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## A Primer on Residential Care Facilities for the Elderly

The Quality Initiative

January 2002

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## Acknowledgments

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# I. Introduction

*Surprisingly little is known about this industry, one that provides vital services to more than one million individuals who are among the oldest and frailest members of society.*

MORE THAN 1.5 MILLION INDIVIDUALS nationally—mostly elderly—live in some form of supportive housing, with more than 800,000 residing in licensed facilities (e.g., foster family homes, small family homes, group homes, social rehabilitation facilities, and residential care) and an equal number estimated to be living in unlicensed facilities, including rooming homes, single-room occupancy hotels, and group quarters with fewer than seven unrelated individuals.<sup>1,2</sup>

These facilities not only provide residents with shelter, but also meals, cleaning, and laundry services. Most licensed facilities also offer help with transportation and shopping, supervision (but not administration) of medications, assistance in obtaining medical and social services, and limited help with activities of daily living such as bathing, dressing, grooming, eating, and transfers into and out of chairs and beds. A few facilities also have licenses and/or regulatory waivers to provide additional services for residents with special needs, such as those who need oxygen or have cognitive impairments.

Surprisingly little is known about this industry, one that provides vital services to more than one million individuals who are among the oldest and frailest members of society. Answers to basic questions such as the following are largely unavailable:

- What is the quality of services provided by these facilities? Who provides the services, and are they meeting the needs of residents?
- Are these facilities cost-effective? In other words, are the costs of care associated with residential care more than offset by “savings” elsewhere, such as reductions in the need for more expensive nursing home services, or avoidance of acute health episodes that result in costly emergency room visits or hospitalizations?

This primer sheds some light on these issues by reviewing the available evidence. But because available data are limited, the report also includes a set of recommendations for policymakers to consider in order to address the information gaps that exist today. It is organized into the following chapters:

- The next chapter provides a profile of the industry across the nation, including key trends for supply and demand, resident

mix, costs and pricing, staffing, and state legislation and regulation.

- The third chapter profiles the industry within California, with a focus on the supply of facilities and the characteristics of the individuals who reside in them.
- The fourth chapter examines what is known about the cost-effectiveness of the services provided by residential care facilities.
- The fifth chapter reviews the state of quality assurance and data systems to monitor the industry within California and nationwide. This chapter also includes a discussion of how other health care data systems could be enhanced to make them applicable to the assisted living industry.
- The final chapter makes recommendations for enhancing our understanding and oversight of the residential care industry.

### Common Terms

Federal and state laws and regulations refer to supportive housing by a variety of terms. The most common ones include board and care, residential care facilities (RCFs), assisted living, continuing care retirement communities and adult congregate care. Because California makes no distinction between the various levels of supportive housing, this report will use the most widely used terms—residential care and assisted living—interchangeably.

## II. A Profile of the Residential Care Industry Nationwide

*The precise growth rate for the supply of and demand for assisted living facilities cannot be determined. Some of the “growth” in supply, for instance, could be the result of existing, unlicensed housing becoming licensed or of changes in state or provider definitions of housing type.*

THIS CHAPTER PROVIDES AN OVERVIEW OF THE residential care industry. Topics include critical changes in supply and demand as well as other key issues affecting the industry, such as trends in resident acuity, pricing, and regulations.

### Supply and Demand Trends

Throughout most of the 1990s, the supply of residential care services, particularly assisted living facilities, appears to have grown considerably. More recently, financial hardship for many for-profit players in the industry and a decline in investor interest have served to reduce this growth.

### The Supply of Residential Care Services

The supply of assisted living facilities grew rapidly during most of the 1990s, which was a “boom time” for the industry. In fact, it is estimated that three-quarters of all senior housing built during the 1990s were assisted living or supportive housing units.<sup>3</sup> Much of this growth was driven by the investor community, which in the early 1990s became enamored with the favorable demographics, stable cash flow, and relative lack of regulation that characterize the industry. These investors gave for-profit institutions, many of which were affiliated with national corporations, access to ample capital to build large facilities (with 80 or more beds) and to acquire existing facilities through cash and common stock.

Large, for-profit facilities account for only a portion of the supply. Most facilities are small, independent, for-profit operations that are often run by a family. In California, for example, 85 percent of licensed residential care facilities for the elderly (RCFEs) have fewer than 16 beds. A third component of the industry is facilities owned and operated by not-for-profit organizations. Growth in these latter two sectors has been slower than among the large for-profit chains, as these types of facilities do not have the same access to capital. In fact, small, independent facilities generally have little or no access to loans or grants; over the last ten years, growth in this sector has probably been stagnant or negative. Yet many of these facilities are among the few that cater to individuals with low and moderate incomes. Not-for-profit facilities also have limited access to

capital markets, although they can receive loans from banks under the Community Reinvestment Act for construction of moderate-income housing for the elderly (including assisted living) as well as loan subsidies under programs run by the U.S. Department of Housing and Urban Development (HUD). In addition, not-for-profits can engage in community fundraising and, in many circumstances, can issue state and/or local municipal bonds.

The bottom line is that the industry added significant capacity during the 1990s that was targeted to people with above average incomes. By mid-1999 evidence began to suggest that there might have been too much investment in this narrow housing segment. Average “fill-up time”—the amount of time required to lease a newly constructed facility—increased to 18 months.<sup>3</sup> Not surprisingly, this poor financial performance translated into poor returns for investors, which saw the average assisted living company’s stock price decline by 70 percent.

The net result has been a dramatic cutback in the construction of new facilities: Senior housing construction declined by 46 percent between mid-1999 and mid-2000. Moreover, several large firms have tried to improve their financial position by selling or closing existing facilities. Others have embarked on operational cost-cutting initiatives that have sparked concerns about the quality of care due to overworked staff and high turnover among nurses, administrators, and others.

## The Demand for Residential Care Services

While somewhat difficult to measure with any precision, the demand for assisted living appears to have grown along with the increase in supply. The population living in licensed housing is estimated to have increased by 24 percent between 1990 and 1995.<sup>4</sup> Between 1995 and 1999, growth may have been even more rapid, with rates as high as 40 percent in 15 states.<sup>1</sup> When the full supply of all forms of licensed housing for the aged and disabled are considered, some studies would suggest that there has not been much change between 1990 and 1999 in the total number of people living in such housing.<sup>5</sup>

Regardless of the precise rate of growth over the recent past, demographic trends show rapid increases in the population of elderly individuals for whom assisted living is designed moving into the 21st century. In California, for example, the number of individuals aged 65 and older is expected to double between 1996 and 2020 (see Table 1). The number of people over the age of 85 will more than double during this time period. These growth rates exceed the projected change in the elderly population for the United States, making California a demographically appealing market for residential care/assisted living providers.

Along with favorable demographics, increasing wealth among the elderly is likely to provide a further impetus to growth. It is estimated that between 40 and 60 percent of individuals over

**Table 1. Projected California Population Aged 65+ and 85+ to Year 2020**

Age	1996	2000	2010	2020	% Change 1996-2020
65+	3,303,000	3,704,000	4,605,000	6,622,000	100.5%
85+	323,000	418,000	636,000	809,000	151.0%

Source: American Seniors Housing Association, 1999.



the age of 75 have the financial resources to live in an assisted living facility for at least two years.

That said, one factor that could constrain growth in the demand for supportive housing is the relative reluctance of ethnic populations to make use of such services. This issue is especially relevant within California, which is home to a large number of African American, Latino, and Asian American families, ethnic groups that have historically been less likely than whites to use supportive housing services. Looking ahead, the industry may need to adapt to the interests and needs of these ethnic groups, although little is known about what they view as being attractive or unattractive about residential care.

### **The Demand/Supply Equation Going Forward**

Some analysts argue that eventually supply and demand will equalize and that the assisted living industry will prosper due to the positive demographics and the presumed cost advantages of assisted living over nursing homes. Others caution, however, that since financial markets have long memories, the industry may have to find new sources of capital to renew expansion.

In addition, there is some evidence to suggest that, despite some evidence of market saturation, many communities—especially smaller ones—are home to very few assisted living facilities, especially in comparison to the number of nursing home beds in these areas.

### **Other Trends Affecting the Industry**

Along with supply and demand trends, the following four trends characterize the industry:<sup>6</sup>

1. Rising acuity and turnover levels among residents;
2. Cost (and price) creep;

3. Difficulties in attracting and retaining staff; and

4. Increased competition.

These issues are briefly examined below.

### **Rising Acuity and Turnover Levels Among Residents**

While comprehensive data are not available on residents in all forms of supportive housing, a recent survey by the American Seniors Housing Association suggests that the average age of a resident is roughly 83, and that 60 percent of residents need help with one or more activities of daily living.<sup>7</sup> This combination of old age and frailty not only increases the operational costs of serving residents, but also contributes to a high rate of resident turnover: The current median rate of turnover for the industry is 50 percent per year. High levels of turnover translate into higher marketing costs to fill vacancies and may lead to the acceptance of residents with higher levels of frailty. Wright Mature Market Services estimates that “it now takes 1,000 leads to fill a new 80-unit project.”<sup>8</sup> High turnover also makes it difficult to achieve the 93 percent occupancy rate that is estimated to be necessary to achieve “adequate” profitability.<sup>6</sup> With current vacancy rates at 8 percent, the average facility is running below this level today.<sup>9</sup>

### **Cost (and Price) “Creep”**

The high marketing costs and increased frailty of residents have combined with a tight labor market and demands for investor returns to create a steady increase in the operating costs and prices of residential care facilities. The average basic rental rate rose from \$1,800 per month in 1995 to \$2,200 per month in 1999, a 22 percent rise over a four-year period. This increase has been accompanied by increasing complexity in pricing systems, especially within larger facilities. Some

companies offer several tiers of services: basic support care, personal care, supplemental services, wellness services, and Alzheimer's and special care services. These tiered approaches are also sometimes merged with risk-adjustment systems that adjust rates based on the frailty of the resident.

### **Difficulties in Attracting and Retaining Staff**

The industry has struggled with attracting and retaining qualified staff for many years. Salaries, wages, and benefits have historically been lower in residential care than in hospitals and nursing homes.<sup>10</sup> Low rates of unemployment through much of the 1990s created an even tighter labor market for residential care facilities, which had to compete with fast-food restaurants, retail stores, and other sectors for qualified workers. While salaries and benefits have increased somewhat within the industry, staff shortages remain common. Anecdotal evidence would suggest that rates of staff turnover have increased, while the average experience level and English language skills of both job applicants and staff have fallen. These trends may, in turn, be having a negative effect on the quality of care while simultaneously driving up the costs associated with training and supervision.

### **Increased Competition?**

As discussed, the question of whether market saturation by residential care facilities is widespread or limited to highly visible markets—or to certain consumer segments such as high-income individuals—is not fully known.

Two studies shed some light on the issue. The first finds that the vast majority—93 percent—of assisted living facilities have one or more competitors within their immediate market areas.<sup>11</sup>

This study also suggests that large corporations are using a number of strategies to eliminate or weaken the competition, including the following:

- Mergers and takeovers;
- The “clustering” of facilities in an area to take advantage of economies of scale (for example, in purchasing, marketing, administrative services, and clinical support);
- Vertical or horizontal integration into other types of care (for example, skilled nursing facilities, independent living units);
- Branding; and
- “Niche” positioning (for example, to serve upper-income individuals, or dementia special care).

The second study, on the other hand, finds that competition may not be that severe after all, at least in certain areas of the country. This study compares residential bed supply to nursing home bed supply in each of the counties of five states (Kansas, Maine, Mississippi, Ohio, and South Dakota). To the extent that assisted living is an alternative to nursing home care, the number of beds for each should be roughly the same. Yet in most counties there was less than one residential care bed for every four nursing home beds; no county approached a one-to-one ratio.<sup>12</sup> These findings suggest that market penetration—and hence the level of competition—remains relatively low in many markets, as residential care facilities have failed to compete effectively with nursing homes.

### **Regulatory Trends**

At present, state governments play the primary role in regulating the residential care industry. They influence the supply, demand, and quality of care in these facilities through a number of policies and regulations, such as:

- Stimulating demand for services through income-subsidy programs, most often through the state Medicaid program;
- Setting resident eligibility criteria by defining allowable levels of care and resident acuity within RCFs;
- Setting reimbursement rates for state-funded payments to RCFs (primarily through Medicaid);
- Increasing supply of RCF beds by encouraging the conversion of nursing home beds to assisted living facilities;
- Maintaining adequate levels of quality through quality assurance processes; and
- Protecting residents by mandating disclosure of the terms of residencies, including move-out requirements.

A recent survey conducted by the National Academy of State Health Policy offers insights into each of these areas. Key findings from the survey are presented below.<sup>1</sup>

### **Income-subsidy Programs**

While the predominant source of payment for residential care and assisted living services is private pay, the federal government and virtually all states provide some level of subsidy to assist low-income individuals in accessing these services. The most widespread and enduring public income-subsidy program available to support this type of care is the combination of the federal Supplemental Security Income (SSI) program with State Supplemental Payments (SSP). SSI/SSP directly pays the rent for low-income people, but at a payment level well below the market rate for such housing. Even in generous states such as California—where maximum SSP levels are equal to the federal SSI payment—the combined income is about half the market rent. Another problem with SSI payments in some

states, including California, is that families who supplement them with their own money for RCF rent and other living expenses are penalized, as these additional payments are counted against the resident's income. Eighteen states, however, allow families to supplement SSI payments without penalty.<sup>1</sup>

The inadequacy of the SSI/SSP payments, coupled with the fact that the SSP outlay comes from state funds alone, have led most states to apply for waivers allowing the use of Medicaid funds (50 percent of which come from the federal government) to financially support low-income individuals in need of RCF care. As of 2000, 38 states were using Medicaid to reimburse some services within RCFs, with four other states (including California), and the District of Columbia planning to initiate broad-scale coverage or pilot studies.<sup>1</sup> Medicaid waivers are also popular for two other reasons. First, they are considered a strategy for reducing nursing home expenses by encouraging movement to lower-cost facilities. (This issue is discussed in more detail below.) Second, they provide more choices to beneficiaries. Despite their popularity, however, these waivers currently serve only 59,000 individuals; 80 percent of the low-income population living in RCFs receive no Medicaid-based government subsidy.<sup>1</sup>

### **Criteria for Resident Acuity and Available Services**

In summarizing the changes in state policy between 1998 and 2000, Mollica notes that the general trend is to allow facilities to serve higher-acuity residents and to offer a broader range of services, including health-related services.<sup>1</sup> Partly underlying this trend is the philosophy that since a facility is a home to its residents, they should be allowed to “age in place” rather than being relocated to nursing homes. In addition, states are catering to residents' requests to have the option

of living in the least restrictive settings. Changes in resident eligibility and case mix have in turn begun to require adjustments in fire and safety standards, and in regulations pertaining to staffing levels and experience.

Another widespread shift involves regulations covering Alzheimer's/dementia care. Currently, 28 states permit special units for these patients within licensed facilities. These regulations establish minimum staffing levels and various monitoring and other systems to ensure the security and well-being of residents.

### **Licensing and Reimbursement Policies**

As acuity and service levels have increased, there has also been a need for changes in licensing and reimbursement policies. Most of the changes in state policy to adjust payment according to resident need are being implemented within the Medicaid program. Historically, states have used flat daily rates, but a number of states (e.g., Arizona, Florida, Idaho, Maryland, Mississippi, and Utah) are creating tiered categories where licensing and reimbursement are adjusted to reflect the level of service and the acuity level of the resident. Facilities can be licensed for a single level of care or multiple levels of care. A few states (e.g., Oregon, Hawaii, and Washington) have taken the approach of evaluating facility capabilities and resident needs in order to match them on a case-by-case basis. Maine provides a third variation on this. For its Medicaid waiver program, the state uses a case-mix classification to pay providers as well as to create quality indicators. This system is based on the Minimum Data Set (MDS) already used nationwide in skilled nursing facilities.

### **Nursing Home Conversions and Transfers to Assisted Living**

A handful of states are trying different strategies to stimulate the movement of appropriate residents from nursing homes to assisted living

facilities. One approach for states with an excess supply of nursing home beds is to make funds available to convert them to assisted living facilities. For example:

- North Dakota has provided \$50 million over a two-year period for this purpose.<sup>13</sup>
- Nebraska has converted 42 facilities into 707 assisted living units and 25 adult day health programs.
- New York has made Industrial Development Authority bonds available for construction of or conversion to assisted living facilities.<sup>13</sup>
- In an interesting twist, Iowa's conversion program requires those facilities using conversion funds to reserve 40 percent of the converted beds for Medicaid beneficiaries.<sup>1</sup>

New Jersey's approach represents a different strategy—one that encourages the movement of skilled nursing home residents to assisted living, adult day care, and/or home care. The state's pilot program has set a goal of moving 2,000 nursing home residents, in part by expediting certificate-of-need processes. The program appears to be working. In 1996, there were no assisted living facilities; today there are 70. Not surprisingly, the nursing home industry is unhappy about the program, as it may be removing lower-acuity, lower-cost (and hence higher-profit) residents from the nursing homes.<sup>13</sup>

### **Quality Assurance and Disclosure**

A number of states have put in place mechanisms designed to ensure the quality of services within RCFEs. One approach that is growing in popularity is known as "negotiated risk." With growing concerns about maintaining resident autonomy, these states have passed or introduced legislation that brings residents into the decision-making process regarding what level of care a facility will give and what deficiencies will be borne by the resident.<sup>1</sup> The negotiation process

involves the facility, the resident (including family members), and licensing/regulatory agencies.

A second type of quality assurance system involves giving consumers information on the quality of care or other indicators so as to help them choose among facilities. No systematic “report card” systems were identified, but many Web sites list assisted living facilities and other forms of supportive housing and provide information on the various services and amenities they offer. Some of these listings have links to pages that feature video tours of the facility.

Finally, a third area of state concern involves disclosing to residents and prospective residents the terms of their residencies. A recent General Accounting Office report examined the failure of assisted living facilities to fully notify residents of these terms, including move-out requirements.<sup>14</sup> This report and consumers’ complaints about “evictions” have prompted a few states (e.g., North Carolina and Indiana) to introduce legislation requiring more careful disclosure of these requirements and other conditions affecting continued residency.

## Implications

There is a changing environment for supportive housing within and among states. These changes include increased investment and growth by for-profit corporations, state policies that permit (and in some cases encourage) residents with higher levels of physical and cognitive frailty to remain in licensed and unlicensed residential settings, and demographic trends that suggest growing future demand for this level of service. These changes (and the inherent uncertainty they create) coupled with the relatively poor operational performance of the major companies has, in turn, led to consolidation and mergers and various efforts to control operational expenses. In spite of the efforts of the national trade associations, relatively little is known about the distribution of

supportive housing, especially within states, or how this distribution will change over time under current and future financial and regulatory incentives. State innovations, while increasing in number, have been largely unstudied as to their effectiveness, or their impact on access to care, staff turnover, or other important performance indicators within the delivery system. The collapse of investor confidence in this sector, coupled with the operational losses, raises particular concern about the viability of many operators and the impact that cost-cutting and other survival strategies might have on the quality of care and on consumer rights.

# III. Residential Care in California

*The vast majority of RCFEs are licensed solely for service to the elderly, although some facilities in all size groups have licenses for other age groups as well.*

THIS CHAPTER PROVIDES AN OVERVIEW OF THE residential care facilities system in California, with an emphasis on the variety of licensed facilities, staffing, and the population residing in these facilities. This material is based on documents as well as personal interviews with representatives of residential care associations, the state government, and consumer organizations. We will begin by looking at the number and sizes of facilities.

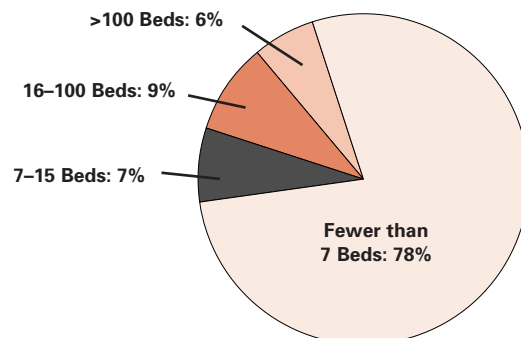
As shown in Table 2, RCFEs account for most of the supportive housing beds in the state, and somewhat more than half of the total licensed adult facilities. The vast majority of these facilities are small, with 78 percent of the 6,165 licensed RCFEs in the state having fewer than seven residents and just 6 percent exceeding 100 beds (see Figure 1).

**Table 2. Licensed Aged and Non-Aged Residential Care Facilities, June 2000**

	Total Capacity	Total Facilities
Adult (non-aged) Residential Care	38,189	4,609
RCF for Chronically Ill	391	29
RCF for Aged (RCFEs)	139,162	6,165
Social Rehabilitation Facility	901	72
Total	178,643	10,875

Source: Department of Social Services (DSS), Community Care Licensing Division. In addition to the above listed facilities, DSS also licenses Adult Day Care (with 29,133 beds and 599 facilities) and Adult Day Support Care Centers (1,661 attendees and 47 facilities).

**Figure 1. California RCFEs by Size**



## Facility Characteristics

Recent data on facility and staff characteristics are not available. However, data from the 1993 Survey of RCFE Operators and Residents, funded by the Henry J. Kaiser Family Foundation and conducted by the University of California, provide a profile of the industry in the early 1990s.<sup>15</sup> This report stands as the only statewide survey of California residential care facilities, and the only existing aggregated source of information on ownership, licensing status, pricing, services, staffing, resident characteristics, demographics, service use, and service quality of residential care facilities in California. There appear no current plans to repeat this survey as of this writing. It involved a two-stage stratified sample. The first stage was a probability sample of facilities, stratified into licensed size groups. The second stage consisted of a probability sample of three residents within the selected facilities. Interviews were conducted with residents (or their family members for those unable to complete an interview) and with facility operators. The instruments used were adapted from instruments developed for the national survey of licensed board and care homes conducted by the Research Triangle Institute under sponsorship of the Office of the Assistant Secretary for Planning and Evaluation.

## Ownership

California RCFEs are predominantly private, for-profit operations. The 1993 survey data show that, depending on the size of the facility, 75 to 95 percent of facilities fell into this category, with a higher proportion of smaller facilities being private, for-profit operations. More than one-third of the operators also owned or operated other RCFEs, and more than 30 percent of the larger facilities (i.e., 50 beds or more) owned or operated a nursing home.<sup>15</sup> The amount of consolidation since 1993 is thought to be substantial, but exact figures are unavailable.

## Licensing Status and Unit Mix

The vast majority of RCFEs are licensed solely for service to the elderly, although some facilities in all size groups have licenses for other age groups as well. Most facilities (about 75 to 90 percent) are licensed for non-ambulatory care, which permits the facility to serve those with either substantial mobility restrictions or dementia. The availability of special care units, especially for dementia, is regarded as an emerging trend within the industry nationally and in California. As of 1997, however, fewer than 20 percent of facilities reported such units.<sup>14</sup>

Multi-occupancy rooms predominate the unit mix, accounting for between 60 to 70 percent of the total rooms. (Two people per room is the regulatory maximum.) Except in facilities of more than 100 beds, shared baths are typical. These physical characteristics are at odds with industry trends toward a higher proportion of private rooms, especially in assisted living.

## Pricing

Base monthly rates for rooms tend to be similar across all facility sizes. Single rooms typically range from \$1,200 to \$3,000 with an average unit going for \$2,200.<sup>16</sup> The total price, however, varies across size groups, since smaller facilities (i.e., those under 50 beds) generally include personal laundry and assistance with eating, dressing, and toileting in the monthly rate, while such assistance often incurs additional charges in the larger RCFEs. In most facilities, incontinence supplies result in extra charges.

Between 50 and 75 percent of RCFEs report that they will accept residents receiving public assistance (i.e., SSI/SSP) at the time of application. Even more (80 to 90 percent) will keep residents who have later qualified for SSI/SSP. In spite of these practices, it is important to note that the SSI/SSP level of \$872 per month (as of September 2001) for a single individual is well below the

market rate for RCFEs, especially those with add-on fees for personal care services.

### Services Offered

Table 3 shows the types of services reported by operators to be available within RCFEs in 1993, and whether these services are provided by staff

or outside vendors. As would be expected, the core activities of personal care, medication supervision, and transportation were widely available and generally provided by facility staff. Skilled care, as represented by nursing and therapy, was much less common in all facility sizes, and typically provided by an outside vendor when available. While these patterns may have shifted

**Table 3. Facility Services By Licensed Size Class**

Services by Paid Staff	1-6 beds (n=77)	7-14 beds (n=72)	15-49 beds (n=65)	50-100 beds (n=70)	>100 beds (n=43)
% Personal care	96.1	95.8	93.8	98.6	93.0
% Medication supervision	94.8	98.6	100.0	100.0	97.7
% Organized activities	88.3	91.7	98.4	100.0	100.0
% Recreational trips	67.5	66.2	80.0	94.3	100.0
% Transportation	85.7	90.3	86.2	92.9	97.6
% Nursing care	27.3	29.2	20.3	18.6	29.9
% Therapy (i.e., OT, PT)	13.0	11.1	13.8	7.2	9.3
% Resident money management	10.4	26.4	30.8	30.0	27.9
% Case management	14.5	20.8	18.5	17.4	16.3
Services by Outside Staff (Past 30 Days)	(n=77)	(n=72)	(n=65)	(n=69)	(n=43)
% Personal care	22.1	23.6	32.8	52.2	72.1
% Adult day care	22.1	40.3	39.1	27.5	46.5
% Senior center	29.0	44.4	40.6	37.7	62.8
% Physician visits on site	39.5	56.9	60.9	57.4	62.3
% Transportation	40.8	71.8	71.9	66.7	83.3
% Nursing care	11.8	29.2	37.5	37.7	38.1
% Therapy (i.e., OT, PT)	10.5	23.6	15.4	17.4	17.1
Who Assists with Medications					
% Licensed RN or LPN	16.9	15.3	29.2	31.9	41.9
% Medications supervisor	16.9	23.9	47.6	60.0	65.8
% Supervisor-in-charge	36.8	54.2	60.9	54.3	47.6
% Operator/owner	80.5	77.8	46.9	25.7	21.4
% Aide	44.2	59.7	53.8	58.0	51.1
% with Medical Director	7.8	15.3	25.0	32.2	31.0

Source: Newcomer, Breuer, Zhang, 1994.



since 1993 because of changes in case mix or other factors (e.g., trends among larger facilities to form their own home health programs), no data exist to indicate what happened.

### **Staffing Characteristics**

Except in facilities of 50 beds or more, the number of staff during the day shift is quite small—usually five people or fewer. The ratio of residents to staff is highest in the small facilities; it falls to about 5:1 in facilities of 100 beds or more. These numbers include staff for housekeeping, meal services, administration, personal care, and specialty services such as recreation and transportation. Whether these staffing levels are adequate depends upon resident mix and the degree to which outside vendors are being used; unfortunately, data are not available to evaluate how staffing levels vary with resident mix or whether they have been changing over time.

Along with overall levels of staffing is the issue of what types of medical personnel are at hand. The 1993 survey suggests that nurses and medical directors have not been widely available, although one would not necessarily expect to find medical staff in the smaller facilities. These staffing patterns suggest that the management of chronic conditions is being left to the residents, their families, and their health providers. While this is similar to how such management would take place for individuals living in their own home, it nevertheless leaves open the question of whether greater collaboration between supportive housing facilities and health care providers would result in more efficient and effective oversight and management of the residents' conditions. About 30 percent of RCFE residents report having a hospitalization in the prior year. It is unknown whether these occurred prior to being a resident, and how many of these might have been avoidable given better disease management.

Another dimension of staffing is training and experience. In 1993, most staff positions tended to be relatively stable, with the mean number of months employed being substantially more than 24. Consistent with the extended tenure, more than two-thirds of staff were trained by their current employer. Whether staff stability continued during the strong economy of the mid- to late-1990s has not been documented, although interviews suggest that facilities may be having problems with retention and recruitment. Changing case mix and increased rates of staff turnover may also be making it difficult for facilities to continue their lead role in training.

A final issue related to staffing is the effect of unionization on the residential care industry. The Service Employees International Union, which contracts with 140 skilled nursing facilities, reports that few residential care facilities have union members. Those that do, have skilled nursing units on the same site. During an interview, a union representative suggested that there were generally too few potential union employees at a given RCFE to justify an organizing effort. However, this representative and those in other unions reportedly have concerns about wages, benefits, and occupational safety in the assisted living industry.

### **Resident Characteristics**

California is home to 140,000 individuals living in residential care/assisted living facilities. The most recent and comprehensive data available on this population come from a 1993 survey of residents and operators that used a statewide probability sample of RCFEs, stratified by licensed size classification.<sup>15</sup> Most of the following information comes from that survey and may not reflect the current situation.

## Demographics

In 1993, the typical RCFE resident was a female in her late 70s or early 80s; some 90 percent of residents were white, although smaller facilities tended to have a higher proportion of African Americans than did larger facilities. Between 60 and 75 percent of residents had completed high school, with at least 30 percent having had some college education. Income did not vary substantially across facility size groupings, although larger facilities (i.e., those with 100 or more beds) had about twice the proportion of people with incomes of \$25,000 or more in comparison with other RCFEs (20 percent versus 10 percent). Between a third and a half of the residents were eligible for SSI/SSP and Medicaid.

## Health and Functional Status

The physical and mental health status of RCFE residents can be briefly summed up as follows:

- More than one-third of all RCFE residents reported at least two limitations in activities of daily living (ADLs, such as bathing, dressing, grooming, eating, transferring), with mean scores highest in the smaller facilities.
- Between 40 and 50 percent of residents showed moderate to severe depression, based on responses to the Geriatric Depression Scale.
- More than half of RCFE residents showed at least some cognitive impairment based on responses to the Mini Mental Status Examination and facility case records.
- Moderate to severe cognitive impairment was reported among more than one-third of those in the smallest RCFEs.<sup>14</sup>

Comparisons of the California survey and two major multi-state surveys with earlier surveys (e.g., Dittmar and Bell, 1983; Gioglio and Jacobsen, 1984) suggest that rates of cognitive impairment, incontinence, and ADL limitations

increased by up to 25 percent between the early 1980s and 1993.<sup>17, 18</sup>

## Service Use Among RCFE Residents

Little can be said about the use of services. California has no ongoing data systems that track or compile statistics on RCFE residents and their use of health care or other services. The only information available on this topic is residents' self-reported estimates of hospital, physician, and other health care use from the 1993 survey. About one-third of residents reported a hospitalization in the prior 12 months, more than 20 percent reported at least one emergency room visit, and between 5 and 8 percent reported nursing visits within the prior 14 days. There is no way to know whether these usage rates are high, or whether the need for some of these services was avoidable. It is also not clear whether there is a relationship between the use of health care services and nursing home placement.

Use of some services does appear to be lower than expected. For example, in spite of high levels of depression within the RCFE population, the percentage of residents reporting use of mental health services was much lower than the percentage suffering from the condition.

## Service Quality

Service quality within the RCFE setting can be directly gauged by evaluating the percentage of people with an ADL limitation who claim to need more assistance.<sup>19</sup> Between 24 and 40 percent of those needing assistance with dressing reported that they needed more help than they received, with fewer complaints among larger facilities. For those needing assistance with walking or wheeling, the percentage needing more help than they got ranged from 50 to 64 percent. On the positive side, very few or no people who needed assistance with transferring in or out of bed or with eating reported needing more help

than they got. Assistance with toileting was also reported as generally meeting the resident's needs, with 14 percent or fewer of the residents sometimes having to wait more than five minutes for assistance.

Resident satisfaction with the facility (including being treated courteously and with respect) and with the safety of the environment was uniformly high (95 percent or more being satisfied) among all RCFE size groups.

### **Housing and Residential Care Trade Associations in California**

There are four major trade associations representing the industry in California:

1. The Community Residential Care Association of California (CRCAC) represents small facilities.
2. The California Association of Health Facilities (CAHF) represents more than 1,600 licensed (mostly proprietary) facilities, including the majority of nursing home beds. CAHF is becoming more important within the assisted living industry as nursing home chains build more of these facilities.
3. The California Association of Homes and Services for the Aging (CAHSA) represents about 400 not-for-profit assisted living facilities and nursing homes.
4. The California Assisted Living Federation (CALF) serves the California operations of more than 500 for-profit and not-for-profit providers of services across the continuum of care.

The policy agendas of each of these organizations vary somewhat. CAHF, which represents many Medi-Cal and Medicare-funded skilled nursing facilities, lobbies for greater funding and less regulation from these programs. CRCAC, whose members are more likely to serve the SSI/SSP population, promotes increases in these payments.

The trade associations are united on one issue, however. None of them favors increasing the role of the federal government in the regulation of assisted living facilities—a position that is shared by the national Assisted Living Quality Coalition (members include Alzheimer's Association, Association of Homes and Services for the Aged, American Association of Retired Persons, American Health Care Association, National Center for Assisted Living, American Seniors Housing Association, and Assisted Living Federation of America). In addition, California's supportive housing associations generally agree that there should be more regulatory flexibility regarding who can reside in licensed housing, and these groups also supported the Medi-Cal Assisted Living Demonstration program (Assembly Bill 499) passed by the legislature and signed by the Governor in 2000.

#### **Experiences in Other States**

Trade associations in California are similar to those in other states with respect to agreeing on policies to promote the expansion of assisted living facilities as a substitute for nursing home care. While agreement among nursing home and assisted living associations occurs in some states, it is not universal. In Georgia and New Jersey, for instance, the nursing home and assisted living sectors have battled over whether Medicaid waivers and expanded service roles for assisted living should be permitted. Nursing homes in these states and elsewhere fear that assisted living facilities will skim off low-acuity, low-cost residents. These conflicts may be more common in states with relatively high numbers of nursing home beds per 1,000 people, but the trend toward cooperation will likely gain momentum if for no other reason than the fact that nursing home chains have diversified into assisted living.

## Implications

California has a large and diverse supply of residential care/assisted living facilities that houses almost 140,000 people. Information about facility, staffing, and resident characteristics is very limited. Data from 1993 suggest that a high proportion of RCFE residents lived with cognitive disabilities, physical frailty, and depression.

Resident satisfaction levels were high in 1993, although there is some evidence that the level of staffing was inadequate to meet the personal care needs of residents, especially with respect to assisting with walking and ambulating. The availability of medical personnel, including nurses and medical directors, was also limited. It is unknown whether there have been substantial changes in resident case mix since 1993; whether problems have emerged related to staff retention and training; or whether staffing and experience levels are sufficient to provide the level of care needed by residents. Small facilities, which serve a disproportionate number of low-income people, are thought to have been the most affected by the changing environment.

## IV. Cost-Effectiveness of RCFEs

*Proponents of residential care and assisted living—including some state policymakers and industry advocates—believe that these facilities can serve as a substitute for higher-cost nursing homes without having a negative effect on the health status of residents.*

IN SPITE OF THE RAPID EVOLUTION OF STATE policy and industry practices nationally and in California, relatively little is known about the cost-effectiveness of RCFEs, particularly with respect to their ability to substitute for nursing home care. One consequence of the absence of research in this area is that states (including California) do not have empirical evidence or documentation to answer important questions:

- Is there a relationship between RCF resident mix and nursing home case mix?
- How and under what circumstances do state nursing home and residential care regulation and reimbursement policies influence case mix?
- Does movement into RCFs actually reduce nursing home days or other health care costs?

Yet proponents of residential care and assisted living—including some state policymakers and industry advocates—believe that these facilities can serve as a substitute for higher-cost nursing homes without having a negative effect on the health status of residents. The Agency for Health Care Policy and Research (AHCPR, now known as the Agency for Healthcare Research and Quality or AHRQ) estimated that between 25 and 35 percent of the one million-plus nursing home residents are in these facilities primarily because of limitations in their ability to perform personal care tasks such as bathing, dressing, and ambulating,<sup>20</sup> and that a number of these individuals could potentially live independently (with support from community-based services) or in supportive housing. Some states, such as Oregon, are explicitly following a policy of diverting nursing home-certifiable residents from nursing homes into residential settings. In fact, as early as 1991, Oregon reported relatively little difference in the functional characteristics of those in nursing homes and those in assisted living facilities.<sup>21</sup>

### A Review of the Evidence

The data on whether residential care facilities for the elderly actually reduce the use of nursing homes are decidedly mixed. Two longitudinal studies conducted in the early 1980s seem to support the thesis that supportive housing in general could

have a positive effect on quality of life and reduce transfers to nursing homes.<sup>22, 23</sup> But more recent studies of continuing care retirement communities (CCRCs, a specific type of multi-level facility that provides independent living, assisted living, and skilled nursing) suggest that the impact on nursing home placements is less clear. One study found that although nursing home placements were more frequent, hospital use was lower among CCRC residents in comparison with people of similar age and functional status living in the community and being served by the same medical group.<sup>24</sup> A second study looking at CCRC residents over a seven-year period found similar results, with 46 percent of residents having at least one nursing home stay during the period.<sup>25</sup>

Two additional studies tracked CCRC residents over their lifetime. The first found that the lifetime expectancy of nursing home placement is 1.5 times greater for CCRC residents than it is for the general elderly population.<sup>26</sup> The second found that three-quarters of CCRC residents had an extended nursing home stay (defined as 30 days or more) sometime before their death, although usage patterns revealed variation among facilities, suggesting that community management, operational characteristics, and facility design could affect transition rates. The study also found that the use of assisted living or personal care facilities was more likely to reduce time in independent living than in nursing homes.<sup>27</sup>

## Implications

While the specific findings from the CCRC studies and the earlier supportive housing studies are affected by prevailing regulations and the levels of care permitted in assisted living units, they nevertheless suggest that the mere presence of enhanced RCFs in a community will not automatically produce reductions in nursing home placements or days of care. Moreover, CCRCs generally monitor residents, care quality, and

access to health care professionals more closely than do most RCF settings. And even if RCFs do have the potential to substitute for nursing home care for certain individuals, it is important to remember that not all communities have an adequate supply of residential care beds, nor do all facilities—especially smaller ones that are frequently staffed by owner-operators and their families—have adequate resources to care for these individuals.

The relationship between residential care and nursing homes, particularly the relative proportion of patients in each who have only cognitive or physical problems, raises a number of important questions. Some states are doing better than others in limiting the proportion of people in nursing homes with presumably lower levels of need. The factors contributing to these differences are not well understood, but they have been shown to be more complex than simple substitutions between residential care and nursing homes.

# V. National and Statewide Quality Assurance and Data Systems

*These critiques focus on both quality of care and consumer rights issues, with recent reports focusing heavily on deficiencies in the latter area.*

SEVERAL STATES ARE ENCOURAGING THE GROWTH of residential care facilities, and industry proponents continue to press for an expanded role and scope of services for residential settings, which will presumably increase the proportion of frail residents they serve. But further growth may only add to current concerns about quality and consumer rights, especially in light of the industry's recent financial troubles.

## **The Need for Increased Oversight**

Over the past decade, federal agencies and offices have issued numerous critiques of the residential care industry (e.g., U.S. GAO 1999, 1997, 1989; U.S. DHHS 1982; U.S. House of Representatives, 1989). These critiques focus on both quality of care and consumer rights issues, with recent reports focusing heavily on deficiencies in the latter area. With the criticisms have come demands for reform and increased regulation at the federal level. And now that states have Medicaid waiver programs in place or in the planning stage, proponents of increased oversight believe that the federal government has a direct financial stake in supportive housing care.

Not surprisingly, residential care trade associations, including the Assisted Living Federation of America, the American Senior Housing Association, and the American Association of Homes and Services for the Aging (which represents not-for-profit entities), have argued against federal regulation as a solution. First, they contend that most of the industry's payment sources are private and that it is therefore inappropriate for the federal government to intervene. Second, they note that state regulation is improving, with more than 38 states becoming third-party payers and thus stakeholders in residential care quality. Third, they believe that federal regulation of the nursing home industry has had a deleterious effect on financial health and quality of care within that industry. Their suggested alternative to a greater federal role is for the residential care industry to regulate itself through accreditation.<sup>28</sup> This chapter examines the status of existing and emerging systems for monitoring supportive housing facilities and their residents in California and around the nation. It also reviews the potential for expanding other data systems so that they have greater applicability to the supportive housing industry.

## The Existing Quality Assurance and Information Infrastructure

To monitor the residential care industry, the state government, national organizations, and the industry itself have put in place quality assurance systems and an information infrastructure.

### California State Government's Systems

California facilities are regulated by the Community Care Licensing (CCL) Division of the Department of Social Services, which both licenses facilities and regulates and monitors those it has licensed. These regulations set requirements for the minimum levels of operator experience and for training and staffing levels. They also establish criteria for accepting residents into facilities, based on their physical and cognitive abilities. CCL performs its monitoring duties through annual, on-site inspections and by responding to consumer complaints.

Through its licensing application, annual and other inspections, and reviews of resident records, CCL collects a great deal of information about residential care facilities (although little that speaks directly to the outcome of services offered). The licensing application provides data that could be used to monitor changes in ownership, corporate chain ownership, and various changes in operating policies, although the data are not currently computerized. The application also offers information on the operations, including staffing plans and staff training plans. On-site records help CCL to ensure the appropriateness of any placement, retention, or discharge of a resident. Annual surveys and inspections include a review of resident and administrative documents, physical inspections of the facility, and observation of selected residents. Any deficiencies, along with correction plans, are also noted. CCL can impose fines on facilities that do not correct identified deficiencies.

However, the storehouse of information collected by CCL is not accessible to Californians.

Categories of potentially useful data include:

- Facility ownership;
- The levels of care the facility provides;
- Whether the facility accepts residents who get public assistance (such as those receiving SSI/SSP or Veterans Administration payments);
- Staff size and type (for example, whether the facility has nurses, nurse aides, or a medical director);
- Affiliations with health care providers (including hospitals, nursing homes, and home health agencies); and
- Which facilities have recently received CCL citations.

In a few communities, this kind of information may be available directly from the provider or through a community-wide provider directory. CCL does maintain an inventory of RCFEs, which is available to the public on a Web site (<http://ccl.dss.cahwnet.gov>), but the site includes only information on size, address, and contact name. Various trade associations, such as the California Association of Homes and Services for the Aging, can provide additional information on their members, such as monthly rates and the services available.

### Industry-based Systems

The residential care industry plays a dual role in quality assurance: accreditation programs and data collection.

#### *Accreditation*

Two accreditation organizations—the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and the Committee for Accreditation for Rehabilitation Facilities (CARF)—have emerged to allow the industry to



play a role in monitoring its own quality.<sup>29</sup> While both organizations have long histories in accrediting other types of facilities, they are new to the residential care industry. As of May 2000 CARF had completed five accreditations and JCAHO had awarded one.

An examination of accreditation standards manuals indicates that both organizations focus on process and function, although each expects institutional information systems to collect outcomes data. While there are significant areas of overlap, there also seems to be a difference of philosophy. JCAHO places much more emphasis on consumerism and resident autonomy, with much discussion of protecting and enhancing residents' rights by providing them with more complete information. CARE, whose goal is to "promote quality, value, and optimal outcomes," seems to focus more on leadership and outcomes management. JCAHO also focuses on collecting outcomes data as a way to drive improvement in care. At this time, however, there is neither standardization of outcome measures across states, nor any process for auditing or validating them.

While these activities to promote accreditation are an encouraging sign, voluntary accreditation schemes raise several potential areas of concern. First, it is possible that only the better facilities will participate, as facilities offering poorer quality are unlikely to want to have their shortcomings posted on the Internet. Second, the costs of participation may be prohibitively high for smaller facilities: JCAHO charges \$5,500 for its program (which can accredit a facility for up to three years), while CARE will cost an average of \$4,650. Third, there is a potential conflict of interest in having representatives of trade associations sit on the board of an accrediting body. In addition, the consequences of having two accrediting organizations competing for the same market are unknown. They may compete to see who has the "best" standard, although it is not clear if "best" means the toughest or the easiest to pass.

That said, there may be several major benefits to having two accrediting bodies. Both surveys are, in many ways, more comprehensive than those used by the state of California. There may also be an opportunity to build a national database and standards, although it will take time to negotiate common measures and construct reliable measurement systems.

### ***Data Collection***

The industry compiles annual reports that describe selected characteristics of facilities. One national system, compiled by the American Senior Housing Association together with PricewaterhouseCoopers and the National Investment Center, annually surveys 57 assisted living communities around the country. The survey excludes small residential care facilities and supportive housing that has not yet adopted the label of assisted living. The survey tends to focus on basic financial and operating features rather than resident characteristics or performance outcomes. While these numbers are widely cited in the association's annual Senior Housing Report, the sampling and response rates do not yield reliable state or national estimates.

Within California, the statewide trade groups also collect some data on their members, but since no single association encompasses all facilities (and since some facilities have dual memberships), it is difficult to be sure that the data are representative of the industry as a whole. Anyone considering building a data system based on trade association data would need to consider obtaining agreements about common minimum data sets and sampling plans that assure that all facilities are represented.

### **Federal Database and Reporting Systems**

Most of the national systems related to long-term care are oriented to nursing homes. This focus is responsive to the fact that nursing homes serve

roughly one million individuals who tend to be vulnerable and are often in need of expensive services. However, this logic has not been extended to assisted living facilities or other forms of licensed housing even as the industry has grown to be of a size approaching that of nursing homes.

Two national databases are compiled on nursing homes (and thus available within California): the Online Survey, Certification, and Reporting System (OSCAR) and the Resident Assessment Instrument (RAI). Since 1991, OSCAR data have been available for all certified nursing homes in the United States. The data are in three files: provider information (including facility characteristics and staffing), aggregated information on the characteristics of a facility's residents, and health survey deficiencies. These data are collected during annual certification surveys conducted by state contracted agencies.

The RAI is also composed of three elements. The primary component is the Minimum Data Set (MDS), which measures each resident's functional abilities, medical problems, and emotional state (e.g., presence of depression and/or behavior problems). The MDS is collected on all residents at or near the time of admission and quarterly thereafter. Data are also collected when a resident is readmitted to a nursing home from a hospital, or if there is a significant change in status. The second and third elements represent additional data that are used for care planning purposes. Unlike the OSCAR data, the MDS is specific to each patient. At present, implementation of the MDS system across facilities and among states is variable in terms of the quality of data and its application in care planning.<sup>30</sup> While most facilities are collecting MDS data, only a few states currently compile this information into statewide data systems. MDS data are also used in several states as a basis for case-mix reimbursement. In California, nursing home inspectors have begun to use the MDS data, but the data are not yet available to the public.

## **Applying Other Systems to RCF Quality Oversight**

Given the relative lack of quality assurance and information infrastructure dedicated to residential care, it is useful to consider whether other systems could help provide greater oversight of the industry. Fortunately, it would appear that a number of existing data systems at the national, state and community levels could be adapted to provide regulators, consumers, and others with a better sense of the quality of services provided by residential care facilities.

### **Hospital Discharge Abstracts**

California is one of many states that compile hospital discharge abstracts from virtually all hospitals, regardless of the patient's age or payer. The tracking of hospital discharges associated with hospital and emergency room use (perhaps stratified by such conditions as skin ulcers, malnutrition, dehydration, injuries, and drug or medication poisoning) could be used as a basic first-order indicator for problems in long-term care, including residential care facilities. All that is needed within such data systems is information connecting the hospital patient to their address or location prior to the hospital admission. Should confidentiality of the records prohibit linking individuals to specific facilities, incidence rates could nevertheless be estimated and reported by community.

### **Minimum Data Set**

Another option is to use the nursing home MDS, an element of the Resident Assessment Instrument discussed earlier, to identify prior residence, targeted diagnoses, and functional and cognitive conditions that were present at the time of admission to a nursing home. By identifying those nursing home admissions that come from residential care or other supportive housing (versus direct from home or transfers from hospitals), the

MDS could help to provide a reasonably complete picture of nursing home stays associated with breakdowns in chronic care delivery in the community and residential care systems.

A few states are experimenting with an MDS-type system for residential care. Generally, these states use a common assessment instrument and reauthorization process for all long-term care beneficiaries. While the MDS-type data are used to classify the case mix and determine the reimbursement rate, the resulting database can also be used to monitor changes in case mix and health and functional status within the population, as well as to gauge the quality of an individual facility.

### **Medicare and Medicaid Claims**

Medicare and Medicaid claims data may be useful for identifying trends, isolating problems, and forecasting or evaluating the results of policy changes related to the assisted living industry. For example, hospital and emergency room encounter reports could be developed if each record had a housing location identifier. Claims data could be used to document individuals treated in the hospital or emergency room who live in RCFEs (or other housing of interest, including nursing homes), monitor their diagnoses and treatment, and track their health care utilization in nursing homes and hospitals. For this adaptation of the claims data to be effective, the claims records would have to include information on the beneficiary's actual address and a delineation of the site or address of care. A potentially problematic limitation is that bills for individual procedures are not submitted for payment under managed care systems and other capitated payment arrangements as they are under fee-for-service reimbursement. The prevalence of managed care insurance coverage among residents of residential care facilities is unknown.

### **Expanding the CCL or Accreditation Surveys**

Both the current annual survey of facilities by California's CCL and the proposed industry-based accreditation processes lend themselves to an OSCAR-type data system for RCFEs and other forms of licensed housing. An essential feature of OSCAR is that the annual recertification visit is used to collect facility-level data on staffing and operator-provided information on resident characteristics. At present, RCFEs are visited annually as a part of relicensing or every three years for reaccreditation. For a low marginal cost, the information collected during these visits could be expanded to include data on staff and resident attributes. Alternatively, the same data could be collected through a partnership between CCL and the emerging industry accreditation process. Either of these approaches could be operational within a few years.

### **Long-term Care Screening Data**

As California implements Medi-Cal reimbursement for residential care, it likely will begin a process of assessing residents prior to placement and assigning residents or facilities to individual case managers who will monitor the clinical performance of the facility. The information from the assessments and case managers could be used to produce a basic, facility-specific information system on resident attributes throughout the state. That said, unless this intake process is expanded to include individuals other than those on Medi-Cal, this reporting system will be limited (but still better than anything available elsewhere).

### **National Surveys**

National housing and health status monitoring systems have not kept pace with the evolving forms of group housing, including growth in

RCFEs and other forms of supportive and group housing. In these surveys, group housing encompasses many types of living situations, including nursing homes, mental health hospitals, and non-institutions such as rooming homes, communes, residential care facilities, homes for the aged and disabled, and halfway housing. Units with five or more unrelated people are also typically defined as a form of group housing.

In addition, the rules differentiating independent from group housing have major implications for how the U.S. Census is conducted, which in turn affects the sample design of many other surveys of the aged and disabled population. The net result is that both national and community-level information about housing and living arrangements substantially undercounts the number of people with disabilities—particularly those living in “group” quarters.<sup>31</sup>

Fortunately, there may be a way to improve this situation. A review of more than 75 national and catchment area surveys concluded that five national surveys could be adapted to improve the measurement of disability across all housing types and to help identify alternative living arrangements and monitor changes in housing choices.<sup>32</sup> These surveys do not currently include people in either licensed or other forms of supportive group housing.

## Implications

Expanding any of these quality assurance and data systems to make them more applicable to the assisted living industry requires dealing with several fundamental issues. Among these are obtaining some reasonable consensus on appropriate measures as well as whether the reporting should be by all facilities or from a sample of facilities (or residents). Agreement must also be reached on the frequency of reporting and acceptable data lags. A multi-level system might be appropriate, with some information coming from all facilities

annually, and more comprehensive, in-depth information coming from a sample of facilities less frequently.

State governments have routinely collected the data necessary to systematically monitor changes in facility and staff characteristics, but information systems have not been developed that allow the information to be analyzed in a meaningful way. Data that would allow the monitoring of resident characteristics and performance outcomes are generally not collected at this time. That said, as states begin to implement Medicaid waiver reimbursement programs for residential care, they are building information systems connected to eligibility and needs assessments. Unfortunately, even these systems will leave out the majority of residents who are private pay. To date, national data systems have not filled any of these information gaps, as all the major population surveys systematically exclude the population living in licensed or group housing. Industry-based accreditation processes offer the potential to complement state monitoring systems, but they too presently do not include resident-level information.

The absence of trend data greatly impairs the ability of government and consumer advocates to monitor how changes in public policy and market factors may affect case mix, supply of services, competition, and ultimately the operational performance of the residential care industry. Looking ahead, data collected by states and the accreditation agencies could be used to build information systems that are designed to help better inform consumers about the quality of care and other features of residential care facilities. Appropriately coded, the use of these data could provide a valuable supplement to the current facility listing data systems.

# VI. Recommendations

*There are no national and few statewide data systems in place to monitor and evaluate changes in resident case mix or how changes in reimbursement, licensing, staffing, and staff functions affect the delivery system and the quality of care provided.*

PUBLIC POLICY IS PLAYING A MAJOR ROLE IN driving changes in supply and demand within the residential care/assisted living industry, yet little is known about the industry, the population served, and the effectiveness of the reimbursement and quality assurance systems being developed. The financial chaos that recently weakened the private, for-profit assisted-living companies raises a further concern about the stability of publicly traded corporations in this industry. In addition, there are no national and few statewide data systems in place to monitor and evaluate changes in resident case mix or how changes in reimbursement, licensing, staffing, and staff functions affect the delivery system and the quality of care provided. These limitations apply nationally as well as in California to both licensed and unlicensed facilities.

This chapter suggests ways to address these issues and concerns within the state of California. The recommendations are organized into three sections: monitoring and planning, special studies, and implementation of demonstration projects.

## **Identifying Leaders and Participants**

This section refers in general terms to several organizations that might participate in the implementation of the recommendations. For these recommendations to become a reality, participating organizations will need to assume a leadership role in convening key groups and in seeking public and private funding for implementation. Public agencies within the state, including the California Health and Welfare Agency and the California Departments of Health Services, Social Services, and Aging, could also play an important role, although the readiness of these and other public and private organizations within the state to participate has not been investigated. At the federal level, the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services) and the U.S. Department of Housing and Urban Development should also be engaged in the effort.

## Summary of Recommendations

### Monitoring and Planning

- Recommendation 1: Expand the ongoing monitoring of licensed housing to include a computerized database on facility, staff, and resident characteristics.
- Recommendation 2: Develop state and community-level plans for the future of supportive housing, including demand and supply estimates.
- Recommendation 3: Work with the Department of Health and Human Services, the Department of Housing and Urban Development, the U.S. Bureau of the Census, and others to convene a work group on National Statistics for Supportive Housing.

### Special Studies

- Recommendation 4: Design and finance a series of studies about RCFE resident outcomes in California.
- Recommendation 5: Develop and implement quality assurance and risk-adjustment processes (using other states' experiences for guidance).
- Recommendation 6: Forge a partnership between government and the private sector to routinely identify and conduct studies into current and emerging issues affecting the supportive housing industry.

### Implementation of Demonstration Projects

- Recommendation 7: Explore the effectiveness of a "market competition" strategy, in which California consumers are provided with objective information to aid in their selection of residential care facilities.
- Recommendation 8: Assist in the planning and evaluation of California's Medi-Cal assisted living reimbursement demonstration.
- Recommendation 9: Study the development of programs to enhance access to residential care facilities among low- and moderate-income individuals.

## Monitoring and Planning

***Recommendation 1: Expand the ongoing monitoring of licensed housing to include a computerized database on facility, staff, and resident characteristics.***

If the state were to computerize the extensive records currently collected by CCL and incorporate industry accreditation data (when available), it would have a relatively comprehensive system for monitoring the licensed housing system. Information on the current system and trends within it will be valuable to government and the private sector in assessing how licensed housing is affected by changes in public policy or local conditions. These data could also aid the state in developing more accurate estimates of demand and more realistic estimates of the service enhancements and quality assurance procedures needed to support shifts in the location of care.

The state might also want to consider incorporating the Medi-Cal reimbursement waiver assessment data into this system, or using the waiver demonstration as a pilot test of the information system. Additional sources of information on provider and system performance that could be used to supplement the basic information system include Medi-Cal or third-party vendor claims related to skilled nursing, personal care, hospice care, hospital and emergency room use, and nursing home placements. Finally, the extension of similar oversight to the unlicensed sector needs further investigation.

***Recommendation 2: Develop state and community-level plans for the future of supportive housing, including demand and supply estimates.***

The growing number of people age 80 and over in California raises concern about the need for supportive housing and other long-term care services in the future, yet little is known about

the adequacy of the current supply across communities, the relationships between supportive housing demand and other long-term care service options, and the incentives and constraints affecting service supply (such as land cost, labor cost, and health care referral and practice patterns). A further complexity arises when considering the changing ethnic mix of many communities and the unknown effect this may have on demand.

Through land-use planning and community development programs, cities, counties, and regional governments have responsibility for planning for and facilitating the provision of low-income housing and various other physical resources within their jurisdictions. Health and long-term care services are generally outside these planning efforts. Licensed and unlicensed supportive housing is thus left in a gray area, with no clearly mandated public role in planning for the development, growth, and replacement of this sector in the housing market. Collaboration between public agencies is needed to establish community-, county-, and regional-level attention and coordination in the provision of an appropriate supply of supportive housing.

***Recommendation 3: Work with the Department of Health and Human Services, the Department of Housing and Urban Development, the U.S. Bureau of the Census, and others to convene a work group on National Statistics for Supportive Housing.***

Currently, the major national population surveys intended to monitor health status and living arrangements of the non-institutionalized population exclude people in licensed housing and other living arrangements considered to be group quarters. Because of this, the population in residential care, other forms of licensed housing, and unlicensed supportive housing tends to be undercounted. In addition, there are no other data sources available to provide a profile of the

population in these settings. Modification of data sources such as the U.S. Census would provide state, regional, and local information on the supply and number of people in licensed and unlicensed supportive housing. Information from other data sources could also permit the monitoring of health care risk, utilization, and movement rates. While these would be national or statewide estimates, the information could inform planning and program monitoring efforts within California.

### Special Studies

#### *Recommendation 4: Design and finance a series of studies about RCFE resident outcomes in California.*

The purpose of these studies would be to test basic assumptions about the effectiveness and efficacy of supportive housing, with an emphasis on evaluating the outcomes of RCFEs. As used here, the term “outcomes” refers to the assumed consequences of receiving residential care relative to nursing home stays or receiving home- and community-based services in unlicensed housing. Among the initial questions are these: Are nursing home days and expenditures reduced? Are emergency room visits or hospital admissions increased? Who is served by home health care? Are there health conditions that make placement in an RCFE particularly problematic or inappropriate? Holding resident conditions constant, do small facilities perform as well as larger facilities? Does staff skill mix, whether from paid staff or outside vendors, make a difference in these outcomes? Does the resident’s primary health care affect, or even compensate for, limitations in the RCF setting? Can the RCF setting compensate for limitations in the resident’s primary health care?

The first set of studies could use existing Medical data sets to describe nursing home place-

ments, ER visits, and hospitalization rates among people in licensed housing, perhaps in comparison to people receiving in-home supportive services or those residing in low-income housing projects. In addition, clinical and service innovations could be designed and tested in targeted settings to determine their impact on program operations as well as resident outcomes.

#### *Recommendation 5: Develop and implement quality assurance and risk-adjustment processes (using other states’ experiences for guidance).*

The existing quality assurance system within California is based on annual reviews and complaints. But as the state implements a Medicaid waiver for residential care, it will need to develop new enrollment, management, and quality assurance processes, just as the other states implementing Medicaid waivers have done or are doing. Some of these states are moving toward risk-adjusted reimbursement, and all of them are building data systems to assess individual need and changes in status over time. These systems are taking several forms. Some adapt the state’s needs assessment process for nursing homes, home care, and community-based care. Others are adapting the nursing home minimum data set process to residential care. The development of processes in California would be accelerated and possibly more easily implemented if the state were to take advantage of the experience of these other states.

#### *Recommendation 6: Forge a partnership between government and the private sector to routinely identify and conduct studies into current and emerging issues affecting the supportive housing industry.*

Since the public sector has an interest in promoting a stable and effective supportive housing delivery system, the government could play a



facilitative role by working with private (both for-profit and not-for-profit) providers to better understand the forces affecting this industry and the consequences of changes in policies and other environmental conditions. Among issues of immediate concern are the rate of ownership turnover and consolidation within the industry and their effect on the delivery system, including operating costs, the distribution of supply, staff retention, staff training, and monthly resident charges.

Another issue with long-range implications is that of consumer preferences with respect to the use of supportive housing. In particular, what are the factors associated with the decision to move into supportive housing, and how do these vary among ethnic and income groups around the state? A third priority issue relates to unlicensed facilities within the state, including low-income housing projects (which are now letting residents “age in place”), apartment houses, retirement hotels, and private homes that operate as supportive housing. This issue is especially important for the non-aged adult disabled population, who tend to prefer unlicensed housing because it places fewer restrictions on the individual.

## **Implementation of Demonstration Projects**

*Recommendation 7: Explore the effectiveness of a “market competition” strategy, in which California consumers are provided with objective information to aid in their selection of residential care facilities.*

Under a market competition strategy, consumers receive timely information on the services, costs, and performance of each residential care/assisted living facility in the state so that they can make better selections based on objective criteria. Such a strategy can be implemented within California by building on existing and emerging records systems, which would need to be enhanced to

provide uniform and authenticated data on facility characteristics (such as staffing, services, and price) and performance measures. These systems could be based on an expansion of either the CCL application and annual survey or industry-sponsored accreditation processes. Information could be made available over the Internet (CCL has an operational Web site, as do the trade associations) and through other vehicles that reach the public.

*Recommendation 8: Assist in the planning and evaluation of California’s Medi-Cal assisted living reimbursement demonstration.*

The California legislature (via Assembly Bill 499) in 2000 required the California Department of Health Services to implement a demonstration using Medi-Cal reimbursement to supplement personal care among residents of licensed residential care/assisted living facilities and among people in low-income housing. While the details of the demonstration have not been formalized, it is apparent that processes for eligibility determination, care authorization, and quality assurance will need to be developed. These administrative and clinical processes and procedures likely can be modeled on the experiences of other states in managing high-risk populations.

However, there are at least two issues of immediate concern in designing the program and its data systems. One is that of understanding the amount of avoidable health care used by those served by the demonstration (relative to the amount used by similar people living in other circumstances). Reductions in avoidable health care use could help offset the expenses of the waiver, while increased use would raise costs for the state and the Medicare program. A second concern is determining the magnitude of the possible increase in the demand for personal care/assisted living that will be stimulated by the availability of coverage.

*Recommendation 9: Study the development of programs to enhance access to residential care facilities among low- and moderate-income individuals.*

In addition to the previously discussed Medicaid assisted living demonstration program, a number of other special studies, simulation analyses, or demonstrations could be conducted to determine the impact of various strategies for enhancing access to RCFEs by low- and moderate-income individuals. For example, one could evaluate the effects of an increase in SSI/SSP program payments through the allowance of additional support by family and friends without financial penalty. The key question is to determine the effect this policy change might have on RCFE demand among SSI/SSP recipients, and the number of people that could potentially receive this support without endangering Medicaid eligibility status or current levels of benefits. If the simulations suggest that this program may prove attractive, then incentives to stimulate these supplemental payments, such as tax deductions or credits, could be explored.

# Resources

The following organizations may help individuals learn more about the residential care industry or find out about particular facilities:

American Association of Homes and Services for the Aging  
901 E. Street N.W., Suite 400  
Washington, D.C. 20004  
202-783-2255

Associated Living Facilities Association of America  
10300 Eaton Place, Suite 400  
Fairfax, VA 22030  
703-691-8100

National Center for Home Equity Conversion  
7373 147th Street West  
Apple Valley, MN 55124  
612-953-4474

## **California Resources**

California State Long Term Care Ombudsman Hotline  
1-800-231-4024 (in California)

California Advocates for Nursing Home Reform  
1610 Bush Street  
San Francisco, CA 94109  
1-800-474-1116 (in California)

California Assisted Living Facilities Association  
455 Capitol Mall, Suite 330  
Sacramento, CA 95814  
916-448-1900

California Association of Homes and Services for the Aging  
7311 Greenhaven Drive, Suite 175  
Sacramento, CA 95831  
916-392-5111

California Association of Health Facilities  
2201 K Street  
PO Box 537004  
Sacramento, CA 95853  
916-441-6400

California Association of Residential Care Homes  
810 Navone Way  
Concord, CA 94518

California Registry  
31921 Camino Capistrano #116  
San Juan Capistrano, CA 92675  
1-800-451-CARE (in California)

Family Caregiver Alliance  
690 Market Street, Suite 600  
San Francisco, CA 94104  
415-434-3388  
1-800-445-8106 (in California)  
Web site: <http://www.caregiver.org>  
email [info@caregiver.org](mailto:info@caregiver.org)

# Endnotes

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