6-6-2022

2022 Adult Foster Home Resident and Community Characteristics Report on Adult Foster Homes

Ozcan Tunalilar
Portland State University, tozcan@pdx.edu

Paula C. Carder
Portland State University, carderp@pdx.edu

Jaclyn Winfree
Portland State University, jwinfree@pdx.edu

Sheryl Elliott
Portland State University, sheryle@pdx.edu

Minju Kim
Portland State University

See next page for additional authors

Citation Details

Tunalilar, O., Carder, P.C., Winfree, J., Elliott, S., Kim, M., Jacoby, D., Albalawi, W. (2022). 2022 Resident and Community Characteristics Report: Adult Foster Homes Portland, OR: Portland State University. Institute on Aging.

AS ACCEPTED BY ODHS ON JUNE 6, 2022
FINAL VERSION PENDING TO BE PUBLISHED BY ODHS

2022 Adult Foster Home

Resident and Community Characteristics Report on Adult Foster Homes

Ozcan Tunalilar Ph.D., Paula Carder Ph.D., Jaclyn Winfree M.S., Sheryl Elliott M.U.S., Minju Kim M.S., Diana Jacoby M.S.G., Wafi Albalawi

A study completed by the Institute on Aging at Portland State University in partnership with Oregon Department of Human Services

Portland State
Institute on Aging

DHS | Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

AS ACCEPTED BY ODHS ON JUNE 6, 2022
FINAL VERSION PENDING TO BE PUBLISHED BY ODHS

2022 Adult Foster Home Resident and Community Characteristics Report on Adult Foster Homes

A study completed by the Institute on Aging at Portland State University in partnership with Oregon Department of Human Services

About the Institute on Aging at Portland State University

IOA/PSU strives to enhance understanding of aging and facilitates opportunities for elders, families, and communities to thrive.

IOA/PSU Study Team:

Ozcan Tunalilar
Paula Carder
Wafi Albalawi
Sheryl Elliott
Diana Jacoby
Minju Kim
Jaclyn Winfree

For more information:

Ozcan Tunalilar, Ph.D.
tozcan@pdx.edu
503-725-5237
P.O. Box 751, Portland, OR 97207

Additional contributors from Portland State University:

Madeline Fox, Megan McLaughlin, Cassidy Rogoway, Nate Parsons

About Oregon Department of Human Services

ODHS is Oregon's principal agency for helping Oregonians achieve wellbeing and independence through opportunities that protect, empower, respect choice, and preserve dignity, especially for those who are least able to help themselves.

ODHS Study Team:

Paul Bellatty
Julia Brown
Max Brown
Lynette Caldwell
Eleni Gialoyrakes
Jay Grussing
Robert Gust
Jordan Purdy

Special thanks to all adult foster home owners and staff throughout the state of Oregon who contributed to this effort.

Suggested citation: Tunalilar, O., Carder, P.C., Winfree, J., Elliott, S., Kim, M., Jacoby, D., Albalawi, W. (2022). 2022 Resident and Community Characteristics Report: Adult Foster Homes Portland, OR: Portland State University. Institute on Aging. Available at: https://www.pdx.edu/institute-on-aging/oregon-community-based-care-project-cbc

Contents

REPORT SUMMARY AND BACKGROUND

This report describes results from a study of Oregon adult foster homes (AFH), including home and owner characteristics; monthly charges and payment sources; resident characteristics, personal and health-related needs; and owners' experiences with supports and challenges due to the COVID-19 pandemic. The study's purpose was to collect and report data that can inform and advise policymakers, state and county agency staff, aging advocates and AFH owners about the status of AFHs in Oregon. The report includes information collected between December 2021 and March 2022 and, where possible, compares it to findings from prior years of this study and to other reports and articles about AFHs and other types of community-based care.

The Oregon Department of Human Services, Aging and People with Disabilities Program (ODHS/APD), licenses AFH owners to provide personal care, supervision health-related services, social and recreational activities, three daily meals, and lodging to older adults and adults living with disabilities detailed in OAR 411-051 (Oregon Department of Human Services Aging and People with Disabilities ([ODHS/APD], 2022). Each AFH is licensed to accommodate one to five residents. While most AFHs are modified single-family residences located in residential neighborhoods, some are purpose-built residences. Most owners live in the AFH and provide direct care to residents with assistance from paid staff as needed.

Nationally, and in Oregon, AFHs provide services to people who have a variety of care needs, including those who primarily benefit from the social environment, and those with complex health conditions, advanced dementia, or a terminal illness. These settings provide an important option for people who prefer a small home rather than an assisted living, residential care, or nursing facility. Many serve the most complex individuals in Oregon's long-term services and supports (LTSS) system. As the population ages, AFHs will continue to be an important sector of the LTSS for older adults, people with disabilities and their families.

This project took place during the second year of the COVID-19 pandemic. The study team recognizes that the owners and staff who completed the study questionnaire were responding to pandemic-related demands in addition to other social and economic challenges.

Prior AFH reports, and the findings from studies of assisted living (AL), residential care (RC), and memory care (MC) communities, are available at: https://www.pdx.edu/ioa/oregon-community-based-care-project and http://www.oregon.gov/DHS/SENIORS-DISABILITIES/Pages/publications.aspx

Study Method

In November 2021, the study team mailed a questionnaire to a geographically stratified random sample of 650 out of the 1,354 AFHs licensed to care for 6,241 residents in Oregon. Of these 650, 37 AFHs were ineligible to participate because their owner informed our interviewers about the closure of their AFH or the ODHS licensing website listed them as closed as of December 2021. The study team received completed questionnaires from 279 of the eligible 617 AFHs, for a response rate of 46 percent. We describe the findings based on data from these 279 responding AFHs unless noted otherwise. These homes reported information about a total of 1,093 current residents.

Additional information about AFHs, including licensed capacity, Medicaid reimbursement rates and state funds paid to AFH owners, was provided by ODHS or identified on the ODHS licensing website by the study team.

Details about the study methods, including questionnaire development, data collection, and data analysis, can be found in Appendix A: Methods of this report.

HIGHLIGHTS

AFHs and Study Participation:

- Of the **1,354** AFHs in Oregon, **650** were included in the sample, of which **617** were eligible to participate.
- **279** AFHs returned a questionnaire, for a response rate of **46%**, in comparison to **48%** in **2021**.

AFH Capacity and Occupancy:

- The licensed capacity was **1,280** residents for the **277** homes that provided this information.
- The occupancy rate for responding homes was **85%**.
- **53%** of homes were at full capacity.

AFH Owners and Staff:

- **90%** of owners lived in the AFH.
- **63%** of these owners had family members living in the AFH.
- **22%** of owners reported holding a current CNA or CMA certification.
- **13%** of owners hold a current RN, LPN, or LVN license.
- **82%** of AFHs employed a total of 670 staff.
- **89%** of the staff employed by AFHs were caregivers.

Medicaid Use and Expenditure:

- **92%** of all APD AFHs had a contract with ODHS to accept Medicaid beneficiaries, and **85%** of owners who responded had a contract.
- **60%** of residents were Medicaid beneficiaries.
- **$2,543** is the base monthly rate, including room and board, paid to owners on behalf of Medicaid beneficiaries effective in January **2022**.
- In **2021**, ODHS paid AFH owners licensed by APD a total of **$130,827,108** on behalf of Medicaid-eligible residents.

Private Payers, Rates and Fees:

- **$54,324** is the estimated average annual private pay charge, based on the average monthly rate for the lowest service level.
- Between **2016** and **2022**, inflation-adjusted average total monthly charges increased from **$3,774 to $4,527** (in December **2021** dollars), a **20%** increase in real dollar terms.
- The average monthly charges vary by region, from **$4,194** (Southern OR/South Coast) to **$4,721** (East of Cascades).

Based on information about residents in the responding AFHs:

- **59%** were female.
- **86%** were White, not Hispanic or Latino.
- **56%** were ages 75 or older.
- **32%** were ages 85 and older.

Length of stay in AFH among residents who moved out or died in the prior 90 days:

- **72%** of AFH move-outs in the 90 days prior to the questionnaire were due to death.
- **36%** of residents stayed less than 6 months.
- **19%** stayed 6 months to 1 year.
- **22%** stayed 1-2 years.
- **33%** stayed 2 years or more.

Resident Health Characteristics:

- **60%** took 9 or more medications.
- **36%** took antipsychotic medications.
- **50%** were diagnosed with hypertension (high blood pressure).
- **45%** were diagnosed with Alzheimer's disease and related dementias (ADRD).

Staff Assistance:

- **30%** of residents received assistance from two caregivers at one time for physical and/or cognitive health needs.
- **48%** received staff assistance to use a mobility aid (e.g., walker, wheelchair).
- **36%** received staff assistance during the night shift.

Recent Health Service Use (90 Days Prior to the Questionnaire):

- **11%** of residents were treated in a hospital emergency department.
- **7%** had an overnight hospital stay.
    - **28%** of those discharged from a hospital returned to the hospital within 30 days.
- **9%** received hospice services.

Falls (90 Days Prior to the Questionnaire):

- **7%** of residents fell at least one time in the prior 90 days.
    - Of residents who fell, **15%** had a fall that resulted in a physical injury, and **18%** required hospitalization.

Assistance with Activities of Daily Living:

- **81%** of residents received assistance with bathing and grooming.
- **63%** received assistance with dressing.
- **60%** received assistance using the bathroom.
- **51%** received assistance with walking/mobility.
- **27%** received assistance with eating.

Family and Friend Involvement:

- **54%** of residents had social visits in the 90 days prior to the questionnaire.
- **54%** received phone calls in the 90 days prior to the questionnaire.
- **29%** went on outings in the 90 days prior to the questionnaire.

ADULT FOSTER HOMES

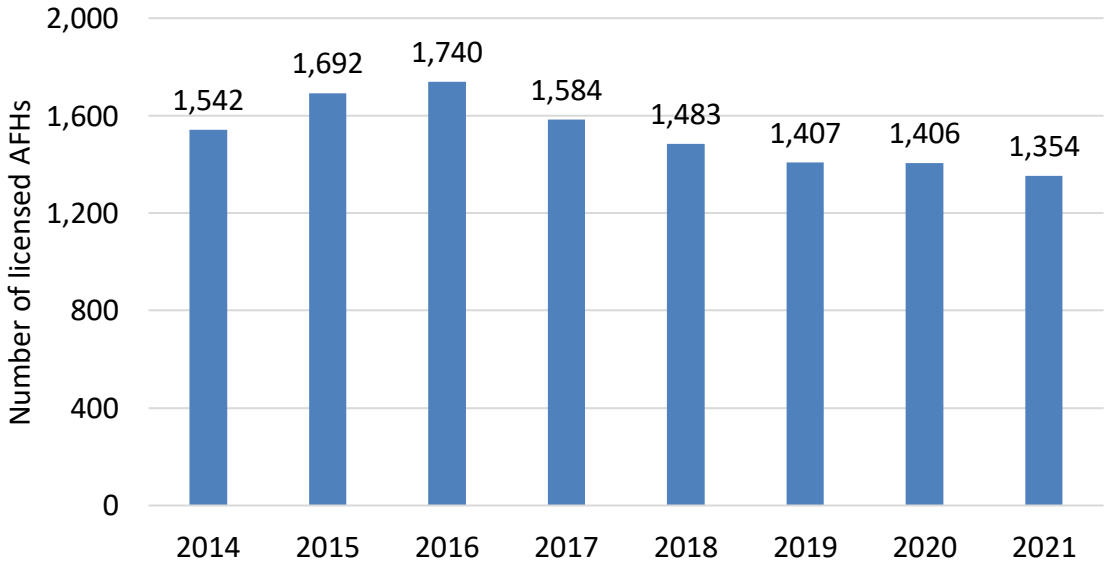
This section describes:

- The number, licensed capacity, and years of operation of all AFHs
- AFH supply by county
- The occupancy rate among AFHs that participated in the study
- The number and percentage of the respondent AFHs at full occupancy

Number, Licensed Capacity, and Years of Operation

Number of AFHs. Tracking the number and licensed capacity of AFHs is an important way to understand older Oregonian's access to a variety of residential long-term services. Figure 1 shows the number of AFHs licensed each fall between 2014 and 2021. As of fall 2021, there were 1,354 AFHs, a decrease of 22 percent from an all-time high of 1,740 in 2016. An ODHS policy analysis (ODHS, 2019) suggests that the steady declines in AFH supply are likely driven by AFH owners choosing to serve other types of clients (e.g., intellectual and developmental disabilities), perceived gap between care costs and Medicaid reimbursement rates, and retirements among long-serving AFH owners. The COVID-19 pandemic may also have exacerbated some of these trends.

Figure 1. Number of licensed AFHs, fall of 2014-2021



Licensed capacity. Licensed capacity refers to the maximum number of residents permitted to reside in an AFH and is determined by the "ability of the staff to meet the care needs of the residents, the fire and life safety standards for evacuation, and compliance with" standards in rules and regulations (OAR 411-49). We estimate that the number of licensed beds declined from 6,416 to 6,241 between fall of 2020 and 2021 - a decline of 175 beds (or 2.7 percent). Among AFHs that completed the questionnaire, most had a licensed capacity of five (81 percent) or four (9 percent) with the remaining 10 percent having one to three beds.

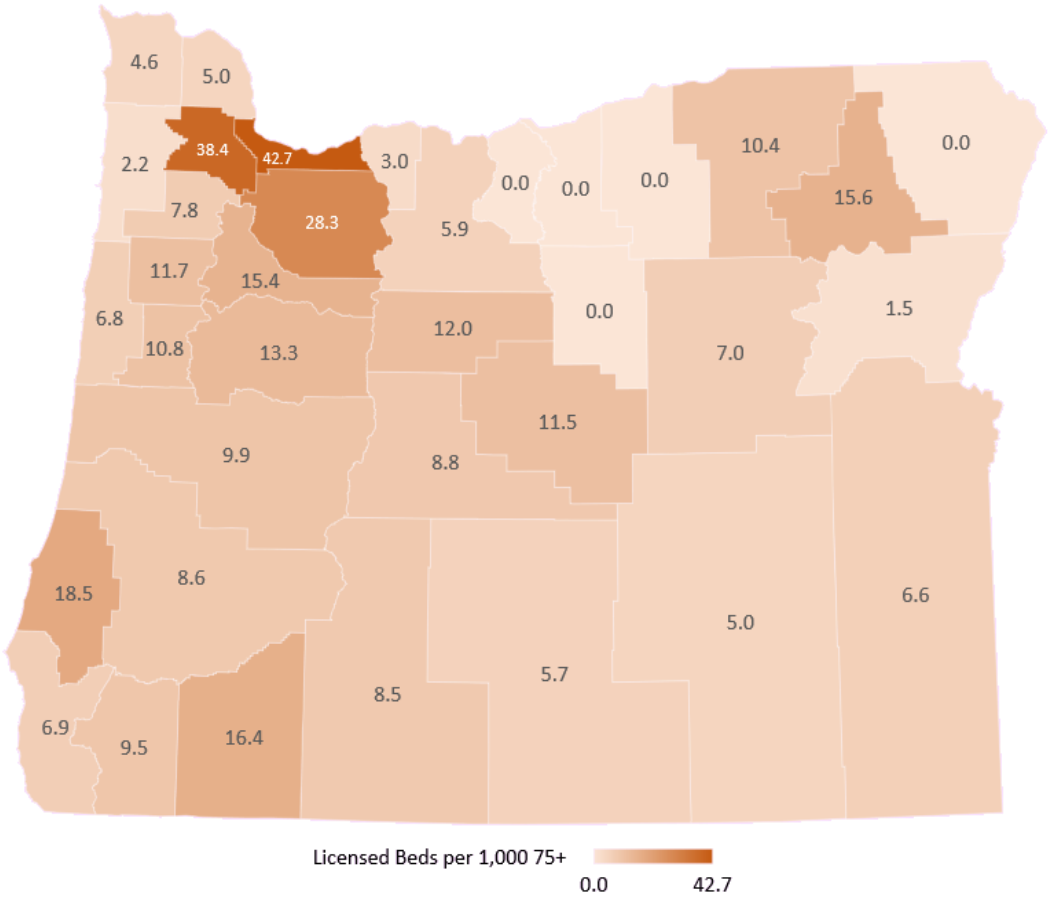
Years of operation. Based on information provided by ODHS, 9 percent of AFHs have been operating for less than one year, 29 percent between one to five years, 20 percent between five and 10 years, and 42 percent for 10 years or more. These numbers indicate that new AFHs are being added to the overall supply, and that a substantial number of owners have been operating for more than five years.

AFH Supply by County

All but five counties (Gilliam, Morrow, Sherman, Wallowa, and Wheeler) had at least one AFH. The number of AFHs by county varies across the state. Six counties had fewer than 10 AFHs (Baker, Harney, Hood River, Lake, Tillamook, and Grant) compared to two counties that each had more than 1,000 AFHs (Washington and Multnomah).

Because the number of Oregonians who may need AFH care may differ by county, we calculated a measure of AFH supply that better accounts for differences in population across counties: licensed capacity per 1,000 persons ages 75 and over (Figure 2). According to this measure, AFH supply was highest in the Portland Metro area (Multnomah, Washington, and Clackamas), followed by Coos (18.5) and Jackson (16.4) counties.

Figure 2. AFH supply by county



Full Occupancy and Occupancy Rates

Higher occupancy rates can increase profitability and contribute to the AFH's economic success by decreasing fixed costs per resident, such as mortgage or lease costs, utilities, insurance, and licensing fees. In contrast, AFHs not at full occupancy may not be able to cover these fixed costs. We created two indicators of AFH financial well-being using occupancy data: percent of AFHs that were at full occupancy and occupancy rate.

We define full occupancy as having the same number of current residents as an AFH's licensed capacity. Of the 277 respondent AFHs with occupancy information, 147 (53 percent) were operating at full occupancy (Table 1). Since 2018, the share of responding AFHs that were operating at full occupancy fluctuated between 51 percent to 55 percent.

The licensed capacity of responding AFHs declined for the fourth year in a row (Table 1). This decline is not surprising, since the number of AFHs declined as well and because the number of respondents was lower this year compared to prior study years.

We calculated the occupancy rate by dividing the number of current residents in respondent AFHs by the licensed capacity for respondent AFHs (Table 1). The 277 responding AFHs with occupancy data were licensed to care for 1,280 residents and reported a total of 1,093 current residents, for an occupancy rate of 85 percent. The occupancy rate remained relatively stable and fluctuated between 83 percent and 87 percent since 2016.

Table 1. Licensed capacity, occupancy rates, and full occupancy among responding AFH, 2016-2022

	2016	2017	2018	2019	2020	2021	2022
Total licensed capacity of respondents	1,401	1,523	1,760	1,729	1,724	1,342	1,280
Occupancy among responding AFH	1,218	1,259	1,485	1,438	1,426	1,114	1,093
Occupancy rate (%)	87	83	84	83	83	83	85
At full occupancy	60	49	54	55	52	51	53

Note: Data for past years retrieved from previous reports. The 2022 figures are based on the 277 responding AFHs with occupancy data. Licensed capacity was self-reported by responding AFHs.

ADULT FOSTER HOME OWNERS

This section describes:

- Owners and their family members who live at the AFH
- Owners who regularly provide care
- Owner certifications
- Owners' future plans for their AFH.

Most owners (90 percent) live in their AFH all or most of the time and regularly provide care to residents. Owners with family members residing in the AFH often express this living arrangement as a benefit or reward of owning and operating an AFH, where they can work from home, allowing them to "be home with family" (Elliott et al., 2021). Most (63 percent) owners have an average of 2.5 of their family members living in those homes. One-third were 17 years old or younger. Over half of family members residing in an AFH were between the ages of 18-64 years, and a few were 65 years or older. This is the first year the response categories for 18-64 years and 65 years or older were reported separately and yield similar results as when these age groups were combined. Results in all categories are similar to previous years (Table 2).

Table 2. Owners and their families living in AFH, 2016-2022

	2016	2017	2018	2019	2020	2021	2022
Live at AFH (%)	85	84	88	90	88	89	90
Family in AFH (%)	72	65	64	67	64	65	63
Average number of family members (*M*)	2.2	2.3	2.2	X	2.3	2.4	2.5
Family members: 17 or younger (%)	32	34	32	X	33	35	32
Family members: 18-64 years old (%)	68	66	68	X	67	65	56
Family members: 65 or older (%)	X	X	X	X	X	X	13
Owner regularly provides care (%)	X	X	92	94	96	94	95

Note: M indicates mean values are reported; average was calculated among AFHs that reported at least one family member living at the AFH. X indicates that the response category was not available in that year. In 2018-2022, owners were asked whether they lived at the AFH all the time, some of the time, or never. The statistics reported here combine "all the time" and "some of the time" responses.

AFH owners are not required to hold a healthcare license or certification, though some do. In Oregon, certified nursing assistant (CNA) training requires completing at least 75 hours of coursework and a competency evaluation, and certified medication assistant (CMA) training requires completing the CNA training followed by more than 800 hours of CNA employment, medication aide training, and a competency examination (OAR 851-001). CNAs and CMAs work under the supervision of a registered nurse (RN) or a licensed practical nurse (LPN). RNs must earn an associate or bachelor's degree from an accredited nursing program, whereas LPNs are required to have a high school diploma. Both RNs and LPNs must pass a national exam and, to remain certified or licensed, these professionals must complete annual training programs. These training requirements prepare individuals for working with residents whose conditions require specialized knowledge and training.

Just over one-third of AFH owners hold a health care certification or license, with nearly a quarter reporting a current CNA or CMA status and 13 percent a RN, LPN, or LVN license. A small number of licensed nurses also held a CNA or CMA. Given the level of training required to complete and maintain a health care certification or license, these findings could have implications for the quality of care received by residents who live in these homes.

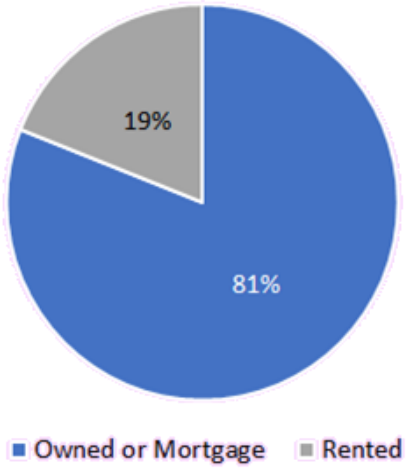
Table 3. Healthcare certification of the AFH owner, 2022

	Yes		No
	CNA/CMA %	RN/LPN/VLN %	%
Certification	22	13	67

Note: 7 AFHs reported certification for both CNA/CMA and RN/LPN/LVN.

This is the first year the questionnaire asked whether the AFH owner or someone in their home owned/had a mortgage or rented the house in which they operate. While the majority owned or held a mortgage on their AFH, nearly one-fifth rented. A small number of AFH owners reported "Other" and noted N/A (n=1), no (n=2), and not-for-profit corporation (n=2). These five responses were excluded from the results.

Figure 3. AFH Ownership, 2022



Note: The five AFHs that selected the "other" option were excluded in calculating the percentage of ownership types.

Self-care, defined as a process of maintaining health and wellness through health-promoting practices and managing illness, has been found to improve the health and overall well-being of healthcare workers (Riegel et al., 2019). Provider responses from previous years show that self-care (or lack thereof) constitutes challenges as well as a venue for finding rewards in their work (Elliott et al., 2021). AFH owners' sense of "self-fulfillment, accomplishment, and satisfaction" were enhanced by providing care in their home to vulnerable older adults, but also resulted in having "limited time for self-care, family, and respite" due to managing the home and caring for residents. Overall, existing research highlights the importance of examining caregiver well-being and its potential correlation to quality care outcomes for older adults (Schulz et al., 2020).

Against this background, and to examine AFH providers' self-reported well-being, we used the six questions from the Rapid Caregiver Well-Being Scale 3.0 (Tebb et al., 2015). AFH owners were asked whether they usually, sometimes, or never participate in any of six common self-care activities. Most current AFH owners reported that they usually take care of personal daily activities, such as meals, hygiene, and laundry, feel good about themselves, feel secure about their financial future, and receive appropriate health care. About half of the owners sometimes take time to have fun with friends and family and treat or reward themselves (Table 4).

Table 4. Owners' self-reported self-care, 2022

	Never %	Sometimes %	Usually %
Taking care of personal daily activities (meals, hygiene, laundry)	0	11	89
Taking time to have fun with friends and/or family	5	51	44
Treating or rewarding yourself	8	59	32
Receiving appropriate health care	7	24	69
Feeling good about yourself	0	17	83
Feeling secure about your financial future	2	26	72

Adult Foster Home Owner Future Plans

Access to AFHs throughout Oregon is important to older adults and their families. However, AFH owners might choose to close or sell their home for a variety of reasons. The AFH owners were asked about their plans to open a new home, move, sell, or permanently close their home in the next year. Most owners did not indicate plans to make a change (Table 5). About one in ten plan to sell or transfer their home to another owner, or permanently close their AFH in the next year (not shown in the table). Of those who responded to one or more categories, most plan to open another newly licensed home, a slightly greater percentage than reported in 2020 and 2021. These findings are positive for future AFH supply given that the number of AFHs decreased between 2017 and 2021.

Table 5. Owners' future plans for the AFH, 2020-2022

	2020 %	2021 %	2022 %
Open another/newly opened adult foster home	13	12	16
Move this adult foster home to a different location/house	6	3	5
Sell or transfer your adult foster home to another owner	7	7	5
Permanently close your adult foster home	5	6	5

Note: See Appendix B: Tables and Figures for 95% for confidence intervals for years 2020-2022.

ADULT FOSTER HOME STAFF

This section describes:

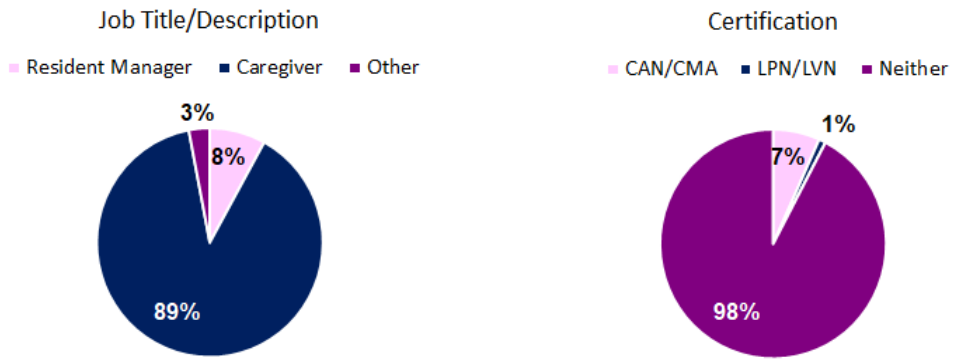
- Current AFH staff information, including caregivers
- The hours staff worked in last week
- AFH staff tenure
- Staff absenteeism reasons, and
- Use of contract/agency staff, including nurses, in the last 90 days.

AFH owners may hire staff, including caregivers, to provide personal care assistance to residents. The qualified caregivers must be awake, as needed, and sufficient in number to meet the 24-hour needs of each resident (OAR 411-050-0735). All caregivers must complete dementia training approved by ODHS before providing direct care and are required to complete an orientation to the home, residents, and any other qualified primary caregiver(s) (OAR 411-049-0125).

This year's questionnaire asked owners the number of staff they employed in their homes in the last seven days and several characteristics for each of these staff members: job title or description (resident manager, caregiver or other), current certification (LPN/LVN, CNA/CMA or neither), hours worked during the previous week and length of employment (e.g., tenure).

Of the 279 AFHs that responded, almost 18 percent did not employ staff in the last seven days. The 229 AFHs that employed staff reported a total of 670 employees and answered questions about 664 of these staff. Most of these 664 AFH staff were caregivers (89 percent); 47 AFH staff (7 percent) held a CNA or CMA certification, and seven AFH staff (1 percent) were licensed as LPN/LVN (Figure 4).

Figure 4. AFH staff job title/description and certification, 2022



Note: Out of the 670 employees reported, 664 had information about their job title and certification.

Information about hours worked in the prior week was available for 657 of the 670 AFH staff reported by owners. Among these 657 AFH staff, 57 percent worked full-time (35 hours or more), and the average and median were 34 and 40 hours, respectively.

Staffing Stability: Tenure, Absenteeism, and Contract Staff

Staffing stability is an important aspect of providing high quality care to residents. This year, we asked four questions to cover this topic: staff tenure and turnover, reasons for staff absenteeism, and use of contract/agency care staff in cases of unplanned staff absences. The wording of the staff turnover was revised this year; however, the revised question resulted in confusion among AFH providers during the fieldwork, suggesting potential validity issues. Consequently, data related to the staff turnover question is excluded.

Staff tenure. We asked AFH owners how many staff had been employed in their homes for more or less than six months. This measure of tenure is intended to reflect the length of time an employee remains in a particular role or within an organization. The study team used six months because it is less burdensome for providers to review records for a shorter time period and because it has been used in published studies (Castle, 2006). Based on information received about 660 AFH staff, the majority (86 percent) have been working at the AFH for longer than six months (581 staff members). This suggests low turnover among staff in AFHs.

Staff absenteeism. This refers to staff who missed work when they were scheduled, which can negatively impact residents and other staff (Harris-Kojetin et al., 2004). AFH owners were provided a list of potential reasons due to which staff might have missed work and asked to select all the applicable ones for why their own staff did miss work in the last 90 days (Table 6). Percentages in Table 6 include AFHs that reported at least one reason (35 percent of responding AFHs). The most common reason for staff absenteeism was personal health issues (60 percent), followed by family illness or emergency, and COVID-19 pandemic-related issues, with each accounting for 33 percent of staff absenteeism. The share of staff who were absent due to transportation problems doubled between 2020 and 2021.

Contract/agency care staff due to unplanned staff absences. AFH owners were asked whether they hired contract or agency care staff (including nurses) in the last 90 days in response to unplanned staff absences. Only four of 278 AFHs reported they have hired contract or agency care staff (including nurses) to cover unplanned staff absences. This low number might be due to AFHs having fewer staff compared to other long-term care settings, relative stability among AFH staff, owners' desire to avoid high

costs of hiring agency or contract staff (particularly during the COVID-19 pandemic) (Hung et al., 2020), having ready access to staff, or other unknown reasons.

Table 6. Reasons for staff absenteeism in the last 90 days, 2021-2022

	2021 %	2022 %
Personal health issues	52	60
Family illness/emergency	39	33
COVID-19-related issues	36	33
Caregiving for a family member	22	17
Other	21	16
Transportation	6	14

Note: Totals may exceed 100% because each provider was able to select multiple reasons for staff absenteeism. See Appendix B: Tables and Figures for 95% for confidence intervals for years 2021-2022.

MEDICAID USE, PRIVATE PAY RATES, AND ADDITIONAL FEES

This section describes the role of Medicaid in funding care provided in AFHs, AFH charges to residents, and services provided by owners. The section covers the following topics:

- Medicaid acceptance, use, and reimbursement rates over time
- Private pay rates by region and over time
- Additional private pay fees for services

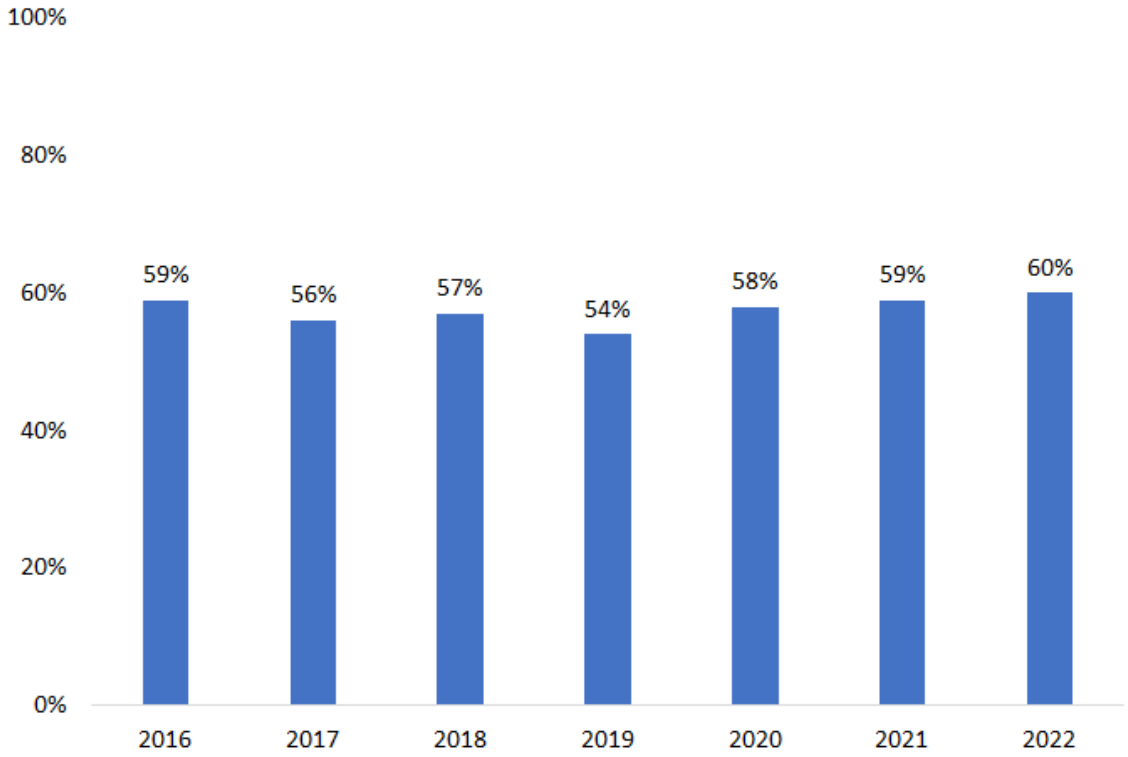
Medicaid Acceptance and Use

Adult foster home providers can have a contract with ODHS to accept Medicaid as a form of payment and AFH residents who meet financial and medical eligibility criteria may have their services paid by ODHS using Medicaid funds.

According to ODHS records, 1,245 of the 1,354 AFHs licensed by APD (92 percent) accepted Medicaid. Most AFHs (85 percent) that participated in the study reported accepting Medicaid payments. For a small share of responding AFHs (16 percent), there were discrepancies in Medicaid contract status between ODHS records and owner reports, with ODHS records indicating a Medicaid contract while the AFH reporting non-Medicaid or vice versa. These discrepancies may be the result of errors in record keeping, potential changes in contract status between when the ODHS records are pulled and the study was conducted (about 3-5 months), question wording, or a combination of these factors.

We asked owners how many of their residents paid primarily with Medicaid or private pay sources (e.g., personal accounts, long-term care insurance, Social Security, pensions). The share of residents paying using primarily Medicaid has increased from 54 percent in 2019 to 60 percent in 2022 (Figure 5), and 79 percent of responding AFHs this year had at least one Medicaid resident. The recent but steady increase in this share has implications for Medicaid LTC spending in Oregon, which is discussed below.

Figure 5. Changes in percent of payers using Medicaid over time, 2016-2022



Note: In 2016 and 2017, the questionnaires informed owners that more than one payment category was possible for each resident. In the following years, owners were asked how current residents *primarily* paid using Medicaid.

Medicaid Reimbursement Rates

ODHS/APD establishes reimbursement rates for Medicaid LTC services. As of January 2022, the base monthly rate that ODHS pays on behalf of eligible Medicaid residents was $2,543 (base rate without add-on but including room & board). As Figure 6 below shows, inflation-adjusted Medicaid reimbursement increased by about 13 percent since 2016, up from $2,245. Furthermore, ODHS pays an additional $343 for each eligible add-on, up to three add-ons, the assessment of which is made individually based on needs documented in the Client Assessment and Planning System (CA/PS) (OAR 411-27-0025). ODHS also contracts with AFH providers to provide care for specific, more complex client needs at higher rates: Enhanced Care at $3,412; Hospice at $9,321; and Advanced Ventilator at $22,015, to give a few examples.

Private Pay Rates by Region

While a majority of AFH residents primarily pay using Medicaid funds, a sizable share uses private or other funds, including but not limited to their own or their family's personal accounts, LTC insurance, or pension. Each year of this study, AFH owners are

asked to provide the average total monthly charge for a single resident living alone in a private room and receiving the "lowest level of care." This question allows the study team to compare averages, although it is possible that the resident who needs the lowest level of care in one home differs from a similar resident in another home, and that owners have different ways of assessing private fees.

The statewide average monthly private pay charge among the responding AFHs with at least one private-pay resident was $4,527, with a median total monthly charge of $4,500 (indicating that 50 percent of all responding AFHs had a total monthly charge below $4,500). Based on the average total monthly rate, the estimated average annual charge would be $54,324 for a private-pay AFH resident in Oregon.

Average total monthly private pay charges varied throughout the state, ranging from $4,194 to $4,721, representing a difference of $527 per month. The highest average total monthly rates were reported in the East of the Cascades and Willamette Valley/North Coast region, followed by the Portland Metro and Southern Oregon/South Coast (Table 7).

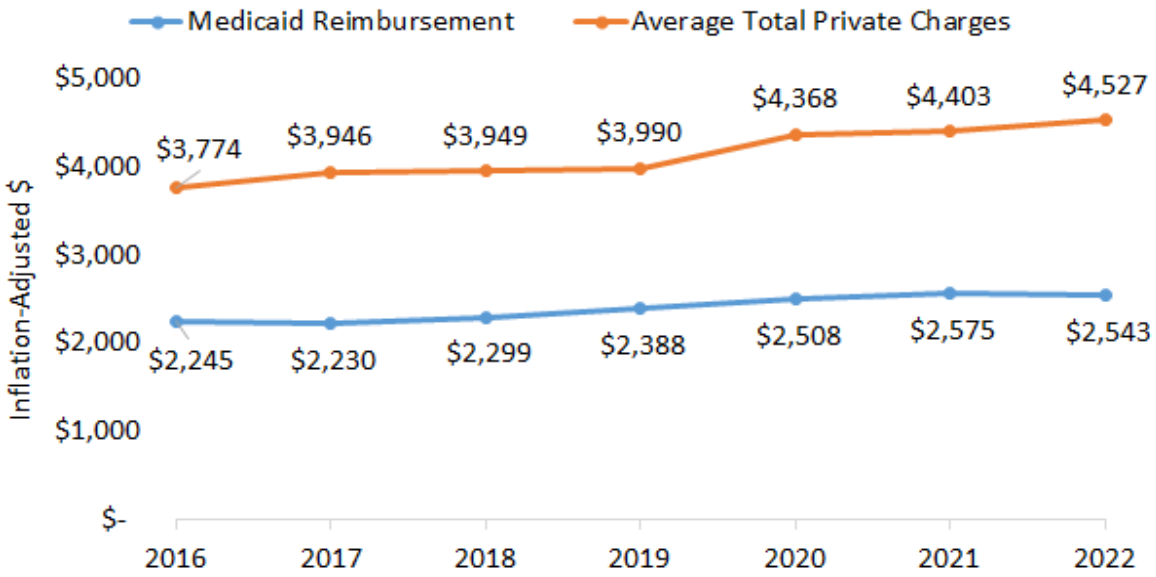
Table 7. Total monthly charge for private room by region, 2022

	Minimum	Average	Median	Maximum
Portland Metro	$2,000	$4,544	$4,500	$8,500
Southern Oregon/South Coast	$2,500	$4,194	$4,525	$6,000
East of the Cascades	$3,000	$4,721	$4,375	$7,515
Willamette Valley/North Coast	$3,000	$4,632	$4,500	$9,500
Total	$2,000	$4,527	$4,500	$9,500

Note: This table excludes AFHs where only residents who primarily pay via Medicaid reside.

Between 2016 and 2022, inflation-adjusted average total monthly charges increased from $3,774 to $4,527 (in December 2021 dollars), a 20 percent increase in real dollar terms (Figure 6 below). To compare, according to one industry estimate (Genworth, n.d.), between 2016 and 2021, annual national median cost for a nursing home private room and assisted living facility care increased by 17 percent and 19 percent, respectively. The one-year increase between 2021 and 2022 was 2.8 percent, larger than the increase between 2020 and 2021 (0.8 percent) but smaller than the increase between 2019 and 2020 (9.5 percent).

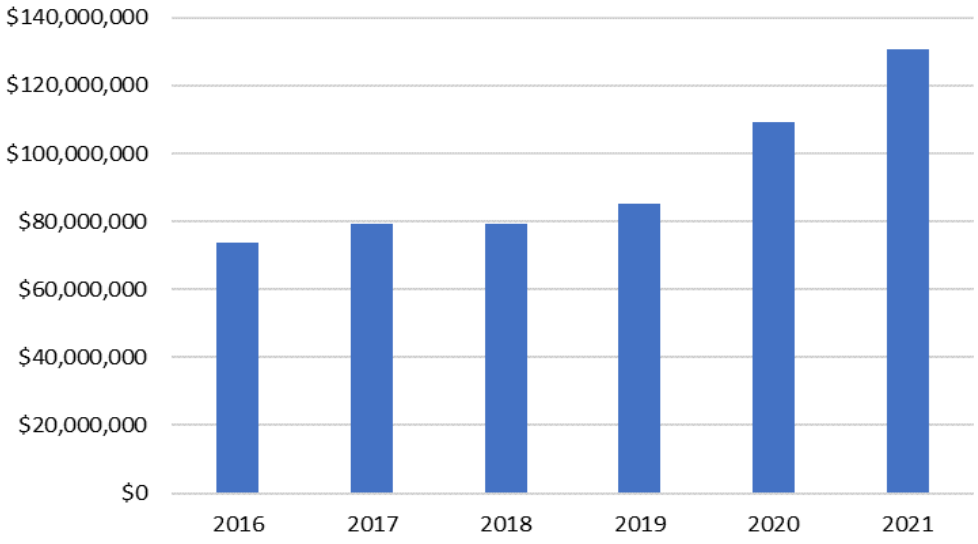
Figure 6. Inflation-adjusted Medicaid reimbursement rates and average total monthly charges in private pay rates, 2016-2022



Note: Values are inflation-adjusted to December 2021 dollars using the Bureau of Labor Statistics (BLS) inflation calculator. Medicaid reimbursement rates were calculated based on January 1 of each year.

As in prior years, more than half of AFH residents in the responding homes were Medicaid recipients. Based on data for all AFHs licensed by APD in Oregon provided to the study team by ODHS, in 2021, the state paid AFH owners a total of $130,827,108 on behalf of residents who were Medicaid beneficiaries (Figure 7). Since 2016, when the amount was $73,737,191, there has been a 77 percent nominal increase (ignoring inflation) or 61 percent increase in real dollars (accounting for inflation).

Figure 7. Medicaid expenditures paid for Adult Foster Care, 2016-2021



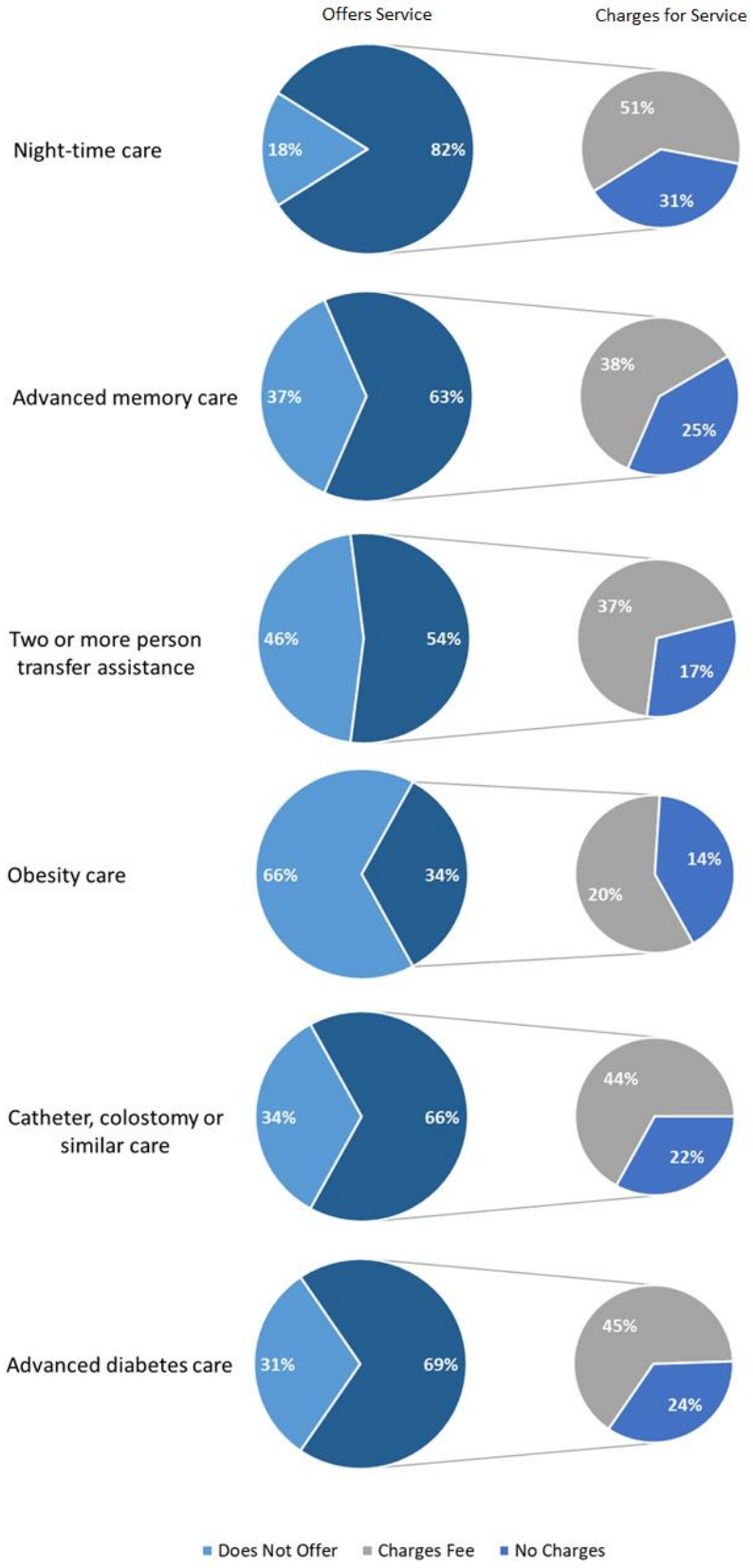
Additional Private-Pay Services and Charges

AFH providers are required to enter into a written contract ("Residency Agreement") with residents (or residents' representatives) that pay using private funds, including the details about the services to be provided and the rates to be charged (OAR 411-050-0705). We asked owners which of the six services listed in Figure 8 they offered; if they offered a particular service, they were also asked if they charged an additional fee for that service.

The top three services of those included in Figure 8 were night-time care (82 percent), advanced diabetes care (69 percent), and catheter, colostomy or similar (66 percent) (Figure 8). Of the 271 AFHs that responded, 7 percent offered none and 21 percent offered all six of these services (not shown).

Among AFHs that offered each service, the three most common services for which there was an additional fee were two or more-person transfer assistance, catheter, colostomy, or similar, and advanced diabetes care. These services require additional staff and staff with specialized knowledge and training.

Figure 8. Percentage of AFHs offering and charging for certain services, 2022



RESIDENTS

This section describes who lives in AFHs and what kinds of services they receive. The following resident information is summarized:

- Demographics
- Move-in and move-out locations
- Length of stay
- Personal care needs
- Types of assistance received, and
- Health conditions and health service use.

Resident Demographics

The AFH demographic profile has remained relatively constant since 2016. The 279 responding AFHs included a total of 1,208 residents. About one in five AFH residents were younger than 65 years of age. Among those ages 65 and older, nearly one in three were ages 85 and older. The percentage of residents ages 65 to 84 has increased significantly since 2016 (Table 8), from 35 percent to 47 percent.

Table 8. AFH resident gender and age, 2016-2022

	2016 %	2017 %	2018 %	2019 %	2020 %	2021 %	2022 %
Gender							
Male	34	38	38	38	36	40	40
Female	66	62	62	62	63	60	59
Transgender	<1	X	<1	<1	<1	<1	<1
Age							
18-49	6	5	6	5	5	5	5
50-64	16	16	17	17	18	16	16
65-74	17	17	19	20	21	20	23
75-84	18	19	21	21	20	23	24
85 and over	42	42	38	37	36	37	32

Note: Totals may not add up to 100 percent due to rounding. X indicates that there were no residents in that category in a particular year. See Appendix B:Tables and Figures for 95% for confidence intervals for years 2016-2022.

Similar to the general state demographics, the majority of AFH residents were White. The race/ethnicity of those who were not White comprised 14 percent of AFHs population (Table 9). American Indian/Native American or Alaska Natives, Asian, and Black/African American residents each comprised about 3 percent of AFH residents.

Table 9. AFH resident race/ethnicity, 2016-2022

	2016 %	2017 %	2018 %	2019 %	2020 %	2021 %	2022 %
Hispanic/Latino of any race	2	2	3	2	2	3	2
Non-Hispanic/Latino							
American Indian/Native American or Alaska Native	1	1	2	3	3	3	3
Asian	2	2	3	3	2	2	3
Black/African American	2	2	2	2	2	3	3
Native Hawaiian or Other Pacific Islander	<1	1	1	1	<1	<1	1
White	90	88	86	87	88	86	86
Two or more races	1	1	1	1	2	2	1
Other/unknown	1	2	3	1	1	1	1

Note: Totals may not add up to 100 percent due to rounding. See Appendix B:Tables and Figures for 95% for confidence intervals for years 2016-2022.

Move-In and Move-Out Locations

Adult foster home residents move into this setting from a variety of places. Moving to a residential setting might be planned in advance or occur without warning, such as after an injury, illness, or transfer notice, and can be stressful to older adults and their relatives. Of the prior residences included in Table 10, the largest share of current residents moved from another AFH. In total, 50 percent of current AFH residents moved to the home from another licensed care setting (e.g., AL/RC, MC, other AFH, NF), and an additional 13 percent moved in from a hospital. Fewer than one in five moved in from their own home, although the share increases to 27 percent when we combine those who moved from their own home or the home of a relative. With the current data, we cannot know the reasons that current residents move into AFH, including whether the move was a resident's choice, if they were transferred from another long-term care residence, or if they needed a higher level of care.

Of the residents who moved out of the AFH, the largest share (72 percent) includes those who died. Among those who moved, 15 percent went to another licensed care setting and six percent moved to their own home or into the home of a relative. Future research could collect information, preferably from residents, to inform our understanding of why some residents move into and out of AFHs.

Table 10. Current resident move-in locations/Resident move-out locations in prior 90 days, 2022

	Current Resident Move-in %	Move-out in Prior 90 Days %
Died	-	72
Home	18	3
Home of Child or Other Relative	9	3
Independent Living	7	1
Assisted Living/Residential Care	13	1
Memory Care Community	4	3
Another Adult Foster Care/Home	23	8
(Skilled) Nursing Facility	10	3
Hospital	11	3
Psychiatric Hospital	2	1
Houseless/Homeless	2	X
Criminal Justice System	<1	0
Other	1	2
Don't Know	<1	0

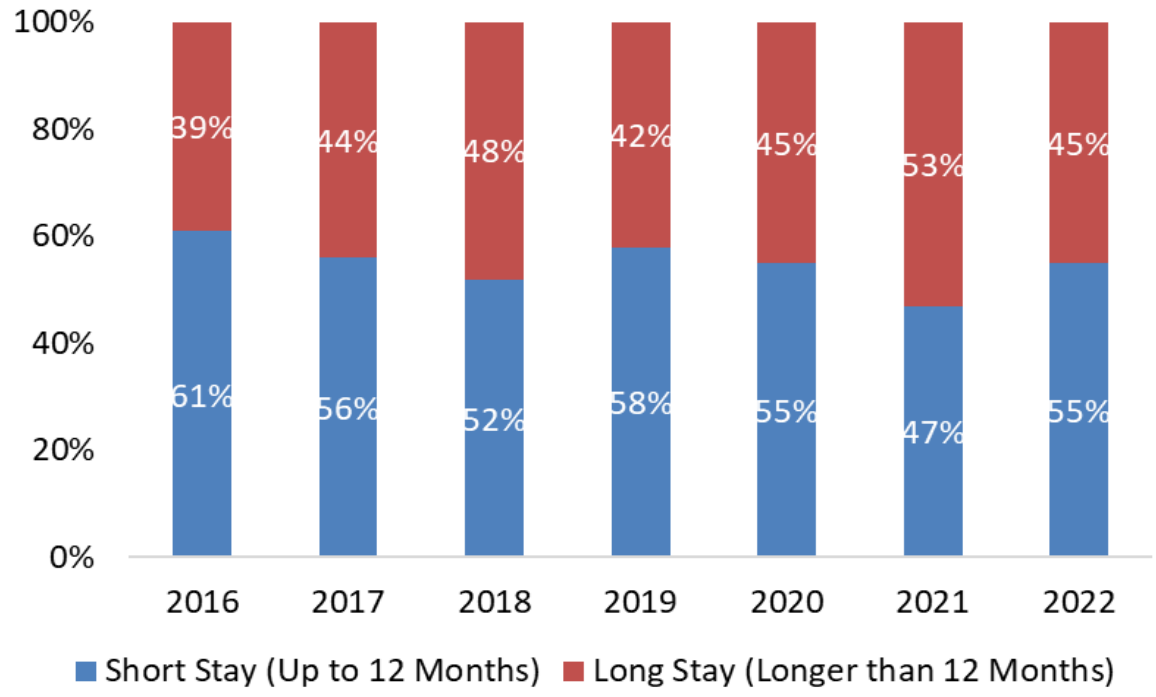
Note: Totals may not add up 100 percent due to rounding. X indicates that the response category was not available in that year. See Appendix B:Tables and Figures for 95% for confidence intervals for years 2016-2022.

Length of Stay over Time

Studies show that older adults prefer to stay in their own home as long as possible, and to remain in a residential care setting after relocating to one (Golant, 2020; Binett et al., 2017). Figure 9 describes length of stay for residents who moved out or died in the prior 90 days, reported since 2016. Most residents stayed in their AFH one year or less. The share of residents who stayed for more or less than 12 months has remained relatively constant.

It is useful to look at the share who stayed in their AFH for different lengths of time. Of the current residents, 36 percent stayed up to six months, 33 percent stayed two or more years, 19 percent stayed six months to one year, and 12 percent stayed one to two years (Table B8, Appendix B). These rates, in addition to the information about move-in locations and the percent who died, suggest that some AFHs experience significant resident turnover.

Figure 9. Resident length of stay over time, 2016-2022



Personal Care Services

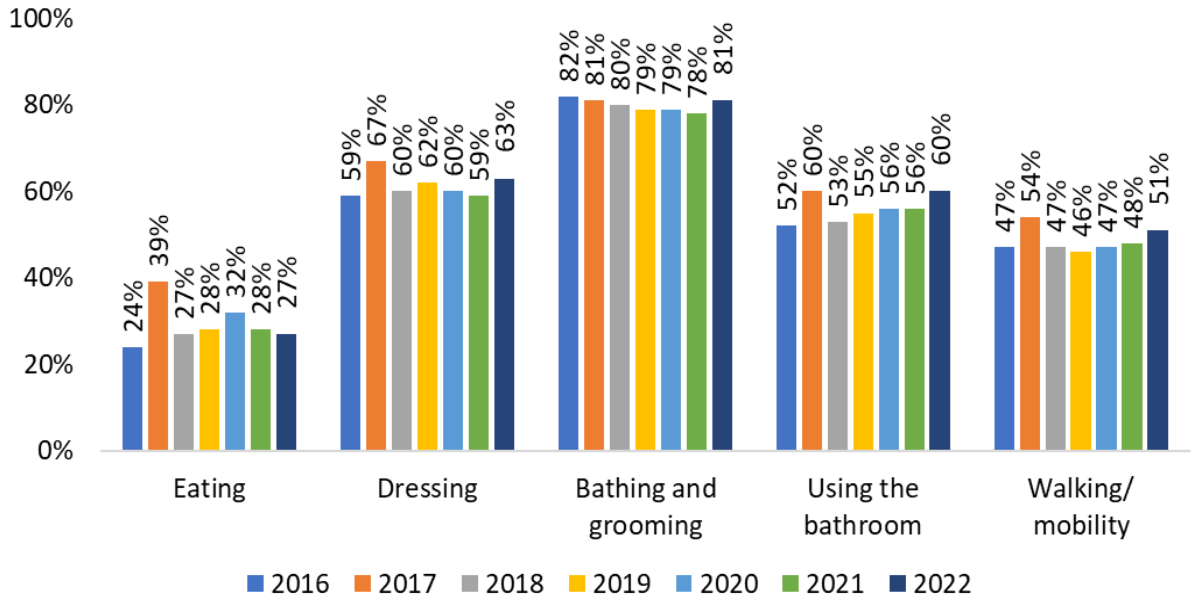
Activities of daily living (ADLs) encompass routine self-care tasks, such as eating, dressing, bathing and showering, using the bathroom, cognitive supports and mobility. Aging, chronic health conditions, acute illness, and cognitive decline can increase the need for assistance with ADLs (Edemekong et al., 2022) and the need for assistance

with ADLs constitutes a major reason that older adults and people with physical disabilities make use of LTSS, including AFHs. Nationally, 21 percent of adults ages 85 and older, seven percent of those ages 75 to 84, and three percent of those ages 65 to 74 need assistance with ADLs (Caffrey et al., 2012).

In AFHs, most residents needed assistance with one or more ADLs, although the share of residents that required assistance varied by ADL. The most frequently reported support need was bathing and grooming (81 percent) and the least reported support need was eating (27 percent) (Figure 10).

Most AFH residents (72 percent) regularly used a mobility aid (e.g., a cane, walker, or wheelchair) to get around (not shown in figure), and a smaller but still sizable share (48 percent) needed assistance to use a mobility aid. About a quarter (24 percent) of all AFHs had at least one resident that needed assistance to use a mobility aid.

Figure 10. Percentages of AFH residents receiving staff assistance with ADLs, 2016-2022



Note: In 2017, AFHs were asked to report both “full assist” and “standby” assistance separately. These two categories are combined in the graph, which may have resulted in higher percentages for that year.

Assistance from Two Staff and Nighttime Care

Residents might need assistance from two staff to complete ADLs, such as to transfer from a bed to a chair, to shower, and because of certain cognitive or behavioral health needs. In addition, residents might need staff assistance during the night, either on a

short- or long-term basis. These types of services can require the AFH to employ additional staff.

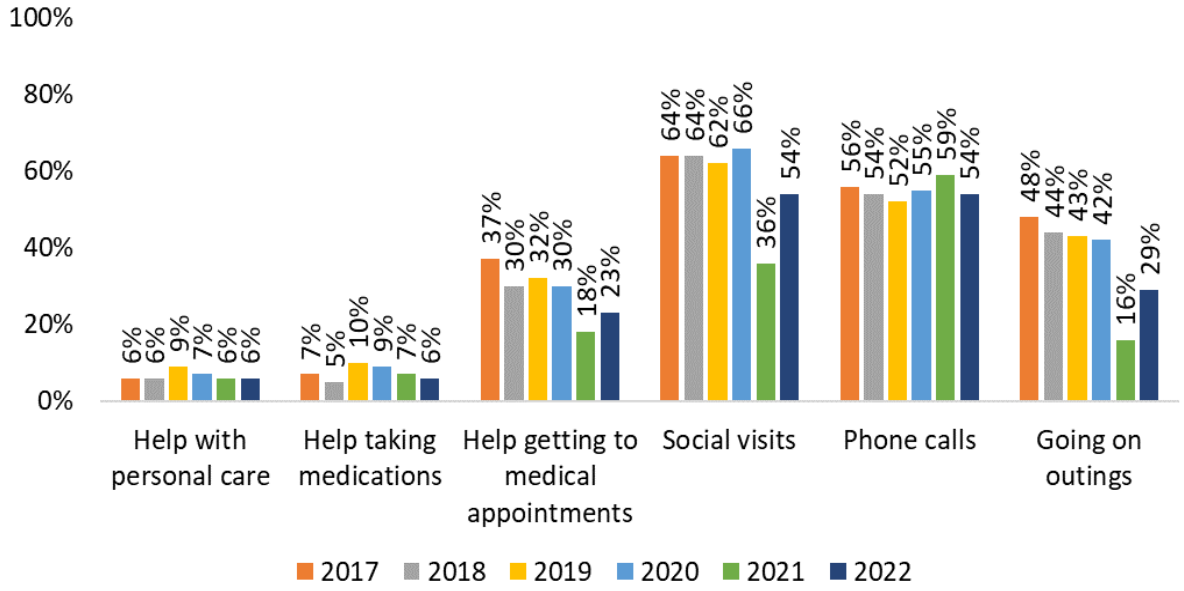
Thirty percent of AFH residents regularly received assistance from two persons for physical and/or cognitive health needs. Thirteen percent of responding AFH reported having at least one resident who received this type of assistance. One-third (36 percent) of AFH residents regularly received assistance from NOC (night shift) staff during the night. Sixteen percent of responding AFHs reported having at least one resident who received assistance during the night. These findings suggest that a sizable share of the AFH resident population receives staff- and time-intensive services, indicating a high level of need.

Visits and Assistance from Family Members and Friends

Residents of residential long-term care benefit from visits from friends and family (Mitchell & Kemp, 2000). Reasons for visits include social gatherings as well as visits to provide assistance with personal care and instrumental tasks (e.g., delivering groceries and medications, providing transportation). Oregon DHS modified the COVID-19 policies regarding visits to AFHs in December 2020, permitting “safe and controlled” visitation depending on the county positivity rates (ODHS/APD, Provider Partners Licensing, 2020). In March 2021, the policy was further revised to allow visitors 14 days after all residents received a second vaccination (ODHS/APD, Provider Partners Licensing, 2021).

The share of residents who received social visits and assistance getting to medical appointments in 2021 nearly rebounded to the rates reported prior to the pandemic (Figure 11). The share of residents who went on outings increased in comparison to 2020, though it did not reach the rates reported prior to 2020, and the share of those who received phone calls declined slightly compared to 2020. For example, 29 percent of residents went on outings in 2022 compared to 16 percent this year and the low 40s in the three prior years. Similarly, the share of residents who received social visits increased from 54 percent in 2022 compared to 36 percent in 2021. The share of residents receiving assistance from family members and friends remained consistent with previous years for help with personal care and taking medications. These rates suggest that for many AFH residents, life began to return to pre-pandemic levels in terms of social visits and assistance from their family and friends.

Figure 11. Resident visits and assistance from family and friends, 2016-2022



Resident Health Conditions and Falls

As shown below in Table 11, the five most diagnosed health conditions of residents were high blood pressure/hypertension, depression, Alzheimer's disease and related dementias, heart disease, and anxiety disorder. These conditions have remained relatively consistent since data collection began in 2016, however, this year our team added general anxiety disorder to the list of health conditions, which could influence how these data are interpreted. Anxiety disorder has come out slightly more prevalent than arthritis. As previously discussed, arthritis remains a prevalent condition for AFH residents. We briefly describe each of the five most commonly diagnosed conditions below.

High blood pressure/hypertension prevalence increases with age and remains common in all older adults. Nationally, 74.5 percent of adults over the age of 60 experience this condition (Ostchega et al., 2020). Since 2016, about half of AFH residents have experienced high blood pressure. Currently, 50 percent of AFH residents have high blood pressure or hypertension.

Similar to high blood pressure, 47 percent of AFH residents experience depression. Compared to last year, depression has increased 6 percent in this population. The COVID-19 pandemic has brought attention to social isolation and loneliness as contributing factors to depression (MacLeod et al., 2021; Berg-Weger & Morley, 2020).

Table 11. Prevalence of AFH residents' diagnosed health conditions over time, 2016-2022

	2016 %	2017 %	2018 %	2019 %	2020 %	2021 %	2022 %
High blood pressure/hypertension	45	50	48	52	50	49	50
Alzheimer's disease and related dementias	49	47	46	48	49	48	45
Heart disease	39	37	38	39	37	39	39
Arthritis	38	37	36	37	33	32	32
Diabetes	22	19	21	23	22	23	20
Depression	40	42	40	46	45	41	47
Serious mental illness (excluding Anxiety disorder and depression)	X	X	X	X	X	X	20
Anxiety disorder	X	X	X	X	X	X	33
Osteoporosis	16	17	18	17	17	12	14
COPD and allied conditions	15	16	15	16	16	17	14
Intellectual or developmental disabilities	9	9	10	10	9	10	6
Cancer	7	8	8	9	7	8	6
Traumatic brain injury	X	7	7	8	9	9	11
Current drug and/or alcohol abuse	4	3	3	5	4	4	4

Note: X indicates that the response category was not available in that year. See Appendix B:Tables and Figures for 95% for confidence intervals for years 2016-2022.

Alzheimer's disease or another type of dementia (ADRD), which includes residents who have Lewy body dementia, Huntington's disease, or vascular dementia comprised almost half (45 percent) of residents in AFHs. Generally, ADRD impacts memory, thinking, and behavior. While these conditions are grouped together, they vary widely in their symptoms and signs. In addition, many of these conditions start slowly and gradually progress (Alzheimer's Association, 2022).

High blood pressure, diabetes, smoking, diet, and excessive alcohol use increase the risk of developing heart disease, is a major cause of disability among older adults, can limit activity, and decrease quality of life among older adults (National Institute on Aging, 2022). Nationally, 17 percent of adults ages 65 and older have heart disease (CDC, 2022). The prevalence of diagnosed heart disease among AFH residents, at 39 percent, has remained consistent since 2016 and is higher than the rate among older Oregonians, at 20 percent (Oregon Behavioral Risk Factors Surveillance System, 2022).

Clinical depression is not a normal part of aging; however, older adults may experience changes in their life that result in feelings of depression (National Institute of Mental Health, 2022; National Institute on Aging, 2022). Relocation to a long-term care community has been found to be a significant life event associated with negative mental health outcomes, including feelings of depression (Costlow & Parmelee, 2020). In a national study, Sengupta & Caffrey (2020) reported that 31 percent of residential care community residents experienced depression. Among Oregon AFH residents in 2022, 47 percent reported a diagnosis of depression.

An estimated 10 percent to 20 percent of adults ages 65 and older have an anxiety disorder (Geriatric Mental Health Foundation, 2022). However, this condition is often undiagnosed since older adults often do not recognize, or do not discuss symptoms with a healthcare provider. The presence of depression and chronic medical conditions increase the likelihood of having an anxiety disorder (Kalin, 2020). As previously mentioned, the COVID-19 pandemic has increased the prevalence in older adults experiencing anxiety or depression (Koma et al., 2020). Currently, 33 percent of AFH residents are diagnosed with an anxiety disorder.

For the first time, this year we asked about SMI distinct from anxiety disorder and depression. Serious mental illness (SMI) refers to an emotional, mental, or behavioral disorder that results in a severe impact that affects one or more major life activities (National Institute on Mental Illness [NIMH], 2022). About 6 percent of the U.S. population has an SMI, and the rate for adults ages 50 and older is 3.4 percent (NIMH, 2022). The share of current residents with an SMI is 20 percent.

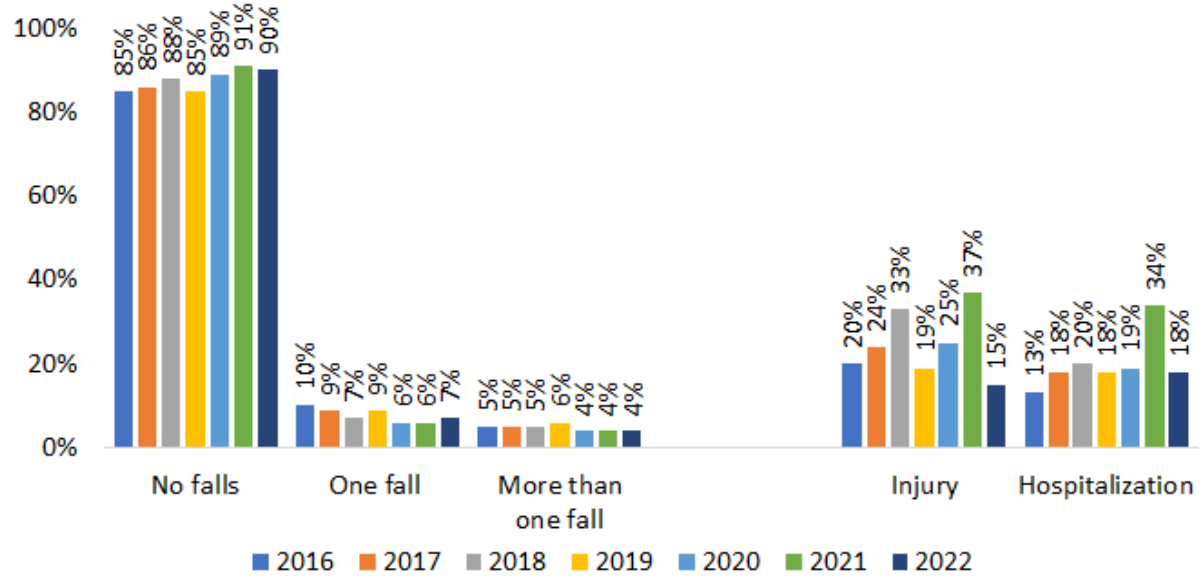
Falls

AFH owners and caregivers receive training to learn why residents are at greater risk of falling, and ways to decrease the likelihood that a resident will fall (Oregon DHS/APD, 2020). Oregon aims to reduce older adults' falls risk by linking clinical practice to

evidence-based fall prevention programs and offering resources to healthcare providers and community-dwelling older adults (Oregon Health Authority, 2022).

Owners reported that most residents (90 percent) did not fall in the prior 90 days and a small share of residents (four percent) experienced multiple falls (Figure 12; left side). Among residents who fell at least one time in the past 90 days, about one-third (37 percent) experienced a fall-related injury and 18 percent went to the hospital because of their fall (Figure 12; right side). Large year-to-year changes in estimates on these fall-related adverse resident outcomes (injury and hospitalizations) are attributable to the small sample of residents on whom these estimates are based.

Figure 12. Falls in the prior 90 days and falls resulting in injury or hospitalization, 2016-2022



Health Service and Medication Use

The increase in the number of older adults with chronic health conditions will likely be associated with commensurate increases in emergency room (ER) visits and hospital admissions (Albert et al., 2013; McDermott et al., 2017). Well-planned transitions between acute, post-acute, and LTC settings can decrease the likelihood of complications and readmission. Prior to admitting or re-admitting hospitalized residents, AFH owners are required to coordinate with healthcare providers to determine whether admission (or readmission) to their AFH is appropriate and to assess their ability to meet the resident's care and safety needs (OAR 411-051-0110). There are also notification requirements associated with medical emergencies and hospitalizations (OAR 411-51-0105).

Owners were asked about their residents' health service use in the 90 days prior to completing the questionnaire. The questionnaire asked about hospital emergency room (ER) use, overnight hospitalization, 30-day rehospitalization, hospice service use, and services received from a licensed or certified home health care agency.

Eleven percent of AFH residents had been treated in the hospital ER and 7 percent had been hospitalized overnight (Table 12). Among residents who had been hospitalized overnight, about a quarter (28 percent) had been re-hospitalized within 30 days. Nine percent of residents were receiving hospice care and about one-fifth (18 percent) were receiving services from a licensed or certified home health care agency. Overall, use of these health services among AFH residents did not change notably between 2016 and 2022.

Table 12. Health service use among AFH residents, 2016-2022

	2016 %	2017 %	2018 %	2019 %	2020 %	2021 %	2022 %
Treated in hospital ER in the last 90 days	14	14	15	13	13	11	11
Hospitalized overnight in the last 90 days	6	8	8	8	7	6	7
Went back to the hospital within 30 days	X	24	30	27	27	24	28
Received hospice care in the last 90 days	10	10	11	10	10	10	9
Received services from a licensed/certified home health care agency	X	X	X	X	19	17	18

Note: X indicates that the question was not asked in that year. See Appendix B:Tables and Figures for 95% for confidence intervals for years 2016-2022.

At-Home and Virtual Visits by Healthcare Providers and Professionals

Some AFH residents have significant functional and health-related limitations that, might make it harder for them to visit health care providers. We asked owners which, if any, of

the eight types of healthcare providers and professionals listed in Table 13 visited their AFH (virtually and/or in person) to provide services for their residents.

Most AFH owners reported that a licensed nurse (RN, LPN, LVN) visited their home, either in person (71 percent) and/or virtually (13 percent). There was a higher prevalence of virtual visits among some provider types, such as medical doctors or nurse practitioners (28 percent) and case managers (23 percent). A small share of AFHs received visits from dentists or dental hygienists (8 percent and 9 percent, respectively).

Table 13. Visiting health care providers to AFH, 2022

	Yes, virtually %	Yes, in person %	No %
Nurse (RN, LPN, LVN)	13	71	26
Medical doctor or nurse practitioner	28	46	38
Mental health provider	12	17	73
Physical or occupational therapist	2	44	55
Social worker	12	33	57
Case manager	23	20	59
Dentist	0	8	92
Dental hygienist	1	8	91

Note: Rows need not add up to 100 percent since some AFHs reported both virtual and in person visits.

Medications Use and Assistance with Medications

Medication management is an important health policy topic for older adults, including those who live in long-term care residences. Specific topics include polypharmacy (Jokanovic et al., 2015; NIA, 2021), or taking multiple prescriptions, as well as the use of medications classified as having the potential for addiction (e.g., certain opioids) and negative health outcomes for older adults. For example, while antipsychotic medications can provide an effective treatment for psychoses (e.g., hallucinations, delusions, and disordered thinking), agitation and aggression, these medications have been prescribed to manage behavioral expressions in people with dementia (Austrom et al., 2018) resulting in falls, illness, and death (Kales et al., 2015). Oregon's legislature enacted HB 3262 in 2017 to specify how and when providers may prescribe certain psychotropic

medications, including antipsychotics, to residents of long-term residential settings (Oregon State Legislature, 2017).

AFH staff support includes administering medications taken through a variety of routes (e.g., oral, topical, injection) as well as storing and ordering medications, and documenting medication use. AFH residents who are capable of doing so may take their own medications (e.g., self-administer) (OAR 411-051-0130).

Psychotropic Medication Use

ODHS recently provided specific guidelines around psychotropic medications and clarified the definition of those medications to include antipsychotics, antidepressants, anxiolytics/hypnotics (ODHS/APD, Provider Partners Licensing, 2019). Following these guidelines and to better understand psychotropic medication use among AFH residents, this year the study team added questions about the use of anxiolytics (for anxiety, restlessness, verbally disruptive behaviors) and sedative-hypnotic medication (for sleep, psychological excitement). In addition, a question about opioid prescriptions (for pain management) was added.

Table 14. Medication use and assistance with medications, 2016-2022

	2016 %	2017 %	2018 %	2019 %	2020 %	2021 %	2022 %
Take nine or more medications	54	53	51	52	53	54	60
Take opioid medications	X	X	X	X	X	X	22
Take antipsychotic medications	34	35	35	36	39	39	36
Take antidepressant medications	X	X	X	X	X	X	48
Take anxiolytic/ sedative-hypnotic medications	X	X	X	X	X	X	24
Self-administer medications	5	5	6	6	6	4	5
Received assistance to take oral medications	80	75	74	75	76	76	77

Note: X indicates that the question was not asked in that year. See Appendix B:Tables and Figures for 95% for confidence intervals for years 2016-2022.

The share of residents who took specific medication types were 48 percent for antidepressant medications, 36 percent for antipsychotics, 24 percent for anxiolytic/sedative-hypnotics, and 22 percent for opioids (Table 14 above). The share of residents taking antipsychotics has remained relatively stable since 2016, ranging between 34 percent in 2016 up to 39 percent in 2020 and 2021.

Polypharmacy and Medication Assistance

Over half (60 percent) of AFH residents take nine or more medications to treat their respective health conditions. The share of residents taking multiple medications increased slightly in 2022 compared to prior years. Only a small share of residents self-administers their own medications, indicating that the majority receive assistance from AFH staff to do so. The latter two rates have remained unchanged over time.

IMPACT OF COVID-19 PANDEMIC

Supports and Challenges

AFH owners, like other LTSS providers, had to implement several new policies and procedures in response to the COVID-19 pandemic. For last year's study, we developed a set of 11 statements that tapped into the impact of the pandemic on AFH owners as well as additional supports and challenges associated with managing an AFH during the pandemic. To track changes in provider experiences, we asked AFH owners those 11 statements again this year. Table 15 shows the share of AFH owners who agreed or strongly agreed with each of these 11 statements in 2021 and 2022 (Table 15).

In terms of supports and resources, AFH owners expressed high rates of agreement for being able to address concerns of their residents' families (82 percent) and of their staff (80 percent), and residents' use of virtual visits (81 percent) and telemedicine or telehealth (76 percent).

Among the challenges included in the questionnaire, AFH owners generally agreed that they could get accurate information about COVID-19 (71 percent), received enough support from various government agencies (66 percent), were satisfied with communications from agency staff (78 percent), had access to personal protective equipment (66 percent), and found the visitor restrictions reasonable (75 percent).

We compared the findings from last year (2020-21) with the current responses and found that of the 11 items, only one significantly changed during the past year. In 2020-21, one-third of AFH owners (37 percent) had agreed or strongly agreed that they had a harder time with staffing. This year, the share increased to 54 percent, indicating that staffing issues, such as hiring, retaining, and scheduling, were an increasingly challenging aspect of operating an AFH during the pandemic. As noted above, only about 18 percent of AFH did not employ staff.

Table 15. Impacts of the COVID-19 pandemic on AFH owners, 2021-2022

In the past 12 months…	2021 %	2022 %
a. We have been able to get accurate information about COVID-19.	71	71
b. We have been given enough support from county/state agencies to deal with issues/problems due to the pandemic.	68	66
c. We have been satisfied with the communication about rules and regulations from the county/state agencies.	76	78
d. We have been able to access personal protective equipment (PPE) (such as eye protection, gloves, N95 respirator masks).	62	66
e. We have been able to address concerns of my residents' families related to the pandemic.	77	82
f. We have been able to address concerns of my staff related to the pandemic.	76	80
g. We have had a harder time finding new residents.	35	34
h. We have had a harder time with staffing (such as hiring, retaining, and scheduling).	37	54
i. Our residents have used virtual visits (e.g., iPad, computer, smart phone) with their family members and friends.	79	81
j. Our residents have used telemedicine or telehealth for purposes of assessments, monitoring, diagnosis, or treatment.	76	76
k. We have found the COVID-19 visitor restrictions enacted by county/state agencies to be reasonable.	75	75

Note: Percentages refer to the share of AFH provider responses that agreed or strongly agreed with each statement, out of the six possible options ranging from strongly disagree to strongly agree, plus not applicable. In 2021, the look-back period was defined as "As of March 2020, since the COVID-19 pandemic started…" instead of "In the past 12 months…"

Owner Experiences with Operating an AFH

To better understand AFH owners' first-hand experiences of operating their homes, they were asked three questions that required written responses:

1. What they liked best about operating their AFH
2. Their biggest challenges
3. What ODHS and IOA/PSU should know about operating an AFH during the pandemic

Below we summarize the key themes associated with the owners' responses. Some responses referred to one or more of these themes, as shown in the below quotes. The quotes are presented as written to maintain the intent of the respondent; thus, there are a few grammatical and word choice errors. See Appendix A for a description of how these open-ended (qualitative) responses were analyzed and reported.

AFH Owner Comments Regarding what They Like Best about Owning, and/or Living in an Adult Foster Home

Of 279 AFH providers who returned questionnaires, 227 offered 422 responses when asked to describe what they like best about operating, owning, and/or living in an adult foster home. Providing care was the most often reported among AFH providers, followed by meaningful work, working from home, and having a resident as family as well as providing good quality care. On the other hand, DHS support/resources, resident health improvement, and resident appreciation were the least reported by AFH providers. Following we provide examples of quotes to support the key themes.

Providing care motivates AFH owners.

- "Taking care of people and seeing them at different stages of their lives."
- "It's good being able to help someone with everyday routine. Having the same person help them, it makes them feel at home with family."
- "In a foster home, we're able to take care of five residents properly, like an extended family. It pays for my home, facilities, our food expenses and a small income to keep."

Taking care of residents is meaningful work for AFH owners.

- "Being a better and healthy person, to be able to help other persons who can't do this for themselves. It makes me happy that I'm able to help. I'm capable to help people who can't do their ADLs or other things."
- "I'm doing what I like to do which is helping someone who really needs help and providing the best care I can give."

Working from home is a benefit to some AFH owners.

- "I got to work at home and not be stressed with commuting to work. I love to be able to help the vulnerable population in our state."
- "Being able to work from home and having that family environment to be able to provide care for people."

Some AFH owners consider their residents as family members.

- "I live in a wonderful, loving, supporting community. My residents are very housemate [sic] who truly be cared family members."
- "These clients are the good parents I never get to take care of. They are my family."

AFH Owner Comments about Their Biggest Challenges Operating, Owning and/or Living in an Adult Foster Home

Of 279 AFH owners who returned questionnaires, 216 offered 606 responses when asked to describe some of their biggest challenges. The most common themes include challenges with operational costs, including paying staff, reimbursement rates and maintaining full capacity; complying with ODHS regulations; staffing; resident care and the owners' own self-care needs.

The most commonly reported challenge concerned operational costs, especially paying staff. Examples of quotes that describe this challenge included:

- I "cannot afford staff with the amount paid (for Medicaid recipients)."
- "Paying staff what they demand."
- Paying "what they are worth, especially with minimum wage going up."

Some owners specified challenges due to Medicaid reimbursement rates.

- "The service pay from Medicaid seniors with disabilities is lower than all other agencies and causes a struggle when living costs are rapidly rising."
- "Low Medicaid payments do not commensurate with 24-hour care."

Others addressed difficulties with operating at full capacity.

- "Finding private-pay residents."
- "Residents that stay."
- "Getting the right fit for your home."
- "Referral agencies that want to charge you a full month's rent to send you a client."

Another commonly reported challenge was complying with ODHS regulations. Some owners described regulations as “unreasonable,” requiring too much paperwork and continually changing. Examples of their comments about rules, and lack of agency support, include:

- “Blanket rules dependent on who is enforcing them and this makes it really hard.”
- “The narrowness with which the state and county applies unilaterally makes rules, by people/licensers, supervisors who did not give one day of direct care and have no in depth understanding of the concept of people and care first.”
- “Are not person-centered or safe.”
- “Moving away from a homelike environment.”
- “More rules added every year add to the stress.”
- “No support from county officials.”
- “Feeling neglected.”
- “Our voice is not heard.”

Staffing challenges was another common theme among AFH owners. Many of these responses were brief and to the point, as in “finding caregivers” or “finding experiences/qualified caregivers.” Additional examples include:

- “Caregivers not showing up for work.”
- “A high amount of staff shortages.”
- “The state should develop additional resources (agency with hiring, incentives and the power for locating them) and help providers by sending them caregivers on a regular basis (not just in emergency situations).”

Challenges associated with resident care were described by some AFH owners. Some of the challenges were associated with the residents’ characteristics, others with external factors, and others described emotional connections and grief associated with residents’ declining health and death. Examples of each include:

- “Working with challenging behaviors/mental conditions. Having patience with residents at certain times.”
- “Finding way to get outings for some residents, especially residents who rely on wheelchairs for mobility.”
- “I can say that during the Covid time it’s hard for the residents and their families. You have to keep them healthy and safe from the Covid. You can’t let them go out or let people visit them anytime they want to come.”
- “Knowing the people I care for, have a bond for so many years, they’ve become family, watch them slowly decline and no longer physically be a part of my life someday.”

The final challenge owners discussed included their own self care needs. They described limited time for their personal interests or family, lack of privacy, and the challenge of "working a 24-hour job." Some explained that they lacked time for their needs because of staffing challenges. Examples of these challenges include:

- "Work/life balance concerns."
- "Being able to take time off, go away for vacations. Everything, there's something that needs attention, day and night, 365 days a year."
- "You don't have privacy. Our life is here, especially now with the pandemic."
- "Losing your personal privacy. People forget it's your home and want to knock on your door."
- "Finding good caregivers so I can take time off."
- "It is hard to hire someone who will commit their one week of time at least for us to get some really good family time away from AFH."

What Owners Want Others to Know about Operating an AFH During the Pandemic

AFH owners were asked what they would like the PSU study team and ODHS to know about owning and operating an AFH during the pandemic. A total of 152 owners offered 261 responses to this question. Most comments focused on added stress that they experienced, and how it impacted resident care, their own worries and concerns, staffing lack of support from ODHS, and relationships with residents and families. Examples of their comments include:

- "Trying to do the best we can to navigate these new kinds of life and challenges."
- "The fear. What if it comes here? What if someone here gets it?"
- "Provider spending too much on supplies for the safety of residents and everybody."

Staffing came up in response to this and the prior question:

- "Hardest working time of my life. Lack of caregivers (good ones) is causing us to want to close, yet we have the nicest AFH in [City], waitlist for residents, and current ones will be upset at finding comparable care facility when we do close. It is very unfortunate. The AFH has taken a toll on me."
- "Employees want increased pay for more work with residents needing increasing levels of care."
- "The staff I did have refused to get vaccinated so they quit and I have not had any luck replacing them."

Again, some owners reported lack of support, understanding, and acknowledgment from ODHS and other public agency staff:

- “We are at the bottom of the food chain in all aspects. Life continues without support.”
- “Unappreciated as an AFH compared to the big facilities.”
- “We should have easy access for PPE… especially to Medicaid resident.”

A small number of owners discussed conflicts with residents’ family and friends who disrupted the homes’ routines, refused to adhere to COVID visitation regulations, and residents who did not follow safety regulations.

- “One of my resident’s family visit even though it’s not allowed. I try my best to be nice and explaining how, but sad part, resident being wild not seeing her family.”
- “A high chance of exposure because residents do not want to wear a mask.”
- “They call me every day, I tell them to leave me alone, let me do the work. Of course I want to protect me and my residents. Families understood and they stayed away.”
- “They all got depressed due to the pandemic.”

A few owners reported that they were able to operate normally and experienced good communication and support from ODHS. Examples include:

- “ODHS did what they should do.”
- “DHS was amazing to work with.”
- They “tried to do their best.”

For additional information about AFH owner experiences, please refer to an article published by the study team in the *Journal of Aging & Social Policy* (see Elliott et al., 2021 listed in the reference section), available by contacting the Institute on Aging.

POLICY CONSIDERATIONS AND CONCLUSIONS

The LTSS system has been greatly affected by the COVID-19 pandemic and related social and economic changes, including the evolving workforce challenges experienced by many employers. In addition to visitor restrictions, changes in the licensing process, and infection control procedures, a temporary policy went into effect requiring AFHs to comply with vaccination requirements for COVID-19. Specifically, AFH owners must maintain proof of vaccination for themselves and staff or document an approved medical or religious exception (OAR 411-050-0745).

The notable findings and policy considerations this year include the supply of AFHs, medication use, resident moves and length of stay, Medicaid spending, and resident acuity metrics.

Supply of AFH. The number of AFHs has decreased over time, as indicated by this study and an ODHS policy report (ODHS, 2019) that suggested that the decline in AFHs serving the aging and people with disabilities population is due to owners choosing to serve other types of clients (e.g., people with intellectual and developmental disabilities), a perceived gap between care costs and Medicaid reimbursement rates, and retirements among long-serving AFH owners. Challenges associated with the COVID-19 pandemic might have further affected the decline. Partially in response to the factors identified in the ODHS report, Medicaid reimbursement rates to AFH owners were increased by 10 percent on January 1, 2020, and an additional 4 percent on July 1, 2020 (ODHS, 2019).

The number of AFHs decreased by 22 percent between fall 2017 and fall 2021, from 1,740 to 1,354. Not surprisingly, the licensed capacity of responding AFHs declined for the fourth year in a row. The supply varies by county, with no AFH in five counties (Gilliam, Morrow, Sherman, Wallowa, and Wheeler) and six counties that have fewer than 10 AFHs (Baker, Harney, Hood River, Lake, Tillamook, and Grant). Based on information provided by ODHS, 42 percent of AFH owners have been in operation for 10 years or more, 20 percent between five and 10 years, 29 percent between one to five years and nine percent for less than one year. These numbers suggest that new AFHs are being added to the overall supply, and that a substantial number of owners have been operating for more than five years. However, the steady decline in total number of AFHs represents a loss to older adults and people with disabilities who want a small-scale residential setting for LTSS.

Medication use. Safe and appropriate medication use is an important policy topic that concerns the quality of life and safety of older adults, many of whom have multiple prescription types, and who are at risk of poor outcomes, such as falls resulting in injuries, morbidity, and death when medications are misused. While the use of some psychotropic medications can relieve certain symptoms associated with dementia, using antipsychotics and some anxiolytic/sedative-hypnotics to control behavioral expressions of dementia is associated with more risks than benefits (Maust et al., 2015). For this and other reasons, professionals and policymakers recommend reviewing the need for these medications as well as using non-pharmacological approaches to managing residents' symptoms (Scales et al., 2018). Notably, depression and anxiety disorder were listed in the top five medical diagnoses addressed in this study. Oregon has standards for when and how AFH operators must evaluate a resident's use of psychotropic medications (OAR 411-051-0130-8).

The share of AFH residents who took a psychotropic medication included 48 percent for antidepressant medications, 36 percent for antipsychotics, and 24 percent for anxiolytic and sedative-hypnotics. Additionally, 22 percent took opioid medications. The share of residents taking antipsychotics has remained consistent since 2016. Future years of this study can compare the rate of use for the other psychotropic medications and opioids.

Resident moves and length of stay. Moves into and out of AFHs, and length of stay are important policy topics. Half of current AFH residents moved to the home from another licensed care setting (e.g., AL/RC, MC, other AFH, NF). Of the residents who moved out of the AFH, the majority died, although 15 percent went to another licensed care setting. Nearly equal shares of residents stayed up to six months or for two or more years (36 percent and 33 percent respectively).

With the current data, we cannot know the reasons that current residents move into AFHs, including whether the move-out was the result of residents' choice, if they were transferred from another long-term care residence, or if they needed a higher level of care. Possibly some residents who moved transferred between different AFHs owned or managed by the same owner or firm. To better understand reasons for moves between licensed care settings and reasons for short lengths of stay (e.g., less than six months), future research could collect this type of information, preferably from residents and their families. In addition, little is known about end-of-life care in this setting, although most residents who left the AFH in the prior 90 days died.

Medicaid spending. This report shows an increasing trend in the share of residents who pay using Medicaid funds as well as a sizable increase in Medicaid spending on AFHs licensed by APD/ODHS in the past five years. While identifying the specific

reasons behind these increases is outside the scope of the current study, there are potentially many drivers of this increase in public funding, such as changes in eligibility criteria, an increase in population-level need accompanying the population aging in Oregon and the US, costs of LTSS exceeding most Americans' ability to afford long-term, and spending down assets to eligibility.

Resident Acuity. Acuity refers to the level of care an individual needs due to physical, mental, and cognitive health impairments. Most residents receive some assistance with activities of daily living, ranging from 27 percent for eating up to 81 percent for bathing and grooming. Nearly three-quarters of residents use a mobility aid and nearly half need staff assistance to use a mobility aid. In addition, about one-third of residents receive assistance from two staff for some care needs or receive night-time staff assistance. Further, nearly half of AFH residents (48 percent) have a diagnosis of Alzheimer's disease or a related disorder, a condition that over time limits the individual's ability to walk, feed themselves or communicate. In sum, these findings indicate that a significant share of AFH residents have high acuity care needs that require oversight, monitoring, and staff support.

Future research. This report raises several topics that warrant additional research. For example, future research could assess the relationship between AFH characteristics (e.g., owner certification as RN, LPN, or CNA/MA; whether the AFH is owned, mortgaged, or rented; housing-related costs) and resident characteristics (e.g., number of chronic health conditions or nursing tasks needed) and resident outcomes (e.g., health service use and place of death).

Nearly one-third of AFH owners indicated that they never or sometimes receive appropriate health care and about one quarter of AFH owners responded that they only sometimes feel secure about their financial future. Further studies could examine whether AFH owners experience barriers to healthcare services and the extent to which AFH owners' financial security impacts their decision to close their AFH or open another licensed home.

Conclusion

The COVID-19 pandemic continues to adversely impact AFH providers, residents, and their families. This report described results from and identified implications of a study of AFHs licensed by APD/ODHS. We hope that the results will inform and advise policymakers, state and county agency staff, aging advocates, and AFH owners about the status of AFHs in Oregon. We thank all the AFH providers and staff for all they do on behalf of Oregon's older adults and people living with disabilities.

APPENDIX A: Methods

This report contains the results from the 8th annual study that collected data by the IOA from a geographically stratified and random sample of adult foster homes licensed by APD/ODHS. Except in 2015, when AFH providers were asked to report information about *all* of the prior year (i.e., 2014), the study questionnaires have been asking about *current* residents or events that occurred during the prior 90 days. Because of this change in the look-back period after 2015, due to concerns about comparability, we did not include results of that year in this report. However, prior reports, including the 2015 report, can be found here:

https://www.pdx.edu/ioa/oregon-community-based-care-project and
http://www.oregon.gov/DHS/SENIORS-DISABILITIES/Pages/publications.aspx

Each year, during a series of meetings that take place in the fall, the IOA develops and revises the study questionnaire used to collect data from AFH providers in partnership with ODHS/APD and its partners, who share topics, questions, and considerations important to them to address. A subset of questions are asked every year or every other year to track changes over time in terms of resident demographics, health needs, acuity, and health services use; AFH owners, their household, and staff; and AFH characteristics policies, and fees.

Last year's report included new questions that focused on staffing issues and the ways in which the COVID-19 pandemic has adversely impacted AFH residents, family members of residents, and AFH staff and providers. This year, we asked the same set of 11 questions again, to track the changes and stability of the impact of the pandemic on AFH. Specifically, we included questions that addressed pandemic-related ODHS licensing rules and restrictions, owners' ability to access accurate information and communicate with government agencies, effects of the pandemic on residents, staff, and staffing, owners' ability to respondent to challenges as a result of the pandemic, and their resource needs. This year's questionnaire can be found in Appendix D.

Study Population

This study aims to represent characteristics of the 1,354 AFHs licensed by APD as of fall 2021, their residents, and their staff. However, we note two caveats in terms of the population to which this study can be generalized. First, it is possible that not all residents of these 1,354 AFHs are APD consumers because I/DD consumers may reside in APD homes. This year's study findings show that 21 percent of residents living in responding AFHs were under age 65, though only 5 percent were under age 50 (see

Table 8). Furthermore, while 6 percent of residents who lived in responding AFHs were reported having a diagnosed I/DD (see Table 11), some of these residents are also likely over the age of 65. Second, some older adults may reside in AFHs licensed for persons with intellectual or developmental disabilities (I/DD). Overall, the results presented in this report might not be generalized to *all APD consumers* since not all APD older adult residents were included in the sample and the sample may have included some individuals who are not traditional APD consumers.

Sample Selection

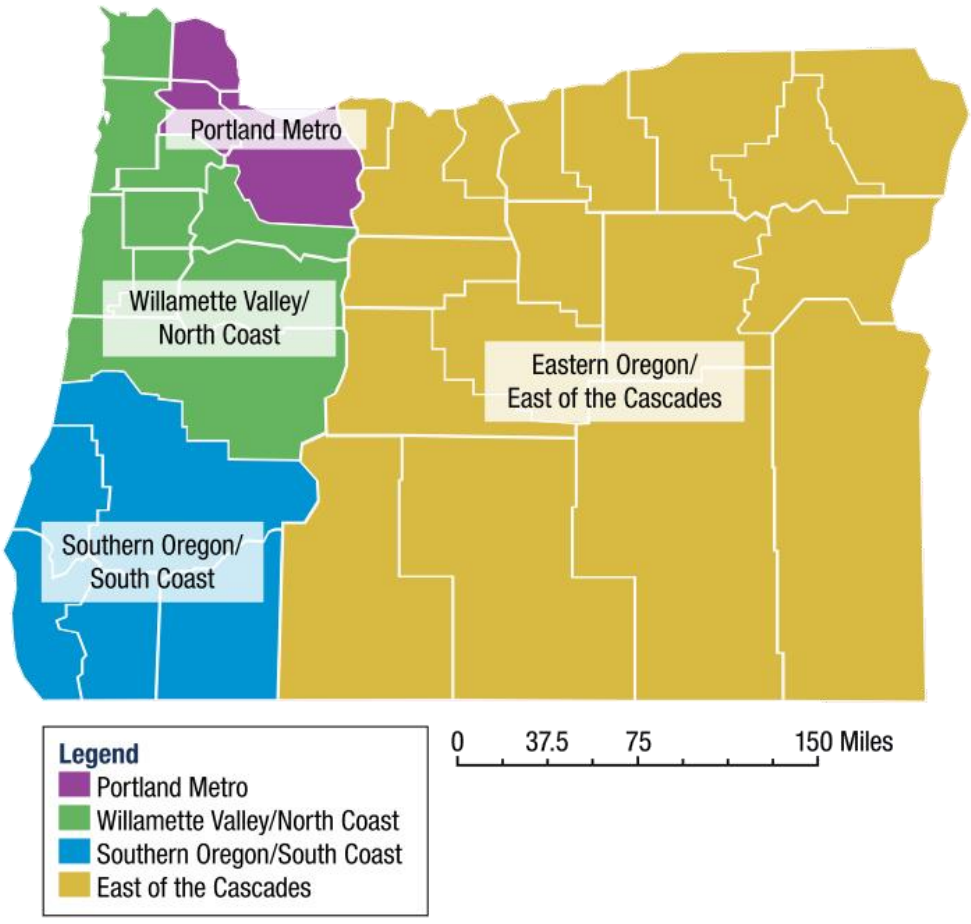
The IOA received a list of 1,354 AFHs licensed by APD as of November 2021. To achieve a sample size that sufficiently represents simple proportions drawn from this population of 1,354 AFHs and assuming the most conservative response distribution (p = .50), the minimum number of completed questionnaires required to achieve 95% confidence and +/- 5% margin of error (MoE) was calculated to be 300 AFHs. We accounted for estimated non-response based on the previous five rounds' response rates by region (Table A1) and selected a final sample of 650 AFHs. To ensure that our sample would be representative of AFHs throughout the state, we aggregated counties into four regions (see Table A2 and Figure A1 below) and calculated the number of responding AFHs needed from each region to create a proportionate analytic sample by region. The realized response rate (46 percent after excluding 37 ineligible AFHs) was slightly lower than the 50 percent expected in the sample size calculation and resulted in a small increase in the MoE from +/- 5.00% to +/- 5.23%.

Table A1. Historical response rates by region over time, 2016-2021

	2016 %	2017 %	2018 %	2019 %	2020 %	2021 %	5-Year Average
Region 1: Portland Metro	48	52	60	54	56	45	53
Region 2: Willamette Valley/North Coast	53	48	60	71	56	44	55
Region 3: Southern Oregon/South Coast	53	63	58	67	64	51	59
Region 4: East of the Cascades	56	50	69	63	73	49	60
Total	51	52	61	60	58	46	55

Portland Metro: Counties of Clackamas, Columbia, Multnomah, Washington, *Willamette Valley*: Counties of Benton, Clatsop, Lane, Lincoln, Linn, Marion, Polk, Tillamook, Yamhill, *Southern Oregon*: Counties of Coos, Curry, Douglas, Jackson, Josephine, *Eastern Oregon*: Counties of Baker, Crook, Deschutes, Gilliam, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, Wheeler.

Figure A1. Oregon counties by region



Study Implementation

The study design was similar to previous years' implementation. The study team sent out a mailed questionnaire to each AFH in the study sample in December 2021. AFH owners were asked to complete the questionnaire and return it to the study team via fax, scan and email, or US postal service using the business reply mail envelope included in the mailed questionnaire packet. In addition to these options, owners could complete the questionnaire over the phone with one of our interviewers. Of the 279 questionnaires that we received, 193 were returned via mail, 47 were sent back via fax, 28 were completed over the phone, and 11 were scanned and emailed back.

During the data collection period (December 2021-March 2022), three rounds of phone calls were made to AFH providers to encourage responses. The first call was a notification that the questionnaires were going to be mailed to the AFH's mailing address. The second call was to confirm that the questionnaire was received and

remind them to complete it by the given deadline. The third call was to inform the provider of the extended deadline to complete and return the questionnaire. If, during these calls, owners reported that they threw away, never received, or did not know about the whereabouts of the questionnaire, we mailed or emailed a new questionnaire to those AFH providers.

Final Disposition of Cases, and Unit and Item Non-Response

Of all the 650 AFHs that were initially sampled, 37 were closed during the study period, resulting in an eligible sample of 613 AFHs. Overall, 279 AFHs responded, for a response rate of 43 percent among all the 650 AFHs that were initially sampled and 46 percent among the eligible 613 AFHs (Table A3).

Table A2. Regional distribution of sample and response rates, 2022

	Population % (n)	Sampled AFHs % (n)	Final respondents % (n)	Response rate %
Region 1: Portland Metro	61 (828)	63 (410)	60 (166)	41
Region 2: Willamette Valley/North Coast	19 (263)	19 (124)	22 (61)	49
Region 3: Southern Oregon/South Coast	13 (175)	12 (78)	13 (35)	45
Region 4: East of the Cascades	7 (88)	6 (38)	6 (17)	45
Total	100 (1,354)	100 (650)	100 (279)	43

Portland Metro: Counties of Clackamas, Columbia, Multnomah, Washington, *Willamette Valley*: Counties of Benton, Clatsop, Lane, Lincoln, Linn, Marion, Polk, Tillamook, Yamhill, *Southern Oregon*: Counties of Coos, Curry, Douglas, Jackson, Josephine, *Eastern Oregon*: Counties of Baker, Crook, Deschutes, Gilliam, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, Wheeler.

While the response rate across regions varied somewhat among the 650 AFHs that were initially sampled, the geographic distribution of the final sample mirrored closely AFHs across Oregon (Table A2 above). For instance, 61 percent of all AFHs licensed by APD were located in the Portland Metro region; 60 percent of the final were. Similarly, only 7 percent of AFHs were located in the East of the Cascades region, similar to the 6 percent of the final sample.

Table A3. Final disposition of all sampled AFHs, 2022

	N
All sampled AFHs	650
Ineligibles due to:	
Closed	37
Total ineligible	37
Total eligible	613
Total response	279
Email	11
Fax	47
Mail	193
Phone	28
Response rate (279/650)	43%
Response rate among eligible AFHs (279/613)	46%

Note: An AFH is considered closed if the provider/owner informed our callers/interviewers about the closure or if the ODHS website lists it as closed as of December 2021; this cut-off date was chosen to avoid misclassifying open AFHs as closed due to potential delays in relicensing.

Excluding closed AFHs, a total of 334 AFHs that were in the sample and eligible did not respond to the questionnaire. In addition to the geographic distribution noted above, the study team examined the response patterns by licensed beds, Medicaid contract, and urban/rural status. None of these characteristics were significantly associated with likelihood of responding to the questionnaire (analyses not shown).

While the majority of AFH providers were receptive to our reminder calls and acknowledged they would participate in the study, there were also some who voiced frustration and expressed they did not want to participate. Reasons given for non-response were similar to those from previous years, indicating the time constraints among AFH owners (“I’m too busy” or “We’re busy with the holidays”), having participated in the study in the prior years (“It’s not random. I get this every year”), the non-mandatory nature of the study, and general disagreement with ODHS policies. In addition to expressed statements from providers who did not return the questionnaire, the most common caller experiences were non-working or disconnected phone numbers, voicemail not set up, hang ups, problems with receiving mail (e.g., mail is stolen, not checked very often), and AFHs in the process of closing.

The study team checked the received questionnaires for missing information and inconsistencies, made multiple follow-up calls or sent emails to owners for clarification when needed, and in some cases, scheduled a time to talk with the AFH owner to fill out the missing information.

Statistical Data Analysis

Quantitative data analysis involved a series of steps that were followed in the previous years. After data were entered into Stata 17 (a statistical software program), they were checked for errors using multiple strategies, including:

- Random spot checks for potential data entry errors,
- Frequencies to eliminate errors due to coding mistakes, and
- Logic checks for skip patterns and outliers.

Data cleaning was followed by data analysis, which involved descriptive statistics (frequencies, percentages, and means) and cross-tabulations when applicable.

Appendix B provides 95 percent confidence intervals (CIs) for the point estimates reported throughout the text of this report. We include CIs to ensure that the reader is aware of the magnitude of uncertainty around point estimates. To calculate these CIs, we used bootstrap sampling, a statistical method that draws subsamples of observations from the sample data repeatedly to construct an empirical (bootstrap) distribution for point estimates. An advantage of this method is its ability to handle population distributions that may not be normal. To account for potential bias and skewness in the distribution of repeated samples, we used the bias-corrected and accelerated CIs and set the number of replications to 500 for each run.

Qualitative Data Analysis

The questionnaire included three open-ended questions to provide room for AFH owners to voice their experiences as care providers: whether there was anything else AFH owners would like to say about operating an AFH during the pandemic; what they like best about operating, owning, and/or living in an AFH; and some of their biggest challenges operating, owning, and/or living in an AFH (see Appendix D for the questionnaire).

Of the 279 AFH owners who returned a questionnaire, 233 wrote a response to one or more of these three questions. The study team read all these responses and then developed codes for each question that summarized the meaning, or theme, of each response. The study team then analyzed these codes quantitatively. The findings represent the most frequently applied codes. Because many of the AFH owners gave more than one response to each question, the number of responses is more than the

number of respondents. Therefore, we used the number of responses as the denominator. The frequencies are not presented, as this approach was used primarily to reliably report the most common themes.

The question about what they liked best about operating their AFH was answered by 227 owners who offered 422 responses; the biggest challenges question was answered by 216 owners who offered 606 responses; and the question about what ODHS and IOA/PSU should know about operating an AFH during the pandemic was answered by 152 owners who offered 261 responses.

APPENDIX B: Tables and Figures

Table B1. AFH owners' future plans for the next year, 2020-2022

	2020 % [CI]	2021 % [CI]	2022 % [CI]
Open another newly opened adult foster home	13 [10,17]	12 [9,15]	16 [11,20]
Move this adult foster home to a different location/house	6 [4,9]	3 [2,6]	5 [3,8]
Sell or transfer your adult foster home to another owner	7 [5,11]	7 [4,11]	5 [3,8]
Permanently close your adult foster home	5 [3,7]	6 [4,10]	5 [2,7]

Note: Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

Table B2. Reasons for staff absenteeism in the last 90 days, 2021-2022

	2021 % [CI]	2022 % [CI]
Personal health issues	52 [43,62]	60 [46,72]
Family illness/emergency	39 [30,48]	33 [22,42]
COVID-19-related issues	36 [27,46]	33 [22,42]
Caregiving for a family member	22 [14,30]	17 [9,25]
Other	21 [13,28]	16 [8,24]
Transportation	6 [2,10]	14 [7,21]

Note: Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

Table B3. Changes in percent of payers using Medicaid over time, 2016-2022

	2016 %	2017 %	2018 %	2019 %	2020 %	2021 %	2022 %
Medicaid	59	56	57	54	58	59	60

Table B4. AFH resident gender and age, 2016-2022

	2016 %	2017 %	2018 %	2019 % [CI]	2020 % [CI]	2021 % [CI]	2022 % [CI]
Gender							
Male	34	38	38	38 [35,42]	36 [33,40]	40 [36,44]	40 [37,44]
Female	66	62	62	62 [58,65]	63 [60,67]	60 [56,64]	59 [56,63]
Transgender	<1	X	<1	<1 [0.0,0.5]	<1 [0.0,0.5]	<1 [0.0,0.4]	<1 [0.0,0.5]
Age							
18-49	6	5	6	5 [4,7]	5 [4,6]	5 [3,6]	5 [4,7]
50-64	16	16	17	17 [15,19]	18 [15,20]	16 [13,18]	16 [14,19]
65-74	17	17	19	20 [18,22]	21 [18,23]	20 [18,23]	23 [20,25]
75-84	18	19	21	21 [18,23]	20 [18,23]	23 [20,26]	24 [21,27]
85 and over	42	42	38	37 [34,41]	36 [33,40]	37 [33,41]	32 [28,36]

Note: Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

Table B5. AFH resident race/ethnicity, 2016-2022

	2016 %	2017 %	2018 %	2019 % [CI]	2020 % [CI]	2021 % [CI]	2022 % [CI]
Hispanic/Latino of any race	2	2	3	2 [1.6,3.2]	2 [1.3,2.9]	3 [1.6,3.8]	2 [1.3,3.5]
Non-Hispanic/Latino							
American Indian/Native American or Alaska Native	1	1	2	3 [2,4]	3 [2,4]	3 [2,5]	3 [2,5]
Asian	2	2	3	3 [2,4]	2 [2,4]	2 [2,3]	3 [2,5]
Black/African American	2	2	2	2 [1,3]	2 [1,3]	3 [2,5]	3 [2,4]
Native Hawaiian or Other Pacific Islander	<1	1	1	1 [0,1]	<1 [0,1]	<1 [0,1]	1 [0,2]
White	90	88	86	87 [84,89]	88 [86,90]	86 [83,89]	86 [83,89]
Two or more races	1	1	1	1 [1,3]	2 [1,4]	2 [1,4]	1 [1,2]
Other/unknown	1	2	3	1 [1,2]	1 [0,2]	1 [0,3]	1 [1,3]

Note: Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

Table B6. Resident move-in locations in prior 90 days, 2016-2021/Current resident move-in locations, 2022

	2016 %	2017 %	2018 %	2019 % [CI]	2020 % [CI]	2021 % [CI]	2022 % [CI]
Home	20	24	20	21 [16,27]	22 [17,29]	17 [11,25]	18 [16,21]
Home of Relative	13	6	10	8 [5,13]	6 [3,9]	7 [3,12]	9 [7,12]
Independent Living	8	6	5	9 [6,13]	5 [2,8]	8 [4,13]	7 [5,9]
Assisted Living/Residential Care	13	18	13	15 [11,21]	15 [10,20]	15 [10,22]	13 [11,15]
Memory Care Community	2	4	4	2 [1,5]	7 [4,12]	1 [0,4]	4 [3,5]
Another Adult Foster Home	16	12	14	14 [10,19]	11 [8,16]	18 [11,27]	23 [20,26]
Nursing Facility	18	22	17	17 [12,24]	17 [12,24]	12 [8,19]	10 [8,13]
Hospital	7	6	12	9 [5,14]	15 [10,23]	18 [12,25]	11 [9,13]
Psychiatric Hospital	X	X	X	X	X	X	2 [1,3]
Houseless/Homeless	X	X	X	X	X	X	2 [1,3]
Criminal Justice System	X	X	X	X	X	X	<1 [0,1]
Other	2	2	4	4 [2,7]	3 [1,5]	4 [2,8]	1 [1,3]
Don't Know	<1	1	0	<1 [0,2]	0	0	<1 [0,1]

Note: X indicates that the question was not asked in that year. Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

Table B7. Resident move-out locations in prior 90 days, 2016-2022

	2016 %	2017 %	2018 %	2019 % [CI]	2020 % [CI]	2021 % [CI]	2022 % [CI]
Died	49	62	64	60 [50,69]	73 [66,80]	78 [69,84]	72 [64,79]
Home	8	4	3	4 [2,9]	2 [1,5]	3 [1,8]	3 [1,8]
Home of Relative	4	2	4	1 [0,4]	3 [1,6]	2 [0,5]	3 [1,8]
Independent Living	2	2	1	1 [0,3]	1 [0,4]	0 [0,0]	1 [0,3]
Assisted Living /Residential Care	5	5	2	6 [3,10]	3 [1,7]	2 [0,5]	1 [0,4]
Memory Care Community	4	6	5	3 [1,6]	3 [1,7]	2 [0,7]	3 [1,6]
Another Adult Foster Home	10	7	7	9 [4,14]	4 [2,9]	7 [3,11]	8 [4,13]
Nursing Facility	5	7	6	7 [5,12]	5 [3,11]	3 [1,11]	3 [1,7]
Hospital	3	4	4	4 [2,11]	3 [1,7]	2 [1,7]	3 [1,8]
Psychiatric Hospital	X	X	X	X	X	X	1 [0,5]
Criminal Justice System	X	X	X	X	X	X	0 [0,0]
Other	2	1	2	3 [1,7]	1 [0,3]	1 [0,5]	2 [1,5]
Don't Know	7	0	0	2 [0,4]	1 [0,3]	1 [0,4]	0 [0,0]

Note: X indicates that the question was not asked in that year. Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

Table B8. Length of stay among residents who moved out in the prior 90 days, 2016-2022

	2016 %	2017 %	2018 %	2019 % [CI]	2020 % [CI]	2021 % [CI]	2022 % [CI]
1 - 7 days	5	6	3	2 [0,4]	7 [3,13]	3 [1,7]	2 [1,6]
8 - 13 days	2	2	2	6 [2,17]	4 [1,7]	5 [2,10]	4 [1,9]
14 - 30 days	5	11	8	7 [4,13]	7 [4,12]	5 [2,10]	4 [2,9]
31 - 90 days	18	13	14	17 [11,25]	13 [9,19]	12 [7,21]	13 [8,20]
3 - 6 months	18	12	9	11 [7,16]	11 [7,17]	6 [2,12]	13 [8,19]
6 - 12 months	14	12	16	15 [11,22]	13 [9,19]	16 [10,25]	19 [13,27]
1-2 years	15	16	9	13 [8,18]	16 [11,23]	16 [10,23]	12 [7,18]
2 - 4 years	9	17	18	15 [10,21]	16 [11,22]	20 [13,28]	18 [12,24]
4 or more years	15	12	21	14 [9,20]	13 [9,20]	18 [11,24]	15 [9,24]

Note: Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

Table B9. Prevalence of AFH residents' diagnosed health conditions over time, 2016-2022

	2016 %	2017 %	2018 %	2019 % [CI]	2020 % [CI]	2021 % [CI]	2022 % [CI]
High blood pressure/ hypertension	45	50	48	52 [49,54]	50 [47,53]	49 [45,53]	50 [47,54]
Alzheimer's disease	49	47	46	48	49	48	45

and related dementias				[45,51]	[45,52]	[44,52]	[42,49]
Depression	40	42	40	46 [42,49]	45 [41,48]	41 [38,45]	47 [43,50]
Heart disease	39	37	38	39 [37,43]	37 [34,40]	39 [36,43]	39 [35,43]
Arthritis	38	37	36	37 [33,41]	33 [30,37]	32 [28,36]	32 [28,35]
Diabetes	22	19	21	23 [21,25]	22 [20,25]	23 [21,25]	20 [18,23]
Serious mental illness	15	15	19	20 [17,23]	18 [15,20]	19 [16,22]	X
Serious mental illness (excluding Anxiety disorder and depression)	X	X	X	X	X	X	20 [17,23]
Anxiety disorder	X	X	X	X	X	X	33 [30,37]
Osteoporosis	16	17	18	17 [14,19]	17 [15,20]	12 [10,15]	14 [12,17]
COPD and allied conditions	15	16	15	16 [14,19]	16 [14,18]	17 [15,19]	14 [12,16]
Intellectual or developmental disabilities	9	9	10	10 [8,12]	9 [7,11]	10 [8,13]	6 [5,8]
Cancer	7	8	8	9 [8,11]	7 [6,8]	8 [6,9]	6 [5,8]
Traumatic brain injury	X	7	7	8 [7,10]	9 [7,11]	9 [8,12]	11 [9,14]
Current drug and/or alcohol abuse	4	3	3	5 [3,6]	4 [3,6]	4 [3,6]	4 [3,6]

Note: In 2022, the questionnaire classified the serious mental illness with anxiety disorder and depression. X indicates that the question was not asked in that year. Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

Table B10. Falls in the prior 90 days resulting in injury or hospitalization among residents who experienced a fall, 2016-2022

	2016 %	2017 %	2018 %	2019 % [CI]	2020 % [CI]	2021 % [CI]	2022 % [CI]
Fall resulting in injury	20	24	33	19	25	37 [27,49]	15 [9,24]
Fall resulting in hospitalization	13	18	20	18	19	34 [25,46]	18 [12,27]

Note: Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

Table B11. Health service use among AFH residents, 2016-2022

	2016 %	2017 %	2018 %	2019 % [CI]	2020 % [CI]	2021 % [CI]	2022 % [CI]
Treated in hospital ER in the last 90 days	14	14	15	13 [12,16]	13 [12,15]	11 [9,13]	11 [9,13]
Hospitalized overnight in the last 90 days	6	8	8	8 [7,9]	7 [6,9]	6 [5,8]	7 [5,8]
Went back to the hospital within 30 days	X	24	30	27 [19,36]	27 [19,37]	24 [15,37]	28 [17,40]
Received hospice care in the last 90 days	10	10	11	10 [8,12]	10 [8,12]	10 [9,13]	9 [7,11]
Received services from a licensed/certified home health care agency	X	X	X	X	19 [14,20]	17 [15,20]	18 [16,21]

Note: X indicates that the question was not asked in that year. Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

Table B12. Medication use and assistance with medications, 2016-2022

	2016 %	2017 %	2018 %	2019 % [CI]	2020 % [CI]	2021 % [CI]	2022 % [CI]
Take nine or more medications	54	53	51	52 [48,56]	53 [50,57]	54 [50,58]	60 [56,64]
Take opioid medications	X	X	X	X	X	X	22 [19,25]
Take antipsychotic medications	34	35	35	36 [33,39]	39 [35,42]	39 [35,42]	36 [32,39]
Take antidepressant medications	X	X	X	X	X	X	48 [45,52]
Take anxiolytic/sedative-hypnotic medications	X	X	X	X	X	X	24 [21,27]
Self-administer medications	5	5	6	6 [4,8]	6 [4,8]	4 [3,6]	5 [4,8]
Received assistance to take oral medications	80	75	74	75 [71,79]	76 [72,79]	76 [71,80]	77 [72,81]

Note: X indicates that the question was not asked in that year. Numbers in brackets show lower and upper limits of 95% confidence intervals (see Appendix A: Methods for details)

APPENDIX C: References

Albert M, McCaig L, Ashman J. Emergency department visits by persons aged 65 and over: United States, 2009-2010. *National Center for Health Statistics, Centers for Disease Control and Prevention.* October 2013;130. NCHS Data Brief, Number 130, October 2013 (cdc.gov)

Alzheimer's Association. *What is Dementia?* 2022. https://www.alz.org/alzheimers-dementia/what-is-dementia

Austrom MG., Boustani M, LaMantia, MA. Ongoing Medical Management to Maximize Health and Well-being for Persons Living With Dementia. *Gerontologist*, 2018;58:S48–S57.

Berg-Weger M, Morley JE. Editorial: Loneliness and Social Isolation in Older Adults during the COVID-19 Pandemic: Implications for Gerontological Social Work. *The Journal of Nutrition, Health & Aging*, 2020;24(5):456–458. https://doi.org/10.1007/s12603-020-1366-8

Binette J, Vasold K. 2018 Home and Community Preferences: A National Survey of Adults Ages 18-Plus. Washington, DC: AARP Research, August 2018. 2018. https://doi.org/10.26419/res.00231.001

Caffrey C, Sengupta M, Park-Lee E. et al. Residents living in residential care facilities: United States. NCHS data brief. 2010; no 91. Hyattsville, MD: https://www.cdc.gov/nchs/products/databriefs/db91.htm

Castle NG. Measuring Staff Turnover in Nursing Homes. *The Gerontologist*. 2006;46 (2):210–219. https://doi.org/10.1093/geront/46.2.210

Centers for Disease Control and Prevention (CDC). Coronary Heart Disease, *Myocardial Infarction, and Stroke - A Public Health Issue.* 2022. https://www.cdc.gov/aging/publications/coronary-heart-disease-brief.html

Costlow K, Parmelee PA. The Impact of Relocation Stress on Cognitively Impaired and Cognitively Unimpaired Long-Term Care Residents. *Aging & Mental Health,* 2020. ;*24*10:1589-1595.

Edemekong PF, Bomgaars DL, Sukumaran S. et al. Activities of Daily Living. [Updated 2022 Feb 17]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www-ncbi-nlm-nih-gov.proxy.lib.pdx.edu/books/NBK470404/

Elliott S, Dys S, Carder P, Winfree J. “This ‘Family Setting’ Is Not that Anymore”: Rewards and Challenges of Adult Foster Home Owners. *Journal of Aging & Social Policy*. 2021. https://doi.org/10.1080/08959420.2021.1926204

Genworth. (n.d.). *Cost of Care Trends & Insights.* Retrieved April 25, 2022, from https://www.genworth.com/aging-and-you/finances/cost-of-care/cost-of-care-trends-and-insights.html

Geriatric Mental Health Foundation. Anxiety and Older Adults: Overcoming Worry and Fear*.* 2022. https://www.aagponline.org/index.php?src=gendocs&ref=anxiety

Golant S. The distance to death perceptions of older adults explain why they age in place: A theoretical examination. *Journal of Aging Studies.* 2020;54:3-9. https://www-sciencedirect-com.proxy.lib.pdx.edu/science/article/pii/S089040652030033

Harris-Kojetin L, Lipson D, Fielding J, Kiefer K, Stone RI. *Recent findings on frontline long-term care workers: A research synthesis 1999–2003*. Washington, DC: Institute for the Future of Aging Services, 2004;1-29.

Hung W, Medina-Walpole A, Ouslander J. et al. American Geriatrics Society (AGS) Policy Brief: COVID-19 and Assisted Living Facilities. *American Geriatrics Society.* 2020;68:1131-1135. https://agsjournals-onlinelibrary-wiley-com.proxy.lib.pdx.edu/doi/pdf/10.1111/jgs.16510

Jokanovic N, Tan EC, Dooley MJ, Kirkpatrick CM, Bell JS. Prevalence and Factors Associated with Polypharmacy in Long-Term Care Facilities: A Systematic Review. *Journal of the American Medical Directors Association*. 2015;16(6):535.e1-12. Prevalence and factors associated with polypharmacy in long-term care facilities: a systematic review - PubMed (nih.gov)

Kales HC, Gitlin LN, Lyketsos CG. Assessment and management of behavioral and psychological symptoms of dementia. *The BMJ.* 2015;*350.*

Kalin NH. The Critical Relationship Between Anxiety and Depression. *The American Journal of Psychiatry.* 2020;177(5):365-367. https://doi.org/10.1176/appi.ajp.2020.20030305

Koma W, True S, Biniek JF, Cubanski J, Orgera K, Garfield R. One in Four Older Adults Report Anxiety or Depression Amid the COVID-19 Pandemic. KFF.org. Medicare. 2020. https://www.kff.org/medicare/issue-brief/one-in-four-older-adults-report-anxiety-or-depression-amid-the-covid-19-pandemic/

MacLeod S, Tkatch R, Kraemer S, Fellows A, McGinn M, Schaeffer J, Yeh CS. COVID-19 Era Social Isolation among Older Adults. *Geriatrics.* 2021;6(2):52. https://doi.org/10.3390/geriatrics6020052

Maust DT, Kim HM, Seyfried LS. et al. Antipsychotics, Other Psychotropics, and the Risk of Death in Patients With Dementia: Number Needed to Harm. *JAMA Psychiatry.* 2015;72(5):438. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2203833

McDermott KW, Elixhauser A, Sun R. *Trends in hospital inpatient stays in the United States, 2005-2014.* Agency for Healthcare Research and Quality. 2017. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb225-Inpatient-US-Stays-Trends.pdf

Mitchell JM, Kemp BJ. Quality of Life in Assisted Living Homes: A Multidimensional Analysis. *Journals of Gerontology Series B: Psychological Sciences & Social Sciences.* 2000;55(2):117. https://doi.org/10.1093/geronb/55.2.P117

National Institute on Aging (NIA). The Dangers of Polypharmacy and the Case for Deprescribing in Older Adults. Updated August 24, 2021. https://www.nia.nih.gov/news/dangers-polypharmacy-and-case-deprescribing-older-adults

NIA. Heart Health and Aging. National Institutes of Health. 2022. https://www.nia.nih.gov/health/heart-health-and-aging

NIA. Depression and Older Adults. 2022. https://www.nia.nih.gov/health/depression-and-older-adults

National Institute of Mental Health (NIMH). Mental Illness. 2022. https://www.nimh.nih.gov/health/statistics/mental-illness.

NIMH. Older Adults and Depression. 2022. https://www.nimh.nih.gov/sites/default/files/documents/health/publications/older-adults-and-depression/19-mh-8080-olderadultsanddepression.pdf

Oregon Behavioral Risk Factors Surveillance System Adult Prevalence Data. Percentage of Oregon adults ever diagnosed with CHD, heart attack or stroke by age group. Oregon Health Authority. Updated February 7, 2022. https://app.powerbigov.us/view?r=eyJrIjoiNTI2NjQwNzktNWQxNy00YjQzLWI5ZmEtMTBlZjczOWE0NWY3IiwidCI6IjY1OGU2M2U4LThkMzktNDk5Yy04ZjQ4LTEzYWRjOTQ1MmY0YyJ9

Oregon Department of Human Services. Report to Legislative Assembly on capacity of adult residential care facilities and adult foster homes under ORS 443.424. 2019. https://digital.osl.state.or.us/islandora/object/osl%3A860161/datastream/OBJ/view

ODHS/APD. Payment Limitations in Home and Community-Based Services. Oregon Administrative Rules, Chapter 411, Division 27. 2022. https://www.oregon.gov/dhs/SENIORS-DISABILITIES/SPPD/APDRules/411-027.pdf

ODHS/APD. Adult foster homes for older adults or adults with physical disabilities—Purpose, Definitions, and Licensure. Oregon Administrative Rules, Chapter 411,

Division 49. 2022. https://www.oregon.gov/dhs/SENIORS-DISABILITIES/SPPD/APDRules/411-049.pdf

ODHS/APD. Adult foster homes for older adults or adults with physical disabilities—Standards of Operation. Oregon Administrative Rules, Chapter 411, Division 50. 2022. https://www.oregon.gov/DHS/PROVIDERS-PARTNERS/LICENSING/APD-AFH/OARs/APD-OAR-Chapter-411-Division-50.pdf

ODHS/APD. Adult foster homes for older adults or adults with physical disabilities—Standards of Care. Oregon Administrative Rules, Chapter 411, Division 51. 2022. https://www.oregon.gov/dhs/PROVIDERS-PARTNERS/LICENSING/APD-AFH/OARs/APD-OAR-Chapter-411-Division-51.pdf

ODHS/APD. Providers-Partners Licensing. Adult Foster Home Provider Alert. Policy updates, rule clarifications and announcements. 2019. 19-0822 HB 3262 OAR Update 7-1-19.pdf (oregon.gov)

ODHS/APD. Providers-Partners Licensing. Adult Foster Home Provider Alert. Limited COVID-19 Indoor Visitation Policy. 2020. https://www.oregon.gov/dhs/PROVIDERS-PARTNERS/LICENSING/APD-AFH/Alerts

ODHS/APD. Providers-Partners Licensing. Residential Care, Assisted Living, and Memory Care Provider Alert CBC-21-001. Updated COVID-19 Policy Guidance. 2021. https://www.oregon.gov/dhs/PROVIDERS-PARTNERS/LICENSING/AdminAlerts

Oregon Health Authority. Falls Prevention for Older Adults. Helping Older Adults Reduce Their Risk of Falling. 2022. https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/FALLPREVENTION/Pages/index.aspx

Oregon State Board of Nursing, Oregon Nurse Practice Act. Rules of Practice and Procedure. Oregon Administrative Rules, Chapter 851, Division 001. 2022. https://www.oregon.gov/osbn/Pages/laws-rules.aspx

OSBN/ONPA, Oregon Nurse Practice Act. Standards for the Approval of Educational Programs in Nursing Preparing Candidates for Licensure as Practical or Registered Nurse. Oregon Administrative Rules, Chapter 851, Division 021. 2022. https://www.oregon.gov/osbn/Pages/laws-rules.aspx

Oregon State Legislature. Citizen Engagement Reports. HB3262 Report Final. Notification of Psychotropic Medication Prescriptions and Long-Term Care Facilities. Updated December 20, 2017. https://www.oregonlegislature.gov/citizen_engagement/Reports/SHS_2017_HB3262ReportFinal.pdf

Ostchega Y, Fryar CD, Nwankwo T, Nguyen DT. *Hypertension prevalence among adults aged 18 and over: United States, 2017–2018*. NCHS Data Brief, 2020;364. Hyattsville, MD: National Center for Health Statistics.

Riegel B, Jaarsma T, Lee CS., Stromberg A. Integrating symptoms into the middle-range theory of self-care of chronic illness. *ANS Advances in Nursing Science.* 2019;42(3):206–215. https://www.google.com/url?q=https://www-ncbi-nlm-nih-gov.proxy.lib.pdx.edu

Scales K, Zimmerman S, Miller SJ. Evidence-Based Nonpharmacological Practices to Address Behavioral and Psychological Symptoms of Dementia. *The Gerontologist* 2018;58(suppl_1):S88-S102. https://pubmed.ncbi.nlm.nih.gov/29361069/

Schultz R, Beach SR, Czaja SJ, Martire LM, Monin JK. Family Caregiving for Older Adults. *Annual Review of Psychology.* 2020;71(1):635-659. https://www.annualreviews.org/doi/abs/10.1146/annurev-psych-010419-050754

Sengupta M, Caffrey C. Characteristics of Residential Care Communities by Percentage of Resident Population Diagnosed with Dementia: United States, 2016. Centers for Disease Control and Prevention, National Center for Health Statistics Reports; 148. Hyattsville, MD: National Center for Health Statistics, 1010. 2020. https://www.cdc.gov/nchs/data/nhsr/nhsr148-508.pdf?

Tebb S, Berg-Weger M, Rubio DM. Rapid Caregiver Well-Being Scale (R-CWBS) (Version 3.0). 2015. https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/pdfs/caregiver-wellbeing-scale.pdf

APPENDIX D: Adult Foster Home Questionnaire

Portland State UNIVERSITY
Institute on Aging

DHS | Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Adult Foster Homes (AFH)

Oregon Community-Based Care

Resident & AFH Characteristics Questionnaire (2021-22)

COMPLETE THE QUESTIONNAIRE ONLY FOR THE ADULT FOSTER HOME AT THIS ADDRESS.

License #:

Owner/Licensee Name:

Address of Adult Foster Home:

Adult Foster Home's Phone #:

Please update any incorrect/outdated information.

Owner/Licensee Name:_____

AFH Phone #: _____

Email _____ Fax # _____

Owner/Licensee's Phone # (if different) _____

Please return your completed questionnaire to PSU by January 28, 2022.

Once complete, please choose one of the following to return the questionnaire:	
Mail:	Please use the postage paid envelope **Be sure to include all 13 pages**
Scan and email to:	cbcor@pdx.edu **Be sure to include all 13 pages**
Fax to:	503-725-9927 **Be sure to include all 13 pages**

If you would prefer to complete the questionnaire over the phone, please contact:
Diana Jacoby at cbcor@pdx.edu or 503.208.6195
If you have questions concerning completing this questionnaire, please contact:
Jaclyn Winfree at cbcor@pdx.edu or 503.725.6563

1

Oregon Department of Human Services (ODHS) requests adult foster homes to complete the questionnaire because it is an important way for ODHS to learn about your residents.

Your privacy matters!

PSU does not publish or share responses from individual adult foster homes.

The reports from prior years are available on these websites:
http://www.oregon.gov/DHS/SENIORS-DISABILITIES/Pages/publications.aspx
https://www.pdx.edu/ioa/oregon-AFH-based-care-project

Questionnaire Instructions:

- First, please check that the information on page 1 is up-to-date and correct.
- Next, answer all the questions.
- Then, please return your completed questionnaire to PSU using one of the methods listed on **page 1.**

We greatly appreciate your time and the work that you do on behalf of older adults and persons with disabilities! The study results will be most accurate if everyone participates.

Please keep a copy of your completed questionnaire for your records.

License Number:

Section A. Resident Information

1. Who is filling out this survey?
Please choose all that apply.

	Yes	No
Owner/Operator		
Resident Manager		
Administrator		
Other, specify: _____		

2. How many of **your current residents** are:
Please count each resident only once and write 0 for any categories with no residents.

☐ Female

☐ Male

☐ Transgender

☐ **TOTAL # OF CURRENT RESIDENTS**

3. What is the age of each of **your current residents**?
Please count each resident only once and write 0 for any categories with no residents.

☐ Resident 1

☐ Resident 2

☐ Resident 3

☐ Resident 4

☐ Resident 5

4. How many of **your current residents** are:
Please count each resident only once and write 0 for any categories with no residents.

☐ Hispanic/Latino (any race)

☐ American Indian/Native American or Alaska Native, not Hispanic or Latino

☐ Asian, not Hispanic or Latino

☐ Black/African American, not Hispanic or Latino

☐ Native Hawaiian or Other Pacific Islander, not Hispanic or Latino

☐ White, not Hispanic or Latino

☐ Two or more races

☐ Other/unknown/or resident would most likely choose not to answer

☐ **TOTAL # OF CURRENT RESIDENTS** (should match total in question #2 above)

Please go to the next page.

All answers are kept private and confidential. None of your individual information is reported to ODHS. 3

License Number:

5. How many of **your current residents** moved in from the following places? *Please write 0 for any categories with no residents.*

# of residents	**Moved in from:**
	Home (alone or with spouse/partner)
	Home of child or other relative
	Independent living apartment in senior housing
	Assisted living/residential care
	Memory care community
	Adult foster care/home
	(Skilled) nursing facility
	Hospital
	Psychiatric hospital
	Houseless/homeless
	Criminal justice system (e.g. prison)
	Other, specify: _____
	Don't know
	TOTAL # of CURRENT RESIDENTS (should match total in question #2 above)

6. **In the last 90 days**, how many residents moved out (permanently) to the following places, or died? *Please write 0 for any categories with no residents. If no residents moved or died, skip to question #8.*

# of residents	**Moved out to:**
	Home (alone or with spouse/partner)
	Home of child or other relative
	Independent living apartment in senior housing
	Assisted living/residential care
	Memory care community
	Adult foster care
	(Skilled) nursing facility
	Hospital
	Psychiatric hospital
	Criminal justice system (e.g., prison)
	Other, specify: _____
	Resident died
	Don't know
	TOTAL – Residents who moved out or died, last 90 days

7. **In the last 90 days**, for the residents who moved out or died, what was the length of stay for each resident? *Please write 0 for any categories with no residents.*

# of residents	**Length of Stay**
	1 - 7 days
	8 - 13 days
	14 - 30 days
	31 - 90 days
	91 - 180 days (3-6 months)
	181 days - 1 year (6-12 months)
	More than 1 but less than 2 years
	More than 2 but less than 4 years
	More than 4 years
	TOTAL – Residents who moved out or died, last 90 days (should match total in question #6 above)

License Number:

Section B. Resident Health, Acuity & Service Use

8. **In the last 90 days**, did any of **your current residents** fall? *Please **CIRCLE ONLY ONE.***

1. Yes 2. No

→ If none of your current residents fell in the last 90 days, SKIP to **question #10**.

9. **In the last 90 days**:

a. How many of **your current residents** fell **only one time**? *Please write 0 if none.*

☐ Number of residents

b. How many of **your current residents** fell **more than one time**? *Please write 0 if none.*

☐ Number of residents

c. How many of **your current residents** had a fall resulting in some kind of injury? *Please write 0 if none.*

☐ Number of residents

d. How many of **your current residents** went to the hospital (emergency room or admitted) **because of the fall**? *Please write 0 if none.*

☐ Number of residents

10. How many of **your current residents** regularly use a mobility aid (e.g., cane, walker, wheelchair) to get around? *Please write 0 if none.*

☐ Number of residents

11. How many of **your current residents** need staff assistance to use a mobility aid? *Please write 0 if none.*

☐ Number of residents

12. How many of **your current residents** regularly receive assistance from NOC (*night shift*) staff during the night? *Please write 0 if none.*

☐ Number of residents

13. How many of **your current residents** regularly receive assistance for physical and/or cognitive health needs from two staff? *Please write 0 if none.*

☐ Number of residents

14. How many of **your current residents** need regular and ongoing staff assistance with each of the following? *Please write 0 for any categories with no residents*.

☐ Eating

☐ Dressing

☐ Bathing and grooming

☐ Using the bathroom

☐ Mobility/Walking

Please go to the next page.

License Number:

15. **In the last 90 days**, how many of **your current residents** regularly received any of the following from their family member(s) or friend(s)? *Please write 0 for any category with no residents.*

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

16. How many of **your current residents**:
Please write 0 for any categories with no residents.

- ☐ Take 9 or more medications?
- ☐ Self-administer most of their medications?
- ☐ Receive staff assistance to take oral medications?

17. How many of your **current residents** take opioid medication [e.g., hydrocodone (Vicodin/Norco/Lortab), oxycodone (Percocet/Endocet), fentanyl, codeine, morphine, hydromorphone, methadone, tramadol)]?
Note: The medications listed are examples and do not include all types of opioid medications. Please write 0 if no residents take opioid medication.

☐ Number of residents

18. How many of your **current residents**:
Note: The medications listed below are examples and do not include all types of antipsychotic, anti-depressant, and anxiolytic/sedative-hypnotic medications. Please write 0 for any category with no residents.

- ☐ Take **antipsychotic** medication [e.g., aripiprazole (Abilify), haloperidol (Haldol), olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal)]?
- ☐ Take **anti-depressant** medication [e.g., sertraline (Zoloft), duloxetine (Cymbalta), venlafaxine (Effexor), bupropion (Wellbutrin), trazodone, citalopram (Celexa), escitalopram (Lexapro), mirtazapine (Remeron), fluvoxamine (Luvox), paroxetine (Paxil, Pexeva)]?
- ☐ Take **anxiolytic/sedative-hypnotic** medication [e.g., lorazepam (Ativan), alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), zolpidem (Ambien), eszopiclone (Lunesta)]?

Please go to the next page.

License Number:

19. How many of **your current residents** have been ***DIAGNOSED*** with each of the following conditions? *Include all diagnoses for each resident. Please write 0 for any categories with no residents.*

- ☐ Heart disease (e.g., congestive heart failure, coronary or ischemic heart disease, heart attack, stroke)
- ☐ Alzheimer's disease and other dementias (including Lewy body, Huntington's disease, and vascular dementia)
- ☐ High blood pressure/hypertension
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Serious mental illness (such as bipolar disorder, schizophrenia). Excludes anxiety disorder and depression.
- ☐ Diabetes
- ☐ Cancer
- ☐ Osteoporosis
- ☐ COPD and allied conditions
- ☐ Current drug and/or alcohol abuse
- ☐ Intellectual/developmental disability
- ☐ Arthritis
- ☐ Traumatic brain injury

20. How many of **your current residents** were:
Please write 0 for any categories with no residents.

- ☐ Treated in the hospital emergency room (ER) **in the last 90 days**?
- ☐ Hospitalized overnight **in the last 90 days**? (Exclude trips to the ER that did not result in an overnight hospital stay.)
  - → ☐ How many residents who were hospitalized overnight went back to the hospital within 30 days?
- ☐ Receiving hospice care **in the last 90 days**?
- ☐ Receiving services from a licensed/ certified home health care agency **in the last 90 days**?

21. **In the last 90 days**, which (if any) of the following health care providers visited your AFH to provide services? *Please check Yes (virtually and/or in person) or No for each health care provider listed below. Check all that apply.*

	Yes, virtually	Yes, in person	No
Nurse (RN, LPN, LVN)			
Medical doctor / nurse practitioner			
Mental health provider (e.g., counselor, psychologist)			
Physical or occupational therapist			
Social worker			
Case manager			
Dentist			
Dental hygienist			

License Number:

Section C. Adult Foster Home Owner/Licensee

If you are not the owner/licensee, SKIP to question 29.

22. Do you (owner/licensee) have any of the following certifications? *Please choose all that apply.*

	Yes	No
I have no certifications		
Certified Nursing Assistant (CNA) or Certified Medication Aide (CMA)		
Registered Nurse (RN) or Licensed Professional/Vocational Nurse (LPN/LVN)		

23. Do you (owner/licensee) or someone in your household own or rent the house where this adult foster home is located? *Please* **CIRCLE ONLY ONE.**

1. Owned or mortgage by you or someone in your household
2. Rented by you or someone in your household
3. Other, please explain: _____

24. Please select the answer that best fits your plans for your adult foster home. *Please check yes or no for each category.*

In the next year are you planning to:

	Yes	No
Open another/newly licensed home		
Move this home to a different location/house		
Sell or transfer your home to another owner		
Permanently close your home		

25. Do you (owner/licensee) live at this adult foster home? Please **CIRCLE ONLY ONE.**

1. Yes, all the time
2. Yes, some of the time
3. No

26. Do you (owner/licensee) regularly provide care to residents living at this home? *Please* **CIRCLE ONLY ONE.**

1. Yes 2. No

27. Below are activities that each of us do or someone does for us. Please put an X in the box that best describes about how often you (owner/licensee) did each of the following activities in the past ***90 days***.

	Never	Sometimes	Usually
Taking care of personal daily activities (meals, hygiene, laundry)			
Taking time to have fun with friends and/or family			
Treating or rewarding yourself			

28. Below are some of the needs we all have. For each need listed, think about your life (owner/licensee) over the past ***90 days***. Put an X in the box that best describes about how often your needs were met during this time.

	Never	Sometimes	Usually
Receiving appropriate health care			
Feeling good about yourself			
Feeling secure about your financial future			

License Number:

Section D. Current Staff

This section asks you for information about each of the staff you employed in your home in the last 7 days. Please do not include owner/licensee in this roster. Please complete one row for each of your current staff.

- A Resident Manager is an employee who lives in the adult foster home, and is directly responsible for the care of the residents. Please include floating resident managers in this category.
- A Caregiver is any employee, other than resident managers, providing care and services to residents. Please include shift caregivers in this category.
- LPN/LVN means a licensed practical or vocational nurse.
- CNA/CMA means a certified nursing assistant or certified medication aide.
- For hours worked last week, please provide your best estimate.
- Current certification means that the employee's license or certificate is up to date.

The first two rows are examples for an adult foster home with two employees:

- Example #1: A resident manager who has a current LPN license, who worked at this home for 40 hours last week and has been working at this home for 6 months or longer.
- Example #2: A caregiver with no certifications, who worked at this home for 10 hours last week and has been working at this home for less than 6 months.

29. How many staff did you employ in this home **in the last 7 days**? *Please write 0 if none.*

☐ Number of staff employed

30. **Staff Employed in the Last 7 days**

	Job Title/Description			Current Certification		Hours Worked Last Week	Worked at this home for…	
	Resident Manager	Caregiver	Other	LPN/ LVN	CNA/ CMA		Less than 6 months	6 months or more
Example #1	*X*			*X*		*40*		*X*
Example #2		*X*				*10*	*X*	
Your Staff #1								
Your Staff #2								
Your Staff #3								
Your Staff #4								
Your Staff #5								
Your Staff #6								
Your Staff #7								
Your Staff #8								
Your Staff #9								
Your Staff #10								

License Number:

31. **In the last 6 months**, did any of your staff leave employment for any reason? *Please **CIRCLE ONLY ONE and fill in the number if applicable.***

1. Yes, the number of staff who left: _____
2. No, I did not employ any staff in the last 6 months.
3. No, I employed staff in the last 6 months but all of them continue to work for this adult foster home.

32. In the last 90 days, have any of your staff missed work for any of the following reasons? *Please select all that apply.*

- ☐ Not applicable
- ☐ Transportation
- ☐ Caregiving for a family member
- ☐ Personal health issues
- ☐ Family illness/emergency
- ☐ COVID-19 related
- ☐ Other: _____

33. In the last 90 days, have you hired contract/ agency care staff (including nurses) to cover unplanned staff absences? *Please **CIRCLE ONLY ONE.***

1. Yes 2. No 3. Not applicable

Section E. Household Characteristics

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

☐ Number of residents

35. Do you (owner/licensee) have family members (e.g., spouse, children, parents) living at this address? *Please **CIRCLE ONLY ONE.***

1. Yes 2. No

→ If no family member is living at this address, SKIP to question **#36.**

If there are family members living at this address, please answer the next question.

a. How many of these **family members** (excluding yourself or your current residents) are: *Please write 0 if none.*

☐ 17 years old or younger

☐ 18 – 64 years old

☐ 65 years and older

☐ **TOTAL** number of family members living at this address

License Number:

Section F. Monthly Rates, Fees & Policies

36. Do you currently have a Medicaid contract or accept Medicaid payment for any of your residents? **Please CIRCLE ONLY ONE.**

1. Yes 2. No

37. **Last month**, how many of **your current residents** primarily paid using the following payment types? *Please count each resident only once and write 0 for any categories with no residents.*

☐ **Medicaid**

☐ **Private sources** - May include resident and/or family personal accounts, Veteran's Aid & Attendance, long-term care insurance, pension, Social Security

☐ **Other:** _____

☐ **TOTAL # OF CURRENT RESIDENTS** (should match total in **question #2)**

38. **Private Pay Only:** For the last month, what was the average **total monthly charge** for a single resident living alone in a **private room** and receiving the lowest level of care?

$ _____ / month

39. Does your AFH offer the following services? If yes, is there an additional fee? *Please write Y for yes or N for no for each service.*

Service	Offer service? (Y/N)	Charge fee? (Y/N)
Night-time care		
Advanced memory care		
Two or more person transfer assistance		
Obesity care		
Catheter, colostomy or similar care		
Advanced diabetes care		

License Number:

40. How much do you agree or disagree with the following statements regarding the coronavirus (COVID-19) pandemic? **Please put an "X" in the column that best describes your experiences.**

In the past 12 months…	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Applicable
a. We have been able to get accurate information about COVID-19.						
b. We have been given enough support from county/state agencies to deal with issues/problems due to the pandemic.						
c. We have been satisfied with the communication about rules and regulations from the county/state agencies.						
d. We have been able to access personal protective equipment (PPE) (such as eye protection, gloves, N95 respirator masks).						
e. We have been able to address concerns of my residents' families related to the pandemic.						
f. We have been able to address concerns of my staff related to the pandemic.						
g. We have had a harder time finding new residents.						
h. We have had a harder time with staffing (such as hiring, retaining, and scheduling).						
i. Our residents have used virtual visits (e.g., iPad, computer, smart phone) with their family members and friends.						
j. Our residents have used telemedicine or telehealth for purposes of assessments, monitoring, diagnosis, or treatment.						
k. We have found the COVID-19 visitor restrictions enacted by county/state agencies to be reasonable.						

License Number:

41. Is there anything else you would like us or ODHS to know about operating an adult foster home during the pandemic?

_____

_____

_____

_____

42. Please tell us what you like best about operating, owning, and/or living in an adult foster home.

_____

_____

_____

_____

43. Please tell us some of your biggest challenges operating, owning, and/or living in an adult foster home.

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire!

Please return your completed questionnaire to PSU.

If you are returning the questionnaire by mail, please use the addressed, postage paid envelope.

All answers are kept private and confidential. None of your individual information is reported to ODHS.

13