AN OVERVIEW OF ADULT FAMILY/BOARDING HOMES IN WASHINGTON STATE: A NEED FOR AN ONGOING QUALITY IMPROVEMENT PROGRAM

By

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ABSTRACT

An issue that challenges our society today is how to provide support for our elders so that they can "age in place." As an elderly person's needs change, he or she may have to move from an independent setting (such as their own home) to a setting designed for more hands-on nursing care. In Washington State, models called Adult-Family Homes, or Boarding Homes are being promoted as viable means to help elders age in place and give residents an opportunity to remain in a homelike environment until death. This paper discusses the Adult-Family/Boarding Home programs in Washington State and compares them with similar facilities in other states. Methods of assessing the quality of resident-care in these community facilities are presented.
INTRODUCTION

The purpose of this paper is to discuss the Adult-Family-Home and Boarding Home programs in Washington State and to compare Washington State facilities with similar programs in other states. Methods of assessing quality of resident care in these community facilities as well as other community-based settings will be presented.

An issue that challenges our society today is how to provide support for our elders so that they can “age in place.” The term age-in-place represents many different concepts to health professionals. As an elderly person’s needs change, he or she may have to move from an independent setting (such as their own home) to a setting designed for more hands-on nursing care. In Washington State, models called Adult-Family Homes, or Boarding-Homes are being promoted as viable means to help elders age-in-place and give residents an opportunity to remain in a home-like environment until death. Support services such as visiting nurses and hospice-care are available to allow residents to remain in these alternative settings thus reducing the need to transfer residents to a nursing home if their health-status deteriorates with the aging process.

ADULT FAMILY HOMES AND BOARDING HOMES IN WASHINGTON STATE

Currently, there are no national standards or requirements for either Adult Family Homes or Boarding Homes. The general public and many health professionals lack an understanding of the programs. A lack of consistent terminology has contributed to this confusion. Some health professionals use the terms Adult-Family-Homes interchangeably with Boarding-Homes, which is not correct for the State of Washington programs.

In Washington State, Adult-Family-Homes are licensed to provide personal care for no more than 6 individuals, who must be at least 18 years of age. On-site nursing staff
is not a requirement for these facilities, which must comply with Washington Administrative Codes (WAC 388-76).

Boarding-Home means any home or other institution, however named, which is advertised, announced or maintained for the express or implied purpose of providing board and domiciliary care to three or more aged persons not related by blood or marriage to the operator. These facilities must comply with Washington Administrative Codes (WAC 388-78A). The Boarding Home program includes the "Assisted-Living" facilities and some of these facilities are required to have Registered Nurses and other health professionals on staff. According to current statistics available from Residential Care Services (a Division of the Washington Department of Social Health Services Agency), there are approximately 2500 Adult-Family Homes and 450 Boarding-Homes in Washington State.

Many elders require assistance to perform activities of daily living (ADLs), such as bathing, dressing, eating, transferring, or toileting, or instrumental activities of daily living such as preparing meals, shopping, housework, taking medication, and managing money. Boarding-Homes and Adult-Family Homes are alternatives to nursing homes, and combine the medical aspects of long-term care with a model of supportive housing and social services. Characteristics that distinguish these residential care settings from other models of elderly housing (such as nursing homes) are their philosophy, setting and services. There is a balance between controlling and allowing for the independence of residents. These alternative settings are "homelike" with resident rooms decorated with personal furnishings. Residential homes are used instead of institutional buildings, and
group dining with caregivers replaces resident dining rooms. The care and services available and required in these residential-care settings vary from state to state.

The available literature regarding alternative community programs in other states is extremely limited. According to Kane, Kane, Illston and Nyman (1991), Oregon State Adult Family Homes are licensed for no more than 5 individuals. According to owners who have licensed Adult Family Homes in Idaho, annual inspections are pre-announced, in homes who are licensed for 6 or fewer individuals. In Hawaii, Adult Family Homes are licensed for 4 individuals and the home owner must live on-site (Davis, 1982). Specific details of other state community programs are not available.

HISTORY OF ADULT-FAMILY HOMES/BOARDING HOMES

A review of the literature on Adult-Family Homes/Boarding Homes identified few articles regarding the history of these community-based programs. The National Library of Medicine HealthSTAR data base included articles focusing on substandard care being given in family homes, and the qualifications of individuals who own and staff the homes. Such issues of this fast growing industry and the inadequacy of current regulatory policies will be discussed later.

According to an article by Hoffman and Romero (1994), adult foster care began in the early 1980's as a homelike alternative to traditional nursing homes—for those individuals who needed supervision and assistance but not continuous nursing care. The term “boarding-out-care”, although somewhat analogous to adult-family-homes in the United States, has a longer history in the United Kingdom (Ware, 1988). In 1858, psychiatric patients were first cared for in Scotland when non-relatives began taking them
into their homes. By 1867, Scotland's program was relatively well developed and served as a model for development of the first adult foster care program in the United States in 1882 in Massachusetts (Ware, 1988).

CHALLENGES FOR THE NURSING PROFESSION

Members of the public who work in the gerontology field have, for a long time, been concerned with conditions in the adult-family-home/boarding home care industry. While the public is now aware of issues such as criminal background of providers and staff, tracking of abusive workers and public access to complaints, nursing's concerns for the foster care industry go much further. Although individuals may enter the family-home/boarding home essentially well, needing support for such activities as eating and hygiene, many eventually need nursing care. Frequently, health care needs go unrecognized until there is an emergency.

Though there is no requirement to do so, some adult-family homes have contracted with nurses to provide oversight of the resident's care needs. In other cases, home health nurses are involved for a limited time after a health crisis has occurred. Hoffman and Romero (1994), advised that when a Registered Nurse (RN) is involved, one can reasonably expect that a resident's health care needs will be met because there is a mechanism for assessment and intervention. These authors further stated that RNs can delegate certain tasks to foster home workers (nurse delegation) which allows the resident to remain in a familiar and desired setting.

Recognizing the value of adult-foster/boarding home care to a population which is rapidly aging, nurses should be working with advocacy groups to bring about changes in regulations which will address safety, respectful care and access to both personal care and
health care. Pressure from nursing professionals, as well as highly publicized incidents such as those reported in the media, have resulted in modifications to current regulations in the State of Washington.

The lack of a precise definition of these residential care settings and the differences in services provided underscore the need for standardized, comprehensive assessment tools and procedures to ensure a good match between the elderly person and the facility. In addition, there is a need to address the emphasis of shared responsibility and risk between caregivers and elders and its effect on nursing practice. Pressure to keep costs for these alternative programs affordable challenges nurses and caregivers to examine their practice for cost-cutting measures. This pressure has the potential for affecting the quality of services provided to elderly clients.

There can be no doubt that, as the elderly population increases, there is a need to provide alternative models of housing and health care. The elderly have become a vocal group, defining their needs and demanding their rights. New models of residential care settings, i.e., adult-homes, boarding-homes, allow elders to age in place, and nurses are called upon to address the challenges this will have on their practice. One implication of these changes is the need to alter the directive focus of our practice to a more assistive model to include boarding and adult-family homes.

At this time, in Washington State, there is no system for determining the quality of resident care/services within the Adult-Family-Home Program, other than the annual “inspection process.” However, in January, 2000, Washington State added a “quality improvement program” (per RCW 74.39A, Long Term Care Services Options-
Expansion) for the Boarding Home program in addition to the current annual “inspection process.” The addition of this new program is an attempt to improve the quality of life and quality of care for residents’ living in boarding-homes in this state.

With the escalating cost in elderly care services, consumers are demanding that more control be placed on managing the cost of care as well as on managing clinical outcomes. This presents opportunities and challenges for nurses to demonstrate quality improvement and effective outcome management for elderly clients. The following literature review explores quality of services in similar types of facilities.

**MEASURING QUALITY OF CARE BY ASSESSING AND EVALUATING OUTCOMES**

Ludwig-Beyer, Ryan, Johnson, Hennessey, Gattuso, Epsom and Czurylo (1993), postulated that patient satisfaction with quality of care was an important consideration in today’s health care environment. First, the level of patient satisfaction may reflect the quality of care actually received. Failing to meet the customer’s expectations of quality results in customer dissatisfaction and usually indicates poor quality. Second, patient satisfaction is essential for attracting patients in the highly competitive health care environment.

Smith and Bezon (1998), outlined the selection of outcome assessment instruments used in home care. These authors indicated that with the shift of services, the majority of mental health clients were being managed in the home or community settings. According to their literature review, 85 percent of older adults needing mental health services are not being reached. These researchers noted that community-based and home care are the fastest growing segments in our society, with the number of home-care-agencies
growing from 208 in 1961 to over 17,500 by 1995 (p.52).

According to Smith and Bezon (1998), traditionally, assessment of outcomes focused on an investigational research method in controlled, experimental conditions. In mental health, a shift has occurred from this research focus to an assessment of clients’ outcomes under naturalistic conditions in hospitals, outpatient services, and home care. The naturalistic approach to measuring outcomes provides the practitioner with measures of structure and process. According to these authors, an effective mental health outcomes management program should measure symptoms, symptom clusters and symptomatic improvement, functional status related to the ability to participate in day-to-day activities, and client/family satisfaction.

In response to the consumer movement, health care organizations have become interested in obtaining feedback through face-to-face contacts with the people using their products and services. Beaudin and Pellitier (1996), described focus groups as one qualitative research method of obtaining information within a social context. Their article described the purpose, design, and methodology of focus groups. They described focus groups as group interviews that were time limited, open-ended, and flexible. It essentially was an interview with a small group of people on a specific topic.

As the area of outcomes research continues to grow, individual researchers or teams of researchers in healthcare organizations who are responsible for evaluating quality of care will have opportunities to develop customized quality assessment programs. Any health care organization can use the face-to-face contact of focus groups to add to their existing knowledge and yield data about how well services are being delivered and patient satisfaction.
The following is a partial list of research compiled on the subject of quality of care and quality of life in adult-family homes, or similar facilities called by a different name (i.e., adult foster home, boarding-out-care, boarding home, assisted-living, etc.).

REVIEW OF THE LITERATURE

The literature available on community alternative programs such as adult-family homes/boarding homes was limited. No comprehensive research studies were available for critical review. Articles consisted of information gathered from caregiver and client interviews.

According to an article by Eckert and Lyon (1991), information about board-and-care homes reported in the media and in federal committee hearings indicated that board-and-care homes are shoddy and exploitative environments that did not provide adequate care. However, they cited some research performed in board-and-care homes in recent years, that demonstrated that these facilities could provide adequate care and a satisfying environment for some of the people they served. They recommended that policy at the federal, state, and local levels should be guided by the need to assure the health and safety of residents.

Stark, Kane, Kane, and Finch (1995), researched the effects on physical functioning of substituting adult-foster-care for nursing home care. Data from Oregon’s Medicaid agency was analyzed to compare change in activities of daily living (ADL) functioning of 1,032 nursing home and 279 adult-foster-care (AFC) residents. Findings indicated that one-third of surviving AFC residents would have been better off in a nursing home, whereas almost all nursing-home residents were placed appropriately. The authors
concluded by stating that further research on outcomes that clients value most along with efforts to support functioning are needed.

LITERATURE REGARDING DEVELOPMENTALLY DISABLED CLIENTS

Seys, Duker, Salemink, and Franken-Wijnhoven (1998), examined the effects of resident behaviors and resident characteristics on the quantity and quality of care received from direct-care staff. Four hundred and fifty residents with severe and profound mental retardation and 416 direct care staff members were involved in this study. Naturalistic observations (observations conducted in a natural/normal environment for participants) were conducted on direct-care staff behavior, that is, staff-resident initiatives, staff affection, staff communicative behavior, on resident behaviors (i.e., maladaptive, stereotypic, and adaptive behavior, position and attending, and communicative behavior), and on resident characteristics (i.e., gender, age, ambulancy, sensory handicaps, and seizure disorder). Residents' ambulatory/motor skills, communicative behavior, and attending behavior accounted for the greatest differences in the quality and quantity of the care they received from direct-care staff. Seys et. al. (1998), concluded that certain resident characteristics can be ameliorated through training, residents themselves may influence, to a certain extent, the care they receive from direct-care staff in residential facilities.

Hatton, Emerson, Robertson, Henderson and Cooper (1995), researched the costs of residential services for adults with multiple disabilities. These authors reviewed the costs and quality of four different service models for 40 adults with multiple disabilities. The four service models were: specialized institution based units; a specialized, campus style, further education service; specialized community-based group
homes; and "ordinary" community-based group homes. These authors reported that on almost all measures of service outcome the specialized group-home model was the "preferred" service model. This model was not associated with particularly high service costs. Perhaps quality care, as determined by client satisfaction, need not be the most expensive care? There was, however, considerable variation in quality within, as well as between, service models, with some residents in all service models experiencing levels of support similar to those found in traditional institutions. A weakness of this study was a lack of discussion regarding the measurement tool and subsequent statistics.

LITERATURE REGARDING ELDERLY CLIENTS

Shepherd, Mujen, Dean and Cooney (1996), studied residential care in hospital and the community. They indicated that the reduction of beds in long-stay hospitals has led to concerns over the quality of care offered to the remaining residents as well as that provided in the community. This study was an attempt to compare the quality-of-care and quality-of-life (reported client satisfaction) from residents in both types of settings. These writers used a cross-sectional comparison of community residential homes and hospital wards drawn randomly from lists provided by local authorities in the outer London area. Results indicated that in general, the most disabled residents were found to be still living in the hospitals in the worst conditions and receiving the poorest quality of care. Although there were some problems with missing data, hospital residents also seemed most dissatisfied with their living situation. There were few differences between community providers regarding either the quality-of-care provided or the levels of reported satisfaction. The authors postulated that purchasers and providers still need to
give attention to the problems of selectively discharging the most able residents to the community, while leaving the most disabled being cared for in progressively deteriorating conditions.

Ware (1988), researched the advantages and disadvantages of Boarding-Out-Care for elderly people. He noted that boarding out care is a common living situation in the United Kingdom. One to four adult clients reside in a private home, the owner of which provides board, lodging, and personal care services and is supervised by a local government authority or volunteer human service organization. A questionnaire was mailed to 34 owners of these homes. In addition, information was obtained via interviews with clients of the homes. Interviews focused on what they clients regarded as advantages and disadvantages of boarding out care. Two major aspects of such care were discussed: (1) the relationship between caregiver and client, and what this means for the client; and (2) the material benefits and problems of boarding out care. The author concluded that residents of United Kingdom preferred the home setting in place of an institutional setting.

Mallick and Whipple (1990), studied the health characteristics of elderly board-and-care home residents to determine whether or not health services were adequate. The health status of 76 residents of 25 different homes in Cleveland, Ohio were assessed and compared with 638 residents in nursing homes who lived independently. Mallick and Whipple determined that board and care home residents had higher levels of function than nursing home residents in all areas except physical health. They concluded that 50% of board and care residents screened positive for possible psychiatric or emotional problems for which they were not receiving treatment. The authors recommended an assessment
service for these identified residents to determine the extent of mental health problems and
to address their social isolation, and to provide interventions and services as necessary.

Miller (1989), studied the costs of providing care to elderly adult care residents.
He indicated that 47 states have or have applied for Community-Based Long-Term Care
programs financed through Medicaid Section 2176 Waivers. Regulations require state
assurances that clients are certified for intermediate or skilled nursing home care, and
that programs be cost effective. Having certified client need, states assure cost-
effectiveness by comparing clients' community care costs to their cost of care if admitted
to a nursing home. The author argued that because clients will be cared for in either
a state’s existing system or in its waivered program, cost-effectiveness would be better
measured by the net additional costs of care in the waivered program. Using this formula,
the author indicated that for the State of California, estimates showed costs falling as
client frailty rises because the effects from the program rise as frailty rises. This author
further explored the inefficiencies introduced by the assurance of cost-effectiveness.

Gerhart (1989), observed the intimidation of residents in adult-care-facilities and
the impact this had on their quality of life. This issue arose from the author’s 10 years of
experience in regulatory administration of adult care homes. The author indicated that
residents usually entered adult-care-facilities with low levels of self-confidence and
collateral support. He also indicated that entering and residing in these facilities would
often exaggerate their fear of loss of control and increase their feelings of powerlessness
to effect change; further, the residents’ choice of alternatives were diminished. The author
pointed out that all these factors plus a distrust of bureaucracies and limited financial
resources combined to make residents candidates for intimidation by providers and others.

McCoin and Miller (1993), discussed the quest for social justice in adult care facilities. They advised that adult residential care is not justly treated in the distribution of societal resources. They postulated that adult residential care and those involved in it suffer from less eligibility in social support and stigma in social status, thus violating axioms of social justice that call for adequate support of basic needs and preservation of human dignity.

LITERATURE REGARDING MENTALLY ILL CLIENTS

Snyder, Wallace, Moe and Liberman (1994), reviewed literature dealing with expressed emotion by residential care operators and residents’ symptoms and quality of life. Expressed emotion was viewed as a construct that reflects the level of stress and burden experienced by those who live with severely mentally ill patients. They suggest that behaviors of patients and relatives intertwined in a spiral of events that determined the quality of the emotional environment in the family. Although the relationship between expressed emotion and relapse has been thoroughly studied in families who have relatives with schizophrenia, bipolar disorder, and depression, this relationship has been poorly studied for nonfamily caregivers of persons with severe mental illness. These authors concluded that the few studies that have been done, were methodically flawed, and used invalidated measures to assess expressed emotion.

Snyder et al. (1994), used well-validated measures to determine (1) the level of expressed emotion in a sample of operators of family-style board-and-care residences, (2) the relationship of expressed emotion to residents’ quality of life and changes in their symptoms, and (3) the consistency of expressed emotion by caregivers across residents.
The study was conducted over an 18 month period beginning in early 1991. The sample consisted of 20 operators of residential care homes with seven or fewer mentally ill residents which were randomly selected from licensed facilities in Los Angeles. Two measures of quality of life and interpersonal environment were administered to residents: the Family Environment Scale (FES) and Lehman’s Quality of Life (QOL).

The residents’ evaluation of the quality of their residential care environment, as measured by the FES and QOL scale, was significantly related to the operators’ attitudes towards the residents. The researchers recommended that future research assess characteristics of facilities that might influence the attitudes or expressed emotion of caregivers and the quality of life and social functioning of residents.

Additional comprehensive research needs to be conducted regarding Adult-Family/Boarding-Homes to improve the quality of life for elderly clients. Current available literature is quite limited and most articles are nonspecific regarding the measurement tool used, variables, as well as the type and quantity of sample used. It is apparent by the above mentioned studies, that not all authors were consistent in their conclusions regarding the quality of care and the quality of life in Adult-Family/Boarding-Homes.

CONCLUSIONS AND RECOMMENDATIONS

The need for standardized and readily available information about adult-family/boarding homes is increasingly apparent. National standards of licensing for these alternative models are necessary to ensure that quality care is delivered for elderly clients regardless of the state in which they reside. Administrators need to describe a facility’s important characteristics in a way that captures its complexity and yet is clear and precise
enough to determine appropriateness of prospective residents.

There are wide variations in residents' characteristics. During review of the limited information regarding community-based alternative programs, several different authors noted the importance of resident-facility matching. Information about residents' preferences can help clarify their choice of and reaction to different group living options. The vital issue of defining and regulating the quality of life in residential care settings and understanding the impact of settings on their residents must not be minimized. There is also a need to understand the influence of group living settings on the social and coping resources of elderly residents.

Health care consumers are able to define the quality-of-care (e.g. level of client satisfaction, open and on-going communication, and respect of resident's civil rights) they receive. The increased emphasis on quality improvement in health care brings with it the recognition that quality is a dynamic customer perception. Dissatisfaction results when customer expectations are not met. The meaning of quality differs between and among patients, health care providers, administrators and researchers. Although agreement on the conditions that must be met for quality care has not been reached, one essential component of quality in health care appears to be “caring”.

According to Ludwig-Beyer et al. (1993), while many nurse researchers and theorists have examined the concept of caring, it remained relatively underdeveloped. Various models of caring have been proposed, but patient perceptions were not always included in the models. Relationship between caring and quality is unclear. Little is known about professional perceptions.

Quality assurance involves knowing the customers: who they are and what they
need. It involves constant improvement in production and service. Nurses and providers need to know their customers more completely and to modify their patient care accordingly. Particularly in this time of complex patients and high technology, professional nurses sometimes view themselves as providing quality care through technical competence. According to Fisher (1996), patients define quality as involving competence and total caring.

Using a variety of methods to collect data on quality of care increases the opportunities for consumer input. In studies reviewed, when only one method of data collection was used, major components of quality care may have been overlooked. For example, without the analysis of multiple interviews of residents, caregivers, administrators, and regulatory staff, much of the impact on the resident's lives is missed.

Koschnitzke, McCracken, and Pranilus (1992), discussed the ethical considerations for quality assurance versus scientific research. They postulated that proposals for QA programs undergo periodic appraisal by an institutionally responsible, disinterested review panel. Doing so protects the subject's rights, protects the investigator from unwillingly rendering harm rather than good, and enhances the ethical credibility of the projects.

Dozier (1998), stated professional standards are key to the success of nurses as health care evolves, new roles are created, and new practice settings established (e.g.: Adult-Family/Boarding-Care Homes). Professional standards serve as the infrastructure upon which the development of institutional standards of care, competency-based education programs and quality assurance programs are built. Using them to link together these key components provides for consistency across practice settings and among
practicing nurses within integrated delivery systems.

Articulated standards and well-developed scientifically based practice guidelines play an important role in monitoring and improving the quality of health care services provided in this country. Guidelines can provide benchmarks for the evaluation of patient care, providing a means for continuous quality improvement. Finally, improvement of patient care is a goal of all nursing research.

The need for alternatives to nursing home care for the frail elderly has been well documented. State governments want to provide less-costly alternatives to the current institutional form of long-term care based on the medical model; but not at the cost of reducing quality-of-care. This paper speaks to the need for research on outcomes that consumers of long-term care services value most.

Washington State has a national reputation for the quality of long-term care services. Residential Care Services in Washington State has a mission statement which focuses on quality resident care, resident safety, and protection of resident rights (WAC 388-76 and WAC 388-78A). Continuous quality improvement is essential in all settings. In my opinion, Washington State is improving in their delivery of services/care to elders in the community programs, such as Boarding-Homes and Adult-Family Homes. In the future, a formal quality-improvement program for the Adult-Family Home program in Washington State may be initiated to co-exist with the newly developed Boarding-Home quality improvement program.

Eckert and Lyon (1991), believe that changes in the way services are financed and delivered to low-to middle-income long term care consumers will have profound effects on small board-and-care homes. Small board-and-care homes may find it difficult to
survive in this changing long-term care financing environment. Only those services that are sanctioned by the states through some form of regulation will be able to receive reimbursement in Medicaid, managed-care, capitated delivery systems. The assisted-living industry, currently perceived as serving middle-to upper-income consumers, is better organized than the board and care industry (i.e., adult home), and is positioning itself to step into the gap if Medicaid reimbursement becomes available in settings for lower levels of care. If policymakers continue to support the home-like environments of Adult Family /Boarding-Homes for certain populations, these financial issues will require further attention and research.

One fact seems clear is that the majority of disabled elderly prefer to remain out of a nursing home if at all possible. We should continue to strive to make this preference a reality, and Adult-Family/Boarding Homes continue to offer an important option.
REFERENCES


