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The Ohio assisted living industry

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Ohio Long-Term Care Research Project

THE OHIO ASSISTED LIVING INDUSTRY

Rebecca L. Utz

November 1999

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The Ohio Assisted Living Industry

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Executive Summary

Assisted living is one of the fastest growing segments of the long term care industry. Guided by the principles of autonomy, independence, and privacy, assisted living theoretically represents a consumer-focused approach to long term care. However, there is great variation in how the philosophy is applied to everyday practices. Highlighting the results from mailed surveys and semi-structured interviews with providers, this report aims to describe and identify the assisted living industry in Ohio.

The data collected from 100 residential care facilities throughout Ohio provide a snapshot of the assisted living industry in terms of environmental features, service delivery, staff and resident characteristics, and facility policies. The typical assisted living facility in Ohio is a purpose-built, freestanding facility that has been in operation since 1993 and costs $2,400 per month. It has approximately 60 studio-type apartments, which are nearly 400 square feet in size and are predominately single-occupancy. Comparing these descriptive findings to other studies done on the national level, the Ohio assisted living industry appears to be similar to the national industry.

While the assisted living industry in Ohio seems to be commonly united under the same philosophical goals, providers expressed difficulty in maintaining a balance between all tenets of the philosophy. Specifically, providers grapple with (1) how much care is appropriate to provide to residents, (2) how to balance the independence and autonomy of residents with the security and safety of residents, (3) how to provide high quality yet affordable care, (4) how to maintain sound business practices while providing individualized care, (5) how to create a homelike environment, and (6) how to determine when to discharge and retain residents.

Results furthermore show that there are some important differences among types of facilities in Ohio. For example, assisted living within continuing care retirement communities and freestanding facilities appear to be serving a population with the highest needs, while assisted living with independent living are serving the lowest need residents and have the lowest costs. Results furthermore suggest that services and amenities increase costs, but providing services according to the assisted living philosophy does not seem to be costly in and of itself.

Finally, providers expressed their opinions about the current and future regulatory issues facing the Ohio assisted living industry. Overall, providers like the flexible nature of the current Residential Care Facility regulations; and more respondents are satisfied than are dissatisfied with the current regulations. In terms of future regulatory issues, a majority of providers would like to see no changes made, while fewer suggested specific changes that ought to be incorporated into any future regulations for the assisted living industry in Ohio. Unlike the shared industry philosophy, there is not a shared opinion on how to reform the regulations for Ohio assisted living.

Acknowledgments

A number of individuals made significant contributions to the research reported here. Many administrators and assisted living staff took the time to answer my questions and were willing to share their experiences and insights regarding the assisted living industry in Ohio. Jean Thompson of the Ohio Assisted Living Association offered her support and endorsement of this project, which assuredly improved the response rate of the mailed questionnaire. Robert Mollica of the National Academy for State Health Policy, as well as Robert Applebaum and Jane Straker of Scripps Gerontology Center provided helpful comments on earlier versions of this report. Thank you to all of you.

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Background and Introduction

Since its development in the mid-1980s, assisted living has become a popular residential option for older adults. Currently over one million Americans live in an estimated 25,000 to 30,000 assisted living residences (ALFA, 1998; Parsons, 1997). These numbers are sure to increase, as the assisted living industry—both on the national and state level—is experiencing a remarkable period of growth.

More than just a type of residential long term care, assisted living is a philosophy of how services ought to be delivered.

Assisted living has been described as a home-like residence that provides personal care and skilled nursing services, while striving to maximize autonomy, privacy, choice, independence, and continuity of lifestyle for older adults (Kane & Wilson, 1993). The Assisted Living Federation of America (ALFA) defines an assisted living residence as "a special combination of housing, personalized supportive services, and health care designed to meet the needs—both scheduled and unscheduled—of those who need help with activities of daily living" (ALFA, 1999). However, more than just a type of residential long term care, assisted living is a philosophy of how services ought to be delivered.

The Assisted Living Federation of America, founded in 1991, developed a ten-point philosophy that commonly unites and ideally guides all assisted living providers through their everyday operations (ALFA, 1999):

- Offering cost-effective quality care that is personalized for individual needs
- Fostering independence for each resident
- Treating each resident with dignity and respect
- Promoting the individuality of each resident
- Allowing each resident choice of care and lifestyle
- Protecting each resident's right to privacy
- Nurturing the spirit of each resident
- Involving the family and friends, as appropriate, in care planning and implementation
- Providing a safe, residential environment
- Making the assisted living residence a valuable community asset

Although not all facilities that use the term "assisted living" in their name or marketing materials embody the principles of this philosophy, it is the distinguishing characteristic that sets assisted living apart

from other long term care options available to older adults.

Despite the shared philosophy, a diverse range of regulatory and service delivery approaches characterizes the assisted living industry. Although there is an on-going effort to adopt national standards and regulations for assisted living (Assisted Living Quality Coalition, 1998), each state currently maintains its own regulations and licensure categories. Although less than half the states (22 states, excluding Ohio) had specific licensing regulations and standards using the term "assisted living" in 1998, many states license and classify such facilities under an already existing category such as residential care facilities, adult care homes, or board and care homes (Mollica, 1998). In Ohio, a majority of facilities offering assisted living services are licensed as residential care facilities (RCFs); however, some are licensed as adult care facilities (ACFs). RCFs provide accommodations and supervision for seventeen or more unrelated individuals, while ACFs provide services and accommodations for a smaller group of individuals (Ohio Department of Health, 1997, Mollica, 1998, Meng & Feliciano, 1998). As of 1998, Ohio had approximately 838 ACFs with 5,544 beds, compared to nearly 400 RCFs with 20,000 beds (Mollica, 1998). Since very few ACFs are assisted living providers, this report will focus solely on the RCFs in Ohio.

Specifically, this report is designed to:

1) provide a snapshot of key industry characteristics,

2) discuss the application of the industry philosophy to everyday practice,

3) distinguish possible sources of variation throughout the industry, and

4) outline providers' opinions on current and future regulatory issues.

Methods

Data were collected through mailed surveys and telephone interviews with assisted living providers throughout the state of Ohio. The survey instrument, which was informed by the qualitative interview data, was comprised of mostly close-ended questions that inquired about facility characteristics, resident characteristics, facility policies, and opinions on regulatory issues facing the industry. (See Appendix A)

Of the two hundred self-identified assisted living facilities profiled in a current consumer directory[1] that received the survey in early February 1999, a total of 100 providers completed and returned the survey, resulting in a 50% response rate. Of the responding facilities, the administrator or director was most likely to complete the survey (78%), while the admissions/marketing director (11%), the director of nursing (1%), or the owner of the facility (9%) completed the survey in some instances.

[1] The Ohio Assisted Living Association compiled the 1998 Directory of Assisted Living Residences in Ohio by sending a survey to all licensed RCFs recognized by the Ohio Department of Health as of January 1997.

Results

WHAT DOES THE OHIO ASSISTED LIVING LOOK LIKE?

As shown in Table 1, the typical assisted living facility in Ohio is a purpose-built, freestanding facility that has been in operation since 1993. It has on average 58 studio-type apartments, which are nearly 400 square feet in size and are predominately single-occupancy. While the average monthly cost of Ohio assisted living is $2,400, there is great variation in the reported fees among Ohio providers, inevitably because some reported fees contain all available services, while others may be a base fee without the additional fees for service. Table 1 also illustrates that the Ohio assisted living industry is indeed quite similar to the aggregated national industry.

The following section highlights the services and features provided by Ohio assisted living facilities, as well as describes resident characteristics and various facility policies. For a complete listing of all available results, refer to Appendix A.

Available Services

Assisted living facilities in Ohio offer a wide range of services. All facilities offer three meals a day, activities, housekeeping, and almost all offer linen/towel laundry service (99%). On the other hand, facilities are not as likely to provide dementia care (73%) or physical therapy (16%). Based on the available information about each facility, services were counted to assess the number of services each facility offers in addition to three meals a day, activities, and linen/towel laundry service. Refer to Appendix B for items included in the Service Index. Respondents averaged 7 out of the 10 services in addition to three meals a day, activities, housekeeping, and linen/towel laundry service. Facilities may offer other services not included in the Services Index.

Facility Features

Survey data show that facilities generally have an activity room (100%), a common dining room (99%), rooms available for private meetings and get-togethers (99%), a beauty parlor or barbershop (97%), common living rooms (94%), and a laundry facility for resident use (86%). More than nine in ten facilities have handrails throughout all hallways (92%) and grab bars in all bathrooms intended for resident use (95%). Two-thirds (66%) of facilities have individual mailboxes for each resident which are generally located in a common area inside the facility. It is less common for facilities to have an exercise facility (53%), gift shop (40%), or chapel (16%).

As a way to describe the features and amenities of assisted living facilities, the number of residential features regularly found in Ohio assisted living facilities was counted for each facility. The Features Index ranges from zero to sixteen and includes one point for each of the following features found in the facility: beauty/barber shop, living room, library/computer room, sun room/porch, resident kitchen, garden/walking path, whirlpool/bath room, smoking area, storage room, exercise room, gift shop, resident laundry facilities, chapel, bank, guest apartments, and pool. Refer to Appendix B for further description of this index. On a scale

Table 1
Ohio Assisted Living Facilities Compared to Existing Ohio Regulations and Available National Data

	OHIO FACILITY CHARACTERISTICS *Source: Survey Data (n=100)*	**OHIO RCF REGULATION**	**COMPARATIVE NATIONAL DATA** *Source: National Investment Conference & ALFA, 1998*
TYPE	1. AL w/ nursing home (16%) 2. AL w/ independent living (15%) 3. AL w/in CCRC (23%) 4. Freestanding AL (46%)		1. AL w/ nursing home (7%) 2. AL w/ independent living (12%) 3. AL w/in CCRC (19%) 4. Freestanding AL (61%)
COST	Average monthly cost: $2,409 Range of monthly costs: $324-$5,664	Medicaid payments are not available.	Average monthly cost: $2,036
MGMT.	Managed by a licensed nursing home administrator (52%)	Administrators are not required to be a LNHA.	
RESIDENT UNIT	Average number of units per facility: 58 Range of units per facility: 10-158 Average unit size: 392 square feet Range of unit size: 95-975 square feet Studio-type unit (56%) One-bedroom unit (39%) Two-bedroom unit (4%) Single-occupancy (74%) Multiple-occupancy (14%)	Facility must provide for 17 or more individuals. Single-occupancy rooms must be at least 100 sq ft. Multiple-occupancy must be 80 sq ft per person, w/ no more than 4 persons per room.	Average number of units per facility: 51 Average unit size: 391 square feet Studio-type unit (61%) Avg. 318 sq ft One-bedroom unit (31%) Avg. 480 sq ft Two-bedroom unit (8%) Avg. 597 sq. ft With a mean of 50.6 units per facility and 9.6 semi-private units, approximately 19% of units are multiple-occupancy.
PROFIT	For-Profit (69%)		For Profit (73%)
PURPOSE-BUILT	Purpose-built (71%) Average length of operation: since 1993		Purpose-built (70%) Average length of operation: 7.5 years

from zero to sixteen, Ohio assisted living facilities generally have 10 features and amenities.

Resident Characteristics

Survey data show that Ohio assisted living residents have varying levels of disability requiring different amounts of assistance with daily activities. As shown in Table 2, it is most common for Ohio assisted living residents to receive assistance with medications (administration and/or reminder) and housekeeping chores, while it is less common for residents to receive assistance feeding themselves. Ohio residents are typical; the percentage of residents receiving assistance with these tasks is similar to that reported in a 1998 nationwide study (National Investment Conference & ALFA, 1998). Ohio residents, on average, also appear to be in compliance with the regulations regarding how much nursing care can be provided in assisted living facilities. Ohio RCF regulations state that residents cannot receive more than 120 days of part-time intermittent care, which is defined as no more than 8 hours of nursing care per day or 40 hours per week.

Table 2

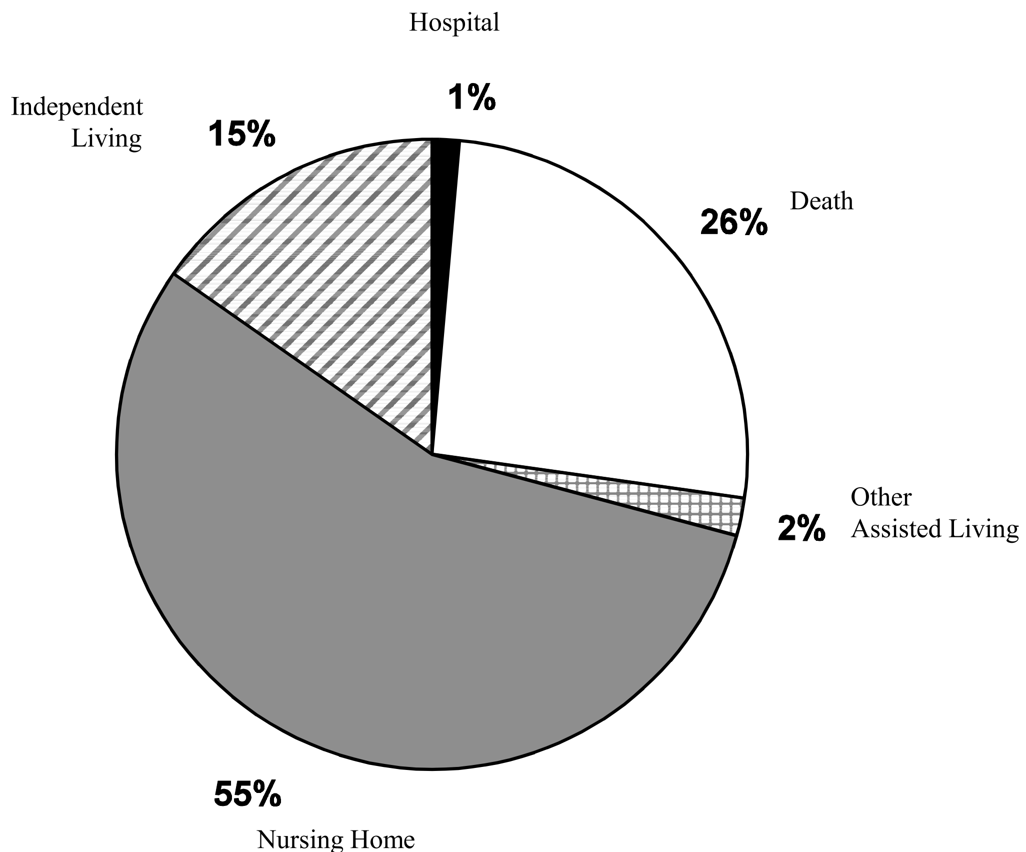
Description of Current Assisted Living Residents in Ohio
(n=100)

Resident Characteristics	**Average % of Current Residents**
Receive assistance cleaning their apartment	**97%**
Receives assistance with medication administration and/or reminders	**68%**
Receive assistance with bathing	**56%**
Receive assistance with dressing or grooming	**45%**
Use a wheelchair, walker, or electric cart	**40%**
Are cognitively impaired/confused	**35%**
Are incontinent (of bowel or bladder)	**25%**
Use home health services	**8%**
Receive assistance with feeding themselves	**5%**

The average length of stay for residents in Ohio's assisted living facilities is 25 months, which is comparable to the national average of 28.5 months (Merrill Lynch, 1997). Fewer than 7% of residents stay less than 3 months. As shown in Figure 1, more than half of Ohio assisted living residents transfer to a nursing home, while 26% remain in assisted living until death. Nationally, 18% of residents stay in their assisted living residence until death, while about 43% transfer to a nursing home (American Health Care Association, 1996). For whatever reason, three out of four residents are transferred out of the assisted living into another living type of arrangement (i.e., nursing home, hospital, other assisted living, or independent living), as shown in Figure 1. This finding indicates that although aging in place is an important goal of the assisted living philosophy, the assisted living facility may not always be able to accommodate a resident with changing health care and personal assistance needs.

Figure 1

Where Do Residents Go
After Leaving the Assisted Living Facility?
(n=100)

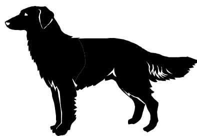


Facility Policies

Inevitably, facilities vary in their policies regarding resident behavior. Table 3 depicts the range in facility policies regarding smoking, drinking, owning pets, and leaving the facility. These policies suggest that, in general, facilities offer residents the opportunity to be autonomous and continue such activities as owning a pet or smoking. On the other hand, the facility may impose policies that supervise or limit such behaviors. For example, most facilities allow residents to go freely in and out of the facility, but also require that they sign in and out. Providers often mentioned that issues of resident safety and security are reasons why they limit or supervise some resident behaviors.

Table 3

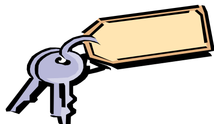
Description of Facility Policies



A majority (58%) of facilities allows residents to have pets. One-quarter (25%) of facilities do not allow pets at all, and another 15% allow pets to visit only.

Facilities may be completely smoke free (10%) or only allow smoking outside (38%). Other facilities allow residents to smoke in designated smoking lounges (36%) or in their individual apartments (31%). A minority of facilities (12%) has a policy that requires staff to supervise residents smoking.

Very few (4%) facilities completely prohibit residents from drinking alcoholic beverages. Facilities allow residents to drink alcoholic beverages in the common areas of the facility (38%), in the dining room (46%), or in individual apartments (81%). More than a third (35%) of facilities supervise or control the amount of alcoholic beverages a resident consumes.



While 87% of facilities allow residents to go in and out of the facility without staff supervision, more than half (53%) ask residents to sign-out when they leave the building. Fewer than one in ten (6%) facilities have a curfew for when residents are expected to be back at the facility in the evening.

WHAT ARE THE PHILOSOPHICAL CHALLENGES TO PROVIDING ASSISTED LIVING IN OHIO?

Assisted living providers were asked to describe the facility philosophy in their own words. While each facility has a unique philosophy of its own, the overall themes expressed by respondents are quite similar. With the exception of involving family and friends in care planning and making the residence a valuable community asset, the philosophies expressed by respondents bear close, if not identical, resemblance to the ALFA ten-point philosophy. Recurring philosophical issues expressed by respondents include the creation of an affordable homelike residence that offers individualized services; the preservation of resident autonomy, independence, and dignity; and the attempt to create a secure environment that promotes aging in place. The following comment succinctly states the general philosophy of assisted living facilities throughout Ohio, "We strive to provide affordable quality housing and services which reflect and support independence, dignity, choice, and individuality in meeting the needs and preferences of all tenants in a homelike setting."

In addition to the above mentioned philosophical issues, some respondents focused on the importance of "maximizing shareholder value" and "increasing profits." Furthermore, some mentioned the need to provide care according to "Christian principles." Also inherent in numerous responses is the idea of being a "leader" or "setting the standard" for the industry. Although these last ideas are not recurrent through all responses, they were explicitly stated by more than a few respondents.

In addition to explaining the facility philosophy in their own words, respondents were asked to identify the most important thing to teach personal care aides during orientation. Above all, providers said that they urge employees to embrace a specific philosophy or mission statement, thus providing a consistent framework from which all employees can carry out their daily operations. Providers also mentioned that they try to teach employees the importance of resident rights. Resident rights focus on treating residents with respect and dignity, ensuring confidentiality and privacy, preserving independence and autonomy, and acknowledging the individual and dynamic preferences of residents. These sentiments are exemplified by the statement, "I teach my staff to have an honest and deep respect for residents and their rights. This is the most important part of their foundation as an employee." Embedded within the recorded comments, providers stressed the importance of giving staff the ability and knowledge to provide individualized and personalized services to every resident. Finally, respondents believe it is important to teach staff the necessary skills to assist residents with activities of daily living and health care needs, as well as appropriate communication skills. The fundamental ideas identified from what providers teach their staff and their stated philosophy are strikingly similar, thus suggesting that providers firmly embrace the philosophy of the industry. Staff training is one way in which the philosophy manifests itself in everyday practices.

Finally, respondents were asked to rank eight items that are related to the tenets of the shared industry philosophy. A rank of "1" represents the most important issue, while a rank of "8" represents the least important

issue. Comparing the eight issues, "providing safety and security for residents" is the most important issue for providers, and "maintaining cost effective business practices" is the least important to providers in everyday practice, as shown in Table 4. Several respondents alluded to the difficulty of this task and made comments such as "they all deserve a 1 (most important), if you want to provide high quality assisted living services." Therefore, it is important to remember that each of the eight items—in and of itself—is very important to the everyday operations of assisted living.

Table 4

Comparison of Key Issues
Facing Assisted Living Providers in Everyday Practice
(n=100)

Rank	Average Score	Key Issues
Most Important	2.76	Providing safety and security for residents
2	3.19	Promoting resident independence
3	3.71	Providing a home-like environment
4	4.03	Giving choice to residents
5	4.81	Assisting residents with ADLs
6	5.37	Promoting "aging in place" for residents
7	5.62	Providing health care for residents
Least Important	6.17	Maintaining cost-effective business practices

Note: Survey respondents were asked to rank each of the eight items from one to eight. A rank of one represents the most important issue in everyday practice and a rank of eight represents the least important issue in everyday practice. The items were ranked in comparison to each other, not by themselves. Therefore, a rank of eight does not mean that the item is not important, it is just less important compared to the others.

In order to provide the highest quality of care in accordance to the philosophy, providers spoke of being pulled in many directions and often times being forced to compromise one aspect of care for another.

Based on the comments from respondents about the difficulty of ranking the eight items and on the twelve qualitative interviews with assisted living providers throughout Ohio, a series of the most important practice issues have been identified. In order to provide the highest quality of care in accordance to the philosophy, providers spoke of being pulled in many directions and oftentimes being forced to compromise one aspect of care for another. The following six themes provide a framework of the philosophical challenges facing assisted living providers in Ohio:

1. Providing assistance for resident *vs*. Doing for the resident

When asked about service delivery, respondents alluded to the fine line between assisting and doing things for the residents. Providers want to provide only enough assistance to keep residents independent, while not doing things for residents that they may be capable of doing themselves. One respondent put it best, "We do as little as possible for our residents, but as much as needed to maintain their independence."

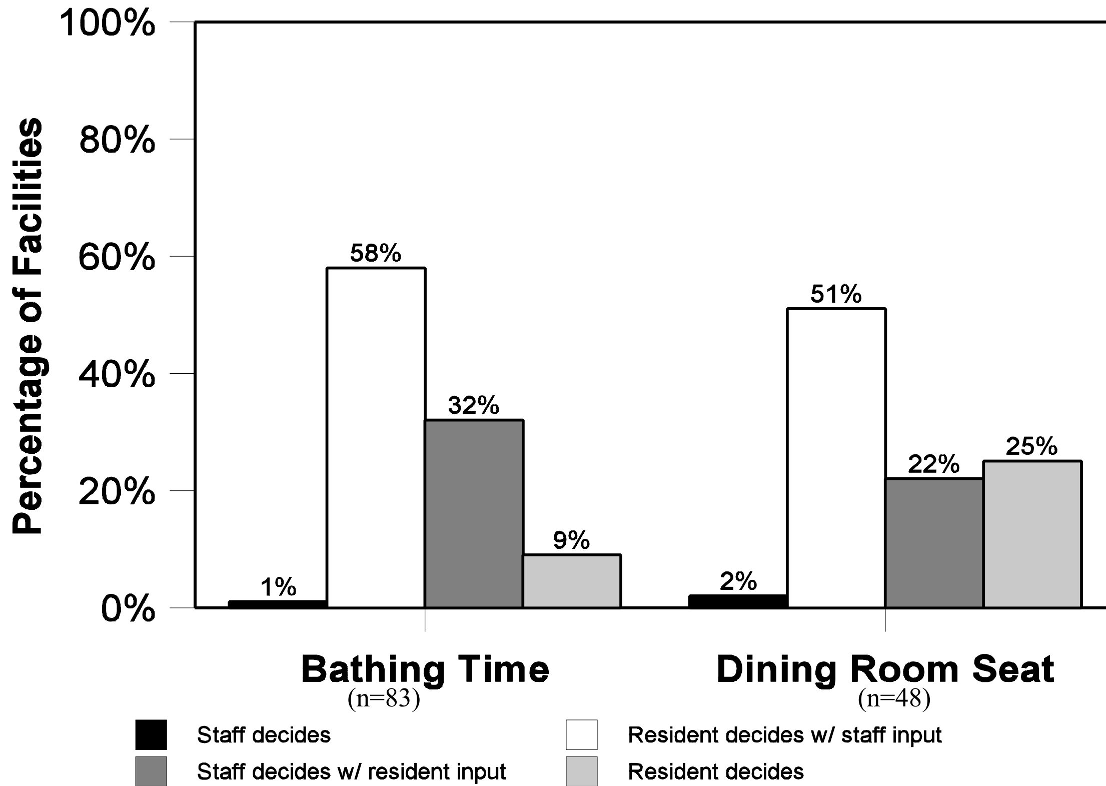
2. Promoting independence and autonomy *vs*. Providing security and safety

Another dilemma that providers face in everyday practice is trying to find a balance between giving residents the autonomy and choice they desire, while not endangering the security and safety of residents. These sentiments resemble the concept of "managed risk" that is inherent to the assisted living philosophy. For example, one respondent told a story of how a resident wanted to smoke in his apartment, but repeatedly left burning cigarettes unattended. As a matter of safety, the staff intervened and now requires the resident to be supervised in a common area when smoking. Promoting the goal of independence and autonomy sometimes jeopardizes the security and safety of residents, and often one is at the expense of the other.

The issues of autonomy are recurrent throughout much of the survey data. The amount of autonomy given to residents may vary based on the situation and on the facility. For example, 43% percent of facilities have a fairly set time at which they awaken residents in the morning. Twelve percent have a fairly set time at which residents should be in bed in the evening. Regarding mealtime, facilities may offer residents a choice in what to eat (84%) or when they eat their meals (63%). However, eight in ten (81%) facilities expect residents to eat in the dining room on a regular basis. While residents are often subjected to specific daily schedules or routines of the facility, they are given the opportunity to have input in some circumstances. For example, nearly all residents have at least some autonomy in deciding a scheduled time for bathing and the seating arrangement of the dining room, as shown in Figure 2.

Figure 2

Amount of Input Residents Have on Scheduling a Bath Time and Choosing a Dining Room Seat



Finally as an attempt to understand the issues of autonomy in assisted living, a summed Autonomy Index, which ranges from one to fourteen, was calculated for each facility. The Autonomy Index includes how much choice and decisional control residents have in their daily lives, especially in regards to roommate selection, discharge procedures, bathing time, meal times, and daily schedules. The higher the score, the more autonomy a facility offers its residents. The exact calculation of this index can be found in Appendix B. Ohio facilities typically score an 8.0 on the 14-point scale.

Despite the arbitrariness of this index, it does highlight a conceptual debate regarding how the assisted living philosophy can be quantified and operationalized into everyday practice and policies. First, does the assisted living philosophy—at least in terms of autonomy—translate into the features outlined in the Autonomy Index? If we can answer yes, we must then ask whether the facilities scoring "low" on the Autonomy Index should actually be classified as providing "assisted living" services since they are not providing high autonomy for residents, which is a key component of the philosophy. Depending on where the arbitrary cut-off point may be, the Autonomy Index illustrates that some facilities in Ohio may not be providing assisted living, yet they have self-identified themselves as such.

Overall, findings suggest that facilities generally attempt to offer residents the opportunity to be autonomous. However, the bounds of autonomy are sometimes limited by concerns of safety for residents and the need to provide care to many people at the same time. As a result, autonomy is often compromised in the form of regimented daily schedules or rules and regulations prohibiting or limiting some behaviors.

3. <u>Quality of care *vs*. Cost of care</u>

Respondents repeatedly mentioned the difficulty in providing services that are both affordable and of high quality. A comment from one respondent best summarizes this issue, "It is difficult to keep costs down while providing the highest quality of care possible."

4. <u>Resident preferences *vs*. Financial expediency</u>

An overriding issue that guides the provision of services is the bottom line of how much it will cost the facility. Providers admit that granting individual preferences does not always make good business sense and that care practices are often based on profit and cost issues rather than resident preferences. The above discussion on the limits of autonomy could also be considered in this light. While autonomy is what residents generally prefer, the business-minded management must sometimes impose daily schedules or rules that limit the amount of autonomy given to residents. For the sake of business, the facility is unable to grant every preference to every resident all the time.

This theme is illustrated by the following quote, "I would like to see more double occupancy rooms because this allows for higher profits, but unfortunately residents do not prefer that arrangement." The data regarding occupancy rates reinforce this idea. In general, facilities are licensed for more residents than actually occupy the facility. Across the industry in Ohio, the maximum number of residents a facility is licensed for ranges from 15 to 316, with an average of 81 residents. However, facilities currently have an average of 50 residents. Taken together, the average occupancy rate (calculated as the # of current residents/ the # of maximum residents) is 65% of capacity. However, the occupancy rate increases from 65% to 88% when looking at the number of current residents in relation to the number of units in the facility. Because the assisted living industry is relatively new, facilities may have low occupancy due to initial start-up. Previous research found that residential care facilities that had been established longer than a year showed occupancy rates of 70% while those established less than a year had an average occupancy rate of 30% (Applebaum, Mehdizadeh, Straker, forthcoming).

5. <u>Institution *vs*. Homelike Residence</u>

Assisted living, as an industry, has tried to create a homelike alternative to the more traditional model of institutional long term care. Both nursing homes and assisted living facilities serve a similar function—to provide care and assistance for residents with chronic conditions and episodic health needs in a residential setting. However, in providers' words, the commitment to creating a "homelike" residence is what sets assisted living apart from other institutional long term care options.

For example, a majority (57%) of assisted living facilities choose to use less intrusive ways to alert staff of residents' needs

by using silent beepers or cordless phones, as opposed to the more traditional system of audible buzzers and overhead intercoms. Furthermore, seven in ten (69%) facilities do not have a traditional nurse station in the middle of the facility with medical charts hanging for all to see. Many facilities have the staff work in common areas of the facility such as the dining room or in an enclosed office-type situation. Based on the description of call-light systems and nurse stations, assisted living providers generally seem to make a concerted effort to make the facility resemble a home rather than an institution.

Nevertheless, providers expressed challenges in providing medical services without compromising the homelike nature of the residence. As a way to ease this challenge, one provider teaches her staff: "We are guests in the residents' home. We behave as such. And above all, our actions must reflect our commitment to creating a comfortable and desirable homelike residence."

In an attempt to capture how important facilities believe providing a homelike environment for residents is, a measure called the Homelike Index was calculated for each facility. The Homelike Index ranges from zero to 25 and tries to classify the homelike nature of the services and features offered in assisted living facilities. Among other things, this index includes whether individual apartments have private showers, bathtubs, kitchenettes, individual thermostats, and cable TV outlets. Facility policies regarding daily schedules (i.e., when to wake up, when to go to bed, when to bathe) and resident behaviors (i.e., smoking and drinking) are also included in this scale. Finally, the types of emergency call-system, the appearance of the nurse's station, and staff behaviors are included in the calculation of this scale. Higher scores represent the most homelike environments. The exact calculation of this index can be found in Appendix B. On a scale from zero to 25, assisted living facilities in Ohio have an average score of 15.8 on the Homelike Index. Similar to an earlier discussion regarding the Autonomy Index, the Homelike Index also potentially identifies facilities that may call themselves "assisted living," yet not uphold a very basic goals of the philosophy—creation of a homelike environment. Therefore, should the facilities with an arbitrarily low value on the Homelike Index really be considered assisted living?

6. Aging in place *vs*. Admission and Discharge Criteria

While some respondents promote the principles of aging in place and "avoid moving a resident at all costs," others said that "assisted living is not appropriate for people with health care needs—and other options such as nursing homes may better serve their needs."

Respondents found it difficult to define specific admission and discharge criteria and acknowledge that often case-by-case decisions, rather than categorical rules, determine who is appropriate for assisted living and who is not. Some believe that regulations for assisted living should include more specific discharge and admission criteria, which would unify the industry in terms of which residents could be appropriately and adequately served.

In order to assess how providers determine which residents are appropriate for assisted living, respondents answered several questions about their admission and discharge criteria. Nearly four out of five (78%) facilities have had to refuse admission to

someone. Reasons mentioned for not admitting a resident include: the prospective resident required skilled nursing care or care beyond that provided by the facility, the prospective resident did not have the financial resources to pay for assisted living, the prospective resident was cognitively impaired, and the facility was at maximum capacity. As a general rule, respondents said that they would admit a resident as long as they could provide adequate care to that resident and as long as the resident could pay for the services rendered.

As a way to further clarify the admission criteria, respondents evaluated whether they would admit a resident with specific conditions or requiring certain types of assistance. In general, facilities are likely to admit someone needing assistance with bathing, dressing, grooming, cleaning their apartment, or with medications; but are not as likely to admit someone who is cognitively impaired, is incontinent, needs assistance with feeding, or cannot *independently* use a wheelchair or walker, as depicted in Figure 3. This suggests that assisted living facilities occupy an important housing niche for older adults who need assistance, but do not require the more medically oriented care offered in nursing homes.

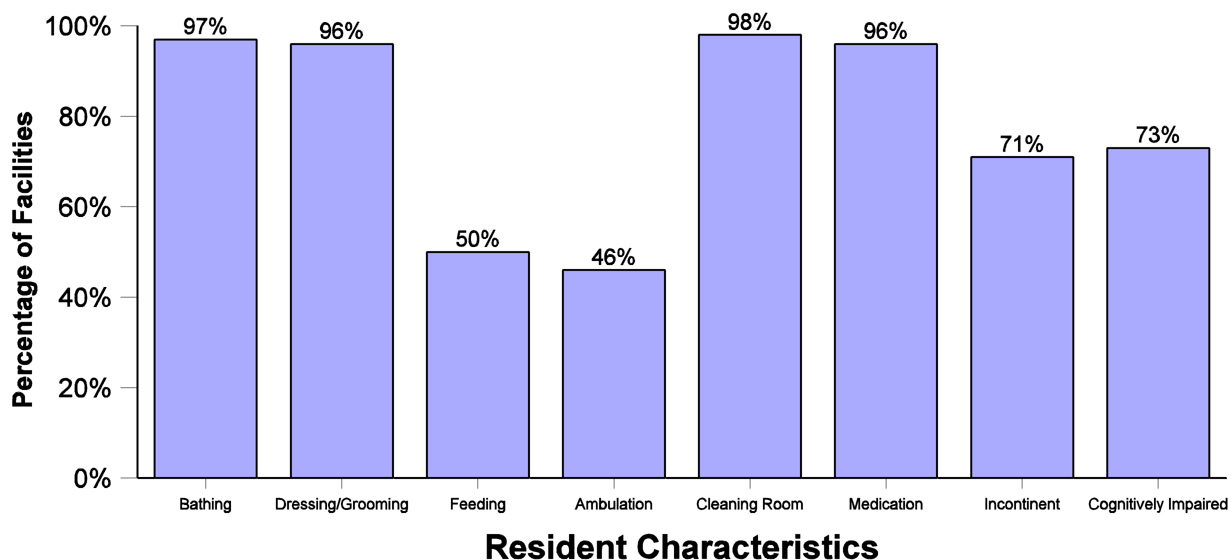
Similar to the reasons for not admitting someone, facilities said they are sometimes forced to discharge residents who require skilled care or more care than the facility is able to offer. Respondents also mentioned that residents whose conditions improve, who desire to return home, who display behavioral problems, whose cognitive impairment worsened, or who experience an inability to pay could be discharged from the facility. In most cases, facilities report soliciting resident input to the decision process, but it is not clear how much effect this input actually has on discharge decisions.

Although survey data do provide insight into specific admission and discharge criteria used by facilities, providers struggle with such decisions in everyday practice. The general sentiment expressed was to retain a resident for as long as possible and as long as the assisted living facility represents the most suitable environment for the resident. Providers continually face the dilemma of making case by case decisions regarding whether they can or cannot appropriately serve residents' needs or whether they can truly maintain their goal to promote aging in place for residents. A study of assisted living in Ohio, Oregon, California, and Florida (General Accounting Office, 1999) found that less than half of the facilities they surveyed clearly spelled out their discharge criteria, suggesting that case-by-case decision-making is quite typical.

In summary, the themes identified from the qualitative interviews and supported by the survey data describe the conflicting values that providers must balance in their everyday practices. In order to provide the highest quality of care in accordance to the philosophy of assisted living, providers must often compromise one aspect of care for another. Through their care and business practices, providers must answer to residents, residents' families, employees, corporate or business offices, and oftentimes shareholders. Clearly, striking a balance between all is not easy to do.

Figure 3

Percentage of Facilities That Will Admit Someone with Specific Conditions or Requiring Specific Assistance
(n=100)



Note: Bathing, Dressing/Grooming, Feeding, Cleaning Room refer to needing assistance with these tasks. Ambulation refers to being unable to *independently* use a wheelchair or walker. Medication refers to needing assistance with medication administration or reminders. Incontinent refers to being incontinent of bowel or bladder.

Even within the same licensing category, characteristic differences exist among assisted living facilities in Ohio.

HOW DO OHIO ASSISTED LIVING FACILITIES DIFFER AND HOW ARE THEY SIMILAR?

One of the hallmarks of the assisted living industry is its diversity. Differences among providers have been related to the type of facility, whether the facility is for profit or not for profit, the size of the facility, management of the facility, and the cost of services (National Investment Conference & ALFA, 1998). Even within the same licensing category, characteristic differences exist among assisted living facilities in Ohio.

Table 5 shows an overall comparison and description of the Ohio assisted living industry in terms of major facility characteristics. The comparisons across the

Table 5
Comparisons of Major Facility Characteristics by Facility Type
(n=100)

	Facility Type				
	Total (n=100)	**Freestanding** (n=46)	**AL in CCRC** (n=23)	**AL w/ NH** (n=16)	**AL w/ IL** (n=15)
	ALL NUMBERS ARE REPORTED IN PERCENTAGES				
% For-Profit	69	87*	42*	60*	67*
% High Cost[1]	47	51	57	50	27*
% More Than 58 Units[2]	41	33*	50	47	47
% High Cog. Impairment[3]	46	53	55	50	30*
% LNHA Manager[4]	51	40*	75*	79*	27*

* Statistically significant at < .01 level, meaning that the characteristic of a type of facility is statistically different from that characteristic of all facilities.

[1] Average monthly cost of Ohio assisted living is $2,409. "High cost" refers to those facilities with monthly costs higher than $2,409.
[2] The average number of units per facility is 58.
[3] The average percentage of residents with cognitive impairments is 28%. "High cognitive impairment" refers to those facilities with more than 28% of residents with cognitive impairment.
[4] "LNHA Manager" refers to those facilities that are managed by a Licensed Nursing Home Administrator.

industry show that Ohio assisted living facilities are similar in many respects, but several important differences should be noted. For example, the four types of assisted living seem to differentiate the industry in terms of cost, specific resident characteristics, size, management licensure, and whether facilities are for profit or not for profit. Assisted living facilities associated with independent living appear to have the lowest cost, when compared to the other three types of assisted living facilities. These facilities are also far less likely to have as many cognitively impaired residents than the other types. Taken together, these findings indicate that assisted living facilities affiliated with independent living may be less expensive because they are serving a less disabled clientele.

Facility type is also related to a facility's profit status. Nearly nine in ten (87%) freestanding facilities are for profit, compared to 42% of facilities within retirement communities, 60% of facilities associated with nursing homes, and 67% of facilities associated with independent living facilities. However, profit status was unrelated to monthly costs.

Finally, facility type is related to whether a licensed nursing home administrator manages the facility. Assisted living facilities within continuing care retirement communities and those associated with nursing homes are far more likely to be managed by a licensed nursing home administrator than freestanding facilities or facilities associated with independent living. This finding makes intuitive sense, since these two types of facilities are operated in conjunction with a nursing home, which mandates that a licensed nursing home administrator be on the staff. Perhaps the administrator is responsible for operations of both the nursing care and assisted living.

In addition to the analysis presented in Table 5, comparisons were made among the facilities in regards to which residents they will admit and which residents the currently serve. Freestanding facilities and facilities within continuing care retirement communities have proportionately more residents who are incontinent (29% and 27% of the resident population respectively) than facilities associated with nursing homes (18%) or independent living communities (11%). Also, about three-quarters of residents in freestanding facilities (73%) and facilities within retirement communities (76%) require assistance with medications, compared to 58% in facilities associated with nursing homes and 49% in those associated with independent living. Results suggest that the level of ADL impairment varies by the type of facility, with freestanding facilities and assisted living facilities within continuing care retirement communities serving residents with higher needs for assistance. Resident characteristics did not vary by other facility characteristics such as size, profit standing, management licensure, or cost.

The comparisons presented above begin to identify how the industry is similar and how it is different. However, they do not assess how individual facilities operate on a day to day basis in regard to the philosophical goals of the industry. In an attempt to characterize the industry in these terms, the four indices (Features, Services, Homelike, and Autonomy) described earlier in this report were examined in relation to the facility characteristics discussed above.

In essence, the Features and Services Indices describe the scope of services and amenities present in a facility, while the Homelike and Autonomy Indices describe how services are provided. Promoting resident autonomy and providing a homelike environment are fundamental goals of assisted living; and the two latter indices describe how policies and procedures of the facility promote the goals of homelike environment and resident autonomy. For each of the four indices, facilities were designated as either “high” or “low” based on whether they scored above or below the average distribution of each scale.

Results show that there are some important distinctions across the industry in terms of how many features or services are offered, as well as how homelike or how much resident autonomy is provided. For-profit facilities are more likely to have a high homelike score (68%) than not for profit facilities (42%). Additionally, assisted living facilities associated with independent living communities (81%) and freestanding facilities (69%) are more likely to have a high homelike score compared to facilities affiliated with a CCRC (29%).

The licensure of the management may also be related to how homelike a facility is. About three-quarters (77%) of facilities run by non-licensed administrators had high homelike scores, compared to 45% of the facilities run by licensed nursing home administrators. This result suggests that licensed nursing home administrators, by virtue of their training or prior experience, may be more apt to provide care under the assumptions of the traditional medical model, rather than emphasizing the homelike nature of the residence. The training and experience of managers is perhaps related to how strongly assisted living providers embrace and apply the philosophical goals, such as providing a homelike environment, to their everyday practices.

Promoting the philosophical goals of the industry may not need to be costly for consumers.

Facilities with higher than average costs generally have higher scores on the Services and Features Indices—the facilities charging more are offering more. On the other hand, there is no relationship between cost and whether facilities score high or low on the Homelike and Autonomy Index; thus suggesting that it may be more costly to provide features and services to residents than it is to have policies and procedures that promote resident autonomy or encourage the creation of a homelike environment. Providing scope in features and services is related to the cost of the facility, while promoting the philosophical goals of homelike environment and resident autonomy are not related to the monthly cost of assisted living. Therefore, promoting the philosophical goals of the industry may not need to be costly for consumers.

Facilities across Ohio appear similar in many respects, but also may have characteristic differences among them. Therefore, caution must be exercised when discussing the industry as a whole. It may be necessary to identify the segment to which one is referring.

WHAT ARE OHIO ASSISTED LIVING PROVIDERS' OPINIONS ON CURRENT AND FUTURE REGULATORY ISSUES?

Finally, respondents were asked to express their opinions on both the current and future regulations of assisted living in Ohio. With this information, the results of this study could then be viewed through the political and regulatory constraints identified by providers. Opinions did not significantly vary according to the type of facility, whether the facility is for-profit or not-for-profit, nor by the job title of the respondent.

Opinion of Current Regulations

In terms of current licensing of the Ohio assisted living industry, more than half (54%) expressed generally positive opinions. In summary, these respondents are satisfied with the current RCF guidelines because they are not too restrictive and allow facilities to mold their individual policies and procedures around them. The following statement typifies this attitude:

> The RCF regulations provide a framework, which ensure a minimum standard of quality throughout the entire assisted living industry, but at the same time they allow for great flexibility and interpretation. I applaud

> the current regulations for not assuming that all assisted living facilities are identical. Under the current regulations, we are able to adequately address the needs of individual residents.

Oftentimes, satisfaction with current regulations is made in comparison to the regulations of the nursing home industry. Respondents in this category believe that "compared to the over-regulated nursing home industry, the RCF licensing is OK!" Finally, respondents in this category often included comments such as "for the moment" and "as it stands now" to their responses. In essence, the comments seem to foreshadow impending changes in the regulations that may jeopardize the flexibility of the current regulations.

Conversely, 17% of respondents expressed generally negative reaction toward the current state of regulations. Unlike those who are satisfied with the current regulations, this group has multiple reasons for their discontentment. Some believe that the industry "may be over regulated" and that the regulations are "too strict," while others believe just the opposite. These providers want "clearer definitions" and believe that the "regulations are very vague in a lot areas which can make some new situations difficult to deal with." Those that would like to see stricter regulations fear that some assisted living facilities are "glorified nursing homes without the regulations of that industry."

Regardless of one's opinion toward the current licensure of assisted living in Ohio, a general fear of overregulation is universal. This fear is characterized by the statement, "I have grave concerns about overregulation. As an industry, assisted living answers to its clients, not the government." Another common thread across all categories of opinions concerns the nomenclature of residential care. Respondents would like to see regulations that use the term "assisted living." They believe this would increase understanding among insurance providers and the general public.

Opinion on Future Regulations

Consistent with the philosophical goal of offering affordable services, fifteen respondents mentioned that they would like to see assisted living covered by Medicaid, which would allow facilities to provide services to lower-income seniors. Respondents demonstrate a clear understanding that if the industry were approved for Medicaid reimbursement, then the industry would likely be subjected to stricter regulations.

A majority (57%) of respondents would like to see no changes made to the assisted living regulations in Ohio, while a quarter (24%) of respondents suggested some sort of specific change they would like to see incorporated into the future regulations of assisted living. Suggestions for future reform fall into five major categories:

Staffing Issues. Suggested staffing issues include enforcing minimum staff ratios and implementing an industry-specific paraprofessional training program. Others suggest that all assisted living administrators should be some sort of licensed professional such as a "licensed nursing home administrator, nurse, or social worker."

Physical Environment. Suggested changes for the physical environment include opinions represented by the following statement, "All apartments should be private,

every bathroom should have a sink, and all bathrooms should be private."

Medication Administration. The third desired change is that "certified nursing assistants should be allowed to administer medications if adequately trained and overseen by an RN."

Admission and Discharge Criteria. Respondents mentioned the need to better define the admission and discharge criteria for assisted living because the decision to admit and discharge residents is so judgmental. Without specific criteria that would necessitate and facilitate transfer, some providers "fear that we are turning into a nursing home."

Survey Process. Respondents commented on the need to modify the survey process to fit the goals of the assisted living industry. Currently, the "survey teams are very familiar with nursing home rules and regulations, but appear to have little knowledge regarding residential care rules and regulations. They are terribly inconsistent in the content, follow-up, and manner of the survey process. Better training is needed so that surveyors do not keep evaluating us as a nursing home."

Implications

Although one can discuss generalities about the Ohio assisted living industry, these findings suggest that care must be exercised when discussing the industry as a whole. Assisted living within continuing care retirement communities and freestanding facilities appear to be serving a population with the highest needs, while assisted living with independent living are serving the lowest need residents and have the lowest costs. The industry may also be differentiated by whether the facility is for profit or not for profit. The characteristic differences identified in the industry suggest that we cannot think of all assisted living facilities as the same. Future regulations that are introduced need to recognize the diversity and range of possibilities within the assisted living industry.

Another possible source of diversity in the industry may be related to the training and licensure of the management. Exemplified in the data, the training and prior experience of assisted living administrators appears to be associated with how homelike a facility is. Currently there is no specific training or license required for assisted living providers; however, many assisted living managers appear to be trained as licensed nursing home administrators. Licensed nursing home administrators have been trained to manage skilled nursing facilities under the assumptions of the traditional medical model, not how to manage an assisted living facility under the philosophy of the industry. Accordingly, a separate training program and licensure process may be appropriate for assisted living administrators. Perhaps a specific management training program that addresses the major challenges specific to this industry would help providers in everyday decision making practices and potentially would unify industry practices under the goals of the shared philosophy.

Future policies need to acknowledge and consider each of the major challenges identified in this study. For example, the issue of resident autonomy is very important to the

concept of assisted living, yet in everyday practice it is often at the expense of the security and safety of residents. The idea of "managed risk" addresses both sides of this issue and may need to be explicitly defined in future policies. Facilities may benefit from a standardized procedure that outlines and documents any managed risk agreements between residents and the facility. A formalized managed risk procedure gives autonomy to residents in planning their own care, but would also document and monitor any potentially dangerous activity. Whether it be this particular challenge between balancing resident autonomy and safety or one of the other challenges identified through efforts of this study, explicit attention to such challenges should be a crucial consideration for future policies impacting the assisted living industry.

Creating an environment consistent with the assisted living philosophy may be a matter of attitude, not merely the scope of services and amenities.

Although many of the challenges identified by providers imply a compromise between financial matters and philosophical goals, it appears that embracing the assisted living philosophy may not cost any more. These results show that it is more expensive to provide a greater scope of services and amenities, but cost is not related to the autonomy provided to residents or the provision of a homelike environment. Rather than focusing on creating an environment with every service and amenity available, providers who are committed to the assisted living philosophy may want to focus on adopting facility policies and daily procedures that embody the goals of the philosophy. Most importantly, providers need to be aware that creating an environment consistent with the assisted living philosophy may be a matter of attitude, not merely the scope of services and amenities.

Finally, providers' responses regarding industry regulation potentially suggest guidelines for regulating the assisted living industry in Ohio. Although many providers are satisfied with current regulations and do not want to see any changes made, others are quite dissatisfied and suggested many different reforms for the regulations. In accordance with the philosophical goal of providing affordable care, some providers would like to see the implementation of Medicaid waivers for assisted living in Ohio. Overarching all sentiments is a fearfulness of overregulation, meaning that regulations should not prescribe every detail of facilities' operations.

Creation of a new "assisted living" licensure category or accreditation process would potentially require a number of facilities to alter their services and practices if they choose to still be considered assisted living.

Even though Ohio assisted living providers cannot unanimously agree on how to exactly reform the industry regulations, they appear to stand in unity on the importance of the industry philosophy. Therefore, it is critical that Ohio adopt or maintain regulations that support and encourage the philosophy of this industry. To this end, the best solution may be the creation of an additional assisted living licensure, while

maintaining the current RCF category. Creation of a new “assisted living” licensure category or accreditation process based on the careful operationalization of the ALFA ten-point philosophy would potentially require a number of facilities to alter their services and practices if they choose to still be considered assisted living. A new licensure category might also provide some relief for consumers who are attempting to choose between facilities that call themselves assisted living, but that actually embrace very different philosophies and provide a very different range of services resulting in distinctly different models of care.

In conclusion, as the industry continues to evolve and expand, policy makers have some major conceptual questions to address: Are the current RCF regulations the most appropriate way to license assisted living? Are all RCFs actually providing “assisted living” in the philosophical sense? And how can the philosophy of assisted living be operationalized into a new set of regulations?

References

American Health Care Association. (1996). Facts and Trends: Assisted Living Sourcebook. In Assisted Living Special Section of Contemporary Long Term Care, 20 (9). 81.

Applebaum, R., Mehdizadeh, S., Straker, J. K. (forthcoming). A Study of Nursing Home and Home Care Utilization in Ohio: Trends 1992-1997. Scripps Gerontology Center: Oxford, OH.

Assisted Living Federation of America (ALFA). (1999). www.alfa.org

Assisted Living Quality Coalition (ALQC): Alzheimer's Association, American Association of Homes and Services for the Aging, American Association of Retired Persons, American Health Care Association/National Center for Assisted Living, American Seniors Housing Association, & Assisted Living Federation of America. (1998). Assisted Living Quality Initiative: Building a Structure that Promotes Quality. Washington, D. C.: Assisted Living Quality Coalition.

General Accounting Office (1999). Assisted Living Quality-of-Care and Consumer Protection Issues in Four States. Washington, DC: Author.

Kane, R. A. &Wilson, K. B. (1993). Assisted Living in the United States: A New Paradigm For Residential Care For Frail Elderly Persons?. Washington, D. C.: American Association of Retired Persons.

Meng, M. E. & Feliciano, T. (1998). Summary of Assisted Living Licensure Statutes and Regulations in the 50 States: Revised Through April 15, 1998. New Haven CT: Murtha, Cullina, Richter, and Pinney.

Merrill Lynch. (1997). Assisted Living Industry. In Assisted Living Special Section of Contemporary Long Term Care, 20 (9), 66 & 81.

Mollica, R. L. (1998). State Assisted Living Policy: 1998. (DHHS Publication No. 100-94-0024). Washington, D.C.: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and evaluation, Office of Disability, Aging, and Long Term Care Policy, and Research Triangle Institute.

National Investment Conference & Assisted Living Federation of America. (1998). National Survey of Assisted Living Residents. Annapolis, Maryland: National Investment Conference for the Senior Living and Long Term Care Industries.

Ohio Assisted Living Association. (1998). 1998 Directory of Assisted Living Residences in Ohio. Columbus, OH: Ohio Assisted Living Association.

Ohio Department of Health (1997). Residential Care Facility Law and Rules, Revised September 1997. Columbus, OH: Ohio Department of Health.

Appendix A

Annotated Survey Instrument

ANNOTATED SURVEY:
Survey of Assisted Living Providers in Ohio

n = 100
50% response rate

DESCRIPTION OF FACILITY

1. In what year did you first begin using the term "assisted living" to describe the services being offered?
   (1970-1999) avg. 1993

2. In what year was your building constructed? ***(1855-1999) avg. 1984***
   71% are purpose-built facilities

3. *If the two years above are different, answer A - D below. If they are the same, skip to # 4.*
   A.) What was the building before it was converted to an assisted living facility? ***(n=29)***

4%	hospital	***0%***	school
12%	nursing home	***15%***	convent/friary
58%	apartment complex	***12%***	hotel

   B.) Describe any changes made to the interior of the facility before it was used as an assisted living facility. ***Compliance with Americans with Disabilities Act and fire and safety regulations, wallpaper, decorations, partial or total renovation.***
   C.) Describe any changes made to the exterior of the facility before it was used as an assisted living facility. ***Total or partial renovation, added covered entrance***
   D.) Describe any changes made in staffing or staff training before it was used as an assisted living facility. ***Hired nursing staff, staff training (personal care/assisted living philosophy), staffed the building 24-hours.***

4. Is the facility operated: ***69%*** For Profit ***31%*** Not-for-Profit

5. Approximately what is the lowest monthly fee paid by a resident? ***($324-$5,664)***
   Approximately what is the highest monthly fee paid by a resident? ***Avg. monthly fee: $2,409***

6. How many total units are in the assisted living facility? ***(10-158) Avg. # of units: 58***
   How many units are currently double-occupancy? ***14%***
   How many units are currently single-occupancy? ***74%***

7. Approximately what percentage of each type of unit does the assisted living facility have?
   56% Studio (one room which serves as living and sleeping room)
   39% One bedroom (one separate bedroom plus a separate living area)
   4% Two bedroom (two separate bedrooms plus a separate living room)

8. What is the approximate size of the smallest resident unit? ***(95 sq ft – 975 sq ft)***

9. What is the approximate size of the largest resident unit? ***Avg. unit size: 392 sq ft***

10. If the facility has any double or multi-occupancy units, how are roommates assigned?
    - ***0%*** Staff/administrators decide by themselves
    - ***18%*** Staff/administrators decide, but residents have input
    - ***7%*** Residents decide, but staff has input
    - ***69%*** Residents decide by themselves

11. How many of the units have individual temperature controls? *Check ONE.*
    - ***5%*** None of the units have individual temperature controls. *(Skip to question 12)*
    - ***5%*** Some of the units have individual temperature controls.
    - ***90%*** All of the units have individual temperature controls.

    Are individual temperature controls ever locked, meaning that residents are not free to control the heat and/or air conditioning as they please in their unit? *Check ONE.*
    - ***79%*** No, temperature controls are never locked.
    - ***1%*** Yes, temperature controls are always locked.
    - ***20%*** Yes, temperature controls are sometimes locked. *Please describe below when and/or why they are locked.* ***confusion, misuse, or family/resident request***

12. Do all units have locking front doors? Yes ***85%***
    If yes, approximately what percentage of staff has a master key? ***55%***

13. Are there exercise facilities on the premises? Yes ***53%***
    If yes, do residents have to be supervised by staff when using equipment? Yes ***36%***

14. Is there a gift shop, commissary, or store for residents within the facility? Yes ***40%***

15. Are there laundry facilities that residents can use to do personal laundry? Yes ***86%***

16. Are rooms available for residents to use for private meetings/get-togethers? Yes ***99%***
    If yes, how is the scheduling of this room handled? *Check ONE.*
    - ***24%*** Residents must reserve it in advance
    - ***51%*** Residents may reserve it, but reservations are not necessary
    - ***24%*** We do not take any reservations. Residents may use it, as long as it is available.

17. Are there handrails throughout all hallways intended for resident use? Yes ***92%***

18. Are there handrails/grab bars in all bathrooms intended for resident use? Yes ***95%***

19. How do residents receive their personal mail? *Check ALL that apply.*
    - ***66%*** Mail is delivered to residents at least once a day.
    - ***32%*** Residents do not have mailboxes, staff delivers mail to residents.
    - ***6%*** Residents do not have mailboxes, residents pick up their mail from a designated spot.
    - ***66%*** Each resident has his/her own mailbox.
    - ***52%*** Mailboxes are locked, and each resident has a mailbox key.

4% Mailboxes are located outside each unit.
0% Mailboxes are located outside the facility.
63% Mailboxes are located in a common area inside the facility.

20. Describe how the emergency-response system works. For example, do staff carry silent beepers alerting them of emergencies or do lights and buzzers alert staff to residents' requests for help? *("emergency response system" is referring to call-buttons, not fire alarms.)*
    57% ***Silent call-system (silent beepers or portable phones)***
    43% ***Audible call-system (flashing lights, audible buzzers, intercom)***

PHILOSOPHY AND MISSION

21. In your own words, what is the facility's mission in providing care/assistance to the assisted living residents? ____

____

22. Although each of these issues are important in providing "assisted living" services, please rank the following issues from the *most* important to the *least* important to the facility. Place a "1" next to the item that is most important, a "2" next to the second most important, and so on. Place an "8" next to the issue that is the least important compared to the others. Do not use any number twice, even though you may feel like the issues carry equal weight in your day to day operations.

5 (4.81) Assisting residents with ADLs
7 (5.62) Providing health care for residents
2 (3.19) Promoting resident independence
4 (4.03) Giving choice to residents
1 (2.76) Providing safety & security
3 (3.71) Providing a home-like environment
6 (5.37) Promoting "aging in place"
8 (6.17) Maintaining cost-effective practices

STAFF DESCRIPTIONS

23. Total number of people employed by the facility: ***42***
    Of these, how many are personal care aides/nursing assistants? ***19***

24. Is the person in charge of the assisted living (i.e., the administrator or director) a Licensed Nursing Home Administrator? Yes ***52%***

25. In your opinion, what is the most important thing you can teach your personal care aides/nursing assistants during orientation/training? ***Respect for residents' individuality, How to treat residents with dignity, Facility philosophy and mission, Resident rights, Caregiving skills, Communication skills, Procedures to ensure security and safety***

26. Do aides/nursing assistants have access to residents' medical/social history records? Yes ***85%***
If yes, how often do they consult them? Always ***22%*** Sometimes ***75%*** Never ***4%***

27. Describe the placement and physical appearance of the "nurse's station," the place where the nurse, aides, and staff work?
9% ***No Nurses Station***
60% ***Office with closed door, business looking***
29% ***Open desk/counter in central location***

28. When entering a resident's unit, staff members usually: *Check ONE.*
0% enter without knocking.
10% knock, then immediately enter.
90% knock, then wait for the resident to answer the door or say "come in."

29. Do personal care aides/nursing assistants wear uniforms? Yes ***55%***

RESIDENT DESCRIPTIONS

30. What is the maximum number of residents that could live in the facility? ***(15-316) avg. 81***
How many residents are currently living in the facility? ***(0-155) avg. 50 residents***
Occupancy Rate: (current res. / max res.) 65%
Occupancy Rate: (current res. / # of units) 88%

31. What is the average length of stay for residents (*in months*)? ***25 months***
What percentage of residents stay less than 3 months? ***7%***

32. Where do residents typically go when they leave your assisted living facility? List the approximate percentage of residents discharged for each of the following reasons.
26% Death
2% Move to another assisted living facility
29% Move to a nursing home within your organization (i.e., within the CCRC)
26% Move to a nursing home unrelated to your organization
2% Move to independent living within your organization (i.e., within the CCRC)
13% Move to independent living outside of your organization
1% Hospital

33. Are there set designations or categories of residents within the assisted living? Yes ***63%***
If yes, describe the categories you use? ____
____
If yes, who determines which level a resident will be? *Check ONE.*
40% Staff/administrators decides by themselves
60% Staff/administrators decide, but residents have input
0% Residents decide, but staff has input
0% Residents decide by themselves

If yes, how often are these assessments made, after the initial pre-admission screening?
____

34. Do residents have the option to participate in their own care planning meetings? Yes ***85%***
If yes, describe how residents are typically involved.____________________________
If yes, approximately what percentage of residents participate in their own care planing meetings? ***58%***

35. Approximately what percentage of residents uses home health services? ***8%***

36. Approximately what percentage of current residents:
56% receive assistance with bathing?
45% receive assistance with dressing or grooming?
5% receive assistance with feeding?
68% receive assistance with medications (either reminders or administration)?
97% receive assistance with cleaning their room?
25% are incontinent of urine or feces?
35% are cognitively impaired/confused?
40% use a wheelchair, walker, and/or electric cart?

FACILITY POLICIES

37. What is the facility's policy on pets?
25% No pets allowed
15% Pets allowed to visit only
58% Pets welcome

38. What is the facility's policy on resident smoking? *Check ALL that apply*
10% Resident smoking is not permitted (inside or outside).
38% Resident smoking is allowed outside only.
36% Resident smoking is allowed in designated areas inside (i.e., smoking lounge).
31% Residents may smoke in their unit.
12% Staff must supervise residents when they want to smoke.

39. What is the facility's policy on residents drinking alcoholic beverages? *Check ALL that apply.*
4% Drinking alcoholic beverages in the assisted living facility is not permitted.
38% Residents can drink alcoholic beverages in the common areas of the assisted living.
46% Residents may drink alcoholic beverages in the dining room with their meals.
81% Residents may drink alcoholic beverages in their unit.
35% Staff supervise and/or control the amount of alcoholic beverages residents drink.

40. Have you ever refused admission to someone? Yes ***78%***

If yes, explain the reason(s) you did not admit someone. ***Required skilled care or services beyond those offered, Financial reasons, Cognitive impairment, Facility was at maximum capacity***

41. For each of the following conditions or problems, please indicate whether you would *admit* a resident:

who needs assistance with bathing	Yes ***97%***
who needs assistance with dressing/grooming	Yes ***96%***
who needs assistance with feeding	Yes ***50%***
who cannot *independently* use a wheelchair, walker, or electric cart	Yes ***46%***
who needs assistance with cleaning their own room	Yes ***98%***
who needs assistance with medications	Yes ***96%***
who is incontinent of urine or feces	Yes ***71%***
who is cognitively impaired/confused	Yes ***73%***

42. Briefly describe your discharge policy. ____

____

43. Who generally makes discharge decisions?

12% Staff/administrators decide by themselves
80% Staff/administrators decide, but residents/families have input
4% Residents/families decide, but staff has input
4% Residents/families decide by themselves

44. Briefly give an example(s) of why you have discharged someone from the facility. ***Financial reasons, Resident needed more/skilled care, Resident went home or improved, Resident displayed behavioral problems or cognitive impairment worsened***

45. Do residents have access to the outside? *Check ALL that apply.*

87% Residents are free to go in and out of facility without staff supervision.
22% Staff has to accompany residents outside.
53% Residents must sign-out if they are going outside.
36% Staff regulates access to outside during inclement weather (ie, storms, cold).
47% There is an enclosed walking path/courtyard outside.
51% There is a covered, sheltered area outside (i.e., screened-in porch, gazebo).
87% There is seating available outside.

46. Is there a time when residents are expected to be back at the facility in the evening? Yes ***6%***

47. Does the facility have a daily procedure to check if any residents are missing? Yes ***86%***

48. Is there a fairly set time at which residents are awakened in the morning? Yes ***43%***

49. Is there a fairly set time at which residents should be in bed in the evening? Yes ***12%***

50. Do residents have a choice in when they eat meals? Yes ***63%***

51. Do residents have a scheduled time for bathing? Yes ***83%***

    If yes, who decides the time? Check ONE.

    1% Staff/administrators decide by themselves
    58% Staff/administrators decide, but residents have input
    32% Residents decide, but staff has input
    9% Residents decide by themselves

52. May residents bring their own bedspreads and/or curtains from home? Yes ***99%***

53. May residents bring large furniture such as bureaus and beds from home? Yes ***99%***

    If yes, approximate percentage of rooms with beds or bureaus from home? ***85%***

54. Are residents expected to eat meals in the dining room on a regular basis? Yes ***81%***

55. Are residents given a choice of entrees every day? Yes ***84%***

56. Do residents have assigned seats in the dining room? Yes ***48%***

    If yes, who decides the seating arrangement? Check ONE.

    2% Staff/administrators decide by themselves
    51% Staff/administrators decide, but residents have input
    22% Residents decide, but staff has input
    25% Residents decide by themselves

57. Are there set visiting hours in the facility?

    94% No. Visitors may come anytime.
    -- No, but visits must be made by appointment.
    6% Yes. What are visiting hours? ______________________________

58. When are the doors to the facility locked (*hours and days*)?

    1% ***Never***
    26% ***Always***
    72% ***Evening/Overnight***

REGULATORY ISSUES

59. Currently Ohio does not have a separate licensure category for "assisted living." Assisted living facilities in Ohio are typically under the category of "residential care." What are your opinions on the current licensing of assisted living? *Please explain and be specific.*

    54% Generally POSITIVE sentiments expressed
    17% Generally NEGATIVE sentiments expressed
    5% Both POSITIVE & NEGATIVE sentiments expressed
    24% No opinion expressed

60. If new regulations for "assisted living" were introduced, what, if any, changes would you like to see made to the existing Residential Care Facility regulations? *Please explain and be specific*

57% ***Would like to see NO CHANGES made***
24% ***Suggested a SPECIFIC CHANGE (ie, admission/discharge criteria, staffing issues)***
7% ***Would like to see LESS regulations***
15% ***Would like to have Medicare/Medicaid REIMBURSEMENT***

61. What is your job title?
78% ***Administrator/Director***
9% ***Owner/CEO***
1% ***Nursing***
11% ***Admissions/Marketing***

Appendix B

Description of Indices

Services Index

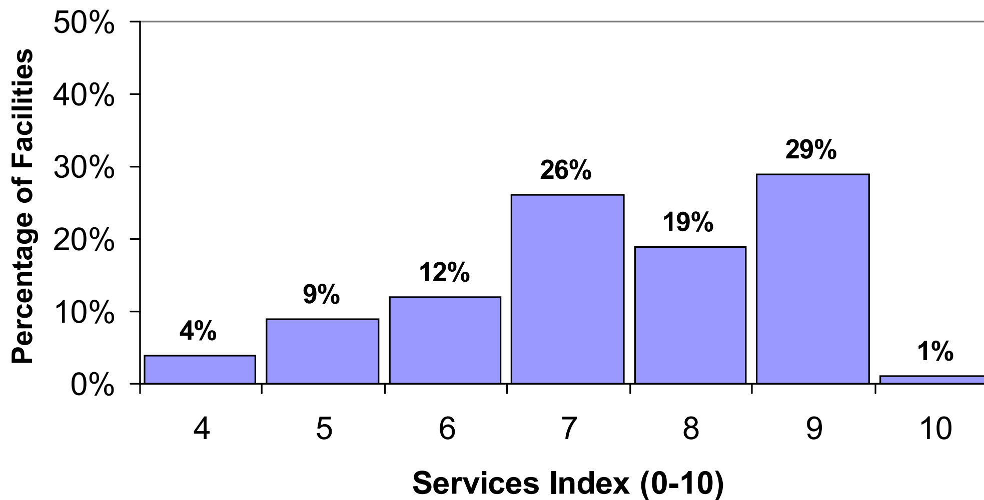
Does the facility offer:

Special diets
Personal transportation
Personal care (some)
Personal care (all)
Medicine administration
Medication reminder
Dementia care
Dementia/wanderer
Pet service
Therapy (physical, occupational, speech)

Facilities are given 1 point for each service available
Possible range of scores: 0-10

The higher the score, the more services offered by the facility

Number of Services Offered by Assisted Living Facilities in Ohio
(n=100)



n = 100
Reliability coefficient; alpha = .42
Range of scores: 4-10
Mean: 7.4
Standard deviation: 1.5

Residential Features Index

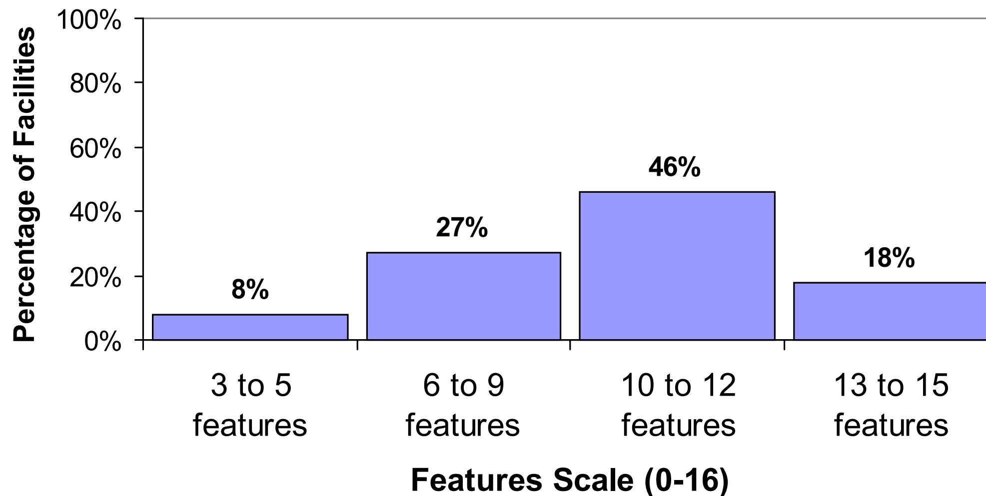
Is there a ------- in the facility?

Beauty or barber shop
Living room
Library
Sun room/porch
Resident kitchen
Garden/walking path
Private dining room
Whirlpool/ bath room
Smoking area
Storage room
Exercise room
Gift shop
Resident laundry room
Chapel*
Ice cream parlor*
Pool*
Computer room*
Game room/billiards*
Fireplace room*
Health/wellness clinic*
Bank*
Woodworking shop*
Guest Apartment*

Facilities are given 1 point each for each residential feature found in the facility, with a maximum of three points out of the 10 starred items.
Possible range of scores: 0-16

The higher the score, the more residential features found within the facility.

Number of Features and Amenities in Ohio Assisted Living Facilities
(n=100)



n = 100
Reliability coefficient; alpha = .70
Range of scores: 3-15
Mean: 10.0
Standard deviation: 2.7

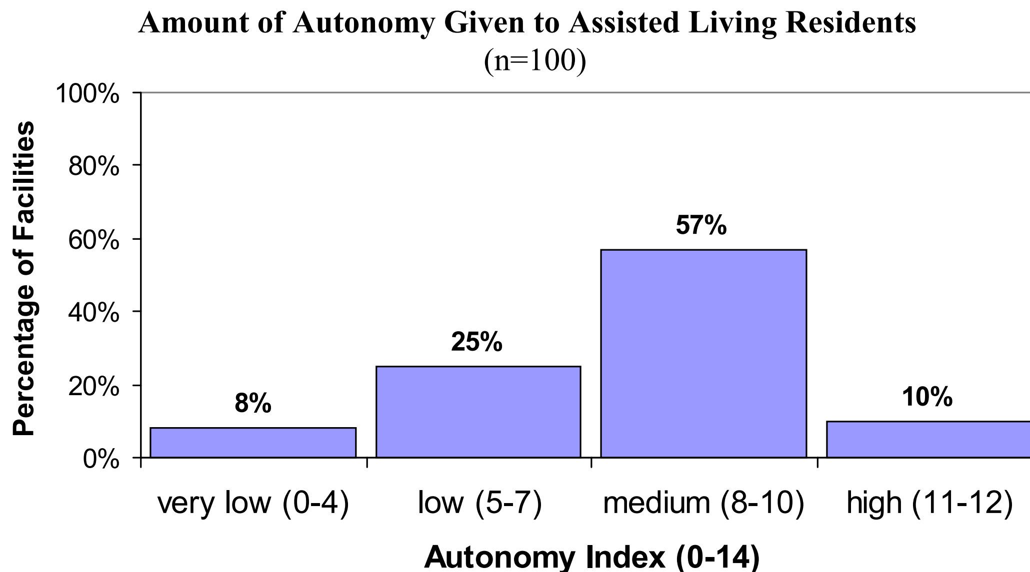
Autonomy Index

True or False

All units have individual temperature controls
Roommate assignment: Residents decide by themselves
Discharge decisions: Residents decide by themselves
Bath time: Residents decide by themselves
Dining room seat: Residents decide by themselves
Residents are not supervised if they want to smoke
Residents are not supervised if they want to drink alcoholic beverages
Residents are free to go in and out of facility without staff supervision
There is not a time when residents are expected to be back in the facility (curfew)
There is not a set time at which residents are awakened in the morning
There is not a set time at which residents are expected to be in bed in the evening
Residents have a choice in when they eat meals
Residents are not expected to eat their meals in the dining room on a regular basis
Residents have a choice of entrees every day

Facilities are given 1 point for each of the above statements that are true.
Possible range of scores: 0-14

The higher the score, the more autonomy given to residents.



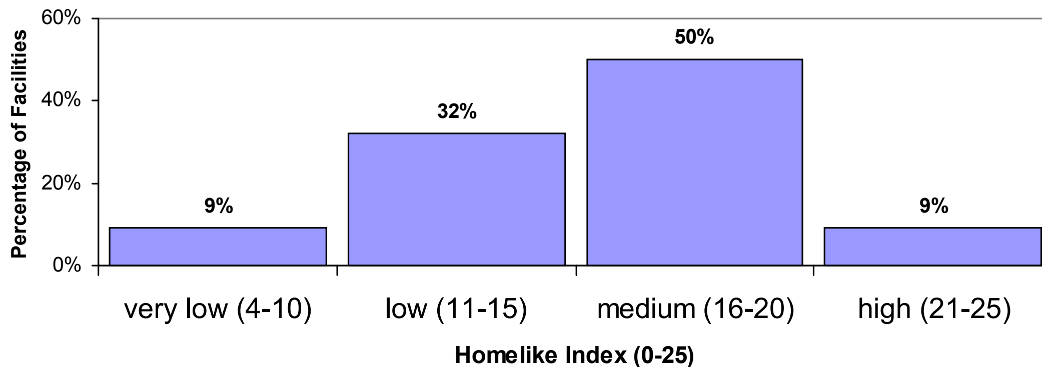
n = 100
Reliability coefficient; alpha = .65
Range of scores: 0-12
Mean: 8.0
Standard deviation: 2.4

Homelike Index

True or False

Less than 25% of the total number of apartments are double occupancy
There are no visiting hours for the facility. Visitors may come anytime.
All units have individual temperature controls
Temperature controls are never locked
Residents have a private shower in their unit
Residents have a private bathtub in their unit
Residents have a microwave in their unit
Residents have a stove in their unit
Residents have a refrigerator in their unit
Residents have cable TV outlet in their unit
The facility has a "silent" call system
When entering a unit, staff knock, then wait for resident to answer or say "come in"
The facility has no nurses' station or an "office-type" of nurses' station
The personal care aides/nursing assistants do not wear uniforms
Pets are allowed in the facility
Residents are allowed to smoke in their units
Residents are allowed to drink alcoholic beverages in the dining room
Resident are free to go in or out of the facility without staff supervision
There is not a time when residents are expected to be back in the facility (curfew)
There is not a set time at which residents are awakened in the morning
There is not a set time at which residents are expected to be in bed in the evening
Residents have a choice in when they eat meals
Residents are not expected to eat their meals in the dining room on a regular basis
Residents do not have a scheduled time for bathing

Facilities are given 1 point for each of the above statements that are true.
Possible range of scores: 0-25
The higher the score, the more homelike the environment.



n = 100
Reliability coefficient; alpha = .77 **Mean: 15.8**
Range of scores: 4-25 **Standard deviation: 4.2**