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Oregon Community-Based Care Survey: Assisted Living, Residential Care, and Memory Care

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Community-Based Care Resident and Community Characteristics Report

Assisted Living
Residential Care
Memory Care

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Spring, 2016

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Executive Summary

This report, prepared by the Institute on Aging (IOA) at Portland State University (PSU) in collaboration with the Oregon Department of Human Services, describes community-based care (CBC) settings that provide residential, personal care, and health-related services, primarily to older adults.

The study collected information from assisted living, residential care, and memory care communities to achieve the following four main goals.

1: Describe assisted living, residential care, and memory care community characteristics, including staffing types and levels, policies, and monthly charges and fees	2: Describe current residents' health and social characteristics
3: Compare current results to prior Oregon surveys and to national studies of similar setting types to identify changes and possible trends	4: Compare setting types for differences that might affect access, quality, or costs

The study findings are intended to provide information that state agency staff, legislators, community-based care providers, and consumers might use to guide their decisions. Providing state-level information was one of the goals of Oregon's LTC 3.0 planning process (Oregon Department of Human Services, n.d.). In addition, as possible, comparisons are made to national surveys of residential care and assisted living conducted by the National Center for Health Statistics. Because of state variation in licensure categories, the national surveys combine residential and assisted living settings and use the term residential care to describe both. It should also be noted that regulatory standards and the types of residents that can be served in AL and RC settings vary by state, as well.

Survey

This report is based on a mailed questionnaire to the 491 licensed assisted living (AL) and residential care (RC) facilities, which includes 160 facilities endorsed for memory care (MC). **Completed questionnaires asking about resident characteristics and available services were received from 253 facilities between January and April 2016, for a response rate of 52 percent.** The study methods are described in Appendix A.

Key Findings

Communities

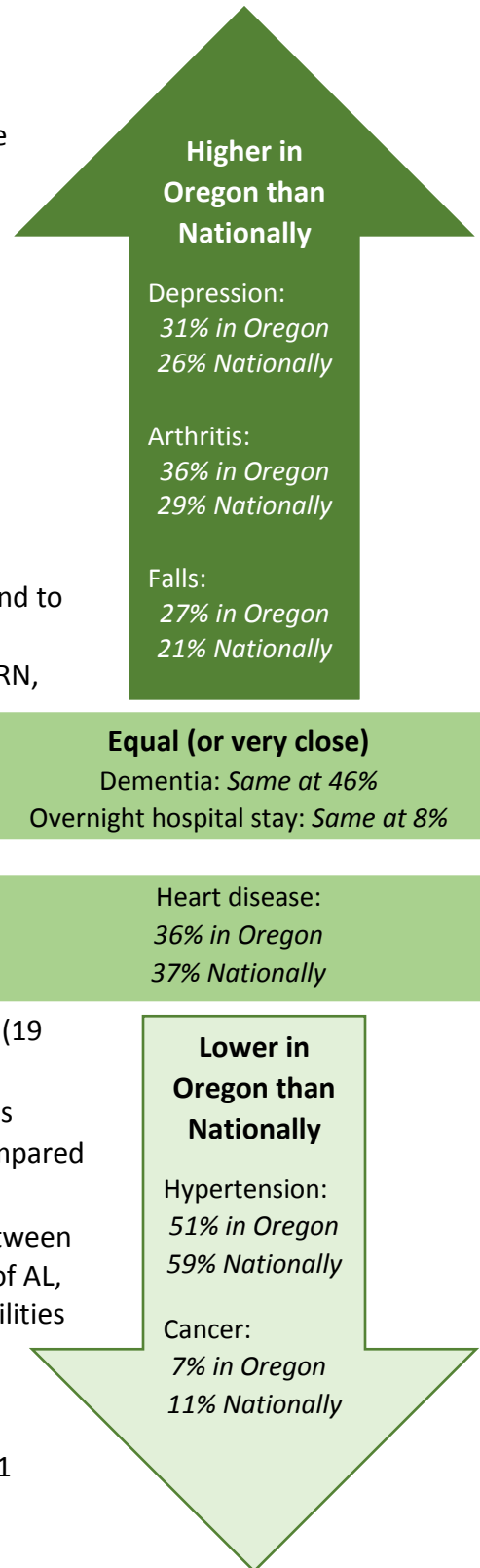
- In total, 52 percent of the 491 licensed settings completed the questionnaire.
- Approximately one-third of Oregon's 491 AL/RCs have a memory care endorsement.
- Oregon has a larger percentage of memory care communities compared to the national average.

Staff

- The total number of persons employed (e.g., administration, facilities, housekeeping, kitchen staff, caregivers) by the 253 responding CBC facilities was 9,723.
- The ratio of employees to residents was higher for MC (1.18) compared to either AL (.77) or RC (.99). These ratios correspond to the acuity level of residents in these different settings.
- A total of 4,672 direct care workers and 395 licensed nurses (RN, LPN/VN¹) were employed.
- Oregon's combined staffing level is 51 minutes higher per day compared to the national level.
- Oregon's staffing levels were higher for personal care staff and LPN/LVNs in MC compared to AL and RC settings.

Rates and Fees

- Oregon had a much higher rate of Medicaid use among AL, RC, and MC facilities (41 percent) compared to the nation (19 percent).
- A larger percentage of Oregon MCs accept Medicaid payments compared to the national average –86 percent in Oregon, compared to 37 percent nationally.
- According to DHS, providers billed a total of \$257,020,390 between January and December 2015 for Medicaid services on behalf of AL, RC, and MC residents in Oregon. Among the 52 percent of facilities responding to the PSU survey, about 41 percent of residents were Medicaid beneficiaries.
- Based on responses and estimates for non-respondents, we estimate that the total private pay charges were \$613,344,711 annually.



¹ Registered nurse (RN), licensed practical nurse/licensed vocational nurse (LPN/VN).

Community Services and Policies

- A much lower percentage of MCs compared to ALs or RCs use a move-out notice for residents hitting others/acting in anger, wandering, or requiring a two-person transfer.
- Eighty-six percent of facilities reported they do use a falls assessment tool.
- Most facilities—85 percent—reported using five or fewer pharmacies, while 15 percent used more than five.
- Eighty-two percent of settings review their medical administration record quarterly, 12 percent do so monthly, and four percent review MARs every six months, or annually.

Residents

- Based on licensed capacity provided by DHS and provider responses, an estimated total of 20,830 adults lived in an AL/RC/MC setting in Oregon.
- Oregon AL/RC/MC settings are somewhat less diverse than the national average.
- Eighteen percent of settings reported stays of one to 90 days compared to 23 percent who stayed 90 or fewer days reported in 2015.
- As many as 1,410 residents (13 percent) might be homebound.
- Fifty-five percent of residents in AL/RC/MC settings take nine or more medications.
- On average, 26 percent of residents took an antipsychotic medication.
- Sixty percent of residents received a flu vaccination this past fall.

Typical Assisted Living Resident

81 years old
Moved in from home
Stayed for 4 or more years
Moved due to end of life
Base monthly charge: \$3,156
Total monthly charge: \$3,475

Typical Residential Care Resident

79 years old
Moved in from home
Stayed for 6 months to 1 year
Moved due to end of life
Base monthly charge: \$3,179
Total monthly charge: \$3,556

Typical Memory Care Resident

82 years old
Moved in from home
Stayed for 2 to 4 years
Moved due to end of life
Base monthly charge: \$4,781
Total monthly charge: \$5,168

Typical Resident across All Settings

Female
White, non-Hispanic
Had not fallen in past 90 days
Received a flu shot
Top five medical conditions: High blood pressure/hypertension, Alzheimer's disease and other dementia, heart disease, arthritis, and depression.

Needed support with bathing, dressing, incontinence
Used a mobility aide
Assessed for falls at move-in
Took nine or more medications with staff assistance

Background

As Oregon's population ages, the availability of community-based care (CBC) settings, including assisted living, residential care, and memory care communities, will become increasingly important. The number of CBC settings has expanded since the 1980s, in part due to the increasing numbers of older adults who need or want assistance with long-term services and because Oregon's Department of Human Services (DHS) Aging and People with Disabilities is committed to building a system that provides CBC options throughout the state. Oregon has long been a national leader in the development of CBC policies and settings. To make informed policy and practice decisions, information about CBC settings, including who lives and works in these settings, is needed. This report complements the 2014 report, published in 2015, available at: <https://www.pdx.edu/ioa/oregon-community-based-care-project>.

Collecting information directly from CBC providers is important because there is no central source of information about private-pay residents, staff, facility services, rates, and policies. This report can be used by DHS and other state and local agencies to inform policy decisions and by CBC providers to assess their services and markets. DHS collects information on Medicaid-funded beneficiaries in these settings, but, unlike nursing facilities, CBC facilities are not required to use a standardized assessment tool to collect and report information on resident characteristics and staffing. DHS is the licensing authority for Oregon's CBC facilities and is required by the Oregon legislature to provide a picture of the CBC landscape that can be used by local and statewide planners and policy-makers. The Oregon legislature appropriated funds to support this statewide study (OR SB21, 2013).

DHS contracted with Portland State University's (PSU) Institute on Aging (IOA) to collect data from CBC providers. Site visits were conducted with providers statewide to inform data collection. All 491 assisted living, residential care, and memory care communities licensed as of the beginning of November 2015 received a questionnaire that asked about residents' health-related needs, demographic characteristics, health service use, and move-in and move-out information; information about staffing types and levels; monthly rates; flu vaccination policies; fees for additional services; and quality assurance policies. The research methods are described in Appendix A. In addition, PSU surveyed a statewide sample of adult foster care homes; that separate report is available from DHS and PSU.

Communities

Assisted Living, Residential Care, and Memory Care

This section describes three types of CBC settings in Oregon: assisted living (AL), residential care (RC), and memory care (MC) communities. These settings provide assistance with daily activities, such as personal care, taking medications, supervision and health monitoring, daily meals, and social and recreational activities. Additional services may be provided or coordinated depending on resident needs and preferences. All settings are staffed 24 hours daily to respond to the scheduled and unscheduled needs of residents, most of whom are aged 65 and older.

Oregon Administrative Rules (OAR 411-54) indicate that these three settings support resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence, and home-like surroundings. Assisted living and residential care settings may be single buildings, complexes, or parts of a complex and are licensed to provide services to six or more seniors or persons with disabilities. Memory care communities must receive an endorsement by meeting an additional set of licensed criteria, on either an AL, RC, or nursing facility license from the Office of Licensing and Regulatory Oversight. This report does not include nursing facilities with MC endorsements. Facilities are licensed for a specific number of residents (capacity) based on the number of living units in the building. In ALs, a unit may be designated for one or two persons who live together by choice (usually married or partnered couples) and in RCs, a unit may be shared by two individuals previously unknown to each other (e.g., roommates).

The topics addressed in the survey include:

- Number of AL, RC, and MC settings and licensed capacity
- Staffing types and levels
- Monthly rates and additional fees for services
- Services and policies
- Resident characteristics and care needs

The total number of ALs and RCs increased by only two (from 489 to 491) since the prior report (Table 1). However, this total number fails to capture the following changes: eight facilities were newly licensed, five closed, and two combined licenses into one, closing out one of those licenses. Several RCs converted existing units to MC, so that the total number of MC communities increased by 8 percent (from 148 to 160 communities). Thus, the primary growth in the AL/RC sector is within memory care. **Approximately one-third of Oregon's 491 AL/RCs have a memory care endorsement** (see Table 2). A stand-alone MC is a setting licensed to provide memory care only, while "combination" refers to settings that have two of these licensure categories co-located on the same property .

Table 1: Number of Licensed Settings and Licensed Capacity, 2016

Type	Description	Total number AL/RCS ¹	Licensed capacity	Units
AL	Assisted Living provides private, single-occupancy apartments with a private bath and kitchenette.	216	14,406	12,115
RC	Residential Care provides single or double rooms with shared bathrooms. Kitchenettes are not required.	275	10,688	8,748
Total		491	25,094	20,863

¹This column include all AL/RCS, including those that have a MC endorsement.

	Total number of MCs (N)	Licensed Capacity (N)
Memory Care Communities are designated for persons with a diagnosis of Alzheimer’s disease or other dementia and have regulatory requirements for staffing, services, and building design features.	160	5,632
Stand-alone MC	128	4,570
Combination AL/RC + MC	32	1,062

Similar to Oregon, there has been steady growth in the number of settings designated for memory care in the U.S. A 2014 national survey identified approximately 30,200 RC settings in the U.S.; of these, 22 percent were designated entirely for dementia care or had a dementia care unit co-located within a larger building or campus (Harris-Kojetin et al., 2016). **Oregon has a larger percentage of memory care communities compared to the national average.**

Memory care communities are an important part of assisted living and residential care. Nationally, an estimated five million adults have Alzheimer’s disease or a related form of dementia (Alzheimer’s Association, 2016). Dementia results in disability and dependence among older adults (Sousa et al., 2009), and is a major driver of long-term service use, including assisted living and residential care (Zimmerman, Sloane, & Reed, 2014).

Providers were asked whether they planned to apply for a MC endorsement in the next year. A total of 10 facilities, including six AL and four RC, indicated they plan to do so, and 21 said that they did not know.

The occupancy rate provides an indication of consumer demand for community-based care settings. The overall occupancy rate of 84 percent among the 253 responding facilities is slightly higher than the rate of 81 percent reported in 2015. The highest rate was reported by MC communities (89 percent this year and 87 percent last year) (see Table 3).

Table 3: *Occupancy Rates*

Community Type & Totals	Licensed Capacity	# of Current Residents	Occupancy Rate
AL	7,081	5,846	83%
RC	2,949	2,439	83%
MC	2,717	2,409	89%
Total	12,668	10,694	84%

Staff

Who works in Assisted living, Residential Care, and Memory Care?

Community-based care employees provide assistance with activities of daily living, medication administration, resident-focused activities, supervision, and various types of support. This section focuses on staff directly employed by facilities, as well as agency staff contracted to supplement regular employees.

The total number of persons employed (e.g., administration, facilities, housekeeping, kitchen staff, caregivers) by the 253 responding CBC facilities was 9,723. Based on the reported occupancy rate for each setting type, we calculated the rate of total employees to residents and found that the **ratio of employees to residents was higher for MC (1.18) compared to either AL (.77) or RC (.99) (Figure 1).** These ratios correspond to the acuity level of residents in these different settings. Specifically, a larger percentage of MC residents compared to either AL or RC residents required assistance with each ADL (see Residents section).

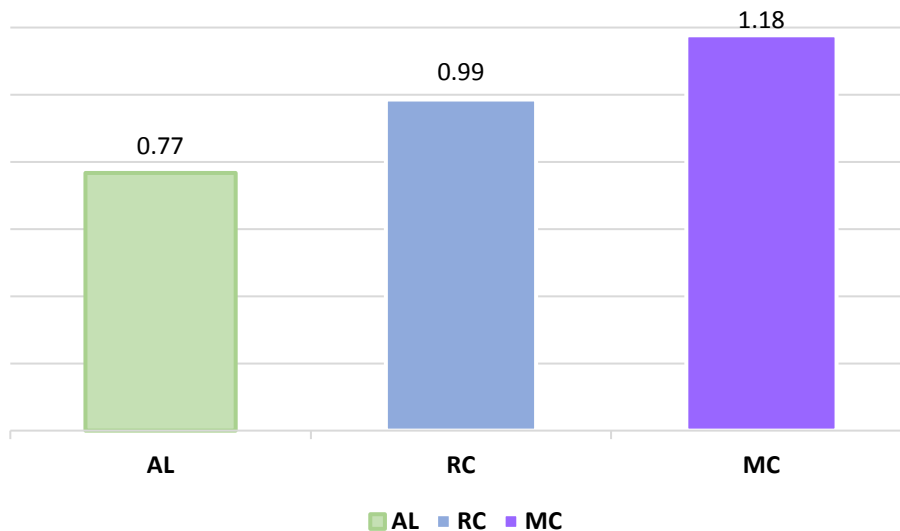


Figure 1: Ratio of All Employees to Current Residents

Care-Related Staff

Providers were asked to give the number of full-time and part-time care-related staff, defined as the following: registered nurses (RNs), licensed practical or vocational nurses (LPN/LVNs), certified nursing assistants/certified medication aides (CNA/CMAs), social workers, and activities directors or staff (Table 4). The 253 responding facilities employed a total of 5,948 care-related staff. These staff represent 61 percent of all responding CBC facility employees.

Table 4: Percent of Staff that were Employed Part-Time or Full-Time,

by Employee Categories

	Part-time % (n)	Full-time % (n)	Total % (n)
RN	2% (123)	3% (175)	5% (298)
LPN/LVN	1% (31)	1% (66)	2% (97)
CNA/CMA	3% (164)	5% (320)	8% (484)
Personal care staff	17% (1,036)	61% (3,636)	79% (4,672)
Social worker	<1% (9)	<1% (22)	1% (31)
Activities Director	2% (125)	4% (241)	6% (366)
Total	25% (1,488)	75% (4,460)	5,948

A total of 4,672 direct care workers and 395 licensed nurses (RN, LPN/VN) were employed. Most—75 percent—of the care-related staff were employed full time. Among the full-time employees, the majority (82 percent) were personal care staff (also known as caregivers, universal workers, or direct care workers), and a larger percentage of personal care staff were employed full time compared to other care-related staff.

Assisted living and residential care facilities are required to employ or contract with a licensed nurse (RN or LPN/LVN). A larger percentage of facilities employ RNs full time, rather than part-time, and RNs are more likely to be employed compared to LPN/LVNs (see Figure 2). There was variation in employment of RNs across settings. A larger percentage of ALs (72 percent) compared to RCs (62 percent) and MCs (58 percent) hire RNs full time, while a larger percentage of MCs (31 percent) compared to ALs (19 percent) and RCs (11 percent) employ LPN/LVNs full time (see Table B2 in Appendix B). These rates are similar to those described in our prior report, in which 88 percent of CBC facilities employed an RN (full or part-time). As reported in the 2010 national survey, 37 percent of RC settings employ an RN, and 32 percent employ an LPN/LVN, either full or part time (Khatutsky et al., 2016).

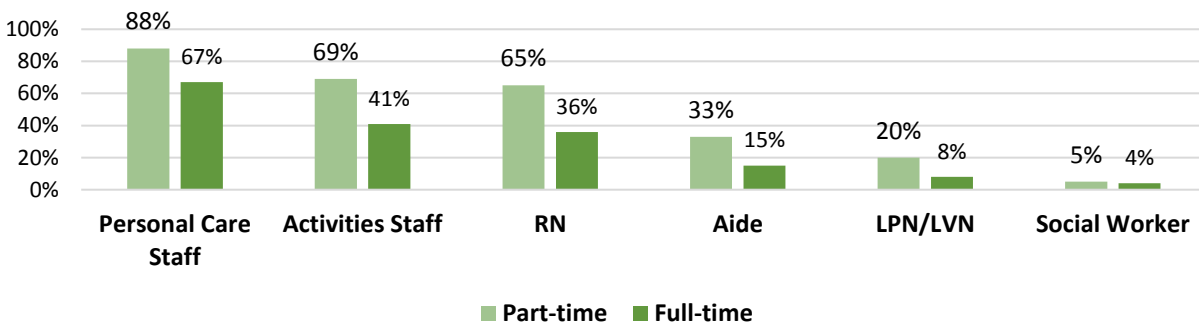


Figure 2: Percent of Facilities that Employed Part-Time or Full-Time Staff, by Employee Categories

Oregon rules do not require facilities to hire CNAs or CMAs. However, 33 percent of facilities employed a CNA/ CMA full time, and 15 percent employed a part-time CNA/CMA. The majority of facilities reported employing an activities director or staff, with 69 percent employing a full-time and 41 percent employing a part-time activities staff person. Facilities are not required to employ social workers, though a small number of settings did. A total of five percent employed a full-time social worker, and four percent employed a part-time social worker.

Use of Contract/Agency Staff

Providers were asked whether they had any nursing, personal care, social work, or activities staff hired on a contract or through an agency: 13 percent did. A smaller percentage of ALs (10 percent) compared to RCs (17 percent) and MCs (16 percent) reported using contract/agency staff. The most commonly reported types of contract/agency staff hired were: personal care staff, RNs, activities, CNA/CMA, and social workers. Nationally, in 2010, 16 percent of RCs used contract workers to supplement their regular employees (Khatutsky et al., 2016).

Staff Hours Per Resident Per Day

Oregon rules require settings to hire staff in sufficient numbers to meet the needs of current residents. They must have a staffing plan that accounts for resident acuity and the total number of residents, and account for scheduled and unscheduled needs. There is no published standard for the meaning of “sufficient,” so, staff hours per resident per day based on a national survey of residential care settings are provided.

The National Center for Health Statistics (NCHS) defines staffing level as the average staff hours per resident per day, calculated as the total number of hours worked by employees divided by the total number of residents. Only facility-employed (not contract) licensed nurses (RN, LPN, LVN), certified staff (CNA/CMA), and aides (referring to personal care staff who do not have a professional certification) were included in this calculation. The staffing level is not a measure of the amount of care given to a specific resident but an average that can be used to compare differences by setting type and to look at trends over time. Using the NCHS method, we calculated staffing levels for different staff types in the three CBC facility types.

In Oregon, personal care (PC) staff account for the largest number of staffing hours, at 2 hours and 32 minutes per resident per day (Figure 3). The staffing level for CNA/CMAs is 49 minutes per resident per day, for LPNs 11 minutes, and for RNs 10 minutes per resident per day. The combined staffing level (RN, LPN/VN, CNA/CMA and PC) is 3 hours and 41 minutes.

The 2015 national study reported an average total staffing level (RN, LPN/VN, and CNA) of 2 hours 50 minutes per resident per day. Nationally, licensed nurse hours per resident per day were 16 minutes for RNs and 12 minutes for LPN/LVNs, and the CNA level was 2 hours and 22 minutes (the national study combines CNAs and staff who lack certification, such as personal care staff) (Rome & Harris-Kojetin, 2016). **Oregon’s combined staffing level is 51 minutes higher per day compared to the national level.**

Oregon’s staffing levels were higher for PC staff and LPN/LVNs in MC compared to AL and RC settings (see Figure 3). For example, the caregiver staffing level in MC was 3 hours and 16 minutes compared to a PC staffing level of 2 hours and 58 minutes in RC and 1 hour and 46 minutes in AL. Similarly, the national study reported higher staffing levels for CNAs in settings that primarily serve residents with dementia – 3 hours and 10 minutes per resident. The total staffing level (including personal care staff and nurses) was higher in settings with a majority of residents with dementia – 3 hours and 37 minutes per resident compared to settings that did not primarily serve persons with dementia (Rome & Harris-Kojetin, 2016).

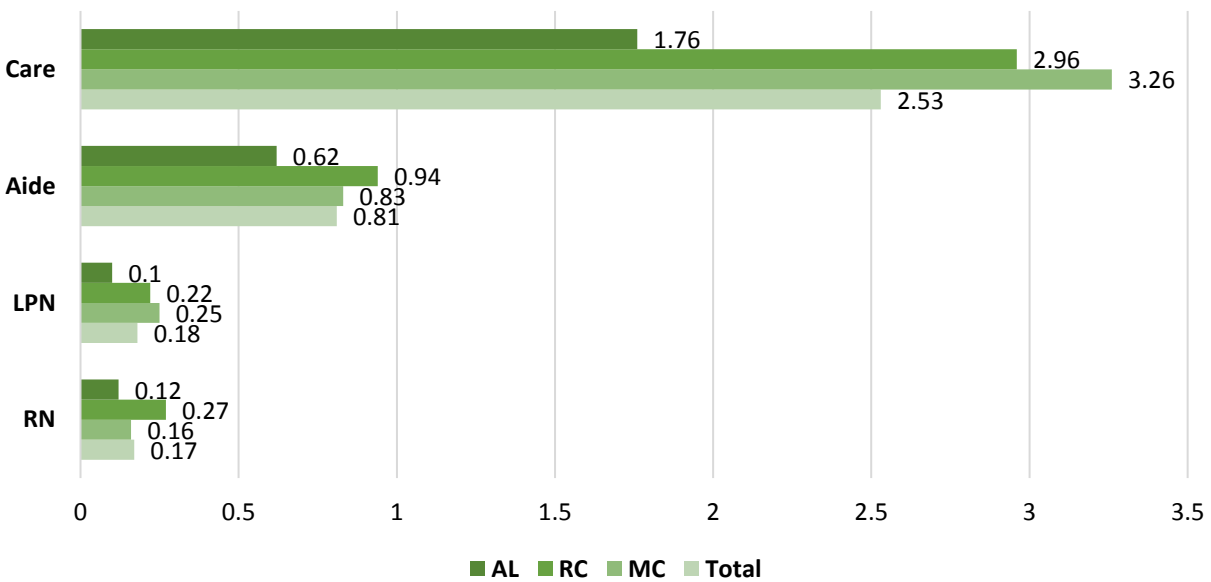


Figure 3: Staff Level in Hours, by Staff and Facility Type

Notes: To convert hours to minutes, multiply the number of hours by 60. “Care” refers to caregivers; “aide” refers to CNA/CMAs; LPN includes LVN.

Staff Training Topics

Staff knowledge and training affects resident quality of life and health-related outcomes (Beeber et al., 2014). Oregon regulations require CBC settings to provide staff training on residents' rights, abuse, infection control, and safety prior to staff beginning their job. Personal care staff must demonstrate caregiving competencies on about 12 topics outlined in OAR 411-54 within 30 days of hire. Providers were asked about the topics covered in staff trainings during the prior year (Figure 4). The four most common topics included:

1. safety,
2. residents' rights,
3. disease-specific conditions, and
4. abuse.

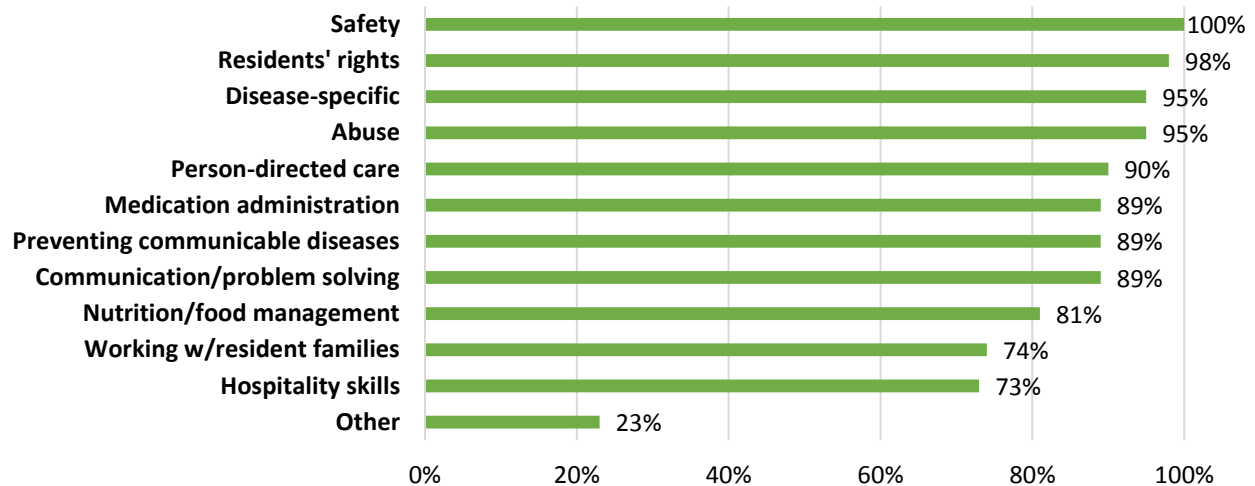


Figure 4: Staff Training Topics Covered in the Prior 12 Months

Besides the staff training options listed in the questionnaire, additional topics listed by providers included preventing accidents (e.g., fall prevention, harm reduction), workplace-specific training (e.g., incident reporting, workplace violence, work safety), work-life balance (e.g., budgeting, balancing a checkbook, effective parenting), and additional training for residents' care needs (e.g., pain management, safe lifting and transfers, how to shower a resident).

Strategies for Retaining Staff

Staff turnover is recognized as a problem in long-term care settings nationally (IOM, 2008). Oregon administrative rules do not require AL/RC settings to have strategies to reduce staff turnover, but providers must maintain a staffing plan and have a sufficient and qualified number of employees. Most—82 percent—of facilities indicated they had a strategy to retain staff and reduce staff turnover. Of those, the three most commonly reported staff retention strategies included:

1. Training and education,
2. compensation and benefits, and
3. awards, recognition, or appreciation programs.

Examples of compensation and benefit strategies included offering above-standard wages, annual bonuses, raises, and formal benefits including health insurance, free flu shots, paid time off, discounted transportation passes, and tuition assistance. Additional strategies included incentive pay and programs, employee satisfaction survey, open communication, as well as providing leadership opportunities, increased responsibility, and career advancement.

Facility Administrators

Providers were asked how long the current administrator had been employed in the administrator position. The mean length of time was five years for all three setting types, with

AL and RC reporting over five years compared to just over three years for MC administrators. The range was from less than one year to over 42 years employed as an administrator.

Flu Vaccination

Oregon statute [§ 433.416] does not permit employers to require vaccinations as a condition of employment, unless such immunization is otherwise required by federal or state law, rule, or regulation [1989 c.949 §3]. However, DHS supports the Centers for Disease Control recommendation that all health care workers be vaccinated annually against influenza (CDC, 2015) and encourages facilities to provide easy vaccination access for staff through on-site flu clinics and to provide staff with accurate information regarding the importance of influenza vaccines.

Overall, 28 percent of Oregon's AL, RC, and MC employees were reported to have received a flu vaccination during the prior fall. This rate varied by setting type, with 35 percent of AL employees vaccinated compared to 16 percent of RC and 29 percent of MC employees. However, 112 settings (44 percent) reported that they did not know or did not track whether their employees had received a flu vaccination.

A recent CDC survey of 1,882 healthcare workers found that 75 percent of workers in a variety of health care settings had received a flu vaccination within the previous year. However, the rate was lower for those working in long-term care settings (63 percent) compared to hospitals (90 percent) and for assistants and aides (58 percent) compared to physicians and nurses (92 percent and 90 percent, respectively). Employees of long-term care settings were most likely to report that their employer did not require or promote flu vaccination, and they were the least likely of survey respondents to report that their employer made vaccination available at no cost for multiple days (Black et al., 2014).

Rates, Fees, and Medicaid Use

How Much Does Care Cost?

The cost of AL, RC, and MC is an important topic to state policymakers who make decisions about Medicaid funding and other issues that affect access to CBC for persons with low incomes. It is also important to current and prospective residents who pay using personal resources. Several questions were asked about the following topics: payment sources (private and Medicaid), monthly base and total charges, fee structures, and additional fees.

Providers were asked to describe the average base monthly private-pay charge for a single resident living alone in the smallest unit and receiving the lowest level of care (Table 5). The difference between MC and AL/RC rates was about \$1,600 per month. For RC and MC, the highest base monthly charge exceeded \$8,600 per month.

Table 5: Monthly Private-Pay Charges by Setting

		AL % (n)	RC % (n)	MC % (n)
Average base monthly charge		\$3,156.42	\$3,178.82	\$4,781.08
	Minimum	\$2,000	\$1,670	\$2,900
	Maximum	\$4,783	\$8,640	\$8,804
Average total monthly charge (including services)		\$3,474.53	\$3,555.75	\$5,168.02
	Minimum	\$2,400	\$1,670	\$2,900
	Maximum	\$5,200	\$8,640	\$8,804

In addition to the base rate, providers were asked to describe average total monthly private-pay charge because some settings charge additional fees based on the level of services provided (e.g., base plus services) (Figure 5). As indicated, some RC and MC settings reported that they charge the same base and total monthly rates. The mean total monthly rates were about 10 percent higher than the base rate, with ALs charging \$3,475, RCs charging \$3,556, and MCs charging an additional \$1,612 to \$1,694 per month, for a total of \$5,168, on average. Based on the maximum monthly charges for RC and MC, some of these settings do not charge an additional service fee. These private-pay rates are similar to the median rate for Oregon, \$3,880 per month, reported in a national survey of assisted living costs (Genworth, 2015). Only 16 percent of ALs and RCs reported no private-pay residents, and all MCs had private-pay residents.

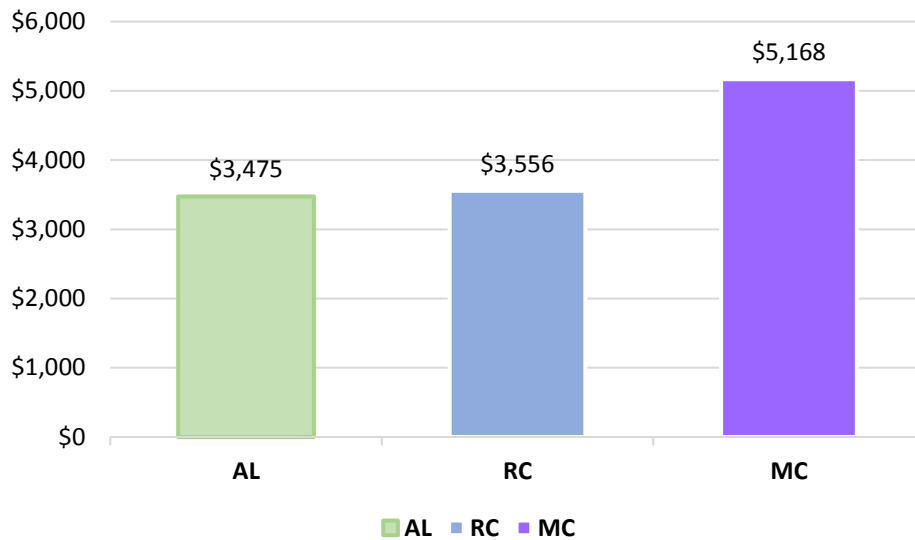


Figure 5: Private-Pay Total Monthly Charges

Although national studies might not be directly comparable because of the variation in states’ dementia care regulations, a 2010 national survey found that the monthly rate for a single room in a setting that primarily served persons with dementia was \$3,843 (Zimmerman et al., 2014). In 2016 dollars, this rate would be \$4,334.

Additional Fees

Providers were asked whether they charge deposit fees and additional fees for specific services. The most commonly reported additional fees were for meals regularly delivered to the resident’s unit (45 percent of facilities), community fees (39 percent of facilities), staff escort of a resident to a medical appointment (30 percent of facilities), and security or damage deposit (26 percent). However, there was variability in the use of fees and deposits by facility type. ALs were far more likely (78 percent) compared to RCs (28 percent) or MCs (17 percent) to charge a fee for regular meal delivery. During phone calls with providers, some indicated that rather than charging additional fees, these services are included in the monthly fee structure.

Medicaid

Based on information received from DHS in 2015, 80 percent (394) of all AL and RC facilities had a contract to accept Medicaid beneficiaries, which accounted for a licensed capacity of 20,557 Medicaid beds. Of the 253 facilities that completed the survey, 86 percent accepted Medicaid, accounting for a licensed capacity of 11,510 beds. **Of the current residents, 41 percent were Medicaid beneficiaries.** A slightly larger percentage of ALs compared to MCs and RCs reported Medicaid acceptance. In addition, 84 percent of all facilities indicated that a current private-pay resident who spent down their assets to the Medicaid level would be permitted to stay and pay with Medicaid (if they qualified).

Based on the 2014 national survey, 47 percent of all RC communities in the U.S. accepted Medicaid payments on behalf of eligible residents (Harris-Kojetin et al., 2016), and the 2010 survey of RC residents found that 19 percent of all residents were Medicaid clients (Caffrey et al., 2012). Nationally, RC settings with dementia care units are less likely to accept Medicaid clients (only 37 percent accept Medicaid clients) than those without dementia care units (52 percent) (Caffrey et al., 2012). However, in Oregon, out of a total of 160 MCs, 128, or 80 percent, accepted Medicaid. Thus, **Oregon had a much higher rate of Medicaid use among AL, RC, and MC facilities compared to the nation. Also, a larger percentage of Oregon MCs accept Medicaid payments compared to the national average –86 percent in Oregon, compared to 37 percent nationally.**

Profession Charges

Based on the average monthly charge for private pay residents reported by respondents, in addition to the amount billed to DHS for Medicaid services, we estimated the total annual charges for these CBC settings (see Appendix A, Table A2 for a description of the calculations). As indicated in Figure 6, the total charges were over three quarters of a billion dollars, or \$870,365,102, of which 30 percent were Medicaid charges (including room and board charges) paid by DHS on behalf of Medicaid-eligible residents. **Based on responses and estimates for non-respondents, we estimate that the total private pay charges were \$613,344,711 annually. According to DHS, providers billed a total of \$257,020,390 between January and December 2015 for Medicaid services on behalf of AL, RC, and MC residents in Oregon.**

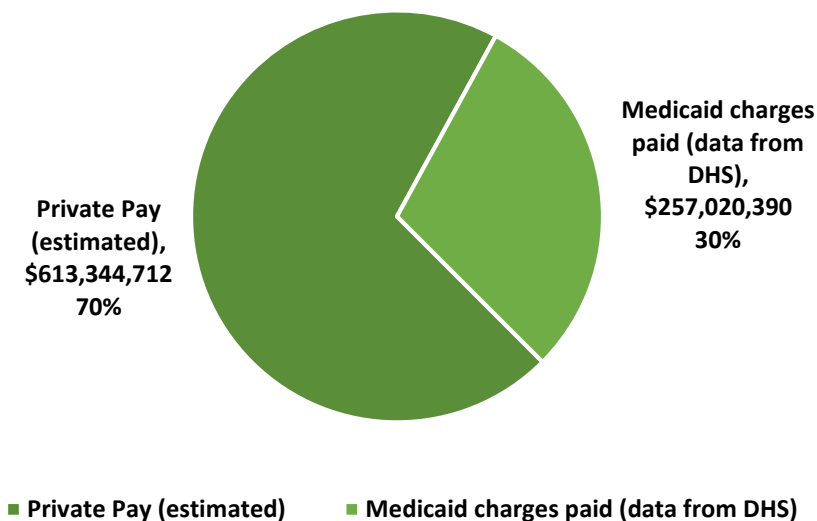


Figure 6: Estimated Total Annual Charges for AL, RC, and MC in Oregon

Community Services and Policies

What are Common Services and Policies?

Several questions were asked about community policies and practices regarding resident services and staffing. The topics included:

- Move-out policies
- Fall risk assessment
- Pharmacy use and medication services
- Dental visits
- Use of quality improvement plans
- Use of resident/family satisfaction survey
- Resident use of medical or recreational marijuana
- Cultural compatibility

Move-Out Policies

Providers were asked which of four needs and behaviors would typically prompt a move-out notice (Table 6). The most common reason for a move-out notice was for a resident who was hitting others/acting in anger, followed by wandering behavior by a resident, a resident needing two-person transfer assistance, and a resident needing sliding-scale insulin injections. The finding for hitting/acting out with anger and wandering is likely because OAR 411-57 requires memory care settings to routinely provide behavior interventions. In contrast AL and RC settings must provide intermittent and periodic, rather than routine, behavior interventions. These move-out triggers were included because they can result in harm to residents and staff (e.g., hitting, wandering) and because they might require additional staff time or skills (e.g., two-person transfer, sliding scale insulin requires staff who are trained to adjust the insulin dosage based on a current blood glucose (“sugar”) level).

Differences across setting types were observed. For example, **a much lower percentage of MCs compared to ALs or RCs used a move-out notice for residents hitting others/acting in anger, wandering, or requiring a two-person transfer.**

Table 6: Resident Needs and Behaviors that Prompt a Move-Out Notice

	AL % (n)	RCF % (n)	MCC % (n)	Total % (n)
Hitting/Acting out with anger				
Communities	82% (90)	75% (57)	69% (52)	76% (199)
Residents	84% (4,896)	82% (1,999)	70% (1,682)	80% (8,577)
Two-person transfer				
Communities	36% (40)	36% (27)	9% (7)	28% (74)
Residents	40% (2,351)	30% (728)	5% (114)	30% (3,193)
Wandering behaviors				
Communities	71% (78)	41% (31)	4% (3)	43% (112)
Residents	75% (4,372)	50% (1,230)	6% (142)	54% (5,744)
Sliding scale insulin				
Communities	5% (6)	8% (6)	4% (3)	6% (15)
Residents	6% (339)	10% (252)	3% (75)	6% (666)

Table 6 also shows the percentage of residents who lived in a facility with each move-out policy. For example, 30 percent of residents lived in a facility that had a two-person transfer move-out policy. This was true for five percent of MC residents compared to 40 percent of AL residents and 30 percent of RC residents (Table 5). Similarly, 80 percent of residents lived in a facility that considered hitting others/acting in anger as a prompt for a move-out notice, but this was true for 70 percent of MC residents compared to 84 percent of AL residents and 82 percent of RC residents. The most striking difference was based on wandering behavior, which is associated with some forms of dementia. While 54 percent of all residents lived in a facility that indicated wandering as a prompt for a move-out notice, the rates differed markedly based on facility type, with only six percent of residents in a MC with this policy, compared to 75 percent of ALs and 50 percent of RCs. These differences are likely due to MCs focus on dementia care, including the requirement that buildings have a means of controlling egress that prevents residents from leaving the building without supervision.

Assessment of Residents' Fall Risk

Falls among older adults are an important public health issue. Falls are the eighth leading cause of unintentional injury for older Americans and have been shown to be responsible for more than 16,000 deaths in one year (Oliver, Healy, & Haines, 2010). Every 14 seconds, an older adult is seen in an emergency department for a fall-related injury (AoA, 2016).

Oregon's DHS encourages CBC 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. The majority of settings—64 percent—indicated that they used a validated falls risk assessment tool to assess every resident, as a matter of standard practice (Figure 7). Twenty-one percent of settings reported using a tool on a case-by-case basis, and **86 percent reported that they used a fall risk assessment tool**. A larger percentage of MCs reported using a falls risk assessment; MCs also reported a larger percentage of residents who had fallen in the past three months (see Residents Section).

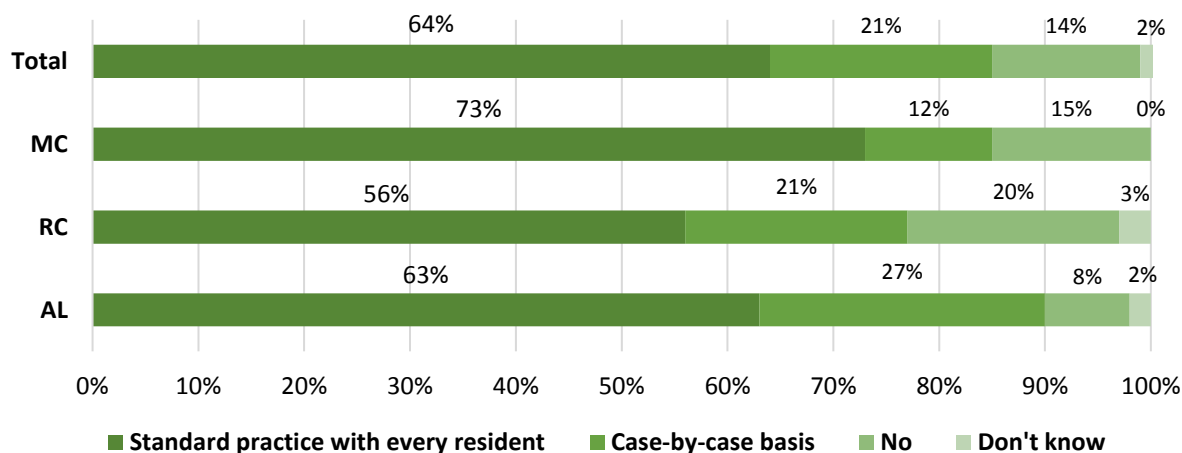


Figure 7: Use of Fall Risk Assessment by Setting

Pharmacy Use and Medication Review

Oregon AL, RC, and MC settings must accommodate residents’ choice of pharmacy, though standard practice is that facilities encourage residents to use the “house pharmacy.” While the regulations allow consumers the freedom to choose their preferred pharmacy, some research indicates that the use of multiple pharmacies introduces challenges associated with different pharmacy policies and procedures, such as medication packaging type, delivery type, hours of operation, turn-around time, documentation methods, and billing methods, among others. As the number of pharmacies delivering medications increases, the policies and procedures in these settings become more complex, possibly introducing errors (Young, Sikma, Reinhard, McCormick, & Cartwright, 2013). Use of multiple pharmacies is associated with problems when an individual transitions between care settings, such as from AL to hospital, then acute care rehab, and back to AL (Chalmers & Coleman, 2006). **Most facilities—85 percent—reported using five or fewer pharmacies, while 15 percent used more than five.**

Facilities administer medications to the majority of residents and must have a system in place for documenting and tracking medication administration on a quarterly basis or more often if needed. Providers were asked to describe the frequency of their medication administration record (MAR) review; **82 percent of settings review the MAR quarterly, 12 percent do so**

monthly, and four percent review MARs every six months, or annually (Figure 8). These four percent are not meeting the regulatory requirement of at least quarterly reviews.

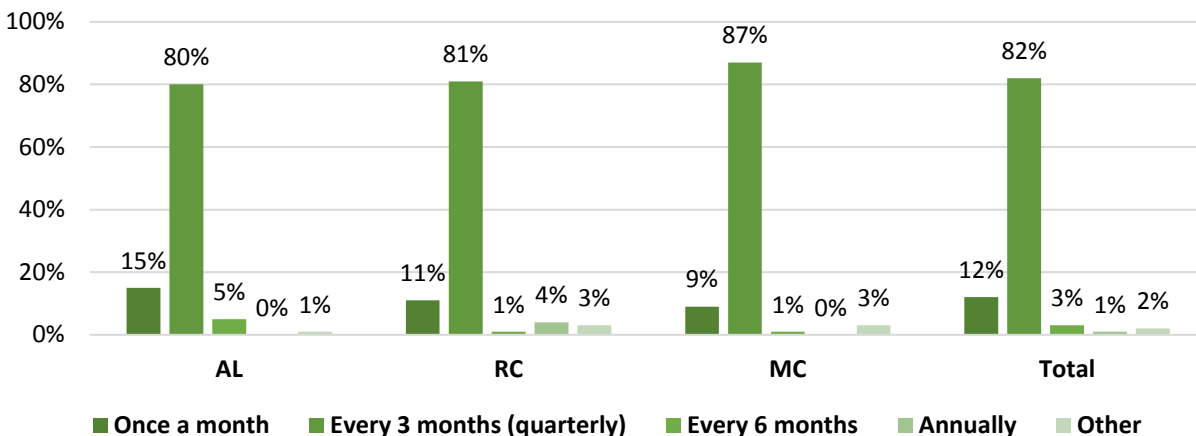


Figure 8: Frequency of Medication Records Review by Setting

On-Site Dental Services

Access to dental services is important for older adults because good oral health is associated with good overall health (AoA, 2016). Nationally, 33 percent of older adults have untreated tooth decay (AoA, 2016). Severe gum disease is associated with chronic disease and severe health conditions including diabetes, heart disease, stroke and respiratory disease (AoA, 2016). Just over one-third (34 percent) of Oregon CBC facilities reported that a dentist or dental hygienist visited to provide dental services to residents, and of these, a larger percentage of MC communities did so. This number is lower than the national average: in 2014, 54 percent of RC communities in the U.S. provided or arranged for residents to receive routine and emergency dental services provided by a licensed dentist (Caffrey, Harris-Kojetin, Rome & Sengupta, 2014). Nationally, low rates of routine dental check-ups may be based on limited health insurance coverage for this service.

Quality Improvement Activities

Oregon Administrative Rules (OAR 411-054) require ALs and RCs to have a quality improvement program that evaluates services, resident outcomes, and resident satisfaction. Providers were asked whether they conducted an annual satisfaction survey of resident/family concerns, and if so, to report the most recent results. Over half—60 percent of facilities—reported conducting an annual satisfaction survey. Of those that conducted a survey in the prior year, 61 percent reported that 90-100 percent of residents/families were satisfied, 28 percent reported that 80-89 percent were satisfied, and 11 percent reported that fewer than 80 percent were satisfied.

Among those that conducted an annual satisfaction survey of residents or families, the top three concerns reported by residents and families were:

1. food,
2. staffing, and
3. activities.

Food-related concerns included: food variety, quality, dining services and environment, food temperature, and menu options. In regards to staffing, turnover rate, education and training, and staffing levels were the most commonly reported concerns. The availability of and variety of activities were listed as activity-related issues. Other concerns that were mentioned with some frequency included housekeeping and laundry, communication (with staff and between staff and families), transportation, cost, noise and maintenance. The prior CBC report indicated that 20 percent of facilities conducted an annual resident satisfaction survey, and 27 percent conducted a staff satisfaction survey; a much higher percent of facilities reported doing so this year.

Providers were asked how frequently they review or update their quality assurance (QA) program (quarterly, monthly, never, or other). Forty-one percent indicated that this review occurs quarterly, with about one-third (32 percent) doing so monthly. However, six percent indicated that they never review their QA program, and 21 percent do so on another time schedule. Most of the providers who chose “other” listed annually as the time frame for reviewing their QA plans, and others listed the following time frames: as needed, daily, weekly, semi-annually, and don’t know.

Providers were asked to describe how they knew whether their facility’s QA plan was working. Of the few who provided a written response, most cited the existence of an auditing and/or review processes as their facility’s method of tracking whether their quality assurance plan was working; slightly fewer reported that feedback from residents and families indicated whether their QA plan was working. For example, one administrator reported that “quarterly meetings to review and compare data and trends” is how they knew whether their quality assurance plan was working. Other administrators reported that the absence or lack of resident complaints and negative incidents were indicators of a successful QA plan.

Because a QA program might not identify problems over time, providers were asked whether there were specific events or activities that would cause them to review their quality assurance program. The majority of CBC administrators report the existence of a formal auditing system as the basis for reviewing their community's QA program. For example, one administrator reported that a review of their QA program is triggered, “when we track or see a trend that could potentially have a less than positive outcome.” Other administrators cited negative incidents, such as resident falls or general issues that arise as events that trigger a review of their community’s QA program.

Marijuana Policy

Oregon has two laws concerning marijuana use that might affect CBC residents. The Oregon Medical Marijuana Act permits individuals with certain chronic health conditions to use medical marijuana to treat symptoms associated with their condition (ORS 475B.010 to 475B.395). In 2015, the state passed legislation regarding recreational use of marijuana. The CBC study included two questions, one asking whether the facility had a written policy that allowed residents to use marijuana for medical reasons and the other asking if there was a written policy that allowed residents to use recreational marijuana.

About one-fourth (27 percent) of all facilities had a written policy that permitted residents to use medical marijuana. Fewer facilities (14 percent) had a written policy that permitted recreational marijuana use among residents, including 17 percent of ALs and 13 percent of RCs compared to only eight percent of MCs. It is possible that facilities had written policies that prohibited the use of either medical or recreational marijuana.

Cultural Compatibility between Residents and Staff

As a possible indicator of fit between residents' and staff's cultures, we asked about languages other than English spoken by both residents and staff. Other than English, the language most commonly spoken by both staff and residents was Spanish, although the numbers were small. Specifically, two percent of all staff and less than one percent of all residents spoke Spanish. Forty-eight facilities reported at least one resident who spoke Spanish, and of these, 42 reported at least one Spanish speaking employee (Table B11 in Appendix).

Residents

Who Lives in Assisted Living, Residential Care and Memory Care?

Based on licensed capacity and provider responses, an estimated 20,830 adults lived in a CBC setting in Oregon (see Table A3 for calculations). The majority were female (70 percent), White (91 percent), and age 85 and over (52 percent). These demographic characteristics are similar to findings from the 2010 National Survey of Residential Care Communities (Khatutsky et al., 2016), which found the same percentages for age and ethnicity but found a slightly higher percentage (54 percent) of residents were aged 85 and over. The Oregon CBC study found a majority of residents were aged 85 and over, but the average ages were 82 for MC residents, 81 for AL residents, and 79 for RC residents (Figure 9 & Table B3 in Appendix).

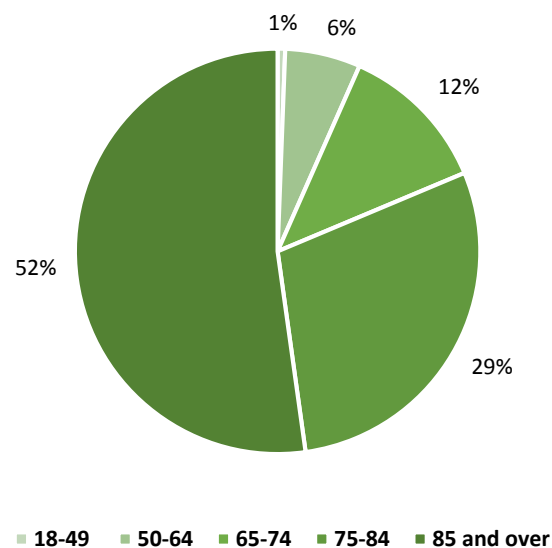


Figure 9: Age Distribution of Residents across All Community-Based Care Settings

Although the majority of residents were White, three percent of Oregon RC residents were Asian and two percent were Black (Table B4 in Appendix). With this exception, the following ethnic/racial categories were reported at one percent or less in all settings: Hispanic or Latino, American Indian/Alaska Native, Asian, Black, Native Hawaiian or other Pacific Islander, and mixed. Residents who identified as other or unknown ethnic or racial background were seven percent of AL residents, six percent of RC residents, and three percent of MC residents. These findings are similar to data from the 2010 U.S. Census data for Oregonians aged 65 and older, as described in the CBC report published in 2015.

The National Study of Long-Term Care Providers indicated that there were 835,200 residential care residents in 2014 (Harris-Kojetin, Sengupta, & Park-Lee, 2016). Of these, 53 percent were aged 85 and older, 70 percent were women, 84 percent were White (non-Hispanic), 4 percent were Black (non-Hispanic), 3 percent were Hispanic (any race), and 9 percent were another race. In general, **Oregon CBC settings are somewhat less diverse than the national average.**

Move-In and Move-Out Locations

Providers were asked to describe residents' move-in and move-out locations during the prior 90 days (Figures 10 and 11 & Table B5 in Appendix). This topic is important for understanding transitions between home, health care settings, and CBC settings. Residents who moved into CBC settings were most likely to move from home (30 percent), though there was variation across setting types. AL residents were most likely to move from home (34 percent) but 14 percent moved from a nursing facility and 13 percent moved from an independent living apartment in senior housing. RC residents moved from home at a rate of 27 percent, while residents also commonly moved from a nursing facility (17 percent) or a hospital stay (15 percent). MC residents were most likely to move from home (28 percent) or AL/RC (22 percent) and slightly less likely to move from a hospital stay (13 percent).

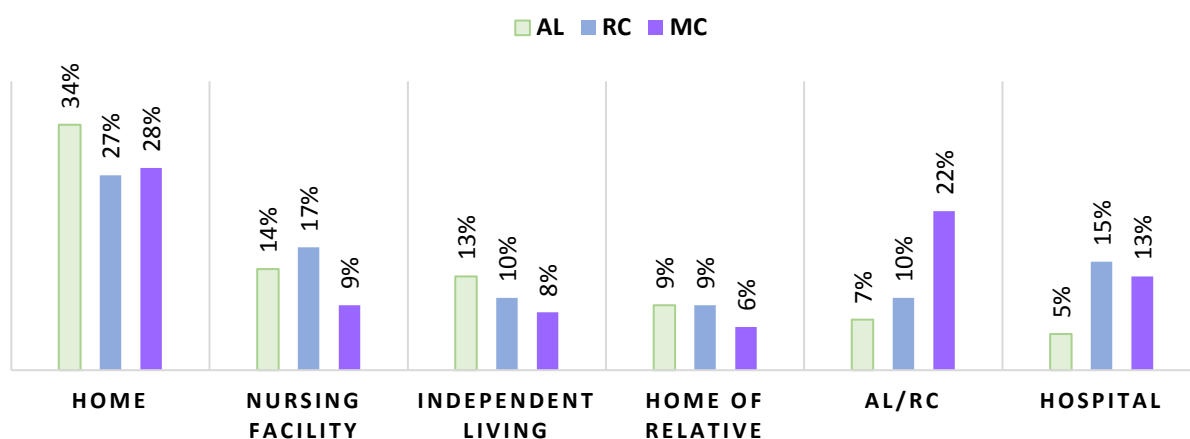


Figure 10: Five Most Common Resident Locations Prior to Move-In

The primary reason for leaving a CBC setting was death (51 percent). More than two-thirds of discharges in MC were due to death (68 percent). This rate has steadily increased, with 56 percent reported in 2008 and 65 percent reported in 2015, indicating that MCs are increasingly more likely to retain residents until their death. Rates of discharge due to death in AL and RC were lower at 45 percent and 47 percent, respectively.

As shown in Figure 11, among residents who moved out of AL, 13 percent moved to a nursing facility, and 12 percent moved to memory care. Moves from RCs were most commonly to nursing facilities (9 percent) and independent living apartments in senior housing (8 percent). Moves from MCs were most commonly to nursing facilities (7 percent) or to other MCs (6 percent).

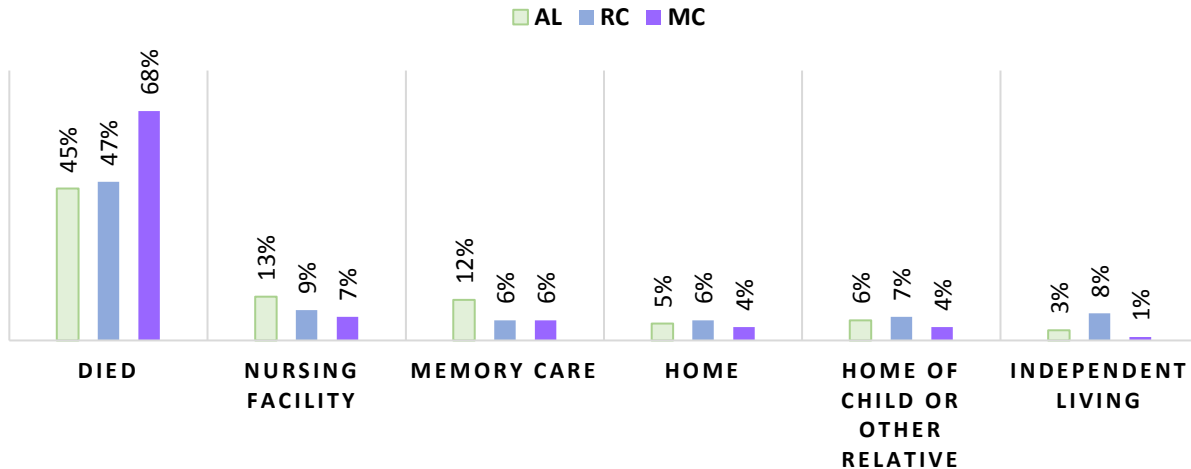


Figure 11: Five Most Common Resident Move-Out Location

Across all setting types, a total of 31 residents (3 percent) moved out in the last 90 days because they could no longer afford to pay or spent down their assets. The highest number of those residents moved out of RC (14 residents, or 45 percent), followed by AL (9 residents, or 29 percent) and MC (8 residents, or 26 percent). Last year’s survey asked how many residents moved out in the prior year; the average figure across settings was two percent (3 percent in MC, and 1 percent in both AL and RC). The prior survey asked providers to describe move-outs for the prior year; the current survey (as with future surveys) asked about move-outs for the prior three months (see Methods section in Appendix A for details). There is no known reason that residents who moved out in the prior three months would differ from a sample of move-outs over an entire year, and the data appear to represent similar findings.

Length of Stay

The length of stay in CBC settings is an important component of quality of care and quality of life for residents. Nationally, the median length of stay is just under two years (Caffrey et al., 2012). Our findings indicate that the majority of Oregon CBC residents who moved out in the prior three months had stayed for one year or longer before moving (58 percent) (Table 7). This is an eight percentage point difference over the rate reported last year. Based on the current survey, ALs had the longest length of stay, with 64 percent of residents staying for one year or longer, followed by MCs, with 53 percent staying one year or longer, and RCs, with 49 percent staying one year or longer.

Table 7: Length of Stay

	AL % (n)	RC % (n)	MC % (n)	Total % (n)
1-7 days	1% (8)	3% (10)	2% (7)	2% (25)
8-13 days	1% (8)	2% (6)	2% (6)	2% (20)
14-30 days	4% (24)	5% (16)	6% (18)	5% (58)
31-90 days	8% (47)	11% (33)	8% (25)	9% (105)
90-180 days (3-6 months)	10% (65)	9% (28)	14% (41)	11% (134)
181 - 1 year (6-12 months)	11% (69)	20% (59)	15% (45)	14% (173)
Total under one year				42% (515)
1 - 2 years	21% (133)	17% (52)	19% (57)	20% (242)
2-4 years	21% (133)	19% (58)	22% (65)	21% (256)
More than 4 years	22% (134)	13% (39)	12% (35)	17% (208)
Total over one year				58% (706)
Total	621	301	299	1,221

Shorter stays of six months or less decreased for all facilities since the 2015 report. In ALs, 33 percent of stays were six months or shorter in 2015, whereas in 2016 that figure was 24 percent. RCs followed a similar pattern with 38 percent of residents staying six months or less in 2015 compared to 30 percent in 2016. MC stays that were six months or shorter changed from 35 percent in 2015 to 32 percent in 2016. Of the current CBC respondents, lengths of stay that were six months or less decreased by five percentage points from 2015 to 2016 (from 34 percent to 29 percent). **Eighteen percent of settings reported stays of one to 90 days compared to 23 percent who stayed 90 or fewer days reported in 2015.** Nationally, only nine percent of RC residents had a stay of less than 90 days, and nine percent stayed for four-five months.

Personal Care Needs

Personal care needs, including the activities of daily living (ADLs), are the daily self-care activities that adults need to function in daily life, including eating, transferring from a bed or chair, dressing, bathing, using the bathroom, and walking/mobility. Respondents reported that nearly two-thirds of residents required staff assistance with at least one ADL (Table 8). The level of assistance needed by a resident can vary greatly; this question refers to any level of staff assistance. Across all setting types 65 percent of residents required assistance with bathing and/or showering, 48 percent required assistance with dressing, 42 percent required assistance with incontinence care, and 39 percent required assistance with using the bathroom. Overall, 30 percent of CBC residents required assistance with mobility, and 70 percent used a mobility aid of some type. Oregon’s residents are similar to residents nationally in terms of their need

for ADL assistance. The 2014 national survey reported the following ADL needs: bathing – 62 percent; dressing – 47 percent; toileting – 39 percent; walking/mobility – 29 percent; transferring – 30 percent; and eating - 20 percent (Harris-Kojetin, Sengupta, & Park-Lee, 2016).

Table 8: Personal Care Needs

	AL % (n)	RC % (n)	MC % (n)	Total % (n)
Eating	3% (150)	7% (178)	27% (642)	9% (970)
Transferring from a bed or chair	22% (1,286)	27% (665)	40% (962)	27% (2,913)
Dressing	39% (2,287)	42% (1,033)	77% (1,854)	48% (5,174)
Bathing and/or showering	54% (3,173)	62% (1,507)	93% (2,233)	65% (6,913)
Using the bathroom	26% (1,542)	33% (813)	74% (1,790)	39% (4,145)
Incontinence care	30% (1,768)	38% (933)	74% (1,774)	42% (4,475)
Walking/mobility	25% (1,483)	25% (602)	46% (1,103)	30% (3,188)

There were important variations among residents in the three Oregon setting types in their need for support with ADLs. The largest number of residents requiring ADL assistance was in in MC settings. Ninety-three percent of MC residents required assistance with bathing, which is similar to the 2015 report that 98 percent of MC residents required bathing assistance. In a national study of dementia prevalence in assisted living, Zimmerman, Sloane, and Reed (2014) found that the most common ADL needs were help with bathing followed by dressing. Need for bathing assistance was the most frequently needed ADL by residents across all Oregon setting types in 2016, with 62 percent of RC residents and 54 percent of AL residents needing bathing support. The second most commonly reported ADL need was dressing, with 42 percent of RC residents and 39 percent of AL residents requiring some support with dressing.

Resident Health & Health Service Use

Older persons are likely to have one or more diagnosed chronic diseases that affect their daily life, including the ability to be independent (Federal Interagency Forum on Aging-Related Statistics, 2012). The five most common diagnosed chronic conditions among residents across the three settings were hypertension (51 percent), Alzheimer’s disease or other dementias (46 percent), heart disease (38 percent), arthritis (36 percent), and depression (31 percent) (Figure 12 & Table B6 in Appendix). Rates of hypertension were similar across settings. Alzheimer’s and other dementias were highest in memory care, as would be expected, at 96 percent. The percent of people living in MC with dementia was not 100 percent because a spouse or other relative might live in the unit if the facility applied for and received a waiver from DHS. Heart disease was most prevalent among AL residents at 40 percent, followed by RC residents at 37 percent, and MC residents at 32 percent. Rates of arthritis were similar among MC residents (39 percent) and AL residents (37 percent), though slightly lower among RC residents (31 percent).

Depression rates were highest among MC residents (39 percent), followed by RC residents (32 percent) and AL residents (28 percent).

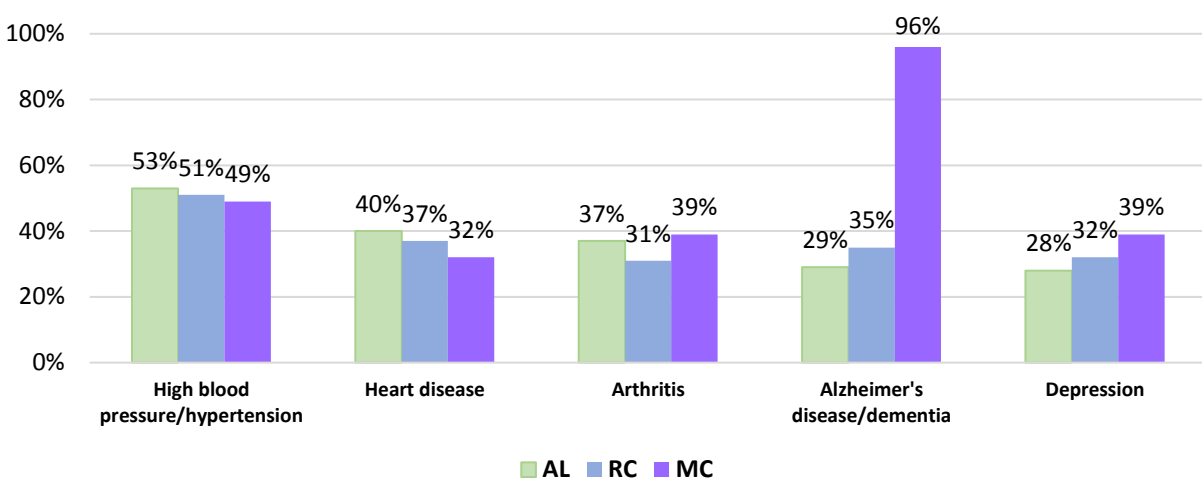


Figure 12: Most Common Diagnosed Chronic Conditions by Setting

The National Survey of Residential Care Facilities reported on the same five chronic conditions among residents aged 65 and over in 2010 (Khatutsky et al., 2016). Rates of hypertension were slightly higher among the national sample, at 59 percent compared to 51 percent in Oregon CBC settings. Alzheimer’s disease and other dementias were the same rate both nationally and in Oregon, at 46 percent, while heart disease was quite close, at 37 percent nationally and 36 percent in Oregon. National prevalence estimates for dementia and cognitive impairment among AL and RC residents range from 40 to 90 percent (Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2016; Rosenblatt et al., 2004; Wiener, Feng, Coots, & Johnson, 2014; Zimmerman, Sloane & Reed, 2014). Depression was slightly lower in the national study, at 26 percent compared to 31 percent in Oregon. Arthritis rates were slightly higher in Oregon, as well, at 36 percent compared to 29 percent nationally. Aside from the top five most common chronic conditions, diabetes rates were slightly higher in Oregon, at 19 percent compared to 16 percent nationally. Cancer rates were lower in Oregon, at seven percent compared to 11 percent nationally among RC residents. Reported rates of Chronic Obstructive Pulmonary Disease (COPD), osteoporosis and intellectual or developmental disabilities were exactly the same in Oregon as they were nationally, at 22 percent, 15 percent and one percent, respectively.

Resident Falls

Most residents did not experience falls within the previous 90 days: 73 percent had zero falls (Figure 13 & Table B7 in Appendix). The highest percentage of falls was among MC residents, with 17 percent falling one time in the previous 90 days and 18 percent falling more than once, meaning that more than one-third (35 percent) of MC residents fell at least once in the previous 90 days. Twenty-five percent of AL residents experienced falls over the same time period, whereas RC residents had slightly fewer falls, at 24 percent. These rates were slightly higher

than national rates of reported falls among RC residents, at 21 percent (Harris-Kojetin, Sengupta, & Park-Lee, 2016).

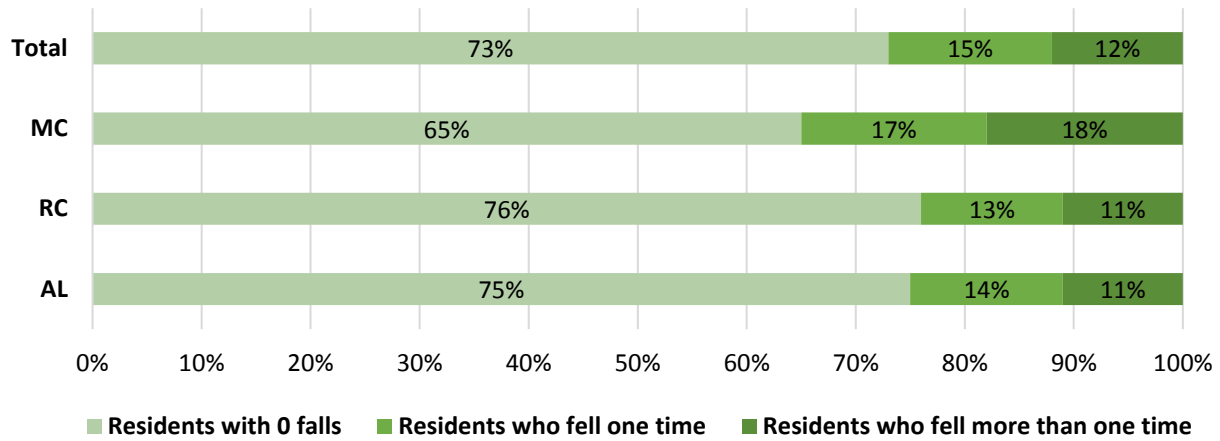


Figure 13: Resident Falls by Setting

Individuals with dementia are at a high risk of falls due to changes in spatial perception and brain function (van der Wardt et al., 2015; Mirelman, et al., 2012). The residents most likely to have a fall resulting in an injury over the previous 90 days lived in MCs (43 percent), but MC residents had slightly fewer falls that resulted in a hospital visit, at 16 percent (Figure 14 & Table B8 in Appendix). Among RC residents who fell in the past 90 days, 38 percent of those falls resulted in some kind of injury, and 17 percent resulted in a hospital visit, whereas among AL residents, 33 percent of falls resulted in some kind of injury and 17 percent resulted in a hospital visit.

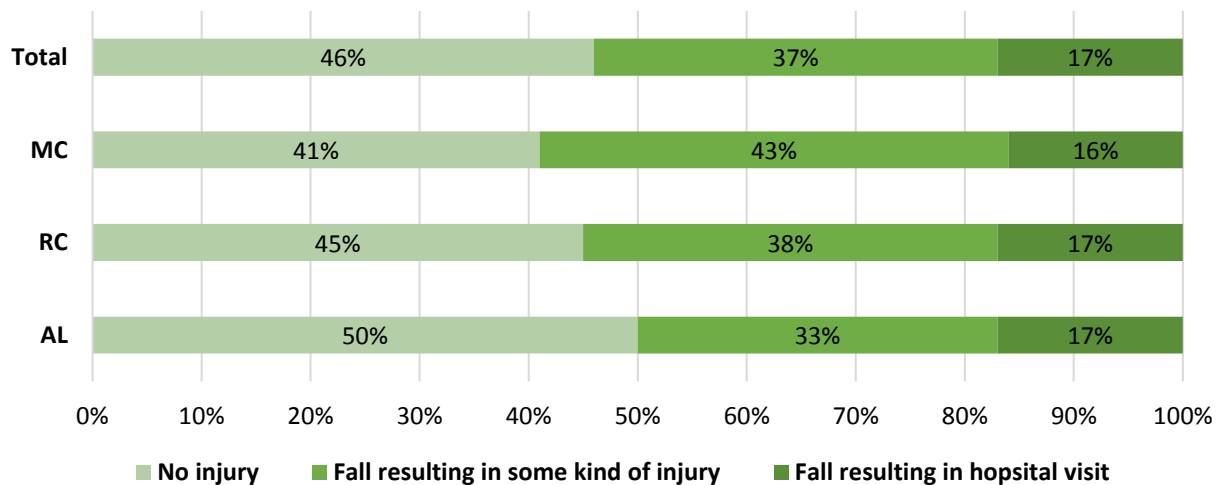


Figure 14: Falls Resulting in Injury or Hospitalization by Setting

Hospital Use

Across all CBC setting types, 14 percent of residents were treated in an emergency department in the previous 90 days (Table B9 in Appendix). This figure is slightly higher than the national average of 12 percent among all long-term services and supports (LTSS) users (Harris-Kojetin, Sengupta, & Park-Lee, 2016). When looking at individual CBC setting types, in Oregon there is some variation, with 14 percent of residents in AL, 13 percent in MC and 12 percent – right at the national average – in RC.

Overnight hospital stays by residents in the previous 90 days across all three settings were reported at the same rate as the national level, eight percent (Harris-Kojetin, Sengupta, & Park-Lee, 2016). Eight percent of AL and RC residents had an overnight hospital stay during the previous 90 days. However, rates for MC residents were slightly lower, at six percent. Research shows that persons who have dementia might be distressed, including onset of delirium or acquisition of new illness or injury, by hospital admission and emergency department use (Becker, Boaz, Andel, & DeMuth, 2012; Mitchell et al., 2007), so decisions about hospital use for this population must be informed by the individual’s status and preferences. The lower hospitalization rate among Oregon MC residents compared to that for AL and RC residents might be explained by decisions not to hospitalize persons with advanced dementia (Mitchell, Teno, Intrator, Zhanlian, & Mor, 2007).

The National Survey of Long-Term Care Providers indicated that 62 percent of residential care communities offer or arrange hospice services (Harris-Kojetin, Sengupta, & Park-Lee, 2016). Although we did not ask if CBC communities offered or arranged hospice services for their residents we did ask providers to indicate how many of their residents had utilized hospice services in the previous 90 days. Overall, only seven percent of residents had received hospice care in the previous 90 days. The rate was the highest for MC residents, of whom 11 percent received hospice care.

Homebound

Oregon CBC respondents reported that, for 13 percent of current residents, leaving the building/community was so physically or emotionally taxing that they were normally unable to leave. Nearly one-third (30 percent) of these residents resided in MCs, while 14 percent lived in RC and six percent lived in AL. The purpose of this question was to identify the number of residents who might be considered “homebound” based on the definition used by the Centers for Medicare and Medicaid Services (CMS, 2014). Medicare recipients might be eligible for physician home visits and other services if they meet the CMS definition of homebound. **Thus, as many as 1,410 residents (13 percent) might be homebound**, though individual residents would need to be assessed to see if they meet the CMS definition.

Medications and Treatments

CBC communities in Oregon administer medications to residents who need or request such assistance. The proportion of residents who take no medications at all is very low, at two

percent overall – four percent in MC, two percent in RC and only one percent in AL. Polypharmacy, or taking multiple medications, presents possible risks of adverse health effects (Maher, Hanlon, & Hajjar, 2014). Nursing facility studies indicate 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; Zimmerman et al., 1995). The National Nursing Home Survey (Dwyer, Han, Woodwell, & Rechtsteiner, 2010) reported that 40 percent of nursing home residents take nine or more medications. Our findings in Oregon reveal that **55 percent of residents in CBC settings take nine or more medications** (Figure 15 & Table B10 in Appendix). This is slightly different from the 2015 report, which indicated that 51 percent of residents were taking nine or more medications. Rates across different setting types were quite similar – 56 percent in RC, 55 percent in AL, and 54 percent in MC.

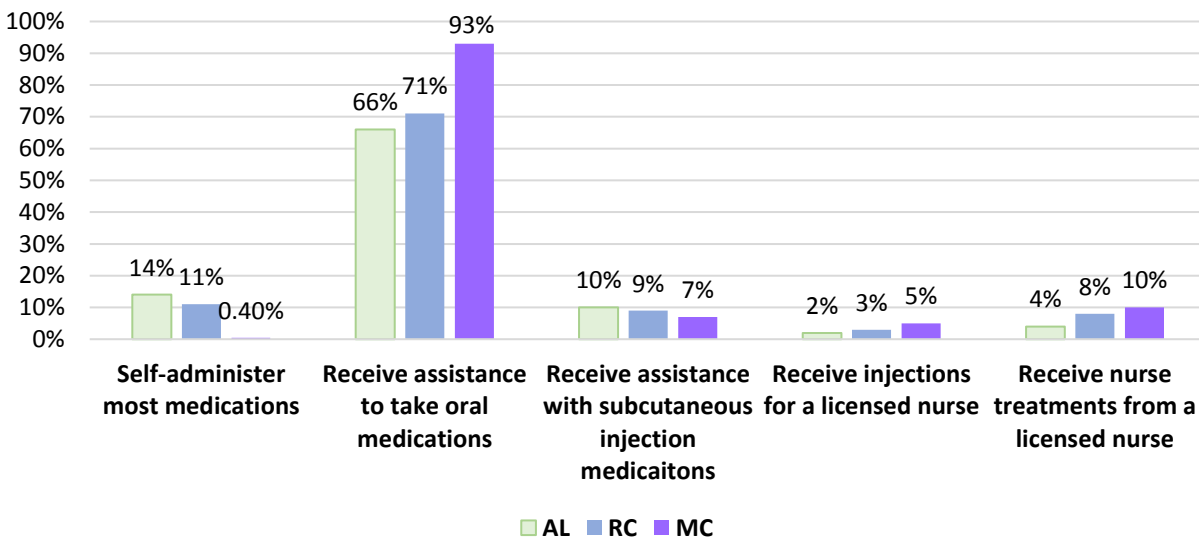


Figure 15: Medication Assistance by Setting

On average, 26 percent of residents took an antipsychotic medication. Antipsychotic medication use was highest in MC at 42 percent, followed by RC at 26 percent of residents, and 19 percent in AL. When looking at these rates in MC as compared to the data reported in 2015, this represents a change in the use of antipsychotic medications, from 45 percent to 42 percent, while the rate for AL and RC increased slightly since 2015 (15 percent and 23 percent, respectively in the 2015 report). However, these rates are similar to those in the 2010 national survey, which found that 22 percent of RC residents are prescribed antipsychotic medications (Zimmerman, Sloane, & Reed, 2014). Additional study is needed to assess how antipsychotic medications are prescribed and used. For example, neither the Oregon nor the national study has information on the reason for the prescription (e.g., to treat behavioral symptoms), whether medications are prescribed as routine or given only as needed (PRN), and whether medications prescribed as PRN are actually used. In addition, the terms psychotropic and

antipsychotic are sometimes treated as the same in the literature, and these terms need to be clarified for policy and practice.

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 National Center for Assisted Living's (NCAL) quality initiative set 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).

Almost three-quarters (73 percent) of residents across the three types of CBC settings received staff assistance to take oral medications. While fewer AL (66 percent) and RC (71 percent) residents used medication assistance, nearly all MC residents (93 percent) received assistance to take oral medications. Across all setting types, receiving assistance with subcutaneous injection medications (9 percent), receiving nurse treatments from a licensed nurse (6 percent), and receiving injections from a licensed nurse (3 percent) were less common.

Flu vaccination rates

The CDC recognizes older adults and individuals with long-term medical conditions as being at a high risk for serious complications resulting from contracting influenza (CDC, 2015). Compared to CBC staff in these settings, who received flu vaccinations at a rate of only 28 percent, **60 percent of residents received a flu vaccination this past fall**. MC residents were more likely (73 percent) than AL (55 percent) or RC residents (59 percent) to have received a flu vaccination. Compared to overall vaccination rates for Oregonians aged 65 and older, at 56 percent among men and 57 percent among women, these rates among CBC residents were fairly comparable (CDC, 2013). Only MC residents currently meet the Healthy People 2020 goal of influenza vaccination rates of 70 percent or higher (ODPHP, 2015). When compared to national rates, Oregon's flu vaccination rates for residents of AL, RC, and MC settings were low.

Policy Considerations and Conclusions

Community-based care settings represent an important part of the long-term care landscape of Oregon. Many residents of these settings have multiple chronic health conditions and physical and cognitive impairments. While most older persons would prefer to remain in their own homes (Farber et al., 2011), CBC settings provide a community-based alternative to nursing home care.

This report provides information about assisted living, residential care, and memory care in Oregon with respect to staffing, services, and rates that had not been previously available. It also updates information from 2015 about residents' health-related and personal care needs. As the population continues to age, CBC settings provide an important option for individuals whose needs might be difficult to manage at home but who do not require on-going skilled nursing care. The findings from this study indicate that AL, RC, and MC settings continue to provide a range of personal care and health-related services and oversight to a primarily frail and elderly population. Following are several policy considerations regarding memory care, staffing in CBC settings, quality improvement, length of stay, and health promotion and risk assessment activities that emerged based on this study.

Memory care is an increasingly important component of community-based care in Oregon. Of the three CBC setting types, the largest increase in number of units is in this sector. As described, there are important differences between AL, RC, and MC residents, staffing, policies, services, and rates. While MC settings charge a higher monthly rate and receive a higher Medicaid reimbursement compared to AL and RC settings, a larger percentage of MC residents require staff assistance with personal care needs, MC settings have higher staffing levels, and fewer MC settings compared to ALs and RCs use two-person transfer, wandering, and hitting others as triggers for discharge. Given the vulnerability of persons who have dementia, MC policies and programs are important public policy topics.

Staffing levels in CBC settings are similar to national rates and appear to increase relative to resident acuity. However, more information is needed about other important staffing topics, such as staff retention, the relationship between staffing and adverse events and substantiated complaints, and the effectiveness of staff training.

Having a quality assurance program is required of CBC settings. While most settings have a QA program and update it on a regular basis, it is less clear how providers know whether their program effectively assesses issues that concern residents, families, or policymakers. More information is needed about how providers monitor and review quality.

Whether CBC settings are affordable is an important topic. The total monthly private-pay charges range from \$41,350 per year for AL to \$62,016 per year for MC. While these annual charges look high and may not account for some of the additional fees described in this report, it is noteworthy that 42 percent of residents had a length of stay of one year or less.

The average length of stay of residents who moved out in the three months prior to the survey is highly variable. Of the 42 percent who stayed for less than one year, 18 percent (nearly one

in five) stayed less than 90 days. Possible reasons for short lengths of stay might include a poor fit between resident acuity and health-related needs and facility staffing capacity, thus these numbers are concerning. While over half (58 percent) of residents lived at the setting for more than one year, this rate is below the national average of two years.

Influenza vaccination of health care providers in LTC settings is important, given that persons with chronic health conditions might experience worse health outcomes of flu, when compared to persons who do not have chronic health conditions. Multiple studies have shown that vaccination of health care workers in long-term care settings offers a health benefit to residents, including reduced risk for mortality (CDC, 2014). Oregon's relatively low rate of flu vaccination among CBC staff deserves policy attention. While the rate among residents is higher than that among staff, overall, 40 percent of residents reside in these settings without immunization against influenza.

Assessment of fall risk among persons with mobility limitations and who are elderly is considered a good practice in long-term care. The majority of settings (64 percent) indicated that they use a falls risk assessment tool as a matter of standard practice, but 14 percent do not conduct a falls risk assessment.

It is important to understand that respect for individual dignity, choice, and independence are foundational values in Oregon's community-based care settings. These values have long been expressed by community stakeholders, most recently during the state's LTC 3.0 strategic planning effort (DHS, 2015). These values have also been described in a ruling that affects CBC settings made in 2014 by the Centers for Medicare and Medicaid Services. Community-based care residents have the right to make choices that counter provider recommendations. For example, residents might choose not to get a flu vaccination or to hold off on medical treatment until a crisis occurs, requiring hospitalization.

In conclusion, Oregon DHS has asked PSU's Institute on Aging to collect additional information from AL, RC, and MC settings over the next two years. Some questions will be new, and other questions will be repeated to allow for comparison over time. We recognize that completing the questionnaire requires staff time and investment, and we appreciate that just over 50 percent of Oregon settings responded. We will continue to work with our stakeholders to ask questions that are relevant to policymakers, providers, and consumers, and we encourage providers to participate when the next questionnaire is distributed. A strong response from providers results in findings that are reliable and valid and shows that providers consider this data collection and analysis effort worthwhile.

Appendix A: Methods

Common Acronyms Used in this Report

LTSS - Long-term Services Supports
APD - Division of Aging and People with Disabilities
DHS - Oregon's Department of Human Services
OHA - Oregon Health Authority
CMS - Centers for Medicare and Medicaid Services
HCBS - Home and Community-Based Services

Data Collection Instrument

This project is the second annual questionnaire conducted by PSU's Institute on Aging as a follow-up to a previous questionnaire last administered by the Office for Oregon Health Policy and Research in 2008. The previous questionnaire (see the 2015 report) was used as a starting point to develop this effort in partnership with stakeholders from:

- DHS, Division of Aging and People with Disabilities,
- Oregon Health Care Association (OHCA),
- Oregon assisted living, residential care and memory care providers, and
- Leading Age Oregon.

Questionnaire topics included facility information, resident demographics, resident activities of daily living (ADLs), resident acuity, facility rates and fees, staffing, additional services, and facility policies. Some provider information reported in 2015 was not asked again because few changes were expected and to keep the questionnaire to a reasonable length.

Based on feedback from stakeholders, we modified the time-frame for questions. The majority of questions described in the 2015 report asked providers to respond based on the prior 12 months (e.g., 2014). We heard from providers, including those who did and did not have electronic record systems, that a 12-month look-back was onerous and time consuming. Providers with a large number of residents were especially concerned about the time it took to, for example, identify all residents who had moved out in the prior 12 months and then to report where the resident had originally moved in from, and where the resident moved to (or died). The national surveys of residential care conducted by the National Center for Health Statistics use a three-month look-back period for these and similar questions (Khatutsky, 2016). Thus, the current and future CBC surveys are using a three-month time frame for questions that ask about events that recently occurred (e.g., falls, hospital use, move-ins and move-outs).

Sample Selection and Survey Implementation

The total population for this study includes all 491 assisted living, residential care, and memory care communities in Oregon that were licensed as of November, 2015. Of these 491, 216 were licensed for AL, 275 were licensed for RC, and of this total, 160 held a memory care endorsement.

As MCs receive an endorsement to offer memory care in addition to their AL or RC license, they can be divided into two categories: stand-alone or combination. Stand-alone MCs offer solely memory care, whereas combination MCs offer memory care units and additional units under their primary licensure type. For example, a community can be licensed to provide 40 RC units and receive an endorsement for 10 memory care units. For the purposes of data collection, we asked combination communities to complete two questionnaires: one for their AL or RC units and one for their MC endorsed units. MC questionnaires were counted separately from the AL and RC totals because of the licensing overlap. Therefore, the total number of cases (261) exceeded the total number of licensed communities (253) who responded to the questionnaire. This allowed us to isolate data from MC communities.

A copy of the questionnaire was mailed to facility administrators during the first week of January, 2016. Providers were asked to complete the questionnaire and return it to PSU's Institute on Aging via fax, scan and email, or US postal service. Returned surveys were checked for missing information and responses. As needed, providers were contacted to clarify missing or confusing responses.

To increase the response rate, we called all providers who had not returned a questionnaire within two weeks of the original mailing. In addition, we called corporate offices for those that owned more than 8 communities, DHS posted two provider alerts, and OHCA and LeadingAge published information about the project in their newsletters.

Survey Response

A total of 253 facilities responded, for a response rate of 52 percent (Table A. 1). Because MCs in the sample were licensed as either AL or RC, the number of MCs is not included in the total number of licensed facilities used to calculate the response rate.

Table A1: Response by Region

	AL % (n)	RC % (n)	MC % (n)	Stand-alone % (n)	Combination % (n)	Total % (n)
Portland Metro <i>Clackamas, Columbia, Multnomah, Washington</i>	31% (34)	47% (37)	42% (32)	37% (24)	67% (8)	38% (95)
Willamette Valley <i>Benton, Clatsop, Lane, Lincoln, Linn, Marion, Polk, Tillamook, Yamhill</i>	27% (30)	17% (13)	31% (24)	34% (22)	17% (2)	26% (65)
Southern Oregon <i>Coos, Curry, Douglas, Jackson, Josephine</i>	15% (16)	17% (13)	12% (9)	12% (8)	8% (1)	15% (37)
Eastern Oregon <i>Baker, Crook, Deschutes, Gilliam, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, Wheeler</i>	27% (30)	19% (15)	16% (12)	17% (11)	8% (1)	22% (56)
Total	43 % (110)	31% (78)*	30% (77)	26% (65)	5% (12)	253

*All stand-alone MCs that were licensed as RCs were considered to be MC only

Some providers reported difficulty with reporting some of the resident data requested because they did not regularly track some of these items, such as length of stay and race/ethnicity of residents. When data availability was a challenge, providers were encouraged to give their best estimate.

Non-response

A total of 238 facilities did not respond to the questionnaire; 106 were ALs and 132 were RC. The licensed capacity per non-respondent community ranged from seven to 186. While all non-respondents in 2015 were contracted to accept Medicaid, of 2016 non-respondents, 74 percent were contracted to accept Medicaid. Reasons given for non-response included business closure, major renovation during 2015, survey not mandatory, change of ownership or major administrative changes, currently too busy, survey length, and administrator was unavailable.

Twenty-eight percent of the 2016 respondents also responded in 2015. However, 22 percent of those who responded in 2015 did not respond in 2016; 23 percent of the 2016 respondents were first-time responders. Twenty-seven percent of settings that were included in the 2015 and 2016 survey have not responded to the survey either year.

Data Analysis

Quantitative data were entered into SPSS, a statistical software program, then checked for errors (e.g., data cleaning). Quantitative data analysis entailed primarily descriptive statistics (counts and percentages). Responses to open-ended questions, were summarized according to themes.

Average staff hours per resident per day were computed by multiplying the number of FTE employees for each type of staff by 35 hours, and then multiplying the number of part time employees for each type of staff by 17.5. These two quantities were summed and the total staff hours were then divided by total number of residents which was further divided by seven to provide average staff hours/resident/day. That is, average hours per resident per day = $((\text{FT staff type} * 35) + (\text{PT staff type} * 17.5)) / \text{total number of residents} / 7$. Any facility with more than 24 hours was recoded to have 24².

Profession Charges

The calculation of industry charges was inspired by a similar calculation conducted using data from the national survey of residential care communities (Khatutsky et al., 2016), resulting in total estimated industry charges nationally. Our study, focused only on AL, RC and MC in Oregon, uses the following method and data from DHS to reach an estimate for industry charges in Oregon. In the following calculations, the estimated percentage of Medicaid residents was determined by applying the ratio of facilities with a Medicaid contract among respondents with those of non-respondents and assumes the same ratio of residents who are Medicaid beneficiaries. Fewer Medicaid contracts among non-respondents likely results in fewer Medicaid beneficiaries among non-respondent facilities. Rates of respondent facilities were applied to non-respondents for occupancy rate and average monthly private pay charges.

² There was only one with more than 24 average hours per day per resident.

Table A2: Estimated Annual Profession Charges for Oregon AL, RC, MC

Estimated Monthly and Annual Profession Charges for Oregon AL, RC, MC					
Questionnaire Respondent Facilities		AL	RC	MC	Totals
Private Pay					
	Total current residents	5846	2439	2409	10694
-	Total current Medicaid beneficiaries	2455	976	988	4419
=	Total of current private pay residents	3391	1463	1421	6275
x	Average total monthly charge incl. services	\$3,475	\$3,556	\$5,168	
=	Total private pay charges	\$11,781,019	\$5,203,485	\$7,345,359	\$24,329,862
Other Facilities in Oregon (non-respondents)					
Private Pay		AL	RC	MC	Totals
	Licensed capacity	7030	2213	2769	
x	Occupancy rate*	0.83	0.83	0.89	
=	Estimated total current residents	5835	1837	2464	10136
x	Estimated % of Medicaid residents**	36%	29%	28%	
=	Estimated total Medicaid beneficiaries	2101	533	690	3323
	Estimated total current residents	5835	1837	2464	10136
-	Estimated total Medicaid beneficiaries	2101	533	690	3323
=	Estimated total private pay residents	3734	1304	1774	
x	Average total monthly charge incl. serv.*	\$3,475	\$3,556	\$5,168	
	Total est. charges for private pay residents	\$12,975,062	\$4,637,128	\$9,170,007	\$26,782,197
Estimated Total Annual Private Pay Charges					\$613,344,712
Total Annual Medicaid Charges Paid (data from DHS)					\$257,020,390
Total Annual Profession Charges					\$870,365,102

*Rate of respondents applied to non-respondents

**Estimated proportion of Medicaid residents applies the ratio of facilities with a Medicaid contract among respondents with those of non-respondents and assumes the same ratio of residents who are Medicaid beneficiaries. Fewer Medicaid contracts among non-respondents likely results in fewer Medicaid beneficiaries among non-respondent communities.

Appendix B: Additional Tables

Table B1: Community Ownership Characteristics, 2015 CBC Report

	AL % (n)	RC % (n)	MC % (n)	Total % (n)
Tax status: For profit	82% (95)	84% (105)	86% (65)	84% (265)
Third party management	57% (66)	58% (52)	47% (36)	49% (154)
Ownership				
Single ownership	29% (33)	38% (47)	34% (26)	34% (106)
Owns 2-25 communities	32% (36)	39% (49)	34% (26)	35% (111)
Owns 26+ communities	40% (45)	23% (29)	32% (24)	31% (98)
Total responding facilities	116	127	78	243*

*MCs not counted in total number of facilities, as MC is additional endorsement for ALs/RCs

Table B2: Facilities that Employed Part-Time or Full-Time Staff, by Employee Categories, by Setting

	AL		RC		MC		Total	
	Part-time % (n)	Full-time % (n)	Part-time % (n)	Full-time % (n)	Part-time % (n)	Full-time % (n)	Part-time % (n)	Full-time % (n)
RN	72% (76)	32% (24)	62% (46)	39% (29)	58% (41)	39% (28)	65% (163)	36% (91)
LPN/LVN	19% (20)	6% (6)	11% (8)	7% (5)	31% (22)	13% (9)	20% (50)	8% (20)
CNA/CMA	25% (27)	13% (14)	41% (30)	14% (10)	38% (27)	20% (14)	33% (84)	15% (38)
Personal Care Staff	88% (93)	67% (71)	89% (66)	68% (50)	89% (63)	65% (46)	88% (222)	67% (167)
Social Workers	2% (2)	3% (3)	9% (7)	5% (4)	4% (3)	3% (2)	5% (12)	4% (9)
Activities Staff	78% (83)	39% (41)	51% (38)	38% (28)	73% (52)	46% (33)	69% (173)	41% (102)

Table B3: Gender and Age of Residents

		AL % (n)	RC % (n)	MC % (n)	Total % (n)
Gender					
	Male	27% (1,594)	38% (918)	29% (707)	30% (3,219)
	Female	73% (4,252)	62% (1,520)	71% (1,702)	70% (7,474)
	Transgender	-	<1% (1)	-	<1% (1)
Age Groups					
	<18	-	-	-	-
	18-49	<1% (25)	2% (45)	<1% (2)	1% (72)
	50-64	5% (309)	10% (234)	2% (58)	6% (72)
	65-74	12% (680)	14% (349)	10% (250)	12% (1,279)
	75-84	28% (1,663)	26% (641)	35% (849)	29% (3,153)
	85 and over	54% (3,169)	48% (1,250)	52% (1,250)	52% (5,589)
Total		5,846	2,439	2,409	10,694

Table B4: Race of Residents

	AL % (n)	RC % (n)	MC % (n)	Total % (n)
Hispanic Latino	1% (34)	1% (29)	1% (33)	1% (96)
American Indian or Alaska Native	<1% (26)	1% (16)	<1% (7)	<1% (49)
Asian	1% (55)	3% (66)	1% (22)	1% (143)
Black	<1% (13)	2% (38)	1% (17)	1% (68)
Native Hawaiian/other Pacific Islander	<1% (10)	<1% (9)	<1% (3)	<1% (22)
White	90% (5,289)	87% (2,131)	94% (2,262)	91% (9,682)
Two or more races	<1% (29)	<1% (6)	<1% (4)	<1% (39)
Other or Unknown	7% (390)	6% (144)	3% (61)	6% (595)
Total	5,846	2,439	2,409	10,694

Table B5: Move-In and Move-Out Location of Residents

Locations	AL		RC		MC		Total	
	In % (n)	Out % (n)	In % (n)	Out % (n)	In % (n)	Out % (n)	In % (n)	Out % (n)
Home	34% (194)	5% (34)	27% (89)	6% (17)	28% (101)	4% (11)	30% (384)	5% (62)
Home of relative	9% (53)	6% (35)	9% (28)	7% (20)	6% (22)	4% (12)	8% (103)	5% (67)
Independent living	13% (72)	3% (17)	10% (31)	8% (24)	8% (29)	1% (3)	10% (132)	4% (44)
AL/RC	7% (43)	4% (27)	10% (31)	5% (16)	22% (80)	4% (12)	12% (154)	4% (55)
Memory care	1% (6)	12% (77)	1% (3)	6% (19)	6% (23)	6% (20)	3% (32)	9% (116)
Hospital	5% (31)	2% (2)	15% (48)	6% (18)	13% (49)	2% (7)	10% (128)	3% (37)
Adult foster care	2% (14)	6% (39)	4% (13)	2% (6)	5% (17)	4% (12)	3% (44)	5% (57)
Nursing facility	14% (83)	13% (81)	17% (54)	9% (26)	9% (31)	7% (21)	13% (168)	10% (128)
Other	4% (24)	1% (8)	5% (17)	2% (6)	1% (4)	1% (2)	4% (45)	1% (16)
Died	-	45% (280)	-	47% (142)	-	68% (209)	-	51% (632)
Don't know	10% (55)	2% (11)	3% (11)	2% (7)	2% (8)	-	6% (74)	1% (18)
Total	575	621	325	301	364	309	1,264	1,232

Table B6: Resident Chronic Conditions

	AL % (n)	RC % (n)	MC % (n)	Total % (n)
Heart disease	40% (2,356)	37% (901)	32% (770)	38% (4,027)
Alzheimer's disease/dementia	29% (1,707)	35% (854)	96% (2,324)	46% (4,885)
High blood pressure/hypertension	53% (3,090)	51% (1,240)	49% (1,173)	51% (5,503)
Depression	28% (1,609)	32% (775)	39% (937)	31% (3,321)
Serious mental illness (bipolar, schizophrenia)	6% (374)	14% (340)	8% (199)	9% (913)
Diabetes	20% (1,165)	21% (518)	13% (309)	19% (1,992)
Cancer	7% (400)	7% (162)	7% (165)	7% (727)
Osteoporosis	21% (1,214)	19% (466)	26% (631)	22% (2,311)
COPD and allied conditions	16% (958)	16% (395)	12% (286)	15% (1,639)
Current drug and/or alcohol abuse	2% (98)	14% (105)	1% (36)	2% (239)
Intellectual/developmental disability	1% (64)	3% (62)	<1% (8)	1% (134)
Arthritis	37% (2,171)	31% (747)	39% (946)	36% (3,864)

Table B7: Resident falls by Setting

	AL % (n)	RC % (n)	MC % (n)	Total % (n)
Residents with zero falls	75% (4,347)	76% (1,780)	65% (1,575)	73% (7,702)
Residents who fell one time	14% (814)	13% (307)	17% (407)	15% (1,528)
Residents who fell more than one time	11% (620)	11% (245)	18% (427)	12% (1,292)
Total	5,781	2,332	2,409	10,522

Table B8: Falls Resulting in Injury or Hospitalization

	AL % (n)	RC % (n)	MC % (n)	Total % (n)
Fall resulting in some kind of injury	33% (478)	38% (210)	43% (357)	37% (1,045)
Fall resulting in hospital visit	17% (242)	17% (93)	16% (134)	17% (469)

Table B9: Health Service Utilization by Setting

	AL % (n)	RC % (n)	MC % (n)	Total % (n)
Treated in a hospital emergency room (ER) in the last 90 days	14% (825)	12% (300)	13% (321)	14% (1,446)
Discharged from an overnight hospital stay in the last 90 days	8% (457)	8% (202)	6% (154)	8% (813)
Received hospice care in the last 90 days	5% (285)	7% (166)	11% (272)	7% (723)

Table B10: Medication Usage and Assistance by Setting

	AL % (n)	RC % (n)	MC % (n)	Total % (n)
No medication	1% (86)	2% (55)	4% (85)	2% (226)
Nine or more medications	55% (3,187)	56% (1,372)	54% (1,289)	55% (5,848)
Antipsychotic medication	19% (1,096)	26% (636)	42% (1,000)	26% (2,732)
Self-administer most medications	14% (819)	11% (272)	<1% (11)	10% (1,102)
Receive assistance to take oral medications	66% (3,887)	71% (1,720)	93% (2,230)	73% (7,837)
Receive assistance with subcutaneous injection medications	10% (571)	9% (221)	7% (157)	9% (949)
Receive injections for a licensed nurse	2% (98)	3% (79)	5% (123)	3% (300)
Receive nurse treatments from a licensed nurse	4% (209)	8% (193)	10% (243)	6% (645)

Table B11: Languages Spoken by Staff and Residents

Languages	Staff (n)	Residents (n)	Languages	Staff (n)	Residents (n)
Spanish	174	48	Dzongkha	1	-
Filipino	15	-	Ethiopian	1	-
Russian	15	-	Hawaiian	1	-
Tagalog	15	-	Marshallese	1	-
Romanian	8	2	Micronesian	1	-
Chinese	6	3	Navaho	1	-
Vietnamese	5	3	Oromo	1	-
German	4	12	Pacific Islander	1	-
ASL	3	2	Palau	1	-
African	3	-	Palauan	1	-
Amharic	3	-	Siam	1	-
French	2	6	Sinhalese	1	-
Malayo	2	-	Sinhalese	1	-
Portuguese	2	-	Yapese	1	-
Samoan	2	-	Polish	-	3
Ukrainian	2	-	Swedish	-	3
Japanese	1	9	Farsi	-	2
Hindi	1	3	Finnish	-	2
Korean	1	3	Hungarian	-	2
Tigre	1	2	Thai	-	2
Arabic	1	1	Tibet	-	1
Bengali	1	-	Laos	-	1
Bosnian	1	-	Italian	-	1
Cambodian	1	-	Hebrew	-	1
Comorian	1	-	Greek	-	1
Chuukese	1	-	Dutch	-	1
Croatian	1	-			

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Appendix D: Survey Instrument



Oregon Community Based Care

2015 Resident & Community Characteristics Questionnaire

Assisted Living + Residential Care + Memory Care

CCMU/Provider # _____	(ex., 70M123 or 50A123; see p. 2)
Name of Community _____	
Address of Community _____	
Management Company _____	
Administrator _____	Community Phone _____
1. Person Completing Report _____	Title _____ Phone _____
2. Person Completing Report _____	Title _____ Phone _____
3. Person Completing Report _____	Title _____ Phone _____
Email _____	Web address _____

Your completed questionnaire is due by January 30th, 2016.

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 have questions concerning completing this questionnaire, please contact:
Jackie Kohon at 503-725-5236 or cbcor@pdx.edu.

Questionnaire Instructions:

This questionnaire is 8 pages – half the length of the one from last year!

The study results will be most accurate if every community completes all questions. If there is someone else at your organization that we should contact for the answer to any of the questions, please let us know and we will call that person.

Please provide your CCMU/Provider number and other information on the previous page, then continue on to answer all questions in the questionnaire.*

**The CCMU/Provider number is a six-digit code, which begins with a “7” or a “5” and includes at least one letter (for example, 70M123 or 50A123 or 50R123).*

A change from last year: *If your organization operates under more than one CCMU/Provider number, please complete one separate questionnaire for each CCMU/Provider number. If you need an additional copy of the questionnaire, please contact Jackie Kohon at 503.725.5236.*

*Please report resident characteristics in aggregate (total of all residents). Many questions will require accessing information contained in resident and employee files and totaling this information for all of your residents and employees. It may be helpful to have your **Acuity Roster** nearby when completing this questionnaire.*

Please provide your best estimate for each question. For open answer boxes, if the answer is “none” or “zero”, please write “0”. If the question does not apply to your organization, please write “N/A”.

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

35

Some questions ask you to mark a box like this:

A few questions ask you to provide a percent “%”. For example, 80 out of 100 is 80%.

Some questions ask about averages. For example, question 3 on page 1 asks about the average age of your current residents. The average is the total of the ages of all of your current residents divided by the total number of residents.

We greatly appreciate your time and the work that you do on behalf of older adults and persons with disabilities. We look forward to hearing from you by **January 30th, 2016**.

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 above.]*

3. What is the average age of your current residents? *[See previous page for instructions.]*

- Average age of all current residents

4. How many of your current residents are:

- 17 years and younger
- 18-49 years
- 50-64 years
- 65-74 years
- 75-84 years
- 85+ years
- TOTAL # OF CURRENT RESIDENTS**
[should match total in question #1.]

5. In the past 90 days, how many new residents moved in (for the first time) from the following places?

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

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

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

7. For the residents who moved out, 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 - 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 moved because they could no longer afford to pay or spent down their assets?

Number of residents

9. Which of the following would typically prompt a move-out notice? [Check all that apply.]

- Two-person transfer
- Wandering outside
- Sliding-scale insulin shots
- Hitting/acting out with anger to other residents/caregivers
- 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

→ If no residents fell at your community during the past 90 days, **SKIP to #12.**

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 community evaluate residents' risk for falling using a fall risk assessment tool?
[Examples include STEADI and 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 have been diagnosed with each of the following conditions? [Include all diagnoses for each resident. 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 illness (such as bipolar disorder, schizophrenia)
- Diabetes
- Cancer
- Osteoporosis
- COPD and allied conditions
- Current drug and/or alcohol abuse
- Intellectual/developmental disability
- Arthritis

14. For how many of your current residents is leaving the building/community so physically or emotionally taxing that they are normally unable to leave?

Number of residents

Resident Health Service Use

15. How many of your current residents were:

- Treated in a hospital emergency room (ER) in the last 90 days?
- Discharged from an overnight hospital stay in the last 90 days?
[Exclude trips to the ER that did not result in an overnight hospital stay.]
- Receiving hospice care in the last 90 days?

16. During the past year, did a dentist or dental hygienist visit your community to provide dental services to residents?

- Yes
- No

17. How many of your current residents received a flu shot this past fall?

- Number of residents
- Don't know/We do not track this

Activities of Daily Living

18. How many of your current residents now need any assistance with each of the following activities?

- Eating
- Transferring from a bed or chair
- Dressing
- Bathing and/or showering
- Using the bathroom
- Incontinence care
- Mobility/Walking

19. How many of your current residents use a mobility aide (e.g., cane, walker, wheelchair)?

Number of residents

Medications and Treatments

20. How many different **pharmacies**, including your home pharmacy and any retail, mail-order, and long-term care pharmacies, does your community currently receive medications from on behalf of your current residents?

Number of pharmacies

21. How often does your primary pharmacy review medication administration records?

- Once a month
- Every 3 months/quarterly
- Every 6 months
- Annually
- Other; specify:

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

Number of residents

23. How many of your current residents...

- Take 9 or more medications?
- Take antipsychotic medication
[Common examples: Haldol (Haloperidol); Quetiapine (Seroquel), Olanzapine (Zyprexa), Aripiprazole (Abilify), Risperidone (Risperdal).]
- Self-administer most of their medications?
- Receive personal care staff assistance to take oral medications?
- Receive personal care staff assistance with subcutaneous injection medications?
- Receive injections from a licensed nurse?
- Receive nurse treatments from a licensed nurse (e.g., oxygen and respiratory treatments, such as nebulizers; rectal medications; suctioning mouth with bulb syringes; wound care, such as staging pressure ulcers and dressing changes)?

Section C. Staff and Care Community Policies

24. How many staff are currently employed by your community? *[Current staff includes all employees, such as direct care, dietary, housekeeping, janitorial, administration, etc.]*

Number of staff

25. Of all your current staff, how many received a flu vaccine this past fall?

Number of staff
 Don't know/We do not track this

26. How long has the current Administrator been employed as Administrator?

 Years Months

These next questions are about **CURRENT care staff only**.

27. For each staff type below, write the number of full-time employees or part-time employees currently employed by your community. [Enter "0" if no employees.]

If any of the below employees work in more than one building or campus, please include only the hours those employees currently work in the building/community listed on the first page.

An individual is an employee if the community is required to issue a Form W-2 federal tax form on their behalf.

# of full-time	# of part-time	Staff Classification
		Registered nurses (RNs)
		Licensed practical or vocational nurses (LPNs)/ (LVNs)
		Certified nursing assistants and certified medication aides
		Personal care staff who are not licensed or certified
		Social workers
		Activities directors or staff

28. Contract or agency staff include individuals or organization staff under contract with and working at this community but not directly employed by the community.

Do you have any nursing, personal care, social work, or activities contract or agency staff?

Yes → Continue to #29
 No → SKIP to #30

29. For each staff type below, write the number of full-time contract or agency staff or part-time contract or agency staff.

[Enter "0" for any categories with no contract or agency staff.]

# of full-time	# of part-time	Staff Classification
		Registered nurses (RNs)
		Licensed practical or vocational nurses (LPNs)/ (LVNs)
		Certified nursing assistants and certified medication aides
		Personal care staff who are not licensed or certified
		Social workers
		Activities directors or staff

Community Rates & Fees

30. Do you currently have a Medicaid contract or accept Medicaid as a source of 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 Don't know

31. Do you currently have private-pay residents?

- Yes No

→ If no, SKIP to #35

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

- Yes No

32. For the past month, what was the average **base monthly charge** for a single resident living alone in the smallest room or unit type (e.g., a studio or alcove unit) and receiving the lowest level of care? (*Private-pay only*)

\$ _____ / month

33. For the past month, what was the average **total monthly charge (including services)** for a single resident living alone in the smallest room or unit type (e.g., a studio or alcove unit) and receiving the lowest level of care? (*Private-pay only*)

\$ _____ / month

34. In addition to your base rate, how are **private-pay residents** charged for services?

- Services are grouped into tiers or levels (e.g., Tier 1 might include all IADLs and some ADLs)
- Point system based on points for specific services (e.g. full assistance to shower)
- Based on the time it takes staff to provide services, such as the amount of time needed to assist a person to dress
- Based on a list of services, each with a fee
- Base rate is all-inclusive. No additional charges for rent and services.
- Other, please describe:

35. Does your community charge for any of the following? If so, what is the charge? [*If provided at no additional charge, please write "0".*]

Yes or No	If yes, how much \$	Fees and Deposits
		Meals regularly delivered to resident's room
		Transfer that requires 2 staff
		Staff escort resident to medical appointments
		Application fee
		Security/damage deposit
		Cleaning deposit
		Administrative fee
		Community fee
		Assessment fee

Community Policies and Staff Training

36. What policies does your community have in place to encourage annual flu immunization of staff? [*Check all that apply.*]

- Annual education and communication with staff to encourage immunization
- Health insurance for employees covers immunization at reduced or no cost
- Provide immunizations to staff through program other than health insurance for free or reduced cost (*on- or off-site*)
- Other – please explain: _____

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

- Disease-specific (e.g., dementia, stroke, diabetes)
- Medication administration
- Safety (fire safety, emergency preparedness)
- Communication and problem solving
- Nutrition and food management
- Residents' rights
- How to prevent communicable diseases
- Hospitality skills
- Person-directed or person-centered care
- Abuse
- Working with resident families
- Other; specify:

38. Does your community plan to apply for a memory care endorsement within the next 12 months?

- Yes No Don't know
- Already have a memory care endorsement

39. Does your community have a written policy that allows cannabis (marijuana) for medical reasons? *[This can include smoking, edibles, and extracts.]*

- Yes No Don't know

40. Does your community have a written policy that allows cannabis (marijuana) for recreational use? *[This can include smoking, edibles, and extracts.]*

- Yes No Don't know

41. Does your community conduct an annual resident and/or family satisfaction survey?

- Yes No Don't know

→ **If yes**, what percent of residents and/or family members were satisfied on the last survey you conducted?

- 90-100%
- 80-89%
- 70-79%
- less than 70%

→ **If yes**, what are the top 3 concerns raised by residents and/or families?

- 1) _____
- 2) _____
- 3) _____

→ **If yes**, what percent of residents and/or family members completed the last satisfaction survey?

- 90-100%
- 80-89%
- 70-79%
- less than 70%

42. Does your community have any strategies to retain staff and reduce staff turnover?

Yes No Don't know

→ If yes, please briefly list what you believe to be your 2 or 3 most effective retention strategies.

43. How often is your quality assurance (QA) program reviewed/updated?

Quarterly Monthly Never Other, please specify:

44. How do you know whether or not your quality assurance plan is working?

45. What events or activities trigger a review of your quality assurance program?

46. What languages, other than English, do your staff speak fluently?

47. How many of your current residents primarily speak a language other than English?

Number of residents

a. Other than English, which languages do your current residents primarily speak?

48. Is there anything else that you'd like to add? Anything we didn't ask about that you'd like us to know?

Thank you for taking the time to complete this questionnaire.