follows a "social model" that should not include health care services.

As assisted living systems in other states have demonstrated, however, health care expertise is not inherently incompatible with a non-institutional living environment. Assisted living residents expect and deserve both needed services and the dignity envisioned by the social model.

This policy issue brief, the second in a series, highlights residents' expectations for health and social services, and recommends that California reject the false choice by incorporating appropriate health care expertise into the assisted living model.

The Reality: Residents Believe Facilities Possess Health Care Competence

Residents generally expect that an assisted living facility has some health care expertise. As explained by a former state health care facility regulator from another state:

Assisted living facilities are health care facilities. If you're a resident, you do not leave your home and move into an assisted living facility unless you have a health care need.

A California assisted living employee explains the resident expectation that facilities provide health care services:

Families come in and think the staff are nurses. I get called a nurse daily. We're wearing

scrubs, and residents have a misconception that scrubs = nurses. They think we have all this health care training we don't have. They ask us questions we can't answer.

In fact, California's assisted living regulatory system was not designed to address health care needs. The California Department of Social Services licenses Residential Care Facilities for the Elderly (RCFEs), which is California's term for assisted living facilities. When this licensure category was created in 1985, facilities developed as places where residents could receive help with day-to-day activities, but where there was no provision of, or need for, health care.

The False Choice between the Social Model and Health Services

California's assisted living system has fostered a misconception that health care competence is incompatible with the social model. In fact, the social model should not restrict residents from receiving the care and services they need. As explained by Brenda Premo, Director of the Harris Family Center for Health and Disability Policy:

The reaction to the social-medical model question is that it has to be one thing or another. All health? All social services? It should not be one thing or another. If we are going to talk about truly integrated programs, we need an integrated system.

The social model promotes dignity, autonomy, self-growth and privacy.¹ The social model is distinct from a "medical model," which focuses on clinical issues, such as medication administration and health care services.² A pure medical model — a hospital, for example — fails to advance the tenets of the social model. That does not mean, however, that health care competence among employees necessarily turns a setting into a health care institution.

The false choice between the social model and health care expertise contradicts the goal of aging in place: to age with choice and independence, along with access to needed services. By excluding health care expertise from RCFEs, California makes it more likely that people will have to move into nursing facilities to have their needs met.

Other States Incorporate Health Care Expertise into Assisted Living Systems

Other states' assisted living systems have blended the social model with the medical model. For example, New York has expanded licensing categories to distinguish facilities that are certified to provide more health care services, such as an "enhanced" assisted living facility that is authorized to employ health care personnel and provide assistance with medical equipment.³

Other states have expanded the role of nurses to strengthen health care delivery. For example, in Pennsylvania, a facility must have a licensed nurse in the building or on call at all times,⁴ and in Arkansas, certain categories of facilities must employ licensed nurses to provide nursing care and medication administration.⁵

1 Sheryl Zimmerman et al., *Assisted Living: Needs, Practices and Policies in Residential Care Care for the Elderly* (2001).

2 GAO, *Assisted Living: Examples of State Efforts to Improve Consumer Protections*, Rep. No. GAO-04-684 (May 27, 2004), available at <http://GAO.gov/assets/250/242236.html>.

3 10 NYCRR 1001.2(a)(10)(n).

4 1 Pa. Code § 2800.60(d).

5 Ark. Code. R. 504.2.2.

Our Recommendation: Exploring Options for a Spectrum of Care

As residents age and care needs progress, the false choice between the social model and health care expertise is no longer a workable option. Other states are actively exploring ways to meet residents' needs. As California contemplates how to meet the needs of older Californians, integrating health care expertise appropriately into assisted living should be a part of the equation.

This policy brief is the second in a series. The series explores how California's current assisted living system addresses residents' health care needs, and how the system could be modified to better serve residents.

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