DHS | Oregon Department of Human Services

ADULT FOSTER HOME RESIDENT AND COMMUNITY CHARACTERISTICS REPORT

Adult Foster Homes

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EXECUTIVE SUMMARY

Adult foster homes (AFH) offer long-term services and supports to older adults and people with disabilities who wish to remain in the community but need assistance with personal care and health-related tasks. This report focuses on Oregon AFHs that are licensed to care for individuals aged 65 and older and younger adults with disabilities. Homes may be licensed for one to five residents and must be staffed 24-hours daily to respond to residents' scheduled and unscheduled needs or requests.

This report provides an in-depth look at a sample of Oregon AFHs. Since no central dataset of AFH services, staff, and residents is available, information for this report was collected from mid-January to mid-March 2017 using a questionnaire that AFH owners were asked to complete. At the start of this project, there were 1,740 AFHs in the state.

The goals of the project described in this report included:

1. Describe AFH characteristics, including staffing types and levels, policies, and monthly charges and fees
2. Describe current residents' health and social characteristics
3. Compare current results with prior Oregon surveys and national studies (as available), and identify changes and possible trends
4. Describe characteristics that could affect access, quality, or cost

KEY FINDINGS

AFH Services and Policies

- 15 percent or fewer AFHs gave a move-out notice to a resident in the past 90 days for one of the following reasons: needed two-person transfer assistance, wandered outside, lease violation, or needed sliding scale insulin.
- 7 percent of AFHs gave a move-out notice to a resident in the past 90 days for hitting others/acting in anger.
- 33 percent of AFHs use a falls risk assessment tool as standard practice with every resident, and 27 percent do so on a case-by-case basis.
- 26 percent of AFHs use a cognitive impairment screen as part of standard practice.

Staff

- 24 percent employed a resident manager.
- 81 percent employed at least one caregiver.
- 21 percent of caregivers had a professional certification as either a certified nursing assistant (CNA), certified medication aide (CMA), or licensed personal nurse (LPN).
- 52 percent of AFH operators received a flu vaccination in the prior survey year.
- 22 percent had difficulty hiring caregivers.
- 36 percent of AFH reported that they had a strategy to retain staff and reduce turnover.

Payer sources

- The two main payer sources for AFH residents were Medicaid (56 percent) and private pay (47 percent). Providers reported that three percent of residents used both Medicaid and private resources.

Provider rates and fees

- The mean monthly rate for a single person living in the smallest unit and receiving the lowest level of care was $3,417 and the median was $3,250. There was a very large range, from $550 to $7,130. The annual charge based on the mean rate would be $41,004.
- Over half of AFHs provide assistance with night-time care, advanced memory care, two-person transfer assistance, catheter or ostomy care, and advanced diabetes care. Of AFHs that provide this assistance, at least half charge private-pay residents an additional fee determined by the provider. Residents paying with Medicaid funds are charged for assistance based on a rate established by DHS.

Medicaid

- 81 percent of providers who responded to the 2017 survey has a contract with DHS to accept Medicaid beneficiaries.
- 73 percent of all AFH in Oregon had a contract with DHS to accept Medicaid beneficiaries.
- In 2017, DHS paid AFH providers a total of $73,727,128 on behalf of Medicaid-eligible residents.

Residents

- 32 percent of AFH reported resident length of stays from one to 90 days compared to 30 percent who stayed 90 or fewer days reported in 2015.
- 62 percent of residents who moved out in the prior 90 days died.
- 39 percent of residents received assistance to eat.
- 86 percent of AFH residents did not experience a fall in the prior 90 days.
- 14 percent of AFH residents had an emergency department visit, and 8 percent were hospitalized overnight in the prior 90 days.
- 10 percent of AFH residents received hospice care in the prior 90 days.
- 53 percent of AFH residents take nine or more medications.
- 35 percent of residents took an antipsychotic medication.

Comparing AFHs to assisted living, residential care, and memory care communities

- 32 percent of AFH residents stay less than 90 days compared to 30 percent in the other CBC settings.
- The same rate of residents in AFH, AL, and RC—47 percent—have a diagnosis of Alzheimer's disease or other dementias.

- 35 percent of AFH residents take an antipsychotic medication compared to 27 percent in CBC settings.

The typical AFH resident is a white, non-Hispanic woman over age 85 who needs support with bathing, dressing, and incontinence. She takes 9 or more medications with staff assistance and has at least one chronic health condition.

Survey Method

In 2017, Portland State University's Institute on Aging (IOA) mailed a questionnaire to a geographically stratified random sample of AFHs in Oregon, and 340 providers responded, representing 1,259 residents. The questionnaire asked about resident and staff characteristics, services, policies, and monthly rates and fees. The study methods are described in Appendix A of the full report. Some questions were asked both this year and last year; of those, we reported trends for payment types, and length of stay for years 2014-15, 2016, and 2017.

BACKGROUND

Adult foster homes (AFHs) are licensed, single family residences that provide care and services to adults who need or want assistance with daily personal care, social activities, and health-related care. The AFHs in this study serve adults age 65 and older and adults with a physical disability. In Oregon, AFHs provide care for up to five unrelated adults in a residence in which the owner's family members might also reside. AFHs offer and coordinate supportive services available on a 24-hour basis. Oregon requires AFHs to provide a home-like environment that cultivates a cooperative relationship between the resident and provider, and promotes choice, dignity, privacy, individuality, and independence for the resident (OAR 411-50).
Services provided in AFHs include help with meals and personal care, medication administration and assistance with behaviors associated with mental health issues and dementia. Additional health-related and social services may be provided or coordinated depending on resident needs or preferences. A wide variety of residents are served in AFHs, including some who primarily need room, board, and minimal personal assistance as well as residents who need full personal care, have dementia (such as Alzheimer's disease), or residents who need short-term skilled nursing care provided with the help of community-based registered nurses. Homes are classified at one of three levels based on the training and qualifications of the provider, as defined by state rules (OAR 411-050-0625).

Adult foster homes are licensed or certified in most states, and they vary in size and the type of services provided (Carder, O'Keeffe, & O'Keeffe, 2015). Some states limit the type of assistance that AFHs may provide to meals and personal care, but Oregon permits AFHs to serve individuals who meet the state's nursing home level-of-care criteria and to receive Medicaid payments on behalf of residents who meet eligibility criteria.

As of December 2016, Oregon DHS licensed 1,740 AFHs. Of these, 650 received a questionnaire, and 340 responded, for a 52 percent response rate. See Appendix A for a description of the study methods. The questionnaire (Appendix C) asked providers about residents' demographic characteristics, move-in and move-out locations, health-related needs, and health service use; information about the AFH owner and licensee; household characteristic including staffing types and levels, training, staff competency and turnover; payment types, rates and fees for additional services, and available services; and satisfaction with primary care staff.

As possible, results from the 2017 survey are compared to prior studies conducted in 2014 and 2016. The 2014 questionnaire asked providers to report on the prior year (2014) and is referred to as the 2014-15 report. The 2016 and 2017 questionnaires asked about current residents and certain events that occurred during the prior 90 days. Thus, some questions from 2014-15 are not comparable to later years. The research methods are described in Appendix A.

This report complements two prior reports available at https://www.pdx.edu/ioa/oregon-community-based-care-project and http://www.oregon.gov/DHS/SENIORS-DISABILITIES/Documents/AFH%20Summary%20Report%20-%202017.pdf. Findings from studies of assisted living and residential care communities are also available at these sites.

ADULT FOSTER HOMES

What are they, how many are there, what is their capacity and occupancy?

Adult foster homes are authorized by Oregon Administrative Rule OAR 411-50. This rule establishes standards and procedures, including the provision that homes provide care and a wide range of services to older adults and adults with physical disabilities in a manner that promotes residents' safety and independence. An important difference between AFHs and other types of community-based care settings is that care and services are provided in a family home or a residence that offers a home-like environment to five or fewer unrelated adults.

Capacity and Occupancy

Each AFH is licensed for a specific number of occupants, known as licensed capacity. The capacity is typically larger than the number of rooms since rooms might be shared. The occupancy rate is calculated by dividing the number of occupants by the licensed capacity.

Of the 650 homes that received a questionnaire, 340 responded. Survey respondents were licensed to care for up to 1,523 residents (capacity) and reported a total of 1,259 current residents (occupancy). The calculated occupancy rate is 83 percent (Table 1).

Table 1. **Capacity and Occupancy Rates of Surveyed Homes**

Total Licensed Capacity of Survey Respondents	Occupancy of survey respondents	Occupancy rate
1,523	1,259	83%

Percent of AFHs at Full Capacity

The occupancy rate described above does not describe the number of homes at full capacity. Given that AFHs are small, operating at capacity might be important for their economic well-being. A home licensed for five residents could have between one and five residents. Overall, 49 percent of AFHs were at full capacity, but this rate is largely explained by the number of homes licensed for one person. Of the homes licensed for three residents, only 29 percent had three residents (see Table 2). This reality explains the difference between the overall occupancy rate of 83 percent and the lower percentage of homes operating at full capacity.

Table 2. **Rate of AFH Respondents at Full Capacity**

# Residents Permitted	Licensed Capacity % (n)	At Maximum Capacity % (n)
1	6% (20)	100% (20)
2	2% (6)	50% (3)
3	6% (21)	29% (6)
4	11% (37)	30% (11)
5	75% (256)	49% (126)
Overall	340	49% (166)

Classification Level

Adult foster homes are classified based on provider qualifications. Depending on the classification, the licensed owner may admit and care for residents with an increasing number of functional impairments. A class one license authorizes the owner to care for residents needing assistance with up to four activities of daily living (ADLs include eating, bathing, dressing, grooming, personal hygiene, mobility, elimination, cognition, and behavior (OAR 411-015-0006). Class two licensees must have two or more years' experience providing care to elderly adults, may admit residents needing assistance with all ADLs, but with full assistance in no more than three ADLs. A class three licensee must hold a current license as a health care professional in Oregon or have a minimum of three years' experience caring for elderly adults or people with disabilities needing full assist in four or more ADLs, and references from two or more licensed health care professionals. Providers in all three classifications must pass the DHS AFH training course (411-050-0630).

Adult Foster Home Owners

Providers reported the number of years they had been a licensed AFH operator. On average, they have been licensed for 11.7 years, ranging from under one year to 31 years. About half had been providers for one to 10 years, and 20 percent had been providers for over 20 years. In addition, eight providers indicated that they had been providing care in their homes for more than 31 years; possibly these individuals were either certified or had received Public Welfare Division approval prior to 1986 when DHS Administrative rules required AFHs to be licensed. Most providers lived at their AFH, and 65 percent had family members living in the home. Of family members who lived in the AFH, about one-third were age 17 or younger. These findings are similar to prior years' findings (See Table 3).

Table 3. **Providers Living in AFH 2014-2017**

		2014-15 % (n)	2016 % (n)	2017 % (n)
Live at AFH		89% (200)	85% (272)	84% (263)
Family in AFH		56% (115)	72% (196)	65% (202)
Average number of family members		2.1	2.2	1.5
	17 or younger	29% (126)	32% (76)	34% (163)
	18 or older	71% (303)	68% (162)	66% (314)

In addition to having children in the home, AFH providers may care for a relative who is elderly or disabled and is not counted as part of the licensed capacity. Of the survey respondents, nine percent (33 providers) cared for a relative who was elderly or disabled (not shown in table).

AFH Provider Certifications

AFH providers are required to hold a professional AFH license, but are not required to hold a health care certification, or medical professional license, or degree. However, 21 percent indicated they were CNAs, the most commonly reported health care certification (see Table 4). The professional certification rates were similar over time, since 2014.

Table 4. **Provider Certification, 2014-2017**

	Provider certification, 2014-15	Provider certification, 2016	Provider certification, 2017
CNA	21% (48)	22% (70)	21% (71)
RN	5% (11)	5% (17)	5% (16)
LPN/LVN	4% (8)	3% (10)	4%(12)
MSW	<1% (1)	1% (2)	1% (2)
Respiratory Therapist	1% (2)	<1% (1)	2% (5)
Other	20% (46)	16% (52)	17% (58)

COMMUNITY SERVICES AND POLICIES

What are common services and policies?

Several questions were asked about AFH policies and practices regarding resident services and staffing. The topics listed below were identified by the DHS and PSU research team, with some questions adapted from national or other state studies. The topics included:

- Move-out notices
- Use of fall risk assessment
- Flu vaccination
- Use of a cognitive screening tool
- Quality improvement activities
- Medicaid transportation
- Communicating with primary care providers
- HIPAA

Oregon permits AFH operators to move out or transfer a resident for specified conditions, such as medical reasons, behaviors that are dangerous to the resident and others, behaviors that interfere with residents' rights, medical reasons, or violation of the home's written policies *[OAR 411-050-0650].*

Move-Out Notices

Providers were asked which of six needs and behaviors would typically prompt a move-out notice to a resident (Table 5). The most common reason for giving a resident a notice was hitting or acting out with anger, and the least common reason was need for sliding scale insulin.

Table 5. **Resident Needs and Behaviors That Prompt a Move-Out Notice**

	AFH (n=327) % (n)
Hitting/acting out with anger	7% (24)
Two-person transfer	3% (9)
Wandering outside	2% (6)
Lease violations (excluding non-payment)	1% (4)
Non-payment	2% (7)
Sliding scale insulin	<1% (1)

Additional reasons for a potential move-out notice described by providers included that the resident's physical and behavioral care needs could not be met, or residents' failure to follow house rules.

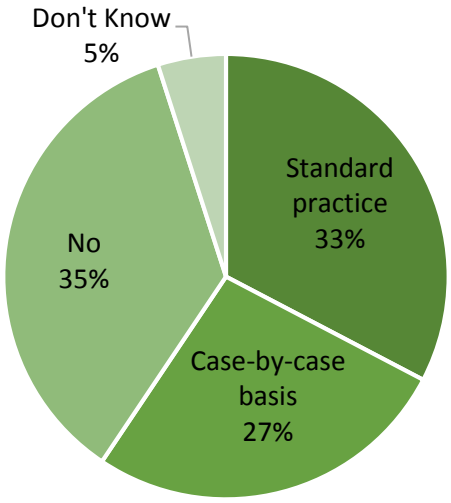
Use of Residents' Fall Risk Assessment

Falls among older adults are an important public health issue; falls are the eighth leading cause of unintentional injury for older Americans and result in as many as 16,000 deaths in a year

(Oliver, Healy, & Haines, 2010). Oregon's DHS encourages AFH providers to use a validated fall risk assessment tool such as the Centers for Disease Control's STEADI (Stop Elderly Accidents, Deaths and Injuries) tool, the TUG (Timed Up and Go) test, or another tool that has been shown to reliably assess fall risks among older adults.

Thirty-three percent of homes used a fall risk assessment tool as a matter of standard practice and 26 percent used such a tool on a case-by-case basis (Figure 1).

Figure 1. **Use of a Fall Risk Assessment Tool**



Providers were asked how many residents who had been assessed for fall risk did not fall. Overall, providers responding to this question reported that 52 percent of residents who had been assessed did not fall in the last 90 days (not shown in table).

Use of Cognitive Screening Tool

The benefits of recognizing and treating dementia include enabling providers to deliver better care and allowing individuals and families to prepare for and manage the disease (Alzheimer's Association, 2015). Cognitive screening is an important first step in determining the need for further evaluation (Alzheimer's Association, 2017).

In 2013, an estimated 5 million Americans aged 65 and older were diagnosed with dementia; by 2050, the number is projected to rise to 14 million (CDC, 2017).

Oregon requires that AFHs collect information from a potential residents' licensed health care provider and family members. An initial screening is required before a resident moves in to identify the prospective resident's service needs, including cognitive needs. The screening process consists of interviews with family members, other care providers, and licensed health care professionals (411-050-0655).

Providers were asked whether they used a standard cognitive screening tool as a matter of practice and 26 percent reported that they did.

Flu Vaccination

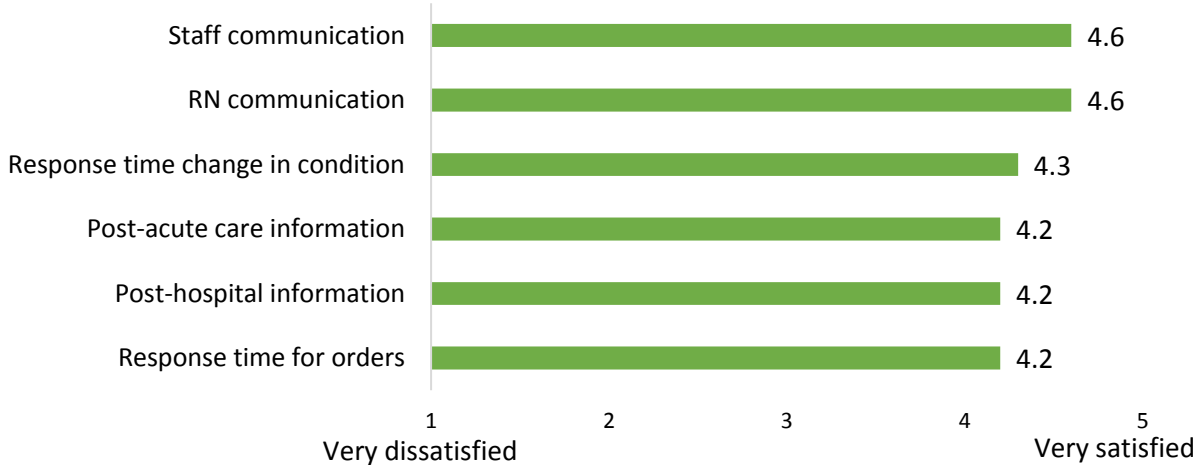
Providers were asked whether they and other staff received a flu vaccination in the prior year. Fifty-two percent of AFH providers (172) reported receiving a flu vaccine. Among 170 AFHs who employed at least 1 staff and had non-missing flu vaccine information, 302 staff received flu vaccines out of 428 total staff, suggesting a vaccination rate of 71 percent.

Communicating with Primary Care Providers

Adult foster care homes must coordinate with residents' primary care providers (PCPs), starting before a new resident moves in and throughout the resident's life in the home. Oregon requires AFHs to document each resident's diagnoses, medications, and other prescribed treatments from the resident's PCP (OAR 411-050-0655). Information about a resident's change in condition, medication changes, hospitalizations, medical appointments, and other health-related information must be exchanged between the PCP office and AFH staff.

The survey included six questions to assess AFH provider's satisfaction with PCP office staff. Overall, 67 percent of AFH providers indicated they were very satisfied, with a score of 4.3 out of five points. The lowest scores were given for the time it takes the PCP office to respond to AFH staff requests for changes in residents' medication orders and the exchange of care-related information following a hospitalization (see Figure 2).

Figure 2. **AFH Provider Assessment of Communication with PCP Offices**



Providers were also asked to describe, in writing, concerns they had about communicating with resident's PCP office staff, how AHF staff partnered with PCP office staff to address resident's health, and advice for improving communication between AFH and PCP staff. The majority of providers answered these questions, summarized below.

What concerns do you or your staff have about communicating with resident's primary care office staff?

The top three responses among the 155 received were:

- Slow response time: "*There can be quite a bit of lag time in responses.*" (63 percent of responses)
- Clarity or completeness of physician orders: "*Difficulty getting current med list*." (17 percent of responses)
- PCPs do not understand AFH rules for staffing and paperwork: "*Most don't want to comply with state rules, or say medical visit form is too long.*" (7 percent of responses)

Other concerns raised by AFH providers included PCPs that do not understand specific population groups, including persons who are too frail to visit the office or have a traumatic brain injury, and that AFH staff are not treated with respect. However, 42 providers explained that they had a positive relationship with PCP office staff.

How have you and your staff partnered with primary care office staff to address a resident's health needs?

A total of 266 responses were given to this question, and the top four were:

- Type or method of communication (48 percent).
    - "*When we need to fax anything we call to let them know. We can call and talk to the nurse of most doctors and they call back with info or advise that residents go in*."
- Attend doctor's appointments with their residents (22 percent).
    - "*We attend all medical appointments with resident, advocate for resident, follow through on all orders, and communicate any concerns*."
- Positive communication (17 percent).
    - "*Mainly just good communications, timely response, and follow through*."
- Frequency of communication (15 percent).
    - "*Continually maintain communication*."
    - "*Usually call twice, then fax. If still no response, call and fax again. Repeat if needed*."

In addition to these responses, some AFH providers mentioned the importance of teamwork, the benefit of home visits made by some PCPs, and the use of PCP visit summaries that included detailed information about medications and diagnoses.

What advice do you have about communicating with resident's primary care office staff?

A total of 260 providers answered this question; some gave two answers, resulting in 386 responses. The top four responses were:

- Develop a relationship with PCP office staff (19 percent).
    - "*Get to know them and keep up a good rapport*."
    - "*Establish a friendly relationship – it will pay off.*"
    - "*Make sure that your doctor is going to work with you on what is best for the resident*."

- Be efficient and organized (18 percent).
    - "*Have all information ready when calling—name, date of birth, symptoms, and signs*."
    - "Write down all concerns before addressing or seeing doctor."
    - "Document time, date, and time of call; it will help if problems later."
- Be persistent (18 percent).
    - "*Be persistent until you get an answer. They have 100s of patients and may forget to answer a fax.*"
    - "Call back and tell them what you need. Know when to have family involved."
    - "Stay professional but make sure to be firm so you can get orders answered in a timely manner."
- Be polite, respectful, and thankful (13 percent).
    - Directed toward PCP: "Be open, caring, almost humble: I am not questioning your ability, I am concerned about my resident and I need your help."
    - Directed toward AFH operator: "Be patient, clear about your needs, and always nice and thankful."

In addition to this advice, 10 percent of the responses included suggestions that PCP office staff should read and/or listen to the information that AFH operators give them, and complete forms or other requested information. Seven percent of responses advised AFH operators to go to doctor's appointments with their residents because doing so was better for the resident, and a good way to develop relationships with PCP staff. Some AFH operators suggested that PCPs should understand more about AFH rules, including required documents, staffing, and the needs of AFH residents (six percent). A small number mentioned the need to have proper documentation in place to permit PCP offices to share information with AFH staff.

Medicaid-Financed Transportation Services

Medicaid beneficiaries are eligible for non-emergency and emergency transportation to and from medical providers' offices and the hospital for Medicaid-approved care (CMS, 2016). The Oregon Health Authority provides non-emergency and emergency medical transportation for eligible Oregon Health Plan recipients, those enrolled in other prepaid health plans, and those enrolled with coordinated care organizations (OR 410-136-3160).

Providers were asked whether Medicaid-financed third-party transportation services were available to eligible residents. Of 339 AFHs, 67 percent indicated that this service was available, 23 percent indicated that this question was not applicable (possibly because the AFH did not have any Medicaid-eligible residents), and 10 percent said that this service was not available to residents.

Providers who reported the service was available (n=226) were asked to rate service quality. Thirty-nine percent of providers found the service was good, 17 percent found the service fair, 7 percent found it to be poor.

HIPAA Challenges

The U.S. Health Insurance Portability and Accountability Act (HIPAA) established guidelines on the sharing of patient's personal health information. These guidelines can create barriers to sharing information between medical care providers and others.

Providers were asked whether HIPAA ever created a barrier in communicating with residents' primary care providers, and 18 percent of AFHs indicated this was a problem.

ADULT FOSTER HOME STAFF

Who Works in Adult Foster Homes?

AFH providers may hire caregivers to provide personal care assistance to residents. These staff are not required to be licensed or certified, but all paid caregivers must complete DHS-approved training, complete in-home training provided by the owner/manager of the AFH, and be competent to address residents' needs (OAR 411-050-0625).

If the licensed AFH provider does not live in the home, a resident manager must be employed and reside on-site. Resident managers were employed by 24 percent of AFHs (81 homes), the same rate as in 2016. Of the homes that employed a resident manager, 79 percent had one resident manager while 13 percent employed two (not shown in table).

Most (90 percent) of resident managers worked full-time (40-hours per week). Fifty-five percent of resident managers worked over 40 hours per week, possibly because they lived in the AFH and provided nighttime care.

Care-Related Staff

Eighty-one percent of homes employed at least one caregiver (see Table 6). Most AFHs employed two caregivers. The percent of homes that did not have any paid caregivers was similar in 2014-15 and 2017 and lower in 2016.

Table 6. **Number of Caregivers Employed, 2014-2017**

Number	2014-15 % (n)	2016 % (n)	2017 % (n)
0	20% (46)	12% (38)	19% (62)
1	35% (80)	23% (72)	21% (68)
2	26% (58)	32% (100)	33% (109)
3	9% (20)	19% (61)	13% (43)
4	2% (4)	8% (24)	8% (27)
5 or more	8% (18)	7% (21)	7% (23)

Oregon does not require AFH caregivers to hold healthcare certifications, although some providers choose to hire certified staff. Providers were asked whether their caregivers, including resident managers, held a healthcare certification or license, and 21 percent (n=153)did (see Table 7). Overall, among staff with these three classifications, the most prevalent type was CNA (78 percent).

Table 7. **Care Staff with Certifications**

	Care-related Staff % (n)
LPN	2% (12)
CNA	16% (119)
CMA	3% (22)

Difficulty Hiring Staff

Providers were asked if they experienced difficulty hiring caregivers, resident managers, and RN consultants. Few providers reported having difficulty hiring any staff type, with 22 percent reporting difficulty hiring caregivers, 19 percent difficulty hiring resident managers, and 11 percent reporting difficulty hiring CNAs or CMAs. Notably, only six percent had difficulty hiring an RN consultant.

Few providers reported difficulty with hiring or contracting with caregivers, resident managers, licensed practical or licensed vocational nurses, or RN consultants. The top three responses from 110 providers who did experience hiring difficulties were:

1. Lack of qualified applicants
2. Inability to fulfill salary and benefit requests
3. Scheduling issues including applicants not wanting shift work, long hours, or to live in the home

Other reasons given were that applicants and newly hired workers were unreliable or un-trustworthy, and that applicants were not willing to wait for the time it took for a background check.

Staff Absenteeism

Worker absenteeism can have a negative impact on residents as well as other staff (Harris-Kojetin, Lipson, Fielding, Kiefer, and Stone, 2004). Providers were asked if staff had missed work in the prior 90 days due to any of the below reasons, listed in rank order:

1. Personal health issues (24 percent)
2. Family illness or other family issues (16 percent)
3. Transportation problems (11 percent)

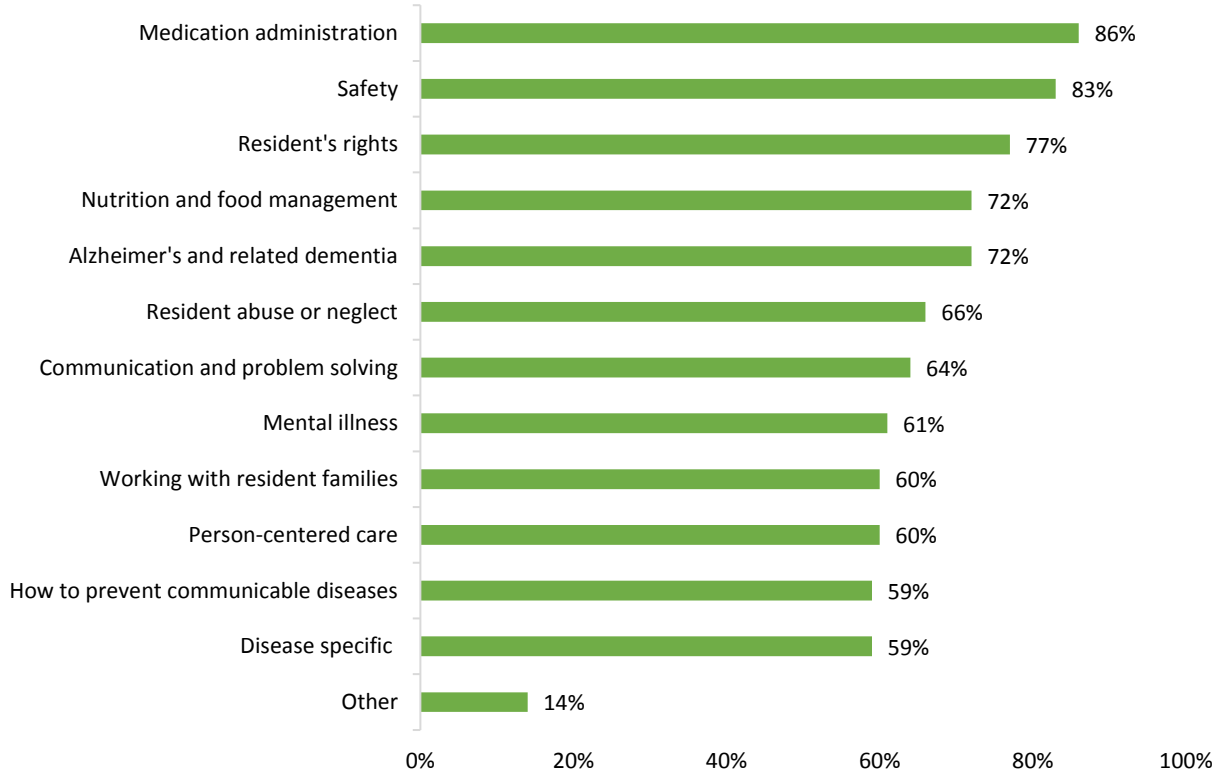
A small percentage of providers (2.4 percent) reported use of contract care staff to cover unplanned staff absences.

Staff Training Topics

Adult foster home providers, resident managers, and caregivers are required to complete at least 12 hours of annual continuing education (OAR 411-050-0625). Providers were asked whether they had covered any of several training topics in the prior 12 months. Alzheimer's and other related dementias, and mental illness were new training topic areas added for this year's report.

As shown in Figure 3, over half of providers indicated that they had covered the training topics included in the questionnaire. Over 70 percent of providers covered medication administration, safety, resident rights, nutrition, and dementia.

Figure 3. **Staff Training Topics Covered in the Prior 12 Months**



Other training topics were described by 67 providers in response to an open-ended question including:

1. Resident care (e.g. recognizing and treating, and monitoring illness, end of life care, and communicating with residents) (63 percent).
2. AFH rules and documentation (22 percent)
3. Staff self-care (e.g. paying taxes, avoiding burnout) (15 percent)

Aside from annual CEUs, no stipulations exist around evaluating caregiver or staff competency to do their work. Providers were asked how often they assessed staff ability and knowledge to

do their work. Multiple responses were allowed. Most reported assessing on an as needed basis (53%), followed by monthly (14 percent), annually (11 percent), or at least every six months or three times per year (eight percent). Eighteen percent of providers assess staff more than one time per year. When asked what other ways direct care workers' competency was assessed most evaluated staff on a daily, weekly, or "ongoing" basis (88 percent of 40 responses).

Strategies for Retaining Staff

One hundred twenty-five (36 percent) of AFH providers reported they had strategies to retain staff and reduce staff turnover. The three most common approaches were to:

1. Offer a competitive salary with benefits and bonuses (35 percent)
2. Foster a positive environment with, respect, trust, and open communication (27 percent)
3. Show appreciation (9 percent)

Other suggestions included providing flexible scheduling, a manageable workload, paid vacations and time off, and personal support.

Providers were asked whether they provided a transportation benefit, such as transit passes, ridesharing, carpools, or other assistance getting to and from work, to their staff. Of 231 responses, 80 percent of providers (n=185) did not offer such a benefit while 14 percent did. Others who responded that the question was not applicable to them likely did not hire additional staff. As noted above in the staff absentee section (page 11),transportation issues accounted for 11 percent of unplanned staff absences in AFHs.

Some providers (n=53) described their transportation benefit. Of these, most reported picking staff up from home or transit stops and stations, or driving them home on an as-needed basis, and a few paid for public or private transportation, or provided gas money to offset transit costs.

RATES, FEES, AND MEDICAID USE

How much do adult foster homes cost?

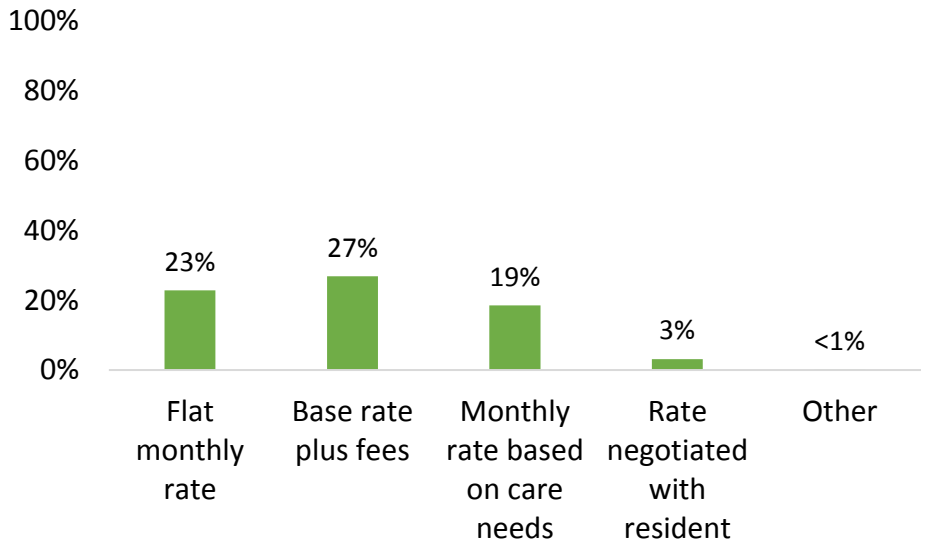
The cost of AFHs is an important topic for both state policymakers and residents who pay using personal resources as well as those who rely on Medicaid. Operators were asked the following topics: how private pay rates are structured, average total monthly charges, payer sources (private resources, long-term care insurance, Veteran's Aid & Attendance, and Medicaid), and additional fees.

Private Pay Rate Structure

Adult foster home operators have different ways of assessing monthly fees—this is known as the rate structure. Some homes charge a base monthly rate of all residents, and others charge a base rate and additional monthly fees based on the amount of services (e.g., assistance with activities of daily living, health monitoring, additional laundry or housekeeping) received by each resident.

AFH providers structure their monthly rates in at least four different ways. Just over one quarter of homes charge a base rate plus fees for services, while just under one quarter charge a flat monthly fee. Very few AFHs (three percent) set rates after negotiating with resident or payee based on ability to pay (Figure 4).

***Figure 4*. Percent of Residents Paying by Different Rate Structures**



Changes in Private Pay Rate Structure over Time

Operators were asked to describe, among those who paid privately, the average total monthly charge for a single resident living alone and receiving the lowest level of care in a private room. The average monthly charge for the responding AFHs across the state was $3,417. When comparing the average total monthly charges by the four regions in Oregon, the highest average rates were found in the Willamette Valley/North Coast and Southern Oregon/South

Coast area (Table 8). In contrast, the maximum monthly rates were in Portland Metro and Southern Oregon.

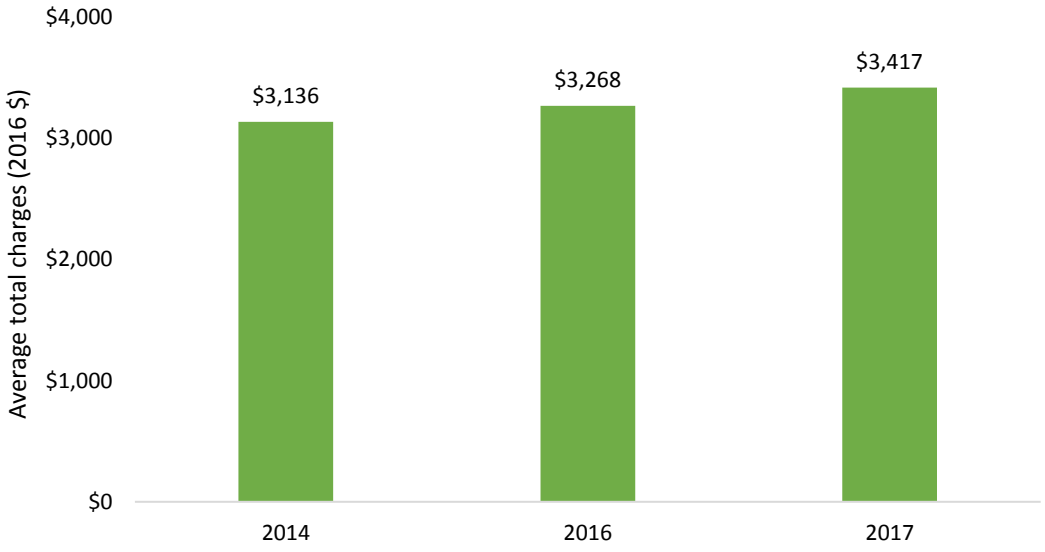
Table 8. **Minimum, Average, and Maximum Total Monthly Charge for Private Room**

	Minimum	Average	Maximum
Region 1: Portland Metro	$550	$3,353	$7,000
Region 2: Willamette Valley/North Coast	$550	$3,512	$6,500
Region 3: Southern Oregon/South Coast	$637	$3,505	$7,130
Region 4: East of the Cascades	$2,000	$3,361	$4,700

Changes in Private Pay Rates over Time

Between 2014 and 2017, inflation-adjusted average total monthly charges increased from $3,136 to $3,417 (in 2016 dollars), an increase of 9 percent (see Figure 5).

Figure 5. ***Inflation Adjusted Monthly Changes in Private Pay Rates over Time***



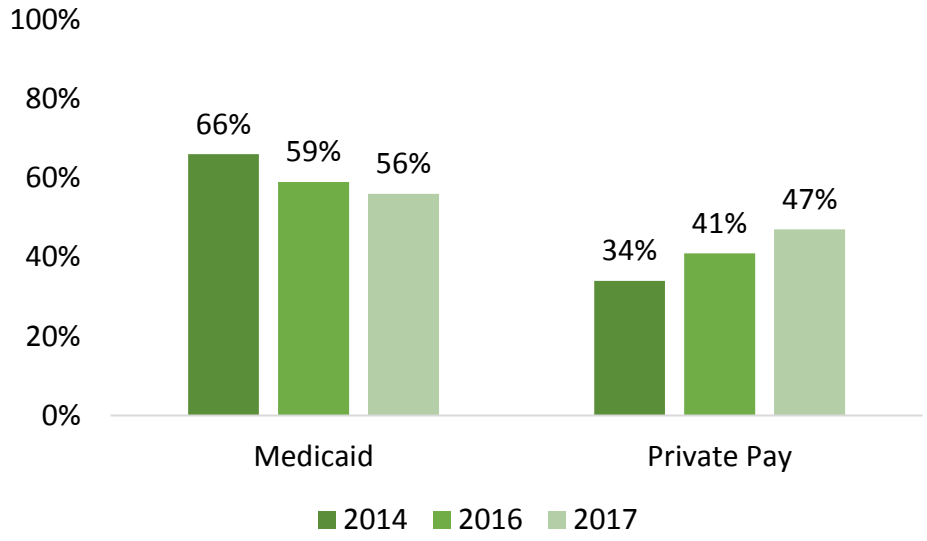
Note: Values are inflation adjusted to December 2016

Changes in Payer Sources over Time

The two main payer sources were Medicaid (56 percent) and residents' personal funds (47 percent of residents). Three percent of providers indicated that residents pay with both Medicaid and personal funds. In total, 51 percent of residents paid using private resources (personal funds plus long-term care insurance). Two percent of current residents received Veteran's Aid and Attendance payments. Other payment sources, accounting for only two percent of residents, included Providence ElderPlace, private foundation funds, worker's compensation, and Social Security disability insurance.

In the 2014-15 report, the share of AFH residents who paid using Medicaid was 66 percent compared to 56 percent this year. The percent of residents who reportedly paid using private resources also changed. The 2014-15 private pay rate was 34 percent compared to 47 percent this year (see Figure 6). **Note that in the 2016 survey this question asked for the *primary* payer source while this year's question asked providers how many residents paid using various payment categories.**

Figure 6. Changes in Percent of Payers using Medicaid or Private Pay over Time, 2014-2017



Additional Private Pay Fees

AFH operators may charge additional fees for certain services (Table 9). AFHs charging additional fees ranged from 27 percent to 68 percent depending on the services provided. Of those that did so, the most commonly reported services for which an additional fee was charged included:

- catheter/colostomy or similar care
- night-time care
- advanced diabetes care
- advanced memory care
- two-person transfer assist

In addition, operators were asked whether they charge additional fees for specific services or deposits. Of the 39 who responded, the three most commonly reported additional fees were for the following:

- Increase or change in ADL care and service needs, chronic conditions, and hospice care
- Increased support for residents' behavioral expressions
- Disregarding house rules including smoking and drug use and distribution

***Table 9*. Services Available and Charged for in AFHs, 2016-2017**

	2016		2017	
	Available % (n)	**Charge % (n)**	**Available % (n)**	**Charge % (n)**
Night-time care	86% (171)	68% (116)	81% (160)	68% (114)
Advanced memory care	68% (134)	72% (97)	69% (135)	58% (90)
Two- or more person transfer assist	68% (133)	72% (97)	51% (99)	54% (70)
Obesity care	41% (82)	46% (38)	25% (48)	27% (26)
Catheter/colostomy	76% (150)	77% (116)	73% (142)	68% (109)
Advanced diabetes care	81% (161)	70% (111)	70% (135)	66% (103)

Medicaid Payment Acceptance and Rates

The majority of responding AFHs— 81 percent—accepted Medicaid as a source of payment for residents. The AFHs that accepted Medicaid reported 67 percent of current residents pay with Medicaid. Thirty-two providers had a Medicaid contract in the past but no longer do. In addition, 91 percent of AFHs that have private-pay residents reported that they would allow a current private-pay resident who spent down their assets to the Medicaid level to stay and pay with Medicaid (if they qualified).

Oregon uses Medicaid funds to pay for AFH services, and other long-term services and supports. Based on information received from DHS in the fall of 2016, 73 percent (1,269) of all AFHs had a contract to accept Medicaid beneficiaries.

Changes in Medicaid Reimbursement Rates over Time

Between 2014 and 2017, inflation-adjusted Medicaid reimbursement rates for AFHs went from $1,918 to $1,937, an increase of $19 in 2016 dollars. Overall, the reimbursement rate kept up with the inflation.

RESIDENTS

Who lives in assisted living, residential care and memory care communities?

Of the 1,259 residents who lived in the responding AFHs, 62 percent were female, 88 percent were White, non-Hispanic, 91 percent single or un-partnered, and 42 percent were 85 years of age or older (see Table 10, and Figure 7). Ages ranged from 22 to 105 years old with an average of 77 years of age. About 21 percent of residents were under 65 years of age. Compared to the last two year's reports, these demographics are nearly unchanged.

Figure 7. **Age Distribution of AFH Residents**

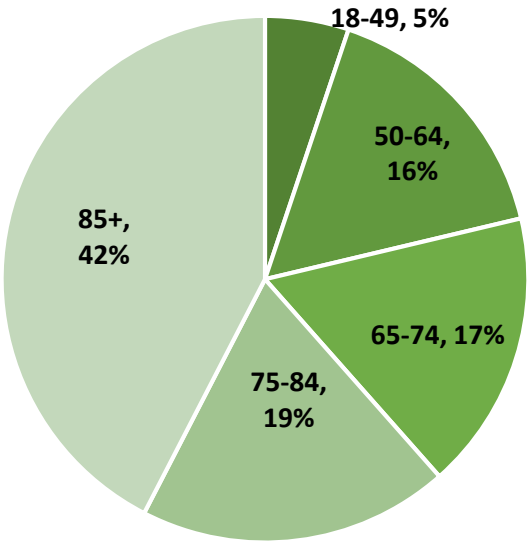


Table 10. **AFH Resident Gender and Age, 2014-2017**

		2014	2016	2017
		% (n)	% (n)	% (n)
Gender				
	Male	37% (305)	34% (409)	38% (340)
	Female	63% (515)	66% (808)	62% (775)
	Transgender	<1% (1)	<1% (1)	-
Age				
	18-49	X	6% (72)	5% (64)
	50-64	X	16% (194)	16% (201)
	65-74	17% (143)	17% (212)	17% (214)
	75-84	22% (181)	18% (222)	19% (238)
	85 and over	38% (314)	42% (512)	42% (528)

Race and Ethnicity of AFH Residents

Although the majority of residents in AFHs were White, non-Hispanic, residents who were Hispanic of any race, Asian or Black each made up two percent of the resident sample (6 percent in total). Other racial or ethnic groups accounted for two percent or less of the resident population (see Table 11).

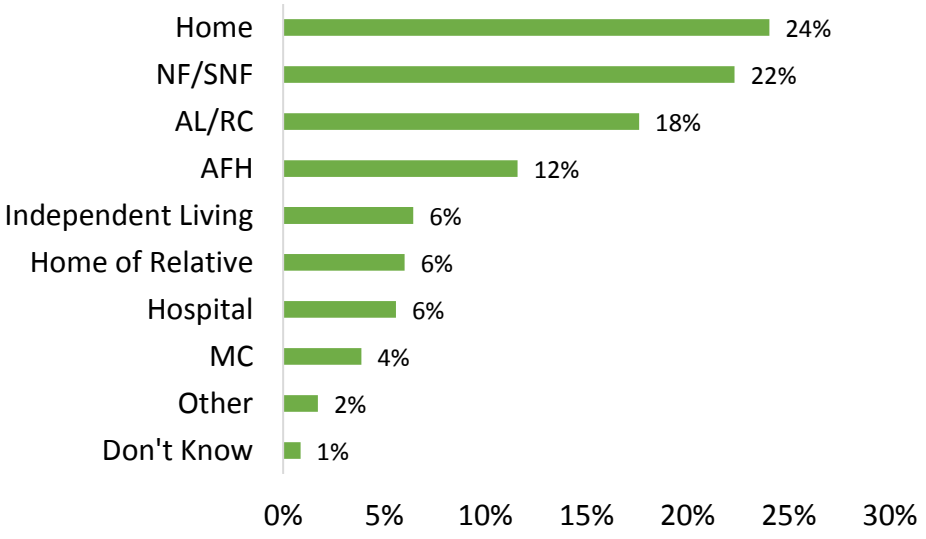
***Table 11*. AFH Resident Demographics, 2014-2017**

	2014	2016	2017
	% (n)	% (n)	% (n)
Hispanic	2% (16)	2% (20)	2% (21)
American Indian/Alaska Native	1% (8)	1% (14)	1% (16)
Asian	2% (15)	2% (24)	2% (24)
Black	2% (15)	2% (28)	2% (28)
Native Hawaiian/Pacific Islander	1% (4)	<1% (5)	1% (9)
White	89% (727)	90% (1,097)	88% (1,114)
Two or more races	1% (8)	1% (15)	1% (16)
Other/unknown	3% (22)	1% (15)	2% (31)

Move-In and Move-Out Locations

AFH operators were asked to describe where residents lived prior to moving into the AFH and the destination of residents who had moved out in the prior 90 days (see Figure 8). The largest percentage of residents moved into their current AFH from their own home (24 percent). Less than 10 percent of residents moved in from each of the following places: independent senior housing, the home of a relative, memory care (MC), or a hospital stay.

***Figure 8*. Resident Location Prior to Move-In**



A total of 169 residents were discharged from their AFH in the prior 90 days. The primary reason for a resident leaving was death (62 percent). This rate is similar to the 2014-15 report, but higher than the rate reported in 2016. Among residents who moved out, most moved to either another AFH (7 percent) or nursing facility (7 percent). As in last year's study, five percent of residents moved out to assisted living or residential care settings (see Table 12).

Table 12. **Resident Move-in and Move-out Locations, 2014-2017**

	2014		2016		2017	
	Move-in % (n)	Move-out % (n)	Move-in % (n)	Move-out % (n)	Move-in % (n)	Move-out % (n)
Home	23% (86)	5% (16)	20% (50)	8% (8)	24% (56)	4% (7)
Home of Relative	10% (38)	5% (17)	13% (33)	4% (4)	6% (14)	2% (3)
Independent Living	X	X	8% (21)	2% (2)	6% (15)	2% (3)
AL/RC	24% (89)	9% (28)	13% (33)	5% (5)	18% (41)	5% (9)
MC	X	X	2% (5)	4% (4)	4% (9)	6% (10)
Hospital	7% (27)	4% (13)	7% (18)	3% (3)	6% (13)	4% (7)
AFH	17% (63)	10% (30)	16% (40)	10% (10)	12% (27)	7% (12)
NF	16% (61)	5% (17)	18% (44)	5% (5)	22% (52)	7% (11)
Other	3% (13)	2% (5)	2% (5)	2% (2)	2% (4)	1% (2)
Died	-	59% (187)	-	49% (48)	-	62% (105)
Don't Know	-	-	<1% (1)	7% (7)	1% (2)	-

Length of Stay over Time

A variety of factors can effect a resident's length of stay in an AFH including changes in health care needs or informal caregiver availability, and personal preferences. Providers were asked to indicate the length of stay of all residents who moved out in the prior 90 days. Most residents had stayed for less than one year (56 percent). Stays of 30 days or less accounted for about 19 percent of moves, and stays of 90 days or less accounted for 32 percent of all moves (Table 13).

Adult foster homes may provide planned short-stay respite care to individuals who are recovering from a health-related circumstance or whose caregiver is temporarily unavailable. Overall, providers reported that 13 percent of residents who moved out in the prior 90 days were there for a planned short-stay (not shown in table).

Table 13. **Length of Stay among Residents moving out in the Prior 90 days, 2016-2017**

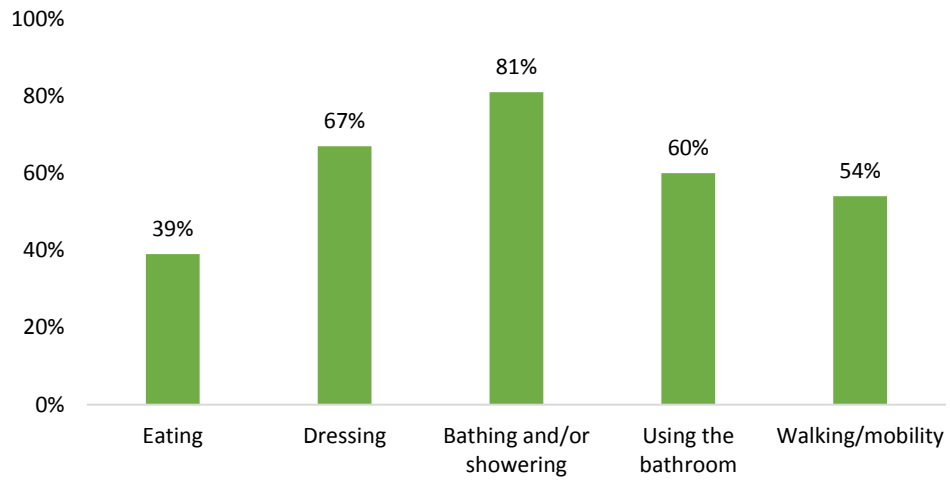
	2016	2017
	% (n)	% (n)
1 - 7 days	5% (5)	6% (10)
8 - 13 days	2% (2)	2% (3)
14 - 30 days	5% (5)	11% (18)
31 - 90 days	18% (17)	13% (22)
3 - 6 months	18% (17)	12% (19)
6 - 12 months	14% (13)	12% (20)
1 - 2 years	15% (14)	16% (26)
2 - 4 years	9% (9)	17% (28)
4 or more years	15% (14)	12% (19)
Total	96	165

Personal Care Needs

Personal care needs include ADLs and other self-care activities that adults need to function in daily life, such as eating, transferring from a bed to chair, dressing, bathing, using the bathroom, support with incontinence, and mobility. Among Oregon AFHs, over half required assistance with dressing, using the bathroom, and walking/mobility. More than three-quarters of AFH residents required staff assistance with bathing. (see Figure 9).

Over half of AFH residents required either full or standby assistance with eating, dressing, using the bathroom and walking/mobility.

Figure 9**. Percentages of AFH Residents Requiring Staff Assistance with ADLs**



Seventy-two percent of AFH residents used a mobility aid such as a walker or wheelchair, and of these, 41 percent received staff assistance to use a mobility aid (not shown in table).

Intensive Assistance: Behavioral Health, Two-Person Assistance, and Nighttime Care

Some residents need additional staff support because of their conditions or personal preferences. Providers were asked how many of their current residents regularly received staff assistance for three common behavioral symptoms associated with dementia: impaired cognition and/or emotional distress (including lack of awareness of safety concerns, poor judgement or decision making, or the inability to orient to surroundings), wandering, and danger to self or others (e.g. aggressive or abusive). Of residents with these behavioral conditions, 44 percent received staff assistance with cognitive/emotional issues, 9 percent because they were a danger to self or others, and eight percent because of wandering.

In addition, providers were asked how many residents needed two-person assistance with physical and/or cognitive health needs on a regular basis, and 18 percent of residents were reported to need this assistance. Reasons given for two-person assistance were listed by 122 providers, who gave 189 reasons:

The top four responses were:

1. Transferring, positioning of bed bound and immobile residents, assisting large individuals and those at risk of falling (57 percent)
2. Supporting those with combative behavioral expressions (12 percent)
3. Assisting with ADLs such as bathing and toileting (11 percent)
4. Caring for residents with chronic illness such as stroke, Parkinson's disease, or paralysis (11 percent).

Oregon requires AFHs to have a caregiver available and awake if necessary to meet the care and service needs of the residents 24 hours per day (ORS 411-050-0645). Providers indicated that 27 percent of residents received assistance from the night shift staff (e.g., 11 pm to 6 am).

Visits from Friends and Family

Maintaining strong family ties is important to older adults (Connidis, 2010). According to the Centers for Disease Control (CDC), social ties, including family ties, are one of the strongest predictors of well-being for adults age 65 and older (CDC, 2017). To understand whether residents living in AFHs remained connected to loved ones, providers were asked how many residents had family or friends call or visit at least once per month and most (82 percent) did. Most residents have social visits from family members or friends (64 percent), and over half have phone contact (56 percent). Fewer than half (48 percent) go on outings with family or friends (i.e. on walks, shopping, or eating meals out).

Assistance from Family Members and Friends

In addition to providing social support, AFH residents might receive personal care from relatives, and for some residents, a family member serves as a legal representative (OR 411-050-0602).

Providers were asked whether residents regularly receive certain types of assistance from their family members and friends. Thirty seven percent of residents were reported to have family members take them to medical appointments. Very few get help taking medications (seven percent), or are assisted with personal care such as eating, dressing, bathing and grooming (six percent).

Resident Health & Health Service Use

Older persons are likely to have one or more chronic conditions that affect their ability to be independent (Federal Interagency Forum on Aging-Related Statistics, 2012). The five most common chronic conditions in AFHs were hypertension, Alzheimer's disease or other dementias, depression, heart disease, and arthritis (see Table 14).

Table 14. **Chronic Conditions**

	%
High Blood Pressure/ Hypertension	50%
Alzheimer's/dementia	47%
Depression	42%
Heart disease	37%
Arthritis	37%
Diabetes	19%
Intellectual/developmental disability	19%
Osteoporosis	17%
COPD	16%
Serious mental illness	15%
Cancer	8%
Traumatic brain injury	7%
Drug and/or alcohol abuse	3%

Some of these health conditions can be compared to rates in the general population in Oregon based on data from the Behavioral Risk Factor Surveillance system (BRFSS, 2015).The prevalence of depression and heart disease among AFH residents (42 percent and 37 percent, respectively) was double the rates in the general population of adults aged 65 and older in Oregon (20 percent and 16 percent, respectively). Sixteen percent of AFH resident experienced COPD compared to 10 percent of Oregonians age 65 and older. Half of AFH residents had an arthritis diagnosis compared to 57 percent of the general population of older Oregonians, and the rate of diabetes in AFH residents (19 percent) was similar to the general population of older adults in Oregon (21 percent).

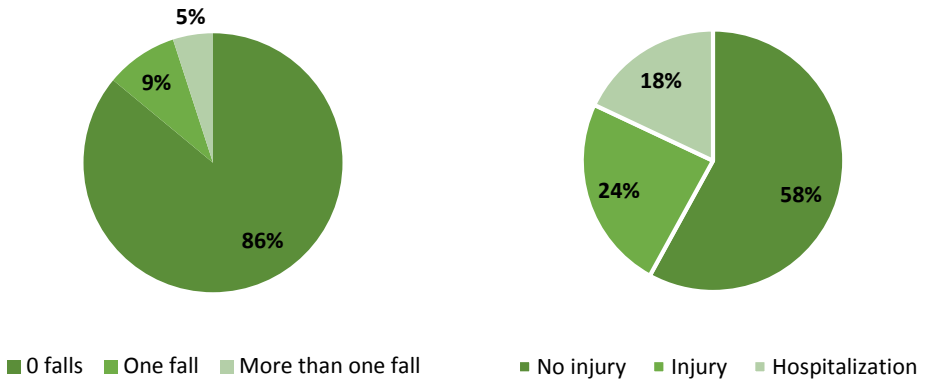
Resident Falls

Falls among older persons are a significant public health concern. Each year, 1.6 million older adults in the U.S. are treated in emergency departments for falls-related injuries and falls are the primary cause of fractures, hospital admissions, loss of independence, injury, and death for the elderly (NIH, 2017). In 2015, Medicare costs associated with falls totaled over $31 billion (CDC, 2017).

Most AFH residents did not fall in the prior 90 days – 86 percent had zero falls. Nine percent of residents had one fall and 5 percent had more than one fall in the prior 90 days (Figure 10). Similarily, last year's report found that 15 percent of AFH residents had at least one fall in the past 90 days. In 2014 providers were asked if a resident had a fall in the past 30 days and 11 percent did.

Of the AFH residents who fell, 24 percent experienced a fall that resulted in an injury and 18 percent had a fall that resulted in hospitalization (Figure 11). These rates are similar to the 2016 report which found that 20 percent of resident falls resulted in injury and 13 percent resulted in hospitalization. This question was not asked in 2014-15.

***Figures 10 & 11* – Falls in Prior 90 days and Falls Resulting in Injury or Hospitalization**



Health Service Use

Health service use includes hospital stays, emergency room visits, hospice services, and behavioral health services. Eight percent of AFH residents had been discharged from an overnight hospital stay in the prior 90 days, which is the same rate as a study of long-term services and supports users that included nursing facilities, residential care, home health, and hospice (Harris-Kojetin et al., 2016). Of the residents who were hospitalized, providers indicated that 24 percent returned to the hospital in 30 days. Avoiding rehospitalizations is a quality indicator in other settings, including assisted living and nursing facilities (NCAL, 2016).

AFH providers reported that 14 percent of residents had been treated in a hospital emergency room in the prior 90 days, which is slightly higher than the national average of 12 percent among LTSS users (Harris-Kojetin et al., 2016). Just eight percent of AFH residents were reported to have been discharged from an overnight hospital stay. A total of 10 percent of AFH residents received hospice care (see Table 15).

Table 15. **Health Service Use Among Residents, 2016-2017**

	2016	2017
	% (n)	% (n)
Treated in hospital ER	14% (170)	14% (172)
Discharged from overnight hospital stay	6% (76)	8% (103)
Went back to the hospital within 30 days	X	24% (22)
Received hospice care	10% (120)	10% (116)

Assistance with Medications and Treatments

Oregon AFHs provide medication administration to residents who need or request this assistance. Only two percent of residents take no medications or injections, while seventy-five percent received staff assistance to take oral medications. Nine percent received staff assistance with injection medications, two percent received injections from a licensed nurse, and eleven percent received other types of nurse treatments from a licensed nurse (see Table 16). Use of nurse treatments can be an indicator of resident acuity (Beeber, et al., 2014).

Table 16. **Assistance with Medications and Treatments, 2016-2017**

	2016	2017
	% (n)	% (n)
No medications/injections	2% (35)	2% (20)
Nine or more medications	54% (659)	53% (658)
Antipsychotic medications	34% (419)	35% (435)
Self-administer medications	5% (65)	5% (68)
Receive assistance for oral medications	80% (970)	75% (929)
Receive assistance with injection medications	11% (137)	9% (108)
Receive injections from a licensed nurse	2% (24)	2% (26)
Receive nurse treatment from a licensed nurse	8% (95)	11% (131)
Total	1,218	1,237

Multiple Medications

Taking multiple medications presents possible risks of adverse health effects (Maher, Hanlon, & Hajjar, 2014). Nursing facility studies show that patients who are prescribed nine or more medications are at a higher risk of hospitalization (Gurwitz et al., 2005). The Centers for Medicare and Medicaid Services uses clinical management of nine or more medications as a quality indicator to assess health and health risks of nursing facility residents (CMS, 2013). Among Oregon AFHs, 53 percent of residents took nine or more medications.

Antipsychotic Medication Use

Antipsychotic medications are sometimes prescribed to treat behavior associated with dementia, but this practice is not supported clinically and is considered off-label by the Food and Drug Administration (CMS, 2015; FDA, 2008). The Oregon DHS Ensuring Quality Care (EQC) Tools and Resources website has information about the inappropriate use of antipsychotic medications in older persons. In addition, the National Center for Assisted Living's (NCAL) quality initiative could be applied to AFH settings. The NCAL has a goal of reducing antipsychotic medication use in AL settings by 15 percent or achieving a low off-label usage rate of five percent (NCAL, 2015).

Antipsychotic medications were used by 35 percent of AFH residents compared to the national rate of 19 percent among nursing home residents (CMS, 2014). This rate must be viewed with caution because we lack information about the types of antipsychotic medications in use, whether they are prescribed routinely or on an as-needed basis, and the reasons that these medications are prescribed.

Behavioral Health Services

Oregon Aging and People with Disabilities may provide behavioral health services, including mental health treatment or addiction services, to persons who have severe and persistent mental illness in nursing and residential care communities. Case managers, long-term care ombudsman, and other Oregon DHS support service staff assess service level needs, offer service choices, authorize, and respond to the need for protection from abuse (OAR 411-028-0010). DHS provides older adult behavioral health specialists to coordinate service providers and services, consult on difficult or complex cases, and assist with planning and problem solving on behalf of those in need of services (DHS, OHA, 2015).

Providers reported that 12 percent of residents received assistance from a State or County behavioral health specialist or other service providers.

POLICY CONSIDERATIONS AND CONCLUSIONS

This is the third statewide survey of adult foster homes. The people who live and work in these settings provide and coordinate long-term services and supports to individuals who have chronic health conditions and physical and cognitive impairments that limit their ability to manage daily personal care and health-related needs. In addition, AFHs provide a family-style residential alternative to nursing facilities, assisted living, and residential care communities. The majority of providers live in their AFH (85 percent), and 65 percent have family members living in the home.

Based on findings from both the current and prior studies, the following topics may deserve additional policy discussions:

- The number of AFHs increased from 1,692 in 2016, to 1,740 in 2017. However, most AFHs were operating below capacity, with only 49 percent of homes certified for five residents at capacity, and 30 percent of homes certified for four residents at capacity.
- The majority of residents who exited had lengths of stay less than one year based on the current and prior report. This year, 19 percent of residents stayed less than 30 days, compared to 12 percent last year. Yet only 13 percent of AFHs indicated that recent movers were there for a planned short-term stay. More information is needed to assess the potential reasons for short stays and the impact of these stays on resident well-being.
- Having visitors is important for resident's quality of life. The majority of residents (82 percent) received a monthly visit from a friend or family member.
- Taking nine or more medications may affect older adults' quality of life and quality of care. Because over half of AFH residents take nine or more medications, reducing many multiple medications should remain a policy goal.
- The rate of antipsychotic medication prescriptions, at 35 percent, should be reviewed. AFH providers as well as prescribers and pharmacists need information on the risks and benefits of antipsychotic medication use in older persons.
- The percent of residents who had a fall remained unchanged in the past two years. Sixty percent of AFHs use a falls risk assessment tool.
- Just under half of AFH residents had dementia, and 72 percent of providers indicated they had received dementia care training in the prior year. However, only 27 percent use a cognitive impairment screening tool.
- Nearly one quarter of residents who were hospitalized were re-hospitalized within 30 days. Returning to the hospital is difficult for older persons and is costly to health insurers. More information about reasons for hospital use in this population is needed.

- Adult foster home providers indicate that physicians lack an understanding of AFHs, including state requirements for paperwork that physicians need to sign. DHS might consider creating a fact sheet for physicians.
- The response rate of 52 percent was a challenge to achieve, requiring multiple telephone calls to AFH providers. We heard from AFH providers who were overburdened with paperwork, and some questioned why the state needs, or even has the right, to request the information described in this report. DHS could clarify whether AFH operators are required to complete the questionnaire.

Appendix A: Methods

Data Collection Instrument - Questionnaire

This report represents the third year of data collection from adult foster homes in Oregon.

The questionnaire was developed in partnership with stakeholders from:

- DHS, Division of Aging and People with Disabilities,
- Oregon Health Care Association (OHCA)
- Service Employees International Union Local 503

Questionnaire topics included information about home settings and policies, resident demographics, personal care needs, resident acuity, staffing, flu vaccination, and payment information, such as rates, fees, and services.

Sample Selection and Survey Implementation

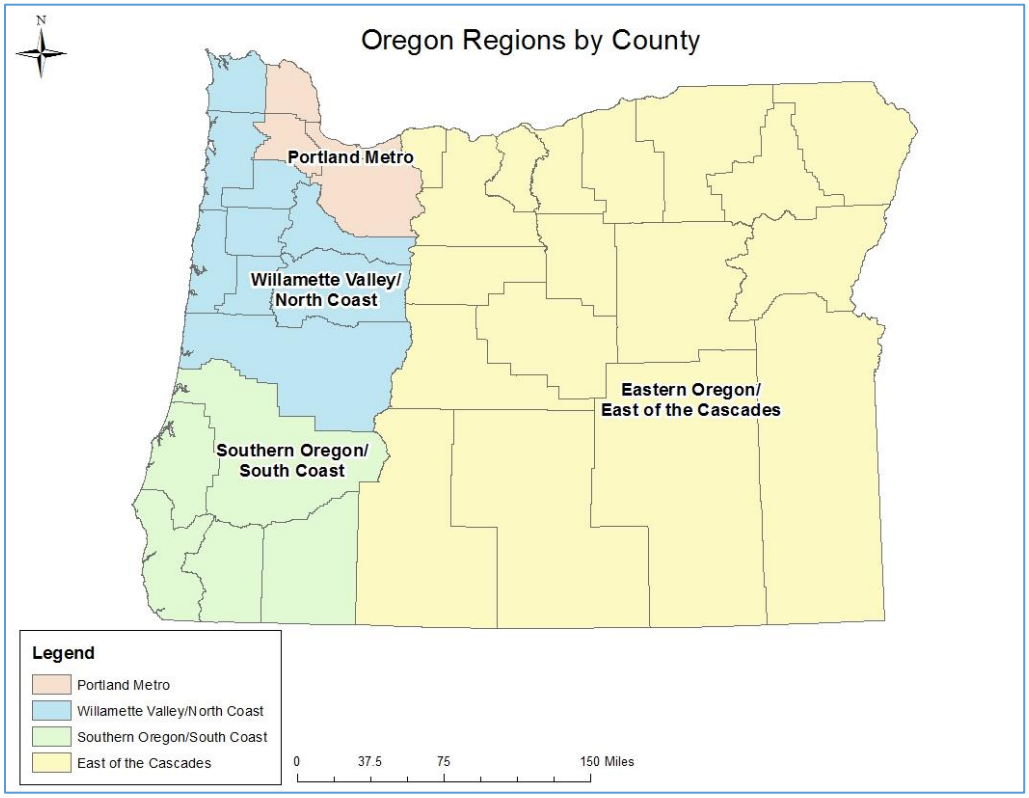
The population of licensed adult foster homes in Oregon as of December 2016 totaled 1,740 statewide. To achieve a sample size to sufficiently represent simple proportions drawn from this population assuming most conservative response distribution (p = .50), the minimum number of completed surveys required to achieve 95% confidence and +/- 5% margin of error was calculated to be 315 AFHs. Assuming previous year's response rates by region to account for non-response, we selected a sample of 650 AFHs. To select a sample that would be representative of AFHs throughout the state, we aggregated counties into four regions (see Table A.1) and calculated the number needed from each region to create a proportionate sample by region.

A questionnaire was mailed to each AFH in the sample in Juanuay 2017. AFH providers were asked to complete the questionnaire and return it to PSU's Institute on Aging (IOA) via fax, scan and email, or US postal service. Providers were also given the option of completing the questionnaire over the phone, which 31 respondents did. Completed questionnaires were checked for missing information or inconsistencies and follow up calls were made to providers for clarification when needed. Follow-up calls were made to providers to encourage a favorable response rate. During the follow-up calls, if AFHs reported they threw away, never received, or did not know the whereabouts of the questionnaire, we re-sent a new questionnaire to the AFH. Data were entered into a database by IOA staff.

Table A.1. **Regional Distribution of Sample and Response**

	Population % (n)	Sample Population % (n)	Respondents % (n)	Response Rate % (n)
Region 1: Portland Metro	49% (856)	52% (337)	51% (174)	52% (174)
Region 2: Willamette Valley/North Coast	25% (431)	24% (154)	22% (74)	48% (74)
Region 3: Southern Oregon/South Coast	16% (279)	15% (99)	18% (62)	63% (62)
Region 4: East of the Cascades	10% (174)	9% (60)	9% (30)	50% (30)
Total	1,740	650	340	52% (340)

Figure A1. **Oregon Regions by County**



Survey Response

A total of 340 AFHs responded, for a response rate of 52 percent. See Table A1 for details about responses to the questionnaire by region. The region with the highest concentration of AFHs was the Portland Metro region, while the East of the Cascades had the fewest. The highest percentage of respondents was from Southern Oregon/South Coast, while the lowest percentage was from the Willamette Valley/North Coast region. Overall, respondents reflected the distribution of AFHs across Oregon by region.

Non-Response

A total of 310 AFHs from the sample did not respond to the questionnaire. Reasons given for non-response included that response was not mandatory, the licensee was not comfortable sharing information about their homes or residents, and too busy.

In addition to the AFHs who did not respond, some providers returned questionnaires that were incomplete. This is common for self-administered surveys. Although all providers were called multiple times to request such missing information, we were not able to retrieve all missing information for all facilities.

Data Analysis

Quantitative data were entered into SPSS (a statistical software program) and checked for errors using multiple strategies. First, we spot-checked a subsample of questionnaires for potential data entry errors. Second, we used frequencies to eliminate errors due to coding mistakes. Finally, we applied logic checks for skip patterns and outliers. Data analysis involved descriptive statistics (frequencies, percentages, and means) and cross-tabulations.

Appendix B: References

Alzheimer's Association. (2017a). *Diagnosis of Alzheimer's disease and dementia.* Retrieved from http://www.alz.org/alzheimers_disease_diagnosis.asp

Alzheimer's Association. (2017b). *2017 Alzheimer's disease facts and figures.* [Fact sheet]. Retrieved from http://www.alz.org/facts/overview.asp

Beeber, A. S., Zimmerman, S., Reed, D., Mitchell, C. M., Sloane, P. D., Harris-Wallace, B., & Schumacher, J. G. (2014). Licensed nurse staffing and health service availability in residential care and assisted living. *Journal of the American Geriatrics Society, 62(5)*, 805-811.

Behavioral Risk Factor Surveillance System. (2015). *BRFSS Prevalence & Trends Data*. Retrieved from: https://www.cdc.gov/brfss/brfssprevalence/

Carder, P., O'Keeffe, J., & O'Keeffe, C. (2015). *Compendium of residential care and assisted living regulations and policy: 2015 edition.* U.S. Department of Health and Human Services. Retrieved from https://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition

CDC (Centers for Disease Control and Prevention). (2015b). BRFSS Prevalence & Trends Data. Retrieved from: http://wwwdev.cdc.gov/brfss/brfssprevalence/.

CDC (Centers for Disease Control and Prevention). (2016). *Health-related quality of life: Well-being concepts.* Retrieved from https://www.cdc.gov/hrqol/wellbeing.htm

CMS (Centers for Medicare & Medicaid Services). (2015). *Atypical antipsychotic medications: use in adults*. Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Pharmacy-Education-Materials/Downloads/atyp-antipsych-adult-factsheet11-14.pdf

CMS (Centers for Medicare & Medicaid Use). (2014). *Partnership to Improve Dementia Care in Nursing Homes. Antipsychotic Drug use in Nursing Homes Trend Update.* Retrieved from: https://www.cms.gov/Medicare/Provider...and.../AntipsychoticMedicationQM.pdf

Connidis, I. (2010). Family Ties and Aging. Thousand Oaks, CA, Pine Forge Press.

Dwyer, L.L. Han., B., Woodwell, D.A., & Rechtsteiner, E.A., (2010). Polypharmacy in nursing home residents in the United States: Results of the 2004 National Nursing Home Survey. *American Journal of Geriatric Pharmacotherapy, 8(1),* 63-72.

Federal Interagency Forum on Aging-Related Statistics. (2012). Older Americans 2012: Key Indicators of Well-Being. *Federal Interagency Forum on Aging-Related Statistics.* Washington, DC: U.S. Government Printing Office.

FDA (Food and Drug Administration). (2008). FDA requests black box warnings on older class of antipsychotic drugs. Retrieved from http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2008/ucm116912.htm

Gurwitz, J., Field, T., Judge, J., Rochon, P., et al. (2005). The incidence of adverse drug events in two large academic long-term care facilities. *American Journal of Medicine, 118(3),* 251-258.

Harris-Kojetin L., Sengupta M., Park-Lee E., et al. (2016). Long-term care providers and services users in the United States: Data from the National Study of Long-Term Care Providers, 2013–2014. National Center for Health Statistics. *Vital Health Stat 3(38).*

Hedrick, S. C., Sullivan, J. H., Sales, A. B., & Gray, S. L. (2009). Mom and Pop Versus the Big Boys: Adult Family Homes as Providers of Medicaid-Funded Residential Care. *Journal Of Aging & Social Policy, 21(1),* 31-51.

Khatutsky G., Ormond C., Wiener J.M., Greene A.M., Johnson R., Jessup E.A., Vreeland E., Sengupta M., Caffrey C., & Harris-Kojetin L. (2016). Residential care communities and their residents in 2010: A national portrait. DHHS Publication No. 2016-1041. Hyattsville, MD: National Center for Health Statistics.

Maher R.L., Hanlon J., Hajjar E.R. (2014). Clinical consequences of polypharmacy in elderly. *Expert Opinions in Drug Safety 13*, 57-65.

Multnomah County, Aging and Disability Services Department. (2011). Adult care home program administrative rules for the licensure and regulations of adult care homes. Retrieved from http://multoco.us/file/17882/download.

NCAL (National Center for Assisted Living). (2015*). The quality initiative for assisted living.* Retrieved from https://www.ahcancal.org/ncal/quality/qualityinitiative/Pages/default.aspx

Oliver, D., Healy, F., & Haines, T.P. (2010). Preventing falls and fall-related injuries in hospitals. *Clinical Geriatric Medicine, 26(4),* 645-692.

Oregon Department of Human Services, Resources for Aging and People with Disabilities. (2016). Oregon adult foster home administrative rules and revised statues for seniors and adults with physical disabilities. Retrieved from http://www.oregon.gov/dhs/spd/pages/provtools/AFH-apd/rules.aspx

United States Census Bureau. (2012). 2012 national population projections: Summary tables. Retrieved from http://www.census.gov/population/projections/data/national/2012/summarytables.html.

Zimmerman, S., Love, K., Sloane, P., Reed, D., Cohen, L., & Carder, P.C. (2011). Medication administration errors in assisted living. *Journal of the American Geriatrics Society, 59*, 1060-1068.

Zuckerbraun, S., Wiener, J., Eicheldinger, C., McGinn-Shapiro, M., Porter, K., Dai, L., Williams, J. (2015, January). Wages, fringe benefits, and turnover among direct care workers employed by long-term care providers in Oregon. Research Triangle Park: NC. RTI International. Retrieved from http://www.oregon.gov/dhs/aboutdhs/dhsbudget/20152017%20Budget/Oregon%20Final%20Direct%20Care%20Wage%20Report%20to%20DHS.pdf

Appendix C: Survey Instrument

Portland State UNIVERSITY
Institute on Aging

DHS Oregon Department of Human Services

Adult Foster Homes

Oregon Community Based Care
2017 Resident & Community Characteristics Questionnaire

License # _____ Adult Foster Home's Phone # _____

Name of Home (if applicable)

_____

Address of Adult Foster Home

_____City_____State_____Zip_____

Owner/Operator Name

Department of Human Services requires adult foster homes to complete this questionnaire.

Please return your completed questionnaire to PSU by February 28, 2017.

Once complete, please choose one of the following to return the questionnaire:

1. Scan and email to: cbcor@pdx.edu
   (Be sure to include both sides of paper, if printed double-sided)
2. Fax to: 503.725.9927
   (Be sure to include both sides of paper, if printed double-sided)
3. Mail to: CBC Project - Institute on Aging
   Portland State University
   PO BOX 751
   Portland, Oregon 97207

If you would prefer to **complete the questionnaire over the phone**, please email or call Sarah at: sdys@pdx.edu or 503.725.9252.

If you have questions concerning completing this questionnaire, please contact: Sheryl Elliott at cbcor@pdx.edu or 503.725.2130

Oregon Department of Human Services (DHS) **requires adult foster homes to complete the questionnaire** because it is an important way for DHS to collect information about residents.

PSU does not publish or share responses from individual Adult Foster Homes. DHS receives a summary report posted on these websites: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/Pages/publications.aspx & https://www.pdx.edu/ioa/oregon-community-based-care-project

Instructions:

First, write your home's license number and other information on page 1, then go to page 3.

We expect that the owner/operator will complete this questionnaire. If you operate more than one adult foster home, complete the questionnaire only for the license number and address on the envelope.

Some questions ask about "staff" who work at your home—this means anyone who is paid by you to provide services, such as caregivers, resident managers, and your family members who serve as qualified caregivers.

For some questions, you might need to look at information in current resident files and provide a total for all residents.

Most questions ask you to write the number based on your current residents, in a box like this: **4**

Please provide your best answer for each question. For boxes like the one above, if the answer is "none" or "0", please write "0". If the question does not apply to your home, please write "N/A."

Some questions ask you to check a box like this: ☒

We appreciate your time and the work that you do on behalf of older adults and persons with disabilities. The study results will be most accurate if everyone participates. We look forward to hearing from you by **February 28, 2017**.

Section A. Resident Information

1. How many of your current residents are:

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ **TOTAL # OF CURRENT RESIDENTS**

2. How many of your current residents are:
[Please count each resident only once.]

- ☐ Hispanic/Latino (any race)
- ☐ American Indian or Alaska Native, not Hispanic or Latino
- ☐ Asian, not Hispanic or Latino
- ☐ Black, not Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander, not Hispanic or Latino
- ☐ White, not Hispanic or Latino
- ☐ Two or more races
- ☐ Other/unknown/or resident would most likely choose not to answer
- ☐ **TOTAL *[Should match total in question #1.]***

3. What is the age of each of your current residents?

- ☐ Resident 1
- ☐ Resident 2
- ☐ Resident 3
- ☐ Resident 4
- ☐ Resident 5

4. During 2016, how many residents had family or friends call or visit at least once per month?

- ☐ Number of residents [*Write 0 if none*]

5. In the **past 90 days**, how many new residents moved in (*for the first time*) from the following places? *[If no new residents in past 90 days, write "N/A".]*

# of residents	**Moved in from:**
	Home *(alone or with spouse or partner)*
	Home of child, other relative
	Independent living apartment in senior housing
	Assisted living/residential care
	Memory care facility
	Hospital
	Adult foster care
	Nursing facility (NF) or Skilled nursing facility (SNF)
	Other, specify:
	Don't know
	TOTAL new residents, past 90 days

Thank you for taking the time to complete this questionnaire.

6. In the **past 90 days**, how many residents moved out (*permanently*) to the following places, or died?

➔ If no residents moved out in past 90 days, write "N/A" and **SKIP to question #9**.

# of residents	Moved out to:
	Home *(alone or with spouse or partner)*
	Home of child, other relative
	Independent living apartment in senior housing
	Assisted living/residential care
	Memory care facility
	Hospital
	Adult foster care
	Nursing facility (NF) or Skilled nursing facility (SNF)
	Other, specify:
	Resident died
	Don't know
	TOTAL Residents who moved out, past 90 days

7. For the residents who moved out in the past 90 days what was the length of stay for each resident?

# of residents	Length of Stay
	1 - 7 days
	8 - 13 days
	14 - 30 days
	31 - 90 days
	91 - 180 days (*3-6 months*)
	181 days - 1 year (*6-12 months*)
	More than 1 but less than 2 years
	More than 2 but less than 4 years
	More than 4 years
	TOTAL *[Should match total in question #6 above]*

8. Of the residents who moved out in the past 90 days, how many were in your home for a planned short-stay (*respite or similar care*)?

☐ Number of residents [*Write 0 if none*]

9. Did any residents receive a move-out notice in the ***last year*** for any of the following reasons? *[Check all that apply.]*

☐ Two-person transfer

☐ Wandering outside

☐ Sliding-scale insulin shots

☐ Hitting/acting out with anger to other residents or staff

☐ Lease violation

☐ Non-payment

☐ None

☐ Other – please explain: _____

_____

Section B. Resident Health, Acuity & Service Use

10. During the past 90 days, how many residents were in the following categories?

☐ Residents with 0 (zero) falls

☐ Residents who fell one time

☐ Residents who fell more than once

☐ **TOTAL** *[Should match total in question #1.]*

➔ If no residents fell during the past 90 days, **SKIP to 12**

Thank you for taking the time to complete this questionnaire.

11. Of the residents who fell in the past 90 days:

a. How many had a fall resulting in some kind of injury?

☐ Number of residents

b. How many residents went to the hospital (*emergency room or admitted*) because of the fall?

☐ Number of residents

12. Does your home assess a resident's risk for falling using a fall risk assessment? *[Examples include Stopping Elderly Accidents, Deaths, & Injuries (STEADI) and Timed Up and GO (TUG)]*

☐ Yes, as a standard practice with every resident
☐ Yes, only case-by-case depending on each resident
☐ No
☐ Don't know

13. How many of your current residents that have been assessed for fall risk <u>*did not fall*</u> in the last 90 days?

☐ Number of residents

14. Do you use a standard tool for assessing cognitive impairment? *[Examples: The General Practitioner Assessment of Cognition (GPCOG), the Mini-Cog, the Mini-Mental State Examinations (MMSE)]*

☐ Yes ☐ No

15. How many of your current residents regularly use a mobility aid [*e.g., cane, walker, wheelchair*] to get around?

☐ Number of residents

16. How many of your current residents need staff assistance to use a mobility aid?

☐ Number of residents

17. How many of your current residents have been ***<u>DIAGNOSED</u>*** with each of the following conditions? *[Include all diagnoses for each resident even if controlled by diet, medication or other treatment. Enter "0" for any categories with no residents.]*

☐ Heart disease (*e.g., congestive heart failure, coronary or ischemic heart disease, heart attack, stroke*)

☐ Alzheimer's disease and other dementias

☐ High blood pressure/hypertension

☐ Depression

☐ Serious mental health illness (*such as bipolar disorder, schizophrenia*)

☐ Diabetes

☐ Cancer

☐ Osteoporosis

☐ COPD and allied conditions

☐ Current drug and/or alcohol abuse

☐ Intellectual/developmental disability

☐ Arthritis

☐ Traumatic brain injury

Thank you for taking the time to complete this questionnaire.

18. How many of your current residents were:

☐ Treated in a hospital emergency room (ER) in the last 90 days?

☐ Hospitalized overnight in the last 90 days? *[Exclude trips to ER that did not result in an overnight hospital stay.]*

→ ☐ How many of these residents went back to the hospital within 30 days?

☐ Receiving hospice care in the last 90 days?

19. How many of your current residents regularly receive staff assistance because of the following behavioral symptoms:

☐ Lack of awareness of safety concerns, or poor judgment, decision making, or inability to orient to surroundings

☐ Wandering

☐ Is a danger to self or others [*disruptive, aggressive, abusive, sexually inappropriate*]

20. How many current residents regularly receive assistance from NOC (*night shift*) staff during the night (*for example, from 11 pm to 6 am*)?

☐ Number of Residents

21. How many current residents regularly receive assistance for physical and/or cognitive health needs from two staff?

☐ Number of Residents

21a. Please describe reasons for two-person assistance:

_____

_____

22. How many of your current residents need regular and ongoing staff assistance with each of the following:

ADL	# Full assist	# Standby	Total # (both)
Eating			
Dressing			
Bathing & grooming			
Using the bathroom			
Mobility/Walking			

23. How many of your current residents regularly receive any of the following from their family member(s) or friend(s):

	# residents
Help with personal care such as eating, dressing, bathing & grooming, using the bathroom, or mobility & walking	
Help taking medications	
Help getting to medical appointments	
Social visits	
Phone calls	
Going on outings *[i.e., meals, walks, shopping, activities]*	

24. **In the past 90 days**, how many of your current residents received assistance with behavioral health symptoms [*e.g. mental health treatment, addiction services*] from a State or County behavioral health specialist or other service provider?

☐ Number of residents (*Write 0 if none, DK if don't know*)

Thank you for taking the time to complete this questionnaire.

25. How many of your current residents take ***no*** medications and ***no*** injections?

☐ Number of residents [*Write 0 if none*]

26. For each item below, please write the number of current residents [*write 0 if none*] who…

☐ Take 9 or more medications

☐ Take antipsychotic medication *[Common examples: Haldol (Haloperidol); Quetiapine (Seroquel), Olanzapine (Zyprexa), Ariprazole (Abilify), Risperidone (Risperdal).]*

☐ Self-administer most of their medications

☐ Receive staff assistance to take oral medications

☐ Receive staff assistance with subcutaneous injection medications

☐ Receive injections from a licensed nurse

☐ Receive nurse treatments from a licensed nurse *[Common examples: oxygen and respiratory treatments, such as nebulizers; rectal medications; suctioning mouth with bulb syringes; wound care, such as staging pressure ulcers & dressing changes]*

Section C.
About You: Adult Foster Home Owner/ Licensee

27. How many years have you (*owner/licensee*) been a licensed AFH operator?

_____years

28. Do you have any of the following certifications?

☐ CNA ☐ LPN/LVN

☐ RN ☐ Respiratory Therapist

☐ MSW ☐ None

☐ Other: _____

Section D. Household Characteristics & Staffing

29. How many residents are you licensed to care for?

☐ Number of residents

30. What is the ***highest*** class level that your home is licensed to provide for any current resident?

☐ Class 1

☐ Class 2

☐ Class 3

☐ Other: _____

31. Do you live at this adult foster home?

☐ Yes

☐ No

Thank you for taking the time to complete this questionnaire.

32. How many of your family members (*e.g., spouse, children*) ***who are not residents***:

☐ Live at this address?

☐ Are 17 or younger

☐ Are 18 or older?

[*If none write 0*]

33. Do you currently care for an elderly or disabled ***relative*** in your adult foster home?

☐ Yes → **How many?** ☐

☐ No

34. Does your home currently employ a resident manager?

☐ Yes → **continue to question #34 a. & b.**

☐ No → **SKIP to question #35**

a. How many resident managers does your home currently employ?

☐ Number of resident managers

b. When on duty, how many hours a week does your resident manager(s) work?

☐ Number of hours worked by resident manager

☐ Number of hours worked by second resident manager (*if 2 are employed*)

35. How many caregivers (*not resident managers*) does your home currently employ? [*If none, write 0*]

☐ Number of caregivers

36. Did you receive a flu vaccination this past fall? *[While flu vaccines are not mandatory, they are strongly encouraged by the Centers for Disease Control. You will not be penalized for your response to this or any other question.]*

☐ Yes ☐ No

37. How many of your current staff (*all resident managers and caregivers described in numbers 34-35 above*) received a flu vaccine this past fall?

☐ Number of current staff who got a flu vaccine this past fall

☐ Don't know ☐ N/A

38. What is the level of certification for each of your ***current*** staff? [*Note: AFH staff are not required to be licensed or certified.*]

# of staff	Staff Classification
	Licensed practical or vocational nurses (LPNs)/ (LVNs)
	Certified nursing assistants (CNAs)
	Certified medication aides (CMAs)
	Other:

39. Have you had difficulty, for any reason, hiring or contracting with any of the following**:**

	Yes	No	N/A
CNAs/CMAs			
Resident managers			
Caregivers who are not certified or licensed			
LPN/LVN			
RN consultant			

N/A = not applicable

40. If yes, please describe reasons:

_____

_____

Thank you for taking the time to complete this questionnaire.

41. In the past 90 days, have you hired contract care staff (*including nurses*) to cover ***unplanned*** staff absences?

☐ Yes ☐ No

42. In the last 90 days, have staff missed work due to any of the following problems? [*Check all that apply*]

☐ Transportation problems

☐ Family illness or other family issues

☐ Personal health issues

☐ Other_____

43. Do you offer a transportation benefit to staff such as a transit pass (*for bus or other transit*), car pools, ride share, or other assistance to help staff get to and from work?

☐ Yes ☐ No ☐ N/A

Please describe: _____

_____

_

44. Which of these topics have been covered in staff trainings during the past year? *[Check all that apply.]*

☐ Alzheimer's and related dementia

☐ Mental illness *(e.g., depression, substance abuse)*

☐ Disease-specific (*e.g., stroke, diabetes)*

☐ Medication administration

☐ Safety *(fire safety, emergency preparedness)*

☐ Communication and problem solving

☐ Nutrition and food management

☐ Residents' rights

☐ How to prevent communicable diseases

☐ Person-directed or person-centered care

☐ Resident abuse or neglect

☐ Working with resident families

☐ Other; specify: _____

45. Does your home have any ways to retain staff and reduce staff turnover?

☐ Yes ☐ No ☐ Not applicable

➔ **If yes,** please list what you believe to be 2-3 good ways to retain staff and reduce turnover.

1._____

2._____

3._____

Thank you for taking the time to complete this questionnaire.

46. How often do you assess caregivers' and resident managers' competency, including their knowledge, skills and abilities, to do their work?

- ☐ Annually *(once a year)*
- ☐ At least every 6 months
- ☐ At least 3 times a year
- ☐ Monthly
- ☐ As needed
- ☐ Don't know/not applicable
- ☐ Never
- ☐ Other; specify: _____

Section E. Monthly Rates, Fees & Policies

47. **Last month**, how many residents paid using the following payment type(s)?

More than one payment category is possible for each resident, so the number might be higher than the total number of residents. ***[Write "0" for any categories with no residents.]***

PAYMENT TYPE	
	# of Residents
Resident and/or family pay using private resources	
Resident's long-term care insurance	
Veteran's (Aid & Attendance)	
Medicaid	
Other, specify:	

48. Do you currently have a Medicaid contract or accept Medicaid payment for any of your residents?

☐ Yes ☐ No

a. **If yes**, how many of your current residents are Medicaid beneficiaries/clients?

☐ Number of residents

b. **If no**, have you had a Medicaid contract or accepted Medicaid in the past?

☐ Yes ☐ No

49. Do you currently have private-pay residents?

☐ Yes ☐ No

➔ **If NO, SKIP to #54**

a. **If yes:** If a private-pay resident spends down their assets, may they stay in the home and pay via Medicaid, if they qualify?

☐ Yes ☐ No

50. How many of your current residents who pay privately had a rate increase in the past 12 months?

☐ Number of residents

51. For the last month, what was the average **total monthly charge** for a single resident living alone in a **private room** and receiving the lowest level of care? (***Private-pay only***)

$ _____ / month

Thank you for taking the time to complete this questionnaire.

52. How many of your current residents who pay privately were charged in the following ways: ***[Write "0" for any categories with no residents.]***

- ☐ Paid a flat monthly rate
- ☐ Base rate plus additional fees based on services provided
- ☐ Monthly rate based on care needs
- ☐ Rate negotiated with resident (or payee) based on ability to pay
- ☐ Other method (Specify): _____

_____

53. Which services does your home provide and, for the services provided, what are the additional fees charged? *[Please check all boxes that apply. [Y= yes and N= no]*

Available: Y or N	Charge Fee: Y or N	Service
		Night-time care
		Advanced memory care
		Two or more person transfer assistance
		Obesity care
		Catheter, colostomy or similar care
		Advanced diabetes care
		Other, specify:

54. Is Medicaid transport available to your residents?

☐ Yes ☐ No ☐ Not applicable

55. If Medicaid transport is provided by a third-party company, what is the quality of that service?

- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Not applicable

56. Is HIPAA a barrier in communicating with your residents' primary care office staff? *[Note, HIPAA is a law that requires health care providers to keep patient information private.]*

☐ Yes ☐ No ☐ Don't know

Thank you for taking the time to complete this questionnaire.

57. In general, how satisfied are you with your residents' primary care office staff in the following areas:

Please check the box that best describes your overall satisfaction with each topic:						
	Very Satisfied	**Somewhat satisfied**	**Neither satisfied or dissatisfied**	**Somewhat dissatisfied**	**Very dissatisfied**	***NA**
a. Efficiency of communicating between your contract RN and residents' primary care offices						
b. Efficiency of communicating between your staff *[e.g., resident manager, caregivers]* and residents' primary care office staff						
c. Response time regarding notices from your home to the primary care office about a resident's change in condition						
d. Response time to requests for changes in residents' medication orders and other physician orders						
e. Exchange of care-related information following a hospitalization						
f. Exchange of care-related information following a stay in a rehabilitation or skilled nursing facility						

***NA=Not applicable**

58. What concerns do you or your staff have about communicating with resident's primary care office staff?

_____

59. How have you and your staff partnered with primary care office staff to address a resident's health needs?

_____

60. What advice do you have about communicating with resident's primary care office staff?

_____

61. What are some ways to improve communication between adult foster homes and primary care offices?

_____