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Historical Evolution of Assisted Living in the United States, 1979 to the Present

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Purpose: This article provides a historical overview of the emergence of assisted living in the United States over a 25-year period to identify goals and key concepts that underpinned the emerging form of care. ***Design and Methods:*** The method is historical analysis based on records and my own personal experiences in conceptualizing and implementing assisted living in Oregon and nationwide. ***Results:*** I identified four time periods: (a) 1979 to 1985, when a paradigm shift occurred on both the East and West coasts, motivated by distaste for nursing facilities and idealistic values regarding residential environments, service capacity, and consumer-centered care philosophy; (b) 1986 to 1993, when providers, consumers, and state governments became interested and four identifiable types of assisted living (hybrid, hospitality, housing, and health care) appeared, each of which informed the evolution of assisted living; (c) 1994 to 2000, a period of expansion, Wall Street money, dilution of the ideals, and emerging quality concerns; a crisis of confidence and a crossroads for assisted living; (d) 2000 to the present, a time of regrouping, slow-down in growth, and reexamination of earlier efforts to define and set standards for assisted living. ***Implications:*** Well-conceptualized and designed research may provide a mechanism to suggest practice, regulatory, and payment models. I recommend that researchers conduct studies from the values premises underlying the assisted living approach.

Key Words: Housing with services, Environments, Autonomy, Values

This article describes the emergence of modern assisted living in the United States. For nearly 30 years, I have participated in this history as a consumer on behalf of family members; as an assisted living administrator, owner, and developer; as a consultant on assisted living to state governments; as the chief executive officer of a publicly held company; as an educator; and as a researcher. From the early 1980s until about 1985, individuals developed and operated assisted living models working largely in isolation from one another and from existing providers of housing and long-term care. The years 1986 to 1993 were characterized by growing awareness and interest from consumer groups and public policy leaders, and continued development and small-scale replication by care providers. The third period, 1994 to 2000, was one of explosive growth. In the period since 2000, assisted living has faced increasing scrutiny, criticism, and self-criticism, well-publicized negative events, and investigative journalism (e.g., ; Fallis, 2004; Fallis, 2004; Fallis, 2004; Fallis, 2004).

Birth of a Paradigm Shift: 1979 to 1985

Residential Care Before Assisted Living

Residential settings for older people with health problems, ranging from ordinary boarding homes to philanthropically funded organizations often called *homes for the aged*, typically predated the 1965 enactment of Medicare and Medicaid, which shaped the modern nursing facility (Cohen, 1974). After 1965, many homes for the aged converted to nursing facilities with encouragement from state governments,

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Table 1. Jessie's Vision

As a result of a severe stroke, during much of the time my mother resided in a nursing facility, she was unable to bathe herself, cut up her food, go to the bathroom by herself, groom herself, or take her medications. In spite of the assistance she routinely needed, her focus was always to get out of "there." She wanted her own place so she could have *a life*. Even as her health declined and she needed more oversight and nursing care, she steadily proclaimed that with the right help she could live on her own. Routinely she was told no such alternative place existed. It was hard as a daughter to hear her ask why such a place did not exist or why Medicaid would not help her stay out of the nursing facility.

Why not indeed? Her vision was simple. She wanted a small place with a little kitchen and a bathroom. It would have her favorite things in it, including her cat, her unfinished projects, her Vicks VapoRub, a coffeepot, and cigarettes. There would be people to help her with the things she couldn't do without help. In this imaginary place, she would be able to lock her door, control her heat, and have her own furniture. No one would make her get up, turn off her favorite soaps, or ruin her clothes. Nor could anyone throw out her "collection" of back issues of magazines and Goodwill treasures because they were a safety hazard. She could have privacy whenever she wanted, and no one could make her get dressed, take her medicine, or go to activities she did not like. She would be Jessie again, a person living in an apartment instead of a patient in a bed. Then a graduate student, I was empathetic with her complaints, but I also felt bad for those nursing facility staff trying to provide care and guilty because I couldn't personally do more. When I told her I was studying to be a gerontologist, she asked me a question that changed my life: "Why don't you do something to help people like me?"

which welcomed matching federal money to help state and local governments finance long-term care for low-income people. The nursing facility sector expanded rapidly after Medicare's and Medicaid's enactment. Over time, nursing facilities became more hospital-like in their design and physical operation (Vladeck, 1980). But some residential care facilities did not convert to certified nursing facilities, either because they could not meet the regulatory standards even for the lesser level (then known as intermediate care facilities) or because they did not aspire to offer health-related services. They came to be known by many names: boarding homes, board and care homes, domiciliary care, adult care homes, rest homes, retirement homes, and convalescent homes, among others.

The residential care industry continued to expand even as the demand for nursing facility beds grew. Retirement housing aimed at well-to-do seniors was sold as a lifestyle choice to seniors seeking company, meals, and housekeeping. Other residential care settings were more modest in their amenities, including county "poor farms" and former boarding homes catering to single workers. Residential care facilities often served those at the lowest end of the economic spectrum, including Supplemental Security Income recipients and people with mental retardation and developmental disabilities or mental health diagnoses. Some settings targeted low-income elders who needed "some" help with room and board. (The phrase *three hots and a cot* is so pervasive a depiction of the minimalist component of the board-and-care industry that its origin is hard to pinpoint.) The quality of this residential care was uneven and has been the focus of numerous media exposés and public inquiries (Dobkin, 1989; General Accounting Office [GAO], 1989; U.S. Senate, 1999; U.S. House of Representatives, 1989).

It is also difficult to discern the beginnings of assisted living. To my knowledge, the first written use of the term (and my first such use of it) was in a 1985 proposal to the State of Oregon to fund a pilot study whereby the services for 20 nursing-home-level Medicaid recipients would be covered in a new residential setting. By 1988, *assisted living* was being used in presentations at professional meetings and in early trade publication articles. By 1991, when Hawes, Wildfire, and Lux (1991) published a national study of board and care homes, many residential care facilities that offered or arranged care were calling themselves *assisted living*, and the study included assisted living as an explicit subset of residential care.

Some critics see assisted living largely as a residential care facility with additional amenities directed at wealthy customers, but this charge misstates the genesis of the assisted living sector. More creditably, the early models of assisted living emerged in reaction to nursing facilities and a vision of a different way of bringing physical environments, care and service capacity, and philosophy together to offer a more desirable product to older people, many of whom were in or destined for nursing facilities. My mother became a nursing facility resident in November 1969; her discontent during the following 10 years informed my own ideas for new models of housing and services (see Table 1).

As a doctoral student in 1979, first influenced by my mother, then informed by environmental psychology theory and later encouraged by the work of developmental disability specialists (Hull & Thompson, 1981; Janicki, Krauss, & Seltzer, 1988; Tully, 1986), I began to conceptualize a new model, heavily influenced by Powell Lawton's work and his ecological theory, enunciated in the 1970s (Lawton & Nahemow, 1973). His theoretical construct held that if stressors in the environment were high and personal competence was low, individuals would have difficulty living in that particular setting. I speculated about how to lower environmental and organizational stress while increasing support for individual competence. Although both the design of the setting and the availability of supportive services would be important, personal control for residents

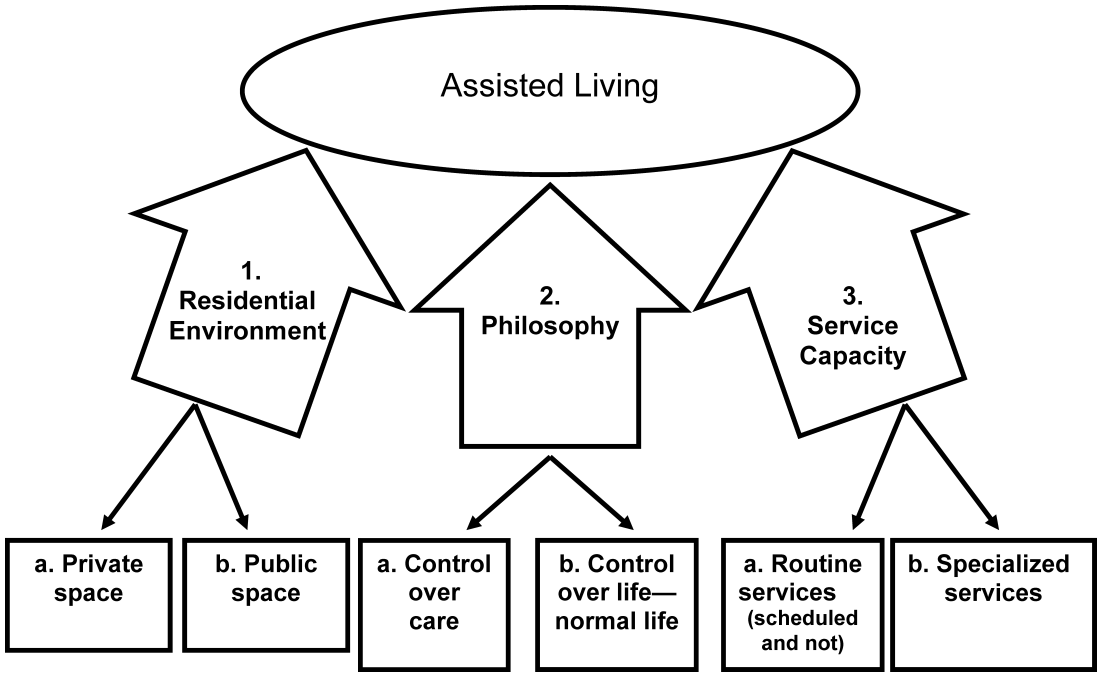

Figure 1. The three-legged stool of assisted living. Adapted from Kane and colleagues (1998).

also was crucial for individuals such as my mother. Thus, the model of assisted living I began working on in the early 1980s included a fully accessible apartment building with private living space, a full array of services, an emphasis on consumer autonomy, and the right to make choices regarding daily activities and health care.

While working for a nonprofit trade association in 1981, I continued to advocate with the head administrator of the newly formed Senior Services Division in the State of Oregon to add services to existing low-income housing settings. My thinking had coalesced around three general components of assisted living as a form of housing and services:

1. A residential-style physical environment, pertaining to (a) a resident's private space and (b) public community spaces shared by all residents;
2. A service capacity for (a) delivering routine services—both those amenable to being scheduled and those that could not be scheduled and (b) specialized health-related services; and
3. An operating philosophy emphasizing resident choice and normal lifestyles related to (a) the governance of the resident's time, space, possessions, and contacts in his or her private space; and (b) decisions about accepting or rejecting medical care and other health-related care and services.

Figure 1 shows these elements schematically as a three-legged stool, each leg with three prongs (Kane, Kane, & Ladd, 1998), and Table 2 further elaborates the key concepts in what many were calling a new paradigm according to each of the three legs by the mid-1980s. The way these three spheres subsequently developed distinguished assisted living both from earlier residential care and from nursing home care.

Early Hybrid Models

Assisted living developed independently at about the same time in Oregon and Virginia as a uniquely defined long-term-care option designed to appeal to older people seeking a more residential setting, a more familiar and comfortable lifestyle, and assistance for a wide range of needs. I call these *hybrid models* because they represented a composite of the hospitality, health care, and housing fields. The models were considered novelties during this early period and were quite controversial. Licensing agencies, nursing facility providers, many professionals, and some advocate groups openly talked of their potential to be unlicensed nursing facilities. Financing was largely through private equity capital. Traditional institutional lenders such as real estate investment trusts, the U.S. Department of Housing and Urban Development, commercial banks, and mortgage lenders had virtually no interest in funding their development, and therefore growth was extremely limited.

Early Assisted Living, Eastern Version.—The eastern version of assisted living had its genesis partly in the personal experiences of Paul and Terry Klaassen, founders of what is now Sunrise Senior Living, a large publicly traded company. In 1981, the Klaassens opened their first building, an old nursing

Table 2. Key Constructs in Assisted Living

Concept	Specification
Normalized environments and homelike residential features	a. Architectural style commonly associated with places people have lived and that is thematically recognizable as residential (e.g., with building materials, design, and furnishings found in private homes). b. Interior community space to accommodate recognized public functions (e.g., dining, socializing, shopping, receiving services). c. Accommodation of cultural preferences for privacy (e.g., control over entry to and use of one's personal living space, provisions for bathing and toilet use and for storing and preparing food in one's personal space, no requirements to share personal living space with others unless by choice). d. Amenities in public and in personal space consistent with encouraging choice and continuity of life experiences (e.g., amount and type of community space, size of personal living space, temperature in personal living space). e. Scale (size) and setting (location) congruent with older adults' life experiences in their own communities (e.g., rural, small town, suburban, or urban communities; different cultural communities). f. Features to accommodate the individual's changing abilities (e.g., universal design features such as adjustable closets, lever door hardware; 100% wheelchair-accessible units and common space; roll-in showers to facilitate the ability to remain in the setting if the tenant chooses).
Enhanced service capacity to foster residents' well-being	a. Ability to provide assistance with activities of daily living and instrumental activities of daily living when needed and wanted (e.g., capacity to meet scheduled and unscheduled needs at a time agreed to by the consumer by a universal worker trained to accommodate most needs). b. Appropriate interventions to manage the effects of chronic disease or disability (e.g., the ability to provide health-related services associated with assessment of condition; plan negotiated with the consumer and/or the family for needed services, management of medication use, direct or delegated nursing treatments; follow-through with ordered therapies; and end-of-life palliative care). c. Arrangement for treatment of acute care episodes and mental health issues (e.g., identification, coordination, and monitoring of condition to ensure timely intervention in the assisted living community or by transfer to another setting for specialized treatments; hospital, psychiatric unit, skilled nursing facility, rehabilitation center). d. Attention to all aspects of well-being (e.g., emotional support of individual tenant and his or her family, opportunities to form new relationships and to engage in activities of personal interest, opportunities to be spiritual in a way acceptable to the individual, opportunities to experience continued personal growth). e. Responsibility for the coordination (case management) of services needed for enhanced well-being (e.g., arrangement of services of any type not specifically available in the assisted living community, oversight of transitional events such as move in and move out).
Values orientation to preserve residents' self-worth	a. A focus on ability as opposed to disability (e.g., to support the highest level of independence possible to meeting self-needs and to assist in motivating individuals to set personal goals for increased ability for self-care). b. Focus on decision making, both decisional and executional autonomy (e.g., to offer choices in a way that encourages, facilitates, and respects decisions at all levels of importance). c. Focus on personalization (e.g., to recognize the uniqueness of each individual and to capture that individuality in a negotiated service agreement in partnership with the consumer and his or her family). d. Focus on reciprocity (e.g., to recognize and promote mutual respect, dignity, and responsibility to be shared by the consumer, the caregiver, and those of special importance to the consumer, such as the family). e. Focus on boundaries (e.g., to uphold the personal boundaries related to privacy involving emotional intimacy, information, and the physical body; to use techniques like managed risk agreements as a means to identify and establish boundaries around decision and subsequent behaviors that might cause harm to the person).

facility where they themselves lived and cared for 33 people. In 1985 they opened two residential settings in which they focused on the approach to the delivery of services and worked on the development of training modules.

Built like a large Victorian home, this model had small sleeping rooms, most private but some shared, and a variety of common spaces (sitting rooms, dining rooms, and sprawling verandas) whose use by the residents was actively encouraged. Key elements included a building designed to fit architecturally into a residential neighborhood and to foster an internal sense of community. In some respects, the approach reflected the large family multigenerational

home that Paul Klaassen had experienced with his grandfather in Holland (Assisted Living Success, 2000). Originally they called their settings *retirement homes*, a direct translation of the Dutch terminology. By 1988 they had dissolved their home care business and turned their attention to the replication of a recognized physical model of assisted living.

Early Assisted Living, Western Version.—In 1981, under the leadership of Richard Ladd, administrator of Oregon's newly formed Senior Services Division, Oregon became the first state to apply for and receive a waiver for home- and community-based services, under which consumers were enrolled in 1982. The Senior Services Division held extensive authority and resources related to both nursing facilities and alternative options, and the State of Oregon embarked on a public policy course that emphasized the development of an array of long-term-care options that were explicitly driven by client choice, dignity, and independence. A large client-employed home care program was at the heart of the effort, long before consumer-directed care had become a buzzword. But many Oregon seniors were already in nursing facilities and many others had no place to live and receive care, and user-friendly residential settings became part of state policy.

Oregon's first residential solution was an adult foster care program aimed at clientele needing a dwelling place to receive care other than their own homes, or for nursing facility residents who wanted to move out. The state invested significant resources in the development of this program and funded the service side from Medicaid waivers for those financially eligible for Medicaid and functionally eligible for nursing facilities. An evaluation in 1989 showed that two thirds of adult foster care clientele were privately paying; that privately paying consumers had greater disabilities than those financed by Medicaid; that outcomes, compared to those of nursing facilities, were largely positive; and that the substitution effect was established, although the population in nursing facilities was on average more disabled than that in foster homes (Kane, Kane, Illston, & Nyman, 1991; Nyman, Finch, Kane, Kane, & Illston, 1997; Stark, Kane, Kane, & Finch, 1995). The important principle was established that people with nursing-facility-level needs could receive care in ordinary homes.

In 1982, Park Place Partners (of which I was a part) applied for waivers to exceed current care limits in locking individual apartments with kitchen units. These changes were sought to enable people with a certain level of need to live in congregate housing settings. The resultant development, which became the prototype of the Oregon model of assisted living, relied on project financing from a housing agency using state general revenue bonds (Wilson, 1993). Fortuitously, use of state bond money required that the units have features that allowed them to be defined as housing under federal tax code, including locking doors, a kitchen, a full bath, and separate temperature controls. Defined as senior housing, the tax code included an allowance for congregate, non-income-producing space. This space could be used for common dining, recreation, staff, a laundry, and the like. The overall character was to be residential, but the original model was built with corridor widths and other environmental attributes that facilitated the care of individuals with high levels of disability, and met the environmental standards required for licensed residential care facilities in Oregon. Thus, the availability of financing played a vital role in building an apartment-style service model in Oregon for which private-pay consumers proved willing to pay. The fact that a mortgage lender required Park Place to serve low- and moderate-income individuals also influenced Oregon's assisted living model. When the 112-unit building, Park Place, opened in 1983, the lender and the state licensing agency initially considered it housing with a comprehensive package of services designed to appeal to those seniors who wanted more services. Conflict later emerged with the licensing agency when it became clear that the services were also based on needs typically met in licensed settings such as foster homes, residential care, and nursing facilities.

Accordingly, conceptual models evolved separately in both the East and the West, and operating models for assisted living were well in place by 1985. The eastern version, built with private investment money, grew quietly and slowly, with a distinct lack of interest from commercial real estate lenders and little awareness or involvement of state policy makers. The Klaassens' plan was to replicate the Sunrise model using a franchising approach to help fund development and to establish a standardized approach. The emphasis was on financial feasibility, development, standardized training, and a building that resembled a sprawling, comfortable, old-fashioned mansion. Unlike the western version of assisted living, the eastern version did not seek additional care and service capacity via state policy involvement and did not target lower income and rural communities. Nor did it fully embrace the concept of a locking private apartment with bath and kitchenettes, emphasizing more the utilization of enhanced community space for residents.

Aging in Place and the Divergence of East and West

Although both the eastern and western models shared a philosophy emphasizing resident autonomy in homelike settings, they diverged with respect to service capacity, at least in part because of differing state policy environments. Virginia and other states mandated fairly restrictive residency criteria for those permitted to live in assisted living, resulting

in less incentive for providers to develop internal service capacity. The ability to remain in assisted living despite escalating care needs was often contingent on arrangements for ancillary or third-party providers to deliver services beyond those provided by the setting. Conversely, the State of Oregon was committed to a high level of service in care settings other than nursing facilities and almost from the beginning was willing to use Medicaid as an individual funding stream for services. It also envisaged and implemented policies and programs to encourage heavy care and aging in place to happen, including modification of nurse practice acts and permissive regulations.

Aging in place, as originally envisioned in the context of assisted living, meant that residents were not routinely required to relocate, either to another setting or to another location in the same setting, if they needed more care. For consumers and their families, the notion that all within-setting moves or move outs were to be voluntary was enormously appealing. Three factors were critical to the implementation of aging in place: (a) liberal or at least ambiguous criteria for the amount of disability allowed for occupancy, or (b) a mechanism to waive stringent occupancy criteria or nonenforcement of regulations, and (c) providers' ability to generate the service capacity and rigorous commitment to retaining individuals who wished to stay and whose continued occupancy was questionable under existing regulatory guidelines. The eastern version initially relied on a low-profile approach to service capacity, quietly arranging more service privately with the grateful cooperation of consumers and their families. Because states were not initially partners in the assisted living enterprise on the Eastern seaboard and it was largely a private-pay model, the provision of expanded health-related services initially was more likely to go unnoticed.

The western version took a different direction, including health-related and nursing services as essential components needed to facilitate aging in place. When the first Oregon assisted living setting was built, the partners were unclear how heavy care could be provided within existing state licensure categories; however, ambiguity actually saved the day. The closest existing licensure category for Park Place was that of a residential care facility. However, because of the way Park Place had been funded and developed as a housing project of the State Housing Agency, it looked different from other residential care facilities both in terms of privacy and amenity standards and the ability of the physical plant to accommodate people with disabilities. The request for a residential care license caused a considerable stir. The partners were told the project could not be licensed as a residential care facility because of the locking doors, stoves, and the plan to accept residents who required staff assistance to manage their incontinence or receive an insulin injection.

Fortunately, Oregon's long-term-care policy and its authorizing legislation SB1955 called for older individuals to be able to live in the least restrictive environment, a trump card waiting to be played. The State of Oregon accepted the argument that (a) existing residential care facility rules did not prohibit any of the features or services and that any such interpretation was merely a matter of convention, and (b) any such limitations were contrary to the intent of the legislation that had permitted the development of other long-term-care options such as adult foster homes. Thus, the State of Oregon was persuaded to grant a waiver for its first "living center." (Park Place was initially called a *living center with assistance*, from which the term *assisted living* eventually came to be used.) The ideal of a variable service capacity to facilitate aging in place without strict move-in and move-out criteria was born. This approach permitted a wide range of services, individualized to each resident's needs and preferences, including medication administration, dementia care, incontinence management, and hands-on assistance with all activities of daily living. Immediately, the new model was at the center of controversy, with its detractors citing wide-ranging concerns (e.g., could the carpet be kept free of urine odors, would people be safe behind closed doors, might not pets be dangerous, would staff know what to do if a resident's condition changed?).

To summarize, in its formative period (1979–1985), the eastern and western models of assisted living began to evolve with some common elements. Each committed to a philosophy of consumer autonomy and an environment that enhanced everyday life. Though visitors to the East and West coasts saw variations, the philosophical underpinnings, the residential setting characteristics, and the variable service capacity were common unifying themes. They formed the genesis of the hybrid model upon which early adopters of assisted living focused.

Neither Fish Nor Fowl: 1986 to 1993

New Converts in Oregon: State, Consumers, and Providers

Like many responses to social conditions, political forces, and economics, assisted living developed on an ad hoc basis. The model seemed to work, it was appealing on its face, and, most important, it responded to a current ailment. Research that is conducted on such innovations, if it occurs at all, is typically small in scale and not subject to much methodological rigor.

The State of Oregon conducted one of the earliest such studies of assisted living in 1986 when a second pilot, Regency Park, a 142-unit setting also licensed as a residential care facility under regulatory waivers, opened in Portland. Based upon a demonstration

project proposal I wrote, the state contracted on a capitated basis for the use of a portion of the units for clientele from the home- and community-based services Medicaid waiver program. To evaluate the effectiveness of this effort, the state conducted a small research demonstration project with 20 Medicaid clients who were referred to Regency Park in 1986 and 1987. The purposes were to assess whether assisted living was a financially viable option for Medicaid-eligible clients and to study client outcomes. The state selected prospective residents from existing nursing-facility-eligible clients who might have a variety of problems, including dementia, uncontrolled diabetes, paralysis requiring transfer assistance, incontinence, and the like. Regency Park committed to accepting 20 state-selected Medicaid clients and not to move the Medicaid residents out of the building without prior state approval. The state collected information using standardized measures of health, cognition, life satisfaction, and activity of daily living and instrumental activity of daily living functioning. Wilson, Ladd, and Saslow (1988) reported three major findings: (a) An all-inclusive flat negotiated fee at 80% of the existing nursing facility rates was adequate for the case mix of clients selected by the state; (b) health conditions remained stable, whereas activity of daily living and instrumental activity of daily living functioning improved for the majority of clients; and (c) measures of depression, cognition, and life satisfaction for clients also showed improvement.

Thus reassured, in 1988 the State of Oregon launched a major new statewide initiative to support the development of assisted living. Because assisted living expansion required more capital investment than did foster home development (which largely relied on existing housing stock), the decision to cover assisted living as a waiver service ushered in an 18-month-long process of rule writing, public hearings, and state-sponsored training on the nature of assisted living in Oregon, which also resulted in substantial awareness and buy-in from all relevant state agencies.

The positive results of this study were pivotal in my own life. With a $5,000 loan to myself and with the assistance of my husband, Michael DeShane, a demographer, gerontologist, and developer, in June of 1988 I started a company called Concepts in Community Living, which focused on building small, rural, and affordable assisted living. I remained at Concepts in Community Living until the fall of 1994. I specialized in building assisted living options much smaller than the two Portland prototypes I had previously operated. The new settings were located in small towns and rural areas where land was affordable and older adults had few options. These buildings ranged from 25 to 35 private apartments and typically were one-story structures to avoid construction costs of stairs and elevators while giving tenants easy access to the outdoors. True to the apartment model and Oregon regulation, all units had at least a full bathroom and a kitchenette. Other multiple-owner developers also built assisted living in Oregon during that period. Despite the state's encouragement for nursing facilities to diversify into assisted living, only one nursing facility conversion occurred by 1995 and one nursing facility operator built an adjacent assisted living facility. The others were freestanding or part of housing complexes.

Meanwhile, particularly in the East, business possibilities emerged that forged early relationships in the assisted living business. Early entrepreneurs such as Karrington (based in Ohio), Kensingston (based in Maryland), and Sterling (based in Kansas and later purchased by Alterra) started constructing one building at a time. In the West, collaboration with various state governments (e.g., Washington and Idaho) encouraged early efforts by states to apply the Oregon model. The rapid fill-up of those first assisted living communities, largely by private-pay consumers, seemed to indicate that consumers were equally intrigued. Both hybrid models thus expanded from their original states; their characteristic form continued to depend on state policies for financing and for Medicaid coverage as well as other serendipitous influences on their developers.

Evolution of Models: Diversity Reigns

From its earliest days, assisted living was a lightening rod, attracting arguments about what it was, who it was for, how it should be regulated, and whether it could deliver on its promise. In 1992, AARP commissioned a national study of assisted living, which was the first to propose a working definition of the term: a group residential setting not licensed as a nursing facility that provides or arranges personal care to meet functional requirements and routine nursing services (Kane & Wilson, 1993). The study provided detailed data on assisted living in Oregon, which by June 1992 had 22 licensed assisted living buildings. It also generated a purposive national sample of assisted living settings that adhered to the definition and that were recommended by the fledgling trade association (then called the Assisted Living Facilities Association of America), other trade associations, and state licensing agencies. This sample of 63 disparate settings provided evidence that multiple approaches to assisted living existed, and that not all adhered to the vision described in the beginning of this article.

Differentiation of Four Emerging Models

During this period of evolution, it became possible to identify four different broad types of assisted living that took their predominant character depending on whether they represented the hybrid model (previously mentioned), a hospitality model, a housing

model, or a health care model. Each contributed something to the entity that assisted living ultimately became.

Hybrid Model.—The hybrid model, mentioned previously, emphasized residential-style settings, a variable service capacity, and a philosophy of consumer autonomy. Biannual policy reviews (Mollica, Ladd, Dietsche, Wilson, & Ryther, 1992; Mollica et al., 1995 Mollica & Snow, 1996) characterized this as a new model utilizing purpose-built apartment-style housing with a full array of services available or provided. These settings tended to be purpose built, and they incorporated public space to accommodate 24-hr staffing for onsite provision of personal and health-related services. Additional community space such as libraries, beauty salons, activities, and private dining rooms to encourage social interaction were also developed as a part of the model. Combined with the residential furnishings, these new settings felt warmer and more inviting than existing nursing or residential care facilities, but they did not quite achieve the independent feel of a completely separate apartment complex. This assisted living provider group was largely made up of early adopters who had a personal belief that nursing facilities had taken long-term care in the wrong direction. Companies such as Assisted Living Concepts, Sunrise, Alterra (originally Alternative Living Services, based in Wisconsin), and Karrington (based in Ohio) formed a cadre and were heavily involved in the development of a trade association, Assisted Living Facilities Association of America (later the Assisted Living Federation of America [ALFA]). Carol Fraser Fisk, fresh from service as U.S. Commissioner on Aging, was recruited to serve as the first executive director of ALFA.

Perhaps the greatest contribution of these early adopters to assisted living was their insistence on a philosophy of care or an approach to service delivery that focused on autonomy and its various components, such as client choice. Historically, society has better adapted to demands for autonomy from all other adult disabled populations than it has to demands from aged individuals. Researchers have put forth many theories for why older adults are thusly treated: that society treats mentally ill and developmentally disabled individuals as ''throw-away'' populations; that adults with physical disabilities such as spinal cord injuries are their own advocates; and that parents have been vigorous advocates for people with mental retardation (Shapiro, 1993). But some of the explanation may be that the United States is an ageist society that regularly confuses frailty with incompetence, and that Americans have come to equate respectful care for older adults with simply eliminating bad outcomes from their lives.

The hybrid group of assisted living settings was closely associated with transforming the language of long-term care to emphasize the resident as an active consumer and decision maker and to avoid terms from health care. The word *facility* was shunned in favor of *community, residence, setting*, or even *building. Admission* and *discharge* were replaced with *move in* and *move-out* and, when applicable, *eviction.* A *care plan* was likely to be a *service plan.* In buildings I managed we replaced the term *resident* with *tenant.* The new language made its point, but it also led to significant confusion. The lack of clear definitions and measures for these terms may be partially responsible for some of the methodological problems in assisted living research.

Hospitality Model.—The hospitality model of assisted living was most common in major metropolitan centers and retirement havens. It developed early, perhaps partially as hoteliers-turned-housing-providers tried to respond to consumer demands. Hotel chains invested heavily in senior retirement housing stock as a way to diversify. Subsequently, models of assisted living emerged, typically focusing on concierge-type services such as housekeeping, laundry, meals, activities, and transportation. Visual appeal of public areas was viewed as far more important than private space. Curb appeal, location, and a real estate pricing structure based on location and size of personal space quickly infiltrated this model of assisted living. Direct provision of hands-on personal care and health-related services generally was viewed with reluctance. Any type of licensure was considered undesirable. Often, these providers most strongly identified with the American Seniors Housing Association, initially under the sponsorship of the National Multi-Housing Council. Early adopters of the hospitality–congregate model included Hyatt, Marriott, and Emeritus (the latter based in the State of Washington).

Some of the larger national chains later sold, leased, or entered into agreements for the management of their senior housing when they found the growing market need to provide health care unpalatable (e.g., Marriott now leases its assisted living properties to Sunrise Senior Living). Others that began with the hospitality model (e.g., Emeritus) gradually ratcheted up the level of services as a result of market demand. But the impact of hospitality-oriented models on assisted living remained. Perhaps the most significant impact of this model was the suggestion that client satisfaction should be a central outcome measure of quality for assisted living. One can see the influence of the hospitality roots of assisted living in concepts such as the unbundling of services, a service orientation among staff, a gracious dining experience, and the clear demarcation of private and public space.

Housing Model.—Meanwhile, providers of specialized independent and senior housing in low- and moderate-income housing were trying to add services

to their buildings in a third model of assisted living. Not especially applicable in Oregon because of the state's early investment in purpose-built assisted living, efforts to prevent "premature" relocation to other care settings were strong in many states, including Maine and New York, where advocates and public agencies observed an aging population living in settings in which access to services was limited. State policy for the use of Medicaid waiver dollars influenced movement in this direction. During this period, nonprofit sponsors who had built senior housing using U.S. Department of Housing and Urban Development monies or who were a part of publicly subsidized housing were attracted to the concept of a service coordinator to serve as a case manager, identifying needs and facilitating access to and coordination of service delivery by outside agencies to seniors living in housing (Sheehan, 1999). From the mid-1990s on, many have advocated the rehabilitation of public and subsidized housing stock to accommodate the continued residency of frail elders.

The housing approach was viewed as a way to leverage existing housing stock, to use co-op arrangements to lower per-unit costs for low- and moderate-income clients not financially or medically eligible for Medicaid, and to provide options for individuals who wanted to stay where they were living. In this model, however, most of the services in housing were for limited hours of weekly scheduled assistance for personal care and health-related services rather than to meet heavier care needs. This emphasis comported not only with the preference of housing authorities, but also with some of the views of tenants who did not want to dwell among visibly frail other seniors. Key ingredients often missing from the housing model, therefore, were 24-hr and nonscheduled service capacity and oversight. But some states, such as Minnesota, Massachusetts, and Illinois, expanded on this approach to create a distinct housing-with-services model that they called *assisted living*. Because many early adopters of the housing model were nonprofit organizations and continuing care retirement community providers, they tended initially to identify more with the American Association of Homes and Services for the Aging and its goal of promoting service-rich housing.

Housing-based models also contributed to the development of assisted living. One central set of constructs related to legal rights. These included elements of landlord–tenant law, the Supreme Court *Olmstead* decision, and the Americans With Disabilities Act. Housing models set the highest standard for the definition of *homelike* and provided some of the most concrete ways to measure it, including control over space (locking doors, temperature settings, personal furnishings, presence of others) and control over activities in that space (permission to enter; timing of events such as sleeping, cooking, and storage of food). The most important construct derived from housing models was private living space, which addresses research evidence about the strong importance of privacy for many consumers, including even those with dementia (Hawes, Greene, Wood, & Woodsong, 1997; Jenkens, 1997; Kane, Baker, Salmon, & Veasie, 1997).

Health Care Model.—The fourth type of assisted living evolved from nursing facilities and some licensed boarding homes. To a certain extent this was a response to market demand, as these providers felt forced to adjust to market conditions. Some nursing facilities (and even hospitals) were already engaged in vertical integration with the addition of independent housing on their campuses. Some had added residential care wings to an existing nursing facility. Some nursing facilities were at best reluctant converts, not modifying their setting much beyond certain visible characteristics such as carpeting or wallpaper and not encouraging residents to cook or engage in activities that were so discordant with nursing facility norms. Some carried over many of the more traditional long-term-care practices, particularly as related to care. One of these practices included a preference for strict move-in and move-out criteria, forcing the definition of assisted living to occupy a distinct niche between independent living and nursing facility.

Many of these providers supported the notion that assisted living should serve those needing a lower level of care than most nursing facility clients, more like the population served in pre-Medicaid homes for the aged. They held that individuals needing nursing services on a regular basis generally or with significant dementia were better served in regular nursing facilities or special care units. They did not want to be an alternative to a nursing facility, but a stop along the way or a feeder to them. These providers initially found a voice in the National Center of Assisted Living formed by the American Health Care Association. Early adopters of this model included national for-profit companies such as Integrated Health Care and Manor Care, and regional organizations such as Prestige Care based in Oregon. They often formed different companies or teamed up in some fashion with local hospitality-based assisted living providers. Nonprofit corporations under sectarian auspices such as Presbyterian Homes, Baptist Homes, Lutheran Health Care Centers, Catholic Health Care Centers, and Jewish Health Care Centers invested in assisted living during this period, and their national and state organizations provided support to those efforts.

The health-based model's major contribution to assisted living was in the area of traditional care approaches and measures of health quality. Most of these measures are related to structure and process variables typically associated with regulatory oversight rather than outcomes. These include constructs such as staff educational requirements or establishing

interest-bearing client trust funds (structure); and documentation of medication assistance or occupancy register to record move ins, move outs, and temporary absences (process). But the health care influence also contributed to accepted outcome measures of clinical quality such as reduction of falls, reduction of involuntary transfers, and reduction of medication errors.

The early 1990s saw a period of national discussion about assisted living in all of its forms. Terms such as *paradigm shift* came into common use to discuss this rapidly evolving set of models. Other constructs typically coupled with discussions of assisted living (but with broader applications) included delegation of nursing services, universal workers, negotiated service plans, managed (or negotiated) risk, consumer centered care, client satisfaction, and outcome-based regulation.

Despite this attention, however, there were still few actual working models of assisted living. The new assisted living trade association, ALFA, was still dominated by early adopters, each of whom had only a few fully functional buildings at the beginning of that period. Capital for real estate development was extraordinarily difficult to find and sometimes was acquired because the financial institution did not really understand what it was funding. The early trade association meetings were lofty affairs. Assisted living providers represented at them envisioned changing the face of long-term care. Meanwhile, most of the how-to technical assistance focused on development and how to get money to grow. There was very little focus on the actual implementation of the concepts or the practical problems of delivering quality care and service. Vision held sway, with most believing that good intentions made all things possible.

Growing Pains: From a Model to an Industry: 1994 to 2000

Money to Grow: Assisted Living Goes Public

The situation changed in November of 1994 when newly formed Assisted Living Concepts went public, going to Wall Street for money to build more of its Oregon model of assisted living across the United States. Weary of trying to convince others that a small, moderate-income, high-acuity model offering private living space with kitchens and baths could work outside Oregon, I agreed to head a company to roll out the Oregon model nationally. Even with the help of experienced Wall Street professionals, raising $20 million in what was considered a small initial public offering challenged us to sell a different model of long-term care than the nursing facility model that Wall Street understood. (The original Concepts in Community Living continues to exist more than a decade later, developing and managing assisted living licensed and nonlicensed residential settings.)

In 1995 and 1996, other assisted living companies also went public, including Sunrise, Atria, Sterling, and Karrington, all of which were small early adopters of the hybrid model of assisted living. But now, with Wall Street firmly in the picture, assisted living providers had access to capital and a mandate to grow. For example, I went from operating 6 assisted living residences in 1 state in 1994 with fewer than 100 employees to operating 183 assisted living residences in 18 states with more than 3,000 employees in 2000. Sunrise's growth was even more marked: Beginning in 1999, Sunrise developed and sold properties to others while retaining the management, so that by December 2005 about half of the properties managed were owned by other entities. With its buildings in affluent suburban areas targeted toward upper middle and upper class seniors, Sunrise now reaches as far away as London. As of February 2007, under its changed name, Sunrise Senior Living managed about 415 communities with more than 52,000 employees.

Quickly following this initial flurry of company offerings was a change in strategy of private nursing facility companies that began to explore specialization in skilled care, dementia care, and, in some cases, assisted living. Suddenly, the term *assisted living* was so ubiquitous that it came to be used for a wide range of entities, including home care agencies providing chore services in private homes. Still, the research literature was sparse. In the State of Washington, Hedrick and colleagues (2003) conducted a study comparing outcomes for low-income residents supported by Medicaid waivers in three different types of assisted living all recognized by the state (small family homes, board and care homes, and assisted living apartments). At the end of this period, a longitudinal study comparing 600 residents of Oregon's then 38 assisted living residences to 600 nursing facility residents showed positive results for assisted living (Frytak, Kane, Finch, Kane, & Maude-Griffin, 2001). Researchers undertook a few national or multistate studies during this period of growth (Hawes, Phillips, Rose, Holan, & Sherman, 2003; Zimmerman, Sloane, & Eckert, 2001); the former developed a national probability sample of almost 1,000 assisted living settings and found that only 11% could be classified as both high service and high privacy. These studies collected data during the turbulent period of growth described in this article. Thus, the researchers were required to sample a rapidly moving target. These exceptions notwithstanding, most writing about assisted living at this time was bullet points for presentations, loan applications, investment analyst reports, and newspaper articles describing the latest in business development.

State governments generally were unprepared for the frenzy that descended and often simply added the

term *assisted living* to residential care's existing regulations, occasionally using a layered or tiered approach to differentiate between assisted living and other licensed residential care options. The money did its work, and assisted living was now a presence. To use the term *assisted living* was to guarantee a spike in interest from everyone, including Congress and state legislatures. Even Dear Abby began to suggest considering assisted living as a place to turn for older adults needing long-term care. Assisted living dazzled with its promise at a time when the popular press highlighted major problems with long-term care, especially nursing facilities. As increasing numbers of baby boomers sought long-term-care services for their parents, many realized that there had to be something better. The ''something'' that the public latched onto was assisted living.

With a general desire to adopt the name, suddenly assisted living was a redecorated wing of a nursing facility, or a 16-bed boarding home looking to attract private-pay clients, or congregate housing with dots on the door to identify who got assistance with their medications, or independent living units where residents contracted with home health agencies to provide services. It was also a licensed residential care option that attracted real estate developers, nursing facility operators, and others who wanted to be a part of this phenomenon. Many of these entrants paid scant attention to the nature of the physical setting, were not committed to variable service capacity, and had little interest in upholding founding philosophies. During this period providers muted or changed many of the ideals of the early models. Although operators created lofty expectations with talk of aging in place in a ''unit'' of one's own, early definitions and parameters tended to be lost in the marketing melee, along with the realities of the various state regulations and reimbursement rules that emerged. Most assisted living operators during this period were not focused internally, although some providers touted the idea of client satisfaction as the most accurate measure of quality. Moving full circle, many states renamed large segments of their residential care industries. Retirement homes in North Carolina and adult congregate care facilities in Florida, for example, became assisted living settings.

First Bump in the Road: Questions About Quality

At the turn of a new century, assisted living's charmed existence abruptly ended. First appeared stories of promises unmet and of clients being confused by the marketing hype of assisted living. Regional daily newspapers ran stories of services not being provided and of residents being asked to get extra private help, and advocates for frail elders expressed concerns that individuals were being kept too long in assisted living. These advocates asked pointed questions about what assisted living was and for whom it was appropriate. Assisted living needed clarity, and consumers and payers needed to know what they were buying. The industry answered this concern by vowing support for disclosure, encouraging providers to define their services and providing that information to prospects before they moved in. ALFA began to progressively push the concept of certification or accreditation of providers over the objections of many members.

Concerns from lenders and investors about overbuilding then emerged, especially for high-end private-pay clients in major metropolitan centers. These concerns further fueled stories about assisted living acceptance of and, worse still, retention of individuals ''not appropriate'' for assisted living. Many commentators, policy makers, and advocates perceived assisted living as a point along a well-developed continuum of care with explicit criteria for move in and move out, and the construct of aging in place in assisted living began to take a battering.

At about this time a committee of the Institute on Medicine on which I served found itself in a major split over how to define and measure quality in long-term care (Wunderlich & Kohler, 2001). Some committee members had the perspective that assisted living needed additional traditional process, structure, and clinical outcome measures, arguing that the existing nursing facility survey guidelines, along with certain clinical outcomes such as those measured with data obtained from the Minimum Data Set information required for nursing facilities, were the best indicators of quality. Others viewed these measures as imperfect reflections of quality and consumer experiences, arguing that the structural measures and the inspection apparatus had not solved intractable quality problems in the nursing facility sector and suggesting that nursing facility regulations might have a chilling effect on assisted living. Some committee members argued that little attention was given to quality of life and how to measure it in various settings. The disagreement was so sharp and unresolved that the Committee published minority dissenting views along with the major recommendations (Wunderlich & Kohler, 2001, pp. 287–294). At about the same time, GAO released a report suggesting quality concerns about the services provided (GAO, 1999). Although a valuable source of information, the GAO study had been an effort to respond quickly to a congressional inquiry. Yet this report was received as though it represented empirical findings from a national study.

Taking Stock: A Crisis of Confidence: 2000 to the Present

Seeds of Doubt: Desperately Seeking Certainty

The 1999 GAO report was the beginning of a turning point in how traditional advocacy groups, some state licensure agencies, and the media, among

others, viewed assisted living publicly. After the GAO report, a series of stories in the national media highlighted the shortcomings of assisted living. These stories held forth individuals who had been miserably failed by assisted living as victims of high prices and poor quality care. Sometimes, particularly in larger companies, failure in one building was put forth as proof of poor quality company wide. Wall Street analysts reviewed survey data and made pronouncements about what deficiencies meant. States were held up as doing a poor job of protecting consumers. The problem, many pronounced, was that assisted living had no uniform standards, beginning with its definition and its appropriate clientele base.

During this time, the industry itself was paralyzed by the realities of cash flow during rent-up, staff selection and training, systems development, and many other management problems. Many providers, myself included, found it difficult to consistently support and sustain the espoused values of assisted living. Subsequently, some providers lost their enthusiasm for being innovative. Fearful of survival, providers made getting back to basics the order of the day: improve financial performance and stay out of regulatory trouble. Conscientious providers began to brandish deficiency-free surveys forward as a badge of honor, even as they privately ridiculed the relevance of the nursing-facility-style survey process to quality in assisted living. Some became more defensive and resistant to suggestions about how to improve their operations.

Some commentators, who viewed themselves as advocates for the public interest and vulnerable older individuals, began to assert that autonomy was not all it was cracked up to be. Safety collided with autonomy, becoming an issue as soon as descriptive data began to suggest that many individuals living in assisted living were, in fact, frail. This conflict, along with others about what constituted good outcomes and which outcomes were most important, contributed to a retreat to familiar, comfortable methods of advocacy and regulatory oversight.

Continuing Definitional and Operational Struggles

By the new century, assisted living suffered from a crisis of confidence. Providers and policy makers wanted to provide leadership, and federal and state officials were striving to catch up with the phenomenon and make decisions about regulation, reimbursement, and creating supply. Empirical data available to inform decision makers remained limited.

The continuing struggles of assisted living were evidenced in the work of the Assisted Living Workgroup (ALW; 2003), which was formed to report to Congress on assisted living quality. Prior to its formation, some key concepts had emerged and had become embedded in the culture of early adopters of assisted living. Many of these concepts were first discussed by the Assisted Living Quality Coalition, a consortium of AARP, ALFA, the American Seniors Housing Association, the Alzheimer's Association, and representatives of the two national nursing facility trade organizations (the American Health Care Association and the American Association of Homes and Services for the Aging). The Assisted Living Quality Coalition (1998 report showed the degree to which assisted living had incorporated constructs of hospitality, housing, and health care. In the wake of the GAO report, however, the Senate Committee on Aging held hearings and challenged the assisted living industry to develop quality standards. This time, under the ALW, a much more expansive group of stakeholders was invited to the table, including many professional trade associations with little assisted living experience, and many advocacy or watchdog associations, some with experience only in nursing facilities. For example, the nursing facility medical directors, the consultant pharmacists, the National Citizen's Coalition for Nursing Home Reform, and even Save Our Social Security had seats at the table. Organizations representing the divergent strands of the assisted living model (hospitality, housing, and health care) were present, along with the hybrids, but health care predominated. All told, 50 organizations were represented.

One of the most intractable problems facing ALW was gaining consensus on the scope of its enterprise (i.e., how ALW would define assisted living). This was an old problem in assisted living (and it had analogues in other fields, such as nursing facility special care units for dementia). The dilemma was to decide which attributes of assisted living are definitional and which may vary among entities that have the name assisted living. Unable to reach consensus on its most fundamental task after a grueling and long series of meetings, the ALW reported a definition in three parts and described (but not necessarily vetted) best practices in a number of operational areas. ALW's work was hampered by the lack of assisted living research and involvement of researchers representing a wide variety of disciplines. However, the report (along with issues associated with the key components identified in Figure 1) and the four models described in this article were instructive in establishing parameters for assisted living research.

Conclusions: Parameters for Assisted Living Research

ALW Contributions to Anchoring a Research Agenda

Put simply, the failure of ALW to move much beyond the definition established by the Assisted

Living Quality Coalition in 1998 signals a significant research problem: the need to ensure good criteria for sampling frames. Lack of uniformity is a major problem, particularly if research focuses on care outcomes or costs, and it is not readily resolved unless the sample is exceptionally large and unless descriptive statistics and analyses of correlation are sufficiently detailed. A second area is the obvious need to perform more translational research in all disciplines. By this I mean that the need for empirical evidence to support best practices is critical for the purpose of education and training, as well as setting standards informed by facts, not fueled by antidote.

In this regard the ALW's numerous recommendations provide plenty of ideas for research. Some of the most critical areas involve staffing credentials and levels, use of nurse delegation and the provision of health-related services, and identifying and managing change of individuals' conditions. Many existing standards for assisted living and most of the training have been adopted directly from somewhat unsuccessful efforts to ensure quality care in other care settings. Some of these imported standards are outmoded, based on practices no longer viewed as best, and fail to recognize technological and other changes in the environment or simply respond to a public event that encourages the development of policy informed more by emotion than fact.

Constructs Related to Philosophy

One may loosely characterize these constructs as potential autonomy or philosophy variables that encapsulate the values associated with different aspects of quality of life. More specifically, these constructs define the empowerment of consumers to express preferences and to make and act upon decisions. With respect to applied and policy-related research, there is a tremendous need to better define client-centered care and which policies and practices might best support it. Uniform disclosure, holistic assessments, individualized service plans, and negotiated risk are prime areas for research. There is a need to develop individual measures, scales, and composite indices associated with autonomy variables historically associated with assisted living, including independence, choice, and privacy. But larger societal questions also loom. The balance between safety and autonomy when individuals are vulnerable is an area in which prevailing attitudes clearly favor the aversion of risk at the cost of limiting decision making in areas that pose potential for harm of some type. Another area involves the costs and benefits of unbounded client choice, such as those implicit in the concept of aging in place. A particularly interesting research question is what boundaries on choice should exist (amount of money authorized or benefit bestowed, use of authorized monies, methods of adjudicating domains of competence, etc.) as more experimental policies of money following the client are implemented. What lessons are to be learned from existing hospice participation requirements, food stamp use, or Supplemental Security Income disability payments to the mentally ill? And perhaps the most interesting research questions are related to expectations of assisted living. For some, this means setting and measuring performance around service and care as evidenced by the ALW struggles noted previously. Others might see the value of research in better understanding how relationships with others (staff, family, and fellow residents) impact client satisfaction and what might be the interaction of client satisfaction with other types of outcomes.

Constructs Regarding Setting

Setting constructs refer to the physical environment. Most frequently identified in this group are those constructs that help researchers define home (personal living and community space) and residential character (design, community features, and furnishings). Although undoubtedly significant advances have occurred in finding ways to make assisted living environments appear more homelike, many more important research questions remain. To wit, to address the conflict around private living space, investigators must conceptualize and accurately measure the benefits of privacy. Additionally, experts have not documented well the actual cost of privacy. A serious discussion of whether the cost of privacy is too high is impossible when the data have not yet been systematically collected and analyzed in a comprehensive manner that includes the cost of not having privacy. Another burning issue revolves around the rights of the individual versus the rights of the larger group. For example, how does the concept of community apply to common areas within the congregate setting? Are the concepts of triage or case mix appropriate to use in setting limits on aging in place or to establish other criteria for occupancy in assisted living? And finally, what is the relative impact of sensory-related modifications such as residential design features as compared to policy and practices related to personal furnishings or pets on quality of life?

Constructs Regarding Service

Service constructs are those that describe elements of care and service. In addition to the type of service issues raised by the AWG report, other research questions remain. Among the critical research questions here are how to develop more accurate ways to measure patterns of service need and utilization, the relationship between the degree of variable service capacity and use of ancillary services, and the impact of variable service capacity

on transitions (i.e., move ins, move outs, hospitalization). Another largely unanswered question is how to measure added value of specialized care settings such as specialized assisted living dementia units against their added cost. This is particularly important given the prevalence of some level of dementia in the population most likely to need some form of assisted living.

Model-Related Research

Research should address important and unique distinctions of the various models that contribute to assisted living's current diverse forms. Unique to the hybrid model, for example, is the introduction of many new terms. Curiously, researchers have not explored the impact of this shift in language with respect to either the factors that encourage or resist its use, or its effects. A central question is what immediate and long-term impact such language shifts have on tenants, families, staff, regulators, policy makers, and the public. The influence of the hospitality model should lead to a service orientation among staff and to a pleasant dining experience. An important research question is how much impact such an orientation has on other measures beyond client satisfaction, such as reported pain levels, compliance with health-related regimens, or clinical response to interventions used to treat chronic and acute illness. A very fruitful area of research related to housing models would be comparative analysis of the costs and benefits of ''housing with services'' models and the ''housing and services'' models. Research is needed on the impact of policies that promote the roll-over of housing stock to subsequent generations as opposed to policies that promote extended retention of housing that may reduce access to affordable stock to new entrants into the housing market and reduce the economic viability of aging neighborhoods. More research is needed to examine existing laws that govern housing and those that govern heath care, and the ways that the two conflict with and complement each other. Finally, the impact of the introduction of many mainstream health care professionals, nursing facility practices, and existing methods of measuring long-term quality on assisted living is not known, but the possibility looms large that a continuing drift in that direction would not be particularly positive.

But the most important thing research could do—not for assisted living, but for hundreds of thousands of older adults like my mother—is to revitalize interests in the original meaning of the key constructs outlined above in Table 1. Such research would support the dream of future consumers not to end up in the assisted living version of ''there.'' It would help providers enhance the capacity of assisted living to live up to its early potential. And it would help policy makers set a true higher standard for long-term care. Research that defines, clarifies, and interprets the impact of these concepts as they were originally envisioned might help illuminate how long-term care should be provided in any setting, and how quality is defined and measured. Policy makers who create regulatory and payment policies could more easily work toward the realization of assisted living as a viable option for community-based long-term care if better data were available about the cost and benefits of assisted living with carefully constructed samples using more appropriate measures and well defined research goals. To this end, researchers must pay close attention to what questions they ask and how they ask them, and policy makers and practitioners must be accountable for responding thoughtfully to research findings.

References

Assisted Living Quality Coalition. (1998). *Assisted living quality initiative: Building a structure that promotes quality.* Washington, DC: Author.

Assisted Living Success. (2000, March). *One on one with Paul Klaassen.* Retrieved September, 2007 from http:/www.alsuccess.com/articles/041feat1.html

Assisted Living Workgroup. (2003, April). *Assuring quality in assisted living: Guidelines for federal and state policy, state regulation, and operations* (Report to the U.S. Senate Special Committee on Aging). Washington, DC. American Association Homes and Services for the Aging.

Cohen, E. (1974). An overview of long-term care facilities. In E. M. Brody (Ed.), *Social work guide for long-term care facilities* (pp. 11–26). Washington, DC: U.S. Government Printing Office.

Dobkin, L. (1989). *The board and care system: A regulatory jungle.* Washington, DC: AARP.

Fallis, D. S. (2004, May 23 A01). A dangerous place: Assisted living in Virginia. *The Washington Post.*

Fallis, D. S. (2004, May 25 A01). AL facility chaos bred widespread neglect. *The Washington Post.*

Fallis, D. S. (2004 May 27 A05). Social service chief Warner calls for changes in oversight, conditions of homes. *The Washington Post.*

Fallis, D. S. (2004 June 27 C01). VA records show more problems in AL. *The Washington Post.*

Frytak, J. R., Kane, R. A., Finch, M. D., Kane, R. L., & Maude-Griffin, R. (2001). Outcome trajectories for assisted living and nursing facility residents in Oregon. *Health Services Research, 36,* 91–112.

General Accounting Office. (1989). *Board and care issues* (GAO/HRD-89-50). Washington, DC: U.S. Government Printing Office.

General Accounting Office. (1999). *Assisted living: Quality-of-care and consumer protection issues in four states* (GAO/HEHS-99-27). Washington, DC: Author.

Hull, J. T. & Thompson, J. C. (June 1981). Factors which contribute to normalization in residential facilities for the mentally ill. *Community Mental Health Journal 17,* 2 107-113.

Hawes, C., Greene, A., Wood, M., & Woodsong, C. (1997). *Family members' views: What is quality in assisted living facilities providing care to people with dementia?* Washington, DC: Alzheimer's Association.

Hawes, C., Phillips, C. D., Rose, M., Holan, S., & Sherman, M. (2003). A national survey of assisted living facilities. *The Gerontologist, 43,* 875–882.

Hawes, C., Wildfire, J., & Lux, L. J. (1991). *The regulation of board and care homes: Results of a 50-state survey.* Research Triangle Park, NC: RTI International.

Hedrick, S., Sales, A. E., Sullivan, J. H., Gray, S. L., Tornatore, J. B., Curtis, M., et al. (2003). Resident outcomes of Medicaid-funded community residential care. *The Gerontologist, 43,* 473–482.

Janicki M., Krauss M, & Seltzer M. (1988). *Community residence for persons with developmental disabilities: Here to stay.* Baltimore: Paul H. Brookes.

Jenkens, R. (1997). *Assisted living and private rooms: What people say they want.* Washington, DC: AARP.

Kane, R. A., Baker, M. O., Salmon, J., & Veazie, W. (1997). *Consumer perspectives on private versus shared accommodations in assisted living.* Washington, DC: AARP.

Kane, R. A., Kane, R. L., Illston, L. H., & Nyman, J. A. (1991). Adult foster care for the elders in Oregon: A mainstream alternative to nursing facilities? *American Journal of Public Health, 81,* 1113–1120.

Kane, R. A., Kane, R. L., & Ladd, R. C. (1998). *Heart of long-term care.* New York: Oxford University Press.

Kane, R. A., & Wilson, K. B. (1993). *Assisted living in the United States: A new paradigm for residential care for frail older persons?* Washington, DC: AARP.

Lawton, M. P., & Nahemow, L. (1973). Ecology and the aging process. In C. Eisdorfer & M. P. Lawton (Eds.), *Psychology of adult development and aging* (619–674). Washington, DC: American Psychological Association.

Mollica, R. L., Ladd, R. C., Dietsche, S., Wilson, K. B., & Ryther, B. S. (1992). *Building assisted living for the elders into public long-term care policy: A guide for states.* Portland, ME: National Academy for State Health Policy.

Mollica, R. L., & Snow, K. I. (1996). *State assisted living policy, 1996.* Portland, ME: National Academy for State Health Policy.

Mollica, R. L., Wilson, K. B., Ryther, B. S., & Lamarche, H. J. (1995). *Guide to assisted living policy.* Portland, ME: National Academy for State Health Policy.

Nyman, J. A., Finch, M. D., Kane, R. A., Kane, R. L., & Illston, L. H. (1997). The substitutability between adult foster care and nursing facility care in Oregon. *Medical Care, 35,* 801–813.

Shapiro, J. P. (1993). *No pity: People with disabilities forging a new civil rights movement.* New York: Three Rivers Press.

Sheehan, N. W. (1999). The resident services coordinator program: Bringing services to federally assisted senior housing. *Journal of Housing for the Elderly, 13*(1/2), 35–49.

Stark, A., Kane, R. L., Kane, R. A., & Finch, M. M. (1995). Effect on physical functioning of care in adult foster homes and nursing facilities. *The Gerontologist, 35,* 648–655.

Tully, K. (1986). *Improving residential life for disabled people.* New York: Churchill Livingstone.

U.S. House of Representatives. (1989, March). *Board and care homes in America: A national tragedy* (Publication No. 101-711) Washington, DC: U.S. Government Printing Office.

Vladeck, B. G. (1980). *Unloving care: The nursing facility tragedy.* New York: Basic Books.

Wilson, K. B. (1993). Assisted living: A model of supportive housing. In P. R. Katz, R. L. Kane, & M. D. Mezey (Eds.), *Advances in long-term care* (Vol. 2, pp. 196–218). New York: Springer.

Wilson, K. B., & DeShane, M. R. (1993). *Assisted living in Oregon. Oregon's Journal on Aging, 7*(3), 8–11.

Wilson, K. B., Ladd, R. C., & Saslow, M. (1988, November). Community based care in an institution: New approaches and definitions of long-term care. Paper presented the 41st Annual Scientific Meeting of The Gerontological Society of America, San Francisco, CA.

Wunderlich, G. S., & Kohler, P. O. (2001). *Improving the quality of long-term care.* Washington, DC: National Academy Press.

Zimmerman, S., Sloane, P., & Eckert, J. (Eds.). (2001). *Assisted living: Needs, practices, and policies in residential care for the elders.* Baltimore: Johns Hopkins University Press.

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