Appendix #9

Presentations for the Long-Term Care Subcommittee

June 29, 2004

Overview of 2004 LTC Studies and Proposed Subcommittee Workplan

Presentation to:
Long-Term Care Subcommittee
Joint Commission on Health Care

April Kees
Senior Health Policy Analyst

June 29, 2004
Richmond, Virginia

Long-Term Care Subcommittee

Del. Phillip A. Hamilton, Chairman

Del. Robert H. Brink
Del. Benjamin L. Cline
Del. Franklin P. Hall
Del. R. Steven Landes
Del. John M. O'Bannon, III
Del. John J. Welch, III
Del. Harvey B. Morgan *(ex-officio)*

Sen. Harry B. Blevins
Sen. R. Edward Houck
Sen. Benjamin J. Lambert, III
Sen. Stephen H. Martin
Sen. Linda T. Puller

Presentation Outline

- ***Review of Long-Term Care Studies from the 2004 General Assembly Session***
- **Overview of Subcommittee Activities and Meetings for 2004**

JCHC Studies for 2004 Related to Long-Term Care and Aging Issues

- **Study; Pain Management within Long-Term Care Facilities (HJ 160, Delegate Brink)**
  - —Assessment of the issue of developing a pain management standard for long-term care facilities in Virginia. "State Initiatives in End of Life Care," a report by NCSL, was specifically referenced in the study resolution as a resource.
  - —HJ 160 was tabled in the House Rules Committee with the understanding that the Joint Commission would conduct a study.

JCHC Studies for 2004 Related to Long-Term Care and Aging Issues

- **Study; Nursing Homes - Establishment of Staffing Standards (SB 672, Senator Edwards)**
  - Legislation would have required the "Board of Health, in its licensure regulations, to establish staffing guidelines for nursing homes and certified nursing facilities to ensure the delivery of quality care that must:
    - (i) take into consideration the number of beds in the facility and average occupancy rates across the Commonwealth;
    - (ii) recommend the level of licensure or certification for appropriate staffing of the various nursing positions in nursing homes vis-a-vis the scope of practice of registered professional nurses, licensed practical nurses, and certified nurse aides;
    - (iii) recommend staffing ratio goals for day shifts, night shifts, and weekend shifts according to the individual needs of residents that provide flexibility vis-a-vis the constantly changing characteristics of residents in nursing facilities and the level of care required for residents with moderate and extensive nursing care requirements and lower or higher acuity levels; and
    - (iv) examine staffing needs of nursing homes and ways to facilitate the training and recruitment of adequate staff."
  - SB 672 was left in the Senate Finance Committee with the understanding that the Joint Commission would conduct a study.

JCHC Studies for 2004 Related to Long-Term Care and Aging Issues

- **Study; Access & Availability of Geriatricians (HJ 135, Delegate Morgan) (Continue in 2005)**
  - An assessment of the degree to which geriatrics is covered in a variety of health professional programs at the graduate and undergraduate level. The Commission will review the adequacy of the Commonwealth's programs and their ability to produce an adequate supply of geriatricians.
  - HJ 135 was tabled in the House Rules Committee and a study is being completed at the Chairman's request.

Presentation Outline

- ❑ Review of Long-Term Care Studies from the 2004 General Assembly Session
- ■ *Overview of Subcommittee Activities and Meetings for 2004*

Previous Agenda Items for June 29th Meeting

Assisted Living Facilities

- Maurice A. Jones, Commissioner, DSS
- Cindi B. Jones, Chief Deputy Director, DMAS
- Joani F. Latimer, State Ombudsman, Office of the State Long-Term Care Ombudsman
- Carter Harrison, State Public Policy Coordinator, Alzheimer's Association – Greater Richmond Chapter
- Mary Ann Bergeron, Executive Director, Virginia Association of Community Services Boards, Inc.
- David Sadowski, President, Virginia Coalition for the Aging
- Beverley Soble, Vice President Regulatory Affairs, Virginia Health Care Association
- Grant Goldman, President, Virginia Adult Home Association
- Dana Steger, Legislative Affairs Legal Counsel, Virginia Association of Nonprofit Homes for the Aging

2004 LTC Studies and Proposed Workplan

- Overview of 2004 Studies Relating to Long-Term Care and Aging Issues
- Proposed Workplan

Tentative Agenda for August 4th Meeting

PERSONNEL ISSUES

- Report and Options Regarding Staffing Standards for Nursing Facilities
- Report on the Strategic Plan to Address the Nursing Shortage, SCHEV (HB 2818, 2003)
- Workplan to Address the Availability of Geriatricians

INCENTIVES FOR PURCHASING LONG-TERM CARE INSURANCE

- Update on Potential Incentives of Interest

Tentative Agenda for September 1st Meeting

LIABILITY ISSUES

- Update on Increased Cost of Nursing Facility Liability Insurance

OLMSTEAD PLAN

- Discussion of Recommendations Concerning JCHC

PAIN MANAGEMENT

- Report and Options Regarding Pain Management Within Long-Term Care Facilities

Tentative Agenda for November 15th Meeting

- Vote on Subcommittee Recommendations for Legislation and Budget Amendments.
- Report Subcommittee Recommendations for Legislation and Budget Amendments at the Commission Meeting.

Link to Articles on Assisted Living Facilities

- To access the series of articles on assisted living facilities by David S. Fallis at the Washington Post you may visit:

http://www.washingtonpost.com/wp-dyn/metro/va/homes/

Information Sheet: Assisted Living Facilities
Prepared for Long Term Care Subcommittee
June 29, 2004

Assisted Living Facilities (ALF): A Diverse Industry

- Not a nursing or medical facility
- Licensed at two levels:
  - Residential Living Care – for residents needing minimal assistance with activities of daily living (ADL)
  - Assisted Living Care – for residents requiring at least moderate assistance because of dependency in two or more ADLs
  - Statutorily prohibited from admitting or retaining residents with certain conditions, e.g., ventilator dependency, nasogastric tubes, Stage IV and unapproved Stage III dermal ulcers, treatments or conditions requiring continuous nursing oversight, etc.
- Range of physical and mental disorders is very diverse
- Severity levels have steadily increased
- Elderly residents are entering care later and sicker
- Residents subsidized by the Auxiliary Grant program (AG) cross all diagnostic categories but include, proportionately, more residents with diagnoses related to mental illness or mental retardation.

Licensed ALFs in 2004 (increased by c.13.5% in 10 years)	629*
Facilities in 1994	554
Current bed capacity (increased by c. 32% in 10 years, i.e., average size is increasing). Estimated to be operating at about 86% of capacity	34,725*
Capacity in 1994	26,209
Size range	**4 to c.600
Estimated number of secured units reserved for residents with dementia	105
Residents with mental illness, mental retardation, dementia	Estimated 48% or 14,000
Newly licensed ALFs in their 6-months conditionally licensed period	c. 4.45%
ALFs on 6-months provisional license – not in substantial compliance	c. 1.75%
ALFs on 1-year license – in substantial compliance***	c. 50.1%
ALFs on 2-year license – exceed some requirements****	c. 29.4%
ALFs on 3-year license – exceed requirements****	c. 14.3%
Residents subsidized by AG (average per month)	6293
Maximum AG subsidy per month ($28 per day)	*****$866
Average AG subsidy per resident, per month (80% state 20% local)	******$313.43

*Data drawn June, 2004

**Facilities may voluntarily license beds occupied by residents on independent living status; the purpose is to avoid later disruption as residents' needs change.

***Facilities on 1-year licenses require 3 inspections annually

****Extended licenses require 2 or 1 inspection annually; certain eligibility requirements apply, e.g. length of time in strong compliance, management performance profile, etc. Note: License type does not total 100%; license-type not yet entered on 13 cases

*****$996 in Planning District 8

******State and local share of the maximum AG rate is about 36%, i.e., the AG supplements other federal or private resources up to the maximum AG rate

Opportunities for Improvement

1. Recent media coverage underscores the need to correct serious structural and systemic issues without disrupting an industry that has shaped itself to accommodate state policies and statutes designed to respond to other challenges and issues:

    a. Pursuit of downsizing and community placements for individuals served by DMHMRSAS
    b. Health care cost containment
    c. Technological and medication advances that permit more people to live longer or to receive care in non-medical facilities
    d. Consumer preference for facilities that appear less institutional or medical in nature

2. While progress has been made in addressing the severely problem-ridden facilities of the type featured in the articles, more must be done – and at a much faster pace.

    a. In a relatively few years, large numbers of Baby-Boomers will be entering care. If present trends continue, this surge will be in residents who are older and sicker at admission.
    b. The steadily shrinking state mental hospital system, accelerated by the Olmstead decision, will generate the need for the care and housing of increasingly impaired residents.
    c. The ALF industry, still struggling with the effects of its previous high growth, must be made ready to sustain another, and perhaps larger, growth spurt without exposing consumers to harmful care under these market demands. Of special concern is that the increase in care requirements by the Baby Boomers will coincide with a projected decrease in the age-band that normally supplies the labor pool for the industry.

3. **Five interlocked needs must be addresses to make progress:**

    a. **Laws and regulations must be responsibly strengthened at a pace that will not destabilize the industry, with particular attention to special-needs residents. The new Adult Protective Services Act, which greatly strengthens the tools available to address abuse and questionable fatalities, must be fully implemented and suitably funded.**
    b. **Inspection frequency must be increased. Enforcement and appeal methods must be improved and streamlined to deal effectively and expeditiously with problem-cases.**
    c. **More assistance must be given to help the industry cope with a shrinking labor pool and untrained work force – problems that will worsen as the nation ages.**
    d. **Facilities that accept public money must be fairly compensated and held to strict accountability.**
    e. **Consumers must have better and more accessible information on which to make one of the most important choices they or their families will ever make.**

4. Certain issues should be subjected to serious study before electing to change statutes or regulations. Chief among these is the suggestion made by some organizations to require the separation of elderly residents from those with diagnoses or histories of aggressive behavior. These suggestions were prompted by a number of serious injuries and fatalities that related to poor management of mixed populations.

    a. Prohibiting additional categories of residents from ALFs because of their health or behavioral needs and histories, for their own protection or the protection of other residents, raises issues related to legal rights and impact on an industry that has been allowed or encouraged by current policy to offer "normalizing," open community-based services to a heterogeneous clientele.
    b. Residents do not always fit in a single category. Residents with progressive dementia often go through a stage marked by restless and combative behavior. Residents with histories of high-risk mental illness or criminal histories become elderly and health-impaired as well.
    c. Better management, staffing and staff training might reduce the scope of the problem.
    d. Funding for specialized care is insufficient, whether offered in ALFs or in facilities licensed for DMHMRSAS clientele.
    e. Lowering the bar for nursing home admission also has cost implications even though it would expand the potential for use of Medicaid Waivers

What are some signs of progress?

Recent media coverage is valuable because it focused sharply on systemic problems and accurately reported numerous problems, some current and many that occurred in facilities that were closed. On the other hand, I would be remiss not to point out that many facilities are providing care that is good and safe. I would be equally remiss if I left the impression that progress has not occurred over the past few years despite the very real problems in the system and its infrastructure.

Enforcement

1. Since 1998, the department has revoked or denied 79 licenses and issued 178 intermediate sanctions, primarily fiscal penalties, in the assisted living industry. Not all revocations and denials resulted in facility closures. Some were sold and some were ultimately salvaged through consent agreements based on stringently tailored corrective action plans.
2. Complaints have steadily declined over the past six years. For the three FYs 1998-2000, a total of 1520 complaints were reported. In the next three FYs (2001-2003) a total of 1334 complaints were reported, over 12% fewer. The YTD data in 2004 suggest that the decrease in reported complaints is continuing. The validity rate is also declining, averaging 58% during 1999-2000 and 56% during 2001-2003; the YTD validity rate declined more steeply, to 48%.

Tools

1. Emergency and replacement revisions to the licensing standards significantly enhanced protections for residents with progressive dementia.
2. A new licensing information system was developed in 2003. It allows data entry during inspections and a much-expanded database compared to the 1970's system it replaced. With currently scheduled enhancements, licensing reports can be posted on the department's website for public access this year.

Staffing

1. Inspectors and consultants were added in 1998-2000 to relieve accumulated severe understaffing during a period of industry growth and agency cut-backs.
2. Of the 28 inspectors assigned to the adult care programs, 6 are nurses and 6 are mental health professionals, for a total of nearly 43% with training pertinent to the highest-risk populations in care.
    a) The Division of Licensing Programs' central office includes a nurse and a mental health professional to assist the field offices.
    b) Other inspectors have strong backgrounds across a variety of disciplines and experience, including social work, Adult Services, and the Ombudsman program.

Methods

1. Risk-based decision guidance tools were developed.
2. Internal processing was streamlined for adverse enforcement cases.
3. Licensing administrators were trained on techniques to improve the effectiveness of facilities' corrective action plans.

4. Revision of procedures is underway to improve regulatory consistency.
5. Facility closure protocols were established for local and state agency coordination to ensure protection and assistance to residents during voluntary or involuntary closures.
6. A competency-based training program for inspectors was completed, curriculum development has resumed, and delivery of priority training will begin in July.

Provider training

1. Mandatory prelicensure training for licensees was implemented in July 2000.
    a) The mandated training for applicants emphasizes knowledge of key health and safety standards, residents' rights, and compliance requirements.
    b) Most licensing offices are also able to offer this training to new facility administrators in already licensed facilities and to current licensees whose compliance is problematic
    c) Potential applicants (i.e., inquirers) for ALF licensure have also been offered voluntary training since 2000. This training focuses on the requirements for licensure including the program of care, staffing levels, qualifications of administrators and direct care staff, and the role of the Division of Licensing Programs.
2. The medication administration curriculum was revised and updated in 2000.
3. The direct care staff curriculum was revised in 2002 and a series of train-the-trainer sessions held.
4. A12-hour training in caring for residents with dementia has been offered since December 2000 through a contract with Alzheimer's Association chapters and has trained 1373 assisted living staff members. A 4-hour course on caring for residents with dementia has been offered since 2002 and hundreds of assisted living facility staff members have been trained.
5. All licensing offices have been stocked with training video lending libraries to promote better in-service training on topics critical to direct care staffs.
6. Topics for provider trainings offered by the Division have increased from 5 in FY 1999 to 8 in FY 2004.

Virginia Department Of Social Services
Summary Of Adult Protective Services (APS) Enrolled Bill (Senate Bill 318/House Bill 952)
March 12, 2004
[NOTE: Bolded provisions appear most relevant to ALF Issues]

Senate Bill (SB) 318 and House Bill (HB 952) amend the *Code of Virginia* regarding Adult Protective Services (APS) by:

1) Adding that reports of suspected abuse, neglect, or exploitation may be made to the local department of social services (local department) or the 24-hour, toll-free APS hotline;
2) Requiring local departments to initiate an investigation within 24 hours of the report and clarifying what is meant by a "valid" report;
3) **Requiring the local department to refer matters as appropriate to the appropriate licensing, regulatory, or legal authority for administrative action or criminal investigation;**
4) Allowing the local departments, with informed consent, to take or cause to be taken photographs, video recordings, or appropriate medical imaging of the adult and his environment that are relevant to the investigation;
5) Clarifying that APS will not investigate in state correctional facilities;
6) **Expanding the list of APS situations in which law enforcement must be notified;**
7) **Changing the timeframe for reporting of suspected adult abuse, neglect, or exploitation by mandated reporters to "immediately" except reports by nursing facility inspectors employed by the Department of Health in the course of a survey;**
8) **Adding persons to the list of APS mandated reporters;**
9) noting that a mandated reporter providing professional services in a hospital, nursing facility, or similar institution may, in lieu of reporting directly to APS, notify the person in charge, who shall report such information immediately upon determination that there is reason to suspect abuse, neglect, or exploitation;
10) Adding accounting firms to the list of financial institutions who may report voluntarily;
11) **Prohibiting employers of mandated reporters from preventing a mandated reporter to report directly to APS;**
12) Requiring employers of mandated reporters to ensure that employees are notified that they are mandated reporters and trained on reporting responsibilities;
13) Adding criminal penalties for persons 14 years of age or older who make a false report;
14) Authorizing the Commissioner of the Department of Social Services to impose civil money penalties for cases of non-reporting by all mandated reporters except law-enforcement officers (the courts would take these cases);
15) **Requiring mandated reporters to report immediately to the appropriate medical examiner and law-enforcement agency when there is reason to suspect that an adult died as a result of abuse or neglect and authorizing the medical examiner to order an autopsy;** 16) relieving a mandated reporter from reporting to APS if he has actual knowledge that the same matter has already been reported;
17) Requiring all law-enforcement departments and other state and local departments, agencies, authorities, and institutions to cooperate with APS in the detection, investigation, and prevention of adult abuse, neglect, and exploitation;
18) Requiring the Department of Social Services to develop a plan and cost estimate by November 1, 2004, to prepare, disseminate, and present educational programs and materials on adult abuse, neglect, and exploitation to all categories of newly mandated reporters and that the penalty provisions shall not apply to newly mandated reported until the delivery of such training; and
19) **Requiring the Department of Social Services to develop a model protocol and procedures for, as well as cost estimates for, the operation of, adult fatality review teams by November 1, 2004.**

"Fish or Cut Bait"

A critical issue revisited

By: David L. Sadowski, Sr.
President of the Virginia Coalition on Aging
June 29, 2004

"The Big Picture"

- Flawed Public Policy.
- Lack of internal controls (checks & balances).
- Accountability and responsibility.
- Fragmented organizational structure.
- Lack of relevant consumer information.

2

"The Big Picture"

- Insufficient actions (or no action) to address the concerns identified.
- Reluctant to "Draw the Line".

3

Flawed Public Policy "Hodge-Podge"

- The label/license encompasses a mixture of services, clients, fees from "A to Z".
- Adult Care Facilities have served as the provider of last resort for many mentally handicapped and elderly clients.
- Auxiliary rate is not adequate to serve the needs of the clients.
- Housing the mentally ill and elderly TOGETHER does not work!

4

Flawed Public Policy "Hodge-Podge"

- Lack of sharing of client information between the discharge facility and the Adult Care Home/Assisted Living Facility.
- Risk to elderly clients.

5

Flawed Public Policy "Hodge-Podge"

- The Policy of Virginia of shifting the cost from the State to the Federal Government (Medicaid) has helped to create this "Debtors-Prison", type of service for those clients on Auxiliary grants.

6

Lack of Internal Controls & Reporting Mechanisms (Checks & Balances)

"Hear no Evil – See no Evil."

7

Lack of Internal Controls & Reporting Mechanisms (Checks & Balances)

- Development of a data base which can be utilized by management to enhance the internal flow regarding facility (ies) licensure information.
- A system which ensures accountability and quality must be developed. Recurring licensure and non-compliance problems must be "red-flagged" and reviewed by upper level management and if necessary Advisory consultants.

8

Lack of Internal Controls & Reporting Mechanisms (Checks & Balances)

- The Washington Post and Richmond Times-Dispatch articles clearly document that the current system has failed many times and resulted in serious harm to the residents.

9

Accountability & Responsibility

"It's Not Part of My Job"
Well-Whose Job is It?

10

Accountability & Responsibility

- Are licensing inspectors the only one(s)?
- Adult Protective Services workers (DSS).
- Owner & Staff.
- Are the Provider Associations.
- Management of DSS.

11

Accountability & Responsibility

- Department of Medical Assistance, and other State Agencies.
- Secretary of HHS.
- Governor.
- Local government, Law enforcement, Commonwealth Attorney, Fire Department, Community Service Boards, Area Agencies on Aging, Local Department of DSS.

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Accountability & Responsibility

- The Medical Community – Doctors, Nurses, EMS.
- The Virginia Department of Protection and Advocacy.
- The Virginia Ombudsman Program.
- The Families.
- One, Some or All?

13

Fragmented Organizational Structure for Managing and Providing Long-Term Care Services

"We have a Map-It Contains the Directions."

14

1989 Long-Term Care Study

- Identified fragmented system.
- Need to establish state leadership.
- Found inadequate community alternatives.

15

- 1990 The creation of a Mission Statement for Long-Term care by JCHC.
- 1992 Secretary of HHS "Blackstone" Report to the Joint Commission presented a Long-Term Care Vision Report.

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- 1992 JLARC Report on Medicaid financing of Long-Term Care.
- 1992-93 Home for Adults Task Force Report Proposed legislation to implement Tiered Licensure and JLARC quality of care recommendations.
- 1993 House Bill 2280 established the framework for Tiered licensure and restructure of Auxiliary Grant payments, to be effective June 1, 1994.

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1993 Level of Care Task Force drafts regulations. Recommendations include:

- Upgrade qualifications for the Administration.
- Improve requirements for the Administration of medications.
- Increase staff training.
- Require assessment to determine need.
- Specify services to be covered by the Auxiliary Grant payment.

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- 1993 (October 1) Report of the Long-Term Care and Aging Task Force presented to Secretary Cullum.
- 1993 (October 19) Secretary Cullum. presented the "Long-Term Care Vision Report" to the JCHC.
- Presented a plan to restructure and consolidate the management of Long-Term Care Services for the Elderly, HJR 603.

19

- 1993-94 Plan did not pass; the new administration requested it be delayed.
- Dr. Murray's, staff member of JCHC presented information regarding the reorganization of the Licensing Division of DSS.
- Recommendation by several advocacy organizations that the funding and licensure oversight of Assisted Living be unified within the Adult Services Unit of DSS.

20

Insufficient Action (or no action) to Address the Concerns Identified

"I See Nothing – I Know Nothing."

21

Insufficient Action (or no action) to Address the Concerns Identified

- Riding the merry-go-round for 30 years.
- Numerous newspaper articles and stories which have documented the serious concerns and harm.
- All the JLARC Studies, JCHC presentations, several Tasks Force studies, family complaints, legislative concerns, Secretary HHS concerns, Federal concerns, DMAS concerns, Law enforcement concerns.

22

Lack of Relevant Consumer Information

"Take It or Leave It."

23

Lack of Relevant Consumer Information

- The Center for Medicare Services (CMS) website has a data base for Nursing Homes, which consumer's can access.
- Development of an on-line data base which consumers, family members and case managers could access to assist them in the selection of an appropriate Assisted Living Facility.

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Lack of Relevant Consumer Information

- The data base should also contain additional information regarding Fire Safety Code violations.
- Consumers should also be informed that they can check with their local law enforcement agency to request any information regarding criminal activities.
- Written resource information should be available to consumers regarding the facilities previous history of compliance/non- compliance with the State Code; fines, sanctions & ownership should be included.

25

Reluctant to "Draw the Line"

"The Buck Stops Here."

26

Reluctant to "Draw the Line"

- What is the role of enforcement?
- Compliance with State Code and ensuring the Health and Safety of our frail elderly and handicapped or keeping them in business because - where will we place these persons if we close the facility.

27

Reluctant to "Draw the Line"

Perhaps it is best said by the Yogi Berra "We made too many wrong mistakes" and Oliver Wendell Holmes, "It must be remembered that *legislatures are ultimate guardians* of the liberties and welfare of the people in quite as great a degree as the courts", and President Jimmy Carter, who said, "If you fear making anyone mad, then you will ultimately probe for the lowest common denominator of human achievement".

28

Reluctant to "Draw the Line"

Hopefully, you sense the frustration and, yes, anger that many *residents*, advocates, and family members face everyday; hopefully you are as outraged as we are that this has been going on for 30 years.

29

Reluctant to "Draw the Line"

"DO THE RIGHT THING", and once and for all solve this problem.

Which will it be;

Fish or cut bait?

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Office of the State Long-Term Care Ombudsman

Comments before the Long-Term Care Subcommittee of the Joint Commission on Health Care

June 28 2004

Good morning, Mr. Chairman, members of the Subcommittee: My name is Joani Latimer, and I am here representing the State Long-Term Care Ombudsman Program. I appreciate the opportunity to be here and to share some thoughts on the crisis in our assisted living facilities from an Ombudsman perspective. Thank you for moving the issue of assisted living forward on this year's calendar, and, in so doing, sending a message that this matters - - that the horrific suffering and neglect - that took on a whole new level of reality for many through the pages of the Washington Post - that this kind of needless human suffering matters.

Thank you (and Commissioner Jones as well) for sending a message to the victims and families - as well as unscrupulous operators - that it will not be allowed to continue. The despair over this kind of senseless suffering is not new, the examples not beyond belief. In many cases, they are our own stories - - reflections of advocates' descriptions shared in cases we have documented, testimony we have given, reports we have made to authorities.

Through his singularly thorough and expansive documentation, Mr. Fallis has handed us wide angle view - - of all the places in a very troubled system where things broke down, went terribly wrong, and the most vulnerable not only fell between the cracks, but were crushed in them. He has done his job well. It is our job to take the gift of his work, and shape it into major change.

As most of you know, the Ombudsman Program receives, investigates, and attempts to resolve complaints made by or on behalf of residents who receive long-term care services across the state. While originally designed to serve nursing home residents only, assisted living facilities were added in 1981. By action of the General Assembly, in 1982, the program's jurisdiction in Virginia was extended to include the handling of complaints from person aged 60 and older in the community who receive long-term care services.

A network of local ombudsmen, operating out of our Area Agencies on Aging throughout the state, educate the public about long-term care issues, counsel individuals regarding long-term care options and selection, and advocate for resident and families to help resolve complaints and concerns about the quality of their care. The program has provided information and consultation to over 18,000 individuals so far this year. With variations in coverage from one locality to the next, on the average there is one ombudsman for every 4,000 beds.

In Virginia as well as nationally, the greatest proportion of formal complaints the program handles have been in nursing homes, where residents, families, and staff are more aware of the program's role. The physical and mental limitations of so many of the residents of assisted living facilities to reach out for help, or even to understand that there are rights and resources in that regard, poses a huge obstacle.

Last year in Virginia, the program handled 1,032 complaints in the nursing home setting, and, by contrast, 422 in assisted living residences. The highest proportion of the complaints in the assisted living setting related to quality of care, including issues around medications errors, personal hygiene, failure to monitor wandering behaviors, staff attitudes and general unresponsiveness, physical and mental abuse, unexplained and accidental injuries, and inadequate care plans.

I think there is some significant agreement concerning some clear avenues of critically needed reform:

- Stricter, clearer standards of care, particularly with regard to the levels and qualification of staff (More on that point later)

- A 'higher bar' for administrators and managers of these facilities, including more specific training in dealing with dementia care.

- Clear accountability of administrators through a form of professional licensure (with the potential for license revocation).

- Greater scrutiny of owners in granting and renewing licenses, certainly including a review of track records of facility operation

- More frequent and thorough inspections by inspection/review team, possessing the necessary clinical expertise to evaluate care of residents with complex medical conditions. (Clearly there is a need for an increased number of inspectors)

- Easy access by the public to survey reports, to promote accountability and allow consumers to make informed facility selections.

- Meaningful sanctions for non-compliance with standards and streamlined enforcement actions, so that residents do not continue to be placed a serious risk while owners/operators exhaust their appeals options.

- Creation of a resource to allow for temporary management of facilities, when the facility can be safely and effectively operated under pending new ownership.

- Restructuring of the assisted living system to avoid ill-advised mixing of resident populations (in a way that ensures that the frail 84 year old dementia sufferer does not become the hapless victim of a violent mentally ill resident).

- Increased training for staff in working with the high percentage of residents with cognitive impairments; increased attention to environmental needs and improved standards of care planning, including adequate and appropriate activity programs.

- Increasing the Auxiliary Grant rate to adequately cover the cost of care.

- Ensuring that residents' mental health needs are addressed with adequate community resources, and that assisted living facilities do not continue to serve as default holding areas for some of the forgotten.

All of these things are critically needed. Others you are hearing from this morning are probably better positioned to address the specific logistics of putting those changes into place. I want to focus instead for a few moments on the piece of the problem that looms largest in the ombudsman periscope -

First, it will come as no surprise to you that staffing tops my list. What is surprising perhaps is that there have not been more injuries and deaths, when you consider the foolishly low requirements for those delivering care as well as for those in charge. And again, we are talking about the adequacy of staff in terms of both numbers of staff and the level of training and competency.

As Mr. Fallis described so well, we have a disaster not only waiting to happen, but too often already in progress. The combustible mixture is the combination of vulnerable physically and mentally disabled residents (with increasingly complex health care needs), with administrators and direct care staff of whom we require minimal knowledge and skill.

Qualifications & Training of Staff

There is no question that our system of regulation and enforcement needs immediate overhaul. But quite frankly, until we change the basic standards in terms of staff qualifications, training, and supervision in these facilities, we can 'enforce until the cows come home,' and there will continue to be tragic needless suffering and death.

Consider the basic criteria to qualify as a "Manager" of an assisted living facility -

- Age 21

- Able to read and write and "understand these regulations"

- High school graduate plus one year post-secondary education

- 8 hrs of training (2 hrs focusing on residents with mental impairment if providing care for that population)

And those for direct care staff:

- Age 18 (unless CNA)
- Able to communicate in English
- Training in care of elderly (within first 30 days employment).
- 8 hrs training annually

For far too many facilities, the realities are -

- Minimal training
- Little or no supervision
- Too few staff for too many residents
- Little staff support or respect in the working environment
- Constant turnover, resulting in staff with no familiarity with residents, no understanding of their complex medical conditions, and neither the skills nor the knowledge, (or even sometimes the motivation) to notice, appreciate, exercise good judgment and action regarding significant changes in a resident's condition.

It is at his most immediate level the basic notion and model of care breaks down – No bridges built further down the road will make a difference unless we bridge this chasm. The result of our failure to ensure a sufficient number of trained and qualified staff who are supervised by persons of sufficient knowledge and skill: abuse, neglect, harm, and demise of the very vulnerable persons we entrust to their care.

(Note: Specific staff competency issue: Medication management
Persons qualify to administer medications after 32 hours of training for persons with limited education and sometimes limited English – dispensing multiple medications to very compromised residents.)

Additional recommendations:

I would offer the following thoughts regarding those 'bridges further down the line':

Licensing Multiple Levels of care

I strongly believe that in order to have any meaningful and adequately protective regulation, we must establish a system that licenses multiple levels of care.

Like Commissioner Jones and others, I recognize that there are some exceedingly good small facilities that offer very responsible care even as they serve residents on very limited public funding. Whatever change is wrought should not eliminate the potential for such facilities to offer care. There should, however, be a system for licensing assisted living facilities at differing levels of care, with those levels defining the type and severity of physical and mental conditions of residents a facility can admit.

Expansion of the Ombudsman Program Resources

For the past several years, the Commonwealth Council on Aging has included increased funding for the Ombudsman Program with a goal of doubling staff to allow one ombudsman for every 2000 long-term care beds in its list of legislative priorities. We strongly endorse that recommendation, believing that it is more important than ever that the numbers of ombudsmen statewide be increased to effectively advocate for the most vulnerable residing in our assisted living facilities.

Regional Elder Abuse Teams

What struck me was the level of DICONNECT that became apparent with Mr. Fallis's wide-angle view of our system. Even when the various roles are being played vigorously and effectively, they often fail to connect with the other threads in the system and the 'safety net' for the vulnerable is ultimately full of holes.

In the context of the crisis we are discussing, one of the most hope-filled days I can remember was a gathering a couple of years ago in room not far from this one. Representatives from a wide variety of agencies and professions were assembled in connection with an aggressive initiative to take on some of these pervasive abuse and neglect issues, and specifically to target the facility operators who were among the biggest offenders. Representatives from health, legal services, aging, social service, ombudsman programs, law enforcement, medical examiner, transport services, and advocates came together, each bringing his or her own 'pieces of the puzzle' to the table to see how much we could construct of the total picture.

To my knowledge, there has not rally been an equivalent gathering since. The image of it came to mind as the Post articles outlined the missed cues, information lost in closed files, and cases dropped like batons fumbled in a relay. Would that the consequences were as benign as the outcome of a sporting event.

In addition to the significant regulatory and enforcement reform to which the Department of Social Services has committed itself, I believe we need to reconstitute that multi-disciplinary team - ideally on the regional level - to ensure a systematic and wide-ranging

effort to coordinate and monitor our 'system's' response to abuse and neglect of the frail and vulnerable in facility and non-facility settings alike.

We do all have roles to play, and we must play them responsibly and vigorously. It is the combination of the whole of those roles though - working in clear communication and coordination - that holds the only hope for ensuring that the Theresa's and the Albert's and the Melvin's of this world are not left to fend for themselves in, as one so aptly described it, 'the land of the lost.'

alzheimer's association

ASSISTED LIVING POLICY RECOMMENDATIONS

The Alzheimer Association has identified the following eight recommendations (adapted from the National Assisted Living Workgroup consensus) as the most critical issues in assisted living regulation for persons with Alzheimer's disease and related disorders and their families. The Association is actively promoting their adoption into law and/or regulation as one of its two highest priority state issues this year.

The accompanying fact sheets on the makeup of the population of assisted living document the large number of persons with Alzheimer's disease living and receiving services in these facilities.

1. Definition of Assisted Living

Services and Regulation: Assisted living is a state regulated and monitored residential long-term care option. Assisted Living provides or coordinates oversight and services to meet the residents' individualized scheduled needs, based on the residents' assessments and service plans and their unscheduled needs as they arise.

Services that are required by state law and regulation to be provided or coordinated must include but are not limited to:
24-hour awake staff to provide oversight and meet scheduled and unscheduled needs
Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
Health related services (e.g., medication management services)
Social services, Recreational activities, Meals
Housekeeping and laundry, Transportation

A resident has the right to make choices and receive services in a way that will promote the resident's dignity, autonomy, independence, and quality of life. These services are disclosed and agreed to in the contract between the provider and resident. Assisted living does not generally provide ongoing, 24-hour skilled nursing.

2. Identification of cognitive impairment/dementia

Recommendation: The assisted living facility (ALF) must have in place procedures to 1) increase staff awareness of signs and symptoms of cognitive impairment/dementia in a resident, 2) evaluate or obtain an evaluation of the resident's cognitive status as it relates to the resident's ability to manage his/her

own affairs and direct his/her own care, and 3) adapt the resident's service plan to meet his/her needs, given the resident's cognitive status.

3. 24-hour awake staff

Recommendation: The ALF shall ensure that the right number of trained and awake staff are on duty and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed in the ALR's written emergency and disaster preparedness plan for fires and other natural disasters.

4. Security for wandering residents

Recommendation: If an ALF accommodates residents who exhibit unsafe wandering behaviors, then the ALF shall have a secure boundary or perimeter to safely accommodate residents. In no event shall locking devices violate life safety codes. Approved locking devices shall not be considered a physical restraint. An ALR with secure perimeters shall conduct frequent staff training on the importance of preventing unsafe wandering and maintaining alarm systems and door locking systems in a functional capacity.

5. Care for people with cognitive impairment/dementia and dementia special care units and facilities

Recommendations:

Part I: Care for People with Cognitive Impairment/Dementia

ALFs shall have in place procedures and services that 1) meet the needs of residents with cognitive impairment/dementia, 2) accommodate and balance concerns about safety and autonomy, 3) recognize and build on strengths, capacities choices, and values of the resident*, and 4) reflect the likelihood that the cognitive status of many of these people will change and deteriorate over time.

Part 2: Dementia Special Care Units and Facilities

ALFs that choose to serve only individuals with cognitive impairment/dementia or to establish a special dementia unit or units(s) should define precisely the purpose of the unit(s) and develop admission and discharge criteria, staff training, activity programs, and physical design features that are consistent with that purpose.

6. Pre-admission disclosure for specialized programs of care

Recommendation: ALFs representing in any way that they provide special care programs for persons with Alzheimer's disease or other dementias, or any other specific health conditions, shall disclose how the program and its services are different from the basic services.

7. Activities for special care residents

Recommendation: Assisted living facilities that accommodate special care residents must provide daily interactions and experiences that are meaningful (based upon residents' interests, feelings, and lifestyle), appropriate (for their abilities and functioning levels), and respectful (of their age, beliefs, cultures, values, and life

experiences) of residents, as determined by individual assessments and indicated in their service plans.

Activity programs must be directed by appropriately qualified and trained individuals, who have experience in activities responsibilities and training in special care.

Staff involved in planning and implementing activities for special care residents shall, on an on-going basis, be given training that includes, but is not limited to: basic physiological understanding of dementia and other special conditions of residents being served; behavioral symptoms and consequences; behavioral intervention and management strategies, including redirection techniques; understanding of individual resident's specific needs, appropriate activities and accommodations for meeting special resident needs (e.g. cognitive, language, behavioral, motor, and social skills).

8. Resident Rights and Provider Responsibilities

Recommendation: Within the boundaries set by law, residents have the right to:

- Be shown consideration and respect
- Be treated with dignity
- Exercise autonomy
- Exercise civil and religious rights and liberties
- Be free from chemical and physical restraints
- Be free from physical, mental, fiduciary, sexual and verbal abuse, and neglect
- Have free reciprocal communication with and access to the long term care ombudsmen program
- Voice concerns and complaints to the ALR orally and in writing without reprisal
- Review and obtain copies of their own records that the ALR maintains
- Receive and send mail promptly and unopened
- Private unrestricted communication with others
- Privacy for couples and for visitors
- Privacy in treatment and caring for personal needs
- Manage their own financial affairs
- Confidentiality concerning financial, medical and personal affairs
- Guide the development and implementation of their service plans
- Participate in and appeal the discharge (move-out) planning process
- Involve family members I making decisions about services
- Arrange for third party services at their own expense
- Accept or refuse services
- Choose their own physicians, dentists, pharmacists and other health professionals
- Choose to execute advance directives
- Exercise choice about end of life care

- Participate or refuse to participate in social, spiritual or community activities
- Arise and retire at times of their own choosing
- Form and participate in resident councils
- Furnish their own rooms and use and retain personal clothing and possessions
- Right to exercise choice and lifestyle as long as it does not interfere with other residents rights
- Unrestricted contact with visitors and others as long as that does not infringe on other residents rights and
- Come and go and rights that one would enjoy in their own home

CSBs/BHAs in Virginia:

The Use of Assisted Living Facilities (ALF)

General Observations

- Nationwide, ALFs (and their equivalents in other states) have been a default mechanism for community placement for people with mental disabilities beginning with the de-institutionalization movement in the 1960s and 1970s.
- Original intent as a community placement for those with mental disabilities who need minimal supervision.

General Observations *(cont'd)*

- Variability of quality and quantity of services provided is a function of minimal licensure requirements, as well as:
  - Quality of the physical plant
  - Staff training
  - Facility management training and experience
  - Limitations of the current reimbursement system
  - Working relationship of the home with the local public provider (CSB/BHA).

General Observations *(cont'd)*

- In Virginia, where special CSB/BHA-ALF projects funded by the General Assembly have been established, the quality of services has been improved and close collaboration between the CSB/BHA and the ALF takes place.

STRENGTHS OF THE CURRENT SYSTEM

- ALF homes provide the only community-based option for adults with serious mental illness who cannot or will not live in a home environment and do not need the level of care provided by nursing homes.
- In some parts of the state, especially urban environments, there may be a variety of ALF options available which allow for consumer choice.

STRENGTHS OF THE CURRENT SYSTEM *(cont'd)*

- In some CSB/BHA coverage areas, some ALF staff work collaboratively with CSB/BHA staff which can create a therapeutic environment. In at least one instance a CSB/BHA-run Psychosocial Program is delivered at an ALF site.
- In special projects funded by the General Assembly, such as the project in the City of Richmond, funding has been allocated to the CSB/HHA, which has worked with the ALF to develop model services. Services are monitored and supervised by the CSB/BHA.

STRENGTHS OF THE CURRENT SYSTEM *(cont'd)*

- A well-managed ALF with a decent physical plant will provide a reasonable measure of security for consumers who would otherwise be quite vulnerable in an unsupervised setting.
- When a CSB/BHA and an ALF staff work together, the ALF can admit and support consumers who would otherwise need to be readmitted into a state facility.

GENERALLY OBSERVED PROBLEMS

- Some ALF physical plants are in poor condition, making the living environment depressing and unsanitary.
- Some ALF staff lack adequate training and may be unable to therapeutically provide the needed critical services, including monitoring medications and preventative interventions.

GENERALLY OBSERVED PROBLEMS *(cont'd)*

- Some ALF homes have insufficient quality and quantity of food and inadequate consumer cleanliness of both self and clothing can be observed.
- Reporting inadequate ALF homes has not always led to timely intervention by the licensing agency.
- Some ALF sites avoid CSB/BHA staff contact and this seems to correlate to those facilities with the poorest performance.

OPPORTUNITES FOR IMPROVEMENT

- Encourage greater collaboration between CSB/BHA and ALF staff at any home that intends to serve CSB/BHA referred consumers.
- Clarify and possibly codify the additional requirements necessary to serve consumers with mental illness, mental retardation and substance abuse problems.

OPPORTUNITES FOR IMPROVEMENT *(cont'd)*

- Clarify and possibly codify the oversight responsibilities of DSS and DMHMRSAS in licensing facilities that care for people with mental health, mental retardation and substance abuse problems.
- MOST IMPORTANTLY-Review the current system of re-imbursement for homes and make sure that it is adequate to provide a level of care that is intended.
- ALSO IMPORTANT-ALF services tailored to people with serious mental illness or mental retardation should be funded through the local CSB/BHA, which will assist in the development of the service and will monitor and supervise service delivery.

OPPORTUNITES FOR IMPROVEMENT *(cont'd)*

- EQUALLY IMPORTANT-The ALF model or some other similar model is often the only current housing option for consumers with serious mental illness in the community. If the model fails and no other options exist, it can cause increased use of state facilities and acute inpatient care.
- Gateway House Model as an alternative option. Mission supports serving only people with serious mental illness, supported by a strong core of family members, and entrepreneurial focus facilitates fund raising activities.

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VIRGINIA'S ASSISTED LIVING A DANGEROUS PLACE? NOT THE WHOLE STORY.

It is a tragedy when innocent people are harmed as outlined in the Washington Post's four-part series on assisted living communities in Virginia ("*A Dangerous Place*", May 23-26). It is also a tragedy, however, when hundreds of the state's assisted living communities and thousands of dedicated professionals are maligned due to the incompetence of a few.

The expose indicated that "about 400" of 825 of the state's assisted living facilities received licensing violations during the period between 1998-2003, suggesting a near one-half failure rate. On an annualized basis, however, the number of communities receiving violations (which can be minor as well as severe), averaged only 66 per year - less than 8% of the total. During this same period, it is noted that 86 communities received violations severe enough to warrant a fine, yet again, this would amount to only 1.7% of communities per year - hardly dangerous places to live.

The balk of the reporting focused on issues surrounding the housing of adults suffering from mental illness. This is in fact a legitimate problem for this population (related mostly to lower than cost reimbursement). Yet these individuals represent only about 10% of all assisted living residents in Virginia, with the vast majority receiving appropriate assistance on a daily basis - so even less cause to indict the entire state.

Finally, the series suggests more than once that a cause for the issues surrounding assisted living communities is their lack of federal oversight, as is in place for skilled nursing facilities. While the story sites 675 claims of neglect or abuse for the more than 34,000 licensed assisted living beds in the state in 2002-03, it does not mention that there were more than 1,000 of the same types of claims for the state's 29,000 federally licensed nursing home beds last year. While it mentions "about" 4400 cases of abuse, neglect, or exploitation of residents since 1995, it does not mention that the state's assisted living residences delivered more than 100 million days of resident care during this same period of time.

Following its series the Post ran its own editorial - further lambasting Virginia's assisted living industry citing, among other issues, that there were "only 30 inspectors for the state's more than 34,000 residents". The fact is there are 30 inspectors for the state's current 627 licensed communities – a caseload of about 20 communities per inspector, or less than two communities per month. In addition, many communities participate in the state's volunteer Ombudsman program, providing an ongoing regulatory presence.

If a newspaper wants to report on individual cases of neglect or poor care – whether it be for hospitals, nursing homes, physicians, or other healthcare providers - that is their right, even their obligation. But this kind of "totality" reporting has its own dangers. How many dedicated nurse's aides, in an industry already short of good help, are asking themselves why they should now continue to do this work for low pay and little thanks? How many seniors will now refuse to enter a perfectly good assisted living community to live in solitary confinement in their own homes, eating poorly prepared meals, mismanaging their medications, and risking a fall from which they will not be able to receive any help at all?

The goal of every healthcare provider should be to strive for perfection. But advancement of professionals in this growing industry will bring assisted living to its highest level, not suggestions of federal regulation or the need to assign blame to any and all. In Virginia, George Mason University has implemented the first undergraduate and graduate curricula in the nation dedicated exclusively to the field of assisted living administration. Since its inception in 2002, more than 80 students have taken at least one course towards completion of a concentration in the field - enough to staff more than 12% of the state's assisted living administrator positions. Virginian's should know that their state offers high quality assisted living services, is the home of both the nation's largest senior housing provider and industry association, and is an industry leader in advancements and education in the field. Anything less is less than the whole story.

Andrew Carle, MHSA, Assistant Professor - Director
George Mason University Program in Assisted Living Administration

Department of Medical Assistance Services
Medicaid Assisted Living Alzheimer's/Dementia Waiver

June 29, 2004

- The 2004 Session of the General Assembly directed the Department of Medical Assistance Services to establish a home and community-based care waiver for persons with Alzheimer's disease and related dementias. The waiver shall be for those individuals who meet the functional criteria for admission to a nursing facility, who have a diagnosis of Alzheimer's disease ore a related dementia, and who are eligible to receive an Auxiliary Grant. The waiver enrollment for the first year of such program shall be limited to an enrollment of 200 individuals who choose to move to an assisted living facility.

- The Auxiliary Grant recipients' monthly income limit is not more than $866 for most of the State, and $996 for northern Virginia.

- Nursing facility admission criteria requires a medical nursing need in addition to functional criteria. Medical nursing needs may include the need for supervision of medications.

- Waiver services will be provided in licensed assisted living facilities that meet the requirements of a "safe, secure environment."*

- Minimum staffing mandated (at least 2 direct care staff on duty in the special care unit).* This is the minimum based on licensing requirements. There may be additional requirements for a Medicaid waiver.

- Specialized training for staff required.* There may be additional requirements for a Medicaid waiver.

- Waiver services provided include assisted living services necessary for people who meet nursing facility admission criteria to be successful in an Assisted Living setting. Qualified staff must provide services (to be defined in the Waiver). Must meet DSS licensing requirements for Special Care Units in addition to Medicaid requirements for a HCBS waiver, this includes protections of health and welfare.

- Room and board is to be paid by an Auxiliary Grant, approximately $28 (rest of State) to $32 (noVA) per day.

- Medicaid payment for the assisted living services would be approximately $50/day. (Medicaid payment is payment in full – the resident could not be charged extra for Medicaid-covered services.)

- Of the 671 licensed assisted living facilities in Virginia, 106 have special care units with 2,931 residents. (Source: DSS presentation to JCHC 10/15/03.) It is possible that some of these residents would be eligible for a Medicaid Waiver in addition to people who reside in nursing facilities or in the community.

- DMAS formed a workgroup and has had two meetings to discuss this waiver. Budget language requires DMAS to develop and present this waiver to the Governor and the Chairman of the Joint Commission on Health Care by October 1, 2004, in order that the fiscal impact of such waiver can be considered during the development of the 2005-2006 budget.

* Required by Virginia ALF licensure.

Language from the 2004 Appropriations Act

SS. 1. The Department of Medical Assistance Services shall develop, in conjunction with affected constituents, a waiver pursuant to §1915(c) of the Social Security Act (42 U.S.C. 1396n) from the Centers for Medicaid and Medicare Services to establish a home and community-based care waiver for persons with Alzheimer's disease and related dementias ("Alzheimer's/Dementia Assisted Living Waiver"). The Alzheimer's/Dementia Assisted Living Waiver shall be for those individuals who meet the functional criteria for admission to a nursing facility, who have a diagnosis of Alzheimer's disease or a related dementia, and who are eligible to receive an Auxiliary Grant. The waiver enrollment for the first year of such program shall be limited to an enrollment of 200 individuals who choose to move to an assisted living facility.

2. Out of this appropriation, $1,327,550 from the general fund and $1,327,550 from nongeneral funds in the first year and $1,855,050 from the general fund and $1,855,050 from nongeneral funds in the second year shall be shall be provided for the implementation of the Alzheimer's/Dementia Assisted Living Waiver. The Department of Medical Assistance Services must also receive a waiver pursuant to §1915(c) of the Social Security Act from the Centers for Medicare and Medicaid Services to establish such program. The waiver proposal described herein shall be developed and presented to the Governor and the Chairman of the Joint Commission on Health Care by October 1, 2004, in order that the fiscal impact of such waiver can be considered during the development of the 2005-2006 budget. The agency shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act.

VAHA Virginia Adult Home Association

Presentation to the

Joint Commission on Health Care

June 29,2004

Presented by: Grant Goldman, Past President

VAHA was formed in 1974 by Owners and Administrators of Facilities that cared for the elderly, handicapped, and frail residents of our Commonwealth. Its' purpose is to be an advocate for the rights and well being of residents and the fiscal viability of the Facilities that serve them.

Many people think that a Nursing Home is the same as an Assisted Living Facility. For the record, they are not. The confusion may stem from the fact that Assisted Living Facilities have had many names in the recent past. Homes for the Aged, Adult Homes, Homes for the Elderly, and Adult Care Residences. But the fact is that Assisted Living Facilities cannot be defined with a single description. There are several different types of facilities, different levels of care provided, and different funding levels. Assisted Living Facilities provide room and board, medication management, assistance with the Activities of Daily Living (ADL's), the planning and implementation of social activities, and provides 3 dietician approved meals a day plus 2 snacks. And in Assisted Living Facilities that care for AG residents, that is expected to be done for $28.47 a day per resident.

The view of the industry from the recent articles in the Washington Post is a picture of abusive facilities and State Agencies over burdened to regulate them. This picture is painted with

sensationalism and a want to draw public opinion that these worse case scenarios are typical of the industry. But those of us in the front lines of caring see a different picture. We see Owners, Administrators, and Staff dedicated to providing quality care with ever dwindling resources and ever increasing burdens and expense. We see the Department of Social Services working diligently to regulate facilities and meet ever changing industry trends. Yes, there are bad homes with greedy Owners, incapable Administrators, or under trained staff that put residents in danger and give a black eye to the rest of the industry. But the larger majority of Facilities are run by competent people who genuinely care for the residents they serve. Can the Facilities and the systems that regulate them be improved to provide a higher standard of care? Yes, but only when proper funding is available for both the Department of Social Services for their efforts to oversee and regulate, and proper funding to the recipients of the Auxiliary Grant so that they may afford better care.

When speaking of the funding needed for care, we must first understand the cost of providing the care. The cost to operate an Assisted Living Facility has increased dramatically the past few years. Leading this increase is the skyrocketing cost of liability insurance. The cost of training and retaining care givers and medication technicians has increased. Food and supply cost have increased due to higher gas prices. Heating fuel, natural gas, and other utilities have also increased. There is also a cost to implement new regulations not only by the facilities but also by the agencies that enforce those regulations. SB181 is an example of regulatory cost increases for facilities. And while all these cost have increased, the ability to offset these cost have been minimal. And through all this the majority of facilities have still provided quality care to its Residents.

Private Pay Facilities are those Facilities whose residents pay for their care from personal funds, while AG facilities that accept residents that are dependent on public funds to pay for their care. Some facilities have a mixture of private and public pay residents. The current AG rate for eligible citizens is $866 per month.

Compared to private pay rates that charge anywhere from $1,200 to $4,000 per month. With this disparity in funding it is easy to see why facilities that care for AG residents cannot afford to provide the capital improvements, the benefits for staff for retention, or the increases in operating cost. This is the disparity that directly affects resident care. Many facilities have worn out furniture, walls in need of paint, and staff in need of benefits and salaries reflective of the task that is set before them. Many AG facilities only meet minimum requirements in providing diets and activities due to shoe string budgets. The citizens of our great Commonwealth deserve better than minimum standard care. Once again, the reality is that funding dictates the ability to improve this care.

Many AG Facilities have populations that are mixed with a variety of ages and conditions. The need to fill a vacancy overrides the problems that can occur down the road with this mix of residents. It is the Residents right to choose a facility of his or her choice, but many times they fall through the cracks in this ability to choose. Case managers, the local CSB, and guardians often influence decisions using expediency over long term care objectives as the precedent.

We hear in news reports of Doctors protesting the soaring increases in liability insurance by not performing elective surgeries or refusing to care for litigation attorneys and their families. Assisted Living Facilities have no such recourse. The ability to find affordable liability insurance is becoming more difficult and timely. There are less than three (3) companies providing coverage for a market that is capable of high liability exposure. Cost for policies have tripled while the coverage limits have decreased by two thirds. Many AG facilities that cannot afford these increases have either decided to operate without coverage or shut their doors. Many private pay facilities have a surcharge to offset this cost. Publicly funded Facilities do not have that option either. The amount of paper work involved in renewing or applying for insurance is very time consuming and tedious. Implementation of risk management policies and procedures to reduce exposure is also costly, but very important. We provide care

24 hours a day 365 days a year. But the struggle is becoming harder and more intolerable. In a society where frivolous lawsuits smear the integrity of legitimate claims, the cost to provide liability coverage will reveal itself as a major contributing factor to the facilities that close due to an inability to be fiscally viable. Options to counter this issue include more funding for Residents, State supported Risk Retention Groups, State aided insurance, and Tort Reform.

Implementation and administration of new regulations will not solve the problems that face our industry unless they are funded. The Department of Social Services and other regulatory agencies are working hard to ensure facilities maintain the Standards of Care. That is becoming more difficult with budget impasses, public scrutiny, and under staffing. DSS has made great strides in improving its oversight and relationships with facilities. This is helping everyone work toward to ensuring that residents receive quality care. Is it enough? No, DSS needs more tools that are flexible with the changing trends of this industry. Stronger guidelines to close down problematic facilities is a must. In North Carolina, a facility with a major violation is not allowed to admit new residents and are put on a probationary status. This promotes quick resolution to problems and promotes coherence to the regulations. As an owner/operator in North Carolina, I personally experience the systems in place there to regulate the industry. I would like to note a significant difference in funding. In North Carolina, basic care for a medicaid resident, the equivalent of a Virginia AG Resident, is $1,066. Additional funding is granted if the resident's needs are more than the basic care provided or as their needs increase over time. These would include additional funds for assistance with eating, mobility, etc.. The Virginia system pays the same low rate whether a resident needs assistance with ADL's or not. There are many systems from North Carolina that I can detail for this Committee or the DSS Strategic Steering Planning Committee at a later time if it is relevant to this cause.

Documentation is a key to promoting and preserving quality care. Documentation of concise data is essential in the daily routine of the Care Givers. Many of the model forms given to applicants for

licensing are outmoded and cumbersome. Systems need to be developed that will give agencies maximum data to ensure quality care, while giving staff and management less paperwork to preform. If care givers are filling out forms, they are not providing care. Operators need to be trained or assisted with the policies and procedures to efficiently operate in today's environment. DSS once gave applicants manuals to guide them in the operation of their facility and care of the residents. This may be a consideration of this committee in helping operators fulfill regulatory requirements.

There are many other areas of improvement that is needed from all persons that are party to these issues. Improved training for staff, better assessment of residents, consistent interpretation of regulations by inspectors, Medical Transportation assistance, and non-partisan politics in deciding funding for the citizens that need our help.

" It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life—the sick, the needy and the handicapped."
ATTRIBUTION: Senator HUBERT H. HUMPHREY, remarks at the dedication of the Hubert H. Humphrey Building, November 1, 1977.—*Congressional Record*, November 4, 1977, vol. 123, p. 37287

I hope that what we do here today provides the foundation of ideas that will ensure those in the shadows of life are treated with care and dignity.

Thank You

Supplemental Ideas: