

# Complexities and Challenges in the Long Term Care Policy Frontier: Michigan's Assisted Living Facilities

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September 24, 2002



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# About the Research

This research was funded by a grant from Michigan State University's Applied Public Policy Research Program (MAPPR) facilitated by the Institute for Public Policy and Social Research (IPPSR). This program is made possible through funding allocated by the State of Michigan to develop expertise for Michigan's policymaking community. The MAPPR database of reports is available at [www.ippsr.msu.edu/AppliedResearch](http://www.ippsr.msu.edu/AppliedResearch).

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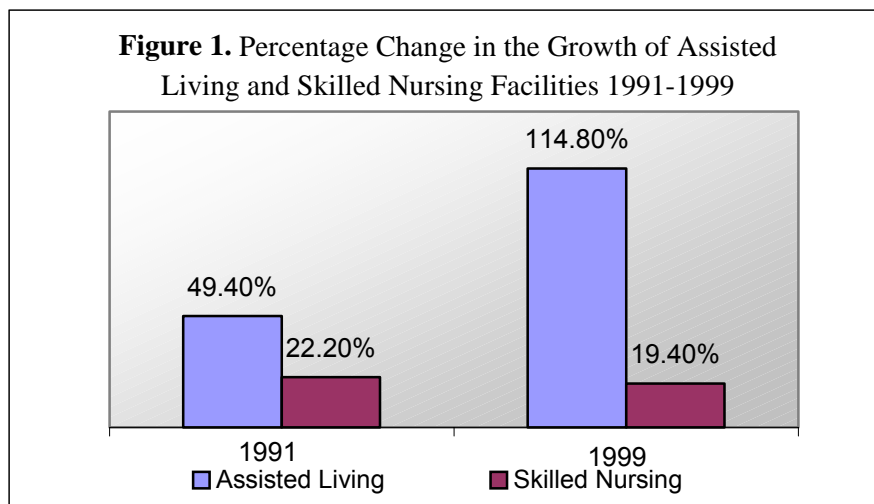
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## INTRODUCTION

The purpose of this paper is to provide an overview of policy issues related to unlicensed assisted living facilities (ALFs) as well as present preliminary data about the types of services provided and individuals served in these settings. This effort represents one of the first attempts to provide a more informed context for a much-needed debate regarding possible strategies and future directions for ALFs in Michigan.

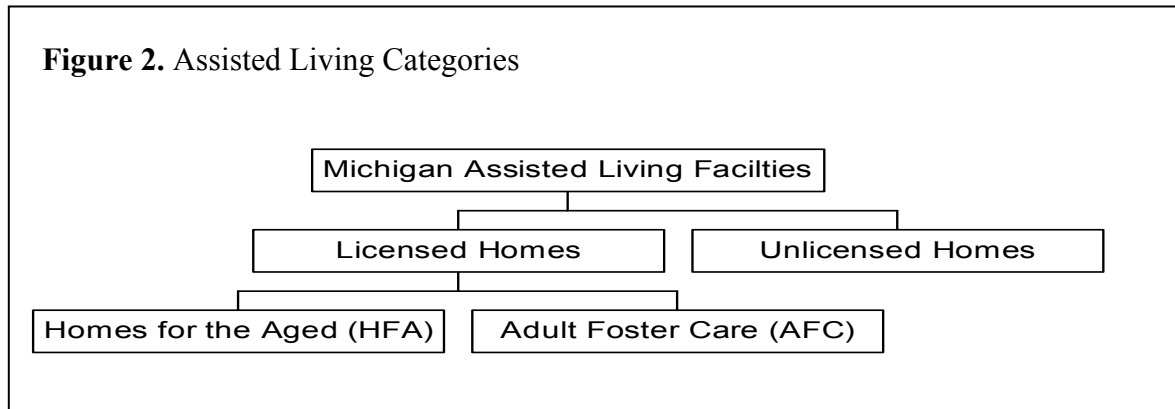
## BACKGROUND

In response to the burgeoning population of older persons and individuals with disabilities who need long term care, a relatively new industry known as assisted living facilities (ALFs) has emerged. While these facilities vary widely in cost, care, and philosophy, they all offer a residential setting, and generally 24-hour supervision, scheduled and unscheduled assistance, social activities, and sometimes health-related services. Typically, ALFs offer a homelike atmosphere, often a distinguishing factor from more institutional settings such as skilled nursing facilities. ALFs have developed in response to the growing needs of individuals who are no longer capable of remaining in their own homes but who seek to receive care in a community setting. Figure 1 illustrates how rapidly this growth has occurred in the U.S., particularly in comparison with nursing homes.



Source: National Investment Center for the Senior Living and Long-Term Care Industries

In Michigan, there are both licensed and unlicensed facilities that fill this niche within the long-term care continuum. For decades, Michigan has licensed and regulated both homes for the aged (HFAs) and adult foster care (AFC) facilities that together can accommodate 47,761 individuals. These facilities will be described in more detail below. More recently, numerous unlicensed and unregulated ALFs have appeared throughout the state. Thus, the term “assisted living” encompasses several different categories in Michigan (Figure 2).



Because of the lack of any governmental oversight, it has not been possible to obtain the most basic information about these settings, including an accurate count of facilities or the number of residents served in unlicensed homes. Nonetheless, the rapid development of unlicensed ALFs is evident in their widespread marketing efforts and their visibility in most communities. These facilities are typically organized around a social model of care offering room and board in a residential setting, often with additional services such as housekeeping, recreational activities, or help with activities of daily living. With few exceptions, unlicensed ALFs are financed through private pay residents.

ALFs often appear attractive to *consumers* for a number of reasons, because they:

- are promoted as home-like alternatives to institutional care;
- are generally less expensive than a nursing home;
- offer the possibility of greater independence and more amenities than the typical nursing home;
- may offer individualized services to meet residents’ preferences and changing needs; and,
- may be billed as facilities in which residents can “age in place.”

ALFs also have significant advantages for *providers*. These include:

- freedom from the burdens and expense of extensive regulatory requirements;
- the absence of governmental involvement in facility development and operations; and,
- the opportunity to respond to individual needs and to create innovative programs.

## LICENSURE POLICIES IN MICHIGAN

**Adult Foster Care Homes.** Adult Foster Care (AFC) facilities house elderly and non-elderly residents. AFC homes provide room, board, personal care and supervision to residents who do not require continuous nursing services. (For state law governing AFC homes, see MCLA 400.701 et seq.) Most AFC homes are small and privately owned and operated. Resident rights within AFC homes depend, in part, on the type of home (different regulatory provisions govern the different types/sizes of AFC facilities. See AC, R. 400.1409 (family homes), R. 400.14304 (small homes), R. 400.15304 (large homes) and R. 400.2418 (congregate homes)). Appendix A lists AFC resident rights that pertain regardless of facility size. There are more than 4,000 AFC homes in the state. As of May 2002, these AFC homes were licensed to provide care for 33,184 individuals.

The Michigan Department of Consumer and Industry Services (MDCIS) Bureau of Regulatory Services is responsible for licensing AFC homes. Regular licensing inspections are to occur on-site at least once every two years. Although the licensing inspection is announced, licensing consultants attempt to make an unannounced visit to each facility in the intervening year between licensing inspections. Moreover, the Office of Fire Safety makes an unannounced visit every year to each facility. An AFC home may also be inspected as a result of a complaint (MCLA 400.724(1)). On-site investigations of complaints are often unannounced. Even if the licensing consultant notifies the provider that he or she intends to conduct and investigate a facility, the consultant may not reveal the nature of the complaint in advance of the visit.

**Homes for the Aged.** Homes for the Aged (HFAs) provide room, board, and supervised personal care to people age 60 and older and accommodate at least 21 residents. HFAs can have fewer than 21 residents if they are a distinct part of a licensed nursing home. (MCLA 333.20106(3)). Many are quite large and some are affiliated with nursing homes. HFAs are

owned by both for-profit and non-profit organizations. There are approximately 188 HFAs in the state. As of May 2002, these homes were licensed to serve 14,577 individuals.

A resident of an HFA has many of the same rights as a nursing home resident under state law (MCLA 333.20201.) See Appendix A for a listing of resident rights in HFAs. Similar to AFC homes, HFAs are licensed by the MDCIS Bureau of Regulatory Services and inspected annually. MDCIS reports significant revisions are currently underway regarding HFA rules, although these changes have not yet been completed.

**Benefits of ALF Licensure.** While licensure requirements for both HFAs and AFCs do impose additional costs and restrictions on facilities, consumers may interpret the fact that the facility is licensed as the state's "seal of approval." Moreover, educated consumers might appreciate their greater rights and remedies in a licensed home and their opportunity to investigate the licensing history of a particular facility. Thus, licensing may be considered a useful marketing tool for facilities.

On very rare occasions, the Department of Attorney General has filed suit against an unlicensed facility for failing to seek licensure. Therefore, homes may seek licensure both to fulfill their legal obligation and to forestall the admittedly remote possibility of a lawsuit.

There are limited financial benefits available only to licensed facilities. The Social Security Administration provides Supplemental Security Income (SSI) for low-income, blind or disabled persons. SSI clients residing in AFCs or HFAs are provided with an additional monthly amount (\$157 for AFCs and \$179.30 for HFAs). If a client qualifies for Medicaid and receives assistance with personal care such as eating and dressing from the provider, AFCs and HFAs can enroll in a model payment system through Michigan's Family Independence Agency for an additional \$174.38/month. Michigan law does not require AFCs or HFAs to accept persons on Medicaid or SSI and many do not since payments are below market-rates.

Finally, while it is difficult to locate unlicensed facilities because of the variety of ways they characterize themselves and the lack of any statewide listing of these homes, licensed facilities are easily identified on the MDCIS website, in Area Agency on Aging and long term care ombudsman lists, and in other information available to consumers.

## CURRENT POLICY CONCERNS FOR UNLICENSED ALFS

### LACK OF DEFINITION

One of the most complicated aspects of developing policy regarding unlicensed ALFs is that there is no single definition of these facilities and the term itself encompasses a wide range of options. In fact, the term “assisted living” is used as a marketing phrase or shorthand for these unlicensed facilities, rather than for regulatory or statutory reasons. Two national ALF trade groups define these facilities from both an operational and philosophical perspective. However, except for the criterion of 24-hour supervision, there is little agreement regarding the operational elements of ALFs. For example, one trade group requires the provision of at least two meals per day while the other does not consider meals as an essential service of an ALF. Additional services are frequently considered to include help with at least two activities of daily living (ADL), recreational opportunities, and housekeeping. From a philosophical standpoint, the trade groups both emphasize autonomy, dignity, and independence. While these characteristics may be present in many Michigan ALFs, one of the state’s ALF trade associations offers no definition of assisted living while the other has simply adopted the definition of its national trade association. (See Appendix C for information on state ALF associations).

It should be noted that a number of states other than Michigan have developed specific policies dependent on a definition of assisted living. For example, Massachusetts determined that there were no substantive distinctions between unlicensed and licensed facilities and therefore, have no unlicensed facilities. Maryland convened an ALF task force in 1995 with recommendations to license all facilities that met the following definition: *a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination thereof that meets the needs of individuals who are unable to perform or who need assistance in performing the activities of daily living or instrumental activities of daily living in a way that promotes optimum dignity and independence for individuals* (Maryland Code Section 19-1801). Legislation was quickly passed based on this definition in January 1996 and regulations took effect in April 1999.



## **ABSENCE OF REGULATORY OVERSIGHT**

Nursing homes are subject to a complex and extensive array of federal and state regulations as well as local zoning, fire and building code requirements. Local requirements and a more modest body of state regulations govern licensed ALFs. In contrast, unlicensed ALFs in Michigan must adhere only to local ordinances. Therefore, no standards exist regarding admission criteria, services, staffing, physical plant characteristics, rental contracts, grievance procedures, or discharge conditions. Moreover, no inspectors with expertise in the care of people with disabilities visit the facilities to ensure compliance with minimum standards; no regulatory body exists to respond to complaints; no sanctions are routinely imposed for neglect, abuse, or exploitation; and no reports or inspections are available for consumers to consider and compare.

ALF providers assert that the lack of regulation enables them to offer more affordable alternatives to nursing homes. They claim that many of the state and federal nursing home provisions require time-consuming documentation or involve other burdensome and costly measures that are not related to the provision of high quality care to ALF residents. The lack of regulation also enables providers far greater flexibility in the development and operation of their facilities although further study is required to determine if ALF facilities actually routinely offer flexible services to suit individual needs and preferences.

An additional argument against governmental licensing and regulation of ALFs is that unlike nursing facilities in which Medicaid is the largest source of funding, ALFs operate in almost all cases with private funds. Providers contend that facilities that do not receive federal and/or state funds should not be subjected to governmental oversight. This position appears to ignore the wide variety of private enterprises, which are regulated because of public safety issues. For example, important regulation within the private automotive industry is necessary due to the enormous public risk involved.

One of the most serious concerns involving licensure and regulation relates to the degree of vulnerability of many ALF residents. Indeed, as ALFs are promoted as facilities in which residents can age in place and/or as alternatives to nursing homes and other licensed facilities, the characteristics of ALF residents are likely to be indistinguishable from those of residents of licensed homes. Moreover, individuals seek ALF services precisely because they suffer from

physical and/or mental impairments, thus making them more vulnerable to abuse, neglect and exploitation and less able to seek redress for these problems. Advocates therefore assert that ALF residents require more protection than the limited legal rights available to mere tenants in other housing situations.

## **AFFORDABILITY**

While ALFs bill themselves as more affordable options in the continuum of care than nursing homes, many of the unlicensed facilities are quite expensive, particularly for low or middle-class individuals. In addition to the basic rental rate, some facilities charge extensive and expensive additional fees for each service the resident opts to receive and many facilities offer luxurious amenities such as health clubs, libraries, and well-appointed lobbies.

Many middle and lower income consumers may have difficulty affording even more modest ALFs because, with the exception of the very limited availability of Medicaid Home and Community Based waiver services in a few facilities, Medicare and Medicaid do not pay for services in ALFs. Thus, once residents have exhausted their private resources in an ALF, even if the ALF continues to be able to meet the resident's needs, residents may be forced to move to nursing homes where Medicaid, and in very limited circumstances, Medicare, will cover the cost of care.

Strategies involving state financing of ALFs appear to increase, rather than decrease use of public resources. However, in the report titled “State Assisted Living Practices and Options: A Guide for State Policy Makers,” co-authors Mollica and Jenkins contend that these costs still are less than what states pay for institutionally based care.\* Given that Michigan is now experimenting with screening tools that would require a higher level of functional disability for community-based services funded by Medicaid amidst the increasing demand for more non-institutional care, states need to be mindful of cost-effective long-term care solutions that are acceptable to the public.

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\* Mollica, R.L. and Jenkins, R. *State Assisted Living Practices and Options: A Guide for State Policy Makers*. National Academy for State Health Policy ([www.nashp.org](http://www.nashp.org))

## **STAFFING AND NATURE OF SERVICES**

Many consumers might think of ALFs as alternatives to nursing homes, but the staffing at ALFs tends to be very different from that of nursing homes. Nursing homes are required to have licensed nurses on duty, to provide at least 2.25 hours of care per resident per day, to provide initial and on-going training to nursing assistants, and to meet certain staff/resident ratios during the day, afternoon, and night shifts. Unlicensed ALFs need not employ any licensed nurses and further, there are no training requirements for the staff or minimum staff/resident ratios. Nevertheless, residents in unlicensed ALFs are likely to need assistance in taking multiple medications and may suffer from numerous, complex medical conditions. Individuals suffering from dementia often require round-the-clock supervision and unlicensed ALFs may have insufficient staff to adequately monitor these residents.

Just as staffing may vary widely at unlicensed ALFs, so too do the services these facilities offer. Some ALFs might provide little more than housing, some meals, and one staff person on duty in case of emergency, while others offer a full range of services including assistance with the administration of medications; transportation; housekeeping; assistance with all activities of daily living; recreational activities; coordination of medical needs; social services; speech, physical and occupational therapy; and rehabilitation services. ALFs may employ sufficient staff to provide these services, have contracts with other providers to serve residents as needed, or may simply help residents coordinate services with the providers of their choice.

The cost of services and method of paying for services also vary. Some facilities offer a comprehensive package for a set monthly fee, some provide basic services and charge for each additional service the resident requires, and some facilities permit residents to purchase services from outside providers. These differing arrangements may be confusing to consumers trying to choose among unlicensed ALFs and the true costs of care in such a facility, particularly as residents' needs increase, may not be easily ascertained.

## **AGING IN PLACE**

Consumers who move into ALFs often hope that these facilities will be their homes for the rest of their lives. Thus, they hope to "age in place" instead of being forced to move to

nursing homes if their needs increase. However, ALFs may not have the services and staffing to care for residents with significant disabilities or be able to arrange for sufficient care in these situations. Nevertheless, residents may choose to accept additional risk to remain in what has become their home rather than face the prospect of moving into a nursing home and loss of the familiar routine and relationships they developed in the ALF.

## **CONTRACTS AND GRIEVANCES**

ALFs have no standardized admissions contract or rental agreement. Some contracts may be extremely short while others may spell out costs, services, grievance procedures, deposit requirements, discharge procedures, when residents will be notified of increases in charges, resident rights, and other obligations of the parties. Because contracts vary, it may be difficult for consumers attempting to choose among facilities to compare the relative costs and merits of different ALFs. Moreover, in the absence of regulation or governmental oversight, the contracts take on great importance because the residents' rights may arise only from the contract itself.

If residents have problems and/or complaints regarding an ALF, they may utilize the facility grievance procedure, if one exists; sue on the basis of the contractual provisions; or simply leave the facility. State and local long-term care ombudsmen have no jurisdiction in unlicensed homes and do not assist residents in resolving complaints. In cases of abuse, exploitation, or fraud, residents may seek assistance from protective services, local law enforcement, or the Department of the Attorney General's consumer protection unit. While voluntary mediation holds promise as a means of resolving certain disputes arising in assisted living, mandatory arbitration clauses are criticized as being "contracts of adhesion" that may deprive consumers of fundamental legal rights and protections.

## **RECENT MICHIGAN ACTIONS**

### **MICHIGAN'S ASSISTED LIVING TASK FORCE**

In 1997 the Michigan Department of Consumer and Industry Services (MDCIS) convened an Assisted Living Task Force to review the need for consumer protections within unregulated ALFs. The task force, which included providers, advocates and government officials, adopted a set of policy recommendations in June 1998. A number of the task force

recommendations were supported by MDCIS, although it is not clear if this endorsement was made public or remained solely as an internal document. (See Appendix B for additional task force recommendations that were not specifically endorsed by MDCIS). The MDCIS report titled “Assisted Living Initiative” contains the following recommendations:

1) Support the development of legislation which will:

a. Utilize the following definition for governing the use of “assisted living” and “assisted living community”:

“Assisted Living” is a business that provides for or arranges supports and services freely chosen by the individual or his or her representative to maintain and/or enhance cognitive and functional capacity, physical and mental health, and personal autonomy.

“Assisted Living Community” is a housing unit or complex that provides assisted living services, directly or through agents in addition to housing.

b. Require a system of registration, clear disclosure of services, resident rights and enforceable contracts for those assisted living communities that are not licensed.

c. Include a list of minimum service options and provide for the uniform definition of terms related to assisted living services including:

“Housing: By definition, housing is included in the services provided by an Assisted Living Community.”

“Other Services: Other services, all of which must be available and may be selected by a resident, include: meals; housekeeping; 24-hour staff; emergency response mechanism and procedures; activities of daily living (ADL) assistance; supervision; activities; assistance with medications; coordination and arrangement of medical/social services; transportation; and a formal grievance procedure. These services may be sold and purchased in specific “bundles” or may be sold individually “a la carte.” If ADL assistance, supervision, assistance with medications or coordination and arrangement of medical/social services are provided directly by the assisted living community or through their agents, a license may be required.”

- d. Establish a minimum assisted living contract terms and resident bill of rights.
  - e. Provide for a central information resource on assisted living providers.
- 2) MDCIS will distribute and use guidelines to assist consumers, providers and the public in understanding when compliance with the adult foster care, home for the aged and nursing home licensing act is required.

### **HOUSING WITH SERVICES CONTRACT ACT**

With the exception of several bills that concern coverage of ALF services within long term care insurance policies and/or adding ALFs to nursing home legislation (i.e. penalties for criminal acts), only one bill has been passed with specific ramifications for unlicensed ALFs. HB 4217, introduced by Representative Judith Scranton, is known as the Housing with Services Contract, and became Public Act 424 effective June 5, 2002.

This new act defines a “housing with services establishment” as a facility that provides leased private units to one or more adults and provides or offers to provide for a fee either one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered directly by the establishment or by another person arranged by the establishment. The Housing with Services Contract Act does not pertain to AFC or HFA or any other facility licensed under the public health code.

Specifically, this law would require a housing with services establishment to operate under a written contract with each resident that would include:

- name, street address, mailing address of establishment; name and mailing address of owner; title and address of managing agent;
- statement regarding whether the housing with services establishment was licensed by a local, state or federal agency;
- term of the contract described in years or months;
- a description of the services the establishment would provide to the resident for the base-rate paid by the resident and additional services available for an additional fee from the establishment or through arrangements with it;
- fee schedules outlining costs of additional services;

- billing and payment procedures and requirements;
- a description of the establishment's complaint resolution process.

An establishment would have to keep the contracts and related documents executed for at least three years after the date of termination of the contract. This law does not require a housing with services establishment to provide a minimum of core services, to serve a specific number of residents or to provide any type of physical plant or facility as long as the establishment is in compliance with state or local codes.

This act may be viewed as laying an important foundation toward greater uniformity of resident contracts, thereby protecting vulnerable individuals living in unlicensed ALFs, a direction strongly endorsed by the Assisted Living Federation of America (ALFA), the largest trade group within the industry. Others argue that this legislation is not enforceable so that contracts in these facilities may not contain the requisite provisions or may not be utilized at all. Furthermore, it should be noted that this act only deals with contractual issues and does not involve any measure of consumer protection or residents' rights as are found within licensed homes. An additional concern with the Housing with Services Contract Act is that some observers allege that we are creating an entirely new and unnecessary type of category within long term care that does not differ in scope or services from licensed facilities. If a facility is already licensed as an AFC home or HFA, this legislation might suggest to facilities that they convert to a housing with services establishment, thereby avoiding licensing/regulation.

## **MICHIGAN ALFS**

### **THE SURVEY**

To obtain a better profile of services and policies within Michigan unlicensed ALFs, a mail survey directed at facility administrators was conducted in the winter-spring of 2002. This survey was approved by the Michigan State University Institutional Review Board and is included in Appendix D. Respondents of the survey were assured confidentiality in which responses from individual facilities would not be reported.

**Sample.** Due to the lack of licensing requirements for ALFs within Michigan, a complete list of facilities was unavailable at the time of this project. Therefore, a list was compiled using a variety of resources. The original intent was to conduct a survey of unlicensed ALFs statewide utilizing databases from the sixteen Area Agencies on Aging (AAAs). AAAs are located in every region of the state and provide a range of services to older persons, including information and referral for senior services issues such as housing options. This strategy proved unsuccessful as many of the AAAs did not have a database of unlicensed ALFs in their regions or provided incomplete or outdated listings. Therefore, the survey conducted for this project focused solely on the greater Detroit and Grand Rapids areas where the greatest concentration of ALFs was likely to be. This included Wayne, Macomb, Washtenaw, Oakland and Livingston counties for the Detroit area and limited solely to Kent County for the Grand Rapids region. An initial list was provided by the AAAs in these regions and the western Michigan office of Citizens for Better Care. These listings were supplemented by a thorough search of area telephone books. Local phone books, however, did not provide an accurate accounting of facilities since few listed “assisted living facilities” as a subheading and many facilities were listed under categories such as “senior housing” or “independent living.” The majority of research was conducted using various Internet sources, including, but not limited to, online phone directories, senior housing locators and assisted living organizations. Once the preliminary list of assisted living and other senior housing facilities was compiled, each facility was compared to the roster of AFC homes and HFA available through MDCIS.

Initially, 167 facilities were identified as ALFs of which 28 were eliminated from the final sample because they were licensed as either AFC/HFAs (17 facilities) or were closed and had no forwarding address (4 facilities). Seven surveys were returned incomplete because the facilities identified themselves as independent living facilities and believed their responses would not be relevant to the study. After an initial mailing and a follow-up mailing to non-respondents, surveys were received from 62 of 139 potential facilities. The response rate for Grand Rapids was 30% (12 of 40) and 50% (50 of 99) for the Detroit region, representing a 44% response rate for the overall sample. The final sample was comprised of 19% of respondents from Grand Rapids with the remaining 81% located in the Detroit region.



**Findings.** As seen in Table 1 below, nearly three-fifths of the ALFs in the sample had been open for five years or more and two-thirds of homes surveyed were for-profit. Seventy percent of the for-profit homes were part of a corporate chain, representing nearly half of the sample in this study. On average, there are 100 units available per facility, and were able to accommodate 120 residents since double-occupancy units were available. The capacity of available units ranges between 5 and 306 within the sampled facilities. Occupancy rates mirror those of current nursing home rates, averaging 84%, again with wide variation among facilities from 20 to 100%. The modal response, however, was 100%. Occupancy levels were highly correlated with costs of services. Facilities with higher monthly costs were associated with greater occupancy rates ( $r=.83$ ).

Respondents were asked how they referred to their facilities. While 20% referred to their facilities as strictly ALF, another 33% referred to themselves as ALF plus one or more additional label(s), such as retirement living, or independent living. Seventeen percent of facilities were marketed solely as “senior housing.”

**Table 1.** Facility Characteristics

	<b>Percent/(n)</b>	<b>Mean/(sd)</b>
<b>Facilities open &gt;5 yrs</b>	57(33)	
<b>For-profit status</b>	66(40)	
<b>Self-identify solely as ALF</b>	20(12)	
<b>Self-identify as ALF + 1 or 2 additional labels</b>	33(19)	
<b>Size (units available)</b>		100(60) Range 5-306
<b>Size (resident capacity)</b>		120(75) Range 12-300
<b>Occupancy rate</b>		84(19) Range 20-100

Table 2 illustrates resident characteristics within the sampled facilities.

**Table 2.** Resident Characteristics

	<b>Mean (sd)</b>
<b>Age</b>	82 (6) Range 54-90
<b>Length of stay (months)</b>	36 (17) Range 6-90
<b>Percent of residents needing ADLs assistance</b>	38 (34) Range 0-100
<b>Percent of residents with legal guardian/conservator</b>	22 (29) Range 0-100

Table 3 displays a ranked listing of the conditions/behaviors determining admission in ALFs.

**Table 3.** ALF Admitting Conditions

<b>Percent of Facilities Admitting</b>	
Wheelchair bound	75
Needs oxygen	75
Mild cognitive impairment	72
Ventilator	46
Assistance with ADLs	43
Catheter	38
Incontinent	30
Non-ambulatory	30
Behavioral problems	18
Significant cognitive impairment	16
24-hour mental health supervision	12
Require two-person transfer	11
24-hour skilled nursing care	10
Danger to self	11
Elopement risk	5
Danger to others	2

Two-thirds (68%) of facilities provide assistance with medications. This assistance consisted of 45% reminder only, 37% delivery/dispensing or 18% both reminder and delivery. The majority of facilities did not have a nurse on staff. Only 28% of facilities reported having an RN employed at the facility. Several facilities noted that they contracted nursing services. There were no significant differences regarding type of assistance based on availability of a nurse on staff. For example, 36% of facilities without a nurse on staff dispensed medications compared to 37.5 % with a nurse on staff.

The most common payment arrangement is a basic monthly fee with additional costs for supplemental services such as laundry, assistance with activities of daily living, or medication dispensation. ALF charges vary widely ranging from \$620-3,500 per month. The average monthly cost among sampled facilities is \$1,824. Seventy percent of ALFs require an entry fee/deposit ranging from \$250-6,000, with \$500 the most frequently cited amount (amount required in 36% of facilities). Nearly all (97%) facilities provide written notice in advance of rate increases to residents.

Most facilities require a contract prior to admission (83%), although there appears to be variation in what the contracts contain. Of those facilities requiring contracts, 80% specify costs of services, 71% contain policies regarding rate hikes and 77% denote specific discharge policies. Only 32% of contracts include language regarding grievance procedures. Of the 32% of facilities that have grievance procedures specified in their contract, few elaborated on what this procedure entails. Several noted that the grievance procedure simply involved discussing problems with the ALF director. One facility cited arbitration/litigation as an avenue for resolving problems.

## **DISCUSSION**

Based on the findings of this study, it appears that there is wide variation in both cost and size of ALFs within the state. At an average rate of nearly \$1,824 a month, the financial ability of low to middle-income individuals to “age in place” may be limited. It should be noted that this figure does not necessarily represent expenses beyond basic services and thus the actual costs are probably even higher. Nonetheless, these costs are still significantly below average monthly

costs for skilled nursing home care (\$3,000-4,000 a month) and the majority of facilities in this sample report full or nearly full occupancy.

The absence of a clear definition or understanding of what constitutes an ALF is apparent from this data. A number of facilities specifically referring to themselves as ALFs use two or more additional definitions. Even identifying ALFs for this study with information available from the aging network and telephone books presented a serious challenge. This challenge is certainly greater for individuals and their families trying to locate and/or compare facilities in the time of a health crisis—a task that is often filled with much anxiety and confusion.

Most facilities require a contract for admission that includes policies regarding costs, rate increases and discharges. It should be noted, however, that although a facility may have an admission and discharge policy in place, setting these policies is completely at the discretion of the provider. For example, residents may be provided only a few days notice of discharge, generally too short a time for families to find an alternative setting for their loved one. The fact that the majority of facilities in this setting report having a contract in place is significantly different from the findings of a recent study by the General Accounting Office (GAO). In 1999 the GAO found that among the four states studied, consumers were not routinely given a copy of the contract or information about discharge policies, or covered services (GAO-HHS-99-27). Similar to the GAO report, this study found that grievance policies are not commonly included in resident contracts. Since there is no governmental oversight of ALFs, residents may lack direction or recourse if problems arise. Several survey respondents noted that residents should discuss problems with facility management. This may be difficult for a resident or family member who is concerned about retribution including possible discharge.

Results of this study suggest that a social model of care is often provided in Michigan ALFs with no medical personnel on staff or available most of the time. This raises serious questions given the advanced age and associated care needs of many ALF residents. Furthermore, untrained personnel are commonly assisting residents with medications, including dispensing. It appears that ALFs are willing to admit residents with a wide range of health problems and clinical conditions. Individuals with more severe mental health problems are less likely to be admitted, such as those with significant cognitive impairments and behavioral problems who are a danger to self/others or pose an elopement risk. However, given the

downward trajectory of most cognitive impairments, such as Alzheimer's disease, it is unlikely that those individuals admitted with mild cognitive dysfunction will be able to remain in the facility over time. Since few facilities employ trained medical personnel, it is interesting to note the relatively high percentage of facilities that admit residents dependent on oxygen and ventilators. This is troubling, because managing chronic illnesses, particularly those with high mortality risks such as pulmonary diseases, is complex and generally requires skilled care.

Overall, these data indicate that an average ALF resident is in his or her 80s, a period in which multiple chronic conditions, including dementing illnesses, are highly prevalent. Since the vast majority of facilities do not employ medical personnel, further study is required to understand how ALFs are managing to meet the health needs of their elderly residents with relatively untrained nursing staff and whether turnover of frontline staff within this industry matches the worrisome levels found in nursing homes.

## **POLICY RECOMMENDATIONS**

**Clarify Whether there are Significant Distinctions Between Residents Served Within Licensed and Unlicensed ALFs.** The results of this initial study indicate a high level of vulnerability among residents in Michigan's unlicensed ALFs, although it did not include a direct comparison to licensed AFC homes and HFAs. Further research is needed to document the extent of mental and physical impairments within unlicensed ALFs, and the resultant need for consumer protection. These efforts should extend beyond self-reported survey data, and include measures of clinical functioning and disability within ALFs. This information would be useful not only for purposes of understanding the level of vulnerability among residents, but also for gauging associated care needs and staffing levels. While the primary purpose of the Michigan Assisted Living Task Force was to assess the need for consumer protection, little has been accomplished since then to move beyond this stated goal. The new Housing with Services Contract Act is based on a very broad definition of a "housing with services establishment." Publicly licensed homes such as AFCs and HFAs are excluded from this definition, although the level of services and care provided may be identical. Therefore, gathering data on distinctions within these various settings is important not just to consumers, but also for effective public policy implementation.

**Examine the Appropriateness of the Two-tier ALF System in Michigan.** If additional research indicates a lack of significant differences in the residents served in licensed and unlicensed homes, there is a strong rationale for ensuring identical protection for these vulnerable individuals. If unlicensed ALFs operate in a similar manner to HFAs or AFC homes, serving the same population of frail individuals, the State of Michigan should consider licensing and providing ongoing oversight of these facilities. Furthermore, penalties might be imposed on those ALFs that meet these definitions, but do not seek licensure.

**Create a State-funded Advocate for ALF Residents in Unlicensed Homes.** Consumers seeking information or advice about licensed facilities can contact the State and Local Long Term Care Ombudsman programs. The staff of the ombudsman program is knowledgeable about licensed facilities and the regulations that govern them and has certain limited statutory authority to protect residents in these facilities. Currently however, Ombudsmen have no funding or statutory authority to assist residents of unlicensed facilities and typically know little about these facilities. If there is evidence that residents in unlicensed ALFs are as vulnerable as those in licensed facilities, it is important that these individuals be provided an advocate or “voice” on their behalf. They could provide information and mediate disputes between residents and ALFs just as ombudsman do in licensed facilities. Given there is no central source of information regarding ALFs, advocates could also offer local referrals to ALFs that seem appropriate to consumers’ needs. Additional state funds would be required to create ALF advocate positions and/or to increase the number of long term care ombudsmen within the existing network.

**Develop Affordable ALF Options.** Greater ALF options need to be developed for low and middle-income individuals. Except in the nursing home context, Medicaid can pay for long term care *services*, but not for room and board costs. Too often, low-income individuals requiring long term care who do not actually need institutional care are nevertheless forced to seek admission to a nursing home. This may occur because low-income consumers cannot afford less restrictive options such as in-home care or care in an AFC home, HFA, or ALF, but can qualify for Medicaid coverage of their nursing home stay. However, state policymakers could set limits on what Medicaid beneficiaries can be charged for room and board in community settings. As is the case with a number of other states, Supplemental Security Income (SSI) along with a state-supported SSI supplement could cover room and board in ALFs. This approach is partially

contingent on finding providers who will admit residents with SSI (minus some personal needs allowance which the resident would keep for personal expenses), a state SSI supplement for room and board costs, and Medicaid for the service component of their care. It is however a promising direction for the future as it capitalizes on available state *and* federal resources to offer ALF as an option to a wider range of individuals. Medicaid Home and Community Based Waiver funding, for supportive services in home and community settings, might also be used in ALFs as it is in a number of states, such as Oregon.

## **CONCLUSION**

The goal of this paper was to provide background, empirical evidence and policy direction regarding unlicensed ALFs in Michigan. Currently, Michigan consumers have a confusing array of choices and often make choices based on physical amenities of facilities, rather than the licensing, quality and/or level of care provided. Although the Michigan Assisted Living Task Force provided a forum for initial discussions and recommendations, the follow-up work and necessary legislation has not occurred. Nearly five years later, the term “assisted living” remains a vague term and individuals who live in unlicensed homes have far fewer rights and protections than their counterparts who reside in licensed facilities. With increased competition, it may be that individuals are free to “vote with their feet” and choose a facility which best suits their needs. The results of this research however, suggest that this is an unlikely event. Individuals in their mid-80s with multiple health problems, particularly mental impairments, are reluctant to move even if dissatisfied, and often adjust poorly to relocation. Since ALFs are believed to be the fastest growing segment of the long-term care market nationwide, outstripping a stagnant nursing home industry, the need to better understand issues pertaining to actual structure, outcomes and consumer protection is paramount.

## **APPENDIX A – RESIDENTS RIGHTS**

### **RESIDENTS RIGHTS IN ADULT FOSTER CARE (AFC) FACILITIES**

1. The right to be free from discrimination.
2. The right to exercise his or her constitutional rights, including the right to vote, to practice his or her religion, the right to freedom of movement, and the right to freedom of association.
3. The right to refuse participation in religious practices.
4. The right to write, send, and receive uncensored and unopened mail at his or her own expense.
5. The right to reasonable access to a telephone for private communications
6. The right to voice grievances.
7. The right to reasonable access to and use of his or her personal clothing and belongings.
8. The right to have contact with relatives and friends and receive visitors in the home at a reasonable time.
9. The right to be treated with dignity, and with recognition of the need for privacy.

### **RESIDENTS RIGHTS IN HOMES FOR THE AGED (HFA)**

1. The right to be free from discrimination on the basis of race, religion, color, national origin, sex, age, handicap, marital status, sexual preference or source of payment.
2. The right to inspect or to receive, for a reasonable fee, a copy of his or her medical record.
3. The right to confidential treatment of personal and medical records.
4. The right to privacy, consideration, respect, and full recognition of his or her dignity and individuality.
5. The right to adequate and appropriate care, to know who is responsible for the care, and to information presented in a way he or she can understand about his or her medical condition and treatment unless such information would be medically contraindicated as documented by the attending physician.
6. The right to refuse treatment and to be informed of the consequences of that refusal. However, exercise of this right might result in the facility seeking to discharge the resident after appropriate notice if the refusal of treatment prevents the HFA from providing appropriate care according to ethical and professional standards.
7. The right to exercise his or her rights as a citizen and to present grievances without fear of restraint, interference, coercion, discrimination, or reprisal.
8. The right to receive and examine an explanation of his or her bill and an explanation of financial assistance that may be available.
9. The right to associate and have private communications and consultations with his or her physician, attorney, or any other person and the right to receive personal mail unopened on the same day it is received, unless the attending physician documents that access to mail is contraindicated.



10. The right to civil and religious liberty, including the right to independent personal choices and the right to meet with and participate in social, religious and community groups at his or her discretion, unless medically contraindicated as documented by the attending physician in the medical record.
11. The right to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician for a specified and limited time or as necessitated by an emergency to protect the resident from injury to self or others.
12. The right to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other patients or residents, or unless medically contraindicated as documented by the attending physician in the medical record.
13. The right to participate in planning his or her medical care and his or her discharge planning, if appropriate.
14. The right to be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for nonpayment of his or her stay.
15. The right to be fully informed at the time of admission and thereafter of services available in the facility and the cost of those services.
16. The right to manage his or her own financial affairs or, if the resident delegates management of his or her funds to the facility, the right to at least a quarterly accounting and a monthly itemized statement of services provided to the resident and services paid for by or on behalf of the resident.
17. The right to meet privately with his or her spouse and, if both spouses reside in the HFA, the right to share a room unless medically contraindicated and documented by the attending physician in the medical record.
18. The right to refuse to work for the HFA unless such work is included for therapeutic purposes in the plan of care.

## **APPENDIX B - ADDITIONAL RECOMMENDATIONS BY MICHIGAN'S ASSISTED LIVING TASK FORCE**

1. People have the right to make choices for themselves.
2. People should be assumed to be competent to make their own choices (or if not, they should receive assistance).
3. Consumers have the right to be educated and informed, including clear information on the provider and services they are purchasing.
4. The delivery system needs to accept that choice may involve risk. It is possible that a consumer may make a decision that others consider to be a "bad choice."
5. The delivery system must be reasonably easy to implement.
6. The delivery system must include a strategy for implementation that can evolve from current systems as the opportunity permits and can be implemented sequentially as portions of the systems are developed and operational.
7. The delivery should promote excellence, not just measure compliance with standards.
8. Prior to move-in it should be recommended to all applicants that they may benefit from the independent assessment of their medical, social, personal housing and financial needs.
9. Funding must follow the individual.
10. Assisted living must provide information on staffing and on the qualifications of the workforce.
11. The workforce must focus on customer satisfaction.
12. The workforce should promote excellence, not just compliance with standards.
13. Standards should promote best practice.
14. Services may be separate from housing.
15. Recognition that assisted living is a "home" setting and that all the rights available in a person's home be available.
16. Degrees and levels of assisted living should be available according to what services the person needs or desires.
17. Housing should support "aging in place" and extend an individual's independence for as long as possible.
18. Efforts to keep assisted living affordable and accessible to low and middle income individuals should be pursued, including the conditions of public benefits including housing subsidies, community-based long term care services, adult home health benefits, food stamps and Supplemental Security Income (SSI).
19. A formal written grievance procedure must be provided to all residents upon moving and whenever the procedure is amended.

## **APPENDIX C - STATE ASSOCIATIONS & CONSUMER CONSORTIUM**

### **STATE ASSOCIATIONS**

In addition to several national trade associations, Assisted Living Federation of America (ALFA) and National Center for Assisted Living (NCAL), two organizations represent ALF providers in Michigan:

**Michigan Assisted Living Association (MALA).** MALA is a nonprofit organization representing 4,300 assisted living, residential care and vocational programs serving more than 32,000 individuals with developmental disabilities, psychiatric disabilities, physical disabilities, closed head injuries, or persons who are elderly. Originally incorporated in 1967 as Statewide Care Home Association, the organization became Michigan Assisted Living Association as of October 1997. According to the organization, assisted living reflects a philosophy of care rather than a particular service or housing model.

As a state affiliate of the national Assisted Living Federation of America, MALA is governed by a 10-member board of directors representing the state on a regional basis. The Association's administrative staff includes four attorneys, a membership services director, a director of communications, and various support staff. MALA's membership benefits include monthly newsletters and special reports, legal consultation, legislative advocacy and training programs.

**MALA: 15441 Middlebelt Road, Livonia, MI 48154 - (800) 482-0118**

**Michigan Center for Assisted Living (MCAL).** MCAL is the assisted living division within the Health Care Association of Michigan (HCAM), the trade association representing more than 400 for-profit nursing homes. MCAL began in 1999 to address the specific needs of assisted living professionals and consumers. Its key function is providing professional development tools and training, as well as advocacy and a collaborative statewide voice for the successful management and operation of members' assisted living facilities.

**MCAL: P.O. Box 80050, Lansing, MI 48909-0050 - (517) 627-3016**

### **CONSUMER CONSORTIUM ON ASSISTED LIVING**

Michigan does not have a separate advocacy organization representing consumers or residents within ALFs. On a national level, the Consumer Consortium on Assisted Living (CCAL) is a non-profit membership organization of consumers, caregivers, advocates, researchers and providers who examine issues within ALFs. The CCAL mission is to ensure quality care; resident rights and protections; affordable options for individuals with low and moderate incomes; and information and resources to assist consumers in making informed choices. CCAL recently released its consumer guidebook for selecting a facility titled "Choosing an Assisted Living Facility: Considerations for Making the Right Decision."

**CCAL: P.O. Box 3375, Arlington, VA 22203 - (703) 533-8121 - [www.ccal.org](http://www.ccal.org)**

**APPENDIX D - ASSISTED LIVING SURVEY**

**OWNERSHIP**

When did your facility open? (month/year) \_\_\_\_/\_\_\_\_

Is your facility for-profit: \_\_\_ Yes \_\_\_ No

If yes, is it corporate-owned (one of multiple facilities) \_\_\_ Yes \_\_\_ No

Is your facility licensed by the State of Michigan as a Home for the Aged (HFA) \_\_\_ Yes \_\_\_ No

How do you refer to your facility (Please check all that apply)?

\_\_\_ Assisted Living

\_\_\_ Retirement Home

\_\_\_ Residential Housing facility

\_\_\_ Senior Living

\_\_\_ Other (Please specify) \_\_\_\_\_

Do you have an RN on staff? \_\_\_ Yes \_\_\_ No

Does your facility provide assistance with taking medications? \_\_\_ Yes \_\_\_ No

**RESIDENTS**

How many units in your facility? \_\_\_\_\_

What is your current occupancy rate (percentage)? \_\_\_\_\_

What percentage of residents has a legal guardian or conservator? \_\_\_\_\_ %

What is the average length of stay for a resident? \_\_\_\_\_

Please estimate the *average* age of your current residents \_\_\_\_\_ years

What percentage of residents needs assistance with 1 or more ADLs \_\_\_\_\_ %

**COSTS**

Does your facility require an entrance fee? \_\_\_ No \_\_\_ Yes → Amount \$ \_\_\_\_\_

Which of the following describes the costs at your facility?

(check one)

\_\_\_ **all-inclusive** (residents pay a flat monthly fee for all services Amount \$ \_\_\_\_\_)

\_\_\_ **basic/enhanced** (basic services included in a flat fee with additional services available on a fee-for service basis)

\_\_\_ **service level** (residents with higher levels of need receiving more services at a higher cost)

Does your facility participate in the State of Michigan Medicaid Waiver program? \_\_\_ Yes \_\_\_ No

Does your facility accept SSI (supplemental security income) as payment? \_\_\_ Yes \_\_\_ No

Please check under which conditions your facility would admit *and* retain a resident:

	Will Admit	Will Retain
<b>Physical</b>		
Is wheelchair bound		
Unable to self-manage incontinence		
Is not ambulatory		
Requires two-person transfer		
Is unable to perform ADLS without assistance		
<b>Cognitive</b>		
Is mildly confused		
Is significantly cognitively impaired		
Requires 24 hour supervision for mental health needs		
<b>Special Nursing Care</b>		
Uses oxygen		
Uses a catheter/ostomy		
Uses a ventilator		
Requires 24 hour skilled nursing care		
<b>Behavioral</b>		
Has behavior problems		
Is a danger to self		
Endangers safety of others		

**CONTRACT**

Is a down payment or security deposit required? \_\_\_ Yes \_\_\_ No

↘ \$ \_\_\_\_\_ Amount

Are residents provided with advance *written* notice of rate hikes? \_\_\_ Yes \_\_\_ No

Does your facility require a signed contract before admission? \_\_\_ Yes \_\_\_ No

**(If you answered no to this question, you are finished with the survey. Thank you for your time)**

Are costs of services included in the contract? \_\_\_ Yes \_\_\_ No

Is your policy regarding rate hikes included in the contract? \_\_\_ Yes \_\_\_ No

Is there a grievance procedure included in the contract? \_\_\_ Yes \_\_\_ No

Please specify what this is \_\_\_\_\_

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