U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

Licensed Board and Care Homes:

Preliminary Findings from the 1991 National Health Provider Inventory

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Office of the Assistant Secretary for Planning and Evaluation

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This report was prepared by HHS's ASPE and the Research Triangle Institute. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The Project Officer was Robert Clark.

LICENSED BOARD AND CARE HOMES:
Preliminary Findings from the 1991 National Health Provider Inventory

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BACKGROUND

Community-based living arrangements for dependent populations (disabled elderly, mentally ill, and mentally retarded or developmentally disabled) are increasingly recognized as "a critical, yet largely untapped resource for long term care" in the United States (AARP, 1989:1). Board and care homes constitute one type of community-based living arrangement for frail elderly and other disabled adult populations.

Board and care homes may be defined as non-medical community-based facilities that provide protective oversight and/or personal care in addition to meals and lodging to one or more residents with functional or cognitive limitations. Locally, these facilities may go by names such as group homes, domiciliary care homes, rest homes, residential care facilities, and personal care homes. There is immense variation in the regulations used by each state to monitor these homes (Hawes, Wildfire and Lux, 1993; Lewin/ICF, 1990; Stone and Newcomer, 1982).

Congress is increasingly concerned about the adequacy of federal and state regulation of board and care homes (U.S. House of Representatives, 1989). Congressional committees, the press, and advocacy groups for elderly and disabled persons have documented instances where board and care home residents have become victims of unsafe and unsanitary living conditions, abuse, neglect and fraud by owner/operators.

The federal role in board and care regulation is primarily defined by the 1976 Keys Amendment to the Social Security Act. It requires states to certify annually to the U.S. Department of Health and Human Services (DHHS) that they have established standards for board and care homes housing Supplemental Security Income (SSI) recipients. Substandard homes are subject to having their federal SSI payments reduced “by the amount of the state supplement paid to SSI recipients for ?medical or remedial care’” (U.S. General Accounting Office, 1989:34). However, such a sanction is widely seen as virtually unworkable in practice (the effect is to penalize the SSI recipient) and has never been enforced.

There are pressures for expanding the federal role in the oversight and regulation of board and care homes (GAO, 1989). At the state level there is evidence of support for national minimum board and care standards (U.S. Department of Health and Human Services, 1990). Among some, there is concern that the government might overregulate and possibly drive out of business a large (but unknown) number of effective and caring providers. At the same time, the protection and well-being of residents, many of whom lack other care options, are paramount.

The development of policy options regarding board and care homes has been hampered by the lack of good data on the industry. Available data on the number of homes and residents nationwide are limited at best. While instances of fraud, abuse and

neglect have received widespread attention, the scope and frequency of such treatment is not known (McCoy and Conley, 1990).

In view of its role as policy advisor to the Secretary, DHHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) has undertaken several recent initiatives to improve our understanding of board and care as a long-term care option. ASPE funded a study conducted by the Research Triangle Institute of the effect of licensure and regulation on the quality of board and care homes in 10 states. ASPE and the Office of the Assistant Secretary for Health (OASH) also collaborated with the Census Bureau to determine whether the decennial Census provides a suitable frame for selecting board and care places.

Most important for present purposes, ASPE provided the funding to support the identification of licensed board and care homes as part of the 1991 National Health Provider Inventory (NHPI). The NHPI, conducted by the National Center for Health Statistics and the Bureau of the Census, provides the first national database of board and care homes. Here, we describe the process we used to identify board and care homes from the NHPI and our findings regarding those facilities.

NATIONAL HEALTH PROVIDER INVENTORY

Content and Scope

The NHPI contains basic information about licensed board and care homes--bed size, ownership, and clientele profile. The inventory also contains data on nursing homes, making it possible to compare nursing homes and board and care homes along a number of important dimensions.

While its coverage is extensive, the NHPI does not include all board and care homes. In constructing the frame for the NHPI, addresses were compiled from a variety of sources including a state-by-state canvassing of agencies which license residential facilities. In developing this list, an intentionally broad perspective was taken, that is, including places that were later determined to be out-of-scope was preferred to excluding places that were in scope. Homes identified as primarily serving children or the chemically dependent, however, were excluded from the list.

In addition, the NHPI includes only licensed board and care homes. There are an unknown number of unlicensed board and care homes. A 1989 U.S. House of Representatives Subcommittee report estimated that there are some 28,000 unlicensed board and care homes nationwide. Some observers believe that this is the fastest growing segment of the board and care industry. For the present, we are limited to what can be learned about licensed board and care homes.

Identifying Board and Care Homes

Because of the intentionally broad perspective taken in constructing the frame, not all of the facilities initially identified as potential board and care homes really were. We developed a series of decision rules to identify board and care homes from amongst respondents. First, places which self-identified themselves as board and care homes were included. Some facilities provided written descriptions of themselves. Facilities identifying themselves using terms known to be used to describe board and care facilities by the state in which they were located were presumed to be board and care homes. In addition, facilities using terms commonly considered as describing board and care homes were included. Next, facilities clearly describing themselves as something other than a board and care facility (e.g., convents preschools), were excluded. Finally, facilities that could not be included or excluded by any of the preceding rules were evaluated based on the services they provided. Facilities that provided protective oversight or other services above and beyond room and board were considered board and care homes.

Non-Response Weights

As with other national surveys, the NHPI experienced significant non-response. As such, in addition to facilities inadvertently omitted from the original frame, some facilities believed to be board and care homes were "lost" to non-response. Initially, nearly 17,200 facilities failed to respond to three rounds of mailings.

Due to financial constraints, only half of these 17,200 facilities received additional phone and in-person follow-up. There were 8,578 initial non-respondents that received no phone or in-person followup. Of the half that were initially non-respondents but were included in the followup, 70% completed the survey and an additional 29% were deemed to be out-of-scope or out-of-business, resulting in an overall 99% response rate. The final one percent (comprising 262 refusals) remained non-respondents (Sirrocco, 1994).

While a 99% conversion rate for the approximately 8,600 facilities that received additional follow-up is outstanding, it still left as non-respondents nearly 8,600 potential board and care homes. Techniques are available, however, to account for any bias in the results caused by these "missing" facilities. We chose to apply non-response weights to the non-missing board and care homes to adjust for any potential non-response bias. This is done by using all available information about homes that chose not to respond and comparing them to homes that did respond.

To create the weights, we first grouped all facilities by bed size--something known about most respondents and non-respondents--and compared response rates within each grouping. (For facilities for which bed size was missing, we imputed bed size based on state and ZIP code using a "hot-deck" algorithm.) This confirmed our hypothesis that bed size was related to the likelihood of responding to the survey. Larger facilities were the most likely to respond, with response rates dropping with the number of beds. Ninety-six percent of large facilities (defined as having 100 or more beds) responded compared to 80 percent of those with five or fewer beds.

Based on these differential response rates, eight bed size categories were used to generate non-response rates. Thus, facilities with characteristics that appeared to be disproportionately represented among non-responders (i.e., small facilities) were weighted more highly than facilities that were more likely to respond (i.e., large facilities). The data presented here are weighted using these non-response weights.

It should be noted that the findings presented here differ somewhat from those reported by Sirrocco (1994), whose data exclude the 8,578 nonresponding board and care cases. The effect of applying our decision rules for including or excluding facilities and of applying nonresponse weights was to generate a higher national total for licensed board and care homes.

FINDINGS

Nationally there were in 1991 an estimated 34,090 licensed board and care homes. Over 90% are in the private sector, either for-profit or non-profit. Over three out of five homes (63.0%) are run on a for-profit basis. (See Table 1.)

TABLE 1. Licensed Board and Care Homes by Ownership: USA (1991)		
	Number	**Percent**
For-profit	21,464	63.0
Non-profit	10,294	30.2
Local Government	750	2.2
State Government	993	2.9
Federal Government	205	0.6
Not Reported	383	1.1
Total	34,090	100.0
SOURCE: 1991 National Health Provider Inventory		

There are 383 homes whose status is not reported. In this as in the following tables, we include such missing information in the total. If these homes were allocated among the other five ownership categories, the for-profit category would rise an additional percent.

As a percentage of the total and based on Census geographic regions, licensed board and care homes are most concentrated in the West (31.6%) and least concentrated in the Northeast (18.2%). (See Table 2.)

TABLE 2. Licensed Board and Care Homes by Region: USA (1991)		
Region	**Number**	**Percent**
Northeast	6,203	18.2
Midwest	9,218	27.0
South	7,892	23.2
West	10,777	31.6
Total	34,090	100.0
SOURCE: 1991 National Health Provider Inventory		

In terms of their clientele, nearly two-thirds (63.8%) of licensed board and care home either serve the MR/DD population primarily (32.4%) or serve no primary type (31.4%). The remainder serve the mentally ill (13.7%), other physically or cognitively impaired persons (17.5%), alcohol or drug abusers (0.2%) or did not report their primary clientele (4.8%) (See Table 3).

TABLE 3. Licensed Board and Care Homes by Clientele: USA (1991)		
Home Primarily Serves…	**Number**	**Percent**
Mentally Ill	4,661	13.7
MR/DD	11,030	32.4
Other Physically/cognitively Impaired	5,892	17.5
Alcohol or Drug Abusers	67	0.2
Other or No Primary Type	10,721	31.4
Not Reported	1,629	4.8
Total	34,090	100.0
SOURCE: 1991 National Health Provider Inventory		

Licensed board and care homes serve over 600,000 persons. (See Table 4.)

TABLE 4. Licensed Board and Care Resident by Age: USA (1991)		
Age of Residents (Years)	**Number**	**Percent**
Up to 21	13,183	2.1
22-64	151,754	24.7
65-84	252,258	41.1
85+	149,420	24.4
Not Reported	46,869	7.6
Total	613,483	99.9
SOURCE: 1991 National Health Provider Inventory		

It has long been held that the majority of board and care residents are elderly. The NHPI data bear out this belief. Nearly two-thirds of all board and care residents (65.5%) are age 65 or over. Almost a quarter are age 85 or over. Age was not reported for nearly 47,000 residents (7.6%).

The majority of board and care residents are female (59.1%). (See Table 5.) About a third are male. Gender was not reported for nearly 50,000 residents (8.9%).

TABLE 5. Board and Care Resident by Gender: USA (1991)		
Gender	**Number**	**Percent**
Male	196,496	32.0
Female	362,377	59.1
Not Reported	54,610	8.9
Total	613,483	100.0
SOURCE: 1991 National Health Provider Inventory		

These figures exclude 419 homes where no information was provided on the previous night's residents (394 homes) or on either number of beds or the previous nights residents (25 homes).

Finally, for comparison purposes we look at board and care clientele by ownership type. (See Table 6).

TABLE 6. Licensed Board and Care Homes by Ownership and Clientele: USA (1991)										
Primary Source	For Profit		Non-Profit		Government (Federal, State, Local))		Not Reported		Total	
	#	%	#	%	#	%	#	%	#	%
Mentally Ill	2,632	12.3	1,595	15.5	370	19.0	65	17.0	4661	13.7
MR/DD	4,739	22.1	5,228	50.8	909	46.7	154	40.2	11,030	32.4
Other Physically/ Cognitively Impaired	4,702	21.9	1,070	10.4	190	9.8	20	5.2	5,982	17.5
Alcohol or Drug Abusers	37	0.2	25	0.2	4	0.0	0	0.0	67	0.2
Other/No Primary Type	8,131	37.9	2,098	20.4	414	21.3	78	20.4	10,721	31.4
Not Reported	1,223	5.7	279	2.7	61	3.1	66	17.2	1,629	4.8
Total	21,464	100.0	10,294	100.0	1,948	100.0	383	100.0	34,090	100.0
SOURCE: 1991 National Health Provider Inventory.										

If we compare the percentage of all homes serving a particular client group with the percent of specific ownership types serving that group, some interesting patterns emerge,

For example, 13.7% of all board and care homes serve the mentally ill. Compared to 15.6% of non-profit homes and 19.0% of government homes, a somewhat lower 12.3% of for-profit homes serves this clientele.

Similarly, 32.4% of all homes serve the MR/DD population. For non-profits, this rises to 50.8% and for government homes 46.7%. By contrast, 22.1% of for-profit homes serve the MR/DD population.

Non-profit and government homes are more likely to have as their primary clienteles the mentally ill or the MR/DD population compared to for-profit homes.

Conversely, for-profit homes are more likely than non-profits or government homes to serve other physically or cognitively impaired persons. They are also more likely not to have a primary clientele. The percentage of licensed board and care homes serving alcohol or drug abuser residents primarily is minuscule.

With respect to age, 65.5% of board and care residents are aged 65 or over. The pattern is similar for two discrete ownership types--67.0% for-profit homes, 66.1% for non-profit homes but rather less for government homes--44.2%. Government board and care homes serve predominantly an non-elderly population.

DISCUSSION

The number of board and care facilities identified by the NHPI is lower than the best previous national listing of board and care homes. A 1991 survey of licensing agencies conducted for the American Association of Retired Persons identified approximately 32,000 board and care facilities (Hawes, Wildfire, Lux, & Clemmer, 1993). Adding to this figure the approximately 4,800 Adult Residential Care Facilities in California omitted from the AARP study yields a total of 36,872 board and care homes. The AARP study, however, did not include facilities licensed by mental health agencies --facilities which are included in the NHPI estimate. As there are some 15,000 facilities which self-identified themselves as homes for the mentally ill or the mentally retarded/developmentally disabled, the difference in the estimates is significant.

Several possible explanations can be tendered. The NHPI estimate excludes facilities that went out of business between frame development and the fielding of the survey. Due to the lag between frame development and data collection however, it also likely excludes a significant number of board and care homes that entered the market following frame development. Annual turnover in the board and care industry appears to be high, perhaps as much as 25%. Thus, new entrants to the market in 1991 may be undercounted on the NHPI.

The NHPI also appears to undercount small homes. A ten-state comparison of board and care facilities by size between the NHPI and the AARP list revealed that the latter identified significantly more homes with 10 or fewer beds. Why the NHPI systematically missed small homes is unclear.

SUMMARY AND CONCLUSION

The 1991 National Health Provider Inventory provides an extremely valuable database with which to examine the nation's board and care industry. In addition to yielding some basic information on the size and characteristics of the industry, it can be used as a sampling frame for more in-depth surveys.

This paper has presented some preliminary findings on board and care at the national level. The data indicate that there were about 34,000 licensed board and care homes in 1991. Over three-fifths were run on a for-profit basis. Non-profits and government-sponsored board and care homes were more likely than for-profits to serve the mentally ill and MR/DD populations. For-profits tended not to focus on one primary type of clientele.

The licensed board and care industry serves over 600,000 persons. Nearly two-thirds of them are elderly and nearly three-fifths are female. The oldest old (persons age 85 or over) make up almost quarter of the board and care resident population.

Longitudinal data are needed to determine how the board and care industry changes over time. Data are needed on unlicensed homes. The data from the 1991 NHPI confirm that the board and care industry plays a significant role in the housing and care of the frail elderly and other functionally disabled populations.

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