The elderly population of the United States is growing rapidly. Between 1990 and 2035, the number of individuals over age sixty-five will increase from 12 percent to 20 percent of the total population, with the greatest growth among those age eighty-five and over. Each year 645,000 individuals reach age sixty-five (American Association of Retired Persons [AARP], 1991).

Most elderly individuals enjoy good health and are able to live independently. However, some require a degree of long-term personal and/or medical care due to chronic conditions or other physical or mental impairments. Long-term care refers to any continuing provision of housing, personal, and/or economic assistance to individuals with functional deficits. The need for long-term care increases with age. While only 2 percent of the elderly population between the ages of sixty-five and seventy-seven are in need of long-term care, approximately 24 percent of those over eighty-five need such care. Overall, about 5 percent of

CHAPTER 8

Sub-institutional Facilities: Board-and-Care Homes

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The Elderly and Long-Term Care

The elderly population of the United States is growing rapidly. Between 1990 and 2035, the number of individuals over age sixty-five will increase from 12 percent to 20 percent of the total population, with the greatest growth among those age eighty-five and over. Each year 645,000 individuals reach age sixty-five (American Association of Retired Persons [AARP], 1991).

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the elderly population resides in long-term care facilities at any given time. Three percent of these individuals live in nursing homes and 2 percent occupy other types of facilities (Atchley, 1991).

Residents of long-term care facilities are most likely to be in their mid- to late-eighties, widowed, and suffering from one or more physical limitations. Many of these individuals have no income other than Social Security (SS) or Supplemental Security Income (SSI) (Down & Schnurr, 1991). Although the greatest need for long-term care is among the elderly, other populations, including the developmentally disabled of all ages and those suffering with debilitating diseases, also require such care (Lieber & Lammers, 1990).

The types of living arrangements currently available may be thought of as falling along a continuum of support levels. Single-family houses provide the lowest level of support. Retirement villages, high-rise apartment buildings, and mobile-home parks for retirees afford moderate levels of support because the householder is freed from some maintenance responsibilities and neighbors are close at hand. Long-term care facilities represent the highest level of support (Streib, Folts, & Hilker, 1984).

Too often, long-term care facilities are narrowly defined as nursing homes. This limited view ignores an array of formal, informal, institutional, and non-institutional care settings (Kemp, 1990) including shared living homes, board-and-care homes (BCHs), lifecare communities and private residences in which family members care for a dependent relative. So too, providers of long-term care are not limited to health care professionals and paraprofessionals but include other practitioners and family members as well (Lieber & Lammers, 1990).

The responsibility for the care of many dependent elderly has slowly shifted from the family to public and private facilities. During the nineteenth and early twentieth centuries, dependent elderly individuals were usually cared for by their families (Brubaker, 1987). Today, many families lack the resources, time, or expertise required to provide adequate assistance to elderly relatives.

Sub-institutional Facilities

Furthermore, changes in social policies and government funding have served to further increase the demand for long-term care facilities. Wyntt v Stickney (1971a, 1971b, 1972a, 1972b) and its associated case law (Wyntt v Aderholt, 1974) imposed minimum standards of care on mental institutions. These standards, although improving conditions in care facilities, escalated the cost of institutionalization. Most states addressed the financial burden by releasing mental patients and developmentally-impaired individuals into the community, often referring them to alternative types of long-term care facilities. State and federal government agencies, such as departments of human resources or the Veteran's Administration, also have referred or discharged individuals to long-term care facilities.

Nursing homes have been unable to keep up with the increased demand. Government restrictions regarding the addition of new Medicaid reimbursable nursing home beds have produced, in part, a general shortage of beds in nursing homes. As a result, a dramatic increase has occurred in the number of alternative types of long-term care facilities, including BCHs, such that the number of BCHs is increasing more rapidly than the number of nursing homes (U.S. Bureau of the Census, 1987; U.S. Bureau of the Census, 1991).

An Overview of Board and Care

The board-and-care home of today is an outgrowth of the old-style boarding home or rooming house where individuals rented spare rooms in their homes to supplement their incomes and/or gain companionship. These facilities typically provided food and lodging to tenants who included "...traveling salesmen, transient workers, and out of town guests" (Down & Schnurr, 1991, p. 21). Although modern BCHs provide more services than old-style boarding homes or rooming houses, they maintain the same "homey" atmosphere. Many people find BCHs "...more satisfying, more natural, and less costly" (Jaggett, 1989, p. 9) than institutional care facilities.

Board-and-care homes may be described as places where residents receive lodging, meals, some help with the activities of
daily living (IADLs such as bathing and grooming) and assistance with instrumental activities of daily living (IADLs such as transportation). BCH operators can also provide residents with social support and opportunities for community contact. Providing transportation to church or recreation centers gives elderly individuals with limited mobility a sense of continuing involvement and allows them to maintain friendships (Down & Schnurr, 1991). These homes offer housekeeping and personal help to those who are unable to live alone but who do not need, or cannot afford the level of care provided by nursing homes (Down & Schnurr, 1991).

Adult foster homes, group homes for the aged, rest homes, personal care homes and domiciliaries are all classified as types of board-and-care homes (Down & Schnurr, 1991). Each of these names implies slightly different facility characteristics. For example, domiciliaries are usually larger and somewhat more institutional in nature than foster homes, which are typically small, family-type facilities (Baggett, 1989). Because of the range of services provided and the different ways in which the facilities can be classified, considerable confusion exists over the various types of these noninstitutional long-term care facilities for the elderly (Stone & Newcomer, 1985; see also Benjamin & Newcomer, 1986; Dobkis, 1989; Mor, Guerin, & Sherwood, 1985).

Most BCHs are owned by individuals, primarily by older widows (Baggett, 1989), but churches and civic organizations sponsor some of the larger facilities (Down & Schnurr, 1991). All BCHs operate for profit; however, most of the smaller facilities experience only marginal financial success. One of the main problems facing the smaller homes is the lack of business training and relative inexperience of the operators; many experience difficulty with bookkeeping and government records. Larger homes tend to have trained administrators with business experience (Baggett, 1989).

Beyond reminding residents to take their medication, BCH staff are generally not permitted to provide medical care. However, because BCHs are often looked upon as low-cost alternatives to nursing homes, some level of medical care is often available for the residents. Existing research suggests that the residents often require a larger amount of such care than should typically be provided in a BCH. Unfortunately, many BCH operators lack training for administering even minimal medical assistance, resulting in potentially harmful situations.

Although state and federal agencies utilize BCH services by referring individuals to or placing them in these facilities, the various levels of government make no direct reimbursement to the homes. BCHs are not eligible to receive Medicare, Medicaid, or other forms of direct government compensation. However, because most residents rely on SS and SSI to meet their expenses, BCHs do receive indirect government support (Baggett, 1989).

Sub-institutional Facilities

Federal and State Regulation of Board-and-Care Homes

A few federal statutes and incentives address BCH regulation. The most directly relevant statute, the Keys Amendment to the Social Security Act (Section 1616[e]), provides that each state will establish or designate an agency to be responsible for the creation, maintenance, and enforcement of standards for any “institutions, foster homes, or group living arrangements” in which a “significant” number of SSI recipients reside (Solomon, 1989). These standards cover such areas as admission policies, safety, sanitation, and protection of civil liberties. Each year, states must certify that they are in compliance with the Act. Failure to comply is punishable by a reduction in benefits to the residents of housing units that fail state standards. Unfortunately, the amendment provides no mechanism for the identification of group living arrangements. States are required to certify the quality of care received in BCHs, but have no federal or state guidelines to aid in their location.

Lack of information at the state level about BCHs makes it difficult for organized social service networks to make decisions regarding placement of dependent individuals. Some states require licensing and inspection of BCHs meeting certain size or organizational criteria (e.g. over six residents, or operating as a
domiciliary) and thereby have at least partial information about
the number and location of facilities. Unfortunately, no other
formal means of identifying or monitoring BCHs exists.

Some controversy continues over the desirability of
additional legislation for BCHs. The lack of regulation allows
some unlicensed facilities to operate in violation of health, fire,
or building codes (Streib, Folts, & Hilker, 1984). However,
government regulation may result in increased operating costs
that would not allow small or medium size homes to operate
profitably (Down & Schnurr, 1991).

Previous Research on Board-and-Care Facilities

Most of the research on noninstitutional long-term care is
anecdotal and incomplete. Some nonsystematic investigations
have been conducted; however, most of this research has focused
on conditions in individual BCHs rather than more general
applications (see, e.g., U.S. House Select Committee on Aging,
1989). Therefore, what is most needed by current policymakers
is basic, descriptive information.

The General Accounting Office (GAO) conducted the first
organized study aimed at identifying and monitoring BCHs
(USGAO, 1979). Because the vast majority of BCH residents were
old, blind, or disabled, GAO speculated that a significant
proportion of these residents received SSI. Relying on State Data
Exchange (SDX) tapes from the Social Security Administration,
GAO was able to produce lists of addresses at which three or
more unrelated SSI recipients resided. Eliminating apartment
buildings, trailer parks, institutions, hotels, and residences
housing recipients with the same surname, GAO found that
approximately 50 percent of a random sample of addresses in
Camden County, New Jersey, and Baltimore, Maryland, met the
criteria for BCHs.

GAO interviewers found that the mentally ill and mentally
retarded (MI/MR) constituted 90 percent of residents who
received SSI disibility and over 50 percent of all residents. Most
were aware that their SSI checks came from the Social Security
Administration, but over half could not recall the amount. Sixty-
eight percent of the respondents endorsed their checks over to
the owner of the BCH but a majority did not receive the required
$30 per month spending money from the facility managers.
Three-quarters of the residents were on prescribed medication
and over half needed assistance in actually taking it.

The facilities themselves were generally in poor condition.
Over half of the BCH operators had no background in health-
related professions and only one-third had received some kind
of specialized training. Nevertheless, virtually all operators
provided twenty-four-hour supervision of residents and some
form of medical management. In short, most of the facilities
studied provided types of care for which the operators had
received no training and for which the facilities were inadequate.

The U.S. Department of Health and Human Services,
Office of the Inspector General conducted the second major
review of the BCH industry (USDHHS-OIG, 1982). Unlike the
GAO study, the USDHHS-OIG study focused on federal and
state responses to developments in the industry. The OIG
surveyed state agencies and examined ongoing federal research,
focusing on policy recommendations meant to increase federal
leverage in an area where federal incentives were few. Although
several of the federal research projects produced results
regarding conditions in licensed and unlicensed BCHs, few of
the findings were reported in the USDHHS-OIG report.

Mor, Sherwood, and Gutkin (1986) examined data from an
Administration on Aging-financed study of licensed residential
care homes in Michigan, Illinois, Massachusetts, Georgia, and
Florida. These facilities ranged in size from small foster homes to
large institutions. Most of the residents of these homes were over
70, female, and widowed. Over half received SSI. Although most
residents were not physically ill, a majority required help with
personal care. Over a third exhibited some evidence of mental
dysfunction. Despite these characteristics, over 70 percent were
happy with their current living situation. External evaluations
revealed that over 85 percent of the residents resided in homes
that provided care at least marginally commensurate with their
physical and mental status. As expected, the level of satisfaction
varied with the quality of the match.
The Denver Research Institute (DRI) conducted the most extensive federal project (Dittmar, 1989) between 1979 and 1983 in seven states (California, Colorado, Florida, Massachusetts, Minnesota, Texas, and Washington). DRI drew a purposive sample of homes from major urban areas. Most of the homes were originally private residences of considerable age (forty-three years on the average) that had been used as BCHs for approximately fifteen years. A majority of the facilities were large and somewhat crowded. Most provided fire alarms and smoke detectors, but not sprinkler systems. Individuals or couples owned a majority of the homes. The typical owner was a white, married female with less than a college education who had worked for over twelve years in the residential care industry. The typical home charged $442 per client per month and the federal government subsidized approximately one-third of this amount, primarily through SSI and Social Security payments to residents. Only about 21 percent of the residents used the owner/operator as their SSI payee. The average client was a sixty-seven-year-old white female who had lived at the home for approximately forty months. Roughly 44 percent of the residents suffered some mental impairment. Most of the residents were in good health, although about one-third suffered physical impairments severe enough to restrict their social functioning.

The American Association of Retired Persons Consumer Affairs Program Department (AARP-CAPD), Dobkin, 1989) conducted the most recent systematic survey of BCHs in Maryland. The AARP-CAPD study investigated the impact of the administrative structure of Maryland's boarding home regulations on BCH effectiveness. The CAPD staff interviewed small purposive samples of BCH operators, residents, and regulators. In general, BCH operators expressed uneasiness about over-regulation and low compensation. State regulators voiced frustration with the continuing referral of clients from social service agencies to unlicensed homes, the poor quality of many residences, the poor training of many operators, the lack of cooperation among responsible state agencies, and their own inability to identify unlicensed homes. The AARP-CAPD staff concluded that BCH programs needed to be centralized under a single state agency for greater visibility and accountability. Furthermore, AARP-CAPD found that the licensing and certification process needed simplification. They also noted that the amount of reimbursement for care should be increased and most operators needed better training.

The results of these surveys and other research, suggest that the current system is in need of change; however, attempts to create new policies and directives are hampered by lack of information. Rapidly increasing costs, administrative and financial fragmentation, and lack of coordinated case management are only a few of the difficulties facing the BCH industry (Morris & Youket, 1981; see also, Brubaker, 1987; Callahan, 1981; Dilworth-Anderson 1987; Montgomery & Hatch, 1987; Quadagno, Sims, Squier, & Wilker, 1987; U.S. House Select Committee on Aging, 1989). To date, studies of the BCH industry have primarily used purposive samples of licensed facilities. With the exception of the GAO pilot study, none of the national or state surveys has attempted to randomly assess conditions in both licensed and unlicensed facilities.

Although BCHs represent an increasingly important component in the long-term care system, very little information is available on the number of facilities, the characteristics of operators and residents, services provided, or even the quality of such living arrangements. Still less is known about referral patterns, health status of residents, and the level of care provided by operators (Baggett, 1989; Down & Schnurr, 1991). One effort to address this need for information was a study conducted in the State of Alabama.

A Study of Board-and-Care in Alabama

The purpose of the study described here was to examine selected characteristics of BCHs in the state of Alabama. Included in this study were both licensed and unlicensed homes. The specific objectives of the research included: a determination of the characteristics of BCH residents; BCH operators; BCH facilities; and examination of the levels of health care provided...
The researchers selected three cities as representative of Alabama Metropolitan Statistical Areas (MSAs). The cities chosen were Huntsville (Madison County), Tuscaloosa (Tuscaloosa County), and Birmingham (Jefferson County). To identify both licensed and unlicensed BCHs in Madison and Tuscaloosa Counties, the study employed the procedure developed by the GAO (1979). The researchers compiled a list of addresses from computer listings for each city where three or more individuals received Supplemental Security Income (SSI) payments. Health and social service agency personnel supplemented the list. After eliminating known apartment buildings, trailer parks, hotels, mental institutions, domiciliaries, and residences housing individuals with the same surname, the staff verified the BCH status of the remaining homes. Identification of facilities in Jefferson County was considerably less complicated since Jefferson is the only county in Alabama that independently licenses and inspects BCHs.

The research team developed, pretested and employed three survey instruments in this study. The first instrument elicited information about characteristics and qualifications of BCH operators. The second instrument gathered information about facility residents. A third instrument assessed the physical structure of the BCHs.

A three- to four-person team visited each site with the permission of the operator. Visits occurred between 9:00 A.M. and 4:00 P.M. and lasted from one to two hours. The visits incorporated owner/operator interviews, environmental audits, and assessments of a sample of up to eight residents in each home. All interviews took place on site.

The interview with the owner/operator took approximately thirty minutes to one hour to complete. The fifty-item instrument gathered information about sociodemographic characteristics; qualifications of the operators; and additional information concerning facility policies and rules, services provided, licensure, and knowledge of a referral network. The DRI instruments provided most of the questions used in the current study (Dittmar, 1989).
railings, and well-lighted corridors. The survey also addressed the provision of necessities such as linen, bedding, toiletries, towels, and laundry facilities. One of the most significant factors for determining the quality of the facility was its level of cleanliness. The environmental audit required researchers to evaluate the overall cleanliness of the kitchens and bathrooms, the condition of bedding, and the smell of the facility.

Descriptive statistics, primarily frequency distributions, served to summarize the data. Results of these analyses appear in Tables 1 through 11.

Results

Residents

Individuals selected for inclusion in the study were at least sixty years of age. As shown in Table 1, subjects ranged in age from sixty to ninety-five with a mean age of seventy-two. Reflecting life expectancy and gender differentials, two-thirds (64 percent) of those surveyed were female and 43 percent were African American, a surprisingly large number because only about 21 percent of the state’s sixty-five-plus population is African American. A slight majority (55 percent) had less than a high school education and the vast majority (92 percent) were unmarried. Half of these were widowed and one-fourth were either divorced or separated. Only one individual had a job outside of the home.

One of the questions under investigation in this study concerned the existence of a referral network between board-and-care operators and other social-service and health-care providers. Table 2 shows information about length of stay, prior residence, and referral source. Even though the majority of the residents was fairly recently arrived (over half reported living there less than two years), the mean length of residence was 4.3 years with 14 percent having lived in the same house for over ten years. Regarding prior residence, information from interviews revealed a common pattern for the 38 percent who moved from independent living arrangements to the BCH. Faced with increasingly more difficult health problems, many found that they needed additional help that was unavailable to them on a day-to-day basis. In addition to this group, another one-third formerly lived in institutional settings such as group homes, mental hospitals, or acute care hospitals. Among this group, most resided in homes for the mentally impaired.
Almost two-thirds (62 percent) had previously lived in the same town, with the remaining one-third living in the same state but in another town. Only one person had lived out-of-state immediately prior to moving into the board-and-care home. While a relative was the single most important referral source (37 percent), health and social service professionals played major roles in referring these elderly residents to boarding homes. Forty percent of all referrals came from BCH operators, social workers and hospital workers. The number would have been even greater if additional information were available about the composition of the “other” referral category. Despite this, professionals accounted for one-fourth of direct referrals.

In general, these residents had both modest incomes and modest expenses. Table 3 illustrates that almost half received SSI payments and about one-third received Social Security checks. Family members contributed little to the upkeep of these BCH residents. Some (8 percent) of the residents worked in the home doing domestic “chores” to supplement their incomes but none earned over $45 per month. Seventy percent received less than $400 monthly from either SSI or Social Security. The mean monthly SSI check for the residents was $318, while for Social Security, monthly checks ranged from $42 to $700 with a mean amount of $396. For the few (6 percent) receiving income from their families, the amount averaged about $51 monthly. Only 7
percent received any other kind of pension: three individuals
reported VA benefits and four were unsure where their income
came from. Clearly, the majority (77 percent) relied on federal
dollars for their basic support.

The low incomes of these residents were matched by low
rates for room and board. Many home operators reported that
they accepted the residents’ SS or SSI checks as payment-in-full
for all board-and-care charges. Some residents paid more than
others because these residents had greater income. Monthly
charges ranged from $100 to $930 with a mean cost of $371 per
month.

Table 4
Physical and Instrumental ADLs
Completed by Residents and Others

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td>77</td>
<td>96.2</td>
</tr>
<tr>
<td>Dressing</td>
<td>72</td>
<td>90.0</td>
</tr>
<tr>
<td>Grooming</td>
<td>70</td>
<td>87.5</td>
</tr>
<tr>
<td>Walking</td>
<td>71</td>
<td>88.8</td>
</tr>
<tr>
<td>Transferring</td>
<td>78</td>
<td>97.5</td>
</tr>
<tr>
<td>Bathing</td>
<td>62</td>
<td>77.5</td>
</tr>
<tr>
<td>Toileting</td>
<td>79</td>
<td>98.7</td>
</tr>
</tbody>
</table>

IADLs+

| BCH Operators | 47 | 62.0 |
| Relative      | 24 | 31.5 |
| Others        | 5  | 6.5  |

* completed by self
+ primary helper

Source: Lorin A. Baumhover et al. 1991. Subterranean Networks of Board and
Care for the Elderly: A Survey of Boarding Home Operators and Residents.

In looking at the daily activities of these residents, passive
activities such as watching television (90 percent) or listening to
the radio (64 percent) occupied much of their time. While almost
two-thirds reported going for walks (64 percent) and talking on
the telephone (61 percent), most spent their time involved in
tasks that required little or no social interaction.

Table 4 includes information on both physical and
instrumental ADLs. Local licensure requirements in some areas
mandated that all BCH residents demonstrate their capability to
extricate themselves from the facility in case of a fire. In addition,
local requirements assume that these individuals are not
sufficiently disabled or disoriented to warrant nursing home
placement. Approximately 90 percent reported they were
capable of carrying out necessary ADLs with the possible
exception of bathing or showering.

A closer examination of IADLs revealed a different
picture. In examining the residents’ ability to handle personal
affairs, such as managing money and making medical
appointments, about three-fourths (74 percent) reported they
needed help in handling these kinds of personal tasks. When
asked who was their primary helper, or the single individual
they would turn to first for assistance, BCH operators were
identified most often. Residents reported that they relied on the
BCH operators two to one over family members or other helpers.
Whereas either personal attachment or proximity could explain
this reliance on BCH operators and staff, an alternative
explanation is the absence of living family members or other
potential caregivers. A majority of BCH residents (53 percent)
also ranked operators as the second choice of helper over family
(33 percent) and others (14 percent).

Table 5 reports the residents’ subjective evaluation of their
personal health. A slight majority (51 percent) of residents
reported their health as only fair or poor. When comparing their
current health to last year, about one-third felt better, one-third
felt the same, and one-third felt worse. Nevertheless, only 27
percent reported that their health interfered with their normal
activities and an overwhelming majority (82 percent) considered
their health better than or the same as others their age.
Residents were asked a series of questions about their use, source, and knowledge of medications they used on a daily basis. These results appear in Table 7. Ninety percent took at least one prescription drug daily, 64 percent took two or more and about one-third (36 percent) took more than three medications per day. In addition, some 40 percent took at least one other nonprescription medicine on a daily basis. By combining prescription and nonprescription drugs, BCH residents consumed, on average, at least three separate medications daily.

Interviewers attempted to determine the extent of multiple drug-taking behavior by ascertaining if medications came from more than one physician or from more than one pharmacy. About 20 percent of the respondents didn’t know if their medications came from multiple sources, one-fourth (28 percent) reported more than one physician prescribed drugs for them and one-third (36 percent) reported receiving drugs from more than one pharmacy.
Table 7
Number, Type, and Source of Medications Used by Residents

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>5</td>
<td>9.8</td>
</tr>
<tr>
<td>1</td>
<td>16</td>
<td>3.4</td>
</tr>
<tr>
<td>2</td>
<td>14</td>
<td>27.5</td>
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<td>3-4</td>
<td>8</td>
<td>15.7</td>
</tr>
<tr>
<td>5-6</td>
<td>8</td>
<td>15.7</td>
</tr>
<tr>
<td>Daily Nonprescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>23</td>
<td>59.0</td>
</tr>
<tr>
<td>1</td>
<td>11</td>
<td>28.2</td>
</tr>
<tr>
<td>2-3</td>
<td>5</td>
<td>12.9</td>
</tr>
<tr>
<td>Purpose of Drug</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understands</td>
<td>31</td>
<td>51.9</td>
</tr>
<tr>
<td>Some understanding</td>
<td>10</td>
<td>15.3</td>
</tr>
<tr>
<td>No understanding</td>
<td>20</td>
<td>32.8</td>
</tr>
<tr>
<td>Medication Schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completely understands</td>
<td>28</td>
<td>42.1</td>
</tr>
<tr>
<td>Somewhat understands</td>
<td>8</td>
<td>11.1</td>
</tr>
<tr>
<td>Cannot explain schedule</td>
<td>21</td>
<td>35.8</td>
</tr>
</tbody>
</table>


Possibly more serious, however, was the very limited understanding that these residents had concerning the purposes of their medications and of their specific medication schedules. Although over half the residents were able to explain the therapeutic justifications for all their medications, 16 percent had only limited understanding and about one-third were not at all able to explain why their medications had been prescribed.

Another very important issue involves the care and accuracy with which older BCH residents take their prescribed medications. When interviewers questioned residents about opening medicine containers, reading instructions, or getting their medicines, very few of the residents reported they had any problems in managing their medications. Observations by the research team, however, revealed that most BCH operators stored the medications, reminded residents to take specific drugs and, at times, administered the medications themselves. Thus, one reason why older residents reported no difficulties in managing their medications was that BCH operators provided these services for them.

BCH Operators

BCH operators interviewed in this study were predominantly African American, married, and female. The operators were typically fifty-five years of age with at least a high school education (see Table 8). Almost 95 percent rated their health as good or excellent. Although over half reported experiencing some degree of job-related stress, most also reported that they had relief staff (80 percent) and some time off (84 percent). About one-fifth of the operators reported their facility was not staffed twenty-four hours a day.

Unlike those in previous studies, 80 percent of the operators in this study reported having some specialized training in boarding home operation, although no evidence existed on the specific nature of such training. These operators had been in the business for a considerable time with an average of nine years experience in BCH management.
Table 8
Operator Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>16</td>
<td>41.0</td>
</tr>
<tr>
<td>African American</td>
<td>23</td>
<td>59.0</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>5.1</td>
</tr>
<tr>
<td>Female</td>
<td>37</td>
<td>90.2</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
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<td></td>
</tr>
<tr>
<td>Married</td>
<td>30</td>
<td>76.9</td>
</tr>
<tr>
<td>Divorced</td>
<td>6</td>
<td>15.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>7.7</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;12</td>
<td>8</td>
<td>21.0</td>
</tr>
<tr>
<td>12</td>
<td>14</td>
<td>36.8</td>
</tr>
<tr>
<td>&gt;12</td>
<td>16</td>
<td>42.2</td>
</tr>
<tr>
<td><strong>Health—self rating</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>13</td>
<td>33.3</td>
</tr>
<tr>
<td>Good</td>
<td>24</td>
<td>61.5</td>
</tr>
<tr>
<td>Poor</td>
<td>2</td>
<td>5.1</td>
</tr>
<tr>
<td>Terrible</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Get time off</td>
<td>32</td>
<td>84.2</td>
</tr>
<tr>
<td>Have relief staff</td>
<td>31</td>
<td>79.5</td>
</tr>
<tr>
<td>Received specific training</td>
<td>30</td>
<td>81.1</td>
</tr>
<tr>
<td>Under considerable stress</td>
<td>20</td>
<td>51.3</td>
</tr>
<tr>
<td>Own multiple BCHs</td>
<td>14</td>
<td>36.8</td>
</tr>
<tr>
<td>Manage multiple BCHs</td>
<td>12</td>
<td>33.3</td>
</tr>
</tbody>
</table>


Operators enjoyed considerable autonomy in determining the types of residents accepted, rules of conduct, services provided, and degree of resident autonomy. Most homes had prohibitions against residents who were potentially dangerous to themselves or others and those with substance abuse problems (see Table 9). In addition, over 60 percent of the homes would not accept individuals with severe physical impairments. Because residents must be able to exit the building without assistance in the event of an emergency, operators were apparently reluctant to accept responsibility for residents who were unable to function independently.

Table 9
Types of Residents Accepted in the Facility

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly</td>
<td>39</td>
<td>100.0</td>
</tr>
<tr>
<td>Prescription medication</td>
<td>39</td>
<td>100.0</td>
</tr>
<tr>
<td>Previously institutionalized</td>
<td>32</td>
<td>82.1</td>
</tr>
<tr>
<td>History of mental illness</td>
<td>31</td>
<td>79.0</td>
</tr>
<tr>
<td>Confused</td>
<td>28</td>
<td>73.0</td>
</tr>
<tr>
<td>Mentally impaired</td>
<td>27</td>
<td>69.2</td>
</tr>
<tr>
<td>Mentally ill</td>
<td>17</td>
<td>47.2</td>
</tr>
<tr>
<td>Severe physical disabilities</td>
<td>15</td>
<td>38.5</td>
</tr>
<tr>
<td>Combative</td>
<td>12</td>
<td>30.0</td>
</tr>
<tr>
<td>Hostile</td>
<td>11</td>
<td>28.2</td>
</tr>
<tr>
<td>Alcoholic</td>
<td>10</td>
<td>25.6</td>
</tr>
<tr>
<td>Drug abuser</td>
<td>7</td>
<td>17.9</td>
</tr>
</tbody>
</table>


Over 60 percent of the homes posted rules governing conduct. While most (75 percent) allowed residents to smoke and had designated smoking areas (81 percent), few (14 percent) allowed alcohol consumption on the premises. Residents could receive visitors in 71 percent of the homes, but regulations usually governed the visiting hours in those homes. Half of the homes also restricted the hours during which residents could leave the premises. This is not too surprising since most of the BCHs in the study were located in areas identified as high-crime areas.
<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make medical appointments</td>
<td>29</td>
<td>74.4</td>
</tr>
<tr>
<td>Remind to take medications</td>
<td>28</td>
<td>73.7</td>
</tr>
<tr>
<td>Keep prescription medicines</td>
<td>22</td>
<td>64.7</td>
</tr>
<tr>
<td>Keep OTC medicines</td>
<td>19</td>
<td>54.4</td>
</tr>
<tr>
<td>Manage money</td>
<td>19</td>
<td>52.8</td>
</tr>
<tr>
<td>Help take medicine</td>
<td>18</td>
<td>47.4</td>
</tr>
<tr>
<td>Help make phone calls</td>
<td>14</td>
<td>36.8</td>
</tr>
<tr>
<td>Help bathe</td>
<td>13</td>
<td>35.1</td>
</tr>
<tr>
<td>Help write letters</td>
<td>12</td>
<td>30.8</td>
</tr>
<tr>
<td>Help dress</td>
<td>9</td>
<td>24.3</td>
</tr>
<tr>
<td>Help with toileting</td>
<td>8</td>
<td>20.5</td>
</tr>
<tr>
<td>Help shave</td>
<td>7</td>
<td>20.0</td>
</tr>
<tr>
<td>Help eat</td>
<td>3</td>
<td>8.1</td>
</tr>
<tr>
<td>Help brush teeth</td>
<td>3</td>
<td>8.1</td>
</tr>
</tbody>
</table>


Services provided by BCHs were generally appropriate to noninstitutional care facilities (see Table 10). Most provided residents some assistance with ADLs. In-house recreational activities were available in most of the homes, and residents in over half of the facilities participated in outside activities. Most operators provided transportation for shopping, recreational activities, church, and medical or dental appointments.

Over half of the operators managed residents' money, and 51 percent were designated as the Social Security payee for at least one resident. The vast majority (85 percent) of those who managed residents' money kept records of expenditures.

Nearly all of the homes kept some type of resident records. These records generally consisted of the resident's name, the name of the resident's nearest relative, the name of the resident's physician and a list of the resident's current medications. In some cases the records contained the name of the resident's dentist and social worker.

In providing meals, 74 percent of the operators said they consulted a dietician and nearly two-thirds reported cooking for special diets. Although one-third of the homes reported having cooks on staff, the operator or a home employee other than a cook were usually responsible for meal preparation.

Nearly three-quarters of the operators assisted residents in scheduling medical appointments. Nearly 50 percent of the home operators reported that they kept residents' over-the-counter and prescription medicines in kitchen cabinets, indicating that residents did not control their own medications. While almost three-quarters of the operators reminded residents to take medicines, nearly half also administered medications. Since operators generally lacked medical training, such assistance is inappropriate. These findings support previous studies indicating that BCH operators sometimes provided services in excess of what is allowable in the regulatory statutes.

A surprisingly high degree of support existed among operators for BCH regulation (68 percent in favor) and licensure by the state (76 percent in favor). In view of the varying numbers and types of permits, certificates, and inspections required to operate a BCH, support for regulation may indicate a preference for uniform standards and reporting procedures.

BCH Structures

A majority of the facilities operated in older buildings (the mean age of the homes was forty-five years) originally constructed as private residences and not as boarding homes. The structures were of moderate size with an average maximum occupancy of ten boarders. These facilities had been boarding homes for an average of ten years. Many of the buildings had not been modified for current usage and were therefore inappropriate or unsafe for the current inhabitants (see Table 11). Although the majority of homes surveyed had only one level, 41 percent had two or more floors and several also had basements where residents lived. Basic safety features, such as handrails at staircases were absent in 20 percent of the multi-level structures. Access to the front door was difficult in 33
percent of the facilities either because of exterior steps without handrails or the absence of a ramp. Lack of these features could retard or prevent physically impaired individuals from exiting the building during an emergency.

Table 11
Safety Features in Homes

<table>
<thead>
<tr>
<th>Feature</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire extinguishers</td>
<td>37</td>
<td>92.5</td>
</tr>
<tr>
<td>Smoke detectors</td>
<td>35</td>
<td>85.4</td>
</tr>
<tr>
<td>Outside stairs have rail</td>
<td>32</td>
<td>80.0</td>
</tr>
<tr>
<td>Windows unblocked</td>
<td>29</td>
<td>70.7</td>
</tr>
<tr>
<td>Outward opening exits</td>
<td>27</td>
<td>67.5</td>
</tr>
<tr>
<td>Exits clearly marked</td>
<td>27</td>
<td>67.5</td>
</tr>
<tr>
<td>Emergency plan posted</td>
<td>20</td>
<td>52.6</td>
</tr>
<tr>
<td>Inside stairs have rail</td>
<td>20</td>
<td>80.0</td>
</tr>
<tr>
<td>Exterior ramps</td>
<td>12</td>
<td>29.3</td>
</tr>
<tr>
<td>Fire sprinkler system</td>
<td>5</td>
<td>12.8</td>
</tr>
</tbody>
</table>


Fire safety equipment, including extinguishers, smoke detectors, and sprinklers, was not present in all facilities. Fire and safety hazards observed in the homes included rooms with blocked windows (30 percent), unmarked exits (32 percent), and inward opening doors at main exits (32 percent). In nearly half of the homes, the operators had not posted emergency plans. Four of the homes had unvented space heaters in residents’ bedrooms and common rooms. These situations highlighted a failure to ensure the safety of the boarders.

Although nearly three-quarters of the buildings appeared to be in good condition, many of the homes had damaged plaster, holes in the walls, and “spongy” or weak floors. In some homes, mechanical or electrical items such as ventilation fans were not operable. Lack of maintenance and the resulting structural deterioration suggested that boarding home income was not sufficient to cover necessary repairs.

Sub-institutional Facilities

Privacy and personal space for residents, essential elements of a home environment, were lacking in many BCHs. Basic amenities, such as sufficient drawer space and individual closet storage space for each boarder, were not consistently provided. Furthermore, residents’ rooms did not have telephones in 85 percent of the homes.

Discussion

The profiles of residents, operators, and homes were fairly consistent across the homes visited. The typical elderly resident was a previously-married, 72-year-old white female, with less than a high school education—although nearly half the residents were African American. The residents moved to the boarding home from a variety of dwellings ranging from their own homes to institutional settings. Approximately equal proportions of relatives and health-care professionals made referrals to the homes. Some homes had high turnover of residents while others catered to long-term residents. The dominant source of income for most residents, and thus for most BCH operators, was Social Security or SSI.

Most residents had somewhat limited physical and mental capacities. Although the vast majority of residents could perform the basic ADLs, most had difficulty with IADLs, which they relied on the BCH operator to provide. They reported their personal health as somewhat poorer than they hoped; yet most residents argued that their health did not interfere with their normal activities and they were better off than most. The relatively passive activities, such as watching television and listening to the radio, in which they engaged may explain the lack of interference from their health. A more serious shortcoming was the relative lack of knowledge they had about their medicines and medication schedules. Half of all residents did not have sufficient knowledge to administer their own medications. Yet most residents reported no problems with taking medication. Clearly, the BCH operators had acquired a central role in the health care of these residents.
The research reported here suggests other instances where the role of the BCH operator is central to the life of the BCH residents. The typical operator was African American, married, and female with at least a high school education. For most operators, Social Security or SSI checks were the sole source of payment for BCH charges. Over half the operators were the designated payee for at least some of their residents. However, the income received was barely sufficient for the BCH operation.

Although 80 percent of the boarding home operators surveyed reported special training, their training was generally not directly related to BCH operation. Training often consisted of past work experience in health care settings, especially as nurses and nurses' aides. Most operators had never operated BCHs before owning and operating the current facility.

Despite the lack of training specific to boarding homes, the operators exercised significant control over the type of resident admitted to the home, the rules of conduct in the home, the type of services provided, and the overall autonomy of the residents. A majority of BCH operators explicitly excluded residents with severe physical limitations, behavioral problems, or chemical dependencies. Most operators limited the types of behaviors allowed in the home, setting rules concerning smoking and consumption of alcohol. A majority of operators also provided services related to the independent functioning of the residents, including the scheduling of medical appointments, medication management, and financial management. Finally, the operators of most facilities limited the movements of their residents by setting curfews and visitation hours.

The homes themselves were generally in fair to poor condition. Most were older structures located in the sections of Birmingham, Tuscaloosa, and Huntsville (all in Alabama) characterized by generally low-income housing. Because the homes were designed primarily as single-family dwellings, few had been adapted to the needs of a partially dependent population. Many had significant obstacles to access, particularly a lack of ramps and handrails. Approximately one-third to one-half of the homes had significant safety problems including blocked windows, unmarked exits, and inward-opening doors.

The overall lack of maintenance suggests that revenues were not sufficient to cover the costs of needed repairs.

Overall the Alabama surveys revealed a reasonably close match among residents, operators, and facilities, confirming much of the earlier research (Littmar, 1989; Dobkin, 1989; Mor, Sherwood, & Gutkin, 1986; USDHHS-OIG, 1982; USGAO, 1979). A significant portion of the board-and-care industry consists of the poor taking care of the poor. BCHs in Alabama were not exceptions. Nevertheless, boarding homes in Alabama, even licensed facilities, may be providing services that exceed their legal appropriateness. It is clear that some residents currently living in BCHs would be more safely housed in facilities providing higher levels of care such as domiciliaries and nursing homes. Conversely, some nursing home residents do not require the level of care provided in these facilities and may better be served in facilities with lower levels of care.

Unfortunately, the development of long-term care facilities in the United States has been fragmented and incomplete. No systematic mechanisms for the development of private or public oversight have been developed. Considerable variation exists between states, and even between counties within the same state, regarding licensure and certification requirements. In addition, little is known about current facilities and little planning has been done concerning the demands that demographic, economic, social, and political changes may impose on the long-term care system. The availability of board-and-care beds is increasing, yet there is little evidence that appropriate planning is being carried out for these new homes. Such limited policy development does not bode well for the future.

Conclusion

Incremental policy decisions and private market forces have produced a subterranean referral network for noninstitutional long-term care in the United States. This network, consisting primarily of health-care professionals who refer individuals to BCHs, does not operate as a coordinated system. Further, there is little coordinated governmental oversight of the
BCHs themselves. Many homes have no supervision at all while several agencies regulate others. For example, in Alabama the Department of Human Resources, the Department of Public Health, the Department of Mental Health, and the US Department of Veterans Affairs all have some regulatory responsibility over the board-and-care industry. In Jefferson County (Birmingham), the Jefferson County Department of Health also directly monitors the industry. Each of these agencies has its own mandates and regulations that frequently place contradictory demands on BCH operators and facilities.

The Alabama data suggest that the match between resident, operator, and facility is fairly good. Nevertheless, the potential for both intentional and unintentional mistreatment exists. The most serious problems would appear to arise from the level of medical care provided by most BCHs. Although some operators have experience in the health-care industry, the administration of medication and the provision of personal care by untrained or undertrained BCH employees poses a significant health risk to BCH residents. This is especially true because the typical Alabama BCH resident takes three medications daily and approximately half of the residents have little or no understanding of either the medication or the schedule for administration.

Despite these shortcomings, board-and-care homes play an important subsidiary role in the provision of long-term care. The only source of income for many elderly and developmentally disabled individuals is Social Security or SSI. BCHs, by accepting these checks as full payment, provide food and shelter for individuals who might otherwise be homeless. For many of these individuals, family members are either unavailable or unwilling to be involved in their lives. In addition, many board-and-care operators were found to be compassionate, caring individuals who became operators, in part, because of their desire to help those worse off than themselves. The homes operated by these individuals, by and large, provide a safe haven for an often-exploited population.

Unfortunately, the aging of the American population and, in particular, the aging of the minority population, is likely to place increasing stress on such an ad-hoc system of care. The increasing demand for such facilities is likely to attract the unscrupulous as well as the caring operator. National and state governments need to do a better job of coordinating and supervising the growth of the industry, before the demand becomes so great that such coordination and supervision are impossible to implement.

NOTE

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CHAPTER 9

Temporary Housing: Adult Daycare and Respite Services

Jan W. Weaver

A number of demographic, socioeconomic, and health-related characteristics affect the housing preferences of older adults. Research has shown that the majority of today’s older persons live in a community setting rather than in institutions (Soldo & Brothman, 1981; Walsh, 1981; Conrad & Guttman, 1991). Since approximately half of these individuals are impaired in some way (Soldo & Brothman 1981), variations in living arrangements occur and are affected by a wide array of factors including functional ability, personal preference, health status, social factors, financial security, and other social and familial circumstances.

The diversity in living arrangements for older adults is also dependent upon the availability of noninstitutional health and social support systems that provide a variety of services for promoting independence and thus maintaining the older person in the community. This system, often referred to as a continuum of care, includes programs such as adult daycare, home care, support services, and other forms of respite that bridge the gap between independent living and institutional care.