

Building Adult Foster Care: What States Can Do

People who need long-term services and supports (LTSS) want more choices for homelike support in small residential settings. As states attempt to “balance” LTSS to offer consumers a broader array of services, they need to consider how to develop, regulate, and fund an array of home and community-based services, including adult foster care.

This In Brief summarizes a new Public Policy Institute report that examines the role of adult foster care (AFC) within the array of long-term services and supports.

The report, *Building Adult Foster Care: What States Can Do*, explores the trends and issues facing AFC providers, discusses the effect of the Nurse Practice Act on the scope of services available in adult foster care, and recommends how states can support the development and growth of AFC services.

WHAT IS ADULT FOSTER CARE?

Adult foster care is a viable alternative to nursing home care for older adults and people with disabilities who prefer to live in the community. It provides residents with a homelike and family-like environment. States use multiple terms for adult foster care, including adult family care, adult family care home, and domiciliary care.

Because AFC is integrated into local communities, individuals can engage in social interactions as they get help with personal care, medications and health-related activities, money management, housekeeping, and transportation to appointments.

DEVELOPMENT AND GROWTH OF ADULT FOSTER CARE

- *AFC is an attractive option for many.* Despite market contraction in several states, state officials, long-term care advocates, and AFC providers view AFC as an important facet of the long-term care landscape. As of December 2008, 30 states reported that 18,901 facilities were operating, with a capacity to serve 64,189 residents.
- *States use a variety of regulatory frameworks.* States typically license providers, although a few states certify them. Twenty-nine states have regulations to license or certify AFC, six states have regulations or standards for AFC to participate in the Medicaid program, and seventeen states cover AFC through assisted living regulations.
- *Many AFC providers started out as family caregivers.* Many of the providers in the studied states were former registered nurses, licensed practical nurses, or certified nursing assistants. Some providers started out caring for a relative or a spouse

and recognized the potential to use these skills to care for others in their own homes while earning a living. The majority of providers enjoy providing this service, but many stress the need for respite services and state support. Most important is access to adult day care and assistance with ongoing training, particularly related to geriatric care and care of persons with more complex needs.

- ***Few AFC providers make a profit; most break even.*** Services in AFC are covered by Medicaid §1915 (c) and §1115 waivers in 14 states, under the Medicaid state plan in 7 states, and through general revenues or Supplemental Security Income in 16 states. In general, AFC providers break even—few indicated profits, with the exception of one privately owned series of homes and two commercially operated chains.
- ***AFC provides services to people with substantial disabilities.*** Despite the expansion of assisted living, the AFC literature and state case studies document the willingness and ability of AFC providers to serve people with high levels of need. Assisted living providers may not find higher need individuals to be attractive clients because of low Medicaid rates and staffing ratio challenges, and some dislike the visual and psychological impact on prospective clients or their families.
- ***Access to nursing care services for AFC providers is a problem.*** Many providers reported challenges accessing nursing care for residents with more intense health care needs. In some states, private duty nursing

is available under the state Medicaid plan or under the same §1915(c) waiver that provides AFC Medicaid funding. In other instances, the state or a local authority coordinates the delivery of nursing care in AFC. Regardless of source, however, AFC providers reported difficulty with securing nurses' time. There is a serious need to examine the extent to which nurses can delegate some of their tasks to others who can safely perform them.

- ***Most AFC providers are small operators and need more training and assistance.*** Providers need appropriate training to serve higher acuity residents, respite services to avoid burnout, and assistance with developing appropriate business tools.
- ***Leveraging natural supports and community connection can help AFC providers.*** Many providers noted the value of engaging family members to assist with care, such as transportation to doctor's appointments, or to provide respite. Additionally, providers realized the value of local or state strategies that link them with other services, such as local volunteer organizations, Area Agencies on Aging services, additional Medicaid benefits, and other public benefits.

POLICY OPTIONS AND PROMISING PRACTICES

Policy-makers interested in developing or expanding AFC should consider the following suggestions:

- Ensure that the single point of entry (SPE) system for long-term care services and supports provides information on AFC.
- Educate consumers about AFC, and develop a matching strategy to ensure that providers can meet the needs of AFC residents.
- Create a uniform disclosure form to provide consumers with comparable information among providers on services and rates.
- Develop clear nurse delegation policies to support AFCs' ability to provide care to residents.
- Implement training programs for providers, resident managers, and family caregivers as a state service within an AFC program.
- Consider developing a tiered reimbursement rate system based on operational costs rather than basing rates on a percentage of nursing home or assisted living payments.
- Establish appropriate case management resources for AFC residents, and develop caseload parameters.
- Develop a systematic, objective mechanism to screen AFC provider applicants for licensure.
- Provide respite personnel or substitute caregivers for AFC providers and resident managers.
- Develop a proactive recruitment process for AFC providers.
- Consider limits on multiple home ownership by an individual provider.
- Consider specialized licensing to address the needs of special populations and residents with higher acuity.
- Consider targeted financial assistance for AFC providers and other small HCBS providers.

CONCLUSION

States are facing major budget shortfalls in the current economic environment and are looking for viable options to provide services and supports to older adults and people with disabilities. Adult foster care may be a cost-effective alternative to institutional care.

From the perspective of consumers, AFC can enhance their ability, regardless of age and income, to participate as fully as possible in all aspects of community living.

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