2014

Resident and Community Characteristics Report 2014: Assisted Living, Residential Care, Memory Care

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Oregon Community-Based Care

Resident and Community Characteristics Report **2014**

Assisted Living
Residential Care
Memory Care

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Executive Summary

In collaboration with the Aging and People with Disabilities (APD) program of Oregon's Department of Human Services (DHS), Portland State University's Institute on Aging (PSU-IOA) conducted this research study of assisted living, residential care, and memory care communities throughout the state of Oregon. The Oregon legislature appropriated funds to DHS in order to collect information from these community-based care providers that will allow DHS, providers, and the public to better understand resident characteristics such as acuity level, demographics, length of stay, move-in/move-out information, and community characteristics.

This project is a follow up to a 2008 survey conducted by the Office for Oregon Health Policy and Research (OOHPR); an additional survey is planned for 2016 in order to examine changes over time and to collect additional information. The 2008 survey was used as a starting point to develop the current survey in partnership with stakeholders from DHS APD program, Oregon Health Care Association (OHCA), Oregon assisted living and residential care facility providers, and Leading Age Oregon.

Survey

This report is based on a mailed survey of the 489 licensed assisted living (ALF) and residential care (RCF) facilities, including 148 facilities endorsed for memory care (MCC). Completed surveys asking about resident characteristics and available services in calendar year 2014 were received from 243 facilities, for a response rate of 50 percent. The study methods are described in Appendix A.

Key Findings

This report provides an overview of community-based care settings in Oregon. The results presented here are derived from surveys completed by 243 facilities serving 9,485 residents. Key changes between the 2008 OOHPR survey and 2014 include:

- Compared to 2008, the number of facilities increased by 13%, with the largest growth in MCCs (41%).
- The proportion of for-profit facilities and facilities managed by a third party increased from 2008 by 8%.
- The acuity level of residents increased on most measures compared to 2008.
- Compared to 2008, residents across all three community types required more assistance with ADLs and used more health services. Residents of MCCs required the most assistance with ADLs and use of health services, which is similar to 2008.
- The percent of residents who used hospice services increased from 2008 by 2%.
- The percent of residents who visited the hospital or an emergency department increased from 10% in 2008 to 28% in 2014.
- The percent of residents using Medicaid increased from 2008 by 10%.

Comparison of Key Findings from 2014 and 2008

2014	2008
Number and Capacity of All Licensed Facilities	
Compared to 2008, the number of facilities increased, with the largest growth in memory care communities.	
• 489 facilities, with 217 ALFs and 272 RCFs, of which 148 were endorsed for memory care.	• 432 facilities, with 205 ALFs and 227 RCFs, of which 105 were endorsed for memory (Alzheimer's) care.
Facility Characteristics	
The proportion of for-profit facilities and facilities managed by a third party increased.	
• 91% of ALFs and 96% of RCFs had less than 100 beds (most ALFs were licensed for 50-99 residents, while most RCFs and MCCs had a capacity of 20-49). • 83% for-profit. • 54% managed by a third party. • The average reported occupancy rate was 81 percent, with the highest rate reported by MCCs (87 percent). • Residents were primarily White, non-Hispanic (93%), female (66%), and over 85 or older (54%).	• 91% of ALFs and 96% of RCFs had less than 100 beds. • 75% for-profit. • 43% managed by a third party. • The average reported occupancy rate was 90%, with the highest rate reported by ACUs (94%). • Residents were primarily female (56%) and 85 or older (51%). Race was not included in the survey for 2008.
Resident Move-in and Move-out Locations	
There was little change in where residents had been living before coming to the CBC, but there were fewer discharges to nursing facilities and more discharges due to death, especially in memory care communities.	
• Most residents moved in from home (38%), independent senior housing (12%), or another assisted living (11%). • 43% of all discharges from CBC were due to death. • 5% were discharged to a nursing facility. • 65% of MCC discharges were due to death.	• Most residents moved in from home (37%), independent senior housing (15%), or another assisted living (12%). • 41% of all discharges from CBC were due to death. • 15% were discharged to a nursing facility. • 56% of MCC discharges were due to death.
Resident's Prior Residence and Average Length of Stay	
Length of stay was slightly longer in 2014 than in 2008.	
• Residents were most likely to move into an ALF, RCF, or an MCC from their own home (38%), with the second most likely location being a nursing home/skilled nursing facility (15%). • 50% of residents who moved out or died in 2014 had lived at the community for more than one year, 13% stayed 4 or more years, and 51% of residents stayed for less than one year.	• Residents were most likely to move into an ALF, RCF, or an ACU from their own home (37%), with the second most likely location being a nursing facility (14%). • 51% of residents who moved out or died in 2008 stayed more than one year, 13% stayed 4 or more years, and 49% of residents stayed for less than one year.

2014	2008
Resident Ambulatory Status, Acuity	
Fewer residents in MCCs were non-ambulatory, but MCC residents also were less likely to be independent in ambulation than in 2008. A higher percentage of residents overall had dementia.	
• Overall, 5% of residents were non-ambulatory, but the percentage was highest among MCC residents (9%). MCC and RCF residents (28% and 28%) were the most likely to be independent in ambulation, as compared to those in ALFs (22%). • A minimum of 23% of all residents required stand-by or full assistance with all activities of daily living except eating (13%). • For residents that required care with incontinence 34% required assistance with bladder incontinence, 20% with bowel incontinence, and 30% with both. • MCC residents were the most likely to have fallen at least once (43%). • 47% of all CBC residents had dementia. • 17% of ALF and 16% of RCF residents went to the emergency department and 11% were hospitalized. • 86% of all residents received assistance to take medications. 51% of residents took nine or more prescription medications. • Nearly one-fourth of all residents took antipsychotic (24%), anti-anxiety (23%), and/or antidepressant medications (36%) • Nearly half (46%) of all residents were being treated for pain with a pharmaceutical, with a slightly larger percentage of MCC residents receiving treatment.	• ACU residents were the most likely to be non-ambulatory (18%). ACU and RCF residents (34% and 28%) were the most likely to be independent in ambulation, as compared to ALF (25%). • Assistance with activities of daily living was not included on the survey for 2008. • 32% of residents required assistance to manage incontinence. • ACU residents were the most likely to have fallen (30%). • 42% of all CBC residents had dementia. • Hospital use was not included on the survey for 2008. • Medication assistance was not included on the survey for 2008. • 37% of residents received either a scheduled or as needed anti-psychotic, anti-anxiety, and/or sleep-inducing medication. MCC residents received this medication (67%) at a higher rate than residents of ALFs (30%) and RCFs (37%). • One in five residents reported having pain issues (19%). However, data for treatment of pain was not included on the survey for 2008.
Payer Source	
A higher proportion of residents were Medicaid clients, and Medicaid reimbursement rates decreased when adjusted for inflation.	
• Private pay (51%), Medicaid (39%), long-term care insurance (6%), VA (2%), and other (2%). • The state limit for room and board charges paid by Medicaid clients was $561, a 3% increase when adjusted for inflation. • Medicaid reimbursement for ALF residents, at the lowest level of care, was $1,073/month, a 3% decrease from 2008 when adjusted for inflation. • Medicaid reimbursement for RCF residents, at the lowest level of care, was $1,338/month, a 3% decrease from 2008 when adjusted for inflation.	• Private pay (65%), Medicaid (29%), long-term care insurance (5%), and other (1%). • The state limit for room and board charges paid by Medicaid clients was $494.70. • Medicaid reimbursement for ALFs, at the lowest level of care, was $1,002/month, beginning on July 1, 2008. • Medicaid reimbursement for RCFs, at the lowest level of care, was $1,249/month, beginning on July 1, 2008.

Background and Definitions

In Oregon, a variety of **community-based care (CBC) settings**, including assisted living, residential care, and memory care facilities, serve older persons who need on-going assistance with daily activities such as personal care and medications, as well as supervision and health monitoring. These CBC settings offer and coordinate supportive services on a 24-hour basis to meet the activities of daily living (ADL), health, and social needs of residents. A person-centered approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence, and home-like surroundings. In Oregon, assisted living facilities (ALFs) and residential care facilities (RCFs) may be single buildings, complexes, or parts of a complex. They consist of fully self-contained individual living units where six or more seniors and persons with disabilities may reside (OAR 411-054).

Assisted Living Facilities (ALFs) are distinguished from residential care facilities in that that they must provide private, single-occupancy apartments with a private bath and kitchenette. **Residential Care Facilities (RCFs)** may provide single or double rooms with shared bathrooms. Resident rooms must be 80 square feet per resident and are limited to two residents. **Memory Care Communities (MCCs)** are special care units in a designated, separated area for patients and residents with Alzheimer's disease or other dementia that are locked, segregated or secured to prevent or limit access by residents outside the designated or separated area. These units are typically co-located in an ALF or RCF, but they may be in a Nursing Facility (NF) or they may be a stand-alone community. Previously referred to as ACUs, or Alzheimer's Care Units, they are now called Memory Care Communities (or Units) to better reflect care provided to residents with a wider range of dementia types.

Common Acronyms

CBC - Community-Based Care
ALF - Assisted Living Facility
RCF - Residential Care Facility
MCC or ACU - Memory Care Community, Memory Care Unit, or Alzheimer's Care Unit
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

The demand for community-based care (CBC) settings is expected to increase as our population ages. More than two-thirds of individuals who reach age 65 may need long-term services and supports (LTSS) during their lifetime (Kemper et al., 2005-06), and the number of persons age 85 and older—those who are most likely to need CBC—is predicted to nearly triple by 2050 (U.S. Census Bureau, 2014). Moreover, the number of Oregonians with Alzheimer's disease will nearly double between 2000 and 2025 (Alzheimer's Association, 2010), further increasing demand for CBC.

Oregon's Department of Human Services (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 community-based care 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.

To meet this need, DHS contracted with Portland State University's (PSU) Institute on Aging to collect data from CBC providers concerning residents, such as their care needs and acuity level, demographic characteristics, length of stay, and move-in and move-out information. Data were also collected about the CBC facilities, such as their size, ownership, and vacancy rates. DHS also provided PSU data about Medicaid beneficiaries who used a CBC setting, and PSU conducted a state-wide survey of adult foster care homes (the findings from these analyses are presented in separate reports). DHS simultaneously contracted with Oregon State University (OSU) to collect similar data from nursing facilities throughout the state (reported by OSU in a separate report).

The findings from this study fill an important gap in our understanding of CBC residents, staff, and community characteristics. The 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.

Facilities

Eighty-four percent of CBC facilities who responded to the survey were for-profit, and 49 percent used a third-party management company (Table 1). Just over one third of responding facilities in 2014 were owned by a single proprietor (34 percent), with another third part of a chain of two to 25 facilities (35 percent), and just under one third part of a multi-community organization of 26 or more facilities (31 percent).

Table 1 – *Community Ownership Characteristics*

Ownership Characteristics		ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Tax status					
	For Profit	82% (95)	84% (105)	86% (65)	84% (265)
	Non-profit	18% (21)	16% (20)	15% (11)	16% (52)
Third party management					
	Yes	57% (66)	58% (52)	47% (36)	49% (154)
	No	43% (50)	42% (73)	53% (40)	51% (163)
Ownership					
	Single	29% (33)	38% (47)	34% (26)	34% (106)
	2-25	32% (36)	39% (49)	34% (26)	35% (111)
	26+	40% (45)	23% (29)	32% (24)	31% (98)
Total responding facilities		116	127	78	243*

*MCCs not counted in total number of facilities, as MCC is an additional endorsement for ALFs/RCFs.

Licensed Capacity of All Licensed CBC Facilities in Oregon

Table 2 reports the total licensed capacity of all three community types based on licensing information received from DHS. These numbers reflect the total licensed capacity by community size category in the state of Oregon in 2014. The total licensed capacity of all facilities in the state of Oregon was 24,897. Sixty-five percent of ALFs were licensed for 50-99 residents, while 41 percent of RCFs and 45 percent of MCCs had a capacity of 20-49. Only 4 facilities in the state had a capacity greater than 150. Thirty-two percent of RCFs and 20 percent of MCCs in 2014 had a capacity of less than 20 residents, compared to 2 percent of ALFs.

Table 2 – *Licensed Capacity Statewide*

Facility Capacity	ALF % (n)	RCF % (n)	MCC % (n)
<20	2% (4)	32% (87)	20% (30)
20-49	24% (52)	41% (111)	45% (66)
50-99	65% (142)	23% (62)	30% (45)
100-150	7% (16)	4% (10)	4% (6)
<150	<1% (2)	<1% (1)	<1% (1)
Total	217	272	148

Oregon has a greater supply of ALF and RCF units, proportionately, than most other states. In 2014, there were 41 ALF/RCF units per 1,000 Oregonians age 65 and older compared to a national average of 23 units per 1000 persons age 65 and older (Stevenson & Grabowski, 2010). Given that Oregon's population of persons 65 and older is projected to increase more than 100% between 2010 and 2040, the need to provide ample capacity in CBC settings is crucial (U.S. Census Bureau, 2012).

Number and Types of Units at Respondent Facilities

The survey collected information about the number of units and unit size of facilities. The remainder of this report describes the findings from the CBC providers' responses to that survey. Of the total of 6,001 ALF units, 59 percent were studio units, 35 percent were one-bedroom, and the remainder were 2-bedroom or other units. Among the 1,873 RCF units, half (50 percent) were one-bedroom and 41 percent were studio units (Figure 1). Facilities endorsed for memory care had a total of 1,816 units (in addition to the ALF/RCF units reported above). Of these units, half (50 percent) were studios, and 42 percent were one-bedroom units. Of the total 9,690 units in all three CBC facility types, studio units accounted for 54 percent, and two-bedroom units accounted for three percent of all units. See Appendix B, Table B. 1 for detailed data.

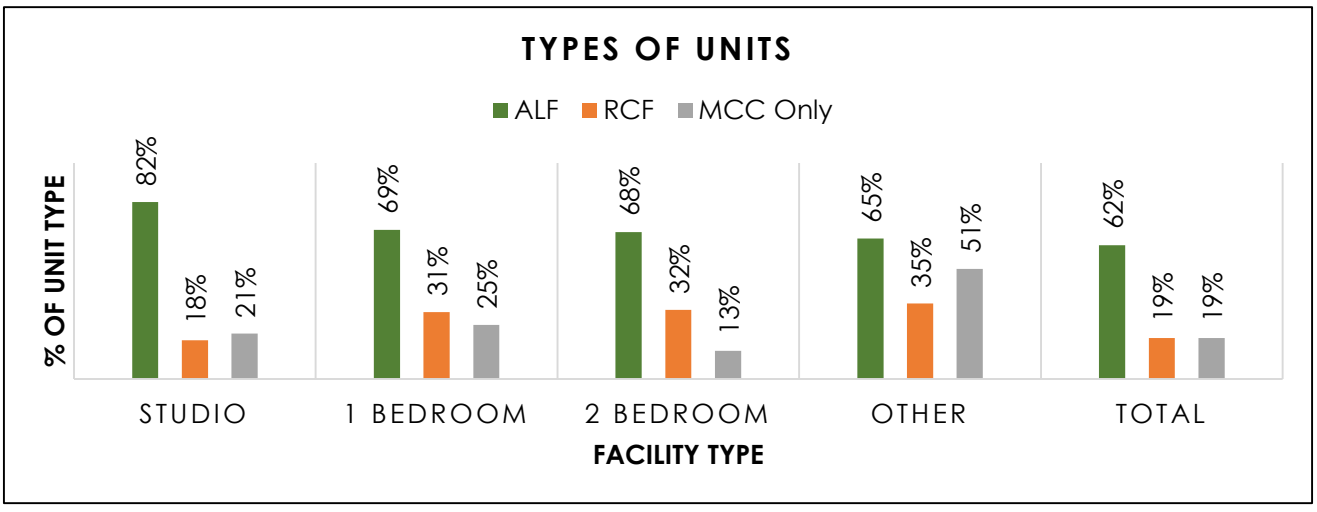

Figure 1 - *Type of Units by Facility*

Community Capacity and Occupancy Rate of Survey Respondents

The licensed capacity of all CBC facilities that responded to the survey was 11,787. ALFs accounted for 60 percent of that capacity. The number of residents served by these facilities was 9,485 and the average occupancy, based on providers' reports, was 81 percent (Table 3).

Table 3 – *Capacity and Occupancy of Survey Respondents*

Capacity and Occupancy of Survey Participants	ALF *n*	RCF *n*	MCC *n*	Total *n*
Licensed capacity of respondents	7,041	2,297	2,449	11,787
Total number of residents on average	5,443	1,903	2,139	9,485
Average reported occupancy rate (%)	73%	83%	87%	81%

The 2008 report found higher occupancy rates, with MCCs having the highest occupancy rate (94 percent), followed by ALFs (92 percent) and RCFs (84 percent), although this pattern of occupancy held true for 2014, as shown in Table 3. The National Survey of Residential Care Facilities (Caffrey et al., 2012) calculated an average occupancy rate of 75 percent, though industry estimates are much higher, at 90 percent (NCAL, 2015). Data provided here are reported rates, therefore actual rates may vary.

Transportation Services and Fees

Oregon's administrative rules require ALFs/RCFs to provide or arrange transportation for medical and social purposes. Seventy-two percent of facilities owned and operated a vehicle. The survey asked about providing transportation outside of a designated area. Over one-third (35 percent) of all facilities reported that they provided transportation outside of a designated service area, and of those who do so, nearly half (48 percent) charged a fee. Seventy-seven percent of facilities reported that they provided transportation to shopping within a designated service area. Of these, only 12 percent reported that they charged a fee for this service. Sixty-seven percent offered transportation to social/recreational activities, and of these, 10 percent charged a fee. Looking at responses by community type, larger percentages of both ALFs and RCFs reported that they owned/operated a vehicle compared to MCCs. More detail on transportation services can be found in Appendix B, Table B. 2.

Community Policies

Three questions were asked about facility policies associated with person-centered care based on a National Institute on Aging-funded study (Zimmerman et al., 2014): These questions asked providers whether the facility gives residents the choice to inform other residents if that resident is hospitalized; whether annual resident satisfaction surveys are conducted and shared with the ALF/RCF/MCC community, and whether annual staff satisfaction surveys are conducted and shared with the ALF/RCF/MCC community. Most

facilities (89 percent) reported that they had a policy to inform other residents when one resident is hospitalized, with a larger percentage of ALFs reporting this policy (Table 4). Just over half (59 percent) reported that they conducted a resident satisfaction survey, with ALFs less likely than RCFs or MCCs to do so. Most facilities conducted a staff satisfaction survey (81 percent), with MCCs less likely to report this policy. According to the National Center for Assisted Living Performance Measures Survey (2014), 89.9% of ALFs measure resident and family satisfaction, while 91.3% of ALFs measure employee satisfaction. These numbers differ from 2014 CBC survey results because of a difference in the questions asked in each survey.

Table 4 – *Facility Policies*

Facility Policies	ALF % (n)	RCF % (n)	MCC % (n)	Average % (n)
Resident choice to update fellow residents	38% (92)	32% (78)	19% (45)	30% (72)
Annual resident satisfaction surveys	10% (23)	31% (76)	19% (45)	20% (48)
Annual staff satisfaction surveys	30% (73)	31% (76)	19% (47)	27% (65)

Residents

The demographics of ALF and RCF residents in Oregon were very similar to prior Oregon-based surveys—the majority of residents were female (66 percent), White (93 percent), and age 85 or over (54 percent) (see Appendix B, Tables B. 3 – B. 5). These numbers were similar to the findings of the 2010 National Survey of Residential Care Facilities (Caffrey et al., 2012), which found that the majority of residents were White and non-Hispanic (91 percent), female (70 percent) and age 85 or over (54 percent).

The majority of all residents were female, however, female residents were most concentrated in ALFs (69 percent), followed by MCCs (67 percent), and finally RCFs (58 percent). The average age of residents across the three types of Oregon CBC settings was 82 (81.6). Only 7 percent of residents were under age 65. MCCs were most likely to have residents age 85 or older (87 percent), followed by ALFs (54 percent), and finally RCFs (49 percent). RCFs were most likely to have residents under age 65 (11 percent), followed by ALFs (7 percent), and finally MCCs at 3 percent.

About 4 percent of all residents were a race other than White, including American Indian/Alaska Native, Black or African American, and Japanese. The following racial/ethnic categories were reported at less than 1 percent for all community settings: Asian Indian, Chinese, African, Filipino, Korean, Vietnamese, Cambodian, Native Hawaiian, Other Asian, Laotian, and other Pacific Islander, Cuban, and Other. In addition, about one percent of residents were reported as Hispanic, and 61 percent of Hispanic residents were of Mexican/Mexican American/Chicano ethnicity.

Compared to 2010 U.S. Census data for adults age 65 and older in Oregon, CBC respondents reported a higher proportion of White residents, 93 percent, compared to 88.8 percent in Oregon. However, when compared with the race by age Census data for Oregon, the demographic characteristics of residents were more closely aligned with those of Oregon's older adult population as a whole. The proportion of African American and American Indian residents in CBC settings was similar to state demographics: In 2010, less than one percent of all adults age 65 or older in Oregon were African American (.91 percent) or American Indian (.7 percent), and African American and American Indian residents comprised one percent each of the residents in CBC settings. Similarly, Japanese was the fourth most prominent racial/ethnic category among adults living in CBC settings, and according to the U.S. Census (2010) Japanese made up the highest proportion within Asian groups in the U.S. Detailed data on gender, age, race, and ethnicity reported in the survey can be found in Appendix B, Tables B. 4 and B. 5.

Move-In and Move-Out Locations

"Resident was living at home with her husband. She was starting to wander. He was having a difficult time getting her to shower. Caring for her was becoming difficult. His doctor and their children encouraged him to find placement. He and his family assisted with helping her get moved. *~CBC provider*

This section describes the locations that residents moved in from, moved out to, and the number of residents who died during the prior year (Figure 2). As with the prior Oregon survey and the national survey, the majority of new residents moved into CBC settings from their own home though there was variation across setting types. Residents who moved into ALFs were most likely to move from their home (45 percent), followed by MCCs (31 percent), with residents of RCFs being the least likely (28%) to have moved from home. Residents who moved into RCFs were more likely to move from a nursing facility or a skilled nursing facility (17%) or independent living (16%). For residents of ALF, this was also the case, but at lower rates compared to RCF residents (16% and 13%, respectively). Unlike those in ALFs and RCFs, residents who moved into MCCs were likely to move in from either an ALF (20%) or the hospital (16%). Published studies report that the majority of ALF and RCF residents move in directly from their homes or from independent living retirement apartments or other ALFs, and only a few are admitted directly after a hospital stay (Reinardy & Kane, 2003).

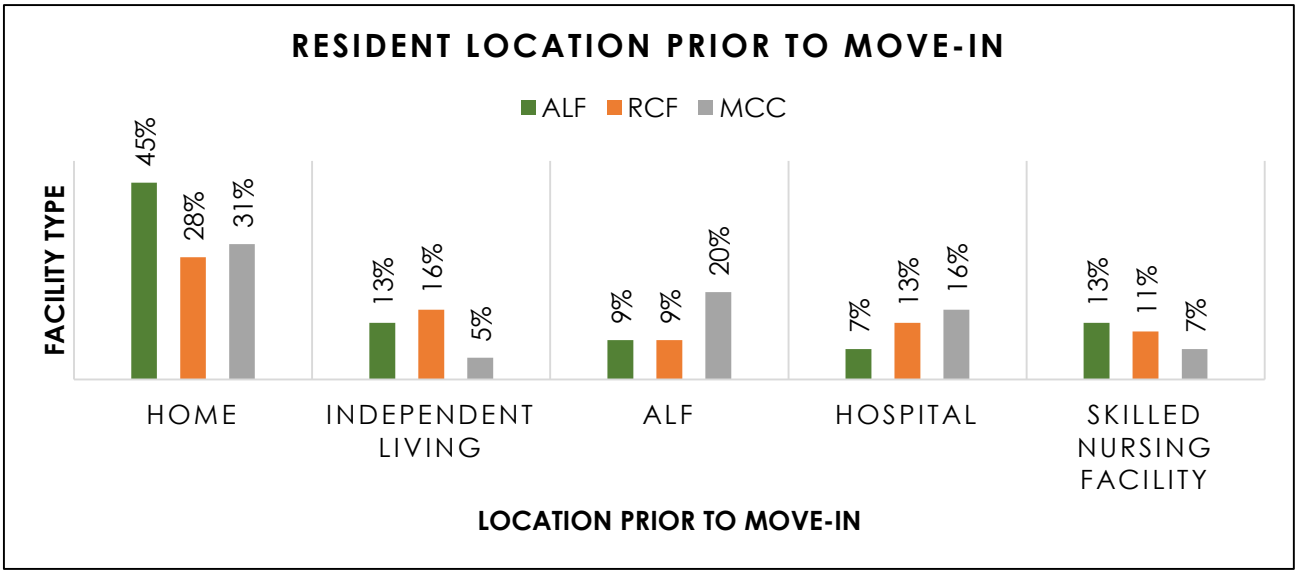

Figure 2 – *Resident Location Prior to Move-In*

The primary reason a resident left a CBC setting in 2014 was death. While just over one third of discharges in ALFs (35 percent) and RCFs (38 percent) were due to death, in MCCs deaths accounted for nearly two thirds of discharges (65 percent). In 2008, fewer (56 percent) MCC residents died at the MCC compared to 2014; this suggests that MCCs are now more likely to retain residents until their death. Among residents of all three CBC settings who moved out, the second most common destination was home (Figure 3). If residents did not pass away at the community or return home, they often moved to skilled nursing facilities (SNF) or nursing homes (NF). Residents of ALFs were the most likely to move to a NF or SNF (15%). Other CBC settings were likely destinations for residents when they moved out. Residents of ALFs (11%), RCFs (7%), and MCCs (5%) were most likely to move into a MCC than any other CBC setting. More detailed data can be found in Appendix B, Table B. 6. Nationally, residents typically move from an ALF to a nursing home (Phillips, Munoz, Sherman, et al., 2003) or die in the residence (Dobbs et al., 2012).

"Our most recent elder who moved out passed away. She transitioned from ALF to MCC about 6 months ago due to a significant change in condition. She continued to decline and was on hospice for about 3 weeks before passing."
~CBC provider

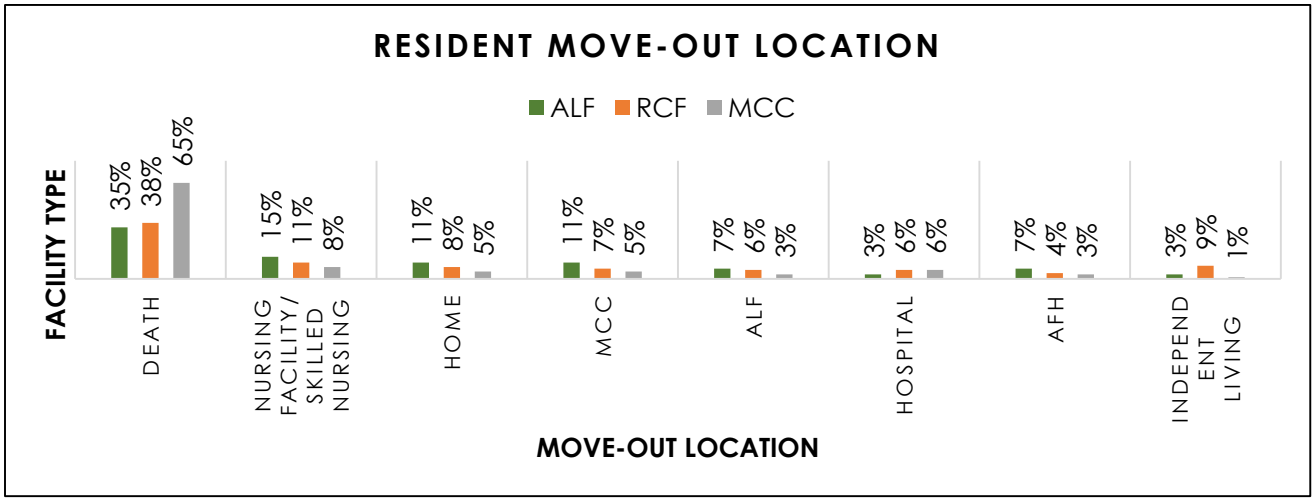

Figure 3 – *Resident Move-Out*

Length of Stay

The length of time that residents were able to live in an ALF or RCF is important to residents' quality of life and health. In addition, discharges can be costly to ALF and RCF providers, who must prepare the unit for a new tenant. Nationally, the median length of stay is 22 months (Caffrey et al., 2012). The length of stay in the 2008 Oregon report was over one year for 56 percent of residents, and more than four years for 13 percent of residents. In the current survey, 50 percent of residents had lived in the community for over one year, and 13 percent for more than four years. (Table 5). Fourteen percent of residents had stays of less than 30 days, and another 37 percent stayed for between one month and one year. Nineteen percent of residents

had lived in the community for one to two years, and 31 percent for two or more years. However, there are important variations between setting types. For example, only 8 percent of MCC residents had stays of more than four years compared to 15 percent of ALF and 12 percent of RCF residents.

Table 5 – *Length of Stay*

Length of Stay	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
1-7 days	8% (173)	8% (60)	3% (31)	7% (264)
8-13 days	2% (39)	5% (36)	2% (17)	2% (92)
14-30 days	4%, (90)	5% (40)	6% (57)	5% (187)
31-90 days	9% (204)	9% (69)	11% (108)	9% (381)
91-180 days (3-6 months)	10% (222)	11% (81)	13% (124)	11% (427)
181 days – 1 year (6 months-1 year)	15% (344)	17% (123)	20% (200)	17% (667)
			Total under one year	50% (2,018)
1-2 years	20% (450)	19% (138)	20% (192)	19% (780)
2-4 years	19% (443)	14% (107)	18% (175)	18% (725)
More than 4 years	15% (340)	12% (91)	8% (80)	13% (511)
			Total over one year	50% (2,016)

Ambulatory Status

Providers were asked to describe the residents' ambulatory status, or their ability to get around, by walking or with an assistive device, in the prior three months. Twenty-nine percent of residents required some staff assistance to get around, and of these, five percent were non-ambulatory. Twenty percent of residents used a non-electric wheelchair, and of those, 65 percent required staff assistance. Twenty-five percent of residents were independent in ambulation.

Resident Acuity

Acuity refers to the measurement of intensity of service needs of an individual related to their cognitive function, health conditions, medication use, psychosocial needs, and other health needs. The aggregation of acuity of individuals at a particular community can inform providers about staffing needs and budget allocation. Higher acuity levels generally translate to a higher need for care. The resident acuity measures used in the survey were drawn from the DHS Resident Acuity Roster and stakeholder input from DHS and OHCA.

Activities of daily living, or ADLs, refer to daily self-care activities, including bathing, dressing, eating, personal hygiene, and functional mobility. ADLs are commonly assessed in order to determine the amount of support an individual needs to function in daily life. Stand-by assistance means that a staff person stands

next to the resident and provides assistance if needed. Full assist or assistance means that the resident requires hands-on assistance to complete the task.

Table 6 – *Activities of Daily Living*

Activities of Daily Living			ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Eating assist			4% (225)	14% (260)	33% (705)	13% (1,190)
Transfer assistance						
	Any assist		23% (1,262)	30% (563)	47% (995)	30% (2,820)
		1 staff	20% (1,072)	23% (436)	34% (734)	24% (2,242)
		2+ staff	4% (191)	6% (118)	12% (253)	6% (562)
		Mechanical device	2% (93)	3% (62)	8% (170)	3% (325)
Dressing assistance						
	Stand-by assistance		23% (1,228)	21% (407)	41% (866)	26% (2,501)
	Full assistance		20% (1,086)	23% (429)	51% (1,100)	28% (2,615)
Bathing or showering						
	Stand-by assistance		30% (1,650)	33% (635)	39% (825)	33% (3,110)
	Full assistance		28% (1,521)	31% (586)	59% (1,253)	35% (3,360)
Toileting						
	Stand-by assistance		20% (1,079)	18% (346)	35% (749)	23% (2,174)
	Full assistance		16% (864)	23% (439)	55% (1,167)	26% (2,470)
Incontinence						
	Bladder incontinence		26% (1,422)	31% (585)	59% (1,259)	34% (3,266)
	Bowel incontinence		12% (629)	21% (407)	42% (904)	20% (1,940)
	Bladder and bowel incontinence		20% (1,107)	26% (494)	60% (1,290)	30% (2,891)

Table 6 describes the types of ADL assistance required by Oregon CBC residents. On average, at least 23 percent of residents required stand-by staff assistance with dressing, bathing/showering, and toileting, and at least 26 percent required full assistance with these ADLs. Thirty percent of residents required assistance due to both bowel and bladder incontinence. Transfer assistance refers to helping an individual move from a bed to a chair, for example, or a wheelchair to a toilet. Twenty-four percent of residents required transfer assistance from one staff person, and six percent required assistance from two staff (a two-person assist). The only ADL that relatively low numbers of residents required assistance with was eating (13 percent). However, 33 percent of MCC residents required eating assistance compared to 14 percent of RCF and 4 percent of ALF residents. A larger proportion of MCC residents required full assistance with ADLs as compared to ALF and RCF residents. These findings are similar to those from the National Study of

Residential Care Communities, which reported that the ADL that residents most commonly needed assistance with was bathing (72 percent), followed by dressing (52 percent) and toileting (36 percent), and 38 percent needed incontinence care (Caffrey et al., 2012).

Medication Services

Oregon facilities are required to provide medication administration to residents who need or request such assistance. The majority—86 percent—of residents received assistance to take medications, with 11 percent receiving assistance with injection medications and about one-fourth receiving assistance to take antipsychotic, antianxiety, and/or antidepressant medications (Table 7). Assistance with antipsychotic, antianxiety, antidepressant, and sleep-inducing medications was higher among MCC residents than residents of other settings.

Table 7 – *Medication Services*

Medication Services	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Medication assistance	84% (4,584)	77% (1,468)	99% (2,115)	86% (8,167)
Injection medication	14% (765)	8% (147)	7% (143)	11% (1,055)
Antipsychotic medication use	15% (837)	23% (439)	45% (960)	24% (2,236)
Antianxiety medication use	18% (963)	23% (447)	36% (776)	23% (2,186)
Antidepressant medication use	33% (1,814)	31% (596)	46% (992)	36% (3,402)
Sleep-Inducing medications	12% (637)	15% (280)	17% (372)	14% (1,289)
Anticoagulant therapy/blood thinners	18% (972)	14% (271)	10% (219)	15% (1,462)
9 or more prescription medications	55% (2,974)	44% (835)	48% (1,029)	51% (4,838)

Older adults who take multiple drugs, referred to as polypharmacy, are at risk of adverse health effects (Maher et al., 2014). Nursing facility studies indicate that patients prescribed 9 or more medications are at higher risk for hospitalization (Gurwitz et. al., 2005). Clinical management of 9 or more medications is a quality indicator used by the Centers for Medicare and Medicaid Services (CMS) to assess health and health risks of nursing facility residents (CMS, 2013; Zimmerman, et al. 1995). Based on the last National Nursing Home Survey (Dwyer et al, 2012), 40 percent of nursing home residents take 9 or more medications. As shown in Table 7, more than half of Oregon CBC residents took 9 or more medications.

Medical Diagnoses and/or Health-Related Risks

Table 8 describes medical diagnoses and health-related risks of CBC residents in Oregon. Fewer residents in ALFs and RCFs (31 percent and 42 percent, respectively) were reported to have some form of dementia compared to at least 93 percent of MCC

"Alzheimer's/dementia is as important, if not more, than most things in the news."
~CBC provider

residents. Oregon administrative rules require that MCC residents have a diagnosis of dementia or cognitive impairment. The national survey of residential care reported that 42 percent of residents have dementia (Park-Lee et al, 2012).

"Assisting people with dementia is physically demanding, extremely emotionally demanding, but by far one of the most rewarding jobs ever. It's much more than just meeting the physical needs; you get to spend every day making people happy and finding new ways to keep them engaged by understanding the disease, knowing their social history, and getting to know them through each phase of life." *~CBC provider*

Table 8 – *Medical Diagnoses and/or Health-Related Risks*

		ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Dementia diagnosis					
	Dementia (all types)	31% (1,647)	42% (808)	93% (1,988)	47% (4,443)
	Alzheimer's	4% (223)	10% (192)	33% (706)	12% (1,121)
	Vascular dementia	5% (298)	5% (102)	11% (239)	7% (639)
	Dementia with lewy bodies	<1% (19)	1% (13)	3% (70)	1% (102)
	Huntington's disease	<1% (4)	<1% (2)	1% (12)	<1% (18)
	Other dementia	5% (252)	4% (78)	13% (285)	6% (615)
Disease-based risk factors					
	Wandering, elopement, repetition	4% (192)	12% (234)	30% (633)	11% (1,059)
	Aggressive or combative	2% (117)	6% (111)	17% (368)	6% (596)
	Serious mental health diagnosis	13% (690)	21% (408)	12% (248)	14% (1,346)
	Alcohol abuse	3% (161)	3% (57)	2% (45)	3% (263)
	Diabetes	18% (986)	11% (219)	12% (260)	15% (1,465)
	Weight change	5% (293)	3% (54)	8% (180)	6% (527)
	Skin issues	6% (353)	6% (122)	5% (112)	6% (587)
	Significant change in condition	9% (484)	8% (159)	16% (335)	10% (978)
Pain issues					
	Pharmaceutical interventions to treat pain	43% (2,316)	48% (910)	54% (1,160)	46% (4,386)
	Non-pharmaceutical interventions to treat pain	20% (1,073)	18% (347)	31% (656)	22% (2,076)
Fall risk/history					
	0 falls and not assessed at risk to fall	33% (1,799)	25% (473)	17% (367)	28% (2,639)
	Assessed at risk of falls, but no falls	27% (1,450)	25% (473)	33% (713)	28% (2,636)
	Fell only one time	15% (825)	10% (189)	14% (302)	14% (1,316)
	Fell more than once	16% (892)	17% (332)	29% (629)	20% (1,853)

Disease-based risk factors refer to factors that put residents at risk of poor health outcomes and that require health monitoring and supervision. The two risk categories associated with dementia—wandering/elopement/repetition and aggressive/combative behavior—were more common among MCC residents (47 percent) compared to ALF (6 percent) or RCF residents (18percent). A larger percentage of RCF residents compared to ALF or MCC residents had a serious mental health diagnosis (21 percent, 13 percent, and 12 percent, respectively). Fifteen percent of CBC residents had diabetes, a disease that typically requires on-going health monitoring.

"98 year old female with severe dementia. Requires two staff to do care due to aggressiveness, staff handles with redirection and offers candy." *~CBC provider*

Pain is both a quality of life issue and a condition that requires monitoring and treatment (American Geriatrics Society, 2002). Nearly half of residents (46 percent) were reportedly being treated with pharmaceuticals for pain, with a slightly larger percentage of MCC residents requiring treatment.

Falls are the eighth leading cause of unintentional injury for older Americans and have shown to be responsible for more than 16,000 deaths in one year (Oliver et al., 2010). Thirty-four percent of CBC residents fell at least one time during 2014, and over half (59 percent) of all residents did not fall in a typical month. ALF residents were the least likely to fall or to be considered to be at risk for a fall (33 percent) compared to MCC (25 percent) and RCF (17 percent) residents (Table 8). MCC residents were the most likely to have multiple falls (29 percent) compared to RCF (17 percent) and ALF (16 percent) residents. MCC residents were the most likely to experience a significant change in condition, which refers to an increased need for care based on assessed changes in health or functional ability.

Health Service Use

Seventeen percent of CBC residents were reported to have visited a hospital emergency department and 11 percent were admitted to the hospital in the prior year (Figure 4 and Appendix B, Table B. 8). The National Survey of Residential Care Facilities found that about a third of residents had an emergency room visit in the past year, and about two fifths of these emergency room users had more than one visit; one quarter of residents had a hospital stay in the prior year (Caffrey et al, 2012).

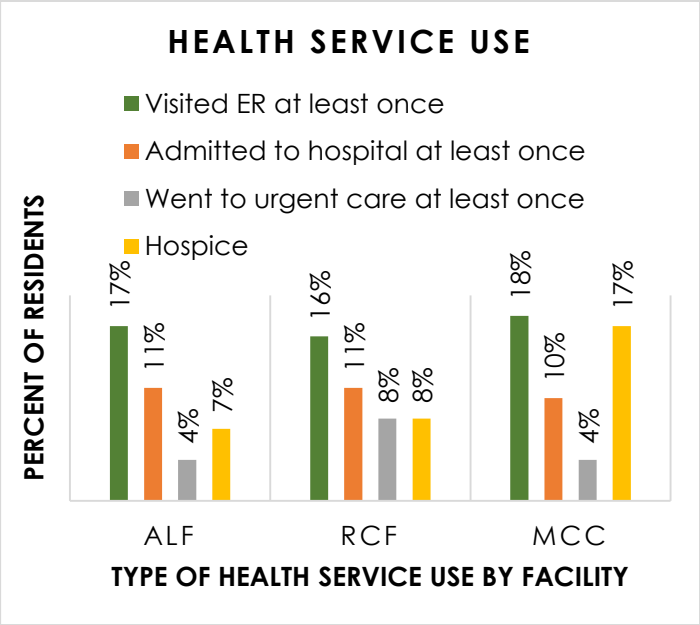

Figure 4 – *Health Service Use*

Payer Information, Rates, Fees & Services

The survey asked about payment sources for the care of current residents. The majority of residents paid privately, followed by Medicaid, long-term care insurance, and Veteran's Aid and Attendance (Figure 5 and more detail in Appendix B, Table B. 9). The percentage of residents reported to be using Medicaid increased since the 2008 Oregon survey, from 30 percent to 39 percent. The National Survey of Residential Care Facilities (Caffrey et al., 2012) reported that 19 percent of residents were Medicaid clients. Oregon has a higher rate of Medicaid CBC clients compared to most other states because of policies enacted in the late 1980s designed to increase access to CBC for people who would otherwise require more expensive nursing home care.

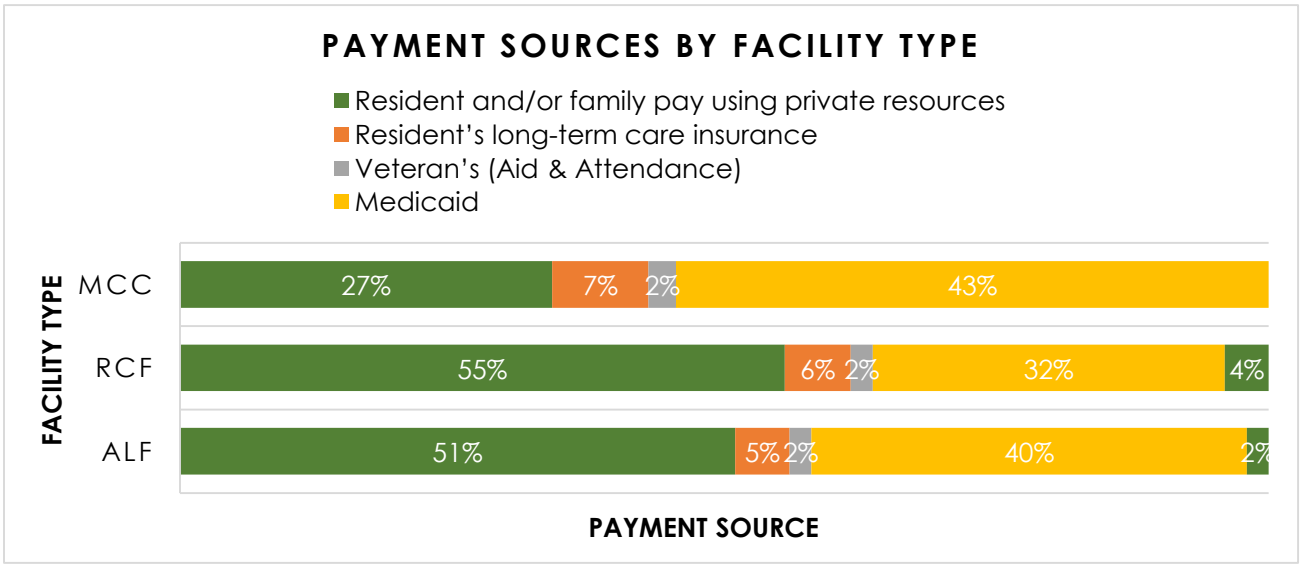

Figure 5 – *Resident Payment Sources by Facility Type*

Two insurance surveys provide comparable rate information. The Metlife Mature Market Institute national survey of ALF costs found that in 2012, the average monthly base rate was $3,550. The survey also found that about half of facilities provided dementia care, and of these, 61 percent charged an additional fee for dementia care services. A recent survey (Genworth, 2015) reported that the median cost of assisted living in Oregon was $3,880 per month.

The vast majority of CBC facilities (88 percent) had monthly charges below $5,000 (Table 9), and most (65 percent) had charges below $4,000. ALFs most often (88 percent) charged less than $4,000. RCFs (24 percent) were more likely than ALFs (13 percent) to charge over $4,000. Memory care communities, on average, charged more than ALFs and RCFs, with 82 percent of MCC residents being charged $4000 or more, and 12 percent paying more than $6,000 per month. Overall, assisted living facilities were less expensive than other community types, followed by residential care, and finally memory care. This is not surprising due to the high level of care required in MCCs.

Table 9 – *Monthly Service Fee Structure*

Average Monthly Charges	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Less than $3,000	34% (39)	41% (21)	1% (1)	26% (61)
$3,001 to $3,999	54% (62)	35% (18)	17% (12)	39% (92)
$4,000 to $4,999	11% (12)	8% (4)	54% (37)	23% (53)
$5,000 to $5,999	-	4% (2)	16% (11)	6% (13)
$6,000 plus	1% (1)	12% (6)	12% (8)	6% (15)

The survey asked how many residents had permanently moved out in 2014 because they spent down their assets and could no longer afford the monthly charges. Respondents indicated that a slightly higher percentage of residents in MCC (3 percent) moved out due to spending down their assets than ALF and RCF residents (1 percent).

The state uses Medicaid funds to pay for ALF and RCF services on behalf of residents who meet financial and medical eligibility criteria. Beginning on July 1, 2008, the monthly Medicaid rates paid to facilities on behalf of Medicaid-eligible clients who required the highest level of care were: $2,355 for ALF (level 5); $1,975 for RCF (base plus 3 care). Facilities could request additional funds to pay for memory care services. In 2014, the monthly Medicaid rates paid to facilities on behalf of Medicaid-eligible clients who required the highest level of care were: $2,522 for ALF (level 5); $2,115 for RCF (base plus 3 care); and a flat rate of $3,508 for endorsed memory care units. Between 2008 and 2014 Medicaid reimbursement rates for the highest level of care client increased by $167 for ALF and $140 for RCF facilities.

Medicaid pays for services, not room and board (rent plus three daily meals plus snacks). Medicaid-eligible residents receive a monthly Social Security Income (SSI) payment and must use a portion of this income payment to pay room and board to the facility. Oregon limits the amount that ALF and RCF providers charge so that residents may keep a monthly personal needs allowance. In 2008, the monthly SSI benefit was $637, and the room and board rate was $494.70, leaving residents with a monthly allowance of $142.30. In 2014, the SSI benefit was $721 and the room and board rate was $561, leaving an allowance of $160. Thus, between 2008 and 2014, the amount of room and board that facilities could charge Medicaid clients increased by $66.30.

Combining the Medicaid and room and board payments, in 2008, the monthly amount an ALF would receive in total for the highest level of care Medicaid client was $2,849.70 ($2,355 + $494.70). In 2014, this monthly rate was $3,083 ($2,522 + $561).

"[A woman] moved in because foster care would not take her back because of behavioral issues. The caregivers were concerned about the patient's mental and psychiatric status as the patient had become quite angry and lashing out at them at times. The family helped with the move to facility. Resident is diagnosed with Schizophrenia and Bipolar disorder. Usually non-compliant eating and not taking medication. Is ambulatory. She is able to feed self. Often refuses to shower. Needs stand-by assistance."
~CBC provider

Residents: Qualitative Summary

Open-ended questions in the survey asked respondents to describe: a resident who recently moved into their community; a resident who recently moved out; and the resident who needed the most care and how staff supported this resident. This section summarizes common themes and provides examples of direct quotes that support the themes. As with any research, this information is based on the respondents' beliefs and cannot be verified. This information is intended to provide the reader with examples that respondents gave in order to provide context that the quantitative results from the survey may not offer.

Move-In

Respondents explained that new residents moved in from a variety of settings as a result of experiencing an array of problems. Residents most commonly moved from their own home due to difficulties living alone. It was also common for residents to transfer from another facility (e.g., assisted living, independent living, and adult foster home) due to changes in needs and level of assistance required. Residents varied widely in regard to acuity and care needs. Providers most often mentioned residents who needed memory care and an increasing level of care. In these instances, new residents were either no longer able to take care of themselves due to a dementia diagnosis, or the facility where they were residing was not equipped to handle their care needs (e.g., wandering, increased ADL assistance, and behaviors).

"Caring for our hospice residents is always a meaningful experience. To ensure that their final days are pain free and that they are surrounded by love is a special experience." *~CBC provider*

Move-Out

Many residents passed away, rather than moved out. However, those who did move out were most likely to move to a different type of CBC community (e.g., Memory Care, AFH) due to increase in acuity level. Just as residents moved into facilities because they required more care than their family or current setting could provide, residents often moved out of their CBC community due to an increase in acuity that the staff could not accommodate. Providers described resident needs that they could

no longer support, such as behaviors and wandering associated with cognitive impairment. In other instances, residents would need more types of assistance such as with feeding (e.g., special diets, puree/juice diets), two or more person transfer assistance, or wound care. Some providers stated that these needs could be addressed by another type of CBC community. If residents did not pass away or move out due to a need for a higher level of care, they would often move to their own home or move in with family due to improvements and low acuity levels.

Describe the resident who requires the most care, whether physical and/or behavioral. How do staff attempt to provide care to this resident?

The majority of providers discussed their most challenging residents as those that had a dementia or mental health diagnosis, non-ambulatory residents, those requiring full assistance with ADLs, and individuals receiving hospice care. Providers described the personalized care that they provide to residents, including physical, mental, and emotional care. Such care included following formal protocol as outlined by plans created by providers, caregivers, and families. In other instances, however, providers and caregivers improvised to accommodate their resident's unique needs, often times performing resident-specific care tasks, such as comforting through direct physical contact, motivational interviewing, resident's preferred activities and distractions, going on walks, and offering snacks.

> **"With respect and kindness treating all residents fairly. Staff are trained to put themselves in the resident's position (i.e., have to leave their homes and independence) and to treat each resident with understanding and to allow him/her as much independence as possible."** *~CBC provider*

Staff

The CBC survey included questions about the number of registered nurses (RN) and direct care workers (DCW).

"Over ten years ago, this person started volunteering for the company. Since then, she has filled many positions: caregiver, health care coordinator, resident care coordinator. She is now our passionate, dedicated, amazing administrator. Running the entire memory care facility, she pours her heart into her work."

~CBC provider

Community-based care settings are required to provide their residents with access to RNs, who may be employees, contracted as third parties, or a combination of employees and contractors. The 2014 CBC survey found that 88 percent of settings employed at least one RN (Table 10). Nearly all ALFs employed at least one RN (91 percent), while RCFs and MCCs were also quite likely to employ at least one RN (88 percent and 85 percent, respectively). Contracting at least one RN was not very common among respondents (5 percent), though a slightly higher proportion of respondents reported that they both employed and contracted at least one RN (7 percent). Twenty-eight percent of providers who responded to the 2014 CBC survey reported that the number of hours which an RN was employed or contracted increased between 2013 and 2014, while 72 percent reported no increase.

Table 10 –*RN Employment*

RN Employment	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Employed at least one RN	91% (102)	88% (106)	85% (63)	88% (271)
Contracted at least one RN	-	7% (9)	8% (6)	5% (15)
Employed and contracted at least one RN	9% (10)	5% (6)	7% (5)	7% (21)

A 2014 survey conducted by RTI International (Zuckerbraun et al., 2015) collected information on direct care workers (DCWs) employed by Medicaid-certified long-term care providers in Oregon. Findings were that RCFs (APD only) employed 1,810 DCWs who were primarily non-Hispanic (75 percent), White (60 percent), and female (60 percent); most were between the ages of 18 and 44 years old (76 percent), had a high school level of education (60 percent), and worked full time (87 percent). Assisted living facilities reported 4,640 direct care workers; most were non-Hispanic (84 percent), White (67 percent), female (82

percent), between the ages of 18 and 44 years (65 percent), and employed full-time (75 percent). Compared to DCWs employed by other long-term care providers, those in ALFs had higher levels of education: 35 percent had graduated from high school or had a GED, 27 percent had some college education and 20 percent had a bachelor's degree or higher. The average number of full-time DCWs across all three CBC settings who responded to the 2014 CBC survey was about 21, and the average number of part-time DCWs was about 7 per facility.

"A 15 year employee [who] has worked as a caregiver the entire time. She is a hard worker, soft spoken who gives excellent care to our residents. She is a treasure, highly valued, and worth far more than what we could ever pay." *~CBC provider*

"One of our long term employees is a senior herself. She has worked on our campus many years."
~CBC provider

CBC facilities are required to conduct a 90-day review of residents' medication and treatment. When asked who conducts these reviews on behalf of their facility, 61 percent of respondents reported that reviews are conducted by a contracted pharmacist, while 65 percent reported using an on-staff nurse to conduct reviews. Four percent of facilities reported using an on-staff pharmacist, and 10 percent used a contracted licensed nurse. Seventeen percent used some other method for conducting 90-day medication administration and treatment reviews.

"She is like family to our residents. She will go out of her way to ensure the residents have a positive experience." *~CBC provider*

Staff: Qualitative Summary

Two open-ended questions in the survey asked providers to describe their staff and the work that they do in caring for their residents. Providers shared what makes this work meaningful to them and what a day in the life of working in their community is like. A summary of themes from these responses is discussed here, along with quotes directly from providers.

Providers used the following words—honest, caring, dependable, hardworking, and dedicated—to describe their long-term employees. Several described being passionate about creating a resident-centered environment and finding reward in improving residents' quality of life, with some describing learning important lessons from their residents. When residents declined or passed away, providers described being a source of comfort for families. Overall, they appreciated and valued positive family interactions and enjoyed supporting families.

While providers expressed that this type of work is very rewarding and meaningful, they also wanted people to know that the work is physically and emotionally demanding, stressful, and fast-paced. Challenges arise

from stressful interactions with family, declining health of residents, and communication with medical providers.

Having stressful interactions with family members or having difficult or unclear conversations with medical providers also made it difficult for staff to provide the necessary care to their residents. The biggest issues seemed not to arise from the care or the residents, but instead from the medical providers, family, and regulatory agencies.

"I love helping residents and enhancing their lives. It makes me feel good to see a smile on their face. It's important to me to give the best care possible." *~CBC provider*

"This is the most rewarding job you will ever have. You will work hard; you will form strong bonds with residents and co-workers. And at the end of the day, you will know you made a difference, and brought joy to those you served." *~CBC provider*

Policy Issues

Oregon is recognized as a national leader in providing community-based care options. According to a recent scorecard compiled by AARP, Oregon ranks third nationally, after Minnesota and Washington, for access to long-term services and supports for older adults and people with disabilities (Reinhard et al., 2014). Oregon policymakers and advocates implemented several policies starting in the 1970s, including administrative rules for adult foster care homes and assisted living facilities, and a Medicaid waiver that pays for CBC services, that led to this national recognition.

In 2014, the Centers for Medicare and Medicaid Services (CMS) published a new HCBS rule that concerns residential care settings (including ALFs/RCFs) that serve Medicaid clients. The CMS rule required states to develop a transition plan that indicates how the state will respond to the requirements. Oregon developed and submitted its plan in October 2014. Based on DHS and OHA review, and stakeholder comments, the state plan indicates that no regulatory changes are required but that some residential settings may need to adapt and change their program design to meet requirements regarding the provision of privacy in the individual's sleeping/living unit, lockable entrance doors, roommate choice, control over daily schedule, access to food at any time, and policies regarding visiting hours. The next survey, to be conducted in the winter of 2016, will collect information on these topics.

Access to quality caregivers is one strategy for supporting older adults and people with disabilities to stay in their home and community that was identified by Oregon's Long-Term Care 3.0, which was mandated by Senate Bill 21. This initiative calls for DHS to create a plan for improving long-term care in Oregon.

Oregon's goals to improve long-term care include setting up systems to help seniors and people with disabilities increase their independence by staying in their homes and communities longer and delaying entry into long-term care settings. The next survey will include questions designed to assess quality of care. The questions will be informed by published literature, the National Center for Assisted Living's quality initiative, and Oregon stakeholders.

What Providers Want Policymakers to Know About CBC

Survey respondents were asked what they would like their state representatives or policymakers to know about their residents and about CBC settings. The two most commonly described issues were concerns about poor care provided to CBC residents by hospital and urgent care staff and concerns about inadequate reimbursement for CBC services.

"Our residents deserve the same medical care and considerations as those who are younger."
~CBC provider

Many providers reported difficulties with the care their residents received from hospitals or urgent care because the staff at those organizations lacked an understanding of how to treat individuals with memory loss. A few suggested that medical staff needed additional training in dementia care. Providers hoped that policymakers and state representatives would recognize the importance of understanding and serving individuals with dementia, including Alzheimer's disease.

Some providers believed that funding for residents with memory care issues is inadequate, potentially leading to a lower quality of medical care than they deserve. A few said that regulations have increased while funding has remained stagnant. The respondents associated the regulations with those of skilled care, but without a comparable reimbursement level. Some respondents were concerned that without the funding necessary to accommodate regulatory changes, the quality of care will be negatively impacted. Overall, providers reported that they want their work to be valued and respected by being given the necessary resources to do their job and provide a high level of care.

"Medicaid reimbursement rates do not cover the cost of providing care and there is a high need for service by those who cannot pay privately."
~CBC provider

"To keep the cost of care reasonable in community-based care, an important consideration is to keep in check the quantity of onerous regulations that take time to comply with." *~CBC provider*

Conclusions

This profile of assisted living, residential care, and memory care facilities provides a much-needed portrait of the community-based care landscape in Oregon. Major topics examined include resident acuity, memory care, medication services, health service use, and reimbursement policies. Given that the population of Oregon is aging, paying attention to residential settings that provide care to an aging population with a higher prevalence of multiple, chronic conditions in the state is critically important.

The findings from this survey indicate that community-based care settings provide a range of personal care and health services to a frail population of, primarily, older persons. On many measures, current residents are more impaired and use more third-party health services, including hospice and hospitals, compared to the 2008 Oregon survey. Also, more residents are receiving care paid for through Medicaid, and more residents have dementia. More than half of CBC residents are taking more than nine prescription medications, a factor shown to increase risk for adverse health effects.

The number of CBC facilities increased, with the largest growth in memory care communities. The proportion of for-profit facilities also grew, as did the proportion of facilities managed by the third party. Many settings provide only limited transportation options, and there is a limited number of two-bedroom units.

Appendix

Appendix A – Methods

Survey Instrument

This project is a follow-up to a previous survey last conducted by the Office for Oregon Health Policy and Research in 2008. The previous survey was used as a starting point to develop this survey in partnership with stakeholders from:

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

Questionnaire topics included facility information, resident demographics, resident ambulation, resident acuity, payer information - rates, fees, and services, staffing, and additional services. The questionnaire also included two randomly assigned in-depth qualitative questions about living and working in community-based care environments.

Sample Selection and Survey Implementation

The total population for this study includes all licensed assisted living, residential care, and memory care facilities[1] in Oregon. As of December, 2014, the total number of 489 CBC facilities included 217 licensed ALFs, and 272 licensed RCFs. Of this total, 148 held a memory care endorsement. The total population of 489 facilities received the survey. A PDF copy of the survey was emailed to facility administrators during the second week of January, 2015. A follow-up mailing of surveys was sent out to all facilities who had not responded within two weeks to account for incorrect email addresses, employee turnover, and administrative changes. 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. Follow up calls were made to providers to encourage survey completion and to help answer questions. Data entry was conducted by PSU's Survey Research Lab.

Survey Response

A total of 243 facilities responded, for a response rate of 50 percent (Table A. 1). Because MCCs in the sample were licensed as either ALF or RCF, the number of MCCs is not included in the total number of licensed facilities used to calculate the response rate.

[1] The sample includes facilities that serve clients that DHS refers to as aged or individuals with physical disabilities (APD).

Table A. 1 –*Survey Response Rate*

ALF/RCF/MCC Response	Licensed Facilities	Total Received	Percent
Assisted Living	217	116	53%
Residential Care	272	127	47%
Total	489	243	50% of total population
Memory Care	148	75	53% of total population

The following table (Table B. 2) details responses to the survey by region in Oregon. The region with the highest concentration of ALFs, RCFs, and MCCs was the Portland Metro Region, and the region consisting of Southern Oregon and the Southern Oregon Coast contained the fewest. Of the ALFs and RCFs that responded, fewer were from Southern Oregon/South Coast, while a lower percentage of MCCs responded from the East of the Cascades region.

Table A. 2 –*Response Rate by Region*

Region	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Portland Metro: Clackamas, Washington, Multnomah, Columbia	33% (39)	43% (54)	40% (31)	38% (93)
Willamette Valley: Marion, Clatsop, Yamhill, Tillamook, Linn, Benton, Polk, Lincoln, Lane	32% (37)	27% (34)	33% (26)	29% (71)
Southern Oregon: Douglas, Coos, Curry, Josephine, Jackson	12% (14)	18% (23)	14% (11)	15% (37)
Eastern Oregon: Hood River, Wasco, Sherman, Gilliam, Morrow, Klamath, Lake, Deschutes, Harney, Jefferson, Crook, Umatilla, Baker, Grant, Union, Wallowa, Malheur, Wheeler	22% (26)	14% (16)	13% (10)	17% (42)
Total	48% (116)	52% (127)	53% (78)	243

*Response by region does not equal number of respondents due to multiple types of licenses at many facilities.

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

Non-response. A total of 177 facilities did not respond to the survey; 74 were ALFs and 103 were RCF. All non-respondent facilities had a Medicaid contract. The licensed capacity per non-respondent community ranged from 7 to 155. Reasons given for non-response included business closure, major renovation during 2014, survey not mandatory, change of ownership or major administrative changes, currently too busy, survey length, and administrator was unavailable.

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), as well as cross-tabulations and chi-square test of independence. Qualitative data, based on responses to two open-ended questions, were summarized according to themes.

Other Notes

The survey asked for the total number of units or beds available at the community, the number of different types of units (studio, one-bedroom, 2-bedroom, other), and the total number of units. However, the total number reported did not equal the sum of the different types of units. Thus, when describing differences in unit types, we use the summed total rather than the reported number.

Appendix B – Additional Tables

Table B. 1 – *Facility Type and Unit Size*

Facility (n)	Studio % (n)	1 BD % (n)	2 BD % (n)	Other % (n)	Total % (n)
ALF (116)	82% (3,535)	69% (2,127)	68% (184)	65% (155)	62% (6,001)
RCF (127)	18% (763)	31% (939)	32% (87)	35% (84)	19% (,1873)
MCC only (77)	21% (902)	25% (758)	13% (34)	51% (122)	19% (,1816)

Table B. 2 – *Transportation Services Provided by Facility*

Transportation Services Provided by Facility	Fees Associated with Transportation	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Owns/operates a vehicle for transporting residents to medical or other services		77% (87)	70% (85)	68% (50)	72% (222)
	Charges fee for transportation outside of a designated service area	11% (9)	25% (21)	32% (16)	21% (46)
Provides transportation to medical services outside of a designated area		27% (29)	40% (48)	38% (27)	35% (104)
	Charges fee for transportation to medical services outside of designated service area	45% (13)	44% (22)	57% (16)	48% (51)
Provide transportation to shopping centers within a designated service area		89% (100)	70% (85)	69% (50)	77% (235)
	Charges fee for transportation within a designated service area	7% (7)	14% (12)	18% (9)	12% (28)
Transportation is provided to social/recreational activities outside of a designated service area		75% (84)	63% (75)	69% (49)	67% (208)
	Charges fee for transportation to activities outside of designated service area	5% (4)	12% (9)	14% (7)	10% (20)

Table B. 3 –*Resident Age and Gender*

		ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Gender					
	Male	31% (1,653)	42% (778)	35% (702)	34% (3,133)
	Female	69% (3,670)	58% (1,091)	67% (1,284)	66% (6,045)
	Transgender	-	-	<1% (1)	<1% (1)
Age Groups					
	18-49	1% (52)	2% (39)	1% (17)	1% (108)
	50-64	6% (328)	9% (172)	2% (35)	6% (535)
	65-74	12% (614)	16% (303)	10% (190)	12% (1,107)
	75-84	27% (1,433)	23% (433)	31% (608)	27% (2,474)
	85 and over	54% (2,896)	49% (922)	57% (1,137)	54% (4,955)

Table B. 4 Race

Race	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
White	93% (4,536)	89% (1,389)	95% (1,796)	93% (7,721)
American Indian or Alaskan Native	1% (51)	2% (36)	1% (16)	1% (103)
Black or African American	1% (28)	2% (36)	1% (9)	1% (73)
Japanese	1% (28)	2% (25)	1% (11)	1% (64)
Unknown	4% (175)	2% (34)	4% (66)	3% (275)
Other	<1% (15)	<1% (3)	<1% (3)	<1% (21)
All other (<1%)	1% (44)	1% (10)	1% (13)	2% (67)
Total	4,877	1,822	1,565	8,324

Table B. 5 –*Ethnicity*

Ethnicity	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Mexican/Mexican American/Chico/a	15% (36)	24% (9)	14% (17)	15% (62)
Puerto Rican	1% (3)	-	4% (5)	2% (8)
Cuban	<1% (1)	-	1% (1)	<1% (2)
Other Hispanic/Latino/a or Spanish Origin	7% (17)	16% (6)	7% (8)	8% (31)
Unknown	77% (190)	74% (90)	59% (22)	75% (302)
Total	247	121	37	405

Table B. 6 –*Location of Residents Moving-In/Moving-Out*

Locations	ALF		RCF		MCC		Total	
	In % (n)	Out % (n)	In % (n)	Out % (n)	In % (n)	Out % (n)	In % (n)	Out % (n)
Home	45% (1,039)	11% (243)	28% (245)	8% (56)	31% (330)	5% (45)	38% (1,614)	9% (344)
Independent living	13% (308)	3% (61)	16% (139)	9% (68)	5% (56)	<1% (2)	12% (503)	3% (131)
Assisted living	9% (199)	7% (151)	9% (7)	6% (46)	20% (210)	3% (28)	11% (486)	6% (225)
Hospital	7% (152)	3% (69)	13% (108)	6% (44)	16% (170)	6% (56)	10% (430)	4% (169)
AFH	3% (58)	7% (148)	3% (29)	4% (32)	3% (29)	3% (30)	3% (116)	6% (210)
Residential care	1% (32)	1% (26)	3% (22)	3% (27)	3% (27)	1% (8)	2% (81)	2% (56)
Memory care	<1% (8)	11% (229)	1% (9)	7% (49)	4% (46)	5% (48)	2% (63)	9% (326)
Hospice	<1% (4)	1% (15)	<1% (3)	<1% (1)	<1% (1)	<1% (2)	<1% (8)	1% (18)
Nursing facility	4% (89)	6% (129)	6% (50)	3% (18)	4% (41)	6% (54)	4% (180)	5% (201)
SNF	13% (293)	9% (186)	11% (94)	9% (63)	7% (72)	2% (22)	11% (459)	7% (271)
Child's/relative's home	5% (118)	3% (68)	3% (30)	2% (14)	4% (47)	<1% (1)	5% (195)	2% (83)
Psychiatric unit	<1% (3)	1% (14)	3% (30)	2% (12)	2% (26)	2% (15)	1% (59)	1% (41)
Other	1% (25)	2% (45)	3% (25)	3% (24)	2% (19)	2% (23)	2% (69)	2% (92)
Died at community	-	35% (745)	-	38% (280)	-	65% (624)	-	43% (1,649)
Total	2,328	2,129	1,074	958	816	729	4,263	3,816

Table B. 7 –*Ambulatory Status*

Ambulatory Status	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Independent	22% (1,208)	28% (527)	28% (608)	25% (2,343)
Independently used a walker, cane, or crutch	41% (2,216)	28% (533)	25% (536)	35% (3,285)
Used a walker, cane, or crutch with assistance	8% (435)	9% (178)	12% (265)	9% (878)
Independently used a non-electric wheelchair	8% (443)	7% (130)	6% (120)	7% (693)
Used non-electric wheelchair with assistance	12% (653)	12% (226)	20% (426)	14% (1,305)
Independently used electric wheelchair or scooter	10% (515)	4% (72)	<1% (2)	6% (589)
Used electric wheelchair with assistance	1% (50)	<1% (7)	<1% (1)	1% (58)
Non-ambulatory	3% (151)	6% (114)	9% (187)	5% (452)

Table B. 8 –*Health Service Use*

	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Visited ER at least once	17% (922)	16% (306)	18% (383)	17% (1,611)
Admitted to hospital at least once	11% (616)	11% (212)	10% (221)	11% (1,049)
Went to urgent care at least once	4% (221)	8% (146)	4% (79)	5% (446)
Hospice	7% (382)	8% (159)	17% (356)	10% (897)
Home hemodialysis	<1% (20)	<1% (2)	<1% (1)	<1% (23)

Table B. 9 –*Payment Source*

Payment Source	ALF % (n)	RCF % (n)	MCC % (n)	Total % (n)
Resident and/or family pay using private resources	51% (2,894)	55% (1,126)	27% (1,041)	51% (5,061)
Resident's long-term care insurance	5% (291)	6% (124)	7% (162)	6% (577)
Veteran's (aid & assistance)	2% (134)	2% (46)	2% (55)	2% (235)
Medicaid	40% (2,309)	32% (661)	43% (967)	39% (3,937)
Other	2% (100)	4% (86)	-	2% (186)

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Appendix D – Survey Instrument

DHS Oregon Department of Human Services

Portland State UNIVERSITY Institute on Aging

Oregon Community-Based Care Communities

Survey of 2014 Resident & Community Characteristics

CCMU/Provider #(s) _____ (ex., *70M123* or *50A123*, see p. 2)

Name of Community _____

Address of Community _____

Management Company _____ Orig. Lic. Date _____

Administrator _____ Community Phone/Fax _____

1. Person Completing Report _____ Title _____ Phone _____

2. Person Completing Report _____ Title _____ Phone _____

3. Person Completing Report _____ Title _____ Phone _____

Your completed survey is due by January 30th, 2015.

Once complete, to return the survey, choose one of the following options:

1. Scan and email to: cbcor@pdx.edu
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 survey, please contact:
Jackie Kohon at 503-725-5236 or cbcor@pdx.edu.

Purpose:

This survey was designed by the DHS-Aging and People with Disabilities program (APD) and Portland State University's Institute on Aging in collaboration with representatives from:

- Oregon assisted living and residential care facilities
- Oregon Health Care Association (OHCA)
- Leading Age, Oregon

The information you provide will help to inform state policy for long-term care planning. A report summarizing all responses will be available to policy-makers, professionals, and the general public. All responses will be aggregated; no information on individual providers will be shared. There is no penalty for answering honestly and to the best of your ability.

Reporting Period:

The reporting period for this survey is **January 1, 2014 to December 31, 2014**. Some questions will ask specifically about averages. For example, question 5B on page 4 asks about the average number of occupied units in 2014. The average would be the number of occupied units for each month divided by twelve months.

How to complete this survey:

Begin by providing your CCMU/Provider number and other information on the cover page (page 1), then continue on to the questions on page 3. 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). If your management company operates under more than one CCMU/Provider number, please complete ***one survey for each street address, building or campus.*** *If you have two or more community types at one location (address, building, campus), and prefer to complete one survey, please include the CCMU/Provider number, name, and address for each community.*

Please answer each question. For open answer boxes, if the answer is "none" or "0", please write "0". If the question does not apply to your organization, please write "N/A."

It may be helpful to have your ***DHS Uniform Disclosure Statement*** *and your* ***Acuity Roster*** *nearby when completing this survey.*

Community Information

1. This community's legal tax-status is: *(Select one)*

   ☐ For-profit ☐ Not-for-profit

2. Is this community managed by a third party (i.e., management company or organization)?

   ☐ Yes

   ☐ No

3. Is this community: *(Select one)*

   ☐ A single independent ownership (only 1 community)

   ☐ Part of a 2-to-25 community chain

   ☐ Part of a 26 or larger community chain

4. What types of licensed units or housing are available at this community location?
   *(Select all that apply **AND** write the number of units/beds in 2014).*

TYPES OF CARE	***Yes, available at this location***	***No, not available at this location***	***Number of units/beds***
Assisted Living Units (ALF) (non-MCU)	☐	☐	
Memory Care Units/Rooms (MCU) (AL/RC)	☐	☐	
Residential Care Units/Rooms (RCF) (non-MCU)	☐	☐	
Independent Living Apartments	☐	☐	
Nursing Home Beds	☐	☐	
Skilled Nursing Facility Beds	☐	☐	
Other, specify_____	☐	☐	

5. Please provide the following information about your community.

How to complete tables:

***If you are an ALF without** Memory Care Units (MCU), only complete the ALF (non-MCU) column.*

***If you are an ALF with** Memory Care Units (MCU), complete the MCU column **AND** the ALF (non-MCU) column.*

***If you are a RCF without** Memory Care Units (MCU), only complete the RCF (non-MCU) column.*

***If you are a stand-alone Memory Care Community**, complete only the MCU column.*

***If you are a combination of ALF and RCF with** Memory Care Units (MCU), complete ALL columns.*

COMMUNITY INFORMATION	***ALF (non-MCU)***	***MCU***	***RCF (non-MCU)***
a. Licensed **capacity** *(number of residents permitted to reside in the community per license)*			
b. Average number of **occupied** units/rooms in 2014			

6. Please indicate the number of licensed rooms and average number of residents in 2014.

***Write "0"** if there are **no units/rooms or residents**. Please write the total number in the bottom row.*

UNIT/ROOM TYPE	***ALF (non-MCU)***		***MCU***		***RCF (non-MCU)***	
	# of units	*# of residents*	*# of rooms*	*# of residents*	*# of rooms*	*# of residents*
Studio/Alcove						
One Bedroom (single or double occupancy)						
Two Bedroom						
Other, specify: _____						
{RESIDENT TOTALS} *****Save these numbers for later questions***	_____ 6a. *Total units*	_____ 6b. *Total residents on average in 2014*	_____ 6c. *Total rooms*	_____ 6d. *Total residents on average in 2014*	_____ 6e. Total rooms	_____ 6f. Total residents *on average in 2014*

Resident Information

1. How many residents **moved in or moved out, or died, during 2014**?

	ALF (non-MCU)	MCU	RCF (non-RCF)
a. Total number of residents who **moved into** the community **from 01/01/14 to 12/31/14**	_____	_____	_____
b. Total number of residents who **permanently moved out from 01/01/14 to 12/31/14**	_____	_____	_____
c. Of those who moved out, how many **permanently moved out in 2014** because they spent down their assets?	_____	_____	_____

NOTE: use 1a and 1b for questions 2 and 3 below.

2. From January 1, 2014 to December 31, 2014, **how many new** residents **moved in (for the first time) from** the following places, and how many residents **moved out (permanently) to** the following places?

COMMUNITY TYPE	***ALF (non-MCU)*** *No. of Residents moved*		***MCU*** *No. of Residents moved*		***RCF (non-MCU)*** *No. of Residents moved*	
	Moved in from	Moved out to	Moved in from	Moved out to	Moved in from	Moved out to
Home						
Independent living apartment						
Assisted living						
Hospital						
Adult foster care *(licensed for 1-5 adults)*						
Residential care						
Memory care						
Hospice facility						
Nursing facility						
Skilled nursing facility						
Child's / relative's home						
Psychiatric unit						
Other, specify: _____						
Resident died at community	N/A		N/A		N/A	
Total						

NOTE: Totals should be the same as 1a (total moved in) and 1b (total moved out) above.

3. Of the residents who moved out between **January 1, 2014 and December 31, 2014**, how long was their length of stay? ***Write "0"*** *for any categories with* ***no residents.***

LENGTH OF STAY ***(FROM move in TO move out or death)***	***ALF (non-MCU)*** ***No. of Residents***	***MCU*** ***No. of Residents***	***RCF (non-MCU)*** ***No. of Residents***
1 – 7 days			
8-13 days			
14-30 days			
31 – 90 days			
91 – 180 days (3-6 months)			
181 – 1 year (6 months – 1 year)			
1 to 2 years			
2 to 4 years			
More than 4 years			
Total			

NOTE: Totals should equal the number from page 5, question 1b (moved out) for each community type.

4. What was the **average age of all residents** in your community in 2014? _____

5. What was the age and gender of all (unduplicated) residents **in 2014**? *Please count each resident only once, even if they came back from a hospital, nursing facility, or other facility stay.*
Write "0" *for any categories with* ***no residents. Write "DK"*** *if you* ***don't know.***

AGE GROUP	***ALF (non-MCU)*** *No. of Residents*			***MCU*** *No. of Residents*			***RCF (non-MCU)*** *No. of Residents*		
	Male	Female	Transgender	Male	Female	Transgender	Male	Female	Transgender
18-49									
50-64									
65-74									
75-84									
85 and over									
Total									

NOTE: The total should equal the number from page 4, question 6 (Resident Totals) for each type of community.

6. **During 2014**, how many residents at your community identified as Hispanic or Latino ethnicity?

NOTE: Please write 0 if none, or DK if you don't know. These categories are defined & required by OAR.

ETHNICITY	ALF (non-MCU) No. of Residents	MCU No. of Residents	RCF (non-MCU) No. of Residents
Mexican, Mexican American, Chicano/a			
Puerto Rican			
Cuban			
Other Hispanic, Latino/a, or Spanish origin			
Unknown			

7. **During 2014**, of the residents at your community, how many were in each of the following racial categories? *(more than one may apply to each resident)*

RACIAL CATEGORIES	ALF (non-MCU) No. of Residents	MCU No. of Residents	RCF (non-MCU) No. of Residents
White			
American Indian or Alaska Native			
Black or African American			
African			
Asian Indian			
Chinese			
Filipino			
Japanese			
Korean			
Vietnamese			
Laotian			
Cambodian			
Other Asian			
Native Hawaiian			
Guamanian or Chamorro			
Samoan			
Other Pacific Islander			
Declined to Answer			
Unknown			
Other:			

Resident Ambulation

1. Please describe your residents' **ambulatory status** during **the last quarter of 2014**.

How many residents…	*ALF (non-MCU) No. of Residents*	*MCU No. of Residents*	*RCF (non-MCU) No. of Residents*
a. were independent in ambulation *(e.g., walk without any assistance from staff or devices such as walker or cane)*	_____	_____	_____
b. independently used a walker, cane, crutch, or other non-electric assistive device without staff assistance	_____	_____	_____
c. used a walker, cane, crutch, or other non-electric assistive device with staff assistance	_____	_____	_____
d. independently used a non-electric wheelchair without staff assistance	_____	_____	_____
e. used a non-electric wheelchair with staff assistance	_____	_____	_____
f. independently used an electric wheelchair or scooter without staff assistance	_____	_____	_____
g. used an electric wheelchair or scooter with staff assistance	_____	_____	_____
*h. were non-ambulatory without staff assistance *(e.g., **require total assistance** to transfer and/or move within the community)*	_____	_____	_____
Total *Total should equal the number from page 4, question 6 (Resident Totals) for each type of care.*	_____	_____	_____

2. Of the residents in question 1, item *h above listed as **non-ambulatory without staff assistance**:

   a. How many were **primarily bed-bound** (e.g., due to terminal illness or other reason)? _____

   b. How many were **primarily room-bound** (e.g., rarely if ever left their room/unit)? _____

A. Resident Acuity

1. **For a typical month in 2014**, indicate the number of residents who were classified in the following acuity categories. *This section contains many of the same conditions that are listed on the **Resident Acuity Form** that state surveyors may ask providers to complete. Residents may have more than one of the following conditions. Please only include conditions that require staff assistance or monitoring, and write 0 if none.*

RESIDENT ACUITY	*ALF (non-MCU) No. of Residents*	*MCU No. of Residents*	*RCF (non-MCU) No. of Residents*
MEDICAL DIAGNOSES AND/OR HEALTH-RELATED RISKS			
Diagnosed Dementia: *A cognitive deficit that impacts a resident's ability to independently direct their daily life; can be from any cause.*			
Dementia, all types (total number)			
Alzheimer's disease			
Vascular dementia			
Dementia with Lewy Bodies			
Huntington's disease			
Other dementia: _____			
Disease-based risk factors: *Resident behaviors that can adversely affect the resident or others.*			
Wandering, elopement, repetition			
Aggressive or combative toward others			
Serious Mental Health Diagnosis: Number of residents with a diagnosis of schizophrenia, bipolar disorder, major depression and/or other chronic mental health illness.			
Alcohol abuse: Number of residents with a current and documented drinking problem.			
Diabetes: Number of residents with a diagnosis of diabetes who require staff to monitor capillary blood glucose (CBG) and/or administer insulin.			
Weight Change: Number of residents who had an unexplained weight loss or gain in the past month.			
Skin Issues: Number of residents with Stage 2+ pressure ulcers or bedsores, and/or a skin condition that requires staff to deliver and/or coordinate treatment in the past month.			
Pain Issues:			
Residents who used **pharmaceutical** interventions to treat pain			
Residents who used **non-pharmaceutical** interventions to treat pain			
Fall Risk/History:	**ALF**	**MCU**	**RCF**
Residents with 0 *(zero)* falls and not assessed at risk of falls			
Residents assessed at risk of falls but did not fall			
Residents who fell only one time			

Residents who fell more than once			
Significant Change in Condition: Number of residents whose needs increased, affecting multiple areas of function or health, since the last evaluation.			
HEALTH SERVICE USE			
Emergency room/department use: Number of residents who had at least one an emergency room visit.			
Hospital admission: Number of residents who had at least one hospital admission.			
Urgent care use: Number of residents who went to an urgent care clinic.			
Hospice: Number of residents who received hospice.			
Home Hemodialysis: Number of residents who received home hemodialysis.			
MEDICATIONS AND TREATMENTS			
Urinary Catheters: Number of residents who needed staff assistance to manage a urinary catheters.			
Medications: Number of residents who needed staff assistance to administer medications and/or treatments.			
Injection Medications: Number of residents who needed staff assistance to administer injection medications.			
Anti-Psychotic Medication Use: Number of residents who took scheduled and PRN medication such as Seroquel (quetiapine), Zyprexa (olanzapine), Abilify (aripiprazole), Risperdal (risperidone), Geodon (ziprasidone), Haldol (haloperidol), or similar.			
Anti-anxiety Medication Use: Number of residents who took scheduled and PRN medications such as Zanax (alprazolam), Klonpin (clonazepam), Valium (diazepam), Ativan (lorazepam), Inderal (propranolol) or similar.			
Antidepressant Medication Use: Number of residents who took scheduled and PRN medications such as Celexa (citalopram hydrobromide), Paxil (paroxetine hydrochloride), Prozac (fluoxetine hydrochloride), Zoloft (sertraline hydrochloride) or similar.			
Sleep-Inducing Medications: Number of residents who took scheduled and PRN medication such as Ambien (zolpidem), Restoril (temazepam), Oleptro (trazodone), Sonata (zaleplon), or similar.			
	ALF	**MCU**	**RCF**
Anticoagulant Therapy/Blood Thinners: Number of residents who took blood thinning medications such as Coumadin, Warfarin or daily full-strength aspirin.			
9 or More Medications: Number of residents who took 9 or more medications.			
Restraints and supportive devices with restraining qualities:			
Number of residents who needed a restraint due to imminent danger to self or others			
Number of residents who needed supportive devices with restraining qualities			
ACTIVITIES OF DAILY LIVING			

Eating Assist: Residents who routinely needed cueing, physical assistance, or both to eat their meals.			
Transfer Assistance: Residents unable to transfer in and out of a chair or bed without assistance.			
Total number who required any transfer assist			
Required assistance from one staff			
Required assistance from 2+ staff			
Required mechanical device (e.g., Hoyer)			
Dressing: Residents who need daily assistance with dressing.			
Residents who needed stand-by assistance			
Residents who needed full assistance			
Bathing or Showering: Residents who need staff assistance with bathing and/or showering.			
Residents who needed stand-by assistance			
Residents who needed full assistance			
Toileting: Residents who need daily assistance from staff to use the bathroom.			
Residents who needed stand-by assistance			
Residents who needed full assistance			
Incontinence:			
Residents who received staff assistance to manage bladder incontinence.			
Residents who received staff assistance to manage bowel incontinence.			
Residents who received staff assistance to manage bladder AND bowel incontinence.			

B. Payer Information + Rates, Fees, and Services

1. **In a typical month in 2014**, how many residents paid using the following payment type(s)? *More than one payment category is possible for each resident, so the number might be higher than the total number of residents.* ***Write "0"*** *for any categories with* ***no residents.***

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

2. How are **private-pay residents** charged? *(Select all that apply)*

MONTHLY SERVICES FEE STRUCTURE	*ALF (non-MCU)*	*MCU*	*RCF (non-MCU)*
Flat fee or set fee (e.g., single all-inclusive rate regardless of level of care or services provided)	☐	☐	☐
Fees are set based on resident needs and/or services provided	☐	☐	☐
Other fee structure (specify):	☐	☐	☐

3. On **average**, what was the **monthly charge in 2014** for a single resident living alone in a studio or alcove unit (e.g., the smallest room or unit) and receiving the lowest level of care? *(Private-pay only)*

AVERAGE MONTHLY CHARGE	**Less than $3000**	**$3001 – $3999**	**$4000 -- $4999**	**$5000 -- $5999**	**$6000+**
Assisted Living (non-MCU)	☐	☐	☐	☐	☐
Memory Care	☐	☐	☐	☐	☐
Residential Care (non-MCU)	☐	☐	☐	☐	☐

4. Does your community charge a fee if a resident uses a non-preferred pharmacy?

   ☐ Yes → If yes, how much? _____
   ☐ No
   ☐ Residents are not allowed to use a non-preferred pharmacy

5. **What would your community charge for the following private-pay resident who lives alone in the smallest studio apartment or room?** *Please review this description and provide the base rate and total monthly rate your community would charge. We understand that you might prefer a full assessment, but please use the available information to estimate fees.*

Edith is an 86-year old woman who needs stand-by assistance to shower twice weekly and is independent in other activities of daily living. She takes 8 prescription medications by mouth (morning, afternoon, and evening) with assistance from staff. Her medications are delivered by the pharmacy preferred by the community. She eats all meals in the dining room and enjoys attending planned social activities.

a. Monthly base rate, as of December 2014: $ _____
b. Additional charges, if any: $_____
c. Notes:

C. Staffing and Services

1. During 2014, did your community: (*select one response*)

☐ Employ at least one registered nurse (RN)
☐ Contract with at least one RN, or
☐ Both employed and contracted with at least one RN

2. Did the number of hours that you employed and/or contracted with an RN increase **between 2013 and 2014**?

☐ Yes ☐ No ☐ Don't know

3. In a typical month in 2014, **how many direct care workers were employed by this community** on a full-time basis? On a part-time basis? *(Provide numbers for both.)*

Number of full-time direct care workers: _____
Number of part-time direct care workers: _____

4. Who does your community's **90-day review of medications and treatments** administered by the community? *(Select all that apply)*

☐ Pharmacist on staff ☐ Pharmacist on contract
☐ Licensed Nurse on staff ☐ Licensed Nurse on contract
☐ Other: _____

5. For **pharmacy services**, does your community use: *(Select all that apply)*
   - ☐ Long-term care institutional pharmacy(ies)
   - ☐ Local pharmacy(ies)
   - ☐ Combination of both long-term care and local pharmacies

6. Please describe the **transportation services provided by your community**.

TRANSPORTATION	**Yes**	**No**
a. Does your community own/operate a vehicle for transporting residents to medical or other services?	☐	☐ *[If no, skip to 6c.]*
b. **If YES**, does your community charge a fee for transportation to medical services within a designated service area?	☐	☐
c. Does your community provide transportation to medical services outside of a designated service area?	☐	☐ *[If no, skip to 6e.]*
d. **If YES**, is there a charge for transportation to medical services outside of the designated service area?	☐	☐
e. Does your community provide transportation to shopping centers (grocers, markets) within a designated service area?	☐	☐ *[If no, skip to 6g.]*
f. **If YES,** does your community charge for transportation to shopping centers (grocers, markets) within a designated service area?	☐	☐
g. Is transportation provided to social/recreational activities outside of the designated service area?	☐	☐ *[If no, skip to question G1.]*
h. **IF YES**, is there a charge for transportation to activities outside of the designated service area?	☐	☐

D. Community Policies

1. If a resident is in the hospital or a nursing home, may they choose to have caregivers update other residents about how they are doing?

   ☐ Yes ☐ No ☐ Don't know

2. Does your community ask residents to complete satisfaction surveys at least once a year and share the results with the AL/RC/MC community?

   ☐ Yes ☐ No ☐ Don't know

3. Does your community ask staff to complete satisfaction surveys at least once a year and share the results with the AL/RC/MC community?

   ☐ Yes ☐ No ☐ Don't know

E. In-Depth

****Each survey participant was assigned only one set of 2 of the following survey questions, resulting in 4 versions of the survey.**

Your answers will provide a more in-depth picture of those living and working in community-based care. Please provide as much information as possible when answering the following questions.

{*SET 1*}

1. Tell us something about the employee who has worked in your community for the longest time.
2. Describe an experience you've had that makes this work meaningful for you.

{*SET 2*}

Describe the resident who most recently moved into your community. For example, why did the person move in and from where? Who helped with the move? How would you describe the resident's acuity level?

What would you want people to know about a day in the life of working here?

{*SET 3*}

Describe the resident who most recently moved out. For example, why did the person move out, and where did he or she go? Who helped with the move? How would you describe the resident's acuity level?

What would you like state representatives or policymakers to know about the work you do?

{*SET 4*}

Describe the resident who requires the most care, whether physical and/or behavioral. How do staff attempt to provide care to this resident?

What would you most like state representatives or policymakers to know about your residents?