THE FLORIDA LEGISLATURE Report No. 97-74

Office of
Program Policy Analysis
And Government Accountability

John W. Turcotte, Director

June 1998

Supplemental Analyses of the Pilot Project Authorizing Direct Admission to Extended Congregate Care

Purpose

This report provides supplemental information about residents that participated in Florida's pilot project authorizing direct admission to an extended congregate care (ECC) facility. Chapter 95-418, Laws of Florida, required our office to conduct a pilot project study of assisted living facilities that directly admit individuals to extended congregate care. The study determined the effects direct admission had on ECC. OPPAGA published its final evaluation in Report No. 97-26 on December 30, 1997. The final report concluded that ECC licensed facilities can provide a less costly, safe alternative to nursing home care in a more homelike setting. This supplemental report provides detailed information about the characteristics of residents in the pilot project facilities and offers preliminary inferences about ECC as a long term-care option.

Background

Assisted living facilities provide housing, meals, and personal services to individuals who, due to age or disability, need supervision or assistance with activities of daily living such as bathing, eating, or dressing. In 1991, the Florida Legislature created the specialty Extended Congregate Care (ECC) license, which allows assisted living facilities to provide residents with additional supportive and nursing services that they would otherwise need to receive in a nursing home. The additional services enable residents to remain in a familiar living environment despite the physical or mental declines that may occur with aging. This concept is known as "aging in place."

The pilot project was implemented effective October 1995 and it allowed a limited number of ECC facilities to directly admit individuals into extended congregate care. The specific objectives of the pilot study were to determine whether direct admissions would significantly increase the number of individuals receiving ECC services, whether ECC provides a cost effective alternative to nursing home care, and whether ECC poses acceptable risks to residents and their families. Prior to the pilot project, facilities were allowed to provide ECC services only to individuals who had resided in their facilities for 90 days or more. The pilot project removed the 90-day limitation on admission, thus, permitting the pilot project facilities to directly admit residents into ECC. [1] A total of 76 assisted living facilities were eligible to participate in the ECC direct admission program.

Methodology

[1] The 1997 Legislature amended the law to allow all ECC licensed facilities to begin directly admitting individuals to ECC services as of May 1997.

To assess characteristics of individuals in ECC, OPPAGA collected information on admissions to and discharges from 52 (68%) of the eligible pilot project facilities over the two-year study period from October 1995 through September 1997. This information included data concerning resident demographics, medical profiles, cognitive and functional impairment levels, and where residents come from upon entry into the facility and where they go when they are discharged from the facility. In addition, newly admitted ECC clients (or caregivers) were asked to provide information on their needs and views about the facility where they resided.

OPPAGA received admission information on 1,465 facility residents, including 1,368 residents admitted into standard assisted living care (ALC) and 97 residents admitted directly into ECC. Discharge information was obtained on 1,573 individuals of whom 153 were discharged from ECC. In addition, we received information from 576 residents (both ALC and ECC) or their caregivers relating to their selection of a particular ECC facility. To further distinguish the characteristics of ALC and ECC residents, the admission and discharge data was divided into two subpopulations: those admitted into ALC and/or discharged from ALC and those directly admitted into ECC and/or discharged from ECC. Due to the small number of people (97 residents) directly admitted into the ECC pilot project facilities during the study period, the study results may not be representative of future trends in ECC.

Pilot Project Data

Information on pilot project residents is presented in the following order:

Data Highlights

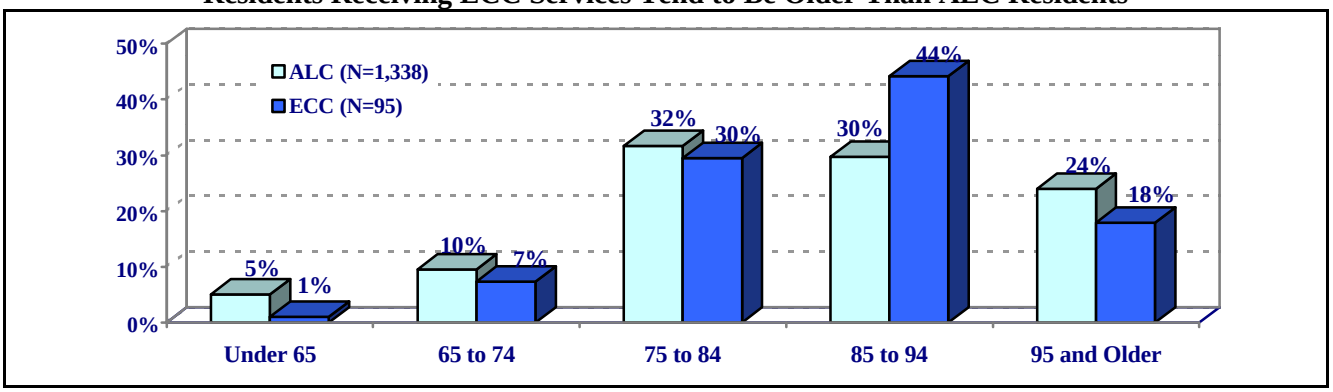
- Nearly three-fourths of the residents receiving extended congregate care (ECC) services needed help with one or more activities of daily living, while about half of the residents in assisted living care (ALC) needed such assistance.
- Forty-two percent of ECC residents were moderately or severely impaired, while only 25% of the ALC residents had such impairments.
- ECC residents tend to be older than ALC residents. The average age of ECC residents was nearly 85 years, while the average age of ALC residents was 82 years.
- The majority of residents receiving either ECC or ALC services were white, widowed females.
- About half of the residents receiving ECC or ALC services reported having heart disease.
- Over half of the residents found out about their facility from a friend or relative.

- The most frequently listed reason for selecting a facility was its location. Other commonly listed reasons included services offered, affordability, reputation, and quality of care.
- Over 60% of the residents admitted into pilot project facilities met Medicaid's monthly income eligibility limit for nursing home care. However, 72% of the residents exceeded the $2,000 asset eligibility limit, and these residents would have to spend down these assets to meet this requirement.
- Most residents (71%) that leave an ECC facility reported that they transferred to another facility, and nearly three-fourths of those transferring indicated that they were discharged to a nursing home.

Demographic Data

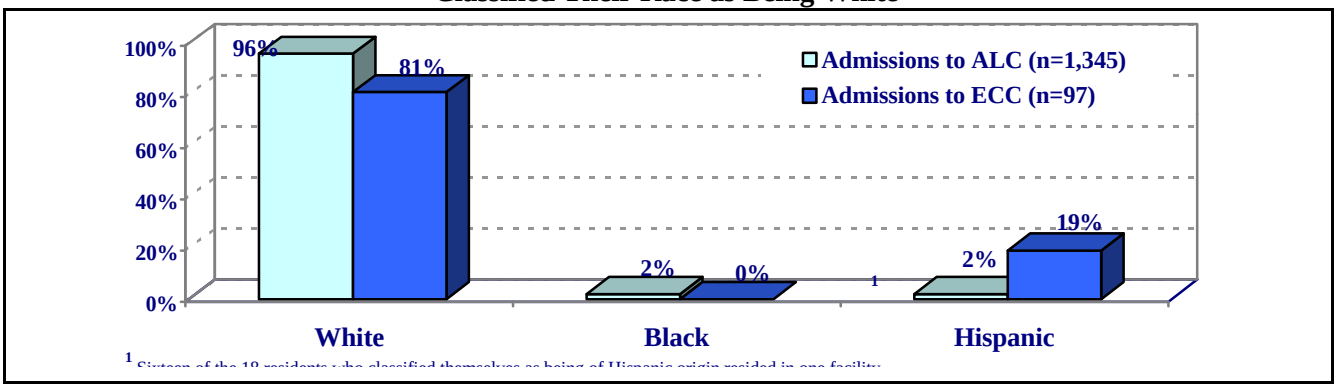
Residents receiving ECC services tend to be older than ALC residents (see Exhibit 1). The average age of an individual admitted to ECC in the pilot project facilities was nearly 85 years, while the average age of an individual admitted to ALC in those facilities was about 82 years. Most residents in both types of care classified their race as being white (see Exhibit 2). While 19% of the ECC residents classified themselves as being of Hispanic origin, nearly all of these residents resided in one facility. The majority of residents in both types of care were widowed (see Exhibit 3) and female (see Exhibit 4).

Exhibit 1: Residents' Age at Admission
Residents Receiving ECC Services Tend to Be Older Than ALC Residents



Note: Total does not equal 100% due to rounding.

Exhibit 2: Residents' Race/Ethnicity
Most Residents Receiving ALC Services (96%) or ECC Services (81%)
Classified Their Race as Being White



[1] Sixteen of the 18 residents who classified themselves as being of Hispanic origin resided in one facility.

Exhibit 3: Residents' Marital Status
The Majority of Residents in Both Types of Care Were Widowed

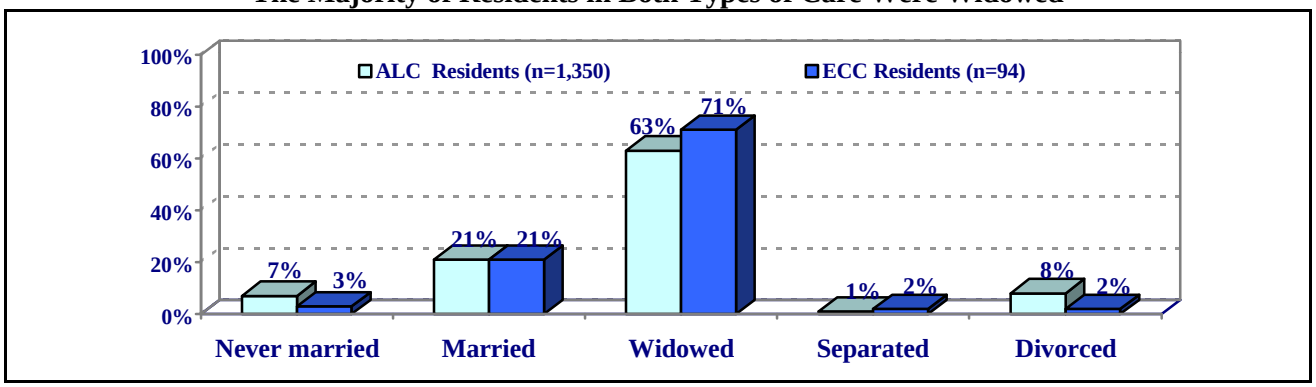
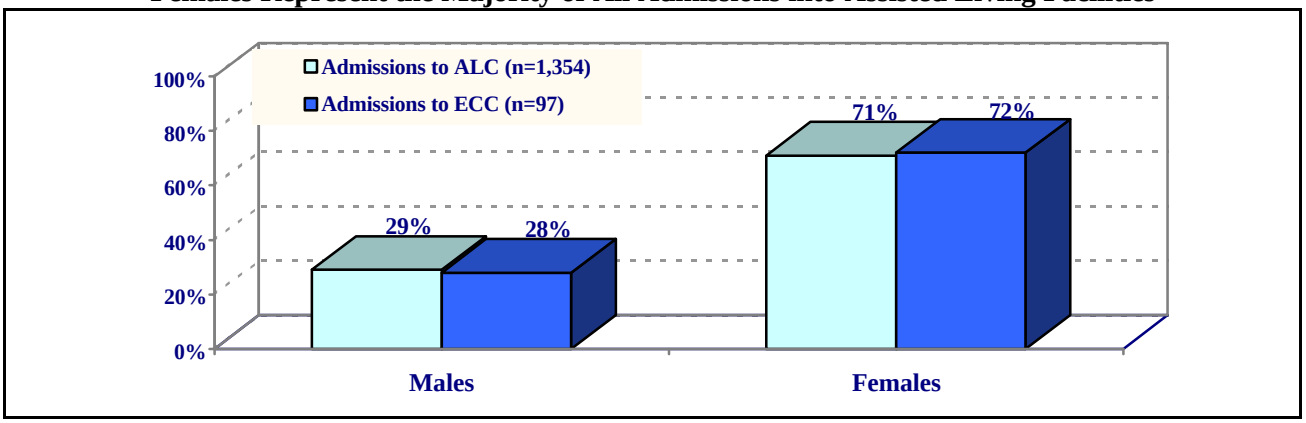


Exhibit 4: Resident's Gender
Females Represent the Majority of All Admissions into Assisted Living Facilities

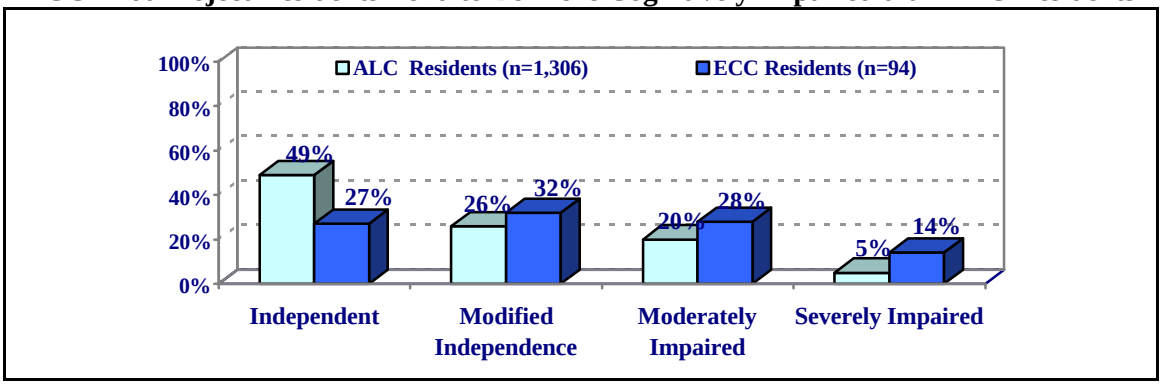


Health Characteristics Data

ECC residents' health care characteristics place them at risk of needing nursing home placement. Residents receiving ECC services are more likely than ALC residents to have severe or moderate cognitive impairments. For example, 14% (13 of 94) of ECC residents were severely cognitively impaired, while 5% (64 of 1,306) of ALC residents were severely cognitively impaired (see Exhibit 5). Activities of daily living (ADLs) are indicators of a person's ability to perform basic functions, such as eating or dressing. ECC residents are more likely than ALC residents to require assistance with one or more activities of daily living. About 75% of the ECC residents needed help with one or more activities of daily living, while only 53% of the ALC residents needed such assistance (see Exhibit 6).

The most prevalent type of medical condition for ECC and ALC residents was heart disease, with approximately half of the residents suffering from this condition. ECC clients in the pilot project facilities experience a number of the same medical problems as the ALC residents (see Exhibit 7).

Exhibit 5: Residents' Mental Health Limitations
ECC Pilot Project Residents Tend to Be More Cognitively Impaired than ALC Residents



Note: ECC total does not equal 100% due to rounding.

Exhibit 6: Activities of Daily Living
ECC Residents Are More Likely to Need Help With One or More Activities of Daily Living

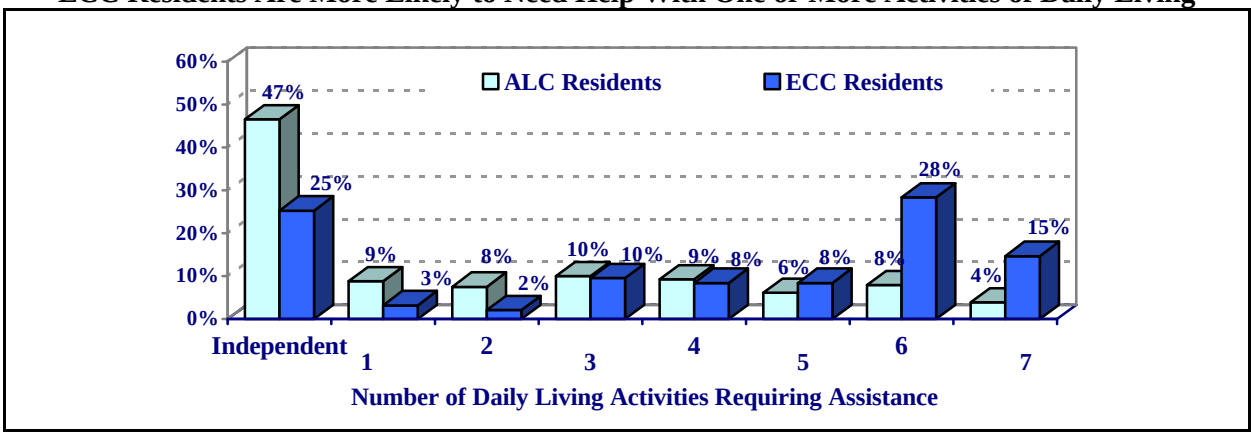


Exhibit 7: Residents' Diagnosis at Admission
Heart Disease Was the Most Prevalent Condition for ECC and ALC Residents, Followed by Neurological Disorder

	ALC Residents		ECC Residents	
Medical Condition	**Frequency**	**Percent**	**Frequency**	**Percent**
Heart Disease	660	49.7%	51	53.7%
Neurological	465	35.0%	48	50.5%
Psychiatric	216	16.3%	16	16.8%
Arthritis	194	14.6%	25	26.3%
Other[1]	943	71.0%	43	45.0%

Note: Respondents could identify one or more medical conditions. The frequencies in this table are based on responses of 1,328 ALC residents and 95 ECC residents. At least one condition was recorded for each resident.
[1]Other conditions most often mentioned include osteoporosis or musculoskeletal system disorder and hypothyroidism.

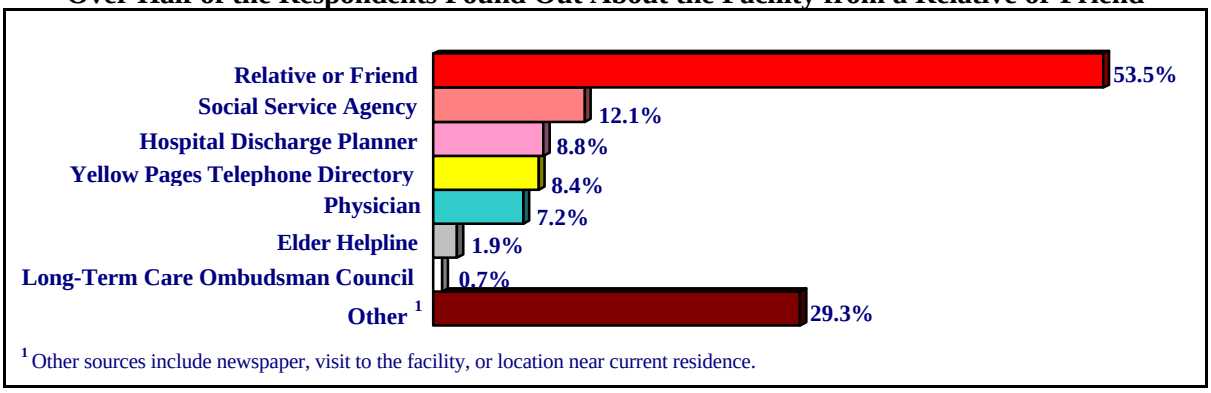
Admission Information

This section of the report compiles responses obtained from the pilot project facilities ALC and ECC residents or their caregivers. It is structured in a question and response summary format. All respondents (N=576) had an opportunity to respond to as many categories within each question as they felt necessary. Respondents were asked to provide information on various questions relating to their selection of a facility; where they were before being admitted to the facility; and cost considerations in selecting a facility. Responses to the following questions are grouped together regardless of the type of care residents were receiving at the pilot project facilities at the time of the study.

How did the resident and/or caregiver find out about this facility?

Summary: (n=570) The institutional sources of referral: physicians, hospital discharge planners, nursing homes, and the Department of Elder Affairs local information and referral services for elders (Elder Helplines) account for 31% of the referrals to the pilot project facilities. Relatives or friends are the most frequent source of information about ECC facilities.

Exhibit 8
Over Half of the Respondents Found Out About the Facility from a Relative or Friend



[1] Other sources include newspaper, visit to the facility, or location near current residence.

Why did the resident and/or caregiver choose this particular facility?

Summary: (n=573) The most frequent reasons given for choosing a facility related to its location and the services offered. Other reasons included affordability, reputation, homelike environment, and quality of care of the facility.

Exhibit 9
Location of the Facility and Services Offered
Were the Most Often Cited Reasons for Choosing a Particular Facility

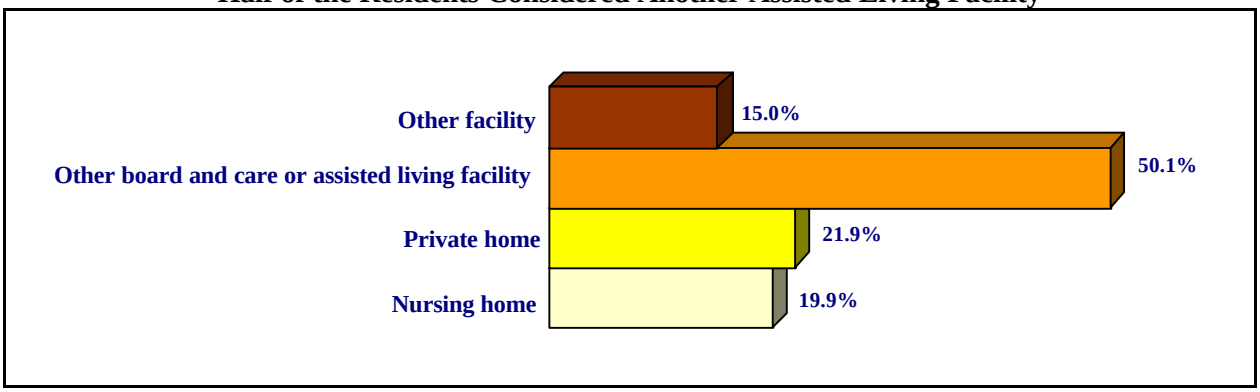
Why did the resident and/or caregiver choose this particular facility?	Frequency	Percent
Location	390	68.1%
Services offered	355	62.0%
Affordability	324	56.5%
Reputation	319	55.7%
Quality of care	302	52.7%
Homelike environment	300	52.4%
Other[1]	92	16.1%

[1]Other reasons include ethnic home, quality, concern of staff, and cleanliness.

What other types of facilities did the resident and/or caregiver consider before choosing this particular facility?

Summary: (n=553) Half of the respondents considered another board and care facility, and 21.9% considered private home before choosing a particular facility.

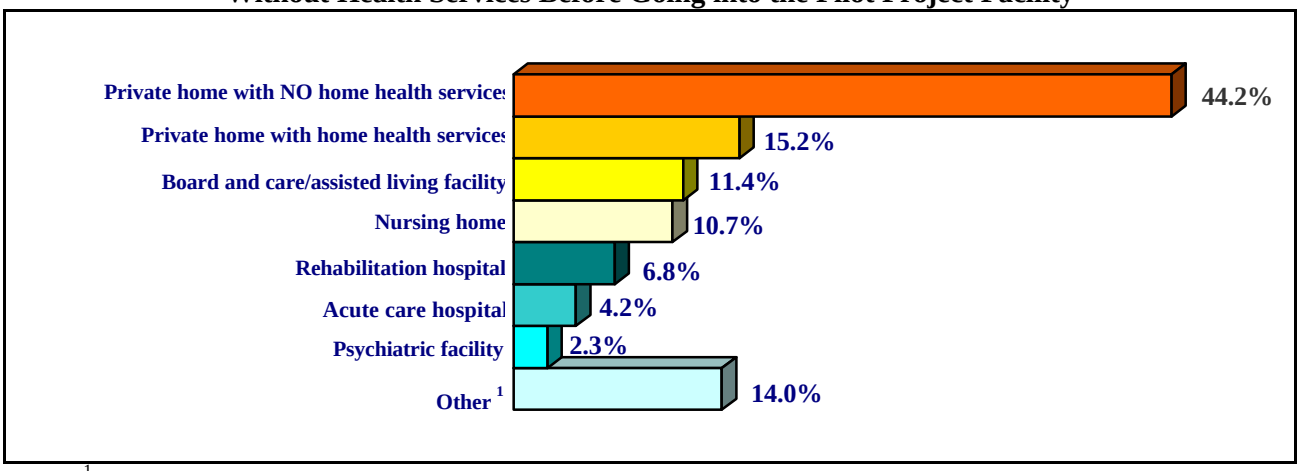
Exhibit 10
Half of the Residents Considered Another Assisted Living Facility



Where was the resident staying before coming to this facility?

Summary: (n=572) Almost half of the residents were living in a private home without any home health services prior to admission into a pilot project facility.

Exhibit 11
Forty-Four Percent of the Residents Were Staying in Private Homes Without Health Services Before Going into the Pilot Project Facility



[1]Other includes retirement home without assisted living services, developmental disabilities facility, and own apartment.

Why did the resident seek admission to the type of care provided in this facility?

Summary: (n=572) Nearly two-thirds of the respondents specified need for services as a reason for placement in the facility and over half of the respondents said they did not need nursing home care.

Exhibit 12
Most Residents Specified Need for Services as Reason for Placement in Facility

Why did the resident seek admission to the type of care provided in this facility?	Frequency	Percent
Need for services	372	65.0%
Do not need nursing home care	296	51.7%
Anticipate need for services	141	24.7%
Not eligible for Medicaid nursing home care	65	11.4%
Other[1]	74	12.9%

[1] Other includes resident who cannot live alone and no caregiver present.

Please indicate what type of care is needed or may be needed in the future.

Summary: (n=540) Almost half of the respondents indicated physical impairment, and about 42% of respondents specified lack of a home caregiver as the most important reasons why they needed or may need assisted living care.

Exhibit 13
Physical Impairment Was the Most Often Cited Reason for the Need of Assisted Living Care

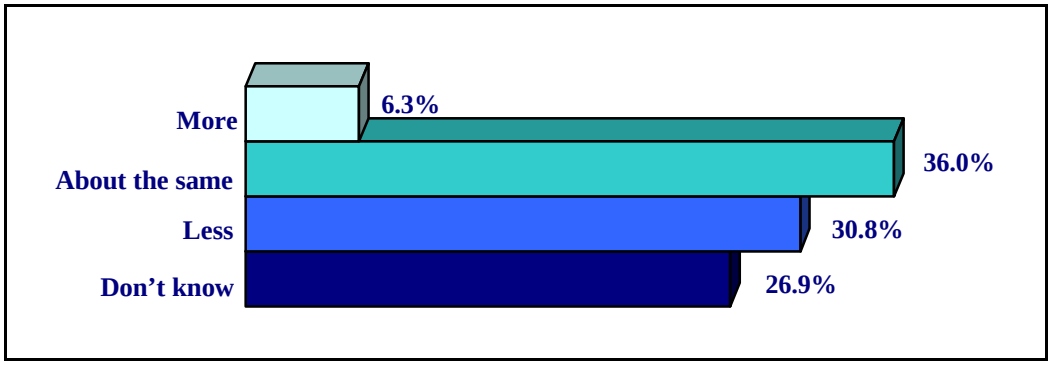
What type of care is needed or may be needed in the future?	Frequency	Percent
Physical impairment	256	47.4%
No home caregiver	225	41.7%
Mental impairment	210	38.9%
Cannot afford in-home services	124	23.0%
Chronic illness	75	13.9%
In-home services not available	73	13.5%
Other[1]	62	11.5%

[1]Other includes in-home care not sufficient, resident cannot be alone, and resident cannot keep up with housework.

How does the cost of this facility compare with the cost of other care options?

Summary: (n=569) The majority of residents felt that assisted living facilities cost was similar or less than the cost of other care options.

Exhibit 14
Two-Thirds of the Residents Felt the Cost of Their Assisted Living Facility Was Similar or Less Than the Cost of Other Care Options



How does the resident and/or caregiver pay for the cost of care in this facility?

Summary: (n=571) Over 75% of respondents indicated that they pay for care using their social security, pension, retirement funds, and savings.

Exhibit 15
Residents and/or Caregivers Used Pension, Retirement Funds, Savings, and Social Security to Pay for Care

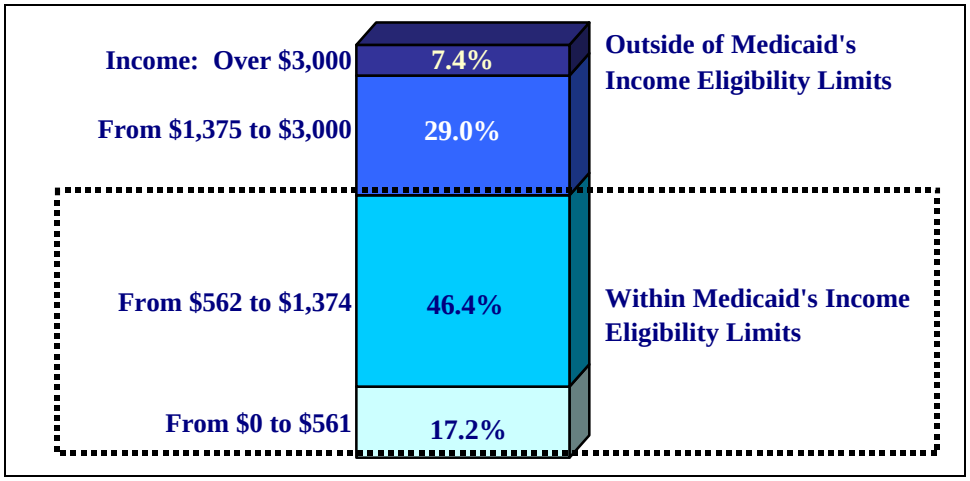
How does the resident and/or caregiver pay for the cost of care in this facility?	Frequency	Percent
Pension/retirement fund/savings	443	77.6%
Social Security	429	75.1%
Money from family on regular basis	72	12.6%
SSI/OSS payments	38	6.7%
Medicaid	21	3.7%
Private insurance	18	3.2%
CHAMPUS/VA	6	1.1%
Don't know	5	1.2%
Other[1]	67	11.7%

[1]Other includes investments.

What is the resident's monthly income range?

Summary: (n=489) Residents were asked to self-report their income to help us assess whether residents would meet Medicaid's monthly income eligibility limit if they transferred to a nursing home. The first two monthly income ranges ($0 to $561 and $562 to $1,364) represent incomes that would allow individuals to meet Medicaid income eligibility for nursing home care as of October 1995. Over 60% of the residents met Medicaid's income eligibility limit. Since October 1995, the Medicaid income limit has increased several times. Thus, more residents would likely meet this eligibility requirement.

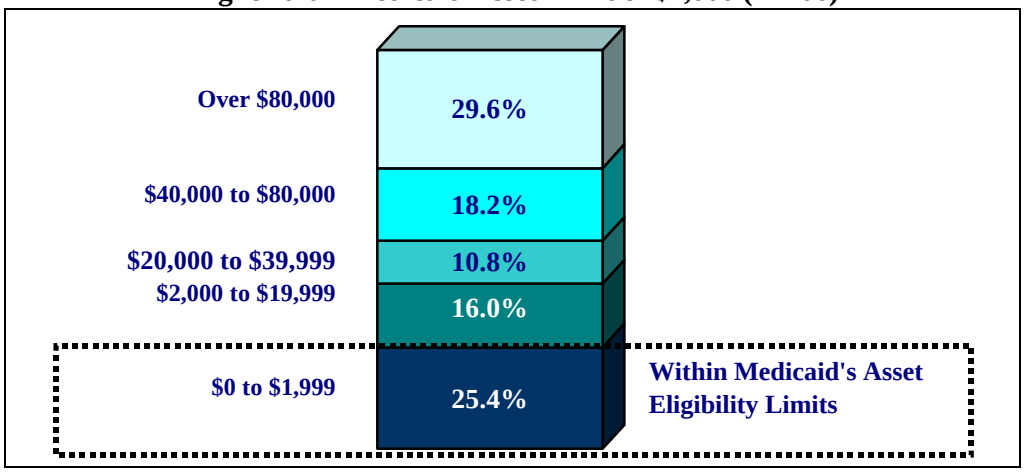
Exhibit 16
Over 60% of the Residents Had Incomes Below Medicaid's Income Eligibility Limit for Nursing Home Care



What is the resident's estimated net worth?

Summary: (n=406) Residents were asked to self-report their estimated net worth to help us assess whether residents would meet Medicaid's asset eligibility limit if they transferred to a nursing home. The first asset range ($0 to $1,999) represents the asset limit that would allow individuals to meet Medicaid's asset eligibility limit as of October 1995. Only one-fourth of the respondents reporting asset amounts met Medicaid's assets eligibility limit. Individuals with higher ranges of assets would have to spend down these assets before meeting this eligibility requirement. Since October 1995, Medicaid asset eligibility limit remains unchanged at $2,000. Thus, the majority of these residents would not meet this Medicaid eligibility requirement unless they spent down their assets.

Exhibit 17
Three-Fourths of the Residents Reported Having Assets Higher than Medicaid Asset Limit of $2,000 (n=406)



Discharge Information

ECC residents were more likely than ALC residents to be transferred to another facility (see Exhibit 16). Furthermore, nearly three-quarters of ECC transfers went to a nursing home, while 57% of the ALC transfers went to a nursing home. Also, admission to a hospital accounts for about 12% of resident discharges in both types of care (see Exhibit 17). Most of the ECC discharges were due to the residents' need for advanced care. (see Exhibit 18).

Exhibit 18: Reason for Discharge
Over Half of the Residents Transferred to a Different Type of Facility

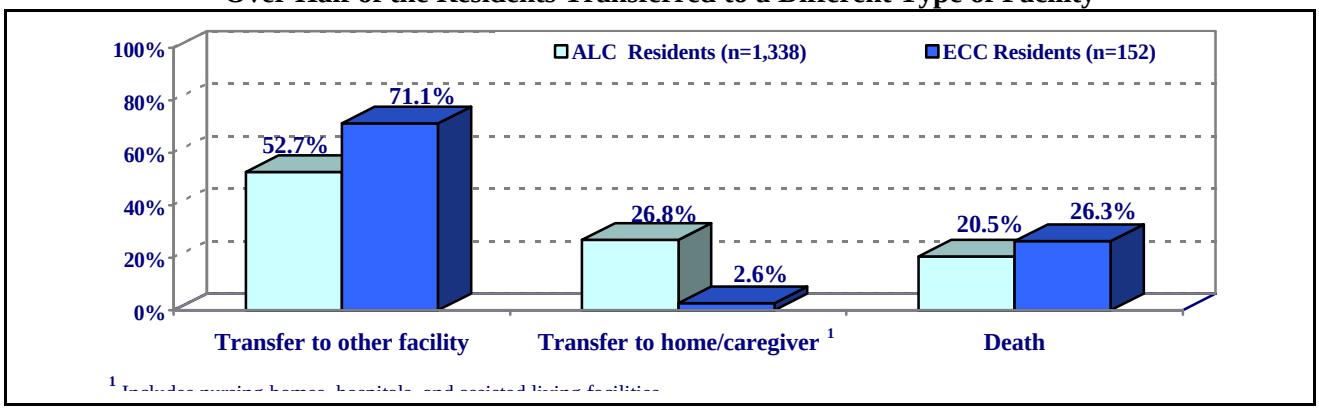


Exhibit 19: Where Residents Go at Time of Transfer
Residents Receiving ECC Services Are More Likely than
ALC Residents to Be Transferred to Nursing Homes

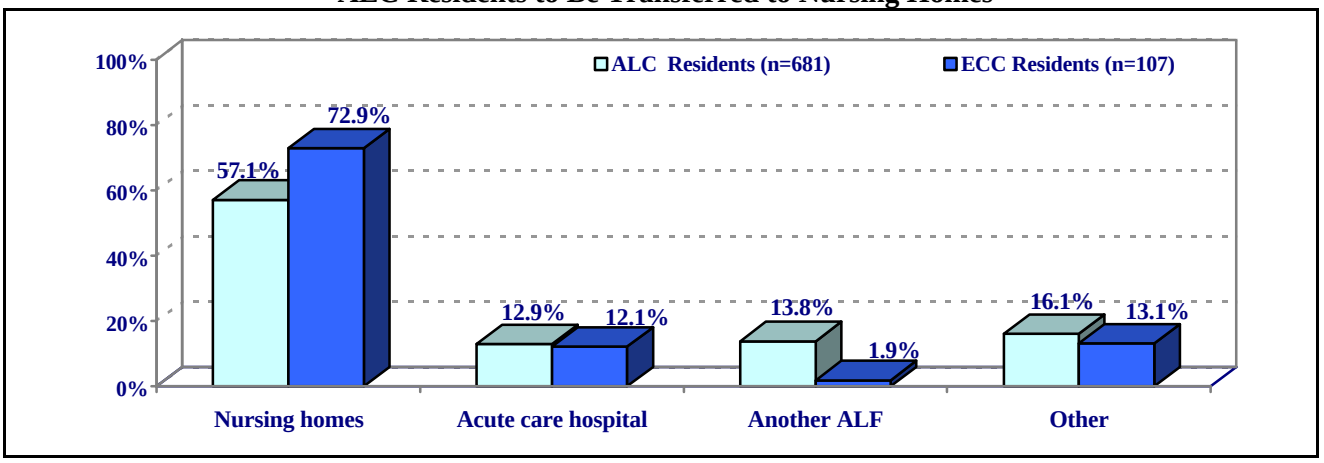
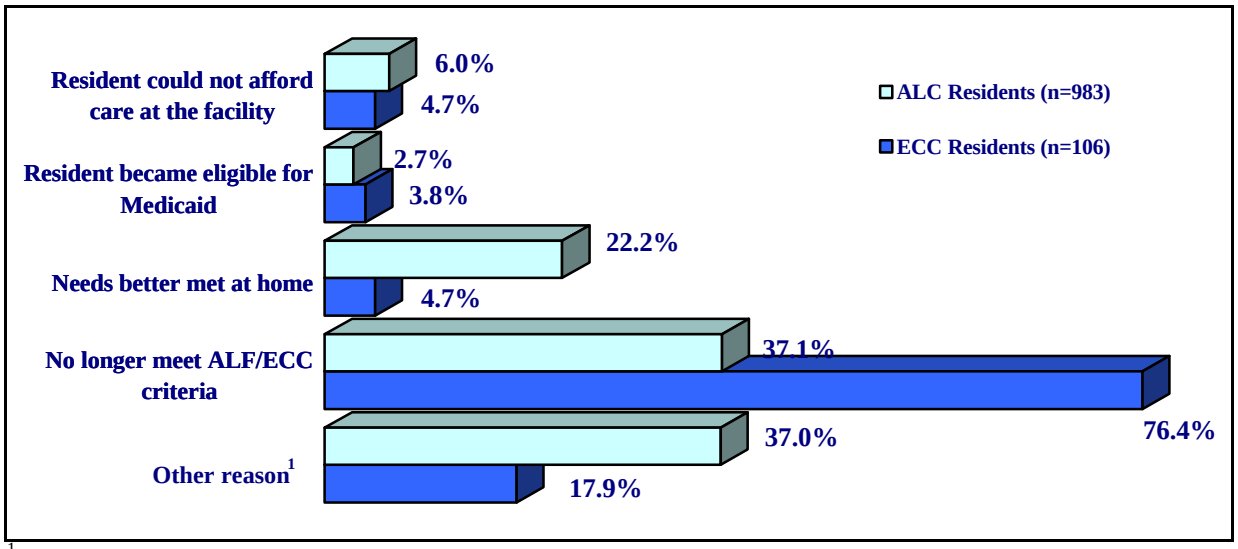


Exhibit 20: Reason for Transfer
Three-Fourths of ECC Residents that Transferred
No Longer Met Assisted Living Facility Criteria



[1]Other reasons for transfer include individuals reported that their physician recommended the move, residents moved because they wanted to be closer to their families; or family requested the move.

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

ANNOUNCEMENT

The Office of Program Policy Analysis and Government Accountability announces the availability of its newest reporting service. The **F**lorida **G**overnment **A**ccountability **R**eport (**FGAR**), an electronic publication specifically designed for the World Wide Web, is now up and operating for your use.

FGAR provides Florida legislators, their staff, and other concerned citizens with approximately 400 reports on all programs provided by the state of Florida. Reports include a description of the program and who is served, funding and personnel authorized for the program, evaluative comments by OPPAGA analysts, and other sources of information about the program.

Please visit **FGAR** at http://www.oppaga.state.fl.us/government. Your comments and suggestions about improving our services are always welcome.

Gena Wade, FGAR Coordinator (850/487-9245)

OPPAGA provides objective, independent, professional analyses of state policies and services to assist the Florida Legislature in decision making, to ensure government accountability, and to recommend the best use of public resources. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person (Claude Pepper Building, Room 312, 111 W. Madison St.), or by mail (OPPAGA Report Production, P.O. Box 1735, Tallahassee, FL 32302).

Web site: http://www.oppaga.state.fl.us/

Project supervised by: Frank Alvarez (850/487-9274) Project conducted by: Monica Rutkowski (850/487-9231)
Sharon Anderson (850/487-9228)