

# Assisted Living that Few Can Afford:



## An Examination of the Over-Medicalization of the Enhanced Assisted Living Residence and a Sensible Alternative

Presented to the Adult Care Facilities and  
Assisted Living Residences Task Force

Prepared by Hinman Straub, P.C. for  
the Empire State Association of Assisted Living

May 2006



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The Empire State Association of Assisted Living (ESAAL) is a not-for-profit organization that since 1979 has been dedicated to strengthening New York State's assisted living industry and promoting the best interests of providers and residents. It is the only association that exclusively represents the assisted living industry, serving more than 240 Assisted Living Residences, Adult Homes and Enriched Housing Programs throughout New York State. These member residences are home to more than 20,000 elderly people. Hinman Straub, P.C. represents ESAAL in legislative, regulatory and legal issues.

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## Introduction

As New York State and the Adult Care Facilities and Assisted Living Residences Task Force (“Task Force”) works to develop regulatory standards for the newly implemented Assisted Living Residence law, stakeholders have been challenged to balance the legitimate issues and concerns of consumers, their advocates, provider representatives, and state regulatory agencies. The shared goal has been to offer assisted living residents, under certain circumstance, the choice to “age in place”, when heretofore that was often not an option, for a variety of reasons. To accomplish this goal, one of the most critical issues being examined is the development of nurse staffing standards in the aging in place model known as the Enhanced Assisted Living Residence (“EALR”).

This paper examines the proper role of nurses in the new EALR model and the feasibility of various nurse staffing requirements. The EALR presents unique challenges as it is intended to be a social model that accommodates residents that need increased assistance with Activities of Daily Living (ADLs), as well as some nursing services, as those needs for services may develop. This hybrid of social and medical models allows residents the opportunity to continue to live in the ALR, but presents regulators and providers with the challenging task of balancing quality of care, respect for consumer preferences, affordability and adequacy of access to care and services. Determining the proper role of registered and licensed professional nurses in the EALR, and appropriate staffing standards, requires the consideration of a myriad of factors, including resident characteristics and needs, availability of nurses, the ability and effectiveness of unlicensed staff to assist nurses, resident preferences, the role of the EALR in the entire health care continuum, the demand for nurses in other parts of the continuum, and the cost of services. It is also prudent to examine what other states have determined to be an appropriate minimum presence of licensed professionals in this setting.

An analysis of the relevant factors supports a minimum nurse staffing requirement that affords each resident regular and ongoing nurse assessment to identify any need for an update of the resident’s Individualized Service Plan. Facilities that admit or retain residents with skilled needs that cannot be met by the on-staff nurse must provide additional nurses to meet such needs. This approach sets a minimum staffing standard that is sufficient to meet the assessment needs that are common to all EALR residents and mandates that facilities add staffing when required to meet the additional identified needs of individual residents.



A significant factor in the nursing shortage is the age of the workforce. In 2002, the average age of a NYS RN was 47.<sup>3</sup> This is substantially higher than in 1995, when the average age was 44, and in 1989 when the average age was 41. This troubling trend is predicted to continue in the future. Moreover, there are fewer younger nurses to take the place of the nurses that retire from the profession. In 1973, 30% of the nursing workforce was age 29 or younger and only 7% was 60 or older. In 1980, the percentage of nurses 29 or younger dropped significantly to 25.1%.<sup>4</sup> In 2002, the percentage of nurses 29 or younger plummeted to 5%, while the percentage of nurses 60 or older climbed to 10%. In 1973 the “youth to age” ratio in the profession was 4:1. In 2002, it was 1:2, representing that young nurses comprise only half as much of the workforce as nurses that are approaching retirement.<sup>5</sup> This is compounded by the fact that the average retirement age for the profession is just 49.<sup>6</sup> This early exit from the profession can be attributed to a number of factors not addressed here, such as mandatory overtime and stressful working conditions. However, the relevant consideration in this analysis is that the average age of the workforce of 47 is only two years shy of the average retirement age, thereby indicating that the profession is likely to soon lose a substantial portion of its workforce.

While many nurses are expected to leave the workforce, entrants into the field barely offset this attrition. Net growth in the profession is stagnant. As shown in Graph 1, in 1997, there were a total of 294,234 nurses registered to practice in New York. That number increased only a modest amount through 2001 to 303,732 and the number of LPNs actually dropped from 70,129 to 68,912.<sup>7</sup> This decrease in nurse supply occurs simultaneously with a growing 85+ aging population in need of services, and large gaps between supply and demand are inevitable.

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<sup>3</sup> “Registered Nurses in New York State, 2002” p 8-9.

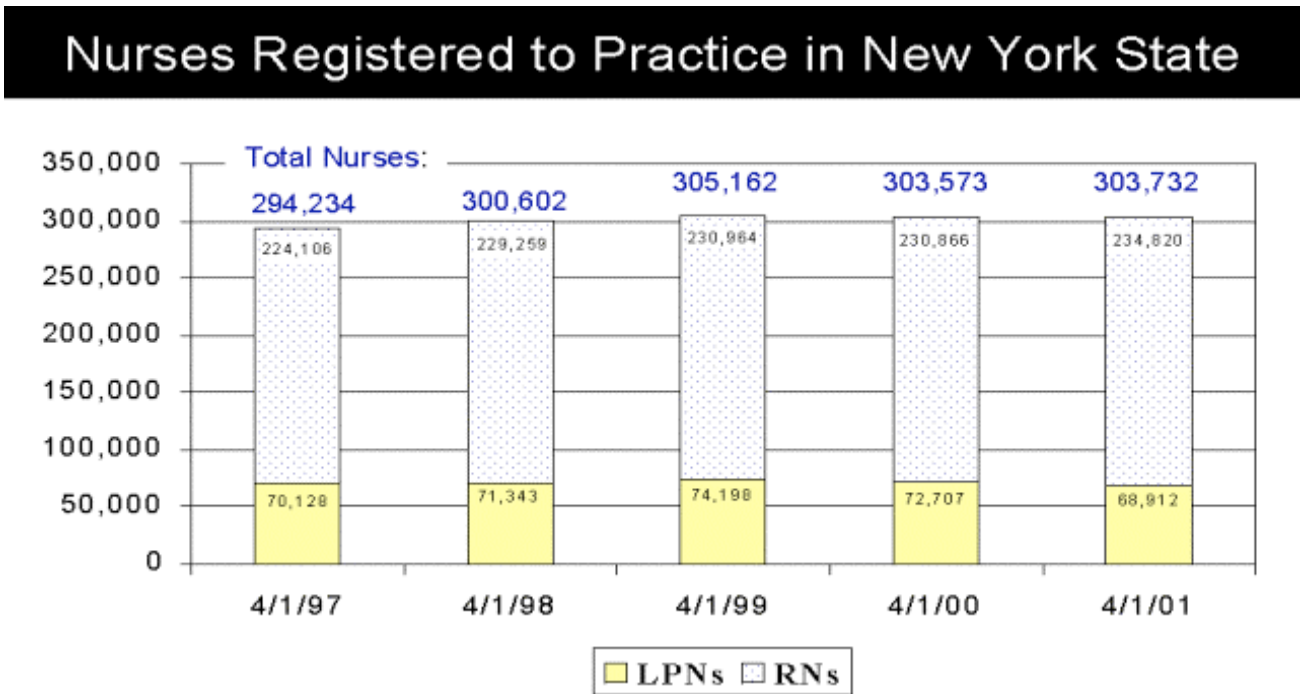
<sup>4</sup> “The Nursing Shortage” A report by The Office of the Professions to the New York State Board of Regents, April 2001, p5.”

<sup>5</sup> “Registered Nurses in New York State, 2002” p10.

<sup>6</sup> “The Nursing Shortage” p 5.

<sup>7</sup> “The Nursing Shortage” p2

**Graph 1**  
**RNs and LPNs Registered to Practice in New York 1997-2001**



*Graph excerpted from “The Nursing Shortage” A report by the Office of the Professions to the New York State Board of Regents, April 2001, p5.”*

Graph 1 reflects that there was zero net growth in nurses **registered and licensed** in New York State from 1997-2001. Similarly, the number of nurses actually serving in New York State was also stagnant between 1996 and 2002 with 165,667 nurses **employed** in New York in 1996 and only 165,640 in 2002 according to the US Department of Health and Human Service’s Health Resources and Services Administration (“HRSA”).<sup>8</sup> Again, at the same time, demand for nurses is expected to increase as the population ages and requires more skilled services, which will increase the shortage. According to the New York State Office for the Aging, the age 75+ cohort is expected to increase by 32% between 1995 and 2025. Those 85 and older will increase by 41% over that same time period. This significant growth will occur simultaneously with only a 3% growth in the numbers of people age 60 and under—our workforce.<sup>9</sup>

While the aging population increases demand for direct care nursing services, the aging of the workforce is reducing the number of nurses willing to work in direct care positions. For example, 21% of the 166,000 active NYS RNs do not work in direct care.<sup>10</sup> Of those RNs age 30 or younger, 96% work in direct care while only 68% of those 60 years or

<sup>8</sup> “Demographic, Educational and Workforce, Characteristics”, p8.

<sup>9</sup> “Demographic Projections to 2025”, New York State Office of the Aging website, <http://www.oag.state.ny.us/seniors/pwrat.html>, p7.

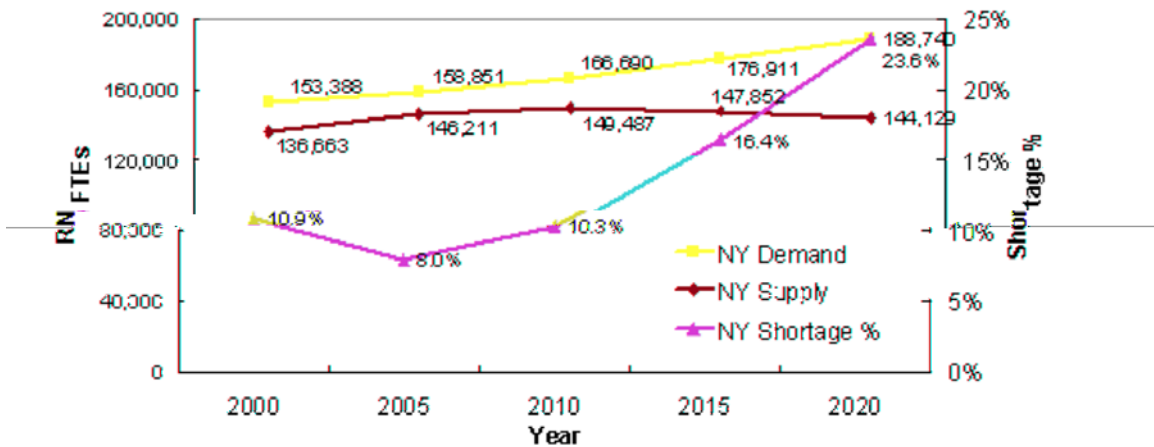
<sup>10</sup> “Demographics, Educational and Workforce Characteristics”, p 89.

older are employed in direct care positions. The Office of the Professions’ report cautions that to meet the growing needs of the population, direct care retention must be improved. Age also impacts the amount of time a nurse will work on average. For example, the average workweek for a nurse is 55.7 hours, but those nurses age 60 and older are less likely to have full-time jobs than their younger counterparts.<sup>11</sup> Thus, as a growing portion of the workforce is over the age of 60, a smaller portion is willing to work in direct care or to work full-time or over-time.

Many of these factors have already converged to produce a substantial shortage of nurses in New York State, which is represented in Graph 2. HRSA’s research shows that in 2000 there was a demand for 153,388 nurses in New York and a supply of only 136,663, leaving a 10.9% shortage. This shortage is projected to be 10.3% in 2010, 16.4% in 2015 and an ominous 23.6% in 2020.<sup>12</sup> Thus, in just fourteen years there is expected to be a shortage of more than 44,000 nurses in New York State alone.<sup>13</sup> Although nursing shortages are not unique to New York State, it has the second to least number of nurses per person (834 nurses per 100,000) than nine northeastern states studied by the Office of Professions.<sup>14</sup>

**Graph 2**  
**HRSA Projected New York FTE RN Supply, Demand and Percent Shortage, 2000-2020**

Figure 7  
HRSA Projected New York FTE Registered Nurse Supply, Demand and Percent Shortage, 2000-2020



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration. *Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020*. (July 2002).

<sup>11</sup> “Demographics, Educational and Workforce Characteristics”, p 11.  
<sup>12</sup> “Demographics, Educational and Workforce Characteristics”, p 132.  
<sup>13</sup> “Demographics, Educational and Workforce Characteristics”, p 132.  
<sup>14</sup> “The Nursing Shortage”, p3. The states examined were Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, New York and Pennsylvania.

All of these factors mean that employers have difficulty in filling open positions. Nearly one-third of New York City hospitals report that it has taken three months or more to fill an open nurse position<sup>15</sup> and 92% of hospitals report they have at least one vacant RN position and 71% have a vacant LPN position.<sup>16</sup> Such shortage issues caused the Office of Professions to recommend that the State “develop ways to better use scarce RNs by enhancing the application of labor-saving technology and improve the training and competence of unlicensed personnel who appropriately assist nurses in the care of patients.”<sup>17</sup> Many states have developed systems to utilize trained personnel to ease the burden on their nurses and ensure that proper levels of nurses are maintained in hospitals, nursing homes, and other medical care settings, as well as in less medically oriented settings such as assisted living residences. The efficient use of this scarce resource has become an important priority throughout the nation, and requires a methodology that allows for adequate nursing coverage in settings where people are often medically unstable (i.e. hospitals and nursing homes) and truly need the ongoing presence of nurses to make clinical judgments.

### **State Minimums for Nurse Presence in Assisted Living Facilities**

Nearly half of all states (24) set no minimum nurse staffing requirement in their assisted living facilities. Of the 26 states that do require assisted living facilities to employ nurses, only a handful of them require their on-site presence.<sup>18</sup> The two states with the strictest standards are Alabama, which requires each assisted living facility to have a nurse to perform assessments of residents, and Mississippi, which requires that a nurse be present eight hours a day.<sup>19</sup> Some states set a lower minimum presence requirement, like Connecticut, which requires that assisted living facilities employ a nurse for ten hours a week for every ten full-time aides it employs.<sup>20</sup> Indiana requires one on-site nurse if there are between 50 and 99 residents who are regularly receiving residential nursing services or medication administration (not assistance), and two are required for facilities with 100 to 149 such residents and so on.<sup>21</sup> Rhode Island requires that an RN visit the facility once every 30 days and file a report on its operation or, for facilities that elect to keep a full-time RN on staff, that nurse must file the report every 90 days.<sup>22</sup>

In several other states, assisted living facilities are simply required to have a nurse approve or oversee their medication management system and assess residents. For example, in Illinois, a nurse must approve the medication management system.<sup>23</sup> In Maryland, a nurse must conduct an on-site review of the medications program every 45

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<sup>15</sup> “The Nursing Shortage” p 4. (Data from 1999.)

<sup>16</sup> “The Nursing Shortage” p 4. (Data from 2000.)

<sup>17</sup> “The Nursing Shortage”, p 10.

<sup>18</sup> Carlson, Eric M “Critical Issues in Assisted Living State Summaries” National Senior Citizens Law Center, May 2005.

<sup>19</sup> Id.

<sup>20</sup> Id.

<sup>21</sup> Id.

<sup>22</sup> Id.

<sup>23</sup> Id.

days.<sup>24</sup> Vermont requires that facilities' medication management systems be under the supervision of a licensed nurse, who would be charged with delegating responsibility, teaching designated staff to properly complete tasks and the difference between assistance with self-administration and administration.<sup>25</sup> In South Dakota, nurses are required to visit the site weekly to review and document resident care and conditions.<sup>26</sup>

Two states, Arkansas and New Jersey, require only that a nurse be on call twenty-four hours a day, seven days a week.<sup>27</sup> Many states have established the sensible standard that nursing presence must be sufficient to meet the needs of the residents and to perform necessary tasks or to oversee delegated tasks (Florida, Hawaii, Idaho, Louisiana, Minnesota, Montana, New Hampshire, North Carolina, Oregon, Tennessee and West Virginia).<sup>28</sup> Those states that allow the delegation of nursing tasks do not require that the nurse be present to oversee the tasks, but instead set standards for review of such tasks. For example, review of delegated tasks in Minnesota can take place up to two weeks after the initial performance of the task and two months after all subsequent delivery of such services.<sup>29</sup> Kansas requires only that the nurse be available by phone when the delegated tasks are being performed.<sup>30</sup> Finally, a number of states require that nurses perform assessments of the residents' health status (Hawaii, Idaho, Indiana, Iowa, Utah and Wyoming).<sup>31</sup>

In short, existing state requirements seem to recognize and acknowledge that valuable and scarce nursing resources ought to be carefully used, and trained staff should be utilized to lighten the workload of nurses where appropriate. **In fact, of the 26 states that require some involvement of a nurse, only one state, Indiana, has an around the clock nursing requirement, and then, only when the facility has 50 or more residents who regularly receive residential nursing services or administration of (not assistance with) medications. Most of those 26 states simply require that residents' needs be met and/or that nurses be involved in resident assessments or review of the medication management program.** (As a side note, this is the same standard that has been sensibly and efficiently applied to New York State's Licensed Home Care Service Agencies, or LHCSAs.)

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<sup>24</sup> Id.

<sup>25</sup> Id.

<sup>26</sup> Id.

<sup>27</sup> Id.

<sup>28</sup> Id.

<sup>29</sup> Id.

<sup>30</sup> Id.

<sup>31</sup> Id.

## The Importance of Minimum Standards

It is important to note that standards set in each of the states listed above are minimum standards. When residents' needs require more staff than is provided by the minimum standard, the facility must arrange for such care or, when necessary, assist the resident in transferring to a higher level of care. **In virtually all states, minimum standards are not set in an attempt to meet each possible condition or need that a resident might develop. Rather, the minimum standard is set so that the supervision, monitoring and assessment services that are universally needed by residents can be delivered. When increased needs are identified, additional services and staff must be provided to meet those needs.**

One of the negative effects of setting a minimum standard too high is that the cost of specialized nursing care of one particular person in need is imposed on other residents in the assisted living community. For example, consider a particular EALR that has 50 residents, only five of which require any nursing services and the other 45 of which require only periodic assessment. If all EALRs are required to have a nurse on staff twenty-four hours a day, then the 45 residents without skilled needs would be paying for, or subsidizing, the care of the 5 who are receiving nursing services. The 45 residents that consume no skilled nursing services will, consequently, "spend down" their own private resources more quickly than necessary and face nursing home placement simply because they cannot continue to afford to pay for services that they did not need in the first place. It is much more fair and economical to set the minimum standard at a level to meet the basic needs of all residents, and to require additional services for those residents that need them.

## Staffing Models with Costs per Resident

The cost to consumers of any minimum staffing model must be considered in order to create a successful and accessible model. In New York, Assisted Living Residences do not typically receive any government reimbursement for medical or nursing care delivered. Thus, the increase in costs to add nursing staff to meet a minimum requirement will be borne by all EALR residents through an increase in the monthly rate. The tables below present DOH data, based upon EALR applicant information posted on the Department's website, to report on the program size distribution of EALR applicants, and also detail the cost of nurses in various regions, the break down of costs for various minimum standards models and the resulting individual resident cost per month.

According to the DOH data, the distribution of EALR program applicants is as follows:

**Table 1**  
**Distribution of EALR programs by Size**

<b>EALR Size</b>	<b>Number of Applicants</b>
<b>100 or more beds</b>	18
<b>75-99</b>	11
<b>51-74</b>	25
<b>36-50</b>	15
<b>21-35</b>	19
<b>11-20</b>	7
<b>6-10</b>	6
<b>1-5</b>	2

As shown, only 18 of the 104 applicants have requested 100 beds or more in their Enhanced ALR programs, with a substantial number of applicants (49) falling in the 50 bed or less range. Thirty-four applicants have requested 35 beds or less, with a small number of those (eight) asking for 10 or less. Based on these trends, in the tables below we project staffing model costs for 100, 50 and 35 bed EALR programs.

In the analysis, we have grouped Rochester/Buffalo/the Capital Region and North Country Regions together under the heading of “Upstate” as salary costs in these areas were quite similar. Salary levels for Long Island and New York City were substantially more, and thus, have been separately listed. Salary levels were collected from two sources: Empire State Association of Assisted Living members’ reported salaries for 2006, and the US Department of Labor salaries for 2004. The Department of Labor 2004 salaries were increased by 7% to represent the increase that would occur over two years. All salary data includes the cost of basic benefits. These figures are shown in Table 2. Table 3 shows the average salaries reported from these two sources to establish the salary rate that will be applied to the various staffing models examined in Tables 4 through 6.

**Table 2**  
**Sources of Salary Data for RN and LPN**

<b>One FT Staff Member</b>	<b>LI – 2006 (member reported)</b>	<b>LI – 2004 adjusted US DOL</b>	<b>NYC – 2006 (member reported)</b>	<b>NYC – 2004 adjusted US DOL</b>	<b>Upstate— 2006 (member reported)</b>	<b>Upstate- 2004 adjusted US DOL</b>
<b>LPN</b>	\$61,028.00	\$58,176.33	\$58,240	\$ 58,745.57	\$50,016.00	\$48,783.87
<b>RN</b>	\$91,291.20	\$93,383.82	\$99,008	\$100,015.47	\$72,152.50	\$70,272.68

**Table 3**  
**Average Cost of RN and LPN Services with Benefits by Region**

<b>Staff</b>	<b>Long Island</b>	<b>New York City</b>	<b>Upstate</b>
<b>LPN – One FT</b>	\$ 59,602.17	\$ 58,492.79	\$ 49,399.94
<b>LPN – Hourly</b>	\$ 28.65	\$ 28.12	\$ 23.75
<b>RN – One FT</b>	\$ 92,337.51	\$ 99,511.74	\$ 71,212.59
<b>RN – Hourly</b>	\$ 44.39	\$ 47.84	\$ 34.24

The staffing model represented in Table 4 was recently proposed by the Department of Health. It shows the cost of having an RN for eight hours a day, seven days a week and an LPN 16 hours a day for seven days a week so that there is around the clock nursing. Even in a larger EALR program (i.e. 100 beds), the additional cost per resident per month is significant, and is between \$198 and \$252. In a thirty-five-bed EALR, the increased cost ranges from \$566 to \$721 per month. According to an annual MetLife Market Survey of Assisted Living Costs, today, in New York State, the consumer pays an average of approximately \$3,000 per month for a comprehensive package of housing and services, including assistance with ADLs, medication assistance, case management services, 24-hour monitoring, assistance with dietary needs, structured activities, room or apartment, all meals, housekeeping, and laundry. The increased costs associated with this minimum nurse staffing standard would likely prohibit many residents from accessing the EALR and its aging-in-place services; this even for people that have no skilled nursing needs at all. Moreover, nurses hired to meet this requirement will not “replace” other facility staff because nurses do not want their jobs to include the types of unskilled tasks that are typically performed by other assisted living employees. Inclusion of such tasks in the nurse’s job description will make it even more difficult to recruit and retain qualified candidates. Moreover, even if the presence of the nurse could replace some other staff needs the substantial difference in salary between nurses and direct care staff would mean that any payroll savings would be minimal in comparison to the substantial additional cost of the nurse.

**Table 4**  
**Cost per Resident per Month of 24 hour Nurse Coverage**  
**(8hr RN, 16hr LPN daily)**

<b>EALR Beds</b>	<b>LI Total = \$ 296,158.58</b>	<b>NYC = \$ 303,096.23</b>	<b>Upstate = \$ 238,017.44</b>
<b>100</b>	\$ 246.80 per month	\$ 252.58 per month	\$ 198.35 per month
<b>50</b>	\$ 493.60 per month	\$ 505.16 per month	\$ 396.70 per month
<b>35</b>	\$ 705.14 per month	\$ 721.66 per month	\$ 566.71 per month

The staffing model represented in Table 5 was discussed by the Task Force as an alternative to the model in Table 4. An RN and LPN would evenly split the first two shifts of the day and trained staff would be on site during the third shift. The monthly cost increase under this model is not as dramatic as the around the clock model, however, the increase in monthly rates for a 50 bed EALR are still between \$281 and \$368, representing an increase of between 9% to 12% simply to meet the minimum staffing requirement. A thirty-five-bed EALR would experience a 13% to 18% cost increase. These increases are likely to be prohibitive for middle income seniors and to severely limit access. Again, residents will be forced to pay these increases even if they have no need for skilled nursing care.

**Table 5**  
**Cost per Resident per Month of 2 Shifts Nurse Coverage**  
**(8hr RN, 8hr LPN daily)**

<b>EALR Beds</b>	<b>LI Total = \$ 212,715.55</b>	<b>NYC = \$ 221,206.33</b>	<b>Upstate = \$ 168,857.54</b>
<b>100</b>	\$ 177.26 per month	\$ 184.34 per month	\$ 140.71 per month
<b>50</b>	\$ 354.53 per month	\$ 368.68 per month	\$ 281.43 per month
<b>35</b>	\$ 506.47 per month	\$ 526.68 per month	\$ 402.04 per month

We believe the staffing model represented in Table 6 to be more reasonable, affordable, and reflective of actual needs of the resident population. This model provides for a meaningful daily presence of nurses at the EALR to ensure that residents are regularly assessed for changes in conditions, and that staff are properly supervised. In addition to the regular assessments conducted by the nurse, residents will also continue to receive periodic assessments from their individual physicians. The physician’s assessment determines what services are provided under and enumerated in the individualized service plan, when a change in services is required and whether the resident is appropriate for continued residency in a particular level or if his or her needs have increased so to require transfer to a higher level of care.

The model set forth below would establish a sensible minimum, and contemplates that, when the resident’s physician or the staff RN identify a skilled nursing need that cannot be met by this level of staffing, but that is an appropriate service in the EALR setting, additional nursing staff must be retained to meet the needs of the individual. It also recognizes and reflects that the nurse will have fewer tasks in a residence with fewer EALR residents, and thus establishes an adjusted minimum staffing level for residences with an EALR census of 35 or less. The additional monthly cost for this model is still significant and a concern, (as is the available supply of nurses to meet this standard) but is at least at an amount that is somewhat more manageable for consumers to access this level of care. Also, the adjusted standard for smaller programs would help to ensure that consumers in rural areas will have access to EALRs and aging in-place services. Moreover, it will promote consumer choice by making it feasible for residents across the

state to access EALR services in both large and smaller settings. In response to concerns that EALRs will serve an increasingly frail population, this proposed standard exceeds the LHCSA regulations, which mandate only that home care agencies staff a number of nurses sufficient to meet the needs of residents in their care, and properly provides for any frail elderly residents by conducting regular RN assessments. Residents served by the EALR model presented in Table 6 will be directly monitored by an RN much more frequently than those served by the existing LHCSA model, and thus will receive assessments that are sufficient in scope and frequency to ensure proper care for existing and changing needs.

**Table 6**  
**Cost per Resident per Month of Daily Nurse Coverage**  
**With Adjusted Minimum for Facilities with 30 EALR beds or less**  
**(8hr RN 5 days, 8hr LPN 2 days)**

<b>EALR Beds</b>	<b>LI Total = \$ 116,178.38</b>	<b>NYC = \$ 122,908.85</b>	<b>Upstate = \$ 90,972.56</b>
<b>100</b>	\$ 96.82 per month	\$ 102.42 per month	\$ 75.81 per month
<b>50</b>	\$ 193.63 per month	\$ 204.85 per month	\$ 151.62 per month
<b>35</b>	\$ 276.62 per month	\$ 292.64 per month	\$ 216.60 per month
<b>Adjusted Minimum</b>	<b>LI Total = \$ 58,089.19</b>	<b>NYC = \$ 61,454.42</b>	<b>Upstate = \$ 45,486.28</b>
<b>35*</b>	\$ 138.31 per month	\$ 146.32 per month	\$ 108.30 per month
<b>25*</b>	\$ 193.63 per month	\$ 204.85 per month	\$ 151.62 per month
<b>20*</b>	\$ 242.04 per month	\$ 256.06 per month	\$ 189.53 per month

\* EALRs with a census of 35 residents or less are subject to an adjusted standard of a 20 hours per week RN and 8 hours per week of LPN coverage on account of the reduced resident population.

### **Making EALR Services Available to People with Low and Moderate Incomes**

The Assisted Living Residence law requires that aging-in-place services provided in the EALR model be made available to people that are indigent or have modest incomes. Like personal care and health care services provided in all other care settings, this means that Medicaid may begin to pay for these enhanced services in the assisted living setting. Just as the private paying consumer will bear the responsibility to pay for the increased costs associated with the minimum nursing standard, so too will government and taxpayers when Medicaid becomes a payer for those who are financially eligible. Therefore, the affordability issue is important for consumers of all income levels, and the nursing standards that are ultimately enforced will have significant impact on our state's Medicaid expenditures, as well as on private pay residents, causing them to spend down more quickly to Medicaid eligibility. Those who cannot afford EALR rates would be forced to go to a nursing home, which raises Olmstead considerations by forcing those

without resources into a higher level of care than they need.<sup>32</sup> In contrast, the Olmstead decision requires that individuals be served in the least restrictive setting appropriate to meet their needs.

### Consumer Preference for Variety

According to a comprehensive study of assisted living performed by the Rutgers Center for State Health Policy, the predominate view of nurses who currently work in assisted living settings is that consumers do not choose assisted living for safety reasons, but rather for quality of life reasons, and that over-medicalization of the assisted living model will make it more of an institution than a home.<sup>33</sup> Consumers want the option of selecting less institution-like settings, both in appearances and practices.<sup>34</sup> In fact, when able residents live together in facilities with less able residents, they create a social hierarchy by disability because the able residents do not want to see the effect of medical conditions that may one day reduce their own abilities.<sup>35</sup> Thus, it makes sense to allow consumers to choose an EALR that best suits their desires. Some people will prefer an EALR that will allow them to age-in-place despite their need for a significant skilled nursing services and others will prefer a facility focused on an active lifestyle that allows them to socialize with similarly situated residents and to age-in-place when they develop enhanced personal care needs or mobility issues, but not necessarily when they develop substantial skilled nursing needs. Consumers should be able to choose from an assortment of models, but setting minimum nurse staffing too high will stifle the variety of models available, and only the wealthiest will be able to afford these overstaffed EALRs.

### Medications

Medication management is an important service that all Assisted Living Residences are required to provide. Some assisted living residents are capable of self-administering their medications, while others require assistance with self-administration. Still others require medications, such as certain injections, that must be administered by a nurse. In all but one state, medication aides are permitted to administer medications or assist assisted living residents with self-administration.<sup>36</sup> Moreover, the number of states allowing medication aides to administer or assist with medications has climbed from 21 states to 49 states since 2002, representing a trend for these tasks to be performed by non-nurses.<sup>37</sup>

Significantly, error rates in medication administration and assistance are no greater for non-nurses than they are for nurses. In fact, in a study of Massachusetts assisted living facilities revealed that facilities that used non-professional direct care staff for

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<sup>32</sup> Olmstead v. L.C., 427 US 581(1999).

<sup>33</sup> Reinhard, Susan (et. al.) “Nurse Delegation of Medication Administration for Elders in Assisted Living” Rutgers Center for State Health Policy, June 2003”, p.21

<sup>34</sup> Id.

<sup>35</sup> “Under One Roof, Aging Together Yet Alone”, The New York Times, January 30, 2005.

<sup>36</sup> “Nurse Delegation of Medication Administration”, Appendix D.

<sup>37</sup> Id. at 2.

medications had an error rate of 3.62%, which was lower than the error rates of the facilities that used registered nurses to actively assist with the medication system or to

## Conclusion

Enhanced Assisted Living Residences offer a higher level of care to residents, but not all EALR residents will require skilled nursing services; many simply require additional personal care services. Indeed, the Assisted Living Residence statute defines the characteristics of persons in need of EALR, all of which are personal care in nature. However, assessment of residents by a professional is critical to ensure that when residents' conditions change, their need for additional services is identified. For these reasons, minimum nurse staffing standard should be set at a level sufficient to meet the universal assessment needs of the resident population. In cases where individual residents require skilled nursing services, such services should be provided or arranged for and charged to the individual resident (or to Medicare if appropriate). This avoids imposing the costs of care for some residents on others in the residence. That is, residents will only pay for the nursing services they consume.

If the nurse staffing requirement is set higher than is necessary to provide regular assessment of residents, the cost of obtaining the nurses and the difficulty in recruiting qualified applicants will stifle EALR availability in two ways. First, residences that realize that their residents can not afford the increased monthly rent associated with the staffing standard, or who feel that they could not attract and retain competent nursing staff, will not apply for the certification, thereby reducing the availability of EALRs. Second, those residences that manage to find and hire the required staffing and provide EALR services will be forced to accept residents with high levels of skilled nursing needs so that they can justify their increased monthly charges. This would have the undesirable effect of limiting access to EALR programs for the very people that it was designed to serve: people with increased personal care needs, not nursing needs!

Finally, the assisted living law does not require that nursing services be part of the basic package provided by EALRs. However, the high nurse staffing standard clouds the issue, and may have the undesirable effect of making services traditionally supported by Medicare no longer reimbursable, and therefore the responsibility of the consumer.

It is for these reasons that an assessment focused minimum staffing model is the most sensible and effective approach to protecting the health, autonomy and choice of New Yorkers residing in Assisted Living Residences and those with a future need for these important services.