Evaluation of the Wisconsin Assisted Living Regulatory System

Prepared for Alfred C. Johnson, Director
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Foreword

This report is the result of collaboration between the La Follette School of Public Affairs at the University of Wisconsin–Madison and the Wisconsin Department of Health Services, Bureau of Assisted Living. Our objective is to provide graduate students at La Follette the opportunity to improve their policy analysis skills while providing Wisconsin policymakers and practitioners an analysis of policies and practices for improving the regulation of assisted living facilities.

The La Follette School offers a two-year graduate program leading to a master's degree in public affairs. Students study policy analysis and public management, and they can choose to pursue a concentration in a policy focus area. They spend the first year and a half of the program taking courses in which they develop the expertise needed to analyze public policies. The authors of this report all are in their final semester of their degree program and are enrolled in Public Affairs 869, Workshop in Public Affairs. Although acquiring a set of policy analysis skills is important, there is no substitute for actually doing policy analysis as a means of experiential learning. Public Affairs 869 gives graduate students that opportunity.

This year, workshop students were divided into eight teams. Other teams completed projects for the City of Madison, the Wisconsin Department of Public Instruction and the Wisconsin Department of Children and Families, the Wisconsin Department of Natural Resources, the School of Medicine and Public Health at the University of Wisconsin–Madison, the Legal Assistance to Institutionalized Persons Project at the University of Wisconsin, the Millennium Challenge Corporation, and the University of Notre Dame Environmental Change Initiative.

Assisted living, a less expensive and more homelike alternative to nursing homes for the elderly and disabled, continues to grow rapidly in Wisconsin at rates twice the national average and to the point where assisted living is used more than nursing homes. Assisted living facilities are accepting residents with increasingly complex medical and mental health conditions that they were not originally designed to serve. The Bureau of Assisted Living (BAL) seeks to ensure regulatory compliance so that residents are safe and properly cared for despite facing a growing and increasingly complex assisted living community, increasing budget constraints, and limited regulatory authority. This study for BAL has addressed the question of how to promote and maintain effectiveness in ensuring regulatory compliance and resident protection under such conditions. Using BAL data on non-compliance and complaints, the team identified factors associated with increased odds of a facility committing a serious violation or multiple violations. Interviewing other key states also helped identify best practices. The report recommends an increase in the number of BAL staff, and that BAL conduct random inspections to obtain a more accurate depiction of regulatory compliance and update admissions standards to prevent unsafe resident placements. They provide six additional recommendations designed to streamline the regulatory process, enhance regulatory authority, and increase regulatory consistency across various types of assisted living facilities and BAL regional offices.

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List of Abbreviations

ADC	Adult Day Care
AFH	Adult Family Home
ALFs	Assisted Living Facilities
BAL	Bureau of Assisted Living
CBRF	Community Based Residential Facility
DHS	Department of Health Services
DQA	Division of Quality Assurance
MA	Medicaid
RCAC	Residential Care Apartment Complex
RO	Regional Office
RCF	Residential Care Facility
SOD	Statement of Deficiency
WCCEAL	Wisconsin Coalition for Collaborative Excellence in Assisted Living

Glossary

Adult Day Care – Daytime facility that provides assisted living services.

Adult Family Home – A type of assisted living facility that provides beds for 4 or fewer residents who need no more than 7 hours of nursing care per week.

Bureau of Assisted Living – Bureau within the Division of Quality Assurance responsible for regulation of Adult Day Cares, Adult Family Homes, Community Based Residential Facilities, and Residential Care Apartment Complexes.

Community Based Residential Facility – A type of assisted living facility that provides beds for 4 or more residents who need no more than 3 hours of nursing care per week.

Directed Plan of Correction – A correction plan imposed by the Bureau of Assisted Living in response to violations, based on the specific problems identified and needs of residents.

Division of Quality Assurance – Division of the Department of Health Services responsible for regulating and licensing programs and facilities that provide health, long-term care, mental health/substance abuse services, and caregiver background checks/investigations.

Enforcement – The implementation of a fine or other sanction in response to a violation.

Key Tag Cite – A citation for a serious violation of regulations that involves resident health and safety.

No New Admissions Order – An order prohibiting a regulated entity from admitting new or additional residents.

Plan of Correction – A tool that requires providers in violation of regulations to provide a plan detailing how they will correct their violation(s).

Residential Care Apartment Complex – A type of assisted living facility that provides private apartments for five or more residents who need no more than 28 hours of nursing care per week.

Root Cause Analysis – A tool available to the Bureau of Assisted Living prior to Act 21 that required providers who had violated a regulation to hire a third-party consultant to analyze operational processes and identify failures that lead to the violation.

Statement of Deficiency – legal record of the surveyor's findings, issued after survey determination of non-compliance, which forms the basis for an enforcement decision.

Executive Summary

Nearly 60,000 elderly and disabled Wisconsinites reside in assisted living communities throughout the state. Assisted living is an alternative to nursing homes that is generally about half as expensive and offers a more home-like environment. These attributes drive increasing demand around the country, yet the growth of assisted living in Wisconsin stands out, as the number of assisted living providers has nearly doubled since the early 2000s. As a result, in 2012, the state utilized assisted living at a rate that was fourth-highest in the country and twice the national average. In that same year, Wisconsin was one of ten states where assisted living was utilized more often than nursing homes. As the population ages and demand for assisted living continues to increase, assisted living facilities are accepting residents with increasingly complex medical and mental health conditions that they were not originally designed to serve.

The Wisconsin Department of Health Services, Bureau of Assisted Living (BAL) seeks to ensure regulatory compliance so that residents are safe and properly cared for, but the agency faces many challenges, including a growing and increasingly complex assisted living community, increasing budget constraints, and limited regulatory authority. BAL asked our team to address three questions: (1) How effective is the existing regulatory system in ensuring regulatory compliance and resident protection? (2) Can the existing statutes, policies, and regulatory strategies be changed to ensure greater compliance and improve resident protection? and (3) What are some best practices to consider?

We used three primary methods to address these questions. First, we reviewed academic literature to identify theories and methods that promote regulatory compliance. Second, we interviewed BAL staff, assisted living providers, ombudsmen, advocates, and assisted living regulators from states neighboring Wisconsin or considered to be leaders in the field. Last, we analyzed trends in provider characteristics and regulatory enforcement and conducted two logistic regression analyses on the relationship between Wisconsin assisted living provider characteristics and regulatory noncompliance.

A number of key findings arose from this work. Most notably, we found that, due to budget constraints, BAL's regulatory capacity has not kept pace with the growth in assisted living and falls well behind that of its peers in other states. As a result, BAL confronts a backlog of over 1,100 facilities – roughly 40 percent of Wisconsin facilities – that it cannot inspect within its targeted two-year timeframe. To compensate, BAL relies upon complaints from assisted living residents, their families, medical professionals, and advocates to help prioritize inspections. These limitations may result in missed cases of noncompliance, particularly when residents are vulnerable adults unable to advocate for themselves. However, our data analysis and the experiences of other states suggest that BAL may be able to use its regulatory resources more effectively by targeting providers that are more likely to be noncompliant.

We provide the following recommendations for BAL to consider. BAL is capable of implementing the first three on its own, while the remaining recommendations would require legislative approval. The recommendations are to: (1) Implement an inspection system focused on poor performers; (2) Conduct random surveys to obtain a more accurate depiction of regulatory compliance; (3) Evaluate the consistency of surveyor performance; (4) Increase BAL staff capacity; (5) Increase BAL authority over AFHs; (6) Increase standards for memory care facilities; (7) Reinstate BAL authority to use impending revocation/root cause analysis; (8) Unify rules for enforcement across provider types; and (9) Update facility admission standards to prevent unsafe resident placements.

Introduction

Assisted living is a popular form of supportive housing for elderly and disabled adults. It is a less costly alternative to nursing homes and was originally designed to provide services for people in need of some assistance with daily activities, but who do not require extensive daily medical care. Demand for assisted living has increased significantly in recent years as residents and their relatives tend to favor the home-like settings that assisted living provides. In response to the increased demand, assisted living providers have evolved to serve a greater number of people with more diverse and complex needs.

Wisconsin, in particular, has experienced significant growth among its assisted living communities over the past 15 years. The number of assisted living providers has nearly doubled since the early 2000s, placing greater strain on the state's assisted living regulatory agency, the Wisconsin Department of Health Services (DHS), Bureau of Assisted Living (BAL). Furthermore, recent statutory changes have affected longstanding regulatory mechanisms, including sanctions previously used to correct cases of serious and persistent regulatory noncompliance. Due to these pressures, BAL requested an evaluation of the state's assisted living regulatory system and recommendations that would ensure greater regulatory compliance among Wisconsin's assisted living providers.

We begin with an overview of assisted living in Wisconsin, the state's current oversight and regulatory systems, recent statutory changes, and general regulatory best practices. We discuss findings from research and interviews with assisted living regulatory agencies from five other states as well as the results of two logistic regression analyses on the relationship between Wisconsin assisted living provider characteristics and regulatory noncompliance. The report concludes with recommendations for statutory and non-statutory changes to Wisconsin's assisted living regulatory system based on findings from our analysis and interviews.

Three research questions guide this report: (1) How effective is the existing regulatory system in ensuring regulatory compliance and resident protection? (2) Can the existing statutes, policies, and regulatory strategies be changed to ensure greater compliance and improve resident protection? and (3) What are some best practices to consider?

Our evaluation resulted in several key findings and recommendations. First, we determined that Wisconsin's assisted living community will continue to grow to keep pace with the state's growing elderly population. Second, the Wisconsin BAL is limited in terms of staff capacity and overall resources when compared to other states' assisted living regulatory agencies. Such limitations will certainly affect BAL's ability to ensure quality and compliance as the assisted living resident population grows. Third, Adult Family Homes and Community Based Residential Facilities are the assisted living provider types that have the greatest odds of committing serious violations and multiple violations. Our recommendations address BAL's ability to monitor regulatory compliance and manage existing constraints on regulatory oversight and staff capacity.

The Wisconsin Assisted Living System

Since the mid-1980s, assisted living has become a popular model of providing services in residential care for adults with medical or mental health issues. As nursing facilities evolve to become more hospital-like in their design and physical operations, assisted living facilities offer services involving three general components: (1) a residential-style physical environment where residents have private or semi-private space and publicly shared community space; (2) routine

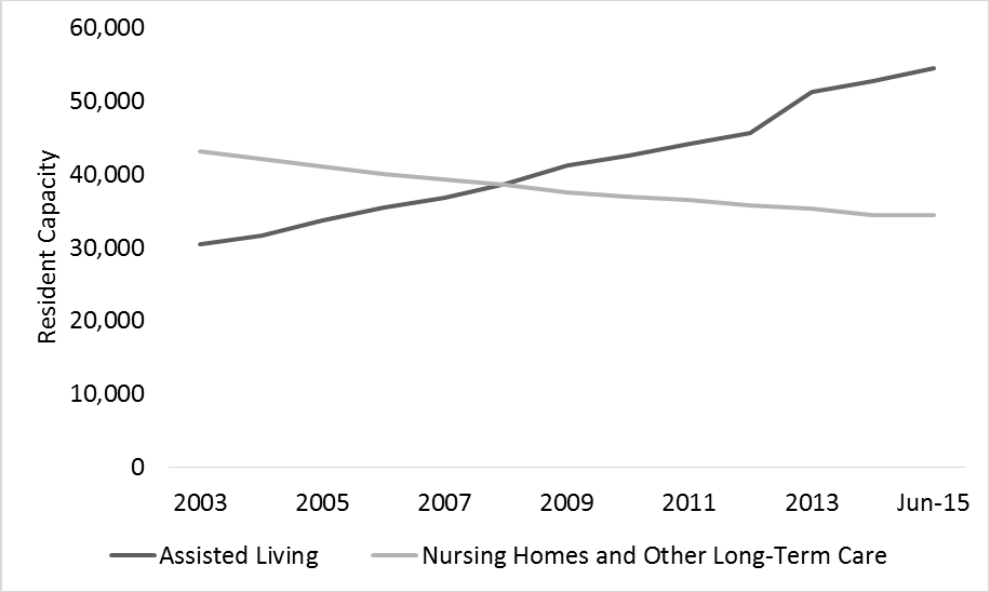
services and specialized health-related services for residents; and (3) an operating philosophy emphasizing resident choice and normal lifestyles related to the governance of the resident's time, space, possessions, and decisions about accepting or rejecting medical care and other health-related care and services (Wilson 2007). Nationally, assisted living care is approximately half as expensive as nursing home care (Genworth 2015).

The adoption of assisted living in Wisconsin is widespread, both in relation to the state's size and in absolute terms. As of 2012, Wisconsin had the fourth highest rate of assisted living use[1] in the country and was one of ten states where utilization of assisted living exceeded that of nursing homes (Harris-Kojetin et al. 2013). Correspondingly, a 2010 national survey found that Wisconsin had the fourth most assisted living beds per 1,000 individuals aged 65 and over – a rate nearly twice the national average. The same survey found that Wisconsin had the second most facilities of the 46 states reporting counts and the eighth most assisted living beds of any state (Mollica et al. 2012).[2]

Wisconsin's assisted living community has grown steadily over time. In 2003, there were 2,370 residential assisted living facilities with the capacity to serve more than 30,000 Wisconsin residents. (DHS 2016a; Wade et al. 2002). Since then, Wisconsin's total number of assisted living facilities has increased 62 percent to a total of 3,837 facilities, while provider capacity has increased 67 percent to a total of 58,125 beds (DHS 2016a).[3] Concurrently, the medical and psychiatric needs of residents have increased in complexity, often requiring that providers serve residents with a variety of needs in a single facility (Traas 2016).

Figure 1 shows that assisted living has grown steadily in Wisconsin in recent years, surpassing nursing homes and other long-term care in terms of resident capacity by 2008.

Figure 1. Resident Capacity: Assisted Living versus Nursing Homes



Source: DHS 2015b

[1] Calculated as the number of residents on a given day per 1,000 persons aged 65 and over.

[2] Of the states not reporting counts, only California, was likely to have more facilities based on prior data.

[3] See *Assisted Living Provider Types* below for a discussion of growth by type of assisted living provider.

Wisconsin currently does not collect data on individual characteristics of assisted living residents. However, an analysis of data from the 2010 National Survey of Residential Care Facilities identified several key distinctions among the populations and needs of residents of small and large assisted living communities nationally. The study found small assisted living communities are nearly three times more likely to house "non-senior" residents under 65 years old. Additionally, small communities care for twice as many residents with severe mental illness (13 percent versus 6 percent), five times as many residents with a developmental disability (10 percent versus 2 percent), and are more likely to house residents with Alzheimer's or other forms of dementia (53 percent versus 41 percent) (Cantiello 2014). These findings suggest that, nationally, residents with different needs are less frequently comingled. However, we spoke with a number of stakeholders concerned that the extent to which various resident populations are comingled in Wisconsin may be detrimental to resident care and protection.

Assisted Living Regulation in Wisconsin

BAL, housed within the Wisconsin DHS, is responsible for regulating assisted living in Wisconsin. Its goals are to provide a reasonable, efficient, and consistent system of regulation, licensing, and certification that: effectively encourages compliance; maintains accountability; protects public health and safety; fosters quality of life; promotes provider responsibility; supports consumer awareness, responsibility, and satisfaction; promotes consumer independence and choice; and protects vulnerable adults.

Assisted Living Provider Types

BAL responsibilities include registering, certifying, licensing, and regulating four assisted living provider types: Adult Family Homes, Community Based Residential Facilities, Residential Care Apartment Complexes, and Adult Day Care. Each of these provider types is unique in terms of services, capacity, and regulations.

Adult Family Homes

Adult Family Homes (AFH) are the most common assisted living provider type in Wisconsin and account for approximately 50 percent of residential providers, but only 14 percent of bed capacity (DHS 2016a). AFHs currently have the capacity to house more than 7,000 residents statewide (DQA 2015).

An AFH is a place where three to four adults who are not related to the operator reside and receive care, treatment, or services above the level of room and board. AFHs can admit and provide services to people of advanced age as well as persons with dementia, developmental disabilities, mental health problems, physical disabilities, traumatic brain injury, AIDS, alcohol and other drug abuse, correctional clients, pregnant women needing counseling, and/or the terminally ill (DHS 2016c). In Wisconsin, the majority (over 60 percent) of AFHs are chain-affiliated and the owner/operator is not onsite to administer care and services (Traas 2016). Wisconsin requires an AFH to be either certified or licensed, although certified AFHs are not

under the jurisdiction of BAL and are not considered in this analysis.[4] In a licensed AFH, no resident may receive more than seven hours of nursing care per week.

When an AFH fails to comply with requirements for licensure, BAL issues a notice of violation and may require the licensed home to submit a plan of correction for approval. BAL may also impose various sanctions, such as requiring the licensee to implement and comply with a plan of correction, prohibiting the licensee from accepting new residents until all violations are corrected, and requiring the licensee to stop violating any regulations. BAL may impose conditions, suspend, or revoke the license of an AFH, but BAL cannot assess a forfeiture like it can with other provider types.[5] If BAL takes enforcement action against an AFH for violating a licensure requirement and subsequently conducts an onsite inspection to review the facility's action to correct the violation, then BAL may impose a $200 inspection fee (DHS 2009).

Community Based Residential Facilities

Community Based Residential Facilities (CBRFs) are the second most common assisted living provider type in Wisconsin, accounting for 42 percent of residential providers. However, CBRFs have the greatest capacity, accounting for 57 percent of bed capacity (DHS 2016a). Currently, CBRF providers have the capacity to provide a bed for more than 28,000 residents statewide and range in size from 5 to 150 beds (DQA 2015, DHS 2016c).

A CBRF is a place where five or more adults who are not related to the operator or administrator reside and receive care, treatment, or services that are above the level of room and board that may include up to three hours per week of nursing care per resident. Similar to AFHs, CBRFs can admit and provide services to people of advanced age; people with dementia, developmental disabilities, mental health problems, physical disabilities, traumatic brain injury, AIDs, alcohol and other drug abuse, correctional clients; pregnant women needing counseling; and/or the terminally ill (DHS 2016c).

CBRFs are required to obtain a license from DHS prior to operating. BAL provides a comprehensive range of sanctions for CBRFs that fail to comply with requirements of licensure, including: forfeitures of $10 to $1,000 per date of violation for any violation; requiring an unlicensed CBRF to stop violating laws governing CBRFs; requiring the CBRF to implement and comply with a plan of correction; prohibiting the CBRF from accepting additional residents until all violations are corrected; and requiring a CBRF to provide staff training (Wis. State § 50.03(5g)). BAL may revoke a CBRF license if it has imposed a sanction and the CBRF continues to violate the regulations; if the CBRF has substantially violated the regulations; if conditions in the CBRF directly threaten the health, safety, or welfare of a resident; and if the CBRF has repeatedly violated the same provisions of the regulations. BAL may remove a resident from a licensed CBRF in cases when violations indicate a need to protect the health and safety of the resident. If BAL takes enforcement action against a CBRF for violating a licensure requirement and subsequently conducts an onsite inspection to review the facility's action to correct the violation, BAL may impose a $200 inspection fee (DHS 2009).[6]

[4] In 2010, there were 1,800 certified AFHs in Wisconsin, representing the largest subset of assisted living providers in the state at that time (Mollica et al. 2010).

[5] However, a person who operates an unlicensed AFH may be fined up to $500, imprisoned up to one year, or both.

[6] Furthermore, a person who operates a CBRF without a license may be fined up to $500 for each day of unlicensed operation, imprisoned for up to six months, or both for the first violation, and fined up to $5,000 or imprisoned up to one year in jail, or both for subsequent violations.

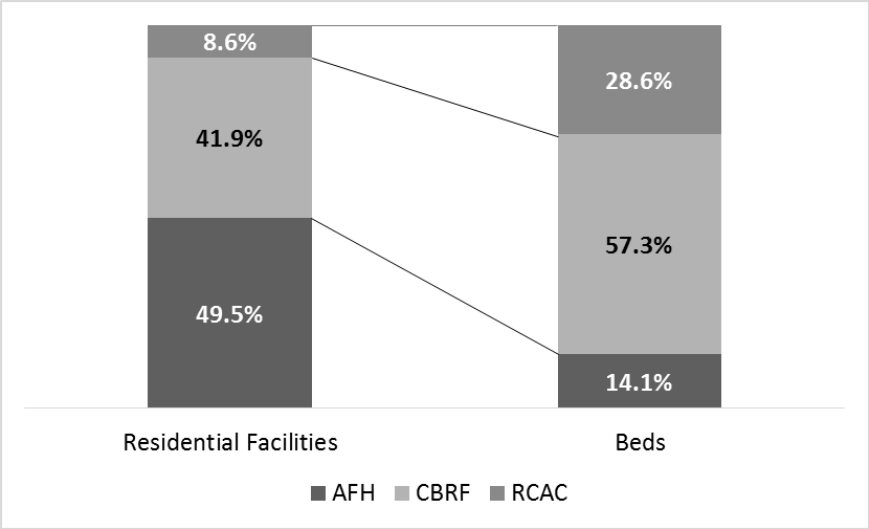
Residential Care Apartment Complexes

Residential Care Apartment Complexes (RCACs) are less common and account for about 9 percent of Wisconsin's residential assisted living providers. However, RCACs have the second greatest capacity. RCACs account for 29 percent of bed capacity statewide, and have the capacity to provide a bed for more than 14,000 Wisconsin residents (DHS 2016a, DQA 2015). RCACs range in size from 5 to 109 apartments, with the average complex consisting of 36 apartments (DHS 2016c).

Of the four provider types, RCACs are most consistent with what is traditionally known as assisted living. An RCAC is an independent apartment complex where five or more adults reside. Apartments must each have a lockable entrance and exit; a kitchen, including a stove (or microwave oven); and individual bathroom, sleeping, and living areas. An RCAC cannot admit persons who are incompetent, have Alzheimer's disease and other dementias, or have other health issues that require in-depth monitoring by health professionals (DHS 2016c). An RCAC must be either certified or registered by BAL. The primary sanction applied to registered RCACs is revocation of registration. Certified RCACs are subject to greater oversight, described below.

BAL may impose sanctions if a violation is found at a certified RCAC, including: forfeitures of $10 to $1,000 per date of violation for violations that are harmful to tenants; ordering the facility to stop its violation of the regulations; ordering that the facility comply with a plan of correction developed by the facility or BAL; ordering that the facility stop admissions until the violations are corrected; ordering that the facility provide or arrange for training of staff in specific areas; ordering that any Medical Assistance reimbursement for new admissions be denied until violations are corrected; ordering that payment for tenant services be disallowed during the period of noncompliance; ordering that the RCAC stop all operations if it is without valid certifications; or ordering that the facility's certifications be suspended in the case that violations require emergency action. BAL may revoke a RCAC's certification if it finds the facility has failed to comply with regulations. If BAL takes enforcement action against a RCAC for violating a certification requirement and subsequently conducts an onsite inspection to review the facility's action to correct the violation, BAL may impose a $200 inspection fee (DHS 2009).

Figure 2. Percentage of Residential Facilities and Beds by Provider Type, 2015



Source: DHS 2016a

Adult Day Care Providers

Adult Day Care (ADC) is the least common provider type, accounting for fewer than 150 non-residential facilities, or 4 percent of all assisted living providers in the state (DHS 2016a). ADCs currently have the capacity to serve more than 4,300 individuals statewide (DQA 2015).

ADCs offer day programming for elderly and other adults when their caregivers are at work or need relief. ADC services may include personal care and supervision, provision of meals, medical care, transportation, and activities designed to meet physical, social, and leisure needs of clients. Adult day care may be provided in family homes, free-standing centers, and multi-use facilities, such as churches, schools, and senior centers (DHS 2016c).

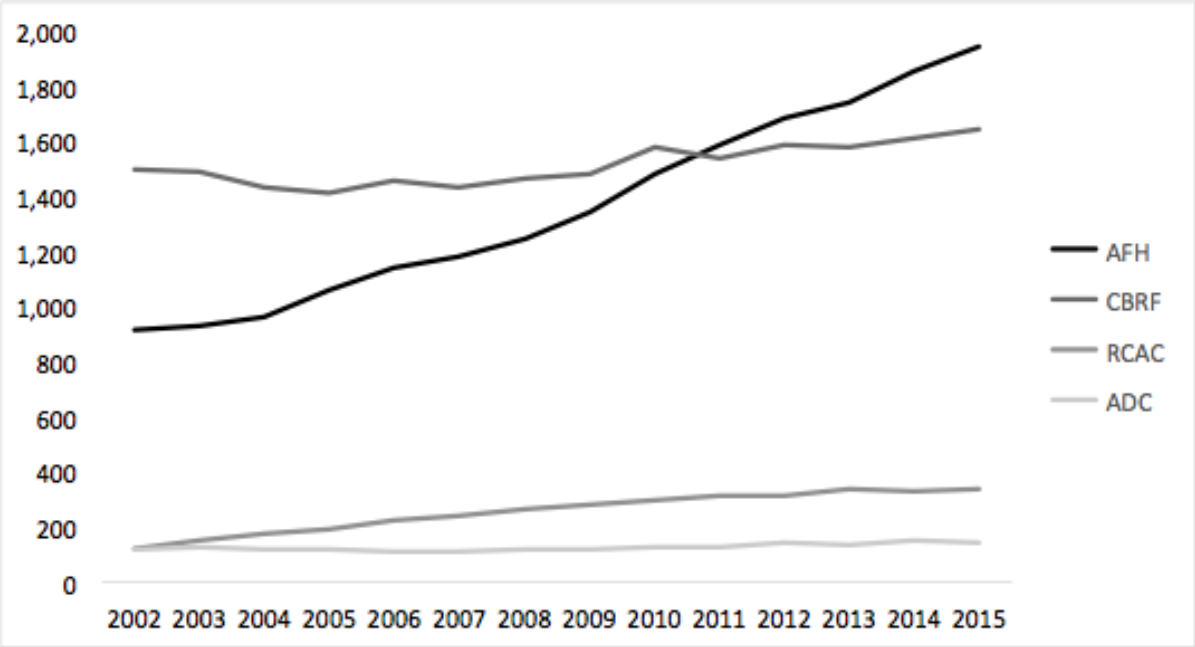
In Wisconsin, ADCs are not licensed, but may be certified. Although certification is not required, ADCs may voluntarily obtain BAL certification to receive state funding. BAL may revoke certification for any certified ADC out of compliance with any federal, state, and local laws or codes that govern the operation of the facility, including, but not limited to, heating, plumbing, ventilation, and lighting systems; fire safety; sanitation; and wage-hour requirements. Furthermore, a certified ADC out of compliance with standards may result in ineligibility for Medicaid Waiver funds. If BAL takes enforcement action against a certified ADC for violating a certification requirement and subsequently conducts an onsite inspection to review the facility's action to correct the violation, BAL may impose a $200 inspection fee (DHS 2009).

Growth by Provider Type

RCACs experienced the largest percent increase in total facilities over the past 13 years, increasing 178 percent (215 facilities) from a total of 121 facilities in 2002 to a total of 336 in 2015. However, AFHs increased the most in magnitude, from 915 facilities in 2002 to 1,945 facilities in 2015, an increase of 1,030 facilities (113 percent). In terms of total capacity, RCACs increased the most in percent and magnitude, from a total resident capacity of 5,094 in 2002 to 15,298 in 2015, which represents an increase of 10,204 (200 percent) (DHS 2016).[7]

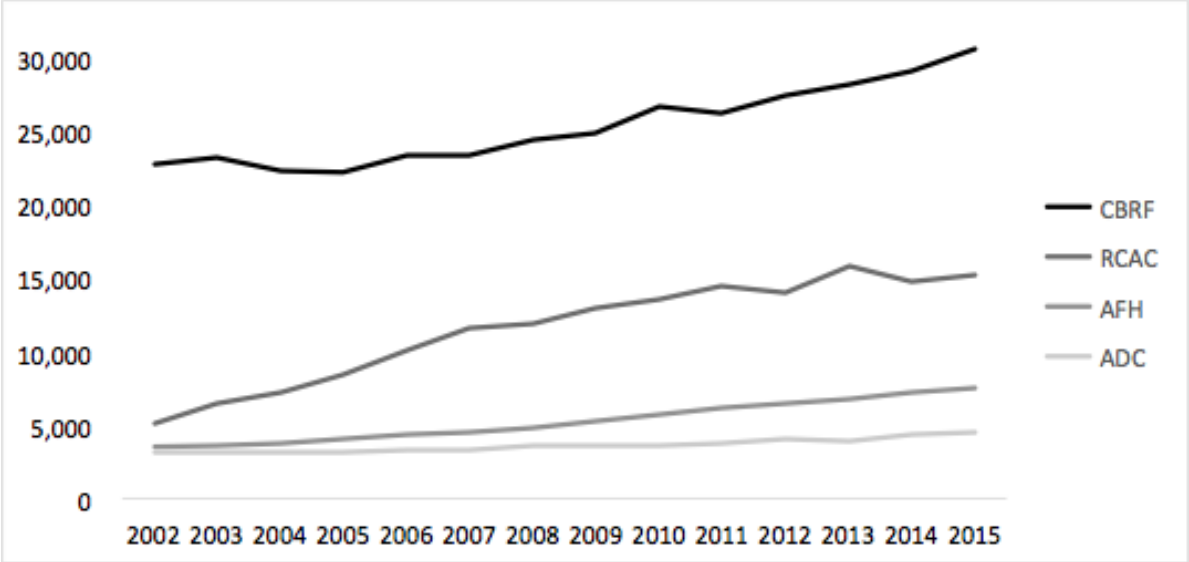
[7] See Appendix A for a detailed table showing facility and capacity increases by provider type from 2002 to 2015.

Figure 3. Growth in Number of Facilities by Provider Type



Source: DHS 2016a

Figure 4. Growth in Capacity by Provider Type



Source: DHS 2016a

Table 1. Comparison of Regulatory Requirements by Facility Type

	AFH	CBRF	RCAC	ADC
Laws and Regulations	Wis. Stat. 50; DHS 88, Wis. Adm. Code	Wis. Stat. 50; DHS 83, Wis. Adm. Code.	Wis. Stat. 50; DHS 89, Wis. Adm. Code.	N/A
Number of Residents	4 or less	5+	5+	N/A
Location Requirements	Community based	Community based	Multi-family dwelling	Varied
Type(s) of DHS Approval	Certified or licensed	Licensed	Registered or certified	May be certified
License Length	**Certified**: 12 Months **Licensed**: 24 Months	Valid until revoked	**Registered**: N/A **Certified**: 36 Months	N/A
Burden of Regulatory Compliance	**Certified** – Low **Licensed** – Medium	High	**Registered** – Low **Certified** – High	**Uncertified** - N/A **Certified** - Low
Max Nursing Hours per Person	7 hours/week	3 hours/week	28 hours/week	N/A
Inspections	Inspection prior to certification or license. Random inspections allowed.	Initial inspection within first year of operation. Announced and random inspections.	**Registered**: No routine inspection. **Certified**: Periodic random inspections.	No inspection required.
Reporting Requirements	**Certified**: annual report **Licensed**: biennial report, report changes to facility	Biennial report	No reporting requirements	N/A
Penalties	**Certified**: Decertification with no renewal for two years. **Licensed**: Upon notice of violation facility must submit a plan of correction for approval. License may be modified. Sanctions include requiring compliance, stopping admissions, suspend or revoke license. Fines not permitted. **Criminal penalties for operating without a license**: Fines up to $500 or imprisoned up to one year.	Stopping operations, terminating employment of operators who do not have licenses, injunctions, compliance with plan of correction, suspension of resident intake, training, removal of residents, revocation of license, and fines of $10-1000 per day per violation. **Criminal penalties for operating without a license**: Fines up to $5000 and jail up to 12 months.	**Registered**: Revoke registration. **Certified**: Require the facility stop violation, stop admissions, require training, deny MA reimbursement, deny receipt of payment, stop operations, suspension, and revocation. Fines are permitted between $10-1000 per violation per day.	**Uncertified**: No authority. **Certified**: Revoke certification.

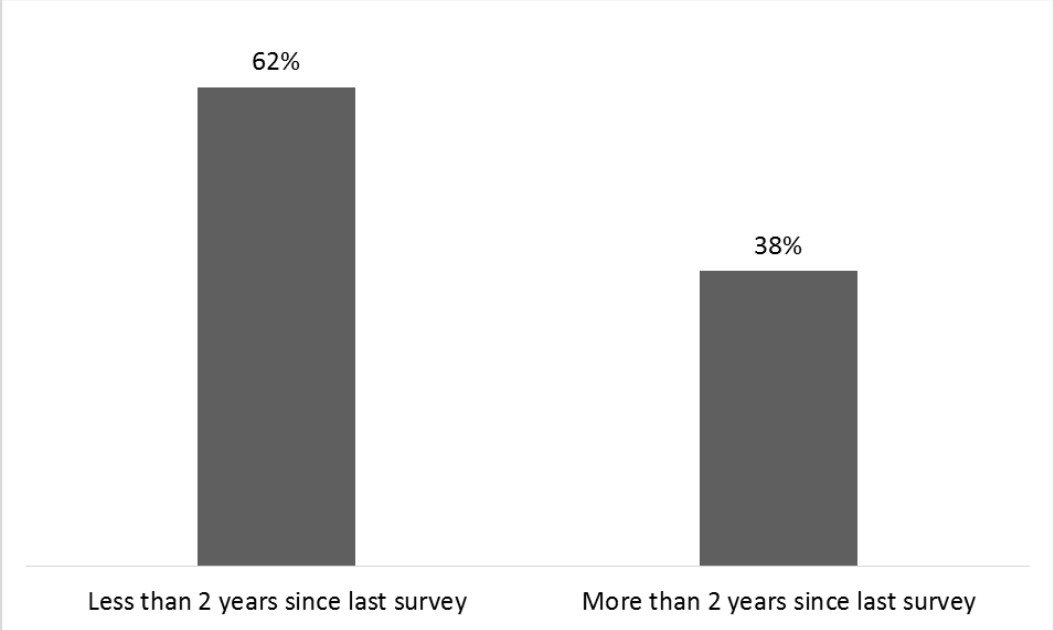
Regulations and Enforcement

Wisconsin State Statute (Chapter 50) and Wisconsin Administrative Codes grant authority to DHS to enforce sanctions and penalties if assisted living facilities do not comply with laws and regulations. This section describes the steps of the enforcement process, as specified in BAL's "Guidelines for Assisted Living Enforcement" (DHS 2009).

Wisconsin's assisted living regulatory and enforcement processes are distinct; each process involves different BAL staff and activities. The regulatory process takes place through BAL's four regional offices, each of which have eight surveyors, and involves conducting on-site licensing/certification surveys and conducting complaint investigations and compliance surveys at assisted living communities. The enforcement process is centralized in the BAL main office to maintain consistency across the four regional offices, and it involves determining sanctions for facilities with serious or persistent violations.

BAL has the goal of surveying every facility for violations at least once every two years; however, the regulatory process is largely complaint-driven; and BAL has been unable to meet its goal. Between 2002 and 2015, 32 percent of surveys were performed in full or partial response to a complaint (DHS 2016a).[8] Furthermore, an analysis of survey data shows that only 62 percent of the 3,050 facilities open during the entire 2014-15 period received a survey in that time (see Figure 5). The same analysis for the two prior two-year periods shows that BAL surveyed more facilities within two years in 2014-15 than in 2010-11, but that at the end of each period the agency faced a backlog of over 1,100 facilities (DHS 2016a).

Figure 5. Percent of Facilities Surveyed Within 2 Years, 2014-15



Source: DHS 2016a

[8] 32 percent of surveys were performed in response to one of the following: a complaint, a complaint and a provider's self-report of an incident, a regularly scheduled survey involving a complaint, or a regularly scheduled survey involving a complaint and a provider's self-report of an incident.

The BAL enforcement system is based on progressive sanctions; sanction severity increases when violations are repeated or increase in seriousness for a given provider. Approximately 10 percent of providers are assessed a penalty or sanction per year (DHS 2016a).

Regulatory and Enforcement Process Steps

The first step in the regulatory process is to conduct a compliance survey or a complaint investigation. A compliance survey is typically scheduled, while a complaint investigation is performed in response to a complaint filed by a resident, relative, facility staff, or others involved in the assisted living community.

A standard survey consists of ten components. First, an off-site review will be completed to gain an understanding of the facility and client group served. Second, the surveyor will conduct an introductory meeting with the staff in charge. Third, the surveyor will conduct a tour of the facility focusing on consumer rights, dignity and privacy, the environment; and safety. Fourth, the surveyor will select a sample of residents to interview. Fifth, the surveyor will make observations based on the sampled residents to evaluate if the facility is promoting and protecting consumer rights and dignity, and how the residents' needs and preferences are met. Sixth, interviews of residents, family members or representatives, and staff will be conducted. Seventh, the surveyor will review the provider's records to make sure they are accurate and up to date with consumer assessments and staff training, for example. Eighth, the surveyor will ensure that the facility is in compliance with the state safety code. Ninth, the surveyor may provide technical assistance to help the provider interpret the regulatory requirements and meet the standards of practice. Finally, there will be an exit conference where the surveyor informs the staff of identified issues (DHS 2016d).

The second step in the regulatory process is to issue a Statement of Deficiency (SOD), which is a written report that follows a compliance survey or investigation in which a provider is found to be out of regulatory compliance. The SOD includes: documentation of whether the violation is a repeat citation or an uncorrected deficiency; verification that the correct regulation has been selected for the deficient practice identified; description of the violation; specific dates of violation; sufficient detail on findings; description of specific results and consequences of the deficient practice; resident and staff identifiers; and details on who was involved, what did or did not occur, how it occurred, what staff did or did not do that led to noncompliance, when the violation happened, where it happened, and how the violation was verified.

After the SOD is issued, surveyors or Assisted Living Regional Directors determine, based on established criteria, whether or not the violation should be referred for enforcement review performed by the BAL Enforcement Specialist. The types of violations that generally warrant referral for enforcement review include those that: result in serious harm, have the potential for serious harm, or indicate a breakdown in facility systems that could lead to serious harm; create a condition or occurrence that present a substantial probability that death or serious mental or physical harm to a resident will result; or create a condition or occurrence that presents a direct threat to the health, safety, or welfare of a resident. If the violation is not referred for enforcement review, then BAL issues the violation and the provider provides an attestation to BAL that a corrective plan will be or has been implemented.

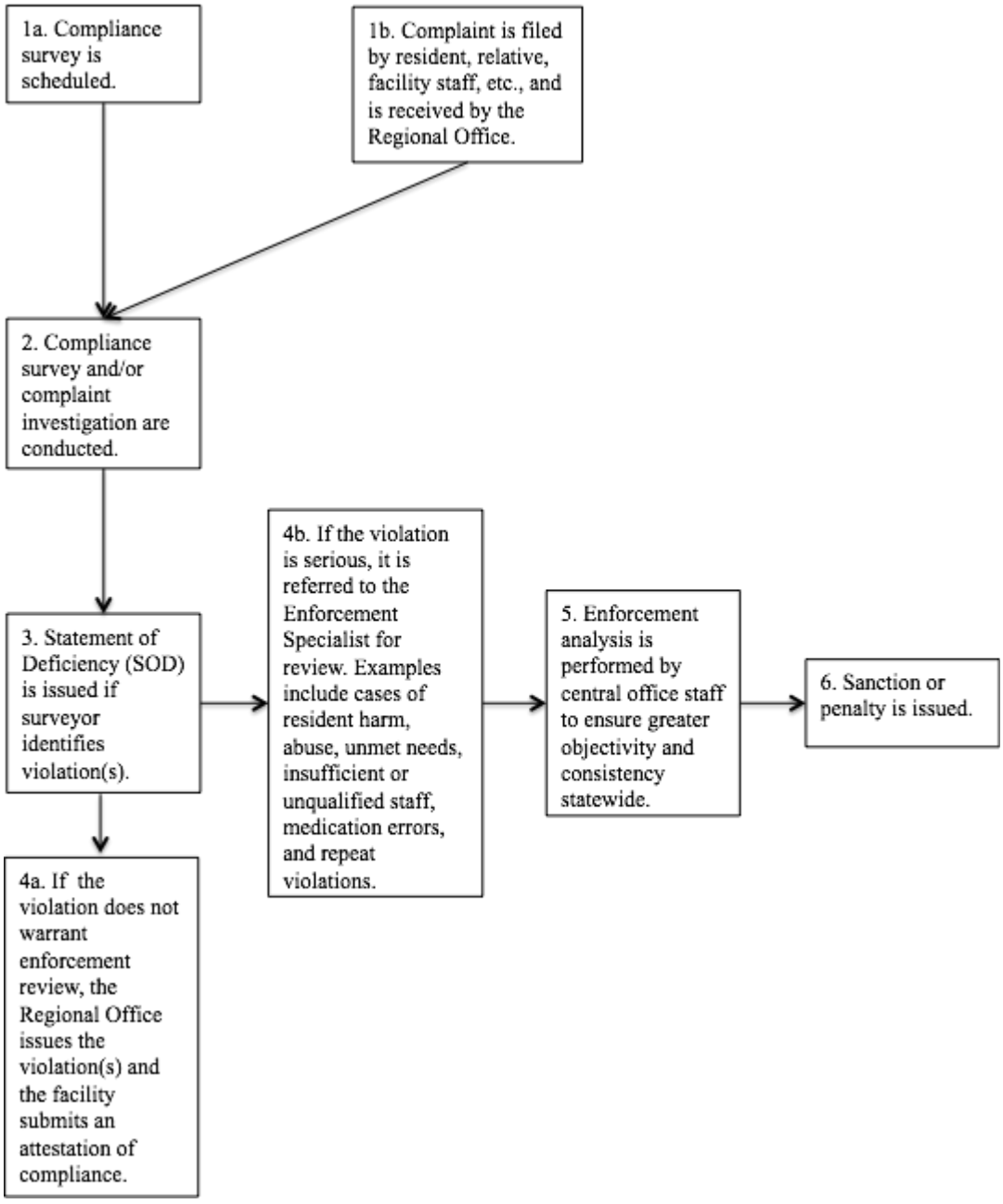
After the SOD is referred to the central office, the BAL Enforcement Specialist evaluates citations to determine which sanctions to impose and the amount of any forfeiture to be assessed. The minimum forfeiture the state can assess is $10 per day and the maximum is $1,000 per day, but AFHs are not subject to forfeiture (Wis. Stat. § 50.03(5g)(c)1). The Enforcement Specialist

considers the following factors in determining whether enforcement action will occur, the sanction to be imposed, and the amount of any forfeiture: the gravity of the violation; "good faith" exercised by the licensee; a provider's compliance history; the financial benefit to the facility of committing or continuing the violation; and sanctions imposed for comparable violations in other facilities.

The assisted living provider is granted ten days to pay any forfeitures assessed, to submit a plan of correction, or to appeal the determined penalty or sanction. If the provider pays the forfeiture within ten days and agrees to waive the right to appeal, then BAL agrees to reduce the forfeiture by 35 percent, including accruing forfeitures. If a provider fails to complete these penalties within the ten-day period, then BAL takes further action. For example, if a forfeiture is not paid within the ten-day period, a "Notice of Overdue Forfeiture" is sent to the licensee with a specific date to pay the outstanding forfeiture. If payment is not submitted by the established deadline, an additional per-day forfeiture may be assessed and the licensee will receive an additional citation from its Regional Office. If the licensee does not pay the initial and overdue forfeitures within the established timeline the Enforcement Specialist will recommend "next steps," such as referral to collections, license revocation, or other action. If BAL imposes a sanction or takes other enforcement action against a provider, then BAL will subsequently conduct an onsite inspection to review the facility's action to correct the violation(s). BAL may impose a $200 inspection fee on the facility for this follow-up inspection.

Figure 6 demonstrates the primary steps of the overall regulatory process.

Figure 6. Simplified Diagram of the Oversight and Enforcement Process



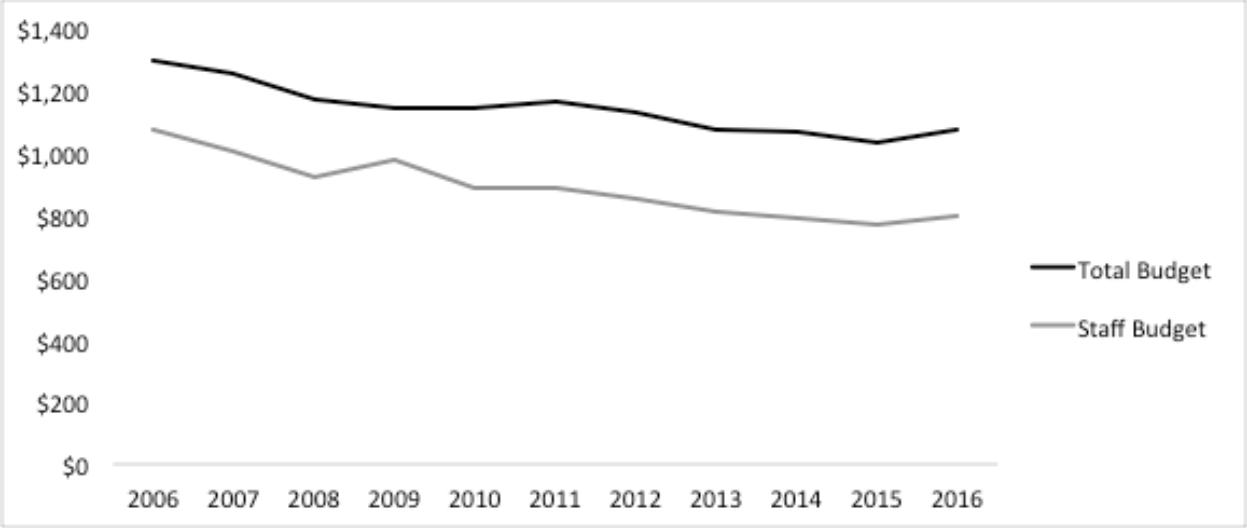
Sources: DHS 2009, Traas 2016

Regulatory Capacity

BAL has been affected by the significant increase in assisted living providers, especially in terms of its resources and staff capacity. BAL's total 2016 budget is $4,873,800. However, BAL resources have not increased in proportion to facility and bed-capacity increases; its total budget and staff budget per facility have decreased over the past ten years when controlling for inflation. Between 2006 and 2016, BAL's total budget decreased from $1,293 per facility to $1,074 per facility, or by 17 percent in real dollars. BAL's staff budget per facility decreased

from $1,071 per facility to $797 per facility, or by 26 percent in real dollars throughout the same period (DHS 2016a, DHS 2016b).

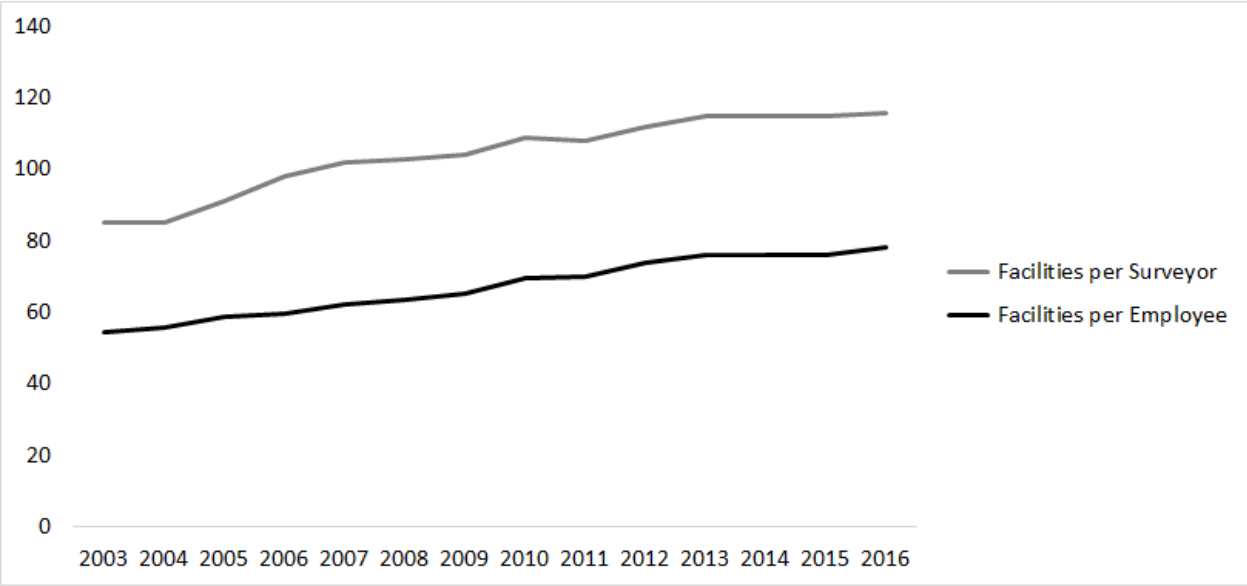
Figure 7. BAL Total and Staff Budget per Facility in Real Dollars



Sources: DHS 2016a, DHS 2016b

The total number of Wisconsin assisted living facilities per BAL employee (including surveyors, other professionals, and clerical staff) increased by 44 percent between 2003 and 2016, while the total number of facilities per BAL surveyor increased 36 percent over that time.

Figure 8. Facilities per BAL Employee

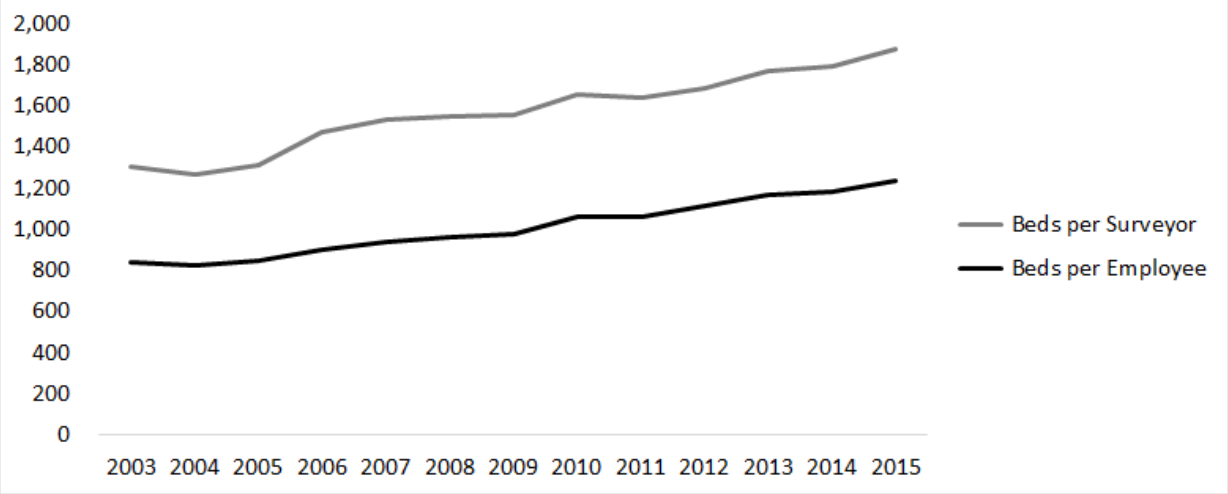


Sources: DHS 2016a, DHS 2016b

Furthermore, the total number of facility beds per BAL employee increased 47 percent between 2003 and 2015, while the total number of facility beds per BAL surveyor increased 43 percent between 2003 and 2015 (DHS 2016a, DHS 2016b). Such increases in facility-to-staff

and bed-to-staff ratios have negatively impacted BAL's ability to perform regularly scheduled assisted living facility surveys, which has contributed significantly to the complaint-based regulatory system in place today.

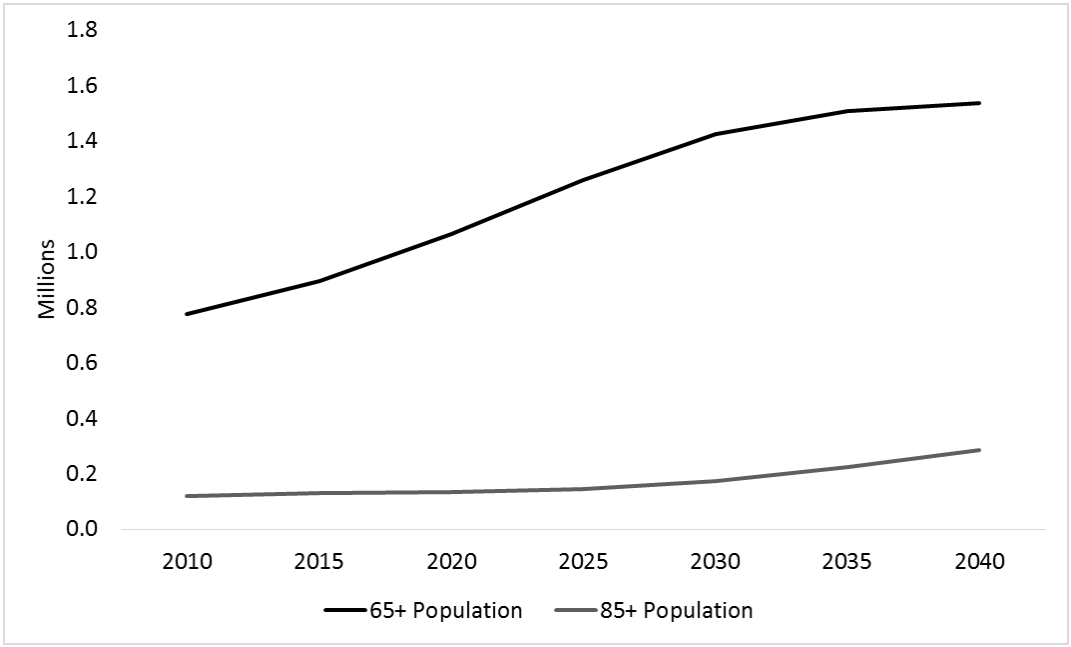
Figure 9. Beds per BAL Employee



Sources: DHS 2016a, DHS 2016b

Pressure placed on BAL and the current regulatory system will only increase as Wisconsin's elderly population grows. Wisconsin's population age 65 and over is projected to grow by 640,000 over the next 25 years, which is a 72 percent increase between 2015 and 2040. Wisconsin's population age 85 and over is projected to increase even more rapidly between 2015 and 2040. Over the next 25 years, this population is projected to grow by 165,095, an increase of 140 percent (DHS 2015a).

Figure 10. Wisconsin's Projected 65+ and 85+ Populations



Source: DHS 2015a

BAL does not collect resident-specific information, but the projected increase in the state's elderly population suggests the demand for assisted living will continue to increase at a rapid rate. Additionally, adults with disabilities are living longer and fuller lives in the community because of the support they receive through Wisconsin's Medicaid programs. Wisconsin's long-term care population, including the elderly and people with disabilities, currently comprise less than 20 percent of state Medicaid enrollment. Yet in Fiscal Year 2016, long-term care costs for this group is budgeted at $3.4 billion, or 40 percent of the Medicaid budget (DHS 2016e). These costs will grow in future years as the elderly population grows, placing greater financial strain on the state budget.

As Wisconsin's elderly population grows, the assisted living community will likely serve considerably more residents with Alzheimer's disease and other dementias, which typically affect those 85 years and older (Cantiello 2014). The anticipated growth in residents of this type reinforces the importance of adequate care and protection for this highly vulnerable group, which typically requires more specialized assistance and greater oversight. In 2015, it was estimated that 115,000 Wisconsinites suffered from Alzheimer's and other dementias. By 2040, that number is expected to increase by 110 percent to 242,000 (DHS 2015a).

In addition to a growing elderly population, assisted living providers and BAL must adapt to the changing complexity of residents' needs. Vulnerable residents with complex medical needs (e.g., unstable diabetes, chronic disease), mental health needs (e.g., psychiatric disorders, behavioral symptoms associated with dementia), and intellectual disabilities continue to be admitted to assisted living facilities where caregivers often do not have health care backgrounds or specialized training. However, regulatory oversight has not evolved to adequately address compliance problems associated with increased medical and mental health needs of residents. As a result, many serious violations issued by BAL in recent years involve residents who do not receive adequate care and services, leading to harm or death (DHS 2014, Traas 2016).

Overall, the historic and projected data on BAL's budget, the number of assisted living providers and beds, and Wisconsin's elderly population suggest a need for greater resources. If BAL staffing and resource trends remain consistent over the next 25 years, then regulating a growing assisted living industry to maintain quality of services and meet increasing market demand will become increasingly difficult.

2011 Act 21 Statutory Changes

A recent statutory change affecting Wisconsin's assisted living regulatory system is 2011 Act 21. Act 21 narrows the rule-making authority of all state agencies by prohibiting agencies from imposing any standard, requirement, or threshold in a rule unless explicitly required or permitted by statute or promulgated rule.

Act 21 prevents BAL from utilizing two enforcement tools that BAL had developed and effectively used to ensure regulatory compliance. First, BAL issued directed plans of correction that required assisted living providers in violation of regulations to complete a root cause analysis to identify and address systemic operational problems to prevent the violation(s) from re-occurring. This often required agencies to hire a consultant at their own expense to complete the analysis, and therefore served as both a corrective and punitive measure. Second, BAL used impending revocations, which outlined specific corrective actions a provider must undertake to avoid a revocation. This method was especially effective in minimizing resident relocations (Traas 2016). However, due to Act 21, BAL stopped using these tools because they were not explicitly required or permitted by statute.

Theories and Methods to Ensure Regulatory Compliance

The purpose of regulating assisted living facilities is to ensure the safety and well-being of residents who often cannot advocate for themselves. Compliance with regulations is achieved through regulatory enforcement, which is narrowly defined as the implementation of punitive sanctions after a violation has occurred. However, compliance efforts more broadly include preventative actions such as inspections, licensing requirements, and education as well as the reactive investigatory process initiated with a complaint or injury. Looking at the broad picture of the regulatory compliance process, defined as the rules and processes that ensure regulated entities comply with regulations, agencies can affect change by placing pressure on specific points in the process. We will address four areas that have the potential to affect the assisted living enforcement process in Wisconsin: 1) preventative inspections; 2) punitive measures and optimal fines; 3) the effect of inspectors on enforcement and compliance; 4) prescriptive regulations and accountability.

Preventative Inspections

Inspections coupled with fines for violations have been shown in multiple settings to improve regulatory compliance and reduce injuries. Gray and Scholz (1993) found a 22 percent reduction in workplace injuries at facilities that were inspected and fined for a violation by the Occupational Safety and Health Administration. Other studies have shown positive effects on legislation and regulation, leading to greater compliance, with increased enforcement. Examples include increased enforcement of traffic violations and seat-belts laws (Lund and Aaro 2004).

A secondary reason for inspections is to measure the effectiveness of the enforcement agency. Enforcement agencies should be evaluated based on their ability to achieve increased compliance and improve the safety and wellbeing of residents through compliance. However, drops in complaints or self-reported compliance issues do not necessarily show that an agency is achieving compliance. Random or representative sampling of inspections are needed to show whether compliance has improved as a result of the agency's actions or if there is a break in the enforcement chain (Sparrow 2000).

Punitive Measures and Optimal Fines

Theoretically, the optimal fine equals the harm, properly inflated for the chance of not being detected, plus the variable enforcement cost of imposing the fine. This theory is based on the idea that a regulated entity is rational and will comply with the regulation if the penalty is equal to or greater than the cost of compliance (Polinsky and Shavell 1998). For a simplified example, if a fine is $100 and the organization expects to be caught once every two years, the annual expected (average) cost of the fine is $50. If the annual cost of compliance is $75, the regulatee will not comply because the fine is less expensive. The expected cost can be increased either by increasing the odds of the organization being caught through more frequent inspection or by increasing the amount of the fine.

The availability of fines as an enforcement tool can support progressive, less punitive measures. Studies show that regulators often prefer serving as technical experts and using less punitive measures to bring about compliance. Regulators expect to have continued interaction with regulated entities and favor less adversarial mechanisms to foster long-term cooperation (Aalders and Wilthagen 1997). Enforcement may be better achieved through the use of gradual

increases in the penalty. Figure 11 shows Wisconsin's enforcement pyramid with the area of each level estimating the frequency of use. The availability of tough sanctions is necessary, because a strategy based entirely on persuasion and self-regulation will be exploited when actors are motivated by economic rationality (Sparrow 2000; Braithwaite et al. 1987).

Figure 11. BAL Progressive Enforcement Pyramid

** Enforcement tools that were used prior to Act 21*
*** Only available for operating without a license*

Criminal sanctions, depending on the goals of enforcement and characteristics of the regulated entity, may not generate significant additional compliance. A study of criminal sanctions and regulatory penalties found that in most situations regulatory penalties are sufficient to generate compliance. However, criminal sanctions may lead to better outcomes when the potential offender is unable to pay, complete deterrence is optimal, corruption is an issue, or the costs of sanctioning innocent persons are large. Additionally, criminal sanctions should provide greater deterrence than monetary fines (Garoupa and Gomez-Pomar 2000). Another factor to consider is that a wider range of enforcement tools – a taller pyramid – encourages inspectors to be more flexible and more supportive of negotiating or bargaining (Gormley 1998).

Role of Inspectors in Enforcement and Compliance

Enforcement styles fall on a spectrum between a deterrence model at one extreme and a bargaining model at the other. A deterrence model seeks to punish, while the bargaining model seeks to persuade. When compared to large federal agencies such as the Environmental Protection Agency, state agencies are less likely to have fully developed professional bodies setting standards and are more likely to rely on common sense. Inspector styles are less reliant on oversight by professional bodies and more reliant on training, work experience, demographic characteristics, partisan affiliation, and perceptions of the regulated entity (Gormley 1998).

In an analysis of daycare inspection agencies and their inspectors, which evaluated style based on leniency, flexibility, and support, both the style of an inspector and the style of the organization influenced the number of tickets written. The key findings of the study showed that inspector demographics had some effect on the use of technical support. Interestingly, former providers were more stringent, as measured by number of tickets provided, but more supportive, as measured by willingness to provide technical support. In contrast, a degree in social work seemed to have no statistically significant effect on inspector styles (Gormley 1998). Other studies have shown that the stringency of inspectors is affected by the inspector's support of the regulations and literal rule orientation (Hedge et al. 1988). These studies show that an agency can select inspectors with specific attributes, which favor deterrence or bargaining. However, studies that evaluated the effects of inspector style on obtaining compliance have found no statistically significant effects on regulatory compliance. This could be explained by inconsistency among inspectors, which insulates a regulated entity from the stylistic differences (May and Wood 2003).

Prescriptive or Outcome-Based Rules

A major factor in making changes to legislation or administrative rules is whether to use a prescriptive or outcome-based rule. Prescriptive or technology-focused rules tell a regulated entity the exact method of obtaining compliance, such as detailing the grade of a wheel-chair accessible ramp. By contrast, outcome-based rules allow a regulated entity to determine the best way to achieve the goals (May 2007; Coglianese and Lazer 2003). Prescriptive rules are more simplistic on the regulatory enforcement side of the equation. Inspectors know exactly what to look for and whether or not there is compliance. On the regulatee side, prescriptive measures may be more expensive when the prescription is not the most efficient way to achieve an outcome. Outcome-based rules allow the regulatee to determine the most cost-effective mode of compliance, but they impose a much larger burden on inspectors who now must evaluate whether the outcome-based measure achieves compliance. Regulated entities will typically know more about the risks of their facilities and are often in a better position to judge where and when accidents are likely to result (Coglianese and Lazer 2003).

Summary

Because companies are expected to underinvest in safety measures absent regulatory enforcement, ensuring the optimal level of safety to consumers requires regulatory oversight (Coglianese and Lazer 2003). The following are four key takeaways that should be considered when implementing changes to improve BAL's oversight. First, random preventative inspections are optimal because they allow BAL to find non-compliance before an injury arises and evaluate its own ability to achieve increased compliance. Additionally, if providers would not normally expect to be surveyed, random inspections can increase the deterrent effect of regulations. Second, BAL can provide compliance more quickly and efficiently when it has a wide range of enforcement tools that can be used progressively. The availability of large fines or criminal sanctions can promote compliance with less punitive measures by deterring a provider from subjecting themselves to the potential for a higher level of punishment. Third, BAL can select characteristics of employees that favor deterrence or bargaining approaches to gaining compliance. Fourth, implementing rules that are less open to interpretation can reduce the burden and cost of enforcement placed on BAL.

Five Comparison States: Promising Practices for Compliance

BAL requested a review of other states with which to compare Wisconsin's regulatory system to identify best practices. States were selected based on their innovations in assisted living regulation and/or their status as a neighboring state. Information was collected through interviews with assisted living regulators in each state and through research. This section reviews each state and highlights promising practices that Wisconsin could consider adopting.[9] Appendix D provides additional information about assisted living regulations around the country, and Table A3 compares Wisconsin with other states.

Illinois

Illinois regulates three types of facilities, each with its own set of administrative code: assisted living facilities for seniors, supportive living facilities, and shelter care facilities. We interviewed the division chief of the agency that oversees about 390 private pay facilities that are either assisted living for seniors (17 people or more) or shared housing (16 people or fewer). This department has eight Health Facility Surveillance Nurses (1 for every 55 facilities) that are federally and state trained and conduct surveys of facilities (Kovarik 2016). This is a greater ratio of surveyors to facilities than Wisconsin, which has 1 for every 120 facilities. As a result, this department is able to conduct annual surveys of facilities as well as complaint surveys.[10] One highlight from Illinois is how the staff are funded. While the agency receives some general state funds, much of the staff is funded through the licensure fee, which facilities must pay annually to renew their license. For shared housing facilities the cost is $1,000 per year, and for the assisted living for seniors it is $2,000 per year plus $20 per unit in the facility (example: an assisted living facility for seniors with 10 units would pay $2,200) (Kovarik 2016).

Michigan

Of the states we interviewed for this report, Michigan's regulatory structure is the most similar to Wisconsin's. The Licensing Division inspects and licenses Adult Foster Care Facilities and Homes for the Aged, which are Michigan's equivalent to Wisconsin's AFH, CBRF, and RCAC facilities. Adult Foster Care facilities range in capacity from 1-20 beds and are home to persons who are developmentally disabled, aged, mentally ill, or who have suffered a traumatic brain injury. Homes for the Aged, vary in size but are solely for residents who are 60 or older. Similar to Wisconsin, each type of facility is regulated under its own statutory code. Two comparative highlights for Michigan are the large number of inspectors and having fewer enforcement tools than Wisconsin.

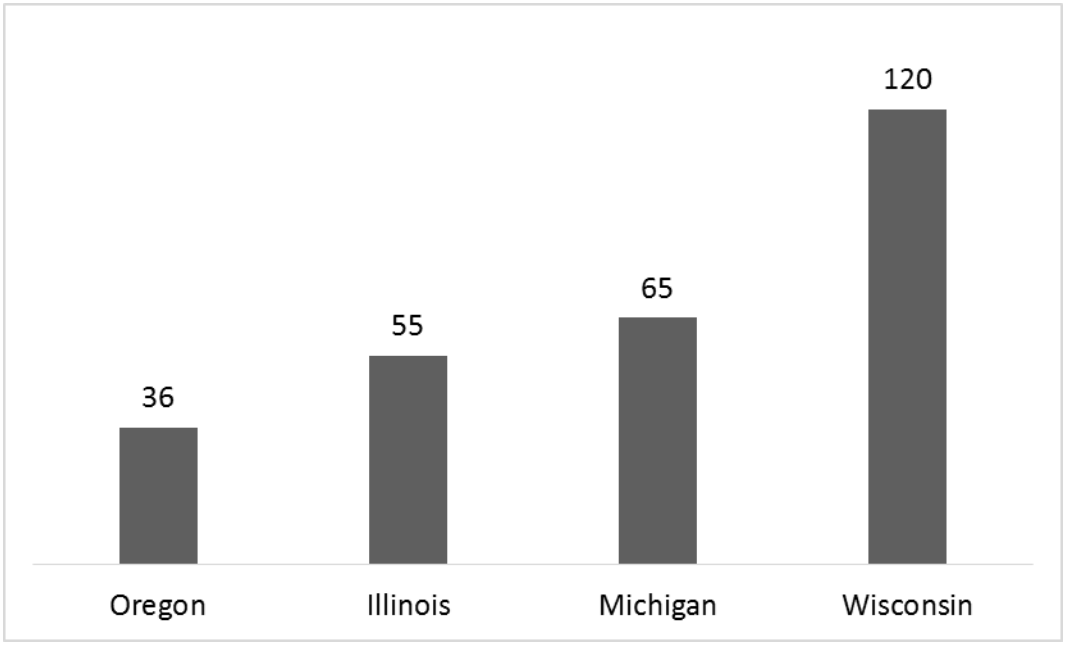
Michigan has nearly twice as many inspectors per facility as Wisconsin, despite inspectors having similar responsibilities. Michigan has a staff of 70 inspectors responsible for licensing and inspecting approximately 4,500 facilities (one inspector for every 65 facilities) (Calewart 2016), compared to Wisconsin, which has 32 for 3,837 facilities (one inspector for every 120 facilities). All inspectors must have a master's degree in a relevant field and, ideally, inspection experience. Like Wisconsin, these inspectors are responsible for ensuring that

[9] Due to a lack of rigorous evaluations of these practices, we deem them 'promising' rather than best practices.
[10] Illinois conducted 159 complaint surveys last year (Kovarik 2016).

provider facilities meet the needs of clients, including factors such as building accessibility, provider training, and adequate staffing levels. Inspectors are responsible for inspecting the facilities in person and determining if there is a violation. If there is a violation, inspectors document the violation and refer it to one of five regional managers. All facilities must be evaluated every two to three years depending on their classification (Calewart 2016).

Another large difference in oversight is the use of fines. Wisconsin regularly uses forfeitures as a part of its progressive enforcement strategy. Michigan cannot give fines unless a facility is operating without a license. Michigan's two main strategies are to give a facility a probationary license for 6 months or to revoke its license (Calewart 2016). The downside of this strategy is that a lot of time can pass before corrective action occurs, especially when facilities appeal the punitive action. However, issuing a probationary license is similar to a fine because reimbursements for Medicaid waiver services are discontinued for that facility. Like Wisconsin, the acuity of patients has increased but the statutes and rules have not been adjusted. Unlike Wisconsin, there has not been a major expansion in the number of facilities, but the state estimates that there are as many as 1,500 facilities operating without a license (Calewart 2016).

Figure 12. Facilities per Surveyor, Interviewed States



Sources: van der Veen and Potter 2016, Kovarik 2016, Calewart 2016, DHS 2016a, DHS 2016b

Minnesota

The main difference between Minnesota's regulatory structure and Wisconsin's is that Minnesota regulates assisted living as a service. This means that the state does not license assisted living as a distinct category; rather, the state defines assisted living as having two elements: (a) a site that is registered annually with the Department of Health as a "housing with services establishment," and (b) a licensed Class A or a Class F home care agency that is either the establishment itself or another entity with which the establishment has an arrangement (Carder et al. 2015). Minnesota issues an AFH license if the home is the primary residence of the license holder and the license holder is the primary caregiver, and the state issues a corporate

AFH license if the license holder does not live at the residence (State of Minnesota Department of Health Services 2016).

Minnesota also has requirements for those who provide specialized services for residents with Alzheimer's disease or other dementias. Facilities are designated as Special Care Units (SCUs) if they market themselves as caring for residents with Alzheimer's disease or other dementias. SCUs must provide written disclosure to the Commissioner of Health if requested, the Office of Ombudsman for Older Minnesotans, and each person seeking to become a resident. Staff and administrators of SCUs must have specific training and continuing education on dementia care topics. This includes direct care staff and staff that provide home management tasks such as housekeeping, meal preparation, and shopping. Specifically, dementia care training topics include: an explanation of Alzheimer's disease and other dementias, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills (Carder et al. 2015).

New Jersey

One potential area of improvement for Wisconsin's BAL relates to how facilities are inspected and monitored. Wisconsin's complaint-driven system and inadequate resources result in some facilities not having an inspection for several years (more than five years in some cases). As a result, violations may go unidentified, including some that result in adverse outcomes for residents or involve circumstances where residents are at risk of adverse outcomes.

New Jersey began a four-year pilot program in 2012 in collaboration with the Health Care Association of New Jersey Foundation, called Advanced Standing, which is a quality-focused program that can help to strategically allocate regulatory resources for inspections (O'Dowd 2012). New Jersey's policy is to inspect its facilities prior to licensure, every two years after, and at any time deemed necessary by the licensing agency (Carder et al. 2015). Advanced Standing is a voluntary program that facilities can participate in if they meet all regulations and certain quality benchmarks. To receive the New Jersey Department of Health's distinction of Advanced Standing, a facility must pass an annual on-site evaluation conducted by a third-party consultant, must comply with all applicable local, state and federal regulations; and must collect and submit quality data to demonstrate that it has achieved benchmarks established by a Peer Review Panel (O'Dowd 2012 and Health Care Association of New Jersey 2016). The Department of Health continues to conduct complaint investigations for all facilities, but limits routine inspections to facilities without Advanced Standing. However, the Department of Health randomly conducts unannounced surveys for a percentage of the Advanced Standing facilities to validate the surveys performed through this pilot (O'Dowd 2012).

This program encourages facilities to improve and maintain quality, and it is a signal to consumers who are searching for a quality provider. This system also has the potential to more effectively allocate resources, because it allows the BAL to focus on the facilities that are not yet up to standards. This type of a program might be especially helpful in a state such as Wisconsin, which has among the most facilities in the country. Similar to New Jersey's collaboration with the Health Care Association of New Jersey Foundation, Wisconsin can consider collaborating with an organization, such as the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL) to encourage providers to meet and exceed quality standards.

Oregon

Oregon licenses two types of facilities: Assisted Living Facilities (ALFs) and Residential Care Facilities (RCFs). The main difference between the two pertains to building requirements. ALFs provide more privacy and RCFs have more shared spaces. Adult Foster Homes, equivalent to Adult Family Homes in Wisconsin, are regulated separately. In contrast to Wisconsin, Oregon is seeing a decline in its number of AFHs (van der Veen and Potter 2016). Oregon is also notably different from Wisconsin in terms of its regulatory staff levels and its regulation of memory care facilities.

The resources available to Oregon's regulatory agency are substantially more than Wisconsin's. Oregon has a staff of approximately 55 people responsible for surveying about 500 ALFs and RCFs and about 1,700 AFHs in Oregon. The Office of Licensing and Regulatory Oversight, which oversees the ALFs and RCFs, divides enforcement responsibilities between policy analysts and corrective action coordinators. Every facility is assigned a policy analyst and a corrective action coordinator. The policy analyst advises facilities on technical matters and provides guidance on rules and how to handle more difficult residents. The corrective action coordinator analyzes reports of abuse, and based on this information has the ability to issue penalties and place conditions on a facility to correct an issue. Oregon's Office of Licensing and Regulatory Oversight has four policy analysts and four corrective action coordinators. A separate office that regulates AFHs has two policy analysts and two corrective action coordinators. There are also 14.5 full-time equivalent positions for state surveyors that are responsible for ALFs and RCFs and over 30 surveyors for AFHs (van der Veen and Potter 2016). Oregon has approximately one staff member for every 40 facilities. In contrast, Wisconsin has 32 surveyors and one enforcement specialist for its 3,837 facilities, a ratio of one staff member per every 115 facilities. Oregon's 12 policy analysts and corrective action coordinators share the same responsibilities assigned to the sole enforcement specialist in Wisconsin.

Following the national trend, Oregon has seen considerable growth in the number of memory care facilities, as an increasing number of residents have been diagnosed with Alzheimer's disease or other dementias (van der Veen and Potter 2016). Unlike Wisconsin, Oregon has a separate set of rules for memory care communities. These communities are licensed as an ALF, an RCF, or a nursing home facility. In Oregon, a memory care community means "a designated, separate area for individuals with Alzheimer's disease or other dementias that is locked, segregated, or secured to prevent or limit access by a resident outside the designated or separated area" (Carder et al. 2015).

A memory care community must meet the licensing requirements for its community type and additional requirements for memory care. Any facility that advertises itself as a memory care community must obtain an "endorsement" of its license or face a civil penalty (Or. Admin. R. 411-057-0130(4)(2016)). In general, the rules for these facilities emphasize person-directed care, resident protection, staff training specific to dementia care, and physical plant and environmental requirements. Some specific examples include: memory care communities must have written policies for pre-admission screening, admission, discharge procedures, and moves to a different unit within the facility; the facility must provide a copy of the disclosure statement prior to admission; only individuals with dementia may reside in a memory care community; negative behavioral symptoms must be evaluated, and approaches for addressing them must be included in the service plan; staff in memory care communities must be specially trained to work with persons who have dementia; administrators must complete at least 10 hours of their required continuing education on dementia care (Carder et al. 2015).

Data Analysis

Data Description

We used five datasets from BAL's assisted living licensure, survey, and enforcement databases for our analysis. These datasets include information on all assisted living facilities, complaints issued against providers, provider self-reports of violations, survey findings, and enforcement actions between 2002 and 2015. The dataset on provider facilities is used as the foundation of our analysis and includes information on 7,256 Wisconsin assisted living facilities in service during all or part of the 13-year period.

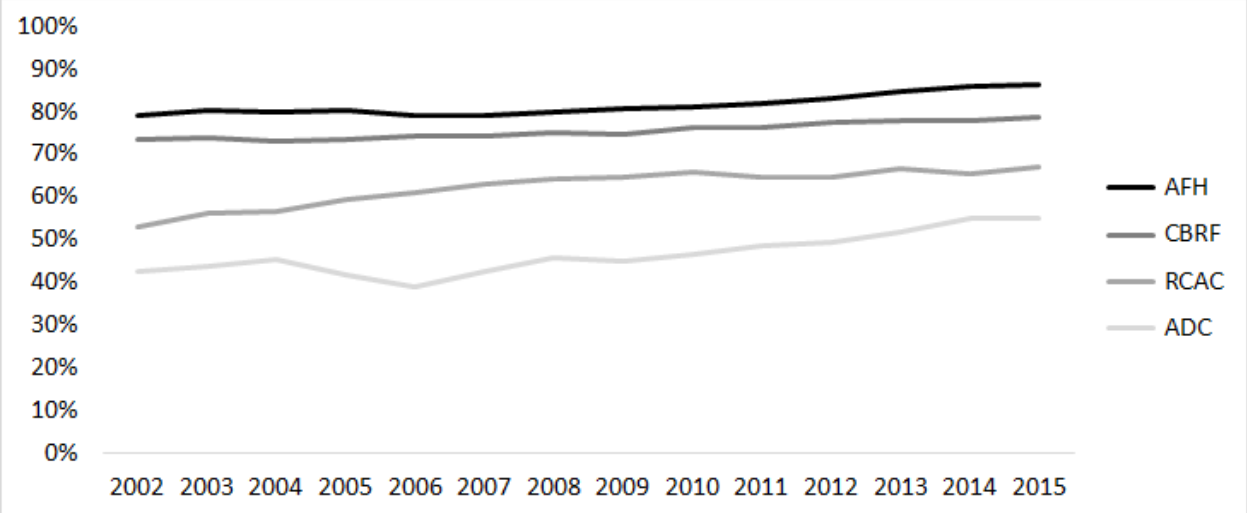
Key Trends

The following charts demonstrate key characteristics of assisted living providers and regulatory trends from 2002 through 2015. These summary statistics are focused primarily on provider type to highlight specific characteristics and issues that could be addressed through modifications to each provider type's unique governing laws and rules. Additional summary statistics can be found in Appendices A and B.

Trends in Provider Characteristics

The following charts demonstrate the percent of three key characteristics by provider type over the past 13 years: percent of facilities with for-profit status; percent of facilities with Medicaid (MA) waivers; and percent of facilities that are licensed to care for residents with dementia. As demonstrated by Figure 13, AFHs are the provider type with the highest percent of for-profit facilities, at 86 percent in 2015, followed by CBRFs at 79 percent in 2015. These trends have remained relatively consistent over the 13 year period.

Figure 13. Percent of Providers For-Profit by Type

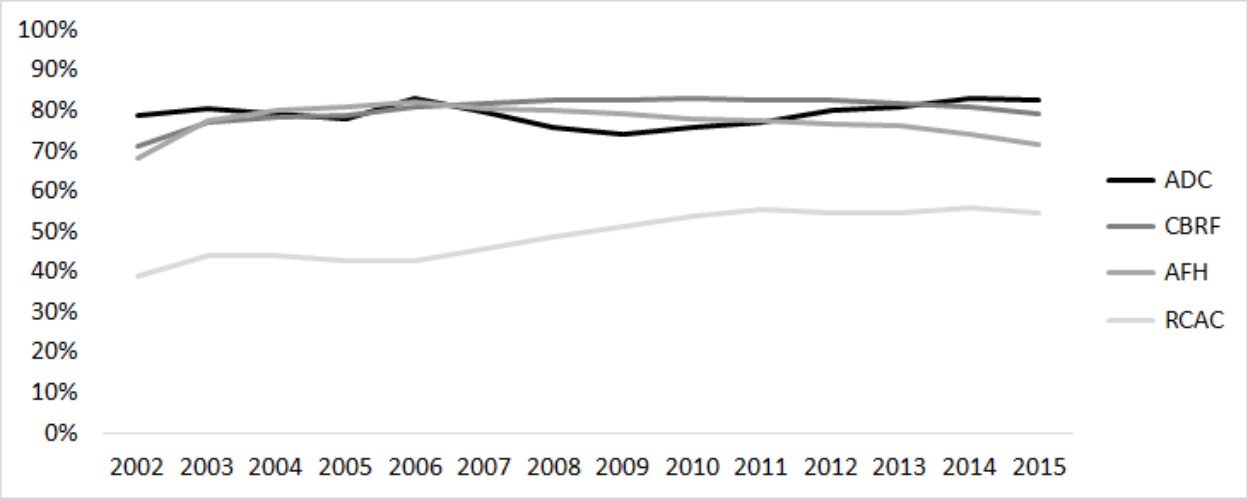


Source: DHS 2016a

Identifying the percent of assisted living providers that receive public assistance through MA waivers is relevant, because it indicates the socio-economic status of the facilities' residents

as well as a provider's financial composition. Figure 14 demonstrates that ADCs, followed closely by CBRFs, have the highest percent of facilities that receive MA waivers, at 83 percent and 79 percent in 2015, respectively. Again, these trends have remained relatively consistent over the 13 year period.

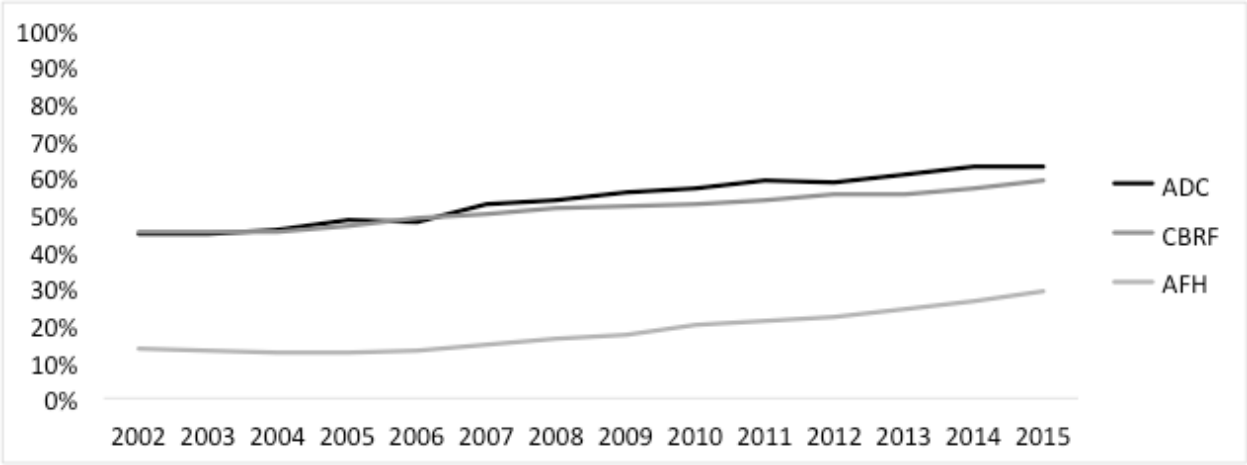
Figure 14. Percent of Providers Receiving Medicaid Waivers by Type



Source: DHS 2016a

ADCs and CBRFs are most likely to be licensed to serve residents with Alzheimer's disease and other dementias. In 2015, 62 percent of ADCs and 59 percent of CBRFs were licensed to care for residents with dementia, while only 29 percent of AFHs cared for residents with dementia. No RCACs were licensed for this purpose.

Figure 15. Percent of Providers Licensed to Serve Dementia Clients by Type



Source: DHS 2016a

Enforcement Trends

The number of surveys, cites, and fines per provider have decreased since 2002, which coincides with a relative decrease in BAL resources. As Figure 16 indicates, BAL currently

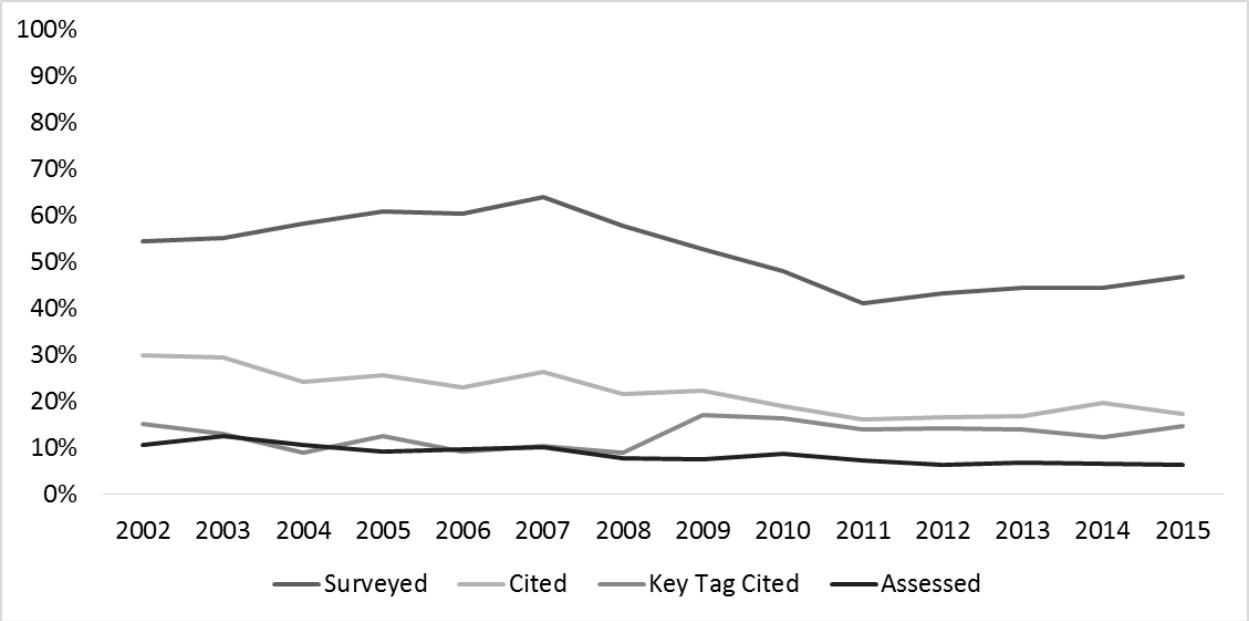
conducts about three surveys for every five providers annually, and issues cites at the same rate. BAL issues about two key tag cites for every five providers annually, and issues less than one fine for every ten providers. Unlike a standard cite, a key tag cite involves the most important areas of resident health and safety, such as resident rights and care planning, adequacy of staffing, medication management, sanitation, and building and fire safety. Appendix B presents this data by provider type. This data reveals that CBRFs receive the most regulatory attention, which is consistent with CBRFs having the most stringent regulations.

Figure 16. Surveys, Cites, and Fines per Provider

Source: DHS 2016a

Corresponding to the decrease in the number of surveys, cites, and fines per provider, BAL is also engaging a smaller subset of providers. Figure 17 indicates the percent of providers surveyed, cited, and fined over time (see Appendix B for this data by provider). The percent of providers surveyed each year has been inconsistent, with an overall decrease from 54 percent in 2002 to 47 percent in 2015. The percent of providers cited and fined have sustained a downward trajectory, decreasing from 30 percent to 17 percent and 11 percent to 6 percent, respectively, from 2002-2015. However, the percent of providers receiving key tag cites more than doubled from 2008 to 2009 and remained relatively constant since then. This is due to an increase in key tag cites issued to CBRFs, which increased in 2009 when rules were changed for that provider type related to required staff training and qualifications.

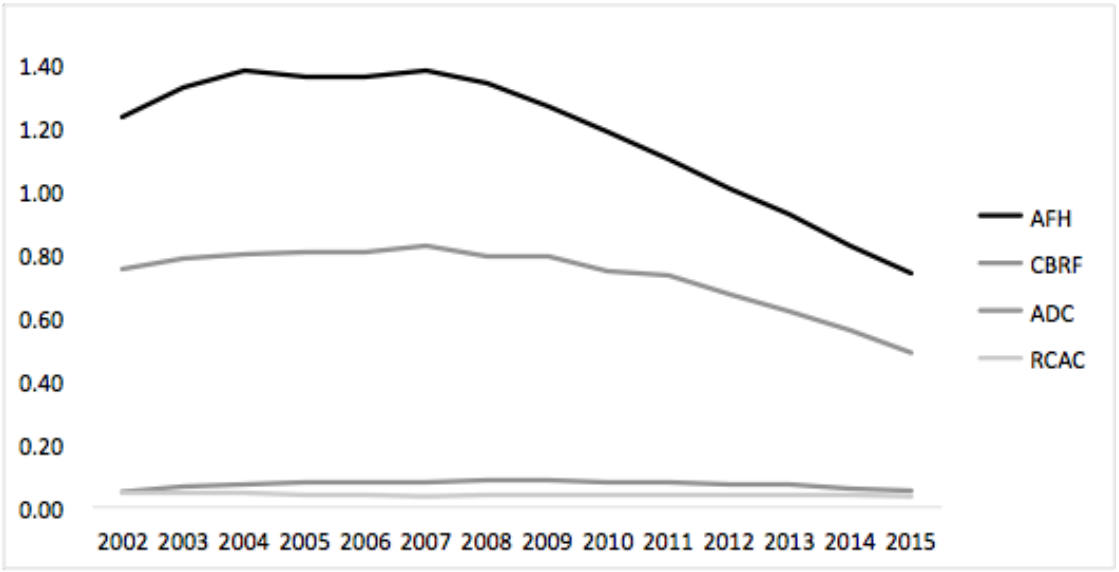
Figure 17. Percent of Providers Surveyed, Cited, and Fined



Source: DHS 2016a

Figure 18 demonstrates that total cites (including key tag cites) have declined for each provider type over the past 13 years. AFHs experienced a sharp decline in total cites, as total cites per bed decreased 40 percent between 2002 and 2015. Similarly, CBRFs experienced a 35 percent decrease in total cites per bed between 2002 and 2015.

Figure 18. Cites per Bed by Provider Type

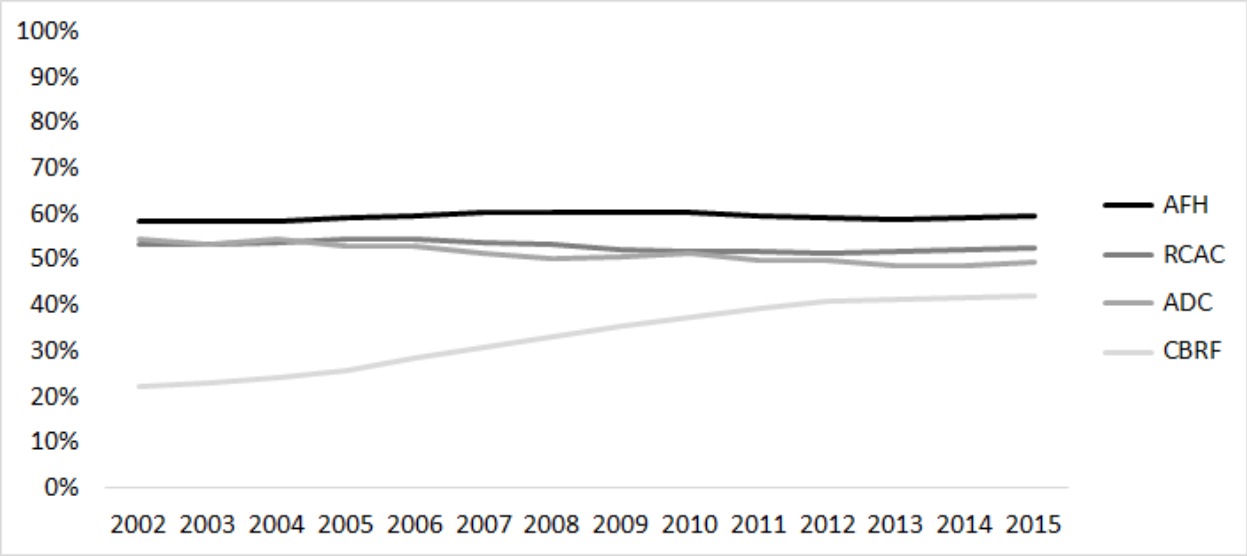


Source: DHS 2016a

Figure 19 shows the percent of cites that are key tag cites for each provider type over the past 13 years. AFHs consistently have the highest percentage of key tag cites over the past 13

years, with 59 percent of total cites being key tag cites in 2015, followed by RCACs, with 53 percent of total cites being key tag cites in 2015.

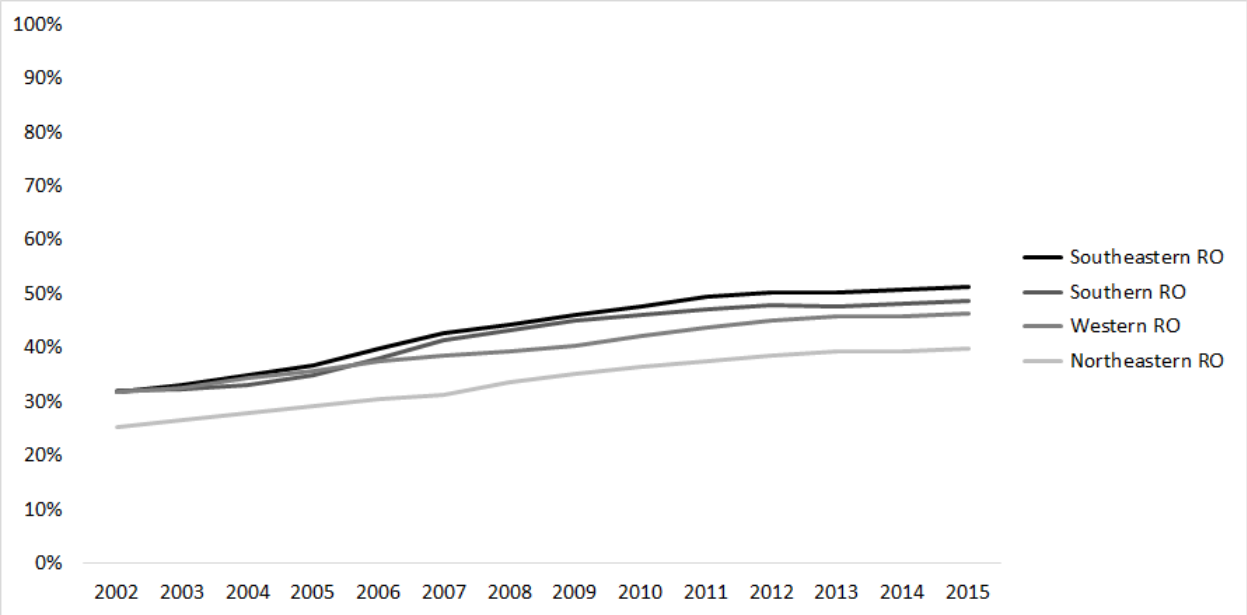
Figure 19. Key Tag Cite Rates by Provider Type



Source: DHS 2016a

Figure 20 shows the percent of cites that are key tag cites issued by each BAL Regional Office (RO) over the past 13 years. The Southeastern RO has consistently issued the most key tag cites over the past 13 years, with 51 percent of total cites being key tag cites in 2015, followed by the Southern RO, with 49 percent of total cites being key tag cites in 2015.

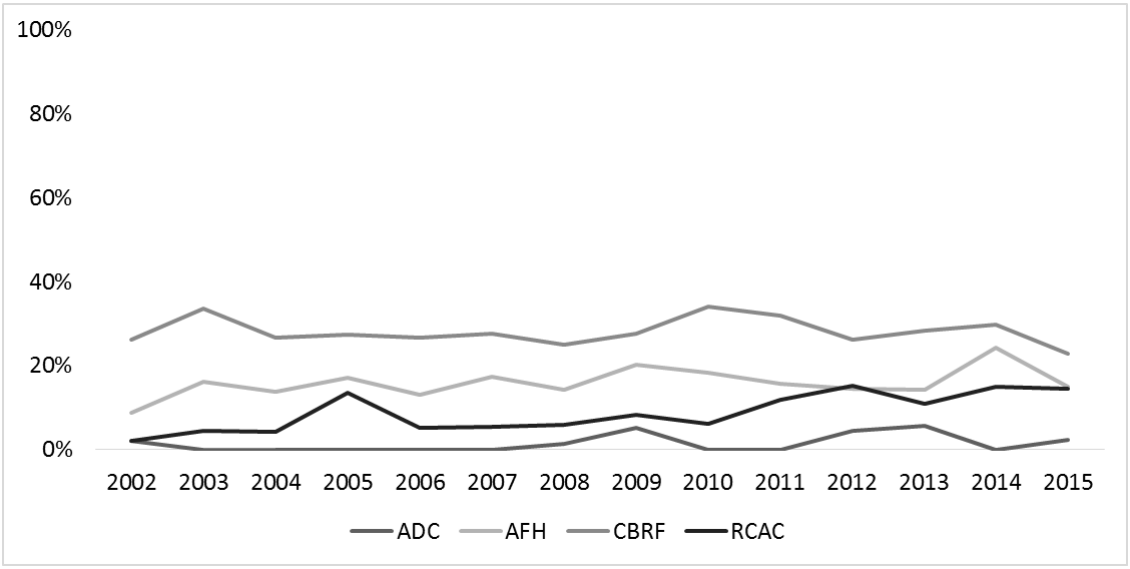
Figure 20. Key Tag Cite Rates by Regional Office



Source: DHS 2016a

The percent of surveys resulting in enforcement action can be used to measure the frequency with which surveys uncover serious violations, such as violations that result in serious resident harm or the potential for serious resident harm. Figure 21 shows that nearly a quarter of CBRF surveys resulted in enforcement action in 2015, compared to 15 percent for AFHs and RCACs and only 2 percent for ADCs. In every year, a higher percent of CBRF surveys result in enforcement action than any other provider type.

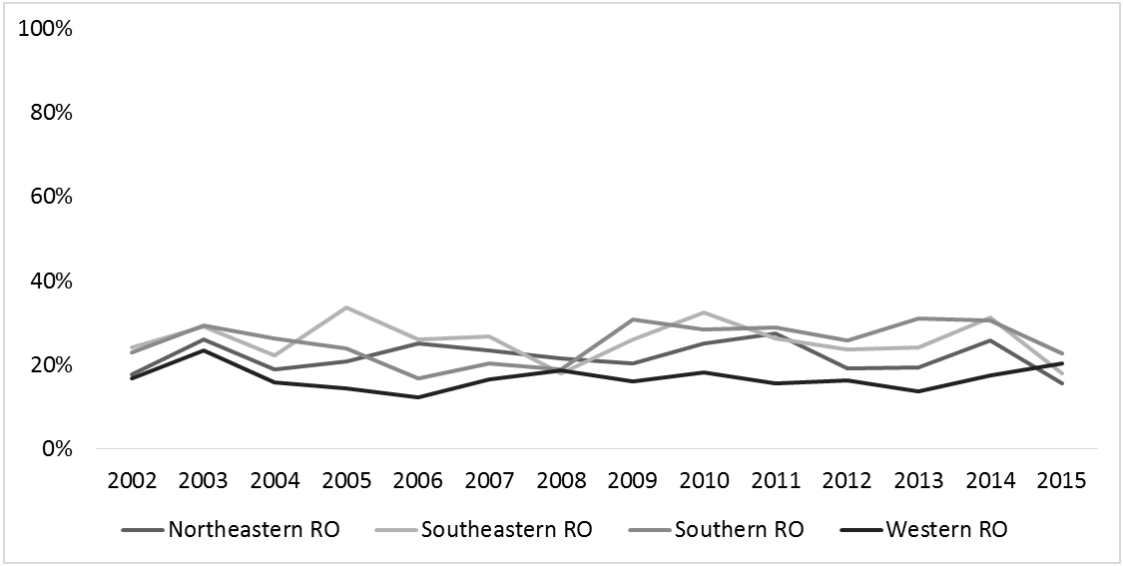
Figure 21. Percent of Surveys Resulting in Enforcement by Provider Type



Source: DHS 2016a

The percent of surveys resulting in enforcement also varies by BAL Regional Office, as indicated by Figure 22. In 2013, 31 percent of surveys in the Southern region resulted in enforcement action, compared to just 14 percent in the Western region. However, by 2015 there was greater consistency across regions, with rates ranging from 16 to 23 percent.

Figure 22. Percent of Surveys Resulting in Enforcement by Regional Office

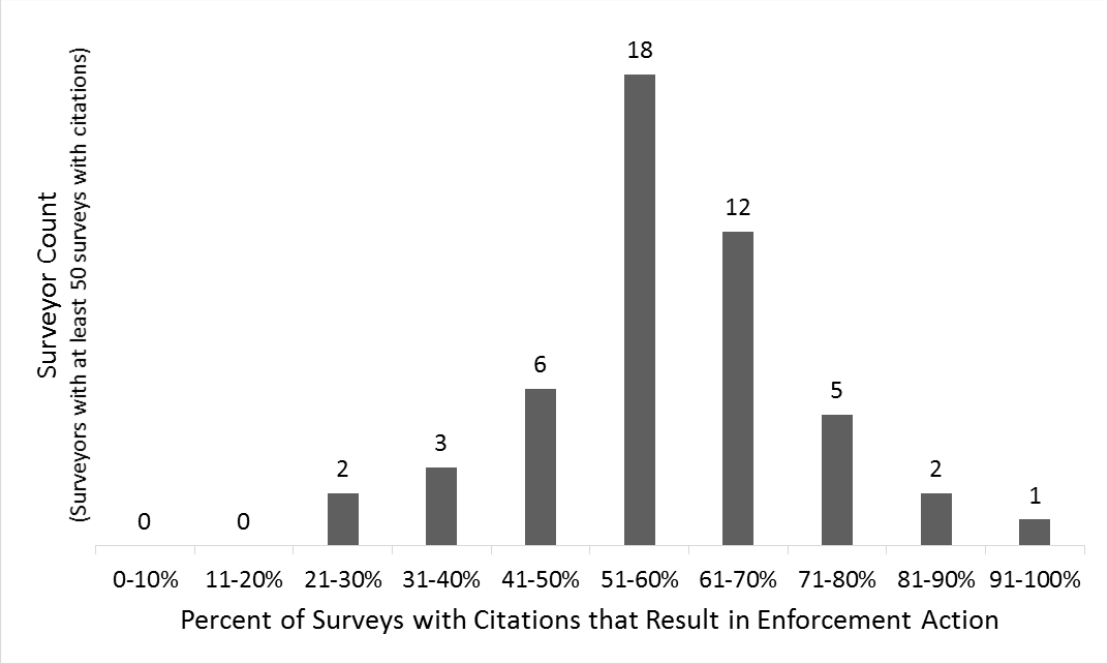


Source: DHS 2016a

The total number of annual surveys conducted by BAL has increased 30 percent since 2002. However, as Figures 21 and 22 demonstrate, the percent of surveys resulting in enforcement review have remained relatively consistent for each provider type and regional office over the past 13 years. This result implies the likelihood of a survey identifying a serious violation has remained relatively consistent.

Figure 23 demonstrates that there is considerable variation by surveyor in the percentage of surveys with cites that result in enforcement. Among surveyors with at least 50 such surveys, a majority had 51 percent to 70 percent of these cases result in enforcement action, but rates ranged between 29 percent and 96 percent. Because the quality of the documentation collected by a surveyor can influence whether BAL is able to prove that a violation was committed and proceed with an enforcement action, this measure is considered to be a good measure of the quality of the work done by surveyors (Traas 2016). Thus, this data suggests inconsistency in the quality of the work of BAL surveyors.

Figure 23. Cites Resulting in Enforcement by Surveyor



Source: DHS 2016a

Regression Analysis and Model Descriptions

Introduction and Model Description

Our analysis uses multivariate regressions to estimate the relationships between several key variables. Regression analysis estimates the association between an individual explanatory variable and an outcome variable, holding other variables in the model constant. While it is important to note that doing so does not establish causality, determining these relationships is important to our evaluation because it could identify characteristics that are more prevalent among providers with records of serious violations and multiple violations. These results,

therefore, could be used to indicate which types of providers may warrant additional attention from BAL.

We used two logistic regression models to explore the relationships between: 1) serious violations and provider characteristics; and 2) multiple violations and provider characteristics. We chose logistic rather than probabilistic models for two reasons. First, each of our outcome variables is binary (e.g., a provider has either had a serious violation or it hasn't), making a linear model an inappropriate fit. Second, we favored logistic regression over probit regression because its results are directly interpretable using odds ratios. This analysis includes the 7,256 providers that were in operation for at least part of the period of 2002-2015.

Interpreting Odds Ratios

The following example illustrates the proper interpretation of odds ratios. If 50 percent of Group A achieves a given outcome, its odds of achieving that outcome are 1:1, since for every success there is one failure. Thus, the *odds* of Group A achieving the outcome are equal to .50/.50 = 1. If 25 percent of Group B achieves the same, its odds of achieving that outcome are 1:3, since for every success there are three failures. Thus, the *odds* of Group B achieving the outcome are equal to .25/.75 = .33. Therefore, the *odds ratio* is equal to the ratio of the odds between the two groups: 1/.33 = 3. In other words, the odds of Group A achieving the outcome is three times the odds of Group B achieving the outcome. In this way, odds ratios represent relative rather than absolute information.

We report odds ratios for each of the explanatory variables in our two models to show which provider characteristics are associated with increased odds of having a negative outcome (a serious violation or multiple violations, depending on the model). For binary provider characteristics (e.g., "association," which indicates whether a provider is a member of a trade association) results are interpreted as follows: if the odds ratio for association is X, then the odds of an association member having the outcome is X times the odds of a non-association member having the outcome, holding all other variables in the model constant.

For provider characteristics that have more than two possible values, such as "regional office" (of which there are four), the interpretation is slightly different. In these cases, all but one of the values is included in the model, and the odds ratio for each of those is interpreted in relation to the value that was excluded. For regional offices, odds ratios are reported for the Western Regional Office (WRO), the Southeastern Regional Office (SRO), and the Southern Regional Office (SRO). Each of these odds ratios, X, shows that a provider belonging to the given regional office has X times the odds of a provider belonging to the Northeast Regional Office (NERO) of having the outcome, holding all other variables in the model constant.

Our "capacity" variable is unique in that it is not binary, as it represents the number of beds in a given facility. For capacity, the odds ratio indicates whether having greater capacity is associated with increased odds of having a negative outcome.

Serious Violations

According to the BAL Enforcement Specialist, a violation is considered serious if it is referred for enforcement action (Traas 2016). Thus, we coded our "serious violations" outcome variable based on whether a provider had at least one BAL survey that resulted in enforcement action between 2002 and 2015. This variable was regressed on a number of explanatory variables: provider type (Certified RCAC, Registered RCAC, CBRF, AFH, ADC), capacity

(number of beds), for-profit status (yes/no), membership in a trade association (yes/no), BAL Regional Office location (NERO, SERO, SRO, and WRO), licensure to serve dementia patients (yes/no), and the provider's acceptance of Medicaid funding (yes/no). These independent variables constitute much of the provider characteristics data collected by BAL and were selected based on findings from interviews with various stakeholders.

Multiple Violations

To determine which providers have had multiple violations, we coded our "multiple violations" outcome variable based on whether a provider had at least two violations cited by BAL between 2002 and 2015. This variable was regressed on the same explanatory variables used in the serious violations model. These independent variables constitute much of the provider characteristics data collected by BAL and were selected based on findings from interviews with various stakeholders.

Regression Results

Full regression results are presented in Appendix C and summarized below.

Serious Violations

We found that provider type has a sizable and statistically significant effect on the odds of having a serious violation on a provider's record. Licensed AFHs have approximately 15 times the odds of an ADC and approximately 20 times the odds of a registered RCAC of having a serious violation, while CBRFs have over three times the odds of a licensed AFH of having the same. These findings are largely consistent with the amount of regulatory burden faced by these respective categories, but they are nonetheless impressive in their magnitude. These results are potentially due to the fact that CBRFs serve the greatest variety of residents with some of the most complex needs. AFHs serve residents with similarly complex needs, but they are subject to less regulation.

Similarly, we found that a number of other variables have a statistically significant effect on the odds of having a serious violation on a provider's record. Providers not belonging to a trade association have approximately 1.3 times the odds of association members. A potential explanation of this result is that membership in a trade association requires a certain level of professionalism and can help spread industry norms and best practices among members.

Providers accepting Medicaid funding have close to twice the odds of those that do not; these findings are also consistent with findings from interviews with various stakeholders. A potential explanation of this result is that Medicaid reimburses providers at rates lower than what providers can charge in the private market, which may negatively impact the quality of care provided. Furthermore, this result suggests those who qualify for Medicaid, who are of lower socio-economic statuses, have greater odds of being mistreated.

Providers under the purview of the Southeastern and Southern BAL Regional Offices have approximately 1.3 times the odds of providers regulated by the Northeastern BAL Regional Office. This result could be due to variation in enforcement across regional offices or to systematic regional differences in provider characteristics, such as staff turnover rates.

Furthermore, increasing bed capacity was found to marginally increase the odds of having a serious violation. A potential explanation of this result is that larger facilities are more likely to have lower staff-to-resident ratios, which could result in more violations.

Conversely, a number of variables had no statistically significant effect on the odds of a provider having a serious violation on its record. In particular, no statistically significant differences were found between: licensed AFHs and certified RCACs; for-profit and non-profit providers; Northeastern Regional Office and Western Regional Office providers; and providers licensed to serve dementia patients and those that are not.

Multiple Violations

As with our serious violations model, we found that provider type has a sizable and statistically significant effect on the odds of having multiple violations on a provider's record. Licensed AFHs have 2.5 times the odds of an ADC and approximately 17 times the odds of a registered RCAC of having multiple violations, while CBRFs have close to 3.5 times the odds of a licensed AFH of having the same. These findings are largely consistent with the amount of regulatory burden faced by these respective categories, but they are nonetheless impressive in their magnitude.

Similarly, we found that a number of other variables have a statistically significant effect on the odds of having multiple violations on a provider's record. Providers accepting Medicaid funding have over twice the odds of those that do not, which is also consistent with findings from interviews with various stakeholders. Providers under the purview of the Southeastern, Southern, and Western BAL Regional Offices have approximately 1.5 times the odds of providers regulated by the Northeastern BAL Regional Office, which is somewhat unexpected given that BAL aims to consistently enforce regulations across its regional offices. However, inconsistencies in surveyor performance corroborate this result.

Conversely, a number of variables had no statistically significant effect on the odds of a provider having multiple violations on its record. In particular, no statistically significant differences were found between: for-profit and non-profit providers; association members and non-members; and providers licensed to serve dementia patients and those that are not.

Recommendations

BAL requested recommendations to change statutory language, administrative code, and DHS policy that could improve regulatory compliance and resident protection. This section provides these recommendations in two categories: non-statutory changes (including administrative code) and statutory changes. These recommendations are based on a thorough analysis of BAL enforcement data and interviews of DHS staff, stakeholders, and various states' assisted living regulatory officials.

Non-Statutory Changes

Recommendation 1: Implement an inspection system that focuses on poor performers and rewards voluntary compliance, using New Jersey's Advanced Standing program as a model.

Rationale: The current complaint-based system can result in violations being missed and some facilities operating for several years without a survey. This system has evolved because resources do not allow BAL to meet its stated goal of inspecting each facility every two years. Wisconsin currently conducts abbreviated surveys for providers in good standing and uses the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL) as a means to improve quality among providers. However, WCCEAL and abbreviated surveys have a limited reach in comparison to the Advanced Standing program, which provides greater guarantees of resident safety and additional benefits to providers. However, WCCEAL is a voluntary membership association with limited reach, while a program like Advanced Standing affects all providers.

Advanced Standing exempts certain providers from the majority of BAL surveys, even abbreviated surveys. A program like New Jersey's allows facilities that comply with all necessary regulations and meet certain quality benchmarks to be in the Advanced Standing program. Such a program signals to consumers, which facilities are of high quality and has the potential to incentivize providers to enhance quality. Additionally, numerous studies have shown that certification programs may lead to faster business growth and increased profits by reducing information asymmetries consumers must face (Viscuci 1978; Terlaak and King 2006).

We expect BAL to spend the same number of hours doing surveys, however the surveys conducted will be more efficiently targeted. Under the current system, BAL conducts an abbreviated survey in roughly 1.5 to 2 hours, whereas a standard survey typically requires a full day. Thus, even if an Advanced Standing program reduced the percent of providers that required regular surveys by a small amount, it could free up much-needed staff resources and allow BAL to reduce its backlog of cases and conduct other surveys with greater regularity.

This recommendation is supported by our regression analysis, which found that providers not belonging to a trade association have 1.3 times the odds of association members of having a serious violation. Like trade association membership, our recommendation requires higher quality assurance standards for providers in Advanced Standing. Thus, we expect members of Advanced Standing would also be less likely to commit serious violations.

Recommendation 2: Conduct random surveys in addition to complaint investigation and scheduled compliance surveys.

Rationale: BAL inspects providers largely in response to complaints. When BAL has not received a complaint about a provider, it is considered a lower priority for inspection. Currently, when fewer complaints are made, it is not clear whether the reduction in complaints can be attributed to effective regulation, the problem occurring less frequently due to other reasons, or BAL not detecting violations. Random surveys of facilities can be used to identify trends in the frequency of violations. Additionally, random inspections will deter violations in facilities that are a low priority or in advanced standing by increasing the risk of being found out of compliance.

This recommendation will require either additional staff resources, such as an additional surveyor per region, or reallocating existing staff from current duties due to the increased number of surveys. The 2016 BAL budget includes $69,510 per surveyor in total salary, benefits, and supply allowance. Therefore, if each of the four regions added an additional surveyor, the total cost could be $278,040 per year. However, additional staff resources for random surveys may be available if BAL chooses to implement an Advanced Standing program, thereby eliminating the need to hire additional surveyors for this purpose. This recommendation could identify providers with otherwise unreported violations, which would provide BAL a more accurate picture of true compliance and an additional safeguard for client protection.

Recommendation 3: Evaluate the reliability and consistency of surveyor performance

Rationale: Our data analysis finds that there is considerable variation by surveyor in the percentage of surveys with citations that result in enforcement, which is considered to be a measure of surveyor quality. Furthermore, our interview findings suggest Wisconsin surveyor qualifications and skills vary significantly. Because surveyors are integral to the identification of violations before a complaint or injury occurs and to the consistency of regulation, we recommend that BAL devote additional attention and resources to this topic.

The variation of surveyor performance may be explained by differences in education, experience, and/or qualifications among surveyors. In our interview, Illinois reported that all of their surveyors are federally and state qualified as Health Facility Surveillance Nurses. In another interview, Michigan reported that surveyors are hired with a master's degree in a relevant field and have some inspection experience. Furthermore, studies show that surveyors who are former providers may be less forgiving about violations but more willing to provide technical support. Based on these examples, BAL might consider implementing increased quality-control measures and/or greater standards for surveyor qualifications.

Statutory Changes

Recommendation 1: Increase the number of BAL enforcement specialists and surveyors.

Rationale: Additional staff capacity will provide BAL the resources to meet its responsibility of surveying all assisted living providers and protect residents. The number of assisted living facilities has grown substantially over the last 15 years, but BAL staff has not kept pace. BAL confronts a backlog of more than 1,100 facilities every year. In 2015, more than 480 surveys found violations that resulted in enforcement action, which is consistent with prior years. Each survey averages approximately three citations, which results in nearly 1,500 citations reviewed for enforcement in a given year by one employee (Traas 2016). Furthermore, Wisconsin has substantially less resources compared to other states. For example, Wisconsin's

one enforcement specialist has multiple responsibilities (e.g., enforcement analysis and determination, program/policy development, staff training, legal testimony) that are split between 12 policy analysts and corrective action coordinators in Oregon.

Wisconsin also has fewer surveyors compared to other states. Our evaluation of other states found that the number of facilities per surveyor range from 36 to 65, compared to 120 in Wisconsin, even though these surveyors have substantively the same responsibilities. Wisconsin's surveyor staff levels have remained consistent over the past 15 years, while facility-to-surveyor ratios increased 36 percent and facility beds-to-surveyor ratios increased 43 percent between 2003 and 2015 (DHS 2016). These figures and comparisons strongly suggest a need for additional BAL staff. For BAL to return to the 2003 surveyor-facility ratio of 1:85, BAL would need to hire 12 more surveyors. The 2016 BAL budget includes $69,510 per surveyor in total salary, benefits, and supply allowance. Therefore, if BAL added 12 additional surveyors, the total cost could be $834,120 per year.

Recommendation 2: Increase BAL's regulatory oversight and enforcement authority for Adult Family Homes (AFHs).

Recommendation 2.1: Grant BAL the authority to assess forfeitures for licensed AFHs for violations.

Rationale: The assessment of forfeitures is a powerful tool to gain compliance and increase resident safety through deterrence. The number of licensed AFHs has grown by 113 percent (or over 1,000 facilities) since 2002, and AFHs now make up 48 percent of providers. Licensed AFHs have approximately 15 times the odds of an ADC and approximately 20 times the odds of a registered RCAC of having a *serious* violation. AFHs also have 2.5 times the odds of an ADC and approximately 17 times the odds of a registered RCAC of having *multiple* violations. Yet, BAL has little to no enforcement authority for these types of facilities.

The acuity of residents at all facilities, including AFHs, has increased. In interviews, multiple stakeholders reported concerns with the lack of oversight over AFHs, as they are not subject to forfeiture assessments, which are considered among the most effective sanctions. Our recommendation is also supported by studies that have shown the assessment of fines can reduce facility violations by as much as 22 percent.

Recommendation 2.2: Evaluate the feasibility of transferring certification and regulation of AFHs from the counties and managed care organizations to BAL.

Rationale: In 2010, there were 1,800 certified AFHs in Wisconsin, representing the largest subset of assisted living providers in the state (Mollica et al. 2010). BAL does not have jurisdiction over these facilities. Given the substantial number of these facilities and the potential costs to counties and managed care organizations, BAL should evaluate if it would be more efficient and enhance resident protection to move certified AFHs under BAL jurisdiction.

Recommendation 3: Increase standards for memory care facilities.

Rationale: Residents with Alzheimer's and other dementias require additional resources to ensure their safety. The growth of residents with Alzheimer's disease and other dementias will

strain Wisconsin's assisted living system. In 2016, it was estimated that 115,000 people in Wisconsin had dementia. That number is expected to increase to 242,000 people, or 110 percent, by 2040 (DHS 2015a). These people require additional attention and special types of care. Currently, facilities in Wisconsin can market themselves as providing memory care and charge residents at increased rates. However, there are very few requirements that distinguish a memory care facility from another assisted living facility.

Many other states have additional dementia care requirements that are either lacking or nonexistent in Wisconsin. For example, 35 states regulate the physical layout of dementia care units, generally with the goal of preventing elopement, which is a significant risk to residents with dementia (Carder et al. 2015). Wisconsin has no such regulations. Oregon's requirement that memory care facilities receive an "endorsement" to operate could offer another mechanism by which BAL could improve the quality of resident care in dementia care units.

Recommendation 4: Revise the statutes or rules to give BAL the authority to use impending (deferred) revocation and root cause analysis.

Rationale: BAL can best obtain provider compliance and resident safety when it have a diverse toolbox of progressive sanctions that can be used to either deter violations or bring a provider back into compliance after a violation has occurred. Interviews with BAL staff have identified impending revocation and root cause analysis as useful tools for correcting violations, improving compliance, and reducing resident relocations. However, the interpretation of DHS's regulatory authority after 2011 Act 21 prevents BAL from using these strategies because it is not explicitly addressed in the statutes.

This recommendation reinstates previous regulatory authority that had effectively improved provider compliance while maintaining resident protection. This recommendation is supported by studies that have found that a wide variety of enforcement tools that are progressively applied are effective in assuring compliance. Furthermore, the strategies are less punitive than alternatives currently available to BAL, such as license revocation.

Recommendation 5: Create more unified rules for enforcement across provider types.

Rationale: Unified rules would reduce regulatory complexity and increase compliance. Each of the four provider types are currently subject to different levels of oversight, and BAL's enforcement authority differs for each type. Some providers are licensed, some registered, and others certified. Each regulated entity type has distinct regulatory requirements and the authority afforded to BAL to conduct compliance reviews and enforcement activities varies by entity type. However, each provider type admits residents with largely similar conditions and needs (e.g., chronic health conditions, mental health needs, or impaired mobility).

BAL can fine CBRFs, but not AFHs or ADCs for the same violations (e.g., unmet needs, unsafe conditions – even those resulting in the death of a resident). Similarly, BAL periodically inspects certified RCACs and can impose sanctions on these facilities, but the same is not true for registered RCACs, even though the resident populations are essentially the same. Creating more unified regulations and enforcement across provider types could reduce complexity and permit greater consistency in regulatory practices. This consistency would benefit providers operating multiple types of facilities by making regulations more understandable, and help BAL allocate resources more efficiently by making regulatory authority similar across provider types.

Recommendation 6: Update admission standards for residents to limit the types of residents that certain facilities can accept.

Rationale: The current system does not guide residents to the facilities that may be the most capable of caring for them. We heard from several stakeholders that CBRFs have become mini-nursing homes and that RCACs provide services originally intended for CBRFs. Many of these facilities care for residents with all types of needs, and it is not clear if the staffing levels, staff quality, physical layout of the facility, or types of residents around them in the community are appropriate. Updating admission standards for residents is one option that would help ensure that residents are housed by the providers that will provide them the most appropriate care.

Conclusion

Our evaluation of the Wisconsin assisted living regulatory system provides nine recommendations aimed at improving this system to increase regulatory compliance and resident protection statewide. By analyzing trends in Wisconsin's assisted living community over the past 13 years and performing comparisons to other states' regulatory agencies, we determine that the current limitations of BAL regulatory authority and resources will continue to negatively affect provider compliance as the state's elderly population grows and the acuity of assisted living resident needs increases. Furthermore, the results of our regression analyses indicate that AFHs and CBRFs are the assisted living provider types with the greatest odds of committing the most serious violations and multiple violations. This data may help BAL use its regulatory resources more effectively by targeting providers that are more likely to be noncompliant.

Through our evaluation, we answer two of our three guiding research questions. Our evaluation identifies potential changes to existing statutes, policies, and regulatory strategies designed to ensure greater compliance. These recommendations are largely informed by promising practices from other states, interview findings, and results from our regression analyses. However, our first research question concerning the effectiveness of the existing regulatory system remains mostly unanswered. Although we determined that serious violations per provider have declined in recent years, we are unable to conclusively state that the number of citations have declined due to increased regulatory compliance. Because of the decline in BAL resources per facility, the agency is unable to survey over 1,100 facilities – roughly 40 percent of Wisconsin facilities – within its targeted timeframe of two years. And while complaints help alert BAL to issues, the lack of timely and random surveys suggests that the agency does not have a complete picture of regulatory compliance and may be missing a growing number of violations over time.

Appendix A: Assisted Living Growth, 2002-2015

The following table demonstrates facility and capacity increases overall and by provider type from 2002 to 2015.

Table A1. Assisted Living Growth, 2002-2015

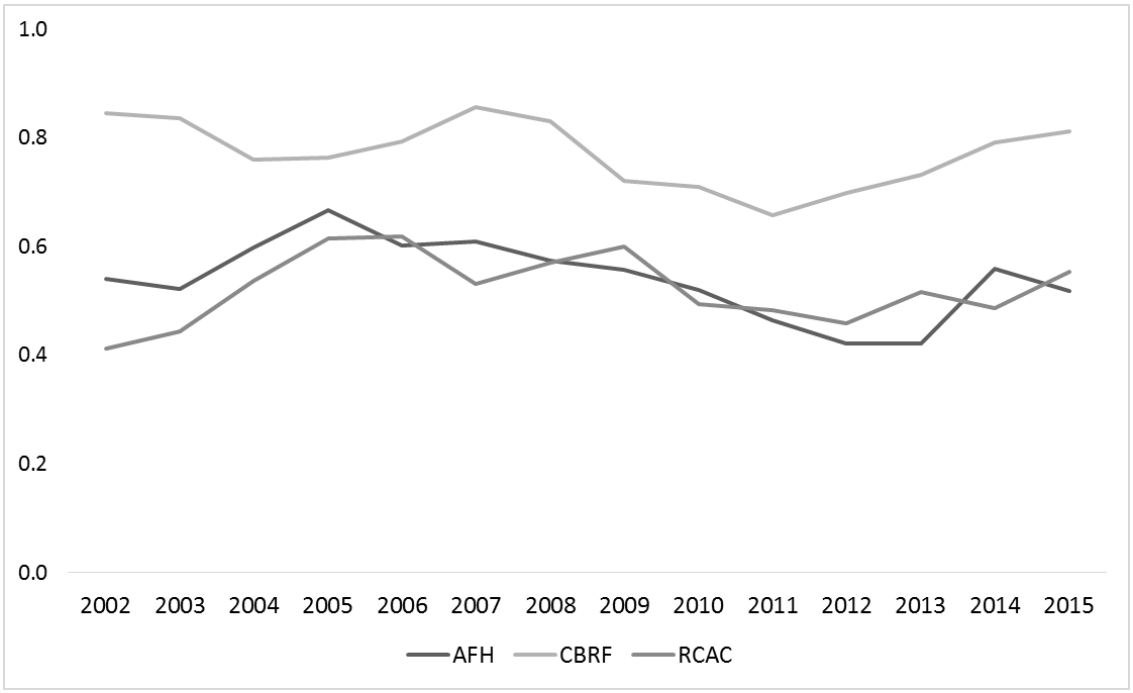
Provider Type	Total Facilities			Total Capacity		
	2002	2015	% Increase	2002	2015	% Increase
ADC	122	144	18%	3,161	4,571	45%
AFH	915	1,945	113%	3,533	7,527	113%
CBRF	1,495	1,646	10%	22,859	30,584	34%
RCAC	121	336	178%	5,094	15,298	200%
Total	2,653	4,071	53%	34,647	57,980	67%

Source: DHS 2016a

Appendix B: Enforcement Trends by Provider Type

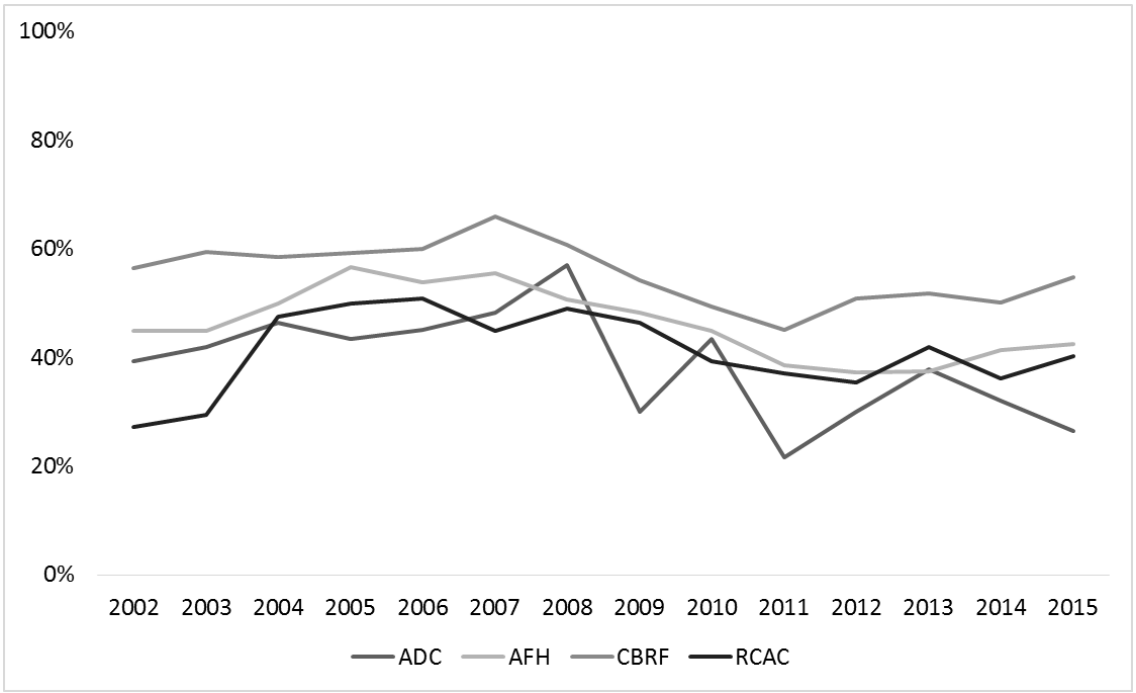
The following charts provide data on surveys, cites, key tag cites, and fines by provider type.

Figure A24. Surveys per Provider by Provider Type



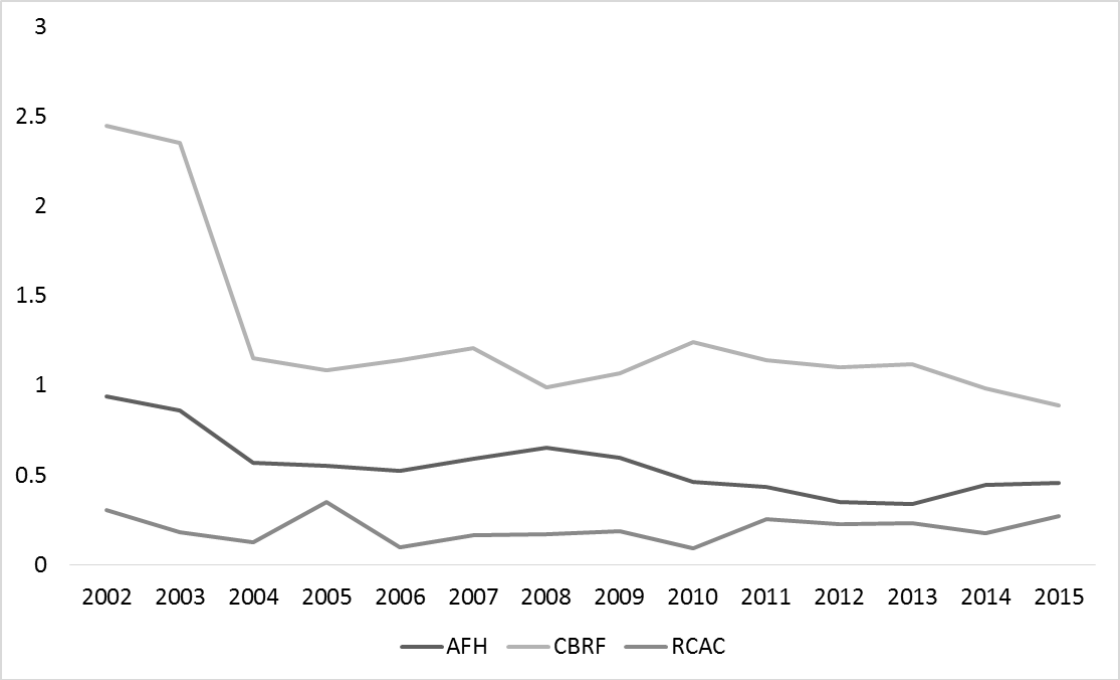
Source: DHS 2016a

Figure A25. Percent of Providers Surveyed by Provider Type



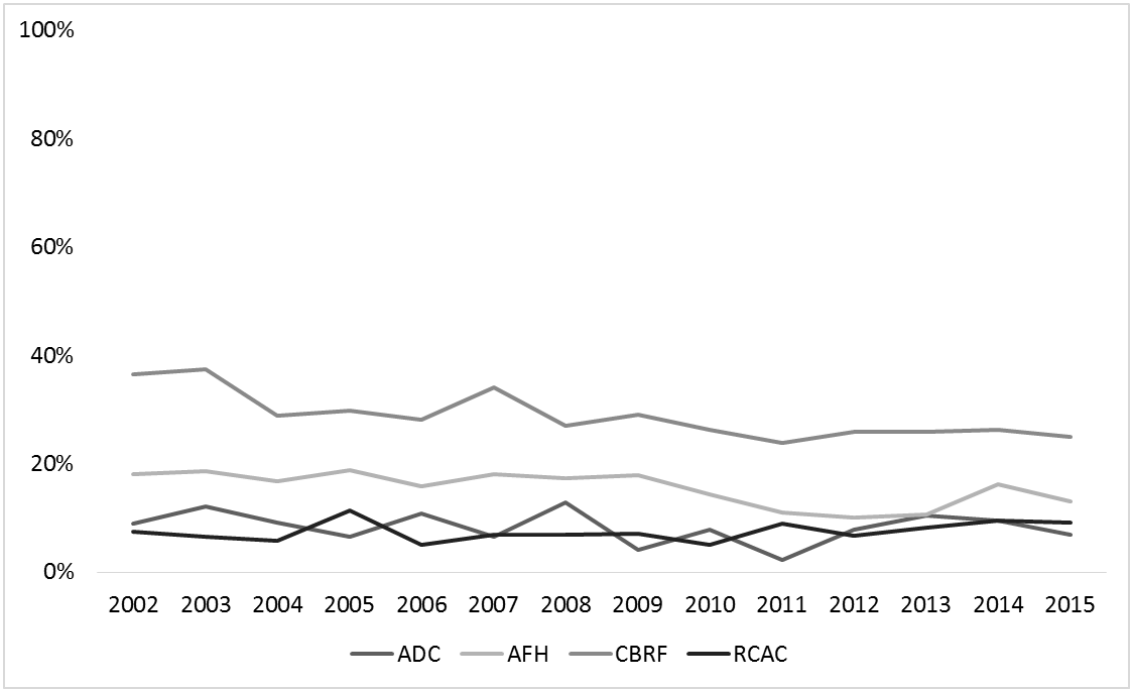
Source: DHS 2016a

Figure A26. Cites per Provider by Provider Type



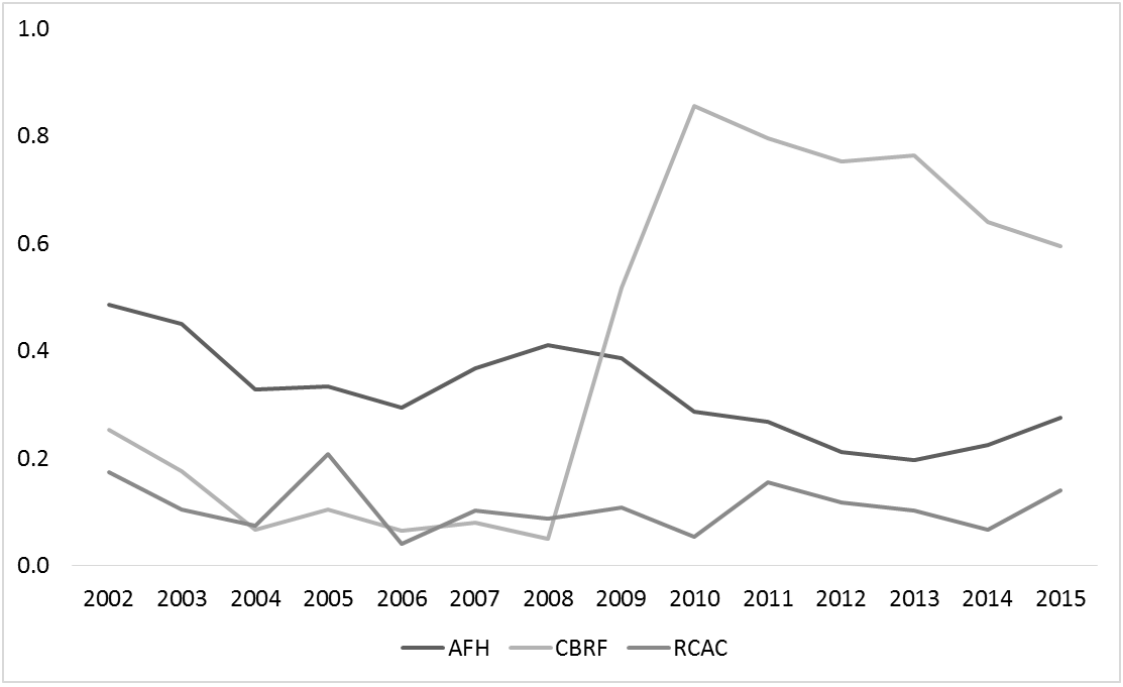
Source: DHS 2016a

Figure A27. Percent of Providers Cited by Provider Type



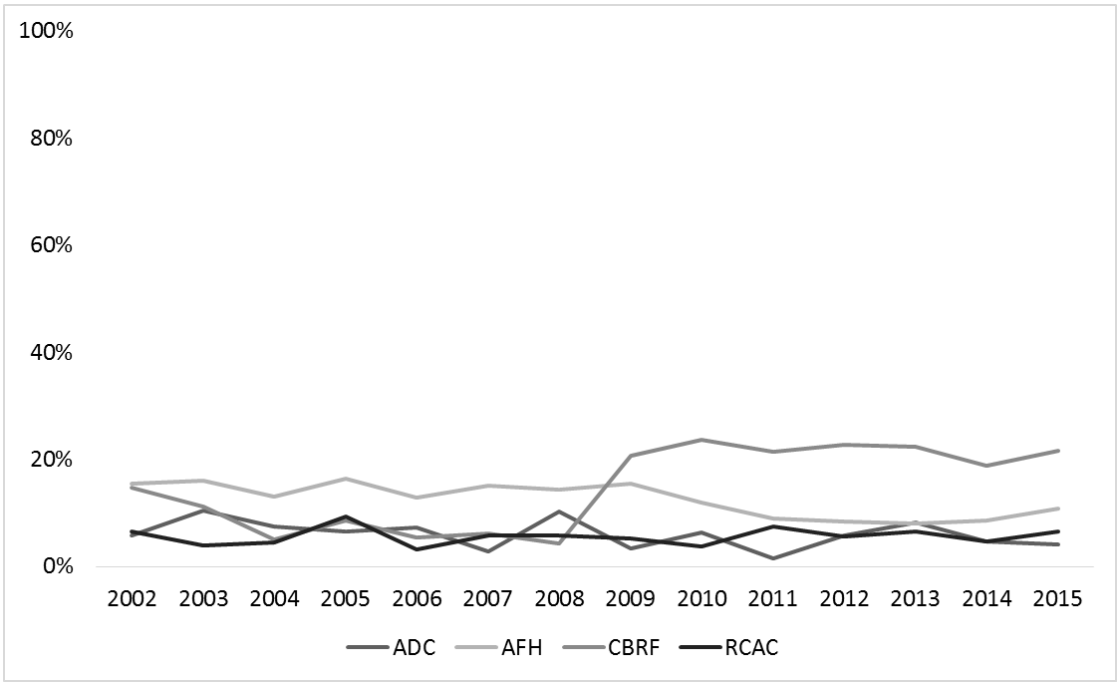
Source: DHS 2016a

Figure A28. Key Tag Cites per Provider by Provider Type



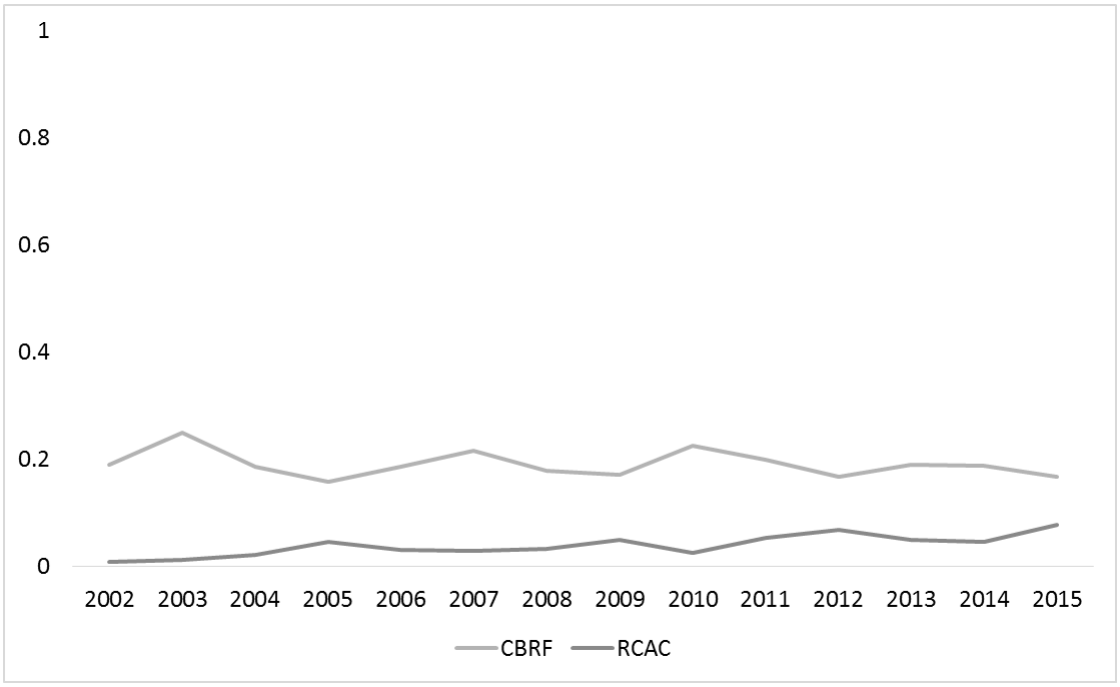
Source: DHS 2016a

Figure A29. Percent of Providers Key Tag Cited by Provider Type



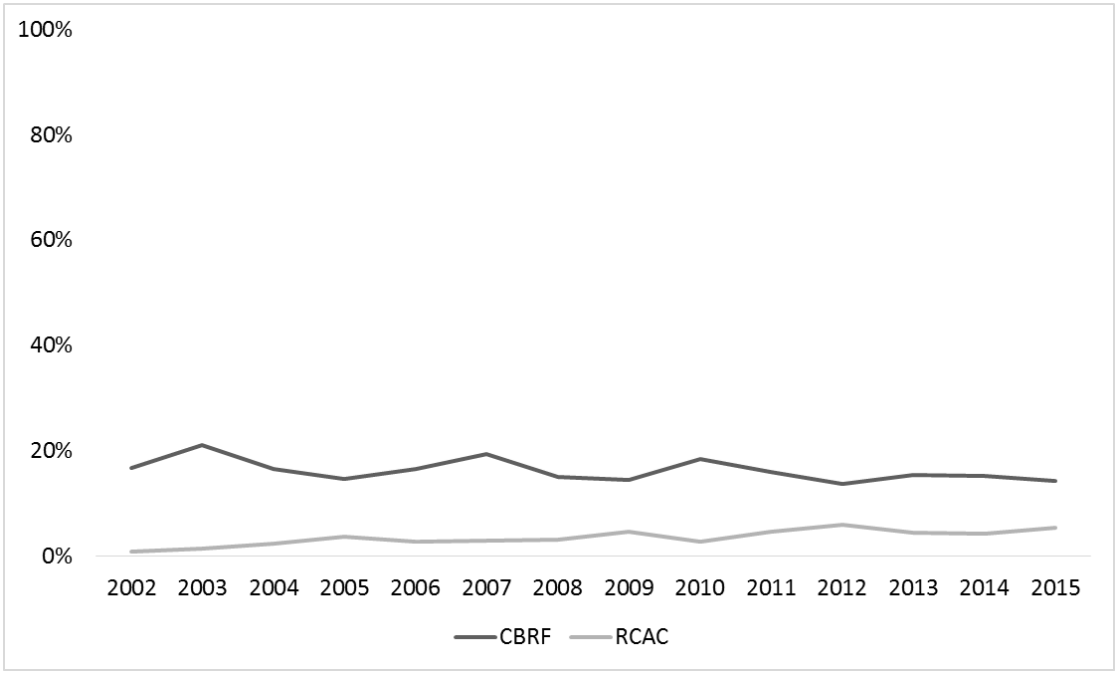
Source: DHS 2016a

Figure A30. Fines per Provider by Provider Type



Source: DHS 2016a

Figure A31. Percent of Providers Fined by Provider Type



Source: DHS 2016a

Appendix C: Regression Results

Table A2. Logistic Regression Results (Odds Ratios)

VARIABLES	Serious Violations	Multiple Violations
ADC	0.0677***	0.404***
	(0.0223)	(0.0624)
CBRF	3.168***	3.489***
	(0.194)	(0.214)
RCAC - Certified	0.793	0.602***
	(0.123)	(0.0901)
RCAC - Registered	0.0507***	0.0484***
	(0.0305)	(0.0256)
Capacity	1.007***	1.007***
	(0.00202)	(0.00198)
For-Profit	1.094	1.015
	(0.0778)	(0.0698)
Association	0.753**	0.843
	(0.0870)	(0.0987)
MA Waiver	1.969***	2.264***
	(0.118)	(0.132)
Dementia	1.064	0.924
	(0.0640)	(0.0548)
Western Regional Office	1.078	1.490***
	(0.0801)	(0.108)
Southeastern Regional Office	1.362***	1.408***
	(0.100)	(0.102)
Southern Regional Office	1.347***	1.638***
	(0.0991)	(0.120)
Constant	0.184***	0.222***
	(0.0178)	(0.0209)
Observations (Providers)	7,256	7,256

Standard errors in parentheses
*** p<0.01, ** p<0.05

Appendix D: Assisted Living Nationally

The following section describes assisted living nationally, including tables comparing Wisconsin to selected states and the United States as a whole.

Number and Characteristics of Facilities

Historically, national estimates of the number of assisted living facilities have varied due to a lack of data and inconsistent definitions (Caffrey et al. 2012). Recently, three studies conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics have significantly improved the quality and availability of national data, though some uncertainty remains with respect to the scope of the assisted living industry nationally.

The 2010 National Survey of Residential Care Facilities (NSRCF) found that the number of residential care facilities in the U.S. totaled 31,100 in 2010, with nearly one million beds nationwide (Park-Lee et al. 2011). This first-of-its-kind survey used a broad definition that encompassed a range of residential care facilities, including assisted living residences, enriched housing programs, personal care homes, and shared housing establishments (Moss et al. 2011).[11] Survey data showed that approximately 82 percent of facilities were for-profit, 38 percent were chain-owned, and that facilities with 26 or more beds accounted for 81 percent of all residents.

The 2012 National Survey of Long-Term Care Providers (NSLTCP), a replacement for the NSRCF, found that there were 22,200 assisted living facilities with 850,000 beds in 2012, along with 4,800 adult day services centers. The survey also found that 78 percent of assisted living providers were for-profit, 59 percent were chain-owned, and that facilities with 26 or more beds accounted for 86 percent of all residents (Caffrey et al. 2014). According to NSLTCP data, assisted living utilization exceeded nursing home utilization in 10 states in 2012, including Wisconsin (Harris-Kojetin et al. 2013). This survey showed a decrease in the number of facilities compared to the NSRCF because it used a narrower definition of assisted living facility.

Initial analyses of the 2014 NSLTCP data show that there were 30,200 assisted living facilities nationwide in 2014, up 36 percent from just two years prior. Survey data show that 82 percent of facilities were for-profit, 56 percent were chain-owned, and that facilities with 26 or more beds accounted for 82 percent of all residents (Caffrey et al. 2015).

Unlike the NSRCF and the NSLTCP, which are based on random sampling, the AARP surveyed state licensing agencies for its 2010 report on assisted living and found that there were approximately 60,000 facilities in the U.S., with a capacity of over 1.2 million beds (Mollica et al. 2012).[12] The vast differences between this estimate and those produced by the CDC illustrate the difficulty of accurately capturing the scope of assisted living nationally. However, data on the number of providers in Wisconsin lends credence to the estimate produced by AARP.

[11] This definition included facilities that have four or more licensed, certified, or registered beds and provide room and board, around-the-clock onsite supervision, and help with personal care or health-related services.
[12] Without California, which didn't report a number of facilities, the report found that there were 51,367 facilities in the U.S. Based on 2007 data from the state, AARP estimates a number close to 60,000 facilities.

Table A3. Characteristics of Assisted Living Nationally and in Selected States

	United States	**Wisconsin**	**Illinois**	**Michigan**	**Minnesota**	**Oregon**
Residential Facility Categories[4]	N/A	3 residential	4 residential	2 residential	1 for physical plant 2 for care agencies Adult Foster Care	2 residential
Facilities (incl. Day Services)	60,000 (2010)[1] 35,000 (2014)[2]	4,895 (2010)[1] 3,485 (2010)[5] 4,072 (2015)[5]	412 (2010)[1]	3,181 (2010)[1]	5,768 (2010)[1]	3,792 (2010)[1]
Residential Beds	1.2 Million (2010)[1] 850,000 (2014)[2]	44,537 (2010)[1]	29,214 (2010)[1]	39,849 (2010)[1]	53,712 (2010)[1]	33,171 (2010)[1]
Beds per 1,000 persons aged 65+ [1]	31	57	18	29	78	62
Residents per 1,000 persons aged 65+ [3]	Assisted Living: 15 Nursing Homes: 26	AL: 35 NH: 30	AL: 10 NH: 32	AL: 13 NH: 23	AL: 33 NH: 32	AL: 35 NH: 10
For Profit	82%[2] (2014)	81% (2015)[5]	N/A	N/A	N/A	N/A
Chain-owned	56%[2] (2014)	70% (2015)[6]	N/A	N/A	N/A	N/A

[1] Mollica et al. 2012; based on 2010 data from state licensing agencies. Wisconsin facility count includes certified Adult Family Homes, which are not under BAL jurisdiction. Illinois' count does not include sheltered care facilities, of which there were 137 in 2007.
[2] Caffrey et al. 2015; based on 2014 data and random sampling.
[3] Harris-Kojetin et al. 2013; based on 2012 data. Utilization rates are calculated based on data from any given day in 2012.
[4] Carder et al. 2015
[5] DHS 2016a. Unlike Mollica et al. 2012, BAL facility counts do not include certified Adult Family Homes. BAL counts include facilities open for at least a portion of the year, and show a 16.8% increase between 2010 and 2015.
[6] DHS 2015b

Categorization of Assisted Living Facilities

Because there is essentially no federal regulation of assisted living, there are no applicable federal categorizations of such facilities. States generally categorize facilities based on size as well as the type and intensity of care provided, though some states opt for more uniform licensure and regulation.

Residency Agreements

Nearly all states require residency agreements, and most require that they include information about services and fees, scope of services, admission and discharge criteria, resident rights and responsibilities, and information related to filing grievances and complaints. Ten states require the agreement to include information about medication management. Most states require residents to sign the agreement, some specifying that this must precede move-in, and others not specifying a timeframe for the signature. A few states, including Wisconsin, require the agreement to be reviewed and updated periodically (Carder et al. 2015).

Disclosure Provisions

At least 39 states have disclosure provisions, which have been a focal point of regulatory and statutory changes over the years (see Appendix E). Eleven of these states require disclosure only if a facility markets itself as a dementia care provider. Sixteen states require that disclosure statements follow a uniform template (Carder et al. 2015).

Admission and Retention Policies

Many states preclude admission and require discharge if an individual has a communicable disease such as tuberculosis or a health condition such as a pressure ulcer, poses a threat to themselves or others, is incapable of independently evacuating the building, or requires skilled nursing. However, some conditions that preclude admission may not require discharge if developed while the resident was in assisted living (Carder et al. 2015).

Staffing Requirements

All states require facilities to employ an administrator responsible for managing operations and regulatory compliance, generally on a full-time basis. Fourteen states require a nurse or licensed health professional to be on staff at least on a part-time basis, and another 24 require one to be available. Direct-care staff are almost always unlicensed, though states may require training (see the following section). Nineteen states specify required staffing ratios, while most others allow facilities to staff flexibly, as long as “sufficient” staff is available to meet residents’ needs (Carder et al. 2015).

Training Requirements

States typically require initial and ongoing training for administrators and direct-care staff, though they vary considerably in the specificity of these requirements. When specified, initial

training requirements range from six to 70 hours for administrators and from one to 80 hours for direct care staff. Continuing education hours, required by 44 states, range from six to 30 for administrators and from four to 16 for direct-care staff. Thirteen states do not state the amount of continuing education hours required for direct care staff. Licensed health care professionals are generally exempt from training requirements (Carder et al. 2015).

Provisions for Residents with Dementia

Regulations aimed at facilities and staff serving residents with dementia have been at the center of recent regulatory changes around the country (see Appendix E). Some regulations specifically target dementia care units, while others apply to any facility or staff serving a resident with dementia. The availability of dementia care services, including dementia-specific staff training and building amenities, is commonly required as a part of disclosure statements.

Regulation of dementia care units vary widely: 10 states have little to no special requirements, while six states require a separate license or certification. Thirty-five states regulate the physical environment within dementia care units, addressing living units, bathrooms, and measures designed to prevent unsafe exits from facilities.

Most states do not require additional staffing for dementia care, but seven states require that a registered nurse be available a minimum number of hours, and seven states require an additional administrator for a dementia care unit that is not a stand-alone facility. Forty-four states require staff training for dementia care, and 23 specify the amount of training required for staff working in dementia care units (range: 2-30 hours initially, 2-12 hours continuing education annually) (Carder et al. 2015).

Frequency and Nature of Inspections

States that conduct regular inspections generally do so every one to two years, though some will extend this period for facilities that have had a history of compliance. Many states also conduct inspections based on complaints received (Assisted Living 411 2011).

Sanctions

The two most common sanctions used by states are civil monetary penalties (fines) and the denial, suspension, and revocation of licenses. Many states also reserve the right to suspend admissions and to offer provisional licenses (Assisted Living 411 2011).

Table A4. Assisted Living Regulations Nationally and in Selected States

	United States	**Wisconsin**	**Illinois**	**Michigan**	**Minnesota**	**Oregon**
Residential facility categories	N/A	3 residential	4 residential	2 residential	1 for physical plant 2 for care agencies Adult Foster Care	2 residential Adult Foster Care
Residency agreements	Nearly all states require; most require client signature, few require periodic updates	Required for CBRFs & RCACs, but provisions vary; periodic updates required	Required; provisions vary by facility category	Required; periodic updates required	Required	Required; must be signed prior to admission; periodic updates required
Disclosure provisions	39+ states; 11 require only for dementia care units; 16 require template	CBRFs: required, incl. staffing patterns & nurse availability; RCACs: required	Required only for dementia care units	Required only for dementia care units in 1 category	Uniform consumer information guide; addl. disclosure for dementia care units	Required; uniform disclosure form; addl. disclosure for dementia care units
Admission policies	Conditions that may preclude admission: communicable diseases, pressure ulcers, requirement of skilled nursing	Various conditions preclude admission, incl. confinement to bed, danger to self or others (CBRF), and incompetence or activated power of attorney (RCAC)	Elderly & dementia clients separated to a great extent; severe mental ill. precludes admission in 3 of 4 categories, inability to convey needs in 2 of 4	Residents must be 60+ yo in 1 category; Needing continuous nursing precludes admission but few other conditions are specified	Residents must be functionally impaired adults in Adult Foster Care; 80% must be 55+ yo in other 2 categories	Conditions that preclude admission not specified
Staffing levels	All states require administrator; 38 require nurse on staff or on call; 19 specify ratios	Administrator required for CBRF, service manager for RCAC; no minimum ratios but “sufficient” staff required	Manager or admin. required; no minimum ratios; CNA on duty on all shifts in category with dementia focus	1:6 for 1 category; admin. required; 1 staff on each shift must be designated care supervisor in 1 category	Ratio between 1:5 and 1:8 in Adult Foster Care; RN on call 24/7 in other categories	No minimum ratios, but staffing must be determined according to resident acuity, staff training, etc.
Staff training	Initial: 1-80 hrs; Continuing: 4-30 hrs	State specifies topics for initial; 15 hours continuing for CBRF	State specifies topics for initial and continuing	Staff training required in 1 category	3 hrs initial; 6-15 hrs continuing; competency test	State specifies topics for initial; 12-20 hrs continuing
Provisions for residents with dementia	35 states regulate physical plant in dementia care units; 44 require dementia training for staff	Dementia care CBRFs must detail services offered for licensing & provide additional training	4-20 hr initial and 12 hr continuing dementia training for staff in 3 of 4 categories	None identified	Dementia training required for all staff; twice as much for those in dementia care units	Additional staff training and physical plant requirements for dementia care units

Source: Carder et al. 2015. Information from Michigan, Minnesota also draws upon MI DHS 2009, MN DHS 2015, and OR DHS n.d., respectively.

Appendix E: Timeline of Significant Regulatory Changes Around the Country, 2005-2012

2005 - Several states strengthen or implement standards for facilities serving residents with dementia; some increase training requirements for staff serving these residents. Several states add or increase disclosure requirements.

2006 – One-third of states make changes to regulations - seven making major changes - continuing the response seen in prior years to increasing resident acuity. Several states add requirements aimed at resident safety, including fire safety, incident reporting, emergency preparedness, and disease control. As in 2005, states continue to strengthen requirements for facilities serving residents with dementia, some by adding staffing requirements. States also continue to add or increase disclosure requirements.

2007 - Twenty states make statutory or regulatory changes - 12 making major changes - as the assisted living industry continues to grow and evolve. As in prior years, states continue increasing requirements related to disclosure and residents with dementia. State changes address a number of topics, including: staffing and staff training, survey procedures, resident rights, resident assessments, criminal background checks, fire safety and emergency preparedness, food safety and dietary standards, and reporting and record keeping.

2008 - Eighteen states make regulatory changes - six making major changes - reflecting a slower pace than 2007. States continue to respond to increased resident acuity by increasing staff training requirements. Changes also address emergency preparedness, medication management, disclosure, and criminal background checks.

2009 - Twenty-two states make changes - eight* making major changes - reflecting an increase when compared to 2008. Changes address fire safety, physical safety, emergency preparedness, disclosure, staffing and staff training, resident rights, resident assessments, criminal background checks, and reporting.

*Including Wisconsin, which implements these key changes:

- The amount of initial CBRF staff training required is no longer specified (was 45 hours). The amount of CBRF staff continuing education required is increased from 12 hours to 15 hours.
- Staff of CBRF facilities serving residents with dementia must receive training within 90 days, rather than six months, of employment (staff in other types of facilities serving residents with dementia are not required to receive such training).
- CBRF administrators must now meet qualifications that are now stricter and more clearly defined.
- CBRFs are newly required to disclose 24-hour staffing patterns and the availability of a licensed nurse, if any.
- Requirements related to the number of residents allowed per room and the availability of bathrooms are also modified.

2010 - Eighteen states make changes - six making major changes. Changes focus on criminal background checks, dementia standards, disclosure, life safety, medication management, and regulatory enforcement.

2011 - Sixteen states make changes - four making major changes. As in 2010, states continue to struggle with fiscal issues, many of them experiencing personnel changes within regulatory agencies. Several states add or change requirements for education and training. State changes also address disclosure, fire safety, disease control, admission and retention thresholds, discharge, medication management, and physical plant.

2012 - Eighteen states make changes - nine making major changes. Changes focus on developing new models for surveys, disclosure and reporting requirements, life safety, disease control, and medication management.

Sources: Polzer 2006; Polzer 2007; Polzer 2008; Polzer 2009; Polzer 2010; Polzer 2011; Polzer 2012; Polzer 2013

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