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Adult care homes in Ohio

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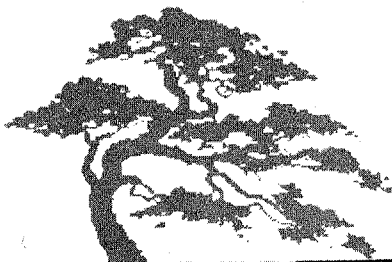
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Ohio Long-Term Care Research Project

**ADULT CARE
HOMES IN OHIO**

**Robert Applebaum
Lynn Ritchey**

September 1992



Scripps Gerontology Center

Miami University

Oxford, Ohio 45056



Dr. Robert Applebaum is an Associate Professor in the Department of Sociology and a Research Fellow at the Scripps Gerontology Center, Miami University, Oxford, Ohio. He has been involved in the development and evaluation of long-term care programs since 1978, working on the Wisconsin Community Care Organization, Wisconsin Community Options Program, Ohio's PASSPORT program and the National Long-Term Care Channeling Demonstration. Dr. Applebaum has most recently been involved in the design and evaluation of a quality assurance system for Ohio's PASSPORT case management program and for in-home services provided under the Older Americans Act.

Dr. Applebaum has been a frequent speaker at national and state conferences on long-term care. He has authored numerous articles, monographs and two books on community based long-term care. Dr. Applebaum was also the guest editor of a special issue on Quality Assurance, published in *Generations*, the journal of the American Society on Aging.

Dr. Applebaum has also served as a member of the Ohio Governor's Home and Community Care Council as well as a number of national advisory boards and local agency boards of directors.

Dr. Applebaum holds degrees from Ohio University (BA), the Ohio State University (MSW), and the University of Wisconsin-Madison (Ph.D.).

Dr. Lynn Ritchey was a Research Associate at the Scripps Gerontology Center during the survey phase of the project. Dr. Ritchey, who received her Ph.D. in Sociology from the University of Cincinnati, was in charge of fielding and managing the initial survey effort.

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Adult Care Homes in Ohio

**Robert Applebaum
Lynn Ritchey**

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Executive Summary

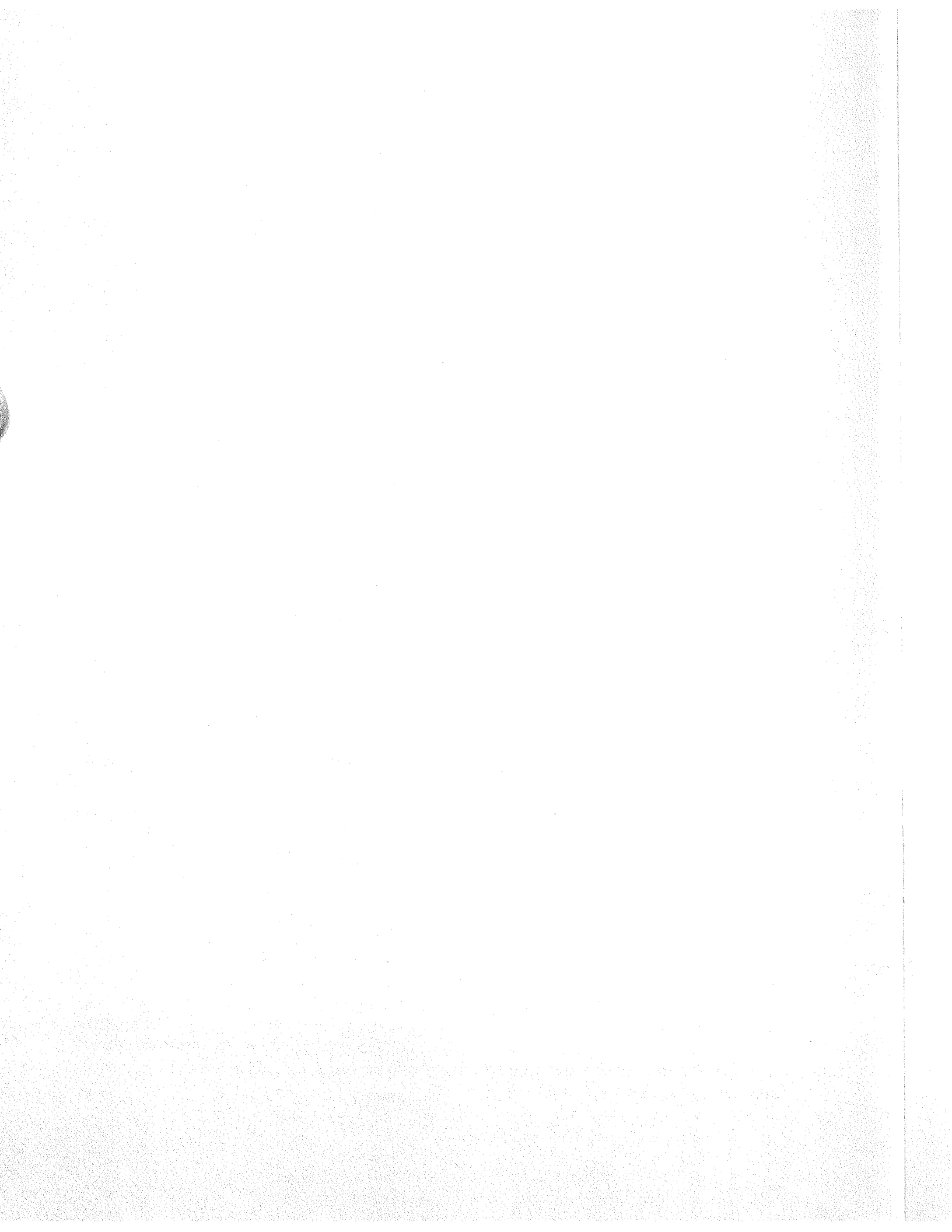
With an increasing number of Americans experiencing chronic disability, efforts to explore long-term care alternatives have expanded. One of the most controversial of these options is the adult care or board and care home. The number of adult care homes in Ohio has been estimated as ranging from 1,000 to 2,500. To date a comprehensive portrayal of adult care homes does not exist. This lack of information is particularly relevant because Ohio has recently passed regulations requiring adult care homes to be licensed.

To examine the topic this study addresses the following critical questions: What is the profile of adult care homes? What regulatory changes have been implemented and how might these affect the delivery of care? What research questions remain?

To assess the profile of adult care homes a random telephone survey of homes was conducted immediately prior to the implementation of Ohio's new licensing regulations and one year later. Major findings from the survey included:

- Most adult care homes are small--about 75% had less than seven residents and 22% had fewer than three residents.
- The homes serve a vulnerable group, with 78% of owners delivering personal care and 57% reporting housing residents with continuing problems of mental confusion.
- Most of the homes were relatively low cost with 30% of owners charging less than \$500 per month, and 61% charging less than \$700 per month.
- The majority of homes (90%) reported being equipped with general safety features such as smoke alarms and fire extinguishers, but were less likely to have wheel chair access (16%) or fire sprinkler systems.
- Applying the current regulations we estimate that about 38% of existing homes would be required to be licensed.
- The one year follow-up found that 14% of homes had gone out of business and that the proportion of homes serving less than three residents had increased from 17% to 24%.

A review of adult care home regulations and interviews with operators suggests that several important issues need to be addressed. Although operators reported that they were in support of regulatory efforts, there was considerable concern about the need to provide resources to implement regulatory requirements. Our review suggests that while some of the identified regulations are clearly important, licensing efforts are dominated by structural requirements. Research efforts in other long-term care arenas suggest that such a strategy will ultimately fail to ensure that residents receive high quality care. Research efforts are needed to help determine which regulatory efforts improve the quality of care and which ones simply add cost to the care delivered.



Background

There is a growing awareness that the United States is facing an almost overwhelming challenge in its efforts to provide long-term care for older and disabled people. Concerns about rapidly escalating costs, poor-quality care, and limited options have resulted in continuous questions about our nation's ability to deliver such care (Kemper and Murtaugh 1991, U.S. CBO 1991). In the context of ever-increasing federal and state budgetary constraints, these concerns have inspired an array of options such as home health care, adult care homes, shared living environments, congregate housing, and continuing care retirement communities. Although each of these options poses a number of policy questions, perhaps the most controversial is the adult care or board and care home.

Adult care homes are designed to provide shelter, food, protection, and some degree of personal care for people who are no longer able to manage a household themselves and yet are independent enough not to need the services of a more formal health care environment (Mor et al. 1985; Namazi et al. 1989). Though these homes have existed for many years (Dittmar 1988), they are often difficult to locate and study. The great majority of adult care homes are unlicensed; in fact, they operate under a number of different names such as board and care homes, adult foster care homes, residential care homes, rest homes, personal care homes, and domiciliary care homes (U.S. Congress 1989). The lack of a

common definition and of regulatory accountability has led to varying reports of even the prevalence of these homes. Estimates of the number of adult care homes nationwide range from 25,000 to 75,000, and the number of residents is estimated between 300,000 and more than 1.5 million (McCoy 1990; Mor et al. 1985; Newcomer and Stone 1985; U.S. Congress 1989, 1992; USDHHS 1982).

With the lack of even such basic information, it is not surprising that our knowledge about the quality of these homes is quite limited.

With the lack of even such basic information, it is not surprising that our knowledge about the quality of these homes is quite limited. Two conflicting portraits exist. On the one hand, the adult care home is viewed as an unregulated facility delivering poor and sometimes abusive care to dependent older and disabled people. On the other hand, it is viewed as a familylike long-term care setting that provides a beneficial service at a lower cost to those in need.

Media coverage and congressional hearings about adult care homes have highlighted potential problems with this type of care. Congressional hearings in 1989, and again in 1992, identified a number of concerns including limitations on residents' rights, inadequate staffing, overmedication of residents, lack of sufficient safety equipment, unsanitary conditions, and physical and verbal abuse of residents. In addition, mass media coverage of poor care, theft, abuse, and (in one well-publicized case) even murder has brought considerable negative attention to these facilities.

Research studies generally have painted a more positive picture of adult care homes (Dittmar 1988; Eckert, Namazi, and Kahana 1987; Lemke and Moos 1987; Mor, Sherwood, and Gutkin 1986; Namazi et al. 1989; Reichstein and Bergofsky 1983). A number of studies have described these homes as typically providing an important long-term care service in a homelike environment at a relatively low cost (Mor et al. 1986; Namazi et al. 1989; Rothwell, Britton, and Woods 1983).

To date, a comprehensive portrayal of adult care homes does not exist. This lack of information is particularly problematic for legislative and regulatory bodies as they address potential concerns about the delivery of board and care.

To date, a comprehensive portrayal of adult care homes does not exist. This lack of information is particularly problematic for legislative and regulatory bodies as they address potential concerns about the delivery of board and care. Accordingly the purpose of this study was to gather descriptive information about characteristics of these homes in the state. Because Ohio recently has passed legislation to regulate adult care homes, the study also examines the potential effects of this legislation and the perceptions of owners and operators about these new licensing requirements and regulations.

ADULT CARE HOMES IN OHIO

At the inception of this study there were about 200 licensed homes in Ohio,

with estimates of unlicensed homes ranging between 1,000 and 2,500. Several studies have examined adult care homes in the state. In 1985, a survey of the 88 county Departments of Human Services was conducted in order to gather information about the number of homes in operation. These researchers concluded that there were 305 licensed or certified adult care homes containing five residents or fewer, 444 identifiable homes, and an estimated additional 1,000 homes located throughout the state.

In a second study, the Boarding Home Advocacy Program in Cleveland interviewed 64 unlicensed home operators from the Cleveland area to determine the nature of adult care homes in Cuyahoga County. This research explored characteristics of owners, residents, and facilities, services provided, cost of care and payment methods, and the environment of these homes. On the basis of these interviews, the researchers concluded that operators of these unlicensed facilities were largely committed to providing good care, but often were limited by constraints such as lack of funds, lack of in-home supportive services, and lack of community support (Eckert and Lyon 1991).

A more extensive study of adult care homes in Ohio was conducted in the northeastern part of the state (Eckert and Lyon 1991). Interviews with 285 residents in 177 adult care homes revealed that the residents are a vulnerable group suffering physical, mental, and social impairments. Although the study acknowledged this vulnerability and recognized that some potential problems of quality existed, they concluded that most of the homes serve a frail and dependent population in an adequate manner.

Although these studies can help us understand the adult care industry, none provide an adequate profile of providers throughout the state.

OVERVIEW OF THE STUDY

As of November 1990, all adult care homes providing between three and 16 adults with personal care were required to be licensed by the Ohio Department of Health. The legislation and the subsequent development of rules, however, took place with only limited information about the nature of the adult care industry. The major goal of this study is to collect data about these regulatory activities in an effort to assess the potential impact of licensing on adult care homes. We address the following key questions:

- * What is the profile of adult care homes in the state?
- * What regulatory changes have been implemented for adult care homes?
- * How might these regulatory changes affect the provision of care and the profile of homes in the state?
- * What research questions still need to be addressed?

Profile of Adult Care Homes

To understand more clearly the characteristics of adult care homes in the state, we conducted a detailed survey of homes before implementation of the new licensing requirements with a brief follow-up one year later. The study focused exclusively on homes with fewer than 17

residents. The initial survey information, which examines the characteristics of operators and residents, will be combined with follow-up information in an effort both to describe the existing homes and to monitor some of the changes that occurred after licensing requirements were enacted.

Choice of Data Source

Because the great majority of adult care homes have been unregulated, it has been difficult to conduct research on this topic. To develop a potential universe of adult care homes, two strategies typically have been used. The first approach relies on data from the Social Security Administration, whose computerized records can be used to identify addresses that are receiving multiple beneficiary checks and hence could be group living quarters. We decided not to use Social Security data because of problems with access to records, programming costs, and time lags.

Instead we chose to follow the second approach, which relies on lists developed by professionals such as those working in the long-term care ombudsman program. Because a number of county and regional administrative units are responsible for monitoring long-term care, we expected that such sources could provide accurate lists of adult care homes. Researchers who have worked previously in Ohio also recommended using the sample generated by the regional long-term care ombudsman programs (Eckert et al. 1990).

Table 1
Outcomes of the Telephone Survey of
Adult Care Homes in Ohio

Outcomes of Full Sample (N=560)	N	Percentage
Completed Interviews	196	35
Wrong number/no listing/ no answer after four attempts	173	31
Currently no residents/no longer in business	107	19
Never in business	17	3
Not interested/refused	67	12
Outcomes of Those Answering Affirmatively to Screening Question: Ever Have Been an Adult Care Home? (N=370)		
Completed interviews	196	53
Currently no residents/no longer in business	107	29
Refused to participate	67	18

Methods

We were able to obtain lists of homes from 11 of the 12 long-term care ombudsman programs in the state. Interestingly, one region refused to provide a list, stating that the adult care homes were their clients and therefore that this release would violate rules of confidentiality. To determine the completeness of the ombudsman program lists, we selected three regions (Planning and Service Areas 1, 4, and 9) for verification. In this process we contacted the major health and social service providers in the area to ask them about their knowledge of adult care homes. These organizations included nursing homes, senior citizen centers, social service organizations, retirement communities, and hospitals. We also secured lists, where available, from the local county departments of social services. In addition, we used local telephone books and newspapers as a resource.

We then compared the completed verification lists with the ombudsman program lists. The ombudsman lists were more inclusive; they contained almost 80% of the homes identified through the verification process. In contrast, only about one-third of the homes on the ombudsman program lists were known to other professionals who participated in the verification. Following the procedures used in the verification process, we also compiled a list of homes for the region in which the ombudsman program did not supply a list. The final list contained 1,028 adult care homes located throughout Ohio.

We chose a random sample of 560 homes, stratified by region. Between November 1990 and January 1991, we mailed the home owners or operators in the sample a letter explaining the study and asking for their participation. Owners then were contacted for a telephone interview. As shown in Table 1, 35% of the homes identified on the sample list completed interviews. About 19% of the homes were no longer in business or had no residents at the time of our screening call. In a few cases, respondents reported never having been in the business (3.0%). The major reason for nonresponse, however, was that in 31% of the cases interviewers were unable to contact the home.

The response rate was 53% for those homes (N = 370) which were identified on the sample list and whose owners or operators answered affirmatively to screening questions about being an adult care provider. Among the remainder of these homes, 29% reported no active residents and 18% were not interested in participating in the study (see Table 1).

The large number of homes that had been identified but could not be contacted is a source of concern. We could not ascertain whether these homes were misidentified or simply had gone out of business. Our sample, then, may be biased toward homes that have been in business for a longer time, and thus may imply greater stability in the adult care industry than actually is the case.

* To develop the survey instrument, we examined a number of previous studies on adult care homes and reviewed the state legislation and regulations. Several broad categories appeared to be important, such as home owners' characteristics, residents' characteristics, operating procedures,

characteristics of the facility, and services provided. In addition, we included questions asking the owners' opinions about the new state regulations for adult care homes. The questionnaire was pretested by both telephone and in-person interviews.

Findings

FINDINGS: ADULT CARE HOMES BEFORE LICENSURE

Size and Composition

Most of the homes surveyed (74%) were small, housing fewer than seven residents: 52% of the homes had between three and seven residents, and 22% had fewer than three residents. The average number of residents across all homes was just under 6. Residents stay in the adult care home an average of four years (see Table 2).

The homes served a vulnerable group of people. Almost 78% of the owners reported providing personal care services to at least some of their residents; 96% reported that all or some of their residents were on medication; and 57% reported having residents with continuing problems with confusion.

Although the regulations require homes with three to 16 residents to be licensed, this requirement applies only to those homes providing personal care services to at least three of these residents. In applying the "personal care" definition to

currently operating homes, we estimate that approximately 38% of these homes actually would require a license.

In 57% of the homes surveyed, all residents were age 60 or older; 38% housed both older residents and residents under 60; and the remainder (6%) housed only residents under 60. Homes that served developmentally disabled individuals exclusively were not included in the survey.

Costs

Most of the homes were relatively low-cost; 30% of the owners charged less than \$500 per month, and 61% charged less than \$700. Twenty-five percent of the residents paid more than \$900 monthly. Homes that cared for a greater proportion of older residents charged higher rent because they needed to provide more personal care.

Size of the home was also related to costs. The smallest homes, those with fewer than three residents, were more likely to charge less. For example, 61% of homes with one or two residents charged less than \$500, compared to 17% for homes serving three to seven, and 22% for homes with more than eight residents. As expected, the higher-cost homes reported serving a larger number of residents who required assistance with personal care.

Operators' Characteristics

Owners of adult care homes were predominately female (90%) and married (61%); 61% reported being 50 years of age or older; 60% had a high school education or less. About four-fifths reported having received specialized training in caring for residents, mainly through community classes such as Red Cross first aid. Most owners

Table 2
Characteristics of Adult Care Homes

Size of Homes	Percentage
Fewer than 3 residents	22
3 to 7 residents	52
8 to 16 residents	26
Homes with Residents with Continuing Mental Confusion	
Yes	57
No	43
Provision of Personal Care Services	
No personal care services provided	23
1 to 2 residents	39
3 or more residents	38
Rental Rates	
Less than \$500	30
\$501 to \$700	31
\$701 to \$900	14
\$901 or more	25
Sources of Rental Payments*	
Social Security	88
Supplemental Security Income	56
Retirement pension	45
Family	38
Private savings	37

*Most individuals have multiple sources of payment.

operate only one home (84%), and 60% have been operating their home more than five years.

A majority of owners (83%) employ other persons to help care for residents; most often these employees are paid part-time workers (46%). In about one-third of the homes, full-time workers are used. In the remainder of the homes, help is provided by un-paid family members, most often the spouse. About half of the homes require employees to have specialized training.

Safety Features

Before licensing, most homes reported that they were equipped with general safety features; more than 90% had standard safety features such as a fire extinguisher, smoke alarms, and first aid kits. Homes were less likely to have wheelchair access (16%) and emergency call buttons or intercoms (40%). Presence of a sprinkler system was related to size of the home: 40% of homes with eight or more residents had a sprinkler system, compared to 7% of homes with fewer than eight residents.

Residents' Rights

Our survey suggests that in general, there is good support for residents' key rights, such as bringing in personal items and having a private area for visitors. A minority of providers (5 to 6%) expressed a lack of support for some basic rights, such as freedom from physical restraints, access to a private area for receiving visitors, or access to food during nonmealtime hours.

Most owners supported residents' autonomy, but in this area they varied

widely. In about half of the homes, residents were allowed to manage their own finances. They were permitted to use the kitchen in about 44% of the homes, and had the opportunity to choose mealtimes in about one-third of the homes.

Adult care homes in Ohio typically serve five or six residents who experience a relatively high level of physical or mental impairment. Homes are generally low-cost, and are staffed primarily by women who have had limited formal education but possess some training in working with older people.

Summary

Adult care homes in Ohio typically serve five or six residents who experience a relatively high level of physical or mental impairment. Homes are generally low-cost, and are staffed primarily by women who have had limited formal education but possess some training in working with older people. In general, owners report positive attitudes about the rights of residents. Systematic data on the quality of care, however, are virtually nonexistent. How licensure will affect this industry and ultimately the quality of care for residents is a question of critical importance for analysis.

FINDINGS: OHIO LICENSURE REQUIREMENTS

Ohio House Bill 253, which regulates adult care homes, was passed largely in response to the increasing number of homes in the state and continuing concerns about the quality of these homes. To implement the bill, the legislature directed the Ohio Department of Health to develop final regulations to become effective in January 1991. Currently about 400 homes have been granted temporary or permanent licenses; an additional 400 homes are awaiting review. To explain and clarify the potential effects of the legislation, we present an overview of the regulations implemented.

As shown in Table 3, the adult care home rules encompass a broad array of regulatory activities including resident assessment requirements, plumbing inspections, staffing, physical property, care delivery, and residents' rights and processes. The regulations emphasize heavily the structural aspects of quality of care, such as building and plumbing inspections, record keeping, space requirements, and food preparation. The rules include extensive requirements for fire, plumbing, building, and heating inspections. Rules concerning requirements for quality of care are less comprehensive. For example, the quality of residents' activities is to be assured through rules stating that residents are to have access to one local newspaper or current activity brochure and an opportunity to engage in a variety of activities.

A great deal of time and resources has been devoted to developing these statewide rules and regulations. How will these regulatory changes affect the adult care home resident and the care provider?

To address this question, we examine data from two sources: the one-year follow-up survey and the initial survey, in which owners were asked to discuss their reaction to the new regulations.

One Year Follow-Up Survey of Adult Care Homes

As noted above, all homes completing the initial study received a follow-up survey after one year. Of the initial 196 homes surveyed, 82% completed the follow-up. Most of the homes not included in the follow-up (94%) were unreachable and presumably were no longer in business.

Some changes were observed in the size of the homes. Fourteen percent reported that they were no longer in operation after one year. The proportion of homes with one or two residents increased from 17% to 24%. There was also an increase in homes containing eight to 16 residents: 33% of the homes at follow-up belonged to that category, compared to 29% at the initial survey. The proportion of homes with three to seven residents declined from 54% to 43%.

Although it is not possible to attribute changes in the composition of homes directly to the new legislation, the one-year results are clearly in the anticipated direction. Given the nature of the legislation, we expected that some adult care homes would reduce the number of residents to fewer than three in order to be exempt from the regulations. We also expected that the proportion of larger homes would increase because an increased number of residents would provide some economy of scale in meeting some of the new regulatory

**Table 3
Summary of Adult Care Facility Regulations in Ohio**

<u>Inspections of Physical Property</u>	<u>Care Delivery</u>	<u>Residents' Rights and Processes</u>
<p>Fire Protection Residents' understanding of written evacuation procedure Manager and staff trained in evacuation and fire control Smoke detectors, fire extinguishers, and fire drills Smoking policy Nonambulatory residents on ground floor Maintenance of heating and electrical systems When homes must have sprinkler system</p>	<p>Minimum staffing requirements At least 16 years old, literate, tested for TB Must complete orientation and training If providing personal care, must be trained in first aid Administration of medicine (what staff can and cannot do) Storage and labeling of medicine Medicine(s) listed for each resident Call buttons necessary if no internal access to residents' rooms</p>	<p>Written agreement before entering home Bill of rights given upon admission Relevant policies explained to resident Procedure for managing a resident's money Written financial statement to resident Procedure for storing residents' valuables No staff member...may be guardian or have power of attorney for a resident Resident may have personal property if not a safety hazard Periodic and initial health assessment by doctor</p>
<p>Plumbing Inspection of water and sewage systems Safety devices in showers and on water heater</p>	<p>Food 3 meals per day, meet recommended daily allowances... Special diets if needed 1-week store of staples and 2 days of perishables Home must have appropriate food service license Assist resident with eating if necessary Provide food with appropriate texture Accommodations for ethnic preferences and religious restrictions</p>	<p>Transfer or Discharge of Residents Discharged if needs services adult care facility cannot provide (e.g., if not able to self-administer medicines)</p>
<p>Common Areas and Residents' Rooms Living and dining areas: Space requirements, furnishings... Bathrooms: nonskid surfaces and handrails Nonpay phone with reasonable access and privacy Dimensions of room and placement of furniture No more than three people to a room Must have window with shade</p>	<p>Services Laundry facilities and/or services provided Activities, must provide: local paper, transportation, or information regarding community activities and activities within facility</p>	<p>Records Confidential record for each individual kept two years after resident leaves Contents of individual records General facility records (e.g., fire inspections, staff)</p>
<p>Safety and Maintenance Handrails on stairs and rails on porches Floors maintained, rugs fastened to floor Common areas and exits well lit</p>		

requirements. Continued monitoring of these trends will provide additional insight.

Owners' Views of Licensing

Forty-eight percent of home owners reported that they had been regulated before the state legislation. Most of this regulation occurred at the local level, typically the county. Requirements varied considerably by region. Almost all owners were aware of the new licensing requirements (92%), but about 25% did not know whether they would have to be licensed under the new regulations.

Concerning the new requirements, owners said that the licensing agency should examine homes for their cleanliness, general safety features and procedures, and to make sure that residents were cared for properly and were not neglected. Owners believed they should be able to make decisions about the home's operations, such as mealtimes and menus and hiring of staff; admission to the homes; when residents' needs for care exceeded services provided by the home; the physical environment, such as size and location of rooms; and safety equipment.

Overall the owners reported that licensing adult care homes was a good idea, and offered suggestions for the new regulations. Very few had negative comments about licensing. Owners were most concerned with regulatory issues that had major cost implications, such as requirements surrounding the addition of a fire sprinkler system. Respondents reported estimates ranging from \$10,000 to \$40,000 for the installation of sprinkler systems. Owners, particularly of smaller homes, did not

necessarily oppose such a requirement, but felt that the costs were simply prohibitive.

Medication Management

The management and administration of medication is another major area addressed in the new regulations. The new rules do not allow staff members of adult care homes to administer medication to residents, although they are allowed to assist in the administration (for example) by taking medication from a locked cabinet or opening a container for the resident. Further, if medicine must be administered to a resident for a short period, a home health agency may be hired for this purpose.

The overwhelming majority of survey respondents (96%) reported that all or some of their residents are on medication. Of these respondents, 40% said that all of their residents manage their own medication; 36% reported that some of their residents manage their own medication; and 25% reported that none of the residents manage their own medication. Further, 70% of owners reported that all medicines are kept in a locked cabinet. In this area, current operating procedures may be in conflict with the regulations: a number of residents need assistance with medications that may be outside the current rules.

Record Keeping

A majority of owners (87%) reported that they kept some type of records on residents. More than 90% of these owners collected information on the residents' next of kin, prescribed medication, and allergic reactions; 47% reported that they had a

record of the residents' personal property or funds. It is clear that there is no standardized method of keeping information on residents.

Discussion

In exploring the status of adult care homes before regulation and one year after licensure was implemented, we found that it is very difficult to track the adult care home industry. From the initial sample of 560 homes, we could contact only 370. This outcome may show that many operators in the industry are transitory. Although 60% of the owners surveyed had been in the business for more than five years, little is known about the homes that we were unable to contact. We cannot ascertain whether these homes were misidentified initially or simply have gone out of business. Possibly the homes we could not contact create a clearer picture of the unstable nature of the industry than the homes we could contact. Although licensing will reduce this problem, our experience suggests that keeping track of homes will remain a challenging task to regulatory agencies.

We did not expect to find that fewer than 40% of adult care homes surveyed would require licensing under the new regulations.

We did not expect to find that fewer than 40% of adult care homes surveyed would require licensing under the new regulations. Possibly more homes will require licensing, depending on the rules concerning the definition of personal care services.

The survey suggests the presence of strong support for key residents' rights such as bringing in personal items and having a private area for visitors. Only a small minority of providers (5 to 6%) expressed a lack of support for some of these basic rights, such as freedom from physical restraints, access to a private area for receiving visitors, or access to food during nonmealtime hours.

In most instances, owners also expressed support for residents' autonomy. In this area, however, we found variability, which may be explained in part by the residents' ability or inability to act autonomously. For example some residents may be mentally unable to manage their own finances. Thus in some instances, the regulations may need to stipulate conditions under which a right may not be granted, as in the case of management of finances.

Most home owners favored licensing. The licensing procedures that owners believed the state should follow were fairly consistent with the legislation. Home owners thought the state should examine general safety features, cleanliness of the home, and proper care of residents. Although many owners said the current regulatory information provided to them was vague, they hoped the licensing requirements would be fair and reasonable.

Our experience with adult care home owners suggests that owners generally are concerned about providing high-quality care within the restrictions of limited funds. We

How can regulations support the good homes and change or eliminate the substandard homes?

found some homes, however, that appear to be delivering substandard care. Thus the regulatory system continues to face this challenge: How can regulations support the good homes and change or eliminate the substandard homes? Such a question appears to be critical as the number of adult care homes will likely increase. This work suggests that our knowledge about what type of regulatory approaches are successful is extremely limited. For example, we know very little about the amount and type of training needed by operators. We know very little about what aspects of care are important to consumers. We know very little about how reimbursement rates effect resident care. These and numerous other research questions have not been addressed. Until such questions are examined, efforts to regulate adult care homes will have limited success.

Thus it is essential to link evaluation of care quality with regulatory activities as these efforts are designed and implemented in adult care facilities.

Unfortunately, the use of regulation to ensure quality has proved difficult. In fact because of the lack of empirical evidence many regulatory activities in long-term care have not helped to improve the quality of care for residents. Yet any regulatory intervention adds cost to the care delivered. Thus it is essential to link evaluation of care quality with regulatory activities as these efforts are designed and implemented in adult care facilities. In this paper we have begun to make that effort by exploring adult care facilities before licensure. We intend to continue to study the homes to assess the impact of licensing, as well as determining how owners and regulatory agents can work together to provide affordable, high-quality care for those who need such services.

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