ASSISTED LIVING

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Edited by
Kevan H. Namazi
and Paul K. Chafetz

AUBURN HOUSE
Westport, Connecticut • London

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Understanding the Context of Assisted Living

Joan Hyde

This chapter addresses three questions that successful assisted living (AL) providers need to answer for themselves (Drucker, 1974). First, what is our business, and what should it be? Second, whom do we serve, and what constitutes "value" for our customers? Third, what is the context in which we operate, and how will that context affect our decisions?

WHAT IS THE AL BUSINESS?

An appropriate first step in deciding what "business" AL providers are in would be to review the brief definition developed by the Assisted Living Federation of America (1998): "An assisted living residence is a special combination of housing, personalized supportive services and health care designed to meet the needs, both scheduled and unscheduled, of those who need help with activities of daily living."

One unique attribute of assisted living is that every assisted living residence serves its own local market and occupies a particular niche defined by the services, amenities, and apartment types it offers, within the broad definition of AL offered above. Beyond that, as has been discussed in this book's introductory chapter, there is considerable variation in philosophy and approach. This diversity provides consumers with a great deal of choice about the characteristics of the residence they choose for their later years.

WHOM DOES AL SERVE?

The larger view of what assisted living should be and what it will become requires us to understand whom AL serves, how AL customers define value, and, most particularly, what is the context in which AL operates. Assisted living facilities (ALFs) serve people who need or want assistance with personal care and other daily activities and who choose to get that assistance in a congregate residential setting. Most AL residents are elderly and have one or more chronic conditions and therefore often need help coordinating medical services, particularly managing their medications.

According to a number of recent studies—National Investment Council (NIC) (1998); Hawes, Wildfire, & Lux (1993); Kane & Wilson (1993)—the average age of assisted living residents is approximately 84 years. Approximately three quarters of residents are women. Residents in the NIC study had been living in their AL facility for an average of about two and a half years. Seventy-three percent of AL residents are widowed, 10% married, 9% never married, and the rest (9%) divorced or separated. The educational level of AL residents is higher than the general population, and 98% speak English as their primary language. Sixty-nine percent moved from home, and the rest from another AL facility, the home of a relative, a nursing home, or other institutional settings.

Approximately one third of AL residents have significant hearing impairment, and a similar number have visual impairment not correctable by glasses. Most have one or more chronic conditions, and 30% are incontinent. About two thirds of AL residents need help with at least one activity of daily living, most commonly bathing. Eighty percent need help with at least one instrumental activity of daily living, most commonly doing laundry. Ninety-eight percent of AL residents take at least one medication, with an average of 5.4 medications per resident. Of those taking medications, approximately three quarters need help managing their medications. About one third of AL residents take medications for "mental, emotional or nervous conditions."

The most prevalent diseases among AL residents (National Investment Council, 1998) are hypertension and cardiovascular disorders (57.8%), arthritis (32.5%), depression (17.7%), congestive heart failure (17.2%), diabetes (13.8%), osteoporosis (10.7%), and thyroid disease (10.5%). Although only 23.6% of residents had diagnoses of Alzheimer's disease or related dementias, 44.4% of AL residents were found to have some level of cognitive impairment, with a distribution of severity from "some difficulty" (24.6%) to "moderately impaired" (15.5%) and "severely impaired" (4.3%). A significantly greater proportion of women than men was likely to have cognitive impairment.

In sum, assisted living residents clearly make the decision to leave home because they have health-related needs that are difficult to manage in their homes. Next they chose AL over other options because they value the more

residential atmosphere and lower cost it offers compared to nursing homes. An example of this progression of needs and decisions in the life of one lady will illustrate the process.

CASE STUDY OF A "TYPICAL" ASSISTED LIVING RESIDENT

Rose Miller was an 82-year-old widow, living alone in the same house she had lived in for 46 years, and where she had raised her three children. She was managing rather well, with some help from her daughter, son, and daughter-in-law, even though she could no longer drive. However, she had fallen twice in the last year and was getting out less and less because of her impaired vision and increasingly painful arthritis. Her son and daughter-in-law had moved an hour away because of a job change. Her neighbor, who had often given her rides to the grocery, had died. The now almost-daily visits were getting harder for her daughter.

Then Rose was rushed to the hospital with a gall bladder attack. In the hospital she became quite confused and disoriented, and several additional medical issues, including high blood pressure, were uncovered. At this point, her oldest son flew in from the coast, and there was an emergency family council. Rose reluctantly agreed with her children that she needed to move to a place where she could get more support. It was a confusing time for all of them. They were not sure whether Rose had some early dementia or if her medical problems were going to get better or worse. They also were not sure what she could afford. They were not sure how much her house would sell for, and in her weakened and confused state she was having difficulty remembering just how much money she had in investments and CDs.

Her children visited one senior apartment, a continuing care retirement community (CCRC), and a nursing home in the area. Given the large intake fees and her already frail health, the CCRC did not seem to be an option. Despite her current medical problems, they hoped and expected that she would not need all the care the nursing home would provide, and they knew that their mother would want her own apartment, not half of a shared bedroom. They therefore narrowed their decision to the two assisted living residences in their town. They took Rose to visit both, and she made the final choice. It was a smaller, locally owned residence which, while not fancy, was home to several acquaintances and friends from around town.

By the time her eighty-third birthday rolled around, Rose had made the adjustment to her new life. Her house was sold, and she had created a life for herself in her new home. She appreciated the support the assisted living residence offered and was glad to be less of a burden on her children. Still, she missed her big old house that held so many memories, and the friends she had made over the years in her old neighborhood.

Over the next three years, several of Rose's medical conditions progressed. She needed more and more help from the assisted living staff and was hospi-

talized twice. Despite her increased frailty, the assisted living residence included her, as well as her children, in decisions about the services she received. Some of the staff remembered her from the days when she volunteered at the high school.

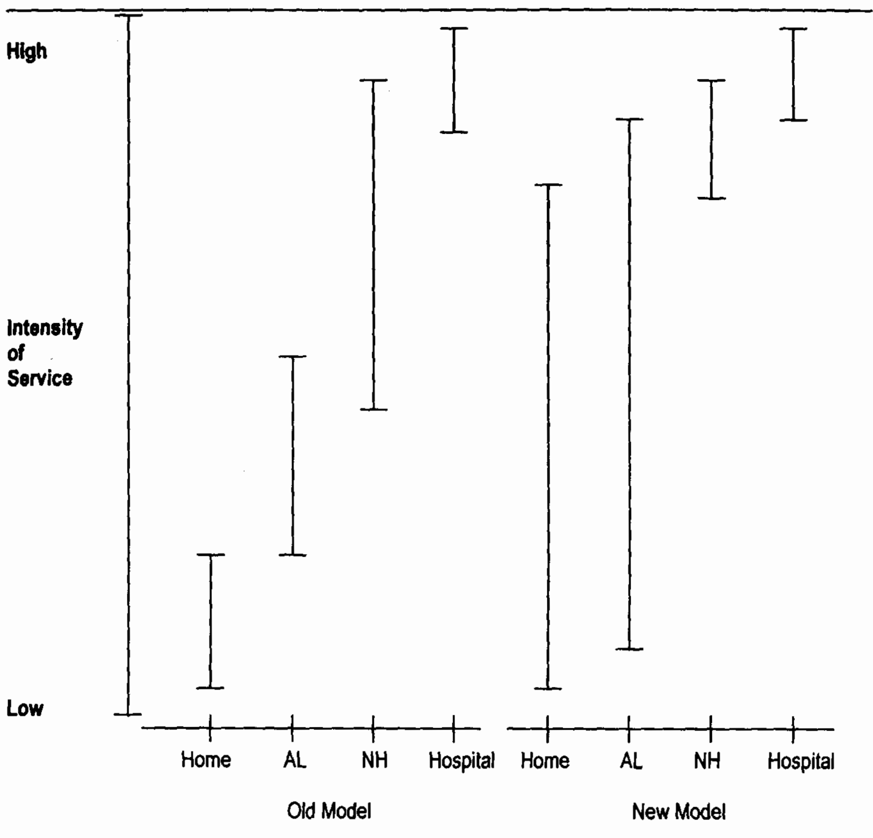
Then, just after her eighty-sixth birthday, she had a stroke. She went to a nursing home specializing in rehabilitation, were she made only modest progress. Nonetheless, after two months, she returned to her apartment in the assisted living residence. She had to pay for more services, and she could not get to many of the activities. Sometimes she could not even make it to the dining room, and they had to bring her meals on a tray, but it was worth it to her. Two months later she had another stroke, and she went back to the nursing home for rehabilitation. Now it took two people to help her in and out of her chair and into the shower. When the nurse from the assisted living residence came out to visit her, she recommended that Rose stay in the nursing home. Rose's children agreed. They knew that she needed more nursing care, and they also knew that her money would soon run out and that the nursing home would accept the Medicaid payments for which she would soon be eligible. Eight months later, Rose suffered her third stroke and died soon after in the nursing home.

WHAT IS THE CONTEXT FOR AL, TODAY AND IN THE FUTURE?

Assisted living arose in response to several demographic factors. First, both in absolute numbers and as a proportion of the population, those elderly who need personal care assistance and some nursing-related services have increased dramatically in the last two decades. Second, the wealth of elderly individuals has also increased both in terms of income, which is now supplemented by social security, and in terms of assets, particularly housing. Seniors are using this wealth to purchase services in settings with a more residential feeling than nursing homes provide. Nursing homes remain the setting of choice primarily for two groups—those with very intensive skilled nursing needs and those who rely on Medicaid to pay for their care. Those who can afford to pay privately, those with long-term care insurance, and those whose service needs are less intense are more likely to opt for assisted living.

Thus, this author believes that we are witnessing a paradigm shift in senior housing. The established paradigm describes senior housing and service options as a continuum, in which the senior's increasing care needs necessitate the senior literally and bodily moving from lighter-care settings, units, or facilities to higher-care settings, units, or facilities. Today, AL, like living at home with the potential for hiring help in the home, is not simply a step in the continuum of care, but rather a platform for the provision of a wide range of service, which may vary over time (Figure 1.1).

Figure 1.1
Old and New Models of the Range of Senior Care Settings



AL = assisted living facilities; NH = nursing homes

THE HEALTH CARE CONTEXT

There is no question that the great majority of AL residents, like the great majority of other older adults, need health care services. There is some evidence that AL residents get more preventive care and therefore are in better health, use fewer acute care services than comparable community-dwelling elders, and, as a group, save health care dollars (see chapter 3, by Nunnelee and Gilliland, in this volume).

Preventive health services in assisted living include many elements. The first is nursing oversight of medication regimes, designed to reduce drug interactions and side effects. A second is medication reminders that ensure that

medications are taken as prescribed. A third is more regular visits to health professionals such as to physicians, podiatrists, dentists, laboratory work, physical therapists, and visiting nurses. Such visits are done more regularly because (a) health care professionals may visit the site, (b) transportation is often more readily available, and (c) on-site nurses may track health-related needs and remind or help arrange visits.

Regulators, third-party payers, and other interested parties hold diverse opinions about the role AL can and should play in the provision of health care, particularly nursing services. Assisted living providers themselves are not of one mind about this issue, even within the same company or site.

The National Investment Council (1998) study found that 44% of AL facilities had formal arrangements to provide temporary nursing services to residents, and 22% had the ability to provide permanent nursing services to residents, if needed. In many cases, such services are provided by a home health care agency rather than by AL facility employees.

In the same study, a distinction was identified between "medical" and "social" models of AL. As would be expected in an analysis of characteristics of these sites, the "medical model" sites served people with an average of 9.3 activities of daily living (ADL) needs, versus 2.9 ADL needs in the "social model" sites.

Researchers have yet to determine to what extent typical AL nursing supervision and wellness services increase residents' overall health. The U.S. Health Care Finance Administration (HCFA) and the Agency for Health Care Policy Research (AHCPR) have both shown interest in determining whether, in fact, AL care improves health and decreases acute health care costs for residents. A preliminary study (Leon, Cheng, & Neumann, 1998) found that AL residents with dementia used fewer acute care services than did dementia sufferers living with family. Another study (Johnson & Bootman, 1995) found that, with respect to elders in the community, for every dollar spent on medication, an additional 90 cents is spent on correcting problems created by medications. If AL residents receive assistance in taking the most appropriate medications for their conditions in the correct way, and if staff oversight reduces unwanted medication interactions common in the elderly, then many of these iatrogenic difficulties can be eliminated. The efforts of these agencies should produce a clearer measure of the health efficacy of AL care in the near future.

THE REGULATORY CONTEXT

Unlike nursing homes, which are regulated federally, AL facilities are regulated by the states. There is considerable variability in how states define AL. There is also a great deal of variation among states regarding what AL facilities, by law, must, may, and may not do and whom they may serve.

There is little consistency from state to state regarding the names used to categorize residential care facilities. Although providers and consumers typi-

cally use the name "assisted living," state regulations may or may not use that term. Among the 21 states and 27 different licensure categories analyzed in a recent study (Hyde, 1995), fifteen different names were employed. Most common among these are listed in Table 1.1.

CONTENT OF REGULATIONS

Regulations are, if anything, even more diverse than nomenclature. While there is consistency in basic requirements, such as that administrators must be "eighteen years of age or older and of good character," regulations differ widely in other areas. Some states have very detailed physical plant requirements, while others address only life safety issues. A few states have dietary regulations that spell out detailed nutritional requirements and health standards while others specify nothing more than the number of meals per day that the facility must serve. The level of specificity and the actual language regarding services, training, and staffing also vary widely. Formats, order of areas covered, even language regarding basic concepts are so different that comparisons are difficult to make.

PHILOSOPHY OF REGULATIONS

There is less regulatory consistency from state to state regarding the goals and purposes for AL facilities than for nursing facilities, which come under

Table 1.1
Assisted Living Nomenclature in Selected States

Residential/Resident Care Facilities/Homes	six states
Personal Care Homes	three states
Board(ing) Home/Lodging/Care Facilities	three states
Assisted Living Facilities/Centers	three states
Homes for the Aged	one state
Rest Homes	one state
Sheltered Care Homes	one state
Domicillary Care	one state

federal regulation with state enforcement. In some states, AL and residential care facilities are seen primarily as housing or social service organizations. These entities are regulated by the state social service, housing, or aging agencies, and there is a tendency to allow more variation in the services allowed and greater impairment among residents. In states where AL or residential care is seen as simply a lower level of nursing home care, regulations tend to mirror the medically based language of nursing homes. Typically, states that have a more psychosocial orientation allow for a greater range of impairment than those with a more medical orientation. However, these two features are not always correlated, and a few states that have instituted new AL regulations have restricted AL settings to relatively independent elders. States that have developed new regulations for "assisted living" tend to foster more resident autonomy and a more residential milieu than those with more traditional nomenclature such as "residential care or home for the aged." Table 1.2 shows the relationship between the range of resident impairment and regulatory orientation in ten states.

Many states have modified, or are in the process of modifying, their AL and residential care regulations. The Assisted Living Quality Coalition, composed of the Alzheimer's Association, the American Association of Homes and Services for the Aging, the American Association of Retired Persons, the American Health Care Association, the American Seniors Housing Association, and the Assisted Living Federation of America, has released the *Assisted Living Quality Initiative* (August 1998). This document contains "Guidelines to States on Setting Minimum Standards for Providers of Assisted Living," which some states are consulting as they create or modify their regulations.

THE STAFFING CONTEXT

As one assisted living operator put it, "we are only as strong as our least experienced worker on the night shift." The largest portion of assisted living budgets, after building costs, is personnel, and most staff members are direct service workers. Regulations mandate different minimum levels of training for these staff members, from a brief orientation to training comparable to the certified nursing assistants found in nursing homes. (See chapter 5: "Creating and Maintaining an Assisted Living Workforce with Commitment to Customer Service").

One unique feature of assisted living is the preponderance of the "universal worker" model, with the same individual typically performing housekeeping, food service, personal care, medication management, and resident activity duties. Staff satisfaction in AL is generally high, presumably because direct care staff are given increased responsibility and flexibility in their jobs. This model creates a very significant need for staff training. The Assisted Living Federation of America and other groups are attempting to address this need with training manuals, videos, and train-the-trainer programs. However, recruiting, training, retaining qualified staff, and paying them an adequate wage while keeping costs in line for consumers will continue to be a major challenge for individual providers and the assisted living industry as a whole.

Table 1.2
Relationship of Resident Impairment to Regulatory Orientation

		RANGE OF IMPAIRMENT	
		Broad	Narrow
ORIENTATION	Psychosocial	Massachusetts Michigan Virginia	California New Jersey
	Medical	Florida Maryland Pennsylvania	Illinois Ohio

THE DESIGN CONTEXT

Regulatory, market, operational, and philosophical factors affect the design of the physical plant. Assisted living buildings range in size from a few units to several hundred. Décor may be more or less residential. Almost all have dining, living, and other common areas. Individual apartments range from shared bedrooms with bathrooms down the hall to two- and three-bedroom apartments with full kitchens and two and a half baths. Construction types run from wood frame residential buildings to fully nursing home–compliant, fire-safe buildings. Decisions about building size, construction type, and décor are

typically attuned with the management's philosophy, state and local regulations and zoning requirements, and the demands of the local market.

THE MICROFINANCIAL CONTEXT

Assisted living continues to be a primarily private pay industry. The way providers charge for their product varies. While almost all have price differentials that reflect the size of the apartment or living unit, service fees can be arranged in any number of ways. Most common is a "tiered" approach, with resident fees bundled within a certain range. The next most common model is "à la carte," in which residents pay for each service or time segment as needed. Finally, a few AL providers offer a flat fee that includes unlimited services.

As the number of buildings operating in each market area increases, there is increased competition. At this time the market is still underserved, with approximately one quarter as many AL apartments as there are elders in need of this type of setting.

Since the bulk of their income is derived directly from residents, AL providers are, of necessity, very responsive to the needs and wishes of their customers. They are likely to align their amenities and services to those aspects of their operations that are perceived as important by the consumer. This may create tension with the "best practice" concepts as developed by various professions, such as social work and nursing, as well as with regulatory agencies.

Assisted living is now receiving some Medicaid reimbursement. This is typically through a state "community-based waiver." Such waivers allow the use of Medicaid long-term care funds for residents of settings other than licensed nursing homes who need a comparable amount of services. According to the most recent statistics (Mollica, 1998), 35 states now participate in, or are considering, some type of Medicaid program that provides funding for AL or other residential care. These programs typically do not cover all AL sites in their states, and they have rules that restrict their availability even among residents who would be entitled to Medicaid in a nursing home setting. Despite the limited numbers of AL residents now receiving such aid, AL operations are often affected by waiver program requirements in such areas as clinical records, staff ratios, and operations. There is now, and there will continue to be for some time, a tension between the requirements of such third-party funders and the expressed needs and wishes of the residents themselves.

Third-party payment, especially through Medicaid, is increasingly making AL available to low- and moderate-income seniors. Some 64% of AL residents (National Investment Council, 1998) have annual incomes below $25,000 per year. Given the costs usually associated with AL, this means that most residents are receiving some financial assistance. Most of the shortfall is made up by proceeds from the sale of their homes or other assets. However, increasing numbers of seniors are able to live in AL with subsidies from family, government, or other third-party payers. In addition, if the link to lower overall health care costs discussed above can be documented, it is likely that managed care will become a significant factor in AL reimbursement.

THE MACROFINANCIAL CONTEXT

The larger financial context consists of the financing of AL companies and of specific properties. There are several financing mechanisms available and in use by AL providers. These include private and bank financing, federal Housing and Urban Development (HUD) funding, state-backed bond issues, large institutional lenders such as insurance companies, and public stock and bond offerings. Increasingly, large lenders and public stock and bond offerings are spurring the expansion of the industry, through the financing of both specific projects and entire companies. These investors expect steady returns that are comparable to those of other industries in which they could invest. The result has been pressure on AL providers in companies with these sorts of funding to achieve consistently high financial returns. This pressure has motivated some AL companies to accept residents they are not prepared to serve. It has also reduced their ability to take the kinds of risks and make the kinds of changes often required of new industries to enhance learning and positive change.

OPERATING IN THE CONTEXT OF A MATURING INDUSTRY

As of this writing (MacPherson, 1999), the top 25 AL companies operate only 11% of the total AL beds in the country. There are still many "mom-and-pop" operations, in which owner-operators manage one or two AL buildings. The NIC (1998) study reports that 36% of the properties in the study were the only one operated by the management group, 19.5% were one of a two-to-five-building group, 8.3% were in a 6-to-20-building group, 4.7 were in an 11-to-15-building group, 2.4% were in a 12–30 building group, and 29% were part of a chain with 20 or more ALFs.

Single or small operators tend to be more flexible and more in tune with local market demands. Larger management groups may have a prototype that gives them more consistency and presumably some cost savings through bulk purchasing. Larger management groups also typically have several models to accommodate different markets and different populations served. In addition, larger groups may have grown through acquisition and thus continue to have considerable variability in building type and operational style from building to building.

As the industry matures, we can expect to see less variability. We may also see a growing ability and willingness to serve residents with greater and more complex service needs. This higher acuity level among residents has already begun to create increased respect in the industry for a "best practices" approach that may be in conflict with flexibility and responsiveness to individual residents' needs and wants

VARIABILITY AMONG AL PROJECTS

Given the state-to-state regulatory differences, the large number of management groups and single owner operators, and the market-driven nature of AL, it is not surprising to see considerable variation among AL sites. Unlike nursing homes, which tend to be constructed and operated in much the same way across the country, there are many differences among AL sites.

Differences can be seen in building size, layout, décor, and construction type. Staffing may include many nurses or none at all, many staff or just a few, close links with home health agencies or only loose ties. Most importantly, the extent of resident services provided and the range of residents served varies tremendously from building to building.

For example, the proportion of residents with cognitive impairment differed significantly among different regions of the country (National Investment Council, 1998). The mid-Atlantic and the Great Plains states had many more residents with severe cognitive impairment, while the Northeast, the West Coast, and the Midwest had only 30%–37% with any cognitive impairment at all.

Another example of variation is the service needs of residents. In overbuilt areas, AL providers are serving residents with complex needs, while in underbuilt areas, many AL providers are still attracting more independent residents, and discharging those who need more nursing care.

THE RESEARCH AGENDA

Given this context, there is considerable need to enhance understanding of the effectiveness of AL. In particular, given the range of AL practices, there are few data substantiating the effectiveness of different types of AL on different populations and different types of outcomes. The following is an overview of the types of issues that need to be addressed (Kane et al., 1999):

- To determine whether the perceived advantages of AL in terms of quality of life, social well-being, and resident autonomy are borne out.
- To clarify health and functional outcomes of AL and, if the concerns of skeptics are justified, to address problem areas.
- To examine the cost-effectiveness of AL as a choice for both private and public payers.

To accomplish this agenda, it will be important to study the structure and process inputs, such as the types of buildings and the organization of services provided, and to relate those inputs to a range of outcomes. Table 1.3 lists topics that may be fruitfully studied as we attempt to understand AL. Any study that examines the clinical and financial effectiveness of AL will inevitably confront four different types of methodological problems: (a) defining the independent variable ("AL"), (b) developing study samples and populations, (c) defining the dependent variables (outcomes of AL), and (d) choosing appropriate comparison groups.

Table 1.3
The AL Research Agenda: Areas for Study

Structure and Process Issues

- Building design
- Staffing patterns and training
- Entry and move-out criteria
- Service coordination and delivery
- Fees and contract terms
- Regulation

Outcomes

- Physical health status
- Functional abilities (ADLs and IADLs)
- Psychological and social well-being
- Resident rights
- Satisfaction (resident and family)
- Move-out status and location
- Autonomy
- Mortality
- Utilization & cost of hospitals, physicians, and other services
- Cost of assisted living

FUTURE CHALLENGES AND OPPORTUNITIES

As AL providers address the issue of what AL will become, they will look increasingly at the priorities of third-party payers and seek to balance the perspectives of regulators and third-party payers with those of the original AL customers, that is, residents and families. The AL industry must also address the maturing of management philosophies, as a body of AL "best practices" vies

with flexibility in response to individual needs and wants. Third, the aging of the population now living in AL settings, in combination with increased market saturation, will put pressure on many providers to retain and serve residents with more complex needs than those they are serving today.

All of these changes will influence the direction AL takes in the future. They will affect operations, staffing, admission and discharge criteria, regulation, building design, third-party payment, and financing. Most of all, they may affect AL's current consumer-centered approach to quality. Assisted living's challenge will be to continue to approach resident and family needs with full respect for their varied and changing definitions of quality and to continue to adapt to those changing definitions.

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Medical Problems and Care Needs of Older Adults in Assisted Living Facilities

Teresa Sligh and Belinda Vicioso

The physician's role in the care of the assisted living elderly is a unique one. The goals of care are often quite different than those for nursing home residents, hospitalized patients, healthy adults, or pediatric populations. Patients continue to have a degree of independence, health, mobility, and decision-making capability. The patient care issues that come to the forefront are those of maximizing independence, autonomy, and physical function while providing for safety, security, privacy, adequate nutrition, personal comfort, and maintenance of dignity (Coons & Reichel, 1988). The ideal mechanism by which to accomplish these goals of care is the establishment, or continuation, of a personal doctor–patient relationship. In today's health care climate, this remains a challenge.

The geriatric population is the most rapidly growing segment of our population. The increase over the past two decades in the number of individuals over the age of 65 has been so dramatic that we now differentiate segments of the elderly population. People 85 and older are now being called the oldest old, and they represent the fastest-growing segment of the U.S. population. The changing composition of today's geriatric populations compared to a generation ago may actually reflect improvements in our environment and preventative health measures. Surprisingly, though, the United States is not in the top ten countries in life expectancy over the age of 65 years (Morley, 1991). This may be a result of the present trend to rapidly discharge people from the hospital. Other possible contributing factors may be lifetime overeating, excess alcohol and tobacco use, dependency on motor vehicles, and inappropri-