Residential Care: An Emerging Sector of the Ohio System of Long-Term Services

March 2021

Meghan A. Young
Jessica Yauk
Jane K. Straker
Matt Nelson
Robert Applebaum

Scripps Gerontology Center
An Ohio Center of Excellence

MIAMI UNIVERSITY
OXFORD, OH • EST. 1809

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ACKNOWLEDGMENTS

We would like to thank many people for their time and effort in creating this report. Thank you to Dr. Jennifer Heston-Mullins for her helpful comments and revisions on earlier versions of this report. We also appreciate the detailed work of Tasha Dean to create the many graphs and charts included in this report. While this report was a long time in the making, we would like to thank Dr. Diane Berish for all her work with the Biennial RCF data in previous years. This project would also not be possible without the funds from a grant by the Ohio Department of Aging and the Ohio Long-Term Care Research Project funded by the Ohio General Assembly through the Ohio Department of Higher Education. Finally, we would like to thank all the RCF and AL administrators who respond to our Biennial survey and provide valuable information about their organizations.

Meghan A. Young, MGS
Jessica Yauk, MGS
Jane K. Straker, PhD
Matt Nelson, MGS
Robert Applebaum, PhD

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This study was funded by the Ohio Long-Term Care Research Project supported by the Ohio General Assembly.

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EXECUTIVE SUMMARY

While more people who need help and assistance in their daily lives are receiving paid care in their homes, the role of residential settings, such as assisted living facilities, remains a critical component of care.[1] Licensed in Ohio as Residential Care Facilities (RCFs), nationally these care settings are often referred to as assisted living (AL). Providing a combination of housing, personal care services, and health monitoring, assisted living was designed as an alternative to the more medically-based model of care provided in nursing homes. With fewer regulations than nursing homes, and a greater emphasis on resident choice, ALs provide an option to older adults seeking assistance with daily activities who do not have complex medical conditions that require the level of care provided by a skilled nursing facility.

This study examines RCFs in Ohio. We describe these settings, the residents who live there, and the kind of care they receive. Data for this report comes from The Biennial Survey of Long-term Care Facilities, distributed to all RCFs and nursing homes in Ohio every two years. The survey completion rate for RCFs has remained consistently high between 85-93% since the survey's inception, with an 88% response rate in 2017.[2] Over 90 percent of surveys were completed by RCF administrators between July and December 2018, reporting data about calendar year 2017.

Beginning in the 1990s, there was phenomenal growth in the national AL industry. Ohio's increase mirrors the nation, with a 270% increase in the number of licensed RCF facilities, going from 265 RCFs in 1995 to 708 RCFs in 2017. Ohio's RCFs are larger than the national average of 35 beds, with an average of 80 licensed beds and 57 units/rooms. At the end of 2017, approximately 85% of Ohio's 40,450 RCF units were occupied, and 68% of the 65,790 total licensed RCF beds were occupied by 30,148 residents.[3]

Ohio's increase mirrors the nation, with a 270% increase in the number of licensed RCF facilities, going from 265 RCFs in 1995 to 708 RCFs in 2017.

RCFs are most often stand-alone facilities but may also be part of a larger community such as a continuing care retirement community (CCRC). CCRCs provide a continuum of care from independent living to skilled nursing care. In 2011, 30% of Ohio RCFs reported being part of a CCRC, but by 2017, largely due to an increase in new free-standing facilities, this percentage decreased to 22%.

In 2017, 61% of Ohio RCFs were part of a chain, up from 58% in 2011. The proportion of RCFs in Ohio that are for-profit (72.6%) is lower than the national average (81%).[4]

Ohio has seen growth in for-profit RCFs, while the proportion of not-for-profit RCFs has declined over 10 years.

Ohio RCFs employed 13,014 direct care workers (DCWs) and 5,422 nurses (RNs/LPNs) in December 2017. DCWs include those who work as State Tested Nurse Aides (STNAs), personal care aides or assistants, and medication technicians or aides. In the average Ohio RCF facility, aides make up about 68% of the direct care staff. RCFs were asked if they were to hire a DCW, RN, and/or LPN what the highest and lowest hourly wage would be for an entry-level employee. On average, the highest hourly wage for DCWs was $12.69; LPNs earned $21.92 per hour; and RNs earned $27.74 per hour.

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Staff turnover and retention of existing staff are challenges nationwide. In Ohio, the average retention rate of DCWs employed in RCFs in 2017 was 64.7%, while the average turnover rate was 78.3%. Nearly nine in ten facilities (88.9%) reported current vacancies among DCWs. Nearly two-thirds (63.2%) indicated they had vacancies because there were an insufficient number of qualified applicants, they were unable to compete with other employers (30.1%), or they were unable to retain employees (27.8%).

As of the last day of 2017, the average Ohio RCF was serving 47 residents. Ohio RCF residents have an average age of 85, similar to the national RCF population. Many of these residents needed assistance with activities of daily living (ADLs) and 40% had at least two ADL impairments. The most common area of assistance was with medications (78%), followed by bathing (64.7%), and dressing (48.7%). Fewer than half of AL residents required assistance with the remaining ADLs.

The overall cost of residential care units for private rooms and memory care has increased since 2013. Rates, which typically include room and board and services, vary greatly across the state ranging from $685 per month to $8,995 per month. There are a wide array of room and service options in Ohio's RCFs.

Residents use a variety of funding sources to pay for their care. The largest payment source is private pay. Within a facility an average of about eight in ten residents pay privately. Residents of Ohio's RCFs also utilize long-term care (LTC) insurance. Approximately 62% of RCFs reported that any of their residents used LTC insurance, but on average fewer than 10% of private-pay residents were using LTC insurance. About half of the RCFs had residents who used the Medicaid Assisted Living Waiver

Among facilities with the AL Waiver program the Waiver was the primary payment source for an average of 26% of residents.

Program. Among facilities with the AL Waiver program the Waiver was the primary payment source for an average of 26% of residents.

A total of 16,587 new residents were admitted to Ohio's 708 RCFs in 2017. While about half of Ohio admissions came directly from the community, community admissions account for about three-quarters (76.9%) of admissions nationally.[5] Ohio reports a higher percentage of individuals moving into an RCF from a nursing home than the national average (24% versus 10%).[6] The percent of residents moving from one RCF to another RCF was also slightly higher in Ohio compared to the national average (5.3% versus Ohio's 8.9%).[7]

There were a total of 13,822 discharges from Ohio's RCFs in 2017. The most common reason (39.9%) for discharge was death. Nearly three in ten discharges went to nursing homes. Additionally, 14% returned home or to independent living within a retirement community. Nearly one in ten (8.8%) moved to another RCF. In addition to reporting where residents went at discharge, we also asked about reasons for discharge. About 16.5% of discharges were due to high memory care/dementia needs or related behaviors. Because the vast majority of RCFs rely on private-pay residents, we also examined how the cost of care affects an individual's ability to remain at an RCF. In Ohio, of the 186 facilities that said they had resident discharges due to an inability to pay, an average of 14.2% of their discharges were because the cost of care exceeded an individual's ability to pay.

Nationally, individuals living with Alzheimer's disease or other dementias make up 41.9% of the residents in RCFs.[8] Long-term care settings have implemented a variety of strategies to care for residents who have dementia; one popular method is memory care units (MCUs). Twenty-two percent of residential care facilities or assisted living facilities across the U.S. offer dementia care units.[9] According to our Ohio data, four in ten (38.6%) RCFs have a dedicated MCU. Most are small with an average unit size just under thirty beds (28 beds), and an overall occupancy rate of 85.3%. The average private pay room in Ohio memory care was about $5700 per month.

According to our Ohio data, four in ten (38.6%) RCFs have a dedicated MCU.

Today's system of long-term services and supports is markedly different from the one just two decades ago. As documented in this study, one of the largest areas of change involves the development of the assisted living industry. While Ohio does not have a separate AL licensure category, the majority of Ohio RCF's can be called AL facilities. The growth of these facilities in Ohio has been

nothing short of dramatic, increasing from 265 facilities in 1995 to 708 in 2017, to about 800 today. The number of licensed beds has gone from 10,000 to more than 65,000. This expansion, which is almost exclusively driven by individuals paying privately for the care option, is responding to the needs of consumers and has filled an important niche in the market. There are many individuals who need residential care but do not need a health-focused nursing home setting, who are now being served in assisted living. Whether it be based on the AL philosophy or being able to operate with less health-focused regulations, the AL industry has been praised for its consumer focus.

This study is a beginning effort to provide detailed information about how the AL industry is developing. Several important issues arise that have implications for policy makers and the assisted living industry overall.

BACKGROUND

As the baby boom generation has moved through the life course, every institution has been impacted. For example, to keep up with the growing number of students, more K-12 schools were built with larger classrooms and universities invested in new dormitories to house an expanding student body. The economy and its workforce expanded to put the talents of this generation to work. Now reaching retirement age, they are caring for older parents and sometimes receiving assistance with their own daily lives. To accommodate their changing needs, we can expect that our system of long-term services and supports (LTSS) will also change in fundamental ways. We are already seeing a shift in the LTSS system as older adults' preferences for independence, autonomy, and choice have led to more person-centered LTSS options.

While more people are receiving paid care in their homes, the role of residential settings, such as assisted living facilities, remains a critical component of care.[10] In 2016, residential care facilities made up 44% of regulated LTSS providers.[11] Licensed in Ohio as Residential Care Facilities (RCFs), nationally these care settings are often referred to as assisted living (AL). Providing a combination of housing, personal care services, and health monitoring, assisted living was designed as an alternative to the more medically-based model of care provided in nursing homes. With fewer regulations than nursing homes, and a greater emphasis on resident choice, ALs provide an option to older adults seeking assistance with daily activities who do not have complex medical conditions that require the level of care provided by a skilled nursing facility.

Ohio has about two million individuals aged 65 and older (Kunkel, Mehri, Wilson, & Nelson, 2019). Although most older Ohioans continue to live independently and thrive, increasing age is associated with higher levels of disability and a greater potential need for long-term services and supports. Today, Ohio has more than 164,000 elders who need daily assistance from family or paid in-home service providers with tasks of daily living such as bathing and dressing.[12] Similar to national growth in RCFs, Ohio has seen residential care or assisted living grow dramatically. In Ohio, these facilities are licensed as RCF's to provide housing and support to 17 or more residents. However, there are established criteria which must be met for an RCF to participate as an assisted living facility in the state's Medicaid Assisted Living Waiver Program

While national surveys provide a broad overview of the RCF industry, the lack of reliable data collection efforts has limited what is known at the state level.[13] For example, nursing facilities and home health services often receive a large portion of their reimbursement from federal and/or state funding sources and data collection efforts for nursing homes such as the Minimum Data Set 3.0, Medicaid Cost Reports, Certification and Survey Provider Enhanced Reports (CASPER), and Medicare/Medicaid claims provide individual-level information about who they are serving, the care provided, and

the cost of the services. Since RCFs mainly rely on private funds, similar data collection efforts do not exist. As a result, we know little about the individuals who are served, how long they stay, the types of services they receive, and cost of services.

The limited information about the services provided, and who they serve has led to several debates in the LTSS research field, such as where RCFs lie on the long-term service and support continuum. Should RCFs be classified with home and community-based services, or should they be classified more as an institutional option? Additionally, basic questions about the characteristics of the industry remain largely understudied. For example, little is known about the qualifications and credentials of the facility administrators or the staff who care for the residents. While national certification standards provide staffing criteria for nursing homes, no similar guidance exists for RCFs.

This study examines residential care facilities in Ohio. We describe these settings, the residents who live there, and the kind of care they receive. We also provide a look at changes in these facilities and their residents over time, using a unique data set with over 20 years of comprehensive information to understand where the industry has been, as well as to anticipate how changes may continue to occur. This study provides an opportunity for an in-depth look at an LTSS option that is increasing in prevalence and importance.

METHODS

Data for this report came from The Biennial Survey of Long-term Care, distributed to all RCFs and nursing homes in Ohio every two years. This survey has been conducted by the Scripps Gerontology Center at Miami University every other year since 1995. The survey completion rate for RCFs has remained consistently high between 85-93% since the survey's inception, with an 88% response rate in 2017.[14] Over 90 percent of those surveys were completed by RCF administrators between July and December 2018, reporting data about calendar year 2017. These high response rates are a result of several factors. First, the 2017 data collection effort was the 13th wave of the industry wide study, which has created widespread awareness of and familiarity with the survey. In addition, statewide provider associations have encouraged their members to complete the survey. Next, the Scripps Gerontology Center provides extensive follow-up contact with providers to boost response rates. Finally, the survey is mandated by the Ohio legislature, and supported by the Ohio Department of Aging.

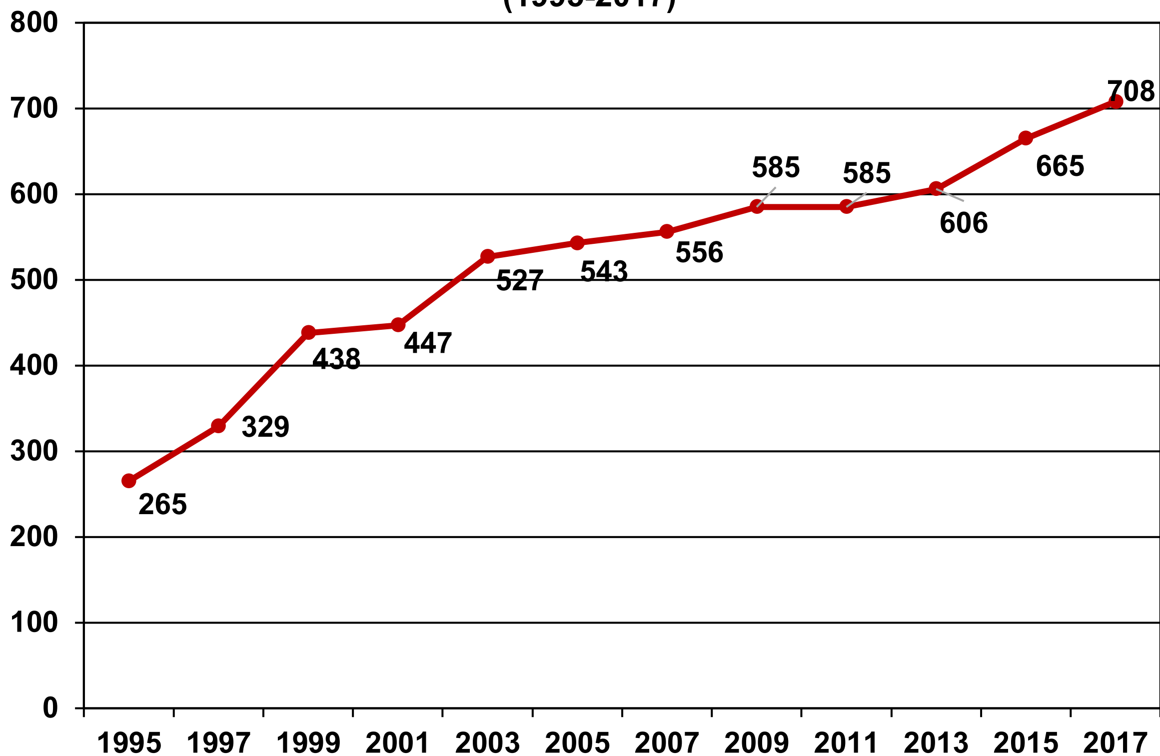
RESULTS

FACILITY CHARACTERISTICS

Size

Throughout the 1990s, there was phenomenal growth in the national assisted living industry. Ohio's increase mirrors the nation, with a 270% increase in the number of licensed RCF facilities, going from 265 RCFs in 1995 to 708 RCFs in 2017 (see Figure 1). Nationally, there were a reported 28,900 RCFs in 2016, housing a total of 996,100 licensed beds. The number of RCF units and beds varies by facility. The national average number of licensed beds per RCF in 2016 was 35, with a range from the largest facility at 518 to a low of 4.[15]

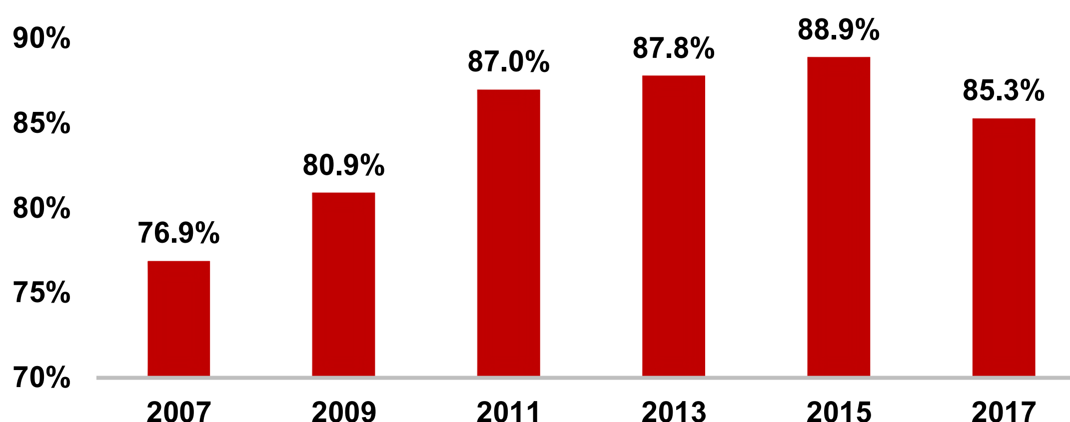
Figure 1. Number of Residential Care Facilities in Ohio (1995-2017)



Even though most apartments or units in Ohio RCF facilities are licensed for two beds and dual occupancy, many are a single room and only house one individual, which is similar to the national trend.[16] For that reason, basing occupancy rates on the number of licensed beds can provide misleading results. Instead, occupancy levels are best reported in terms of units or rooms. Ohio's RCFs are larger than the national average of

35 beds, with an average of 80 licensed beds and 57 units/rooms. At the end of 2017, approximately 85% of Ohio's 40,450 RCF units were occupied, and 68% of the 65,790 total licensed RCF beds were occupied by 30,148 residents.[17] Since 2011, unit occupancy has remained fairly constant. However, unit/room occupancy dropped in 2017 by 4 percentage points from 2015 (see Figure 2). This drop partially reflects an increase the number of RCFs and continued expansion of in-home care services. Ohio's RCFs also showed a slight decline in the average length of stay, dropping slightly from 2.4 years in 2013 to 2.15 years in 2017.[18] Ohio's unit occupancy rate (85.3%) mirrored the average national unit occupancy rate in 2016, of just over 85%.[19]

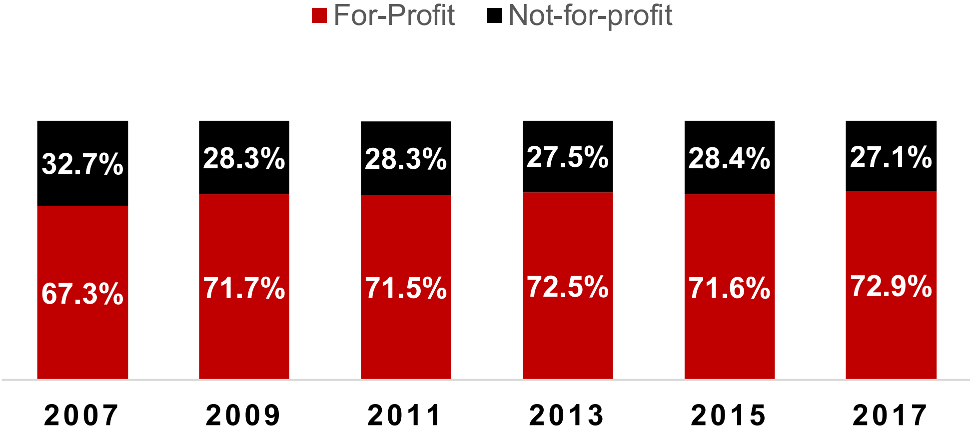
Figure 2. Ohio Unit Occupancy in Ohio's Residential Care Facilities (2007-2017)



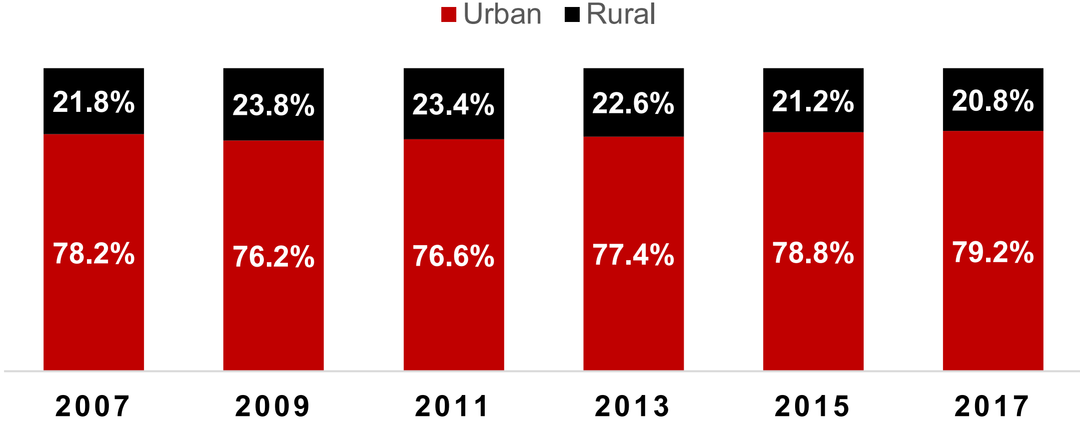
Structure

RCFs are most often stand-alone facilities but may also be part of a larger community such as a continuing care retirement community (CCRC). CCRCs provide a continuum of care from independent living to skilled nursing care. Nationally, less than 10% of assisted living service providers (9.6%) reported being part of a CCRC.[20] In 2011, 30% of Ohio RCFs reported being part of a CCRC, but by 2017, largely due to an increase in new free-standing facilities, this percentage decreased to 22%.

Nationally, nearly six in ten (57.2%) RCFs are part of a multi-facility chain.[21] In 2017, 61% of Ohio RCFs were part of a chain, up from 58% in 2011. The proportion of RCFs in Ohio that are for-profit (72.6%) is lower than the national average (81%).[22] Ohio has seen growth in for-profit RCFs, while the proportion of not-for-profit RCFs has declined over 10 years (see Figure 3).



Nationally, four in five (82.5%) RCFs were in metropolitan areas in 2016 (Harris-Kojetin et al 2019), and Ohio records a rate similar to the national average. In 2017, Ohio had six rural counties that did not have any RCFs- Highland, Vinton, Meigs, Harrison, Perry, and Monroe.[23]



Staffing

Ohio RCFs employed 13,014 direct care workers (DCWs) and 5,422 nurses (RNs/LPNs) in December 2017. DCWs include those who work as State Tested Nurse Aides (STNAs), personal care aides or assistants, and medication technicians or aides. In the average Ohio RCF facility, aides make up about 68% of the direct care staff. As shown in Table 1, of those employed as DCWs, about one-third were a racial minority

and more than one in ten had immigrated to the U.S. About one-quarter of RNs and LPNs were black or Hispanic and just under 10% were born outside the U.S. RCFs were asked if they were to hire a DCW, RN, and/or LPN what the highest and lowest hourly wage would be for an entry-level employee. On average, the highest hourly wage for DCWs was $12.69; LPNs earned $21.92 per hour; and RNs earned $27.74 per hour.

Table 1. Characteristics and Wages of RCF Workers in Ohio

	Direct Care Workers	RNs/LPNs
Hispanic or racial minority (%)	33.9%	26.5%
Immigrants (%)	11.1%	9.9%
Speak English as a second language (%)	13.2%	11.9%
Average highest starting hourly wage	$12.69	$27.74 (RNs) $21.92 (LPNs)
Average lowest starting hourly wage	$10.27	$23.81 (RNs) $18.50 (LPNs)

Training for staff of RCFs has been a concern since there are no federal regulations regarding the amount of training required. According to the Ohio Administrative Code for Residential Care Facilities, depending on the characteristics of individuals who need care, new employees are required to complete two hours of training once hired, followed by four hours of training each year.[24] In 2017, Ohio RCFs required an average of 35 hours of training for newly employed STNAs before they provided care to residents.

Recruitment of DCWs is an escalating challenge among all LTSS providers [25] and RCFs are no different. Low pay, few benefits, heavy workloads, and difficult working conditions that provide little recognition have all been reasons for high staff turnover rates.[26] Since staff turnover is of great concern, RCFs were asked to rate, on a scale of 1-10, with 10 being the most serious, how much of a problem they believed recruitment and retention were for DCWs, RNs, and LPNs. Table 2 shows the proportion of facilities reporting high recruitment and retention problems for each type of worker. RCFs rated DCWs as the most difficult to recruit and retain overall.

Table 2. Recruitment and Retention Problems by Type of Worker				
Worker Type	**Percentage of Facilities with High Recruitment Problems****	**Number of Facilities Reporting**	**Percentage of Facilities with High Retention Problems****	**Number of Facilities Reporting**
DCWs	40.6	576	36.3	565
RNs	33.8	334	16.4	360
LPNs	30.8	532	14.2	508

Note. Facilities responded to scale between 1 and 10, with 10 being the most serious.
**High recruitment and retention problems defined as scoring 8 or higher.

To gauge the extent of the retention problem, we asked facilities to report the number of DCWs on staff at the beginning of 2017 and the number of the same workers who were still employed at the end of 2017, as well as the number of workers who left during the year. This information allowed us to calculate both a retention rate and a turnover rate for each facility. The retention rate refers to the proportion of DCWs who started the year and were still employed at the end of the year. The turnover rate refers to the proportion of DCWs that left the facility during the year. In Ohio, the average retention rate of DCWs employed in RCFs in 2017 was 64.7%, while the average turnover rate was 78.3%. Nationally, staff turnover rates were highest among personal care aides (38%), and higher in communities that had 26-100 beds (45%).[27]

We also asked these RCFs to report whether they currently had vacancies among their direct care staff, and the reasons for the vacancies. Nearly nine in ten facilities (88.9%) reported vacancies among DCWs. Facilities with vacancies were asked to pick from four reasons for vacancies among DCWs. Nearly two-thirds (63.2%) indicated there were an insufficient number of qualified applicants, followed by facilities inability to compete with other employers (30.1%), and the inability to retain employees (27.8%). All RCFs were asked what strategies are or have been used to keep the facility properly staffed, and the vast majority (96.2%) reported that they asked existing staff to pick up additional hours. This was followed by financial incentives (73.6%), using their own "on call" staff (58.2%), sharing staff with their nursing facility (38.0%), and using agency/pool staff (26.7%).

Questions to assess administrator stability were also asked. Respondents were asked how many administrators have worked at the facility since 2015. The average facility had almost three (2.6) administrators since 2015, and four in ten (43.7%) RCFs reported that their current administrator started on or after January 2017.

Resident Characteristics

Functional Impairment

Unlike nursing homes in the U.S., assisted living facilities are not required to complete a uniform data set documenting residents served and so we do not have demographic resident data for Ohio. Nationally, 53% of RCF residents are over age 85. A high proportion are female, non-Hispanic whites with higher income levels.[28, 29]

On the last day of 2017, the average Ohio RCF was serving 47 residents. As shown in Table 3, Ohio RCF residents have an average age of 85, similar to the national RCF population. Many of these residents needed assistance with activities of daily living (ADLs) and 40% had at least two ADL impairments. The most common area of assistance was with medications (78%), followed by bathing (64.7%), and dressing (48.7%). Fewer than half of AL residents required assistance with the remaining ADLs. The number of individuals who needed assistance with dressing and bathing has remained fairly consistent over time. However, the proportion of individuals receiving assistance with toileting, transferring, and walking have all increased. Despite increases in the proportion needing assistance with some activities, the proportion needing assistance with two or more ADLs has shown only a slight increase since 2007. Large differences between Ohio nursing home and RCF residents do exist, with 88% of nursing home residents having two or more ADL impairments compared to half that many (40.2%) in RCFs.[30]

Table 3. Functional Characteristics of Ohio's Residential Care Facilities' Residents (2005, 2007, 2015, 2017)

	2005	2007	2015	2017
Number of Facilities	543	556	655	708
Average Age*	N/A	N/A	85	85.1
Needs assistance in Activities of Daily Living (ADL)				
Medication	69.8	73.5	80.4	78.0
Bathing	63.8	63.8	70.0	64.7
Dressing	46.1	47.1	54.8	48.6
Toileting	27.7	30.9	36.7	46.9
Transferring	19.3	21.3	27.1	28.6
Walking	19.7	20.2	24.9	26.9
Eating	8.4	8.4	8.3	8.6
With two or more ADLs	39.6	37.4	41.1	40.2
Cognitive Impairment	28.5	25.7	29.2	27.3

Note. Data from the Biennial Survey of Residential Care Facilities. Percentages are provided by facilities. The numbers are averaged for all facilities that provided a response to each question.

Nationally, two-thirds of RCFs provided personal care services to residents, with 64% of residents needing assistance with bathing, followed by 57% needing help with walking, and 48% requiring assistance getting dressed. About one in five (19.2%) residents across the country also needed assistance with eating.[31] These large differences by state demonstrate variability in the assisted living options available across the nation.

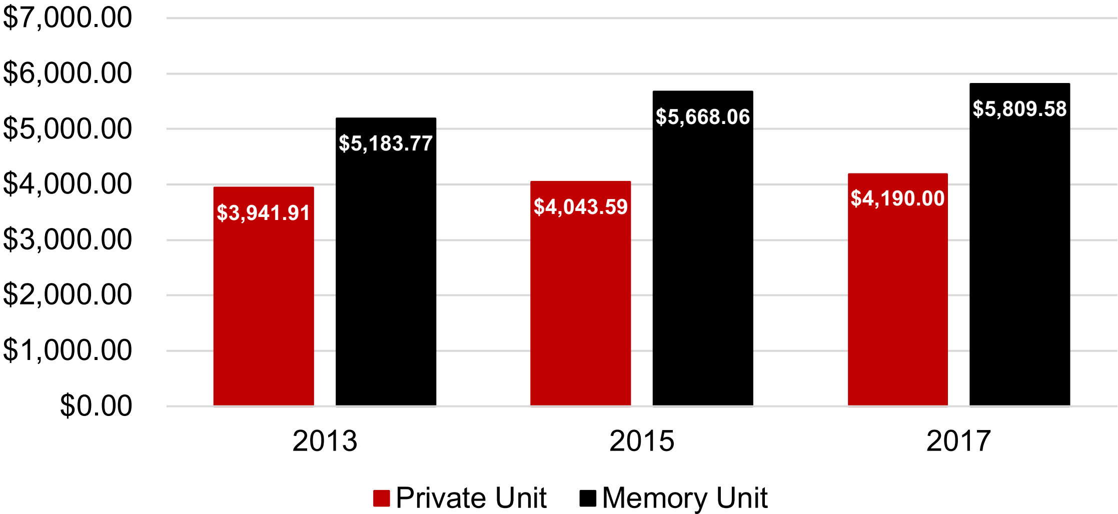
Behavioral Health

A growing challenge in Ohio is an increasing number of residents requiring behavioral health services. Two-hundred and seventy-five facilities reported residents with a diagnosis of severe mental illness (e.g., schizophrenia, bipolar disorder). Of those diagnosed with a severe mental illness, 22% exhibited behavioral issues including socially inappropriate behavior and verbal or physical abuse. Six percent of Ohio RCFs have a designated behavioral health unit.

When RCFs in Ohio were asked to identify barriers to accessing adequate mental health services for their residents, they reported mental health professionals unavailable to come to the facility as the highest barrier (27.8%), mental health professionals unwilling to come to the facility (20.6%), residents' reluctance to see a mental health professional (18.1%), mental health professionals unwillingness to accept Medicaid payments (16.2%), families' reluctance for a resident to see a mental health professional (13.3%), and mental health professionals unwillingness to accept Medicare payments (7.1%). Nationally, over half (55%) of RCFs reported offering mental health or counseling services to residents.[32]

Cost of Care and Payment Sources

The overall cost of residential care units for private rooms and memory care has increased since 2013 (see Figure 5). Rates, which typically include room and board and services, vary greatly across the state ranging from $685 per month to $8,995 per month. There are a wide array of room and service options in Ohio's RCFs.



Facilities were asked to report the percentage of their residents that used a variety of payment sources. The largest payment source for individuals residing in RCFs is private pay (see Table 4). On average, within a facility about eight in ten residents pay privately. Residents of Ohio's RCFs also utilize long-term care (LTC) insurance. Approximately 62% of RCFs reported that any of their residents used LTC insurance, but on average fewer than 10% of private-pay residents were using LTC insurance.

In Ohio, about half of the RCFs said they had residents who used the Medicaid Assisted Living Waiver Program. Among these facilities, the Assisted Living Waiver (AL Waiver) was the primary payment source for an average of 26% of residents. To be considered for the Assisted Living Waiver Program, individuals must meet eligibility requirements that include both financial limitations and impairments in physical functioning.

Table 4. Statewide RCF Payment Sources in Ohio

Payment Source	% of Facilities Receiving Payment	Number of Facilities Receiving Payment	Average % of Residents in Facility with This Payment
Private Pay	98.5	598	81.2
AL Waiver/MyCare	59.6	398	26
Other Payment Sources	10.9	66	14.9
Veterans Administration	7.6	46	8.8

Similar to Ohio, RCFs nationwide are almost exclusively paid for out-of-pocket.[33, 34] Of the RCFs that are not part of a CCRC or do not contain nursing home beds, nearly half (48.3%) reported accepting Medicaid for payment, but only 16.5% of residents used Medicaid to pay for services in 2016.[35] Even though Medicaid assisted living waivers are not provided in every state, the states that provide these waivers have a limited number of beds and waiting lists are common. Because of limited public resources, RCFs have grown mostly without government funding[36, 37, 38]

Resident Admissions

A total of 16,587 new residents were admitted to Ohio's 708 RCFs in 2017. Respondents were asked where residents resided before entering the facility. Table 5 shows the admission source for the facilities that provided admission details. Statewide about half of RCF residents (50.8%) came from the community. However, there is often an event (i.e., hospitalization) that prompts the need for RCF services, with three in ten (29.8%) of residents entering the facility from the hospital or nursing home. The next largest group of admissions came from independent living associated with the RCF or another assisted living or residential care facility.

While about half of the admissions into Ohio's RCF's came directly from the community, community admissions account for about three-quarters (76.9%) of admissions nationally.[39] Ohio reports a higher percentage of individuals moving into an RCF from a nursing home than the national average (24% versus 10%).[40] The percent of residents moving from one RCF to another RCF was slightly higher in Ohio compared to the national average (5.3% versus Ohio's 8.9%).[41] Reasons for moving into an RCF depend on individual circumstances. Research suggests that in seven in ten (71%) cases the decision to move into the RCF was at least partially the future resident's decision, while in the remaining cases the decision was made by another person.[42]

Table 5. Proportion of Statewide Admissions to RCFs from Each Setting, 2017

Residents Admitted From	Proportion of Total Admissions	Total Statewide Admissions
Home/Community	50.8	7,507
Separate nursing home	12.3	1,826
Associated nursing home	11.5	1,703
Another RCF	8.9	1,319
Associated independent living	6.7	998
Hospital	6.0	891
Another place	3.7	542

Resident Discharges

There were a total of 13,822 discharges from residential care facilities in 2017. Table 6 shows where residents were discharged to for the facilities that provided discharge details. The most common reason (39.9%) for discharge from Ohio's RCFs was death. Nearly three in ten discharges were to nursing homes. Additionally, 14% returned home or to independent living within a retirement community. Nearly one in ten (8.8%) moved to another RCF. In addition to reporting where residents went at discharge, we also asked about reasons for discharge. About 16.5% of discharges were due to high memory care/dementia needs or related behaviors. Because the vast majority of RCFs rely on private-pay residents, we also examined how the cost of care affects an individual's ability to remain at an RCF. In Ohio, of the 186 facilities that said they had resident discharges due to an inability to pay, an average of 14.2% of residents left because the cost of care exceeded their ability to pay. In 2010, 28% of RCF residents nationally moved out due to the cost of care.[43]

Table 6. Proportion of Statewide Discharges from RCFs in 2017

Residents Discharged To	Proportion of Total Discharges	Total Statewide Discharges
Death	39.9	5,269
Associated nursing home	16.1	2,134
Independent nursing home	12.6	1,672
Community	12.2	1,606
Another RCF	8.8	1,165
Hospital	4.0	528
Other (not specified)	4.7	618
Associated independent living	1.7	226

MEMORY CARE IN RCFS

Nationally, individuals living with Alzheimer's disease or other dementias make up 41.9% of the residents in RCFs.[44] Estimates of the number of people living in RCFs who have some form of cognitive impairment have been as high as 70%.[45] Long-term care settings have implemented a variety of strategies to care for residents who have dementia; one popular method is memory care units (MCUs). While the number of RCFs implementing memory care or dementia care units is growing, most residents who live in RCFs or assisted living facilities and have dementia do not reside in a dementia care unit.[46] Twenty-two percent of residential care facilities or assisted living facilities across the U.S. offer dementia care units.[47] Although the total number of dementia/memory care units is still low, RCFs will have to navigate caring for a growing number of individuals diagnosed with dementia or a related memory issue. Understanding the role MCUs play in RCFs will help improve care for individuals with dementia and those residing in dementia-specific units.

Ohio has a higher proportion of RCFs with MCUs than the national average. According to the 2017 Biennial Survey data, four in ten (38.6%) of RCFs have a dedicated MCU. One in five MCUs in Ohio were in a CCRC. Most MCUs in Ohio are small with an average unit size just under thirty beds (28 beds), and an overall occupancy rate of 85.3%. The majority of residents in MCUs are private-pay, with the remaining 8.3% of residents using the Medicaid Assisted Living Waiver Program. RCFs in Ohio with MCUs are more likely to be in urban areas. The average private pay room in memory care was about $5700 per month. Table 7 provides a comprehensive break-down of Ohio's MCU structure in RCFs.

With the growing number of people living with dementia in RCFs, regulations of MCUs have come into question. As of today, there is no national standard and states have varied greatly in their regulations regarding staffing and other requirements. A 2017 study assessed how states regulate dementia units and found that only 16 states had specific licenses or certifications for MCUs. Most states included dementia care policies and practice in the general regulations for RCFs, which means that many RCFs do not require additional training to work in MCUs.[48]

Table 7. Structure of Ohio RCF Memory Care Units	
Facilities with Memory Care Unit	
Has a memory care unit (#)	233
Proportion of facilities with a memory care unit (%)	38.6%
Proprietary facility (%)	76%
Part of a continuing care retirement community (%)	21.5%
Description of Memory Care Units	
Beds in facility devoted to unit (%)	32.1%
Occupancy rate (%)	84.1%
Number of rooms in unit	26.3
Number of private rooms in unit	22.3
Number of semi-private rooms in unit	3.4
Number of other rooms in unit	0.6
Percentage of private rooms in unit (%)*	85.9%
Payer-Mix of Memory Care Units	
Medicaid residents (%)	8.3%
Private-pay residents (%)	91.3%
Other payments residents (%) -	0.4%
Average Daily Rates#	
Private room in memory care unit ($)	$191
Semi-private room in memory care unit ($)	$191
Private room in facility for private-pay resident ($)	$153
Semi-private room in facility for private-pay resident ($)	$162
Medicaid reimbursement rate ($)	$96

Source: Straker, J. K., Bowblis, J. R., Kennedy, K. A., & Harrington A. K. (2019). *Dedicated memory care units in Ohio's long-term services settings: Structure and practices.* Retrieved from Miami University, Scripps Gerontology Center website: Scripps.MiamiOH.edu/publications

Note. Sample sizes vary for each question.

*Includes only facilities that reported the number for both private- and semi-private rooms.

Rates for memory care units are not specific to payer. The rates reported for private-pay and Medicaid are restricted facilities that reported a rate for their memory care unit. Rates can vary due to facilities not having certain type of rooms.

POLICY AND PRACTICE IMPLICATIONS

Today's system of long-term services and supports is markedly different from the one just two decades ago. As documented in this study, one of the largest areas of change involves the development of the assisted living industry. While Ohio does not have a separate AL licensure category, the majority of Ohio RCF's are AL facilities. The growth of these facilities in Ohio has been nothing short of dramatic, increasing from 265 facilities in 1995 to 708 in 2017, to about 800 today. The number of licensed RCF beds has gone from 10,000 to more than 65,000. Over the last two decades, we have witnessed the birth of a new line of business. On a positive note, this expansion, which is almost exclusively driven by individuals paying privately for the care option, is responding to the needs of consumers and has filled an important niche in the market. There were many individuals who needed residential care, but not a health-focused nursing home setting, who are now being served in assisted living. Whether it be based on the AL philosophy or being able to operate with less health-focused regulations, the AL industry has been praised for its' consumer focus. On the other hand, a growing industry serving elders with moderate and severe levels of disability needs to have solid mechanisms to share information, well defined monitoring and reporting approaches, and regulatory strategies that recognize the nature of the services provided and the residents served.

This study is a beginning effort to provide Ohio policy makers and RCFs with detailed information about how the industry is developing. Several important issues arise that have implications for policy makers and the assisted living industry overall.

Growth and Occupancy— The number of RCFs in Ohio has grown dramatically over the last two decades, increasing the number of units by more than 250%. Ohio's population age 65 and older and age 85 and above have increased by about 30%,[49] and while substantial, it does not come close to matching the growth in assisted living residences. This report has shown that between 2015 and 2017 the occupancy rates for the RCF industry dropped for the first time since we began tracking this information in 1995. The continued expansion of the industry could put even more occupancy pressures on providers, and in conjunction with the COVID 19 pandemic, the occupancy pressures in 2020 could continue. There remains considerable demand for the AL option, particularly for low- and moderate-income elders with disability, but Ohio's AL Waiver support remains limited. In our review of costs of memory care units, we found the private pay rate of $5700 per month was substantially higher than the $2900 monthly Medicaid rate. Almost one in three AL residents leave to go to a nursing home and for facilities using the AL Waiver there is a strong economic incentive to transfer these individuals to the nursing home setting. In an earlier study, we found the Assisted Living Waiver Program had a much higher rate of transfers to nursing home care than the PASSPORT home care program.[50]

Workers support— Data in this study highlights the challenges associated with the direct care workforce who provide most of the resident assistance in RCFs. The retention rate for the direct care workers delivering the hands-on personal care and other assistance in RCFs was 65%, indicating that one-third of the workforce remained one year or less. Turnover rates at 78% also suggest a segment of the workforce leaving very quickly. Four in ten facilities in the pre-COVID environment ranked DCW retention and recruitment as a serious problem. DCW wages were reported to be between $10 and $12.50 per hour in our 2017 survey. About one-third of the DCWs were workers of color and one in ten were born outside the U.S. Three in ten facilities also reported major problems recruiting nurses to their facilities even though wages were considerably higher. The COVID-19 pandemic is making the worker challenges even more complicated. Direct care workers and nurse staffing will require an industry and a policy response as the older population in all long-term settings continues to grow.

Resident characteristics—The study found that while RCF residents do not experience disability at rates comparable to nursing homes, they do include a segment of residents that meet the nursing home level of care criteria used by Ohio's Medicaid program. Four in ten report two or more activity of daily living impairments and 30% report cognitive limitations. Four in ten facilities in the state have special memory care units and many facilities also reported serving residents with behavioral health challenges. In sum, many RCF residents have high levels of disability and the monitoring, reporting, and regulatory mechanisms have not kept up with the growth of the industry. The Department of Health does complete an annual inspection of RCFs and those residences participating in the Assisted Living Waiver Program are visited prior to being accepted as a provider, but that is by and large the extent of state regulatory efforts. While AL's are different from nursing homes and do not require the same level of inspection, a systematic strategy should be developed. Currently, there is no good mechanism to collect data on residents. Nor is there a systematic approach to look at quality across the industry. Assisted living has matured and turned into a strong component of Ohio's LTSS system and a quality improvement strategy should accompany this maturity.

Memory Care—Four in ten of Ohio's RCFs operate special care memory units and this is a growing service area. While the need to serve individuals with dementia continues to increase, there are questions about the design, structure, and efficacy of these units. Policies on such areas as admission criteria, staffing, training, programming, and cost vary dramatically across the state. It is not easy for consumers to know exactly what they are getting in these facilities when a friend or family member is receiving special memory care services. While Ohio has been exploring recent legislation about training requirements for memory care staff, there are important issues about the design and

operation of these units that need to be addressed by the industry and by regulators. It is also likely that Medicaid will continue to grow as a component of AL financing, and as it does, it will be necessary to refine and develop regulatory strategies for this growing industry.

Future Research

This study has provided an in-depth look at Ohio's RCF industry. A number of issues have been identified in our review of the industry that require attention. What is also clear is that an ongoing mechanism to track the residents using this care option will be critical in efforts to ensure quality. It will also be essential that information about the quality of care be systematically developed and accompanying data collection methods be established. The evolution of the assisted living industry means that a data collection and use strategy needs to accompany the ongoing growth of the industry.

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Additional Resources

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