Florida Assisted Living Research Study: Facilities, Residents, Staff, Training, and Liability Insurance: Executive Summary

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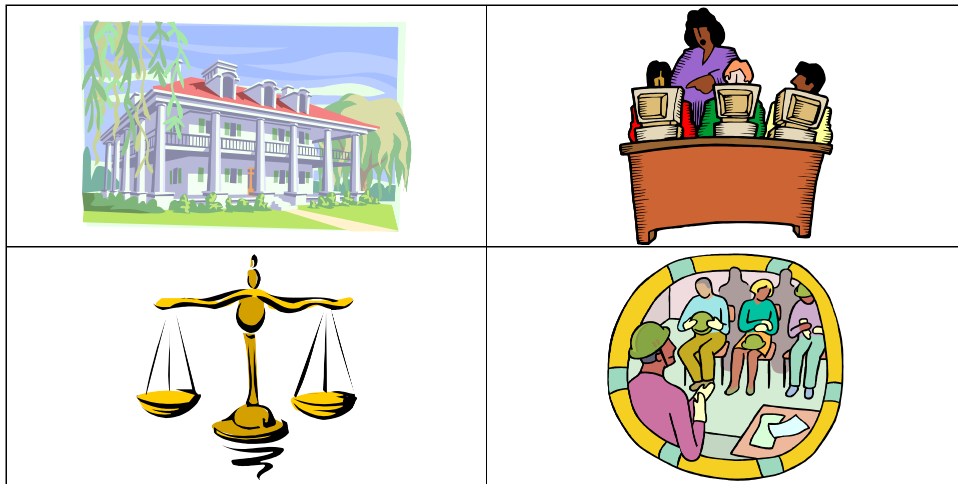

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We are very grateful for the generosity of these individuals and organizations.

Study Aims

The general aims of the study were to: 1) understand the breadth of assisted living in a single, bellwether state in terms of ownership, admission/retention criteria, use of public payments, and room and facility amenities, with a focus on aging in place; 2) understand the capacity of assisted living to train staff through local and distance learning; 3) understand the liability insurance and litigation experiences of assisted living facilities; and 4) explore the characteristics of facilities that serve primarily African American or Hispanic residents. The study was conducted through a mailed self-administered survey available in English and Spanish. Participants had the option to complete the survey online.

Sample and Response Rate

Facilities were selected from the Florida Agency for Health Care Administration's 2003 database of licensed assisted living facilities (N=2,306). We excluded facilities with 5 or fewer beds (n=68, 0.03%) because they are better compared to facilities licensed as Adult Family Care Homes. From this revised population we selected 29% of facilities at random and found the sample to be representative in terms of the distribution of facilities by size, beds, geography, and licensure. Of the 640 facilities selected for the sample, 32 (5%) were no longer in business or could not be located. One-third of the adjusted sample (N=200) participated in the survey (Table 1). Survey participants were more likely to be from larger facilities (49% vs. 40% of all facilities) and less likely to be from the smallest facilities (29% vs. 35%).

Table 1. Responding ALFs

Size	ALFs	Pct of Total	Beds	Pct of Total
6 beds	58	0.29	348	0.04
7-16	44	0.22	516	0.06
17+	98	0.49	7,622	0.90
Total	200	1.00	8,486	1.00

Analytical Methods

For most of the analyses, we compared facilities by size and licensing. The three size categories correspond to differences in regulations: 0-6 beds, 7-16 beds, 17+ beds. Although there are four licensing categories: standard, limited nursing services (LNS), limited mental health (LMH), and Extended Congregate Care License (ECC), we compare facilities by those that have an ECC license and those that do not. The ECC license is required in order to serve more impaired residents and to receive Medicaid Waiver funds. Many facilities with an ECC, also have an LNS. We report on the LNS and LMH licenses when appropriate. For categorical data, we use chi-square analyses; for continuous data, we use t-test to compare two license types and ANOVA to compare three facility size types. In all tables, significance is noted: *p<05, ** p<.01, ***p<.001.

Facility and Resident Characteristics

Ownership Characteristics

ECC facilities are newer and have more licensed beds. They are more likely to be 17+ beds and more likely to have Limited Mental Health (LMH) and Limited Nursing Services licenses (not displayed). There are no differences by ownership. Small ALFs were licensed later and are more likely to be independent and privately owned. Facilities with 7-16 beds were less likely to have LNS but more likely to have LMH license. Larger facilities (17+ beds) more likely to be a Not-for-Profit and National Chain.

Room and Facility Arrangements

ECC facilities were less likely to have bedroom units and more likely to have 1 BR apartments with private full baths (Table 2). Larger facilities had more options for room arrangements and only one-third of units were shared. Smaller facilities are exclusively bedroom units (not apartments) and two-thirds are shared.

ECC facilities have more amenities and are more likely to have a snack bar and chapel; and less likely to have a smoking area in common areas (not displayed). Privacy

enhancing options like a locking door, individual heating/a/c controls in addition to safety features (automatic sprinklers in rooms) are in ECC and larger facilities. Larger facilities were more likely to have snack bar, smoking area, library, and chapel.

Table 2. Room Arrangements (Percent)

	ECC	Non-ECC	0-6	7-16	17+	All
Rooms						
Bedroom only	76	88*	100	95	75***	86
One bedroom	17	6*	0	0	15***	8
Two bedroom	0	1	0	0	1*	1
Other	8	5	0	5	8*	5
Shared units	45	45	64	53	32***	45
Bathrooms						
Private half	7	8	7	14	7	8
Private full	51	42	24	35	57***	44
Shared half	6	5	4	7	5	5
Shared full	34	45	64	45	30*	42

Admission and Retention Policies

ECC facilities are more likely (1=Always; 3=Never) to admit individuals who need assistance with walking and transferring (Table 3). ECC more likely to retain those who need help with walking, toileting, transferring, and eating. Small facilities are more likely to admit any ADL impairment and to retain those who need help with eating. ECC facilities are more likely to admit and retain those with cognitive impairments. They also are more likely to advertise and provide special care including a SCU (not displayed). Very few differences by size with the exception that larger facilities are more likely to advertise special care and have a SCU.

Reasons for Discharge and End of Life Care

ECC facilities just as likely as non-ECC to use hospice and the keep people an average of 2.5 years (Table 4). The distribution of reasons for discharge is similar. Small facilities more likely to use hospice, yet discharge due to end-of-life care needs, exceeding state regulations, and resident not able to afford care. Midsize facilities have the longest length of stay but discharge because resident cannot afford prescription drugs (available at a NH).

Resident Demographics and Needs

Most of the residents in ALFs are age 75+ although ECC facilities have more residents age 60-74 (Table 5). Non- ECC facilities have more residents 59 and younger. Most residents are White but those with an ECC license have more diversity. Small and mid-size ALFs have higher percentages of African Americans. Small facilities have highest percentage of Hispanics. ECC facilities are more likely to have individuals with Alzheimer's disease or other cognitive impairment and more likely to serve those with higher functional impairment (Table 6). Midsize facilities most likely to serve those with developmental disabilities or mental illness (DD/MI) or cognitive impairment.

Table 3. Admission and Retention (Average)

	ECC	Non-ECC	0-6	7-16	17+	All
ADL Needs Admitted (1=always)						
Walking	1.32	1.54*	1.39	1.58	1.52	1.49
Dressing	1.18	1.25	1.20	1.36	1.20	1.23
Bathing	1.13	1.21	1.13	1.31	1.16	1.19
Grooming	1.16	1.20	1.13	1.33	1.15*	1.19
Toileting	1.24	1.41	1.26	1.50	1.37	1.37
Transfer	1.34	1.59*	1.41	1.52	1.60	1.53
Eating	1.42	1.64	0.38	1.56	1.74*	1.60
ADL Needs Continue Residency (1=always)						
Walking	1.18	1.41*	1.28	1.47	1.35	1.36
Dressing	1.06	1.18	1.14	1.32	1.09*	1.15
Bathing	1.06	1.18	1.14	1.26	1.10	1.15
Grooming	1.06	1.19	1.13	1.32	1.10*	1.16
Toileting	1.06	1.33**	1.18	1.38	1.26	1.27
Transfer	1.24	1.53*	1.36	1.38	1.53	1.45
Eating	1.24	1.55*	1.21	1.50	1.61*	1.47

Table 4. Hospice, Length of Stay, and Discharge

	ECC	Non-ECC	0-6	7-16	17+	All
Use Hospice (%)	5	6	11	4	4***	6
Average Length of Stay (mos)	29	31	30	39	28*	31
Reasons for Discharge: (%)						
Exceeded state regulations	45	50	74	46	44*	49
Not provide care	49	42	41	49	42	44
Not afford care	22	24	57	24	20**	25
Not afford Rx	1	6	0	14	3*	5
Behavior dangerous	13	13	15	19	12	14
Cognitive impairment	15	20	25	19	18	19
End-of-Life Care	12	21	44	17	14**	19
Unknown/other	6	23	33	31	15	20
Avg Discharges	22	24	22	30	21	23

Table 5. Resident Demographics (Percent)

	ECC	Non-ECC	0-6	7-16	17+	All
Age						
<=59	9	18	12	29	12**	16
60-74	16	12	8	18	13*	13
75+	75	70	80	52	75***	71
Race or Ethnicity						
African American	6	9	10	12	6	8
White	69	83*	67	79	88***	80
Hispanic	22	7***	22	8	5***	10
Other	3	1	0	1	2	1

Table 6. Resident Needs (Percent)

	ECC	Non-ECC	0-6	7-16	17+	All
Cognitive Status						
DD/MI only	3	17	20	28	8*	14
Cog. impairment	52	27**	38	32	30	32
No cog. problems	45	53	40	38	60*	52
Need ADL Assistance						
0 ADLs	15	25	14	26	24	23
1-2 ADLs	45	45	41	39	47	45
3+ ADLs	40	28	44	28	29	31

Base Rates, Services, and Assistance

ECC facilities offer base rates that are lower than non-ECC facilities for single occupancy but slightly higher for double occupancy (Table 7). ECC facilities are less likely to include services in their base rate (which may explain the lower rate). Mid-size facilities charge the lowest rates and yet include many services within that rate. Large facilities are less likely to include supervision of medications but more likely to include nursing in their base rate. Services not in the base rate are usually provided for extra charge or from an outside service (not displayed).

ECC facilities have fewer residents who pay privately and more who use the OSS/ACS nd Medicaid Waiver (Table 8). Large facilities have the highest number of residents who are private pay. Overall, there is very low use of VA, Section 8, and Food Stamps for assisted living (1-5%; not displayed). ECC facilities are more likely to report individuals on waiting list for food stamps and these are in larger facilities where the food stamp program would be economical.

Attitudes toward Public Programs

There are very few differences by license or size in attitudes toward OSS and ACS (not displayed). Most operators say that it does not cover their costs and in fact, that is why they do not use it. There are very few differences by license or size in attitudes toward ECC and the Assisted Living for the Elderly (ALE) Medicaid Waiver. Most say that they don't use the ECC license because of the cost of liability insurance and they do not use the waiver because it requires the ECC license and does not cover their costs. ECC facilities are more likely to have outside case management but are less satisfied with it (not displayed).

Table 7. Base Rates and Services

	ECC	Non-ECC	Sig.	0-6	7-16	17+	Sig.	All
Monthly Rates								
Single Occupancy	$1,870	$2,008		$1,959	$1,677	$2,081	*	$1,969
Double Occupancy	$1,747	$1,661		$1,544	$1,330	$1,887	**	$1,673
Services in Base Rate								
Supervision of ADLs	78%	91%	*	100%	93%	81%	***	89%
Hands-on Assistance of ADLs	62%	75%		89%	74%	63%	***	72%
Incontinence Assistance	51%	59%		72%	50%	51%	***	58%
Incontinence Supplies	9%	11%		13%	10%	10%		11%
Transportation to Medical Appts.	44%	54%		41%	48%	59%		52%
Transportation to Shopping	58%	56%		27%	49%	73%	***	56%
Assistance with self-administration of Rx	70%	87%	*	93%	98%	72%	***	83%
Intensive supervision cog. impairments	46%	47%	***	54%	48%	40%		46%
Personal care supplies	38%	50%		60%	51%	40%		49%
Nursing services	31%	28%	**	14%	24%	37%	***	28%
Special diets	71%	80%		85%	70%	78%	*	78%

Table 8. Financial Ass`istance

	ECC	Non-ECC	Sig.	0-6	7-16	17+	Sig.	All
Source of Payment (Avg. N)								
Private pay only	62%	71%		69%	54%	76%	**	68%
Long-term care insurance only	1%	1%		0%	1%	2%		1%
Non-governmental charitable support	0%	0%		0%	1%	0%	***	0%
Optional State Supplementation (OSS) only	3%	5%		5%	2%	6%	*	5%
OSS and Assistive Care Services (ACS) only	14%	13%		12%	25%	8%		14%
OSS/ACS and Medicaid Waiver only	14%	6%	*	11%	10%	6%		8%
Resident contribution and any Medicaid Waiver	6%	3%		2%	5%	3%	*	3%

Staffing and Training

Over two-thirds of the Florida ALFs report that they staff their facilities above the state-required minimum levels. ECC facilities were much more likely to staff above minimum levels (84%) compared to non-ECC (not displayed).

Nurse and Direct Care Staffing Patterns
ALFs reported hiring an average of one RN per facility regardless of size (Table 9). Larger facilities were less likely to use contract nurses than smaller facilities. Larger facilities show statistically significant greater number of LPN, CNA, and non-certified staff. On average, large ALFs employed 13 CNAs while medium facilities employed 3 CNAs and small facilities reported slightly more than 1 CNA per facility. Small facilities employed an average of 3 employees while facilities with 7-16 beds employed an average of 4.7 employees and the largest facilities employed an average of 22 staff.

ECC facilities employ significantly more LPNs and CNAs than non-ECC license ALFs. ECC facilities also provide an average of 155 hours of LPN staffing per week as compared to an average of 63 hours in non-ECC facilities. On average, they provide 523 hours of CNA staffing per week in comparison to 192 in non-ECC facilities and 352 hours of non-certified staffing per week in ECC facilities as compared to 197 in non-ECC facilities.

Current Training Programs
Training events are widespread and continuously offered in ALFs especially for ECC-licensed and larger facilities (Table 10). We estimate that facilities provide an average of 270 hours of training for staff every year. Table 10 presents the mean number of total training events and events offering continuing education units provided by ALF's during calendar year 2002. More than 75% of the facilities responding reported that altogether they offered 1,584 events per year or about 10 events per year. ECC-facilities offered 20 events per year while non-ECC offer about 8 events, a statistically different and important difference. Size also dramatically effects how many courses are offered. The largest facilities offered over 14 events per year or more than one per month while facilities smaller than 17 beds averaged approximately 5 events per year. Consistent with employing more licensed staff, ECC-license facilities offered almost double the number of CEU events with an average of eight while non-ECC facilities offered four CEU events per year.

Equally important is the attendance reported by facility type. ECC-license facilities reported an average attendance of 14 staff per event while non-ECC facilities reported only 8 staff at each event. As expected, size also impacts the number attending each event offered. Mean attendance for largest facilities was approximately 15 staff while smaller facilities

Table 9. Average Staffing Patterns Per Week Per ALF

	ECC	Non-ECC	Sig.	0 - 6	7 to 16	17+	Sig.	Total
Registered Nurses								
RN Employees	1.24	0.95		1.05	1.33	0.98		1.04
Contract RN Employees	0.43	0.26		0.57	0.86	0.14	**	0.31
Total RN Hours	51.25	39.96		44.23	40.00	42.79		42.70
Total Hours per RN Staff	41.63	28.95		42.05	13.35	33.17		32.51
Licensed Practicing Nurses								
LPN Employees	3.96	2.08	**	0.50	0.77	3.29	***	2.57
Contract LPN Employees	0.33	0.13		0.17	0.00	0.23		0.19
Total LPN Hours	155.29	62.76	***	22.00	37.20	108.29	**	87.28
Total Hours per LPN Staff	40.03	33.33		33.67	35.07	35.16		35.00
Certified Nursing Assistants								
CNA Employees	15.50	7.08	***	1.44	2.68	12.63	***	8.81
Contract CNA Employees	0.33	0.91		1.00	2.17	0.46		0.76
Total CNA Hours	523.27	192.39	***	63.65	60.57	378.73	***	266.69
Total Hours per CNA Staff	34.34	32.10		32.65	26.59	33.49		32.42
Non-Certified Employees								
Non-Certified Employees	3.94	5.74		1.77	3.21	7.94	***	5.43
Contract Non-Certified Employees	1.67	0.58		0.72	1.17	0.77		0.82
Total Non-Certified Hours	351.80	197.19	*	97.32	172.08	288.78	**	221.53
Total Hours per Non-Certified Staff	34.14	45.25		54.67	54.93	34.55	**	43.28
Total Employees								
Employees	18.28	12.39		3.18	4.70	22.06	***	13.47
Contract Employees	0.50	1.42		1.56	2.38	0.68		1.23
Total Hours	757.67	404.29	*	132.29	208.21	733.82	***	468.35
Total Hours per Staff	30.92	40.39		42.71	34.84	37.62		38.62

reported three to four staff at each event. Of the 62% of ALFs who reported details on the training programs, the average length of training was 2.7 hours and there were no statistically significant difference reported by license type or size of facility.

Fifty-three percent of facilities indicated that they provided Alzheimer's training for ALF staff, with 72% of ECC licensed facilities indicating they provided training (not displayed). However, it is important to note that almost half of non-ECC facilities also provided this training.

Training in ALFs focuses on requirements (not displayed). The most commonly provided training was CPR/first aid, which is required by all staff. Other required training includes AIDS/HIV, medication assistance, and Alzheimer's for those facilities with dementia patients. Other popular and required topics include infection control, providing personal care, food safety, fire safety, and nutrition and dietary. Topics that are frequently offered include resident communication, documentation, elder abuse, and clinical care. Falls prevention classes were offered only four times, despite the frequency of falls in this population, and courses on behavior therapy were also infrequent.

When asked to identify the three most important topics for staff training the list mirrored the courses generally taught: Alzheimer's training, medication management, CPR/first aid and resident communication (not displayed). The requested trainings did not vary by license type despite the more significant nursing and health-related needs of ECC residents.

Table 10. Average Training Events per ALF by Licensure and Size

	ECC	Non- ECC	Sig.	0 - 6	7 to 16	17+	Sig.	Total
Training Events	20.31	7.72	***	5.31	4.97	14.44	***	10.28
Training Events with CEUs	7.88	4.09	**	4.36	2.37	5.70		4.73
Average Attendance per Training	14.37	8.37	**	2.99	4.26	15.19	***	9.91
Average Training Length	2.49	2.71		2.53	2.93	2.60		2.65
Total Training Attendance	80.62	42.34	***	13.40	18.52	82.36	***	52.07

Career Ladders and Staff Development
Over 60% of the facilities reported information about career ladders and staff development programs, especially at the lowest levels (not displayed). Seventy-two percent encouraged non-licensed staff to obtain a CNA certificate. Two-thirds of ALFs report programs to encourage CNAs to pursue an LPN license and about one-third report programs to encourage LPNs to acquire an RN degree. Large facilities appear eager to encourage staff development with 86% of facilities with more than 17 beds reporting a CNA to LPN development program and 52% of these facilities also reporting a LPN to RN program. Smaller facilities clearly do not have the infrastructure and may not have the financial capacity to offer such programs.

Training Infrastructure
The average capacity of training rooms in ALFs varies considerably (not displayed). On average, ALFs have a dual-purpose room that can be used for training and accommodates approximately 30 people at a time. The largest facilities have a room that accommodates an average of 42 people while the smaller facilities accommodate 12 or 13 people respectively. Only one-quarter of the facilities indicated that they have dedicated training space, and that space tended to be smaller – holding about 9 people. There were not differences by size or license when dedicated training rooms were reported.

Off-site Training
The mean number of people sent off-site for training was 5 per site (not displayed). There was no significant difference by license type but size did impact willingness to send staff off-site. Larger facilities were most likely to send staff to outside training and they sent approximately 7 staff offsite, which is more than double the smaller facilities

Equipment
Over 90% of ALFs own a VCR with 96% of the larger facilities have a VCR whereas 85% of medium and 82% of smallest facilities report a VCR (not displayed). About 53% have a dial-up internet access available for training of employees and 20% have high-speed internet access for training with 7% indicating they are planning to purchase this access for training purposes. Almost half (47%) have a computer for training. Over 25% use DVDs and another 7% plan to purchase a DVD for training. Clearly, larger facilities and ECC-facilities have the ability to use computers for training and increasingly are accessing high-speed cable to support staff development.

Insurance, Risk Management, and Consumer Response

Liability Insurance and Litigation
Although total lawsuits reported is small, particularly when compared to nursing facilities, marked differences in lawsuits per bed between ECC and non-ECC facilities are noted as well as substantive annual lawsuit increases from 2000 to 2002 (not displayed). In 2002, ECC facilities experienced 19 times more lawsuits per bed than non-ECC facilities, and ECC facilities experienced over 14 times more lawsuits per bed in 2002 than in 2000. ECC facilities are more apt to have minimum general and professional liability insurance coverage (Table 11). Average insurance premium costs per bed for all facilities increased annually from 2000 to 2002 (Table 12).

Table 11. Liability Insurance (Percent)

	ECC N=36	Non-ECC N=143
Compliance (minimum coverage)	47.2%	41.3%
Standard	36.1%	52.5%
Other (e.g., self-insured)	16.7%	0.7%
Uninsured	0.0%	2.8%

Table 12. Average Premium Per Bed by Size

Size	2000 N=85	2001 N=96	2002 N=106	Change 2000 to 2002
<=6	461.86	715.39	923.75	+100%
7-16	329.85	510.95	2,289.01	+594%
17+	568.87	710.94	965.13	+ 70%
Avg.	474.48	663.38	1,289.07	+172%

ECC facilities paid significantly higher insurance premiums per bed than non-ECC facilities in 2002 (Table 13). However, average general liability (GL) coverage limits for all reporting facilities decreased annually. Approximately 57% of facilities opted not to obtain an ECC license due to costly liability insurance premiums.

Smaller facilities are having greater difficulty maintaining continuous coverage with the same carrier (not displayed. Facilities having 6 residents had been with their current insurer for just 24 months, compared to 35 months for mid-size facilities and 34 months for large facilities.

Table 13. Average Premium $ Per Bed and Limits by License

	ECC	Non-ECC
Premium		
2000	231	521
2001	571	688
2002	2,741	969 *
GL Limits		
2002	1,483,625	1,246,379
2001	1,084,654	1,203,599
2002	915,306	934,128

Among the 26% of facilities that responded to an open-ended question about the status of assisted living, 50% percent were distressed over the cost of insurance premiums.

Risk Management

Less than half (40%) of responding facilities had full- or part-time on-site, multi-facility chain off-site, or outside contracted risk management services (not displayed). Risk manager utilization was significantly correlated with lower per bed insurance premiums for all surveyed years. Only 6% of facilities use mandatory negotiated risk contracts and 22% use optional contracts. The majority of facilities (72%) do not use such contracts. ECC facilities were more likely to describe problem resolution with residents as somewhat difficult.

Consumer Response and Protection

Facilities obtain resident satisfaction feedback using two main methods: 70% through resident councils and 30% through annual surveys (not displayed. A small number of facilities employ both techniques. Approximately 87% of facilities reported having at least one ombudsman visit during 2002 and 52% of them reported that ombudsmen were helpful or somewhat helpful and 19% reported ombudsmen as not very helpful or not helpful at all.

Characteristics of Facilities Serving African Americans and Hispanics

Population

Based on the 2000 Census, African Americans make up 5.9% and Hispanics make up 9.9% of the adults aged 65 and over in the state of Florida. Thus it was expected that roughly 16% of the residents in each of the facilities would be African American or Hispanic. This 16% was used as a cut-off to construct a dichotomous variable for facilities that were “high” or “low” in their minority populations. They were categorized as “low” if 15% or less of their residents were African American or Hispanic, and “high” if 16% or more of their residents were in one or more of these two groups. Of the 200 facilities that responded, five did not provide adequate racial/ethnic

data. As a result, 140 facilities were rated "low" and 55 were rated "high."

Geographic Distribution

Over 38% of the high-proportion minority facilities were located in Miami-Dade County, where 73% of the 65+ population resides (Table 11). The distribution of the other high-proportion minority facilities in Broward, Pinellas, and Hillsborough counties may be accounted for by large number of facilities in each of these counties, in addition to the presence of African American and Hispanic communities.

Table 11. Top Four Counties Serving Minorities in ALFs

	High Minority Facilities	Total Responders	Rank
Dade	38.2%	13.8%	1
Broward	12.7%	13.8%	2
Pinellas	10.9%	13.3%	3
Hillsborough	9.1%	6.7%	4

Facility Characteristics

The smallest facilities are the most likely to serve a high proportion of African Americans and Hispanics (Figure 1). Conversely, a very low percentage of the largest facilities serve a high proportion of minority residents.

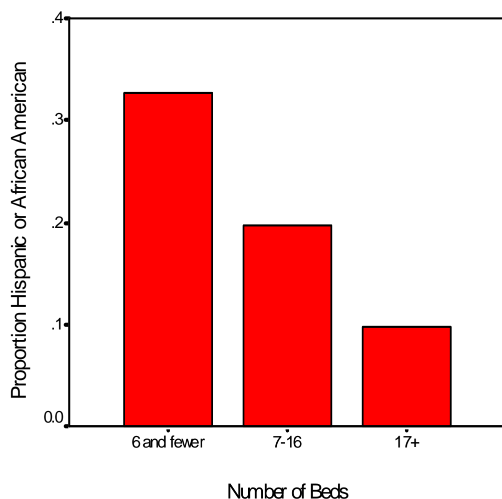

Figure 1. High Minority ALFs by Facility Size

There are a number of facility characteristics that differ between high- and low-proportion minority facilities. The buildings where high-minority facilities are housed are significantly older and have fewer licensed beds. High-proportion minority facilities are more likely to have the Limited Mental Health (LMH) license, to be independent, and not part of a national chain (Table 14). Fewer of these facilities have a chapel/meditation room, a library, a 24-hour snack bar, fire sprinklers, or a recreation room (not displayed). High-minority facilities are equally likely to have a smoking area and Internet access, and more likely to have an outdoor walking area. A greater proportion of low-proportion minority facilities provide transportation to medical appointments and shopping, or nursing services in their base price. High-proportion minority facilities are, however, more likely to include assistance with self-administered medications and personal care supplies.

Table 14. Characteristics of Facilities that Serve a High Proportion of African Americans and Hispanics

	Low	High	Sig.
History			
Year built/last renovated	1990	1979	***
Year first licensed	1993	1991	
Total licensed beds	52	26	**
Licenses			
Extended Congregate Care	19%	25%	
Limited Nursing Services	25%	22%	
Limited Mental Health	6%	49%	***
Ownership			
Independent	46%	64%	*
National Chain	15%	2%	**
Regional Chain	4%	0%	

Facilities serving a high proportion of minorities are more likely to have bedrooms than 1- or 2-bedroom apartments, and thus less likely to have private full baths (Table 15). The facilities with more minorities were less likely to have autonomy enhancing features such as individual heating and a/c controls. They are also less likely to have safety features such as emergency call systems, two-way intercoms, and automatic sprinklers.

Resident Characteristics

High proportion minority facilities have significantly younger residents (not displayed). This may be related to the fact that these facilities also serve a greater proportion of clients who are developmentally disabled or

mentally ill, and fewer clients who have Alzheimer's disease or cognitive impairments.

Facility Costs and Assistance
The cost of staying at a high-proportion minority assisted living facility is significantly lower than staying at one that has a lower proportion of minorities. The single occupancy rate averages $2,165 for "low" facilities and $1,411 for "high" facilities (not displayed). A similar pattern is seen for double-occupancy rooms: Facilities serving a low proportion of minorities cost significantly more per month ($1,897) than facilities with a high proportion of minorities ($1,118).

The sources of payment for services also differ (not displayed). Low-minority facilities have a significantly higher proportion of residents using private pay and low-term care insurance. High-minority facilities had a greater percentage of residents using the Optional State Supplementation (OSS) only, or a combination of OSS and Assistive Care Services (ACS). One interesting finding was that high-proportion minority facilities averaged significantly more people on their waiting lists for financial assistance (4) than low-minority facilities (0.52), even though these facilities tend to be smaller.

Table 15. Room Arrangements by Facilities who Serve Low and High Proportions of African Americans and Hispanics

	Low	High	Sig.		Low	High	Sig.
Room Arrangements				**Resident Room Features**			
Bedrooms	82%	97%	**	Individual heating controls	53%	15%	***
1-Bedroom apartments	11%	0%	**	Individual a/c controls	53%	19%	***
2-Bedroom apartments	1%	0%		Emergency call system	59%	14%	***
Other shared units	6%	3%		Two-way intercom	20%	4%	**
Bathrooms				Automatic fire sprinklers	79%	46%	***
Private half bath	8%	9%		Microwave	*19%*	*14%*	
Private full bath	52%	21%	***	Refridgerator	39%	19%	**
Shared half bath	5%	5%		Telephone jack	87%	65%	**
Shared full bath	35%	63%	***	Locking doors	*76%*	*65%*	

Summary

There is great diversity in assisted living within one large state in terms of licensure and facility size. ECC facilities are serving impaired residents and allowing them to age in place. Small facilities care for more impaired individuals and allow them to stay longer and serve African Americans and Hispanics as well as those with DD/MI. Larger facilities provide for more privacy and autonomy. OSS, ACS, ECC are not covering costs and average rates are higher than reimbursement. This is a major consideration in the use of these programs to make assisted living affordable.

Over two-thirds of the Florida ALFs report that they staff their facilities above the state-required minimum levels. ECC facilities were much more likely to staff above minimum levels compared to non-ECC facilities.

ALF facilities recognize the need to provide training to employees with ECC-facilities and larger facilities providing a great deal of training for staff. Most ALFs have career ladders, especially for non-licensed staff and CNAs. Fewer report programs for LPN to RN levels reflecting the lower level of need for skilled RNs in ALFs. Many ALFs have rooms available for training. Most ALFs provide at least one training a month and many provide two or more sessions for staff. Among the most requested sessions are required training but there are requests for behavior training, clinical care, promoting healthy aging and other topics. Furthermore, many ALFs, especially larger facilities and ECC-licensed facilities have sophisticated training capacity with high-speed computer connections or dial up connections. DVDs rather than VCRs appear to be the mode of choice for future training modalities.

Both ECC and non-ECC facilities are experiencing increasing numbers of lawsuits, although in considerably smaller numbers than seen in other long-term care settings. However, insurance premium rate increases far outpace litigation levels and are of great concern, particularly to smaller facilities that also are struggling to maintain continuous coverage with the same carrier. The use of risk management represents one method of lowering insurance costs for some facilities. Resident councils provide the typical forum for gathering resident satisfaction input and ombudsmen are viewed positively by most facilities.

There are a number of differences between facilities that serve a high-proportion of minorities and those that serve a high-proportion of Caucasians. High-minority facilities tend to have younger residents with developmental disabilities or mental illnesses, and therefore are also more likely to have an LMH license. These facilities tend to be smaller, lower cost, and have fewer extra features. These quantitative differences should not be mistaken for differences in quality of care, which were not assessed in this study.