FOLLOW-UP REVIEW
OF THE JOINT LEGISLATIVE
AUDIT AND REVIEW COMMISSION ON

Homes for Adults in Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 8

COMMONWEALTH OF VIRGINIA
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Preface

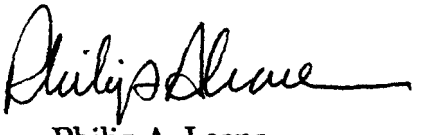
Item 545 of the 1990 Appropriations Act directed JLARC to conduct a follow-up study to the 1979 JLARC report on Homes for Adults in Virginia. In addition, JLARC was instructed to report the findings to the Commission on Health Care for All Virginians prior to the 1991 Session. This report presents staff findings and recommendations regarding the regulation of homes for adults and funding provided residents through the Auxiliary Grants Program.

The 1979 JLARC report identified significant problems affecting adult home regulation, the Auxiliary Grants Program, and the health and safety of adult home residents. Since 1979, improvements have been made in the ability of the adult home system to protect the basic health and safety of residents. However, the regulatory and funding systems have failed to keep pace with the changing nature of adult home care over the past ten years.

Adult homes are caring for larger numbers of residents, many of whom suffer from serious mental and physical impairments. Yet only one set of licensing standards exists to regulate care in all adult homes. In addition, almost all adult homes are receiving the same auxiliary grant rate despite the differences in care provided to the more seriously impaired residents.

This report presents recommendations for the development of a tiered approach to regulating and funding the adult home system. The tiered system would be based on the different levels of care provided adult home residents and would ensure that adequate safeguards exist, especially for the care of those with serious mental and physical disabilities.

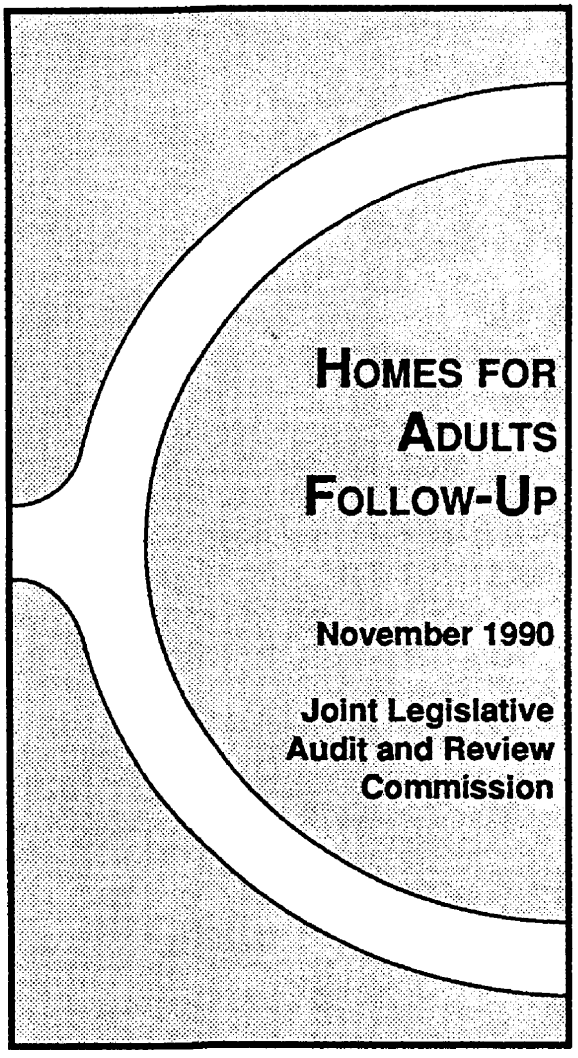
I am pleased to note that the general approach recommended in this report has received the support of the Secretary of Health and Human Resources, as well as the Department of Social Services; the Department of Mental Health, Mental Retardation and Substance Abuse Services; and the Department of Health. On behalf of the JLARC staff, I would like to thank the staff of these departments and the staff of the adult homes, provider associations, and other local and State agencies that assisted in our review.



Philip A. Leone
Director

November 28, 1990

JLARC Report Summary



Homes for adults provide a basic level of residential care (room, board, and general supervision) to four or more aged, infirm, or disabled persons. Homes for adults have been regulated in Virginia since 1954. The Department of Social Services (DSS) is responsible for regulation through licensure and monitoring of adult homes.

The adult home system of care has been the object of repeated and continuing study over the last decade. At least seven different reports have addressed various aspects of adult home problems in Virginia. Concerns have been raised about the health and safety of residents, the effectiveness of adult home licensure and monitoring, and the adequacy of State funding through the auxiliary grants program for some adult home residents. Additional concerns have surfaced about the effective administration of the Auxiliary Grants Program.

In 1979, JLARC evaluated the adult home system and identified numerous problems affecting the health and safety of residents, licensing standards and procedures, and the Auxiliary Grants Program. This follow-up review, directed by Item 545 of the 1990 Appropriations Act, generally found improvements in the system to protect the basic health and safety of residents. However, no action has been taken on a number of previous recommendations, and the problem of providing adequate care and protection has been exacerbated by a sharp increase in residents who have serious mental health or medical needs. In addition, administration of State funding through the Auxiliary Grants Program is no better now than it was in 1979, despite a 272 percent increase in program expenditures.

There has been a notable change in the nature of adult home care and the size of the adult home system from 1979 to 1990. Adult homes now appear to be caring for a more diverse population of mentally and physically impaired adults. In addition, mental and physical impairments of adult home residents seem to be more severe now than they were in 1979. Some residents are receiving medical-type treatment to care for their impairments. Ten years ago this care would have been available only in a nursing home.

The number of homes has grown by almost 50 percent, while the capacity of the system has more than doubled. The num -

The Current Regulatory System Does Not Adequately Protect Residents

Adult home licensing standards do not require homes to employ certified nurse's aides, licensed practical nurses, or registered nurses. In addition, no ratios or guidelines for staffing are provided through the licensing standards. Standards to address the quality of medical care provided residents are also lacking. The examples below are typical of problems facing the adult home system.

One adult home visited by JLARC staff cared for 53 residents with a variety of mental and physical impairments. Some residents suffered from Alzheimer's disease; some had colostomies, serious bedsores, or catheters. DSS files on the home included several complaints from health care professionals on the adequacy of care provided residents.

Three staff from home health care agencies reported problems with improper training of direct care staff to care for residents receiving home health care services, improper dispensing of medication, and failure to isolate one resident with a contagious condition. A director of a nearby rescue squad complained about the excessive number of calls his personnel had to make to the home. He felt that the home's residents were receiving inadequate supervision. A review of the squad's calls indicated that it had made 20 calls to the home during a one-year period for instances of residents falling and being injured.

* * *

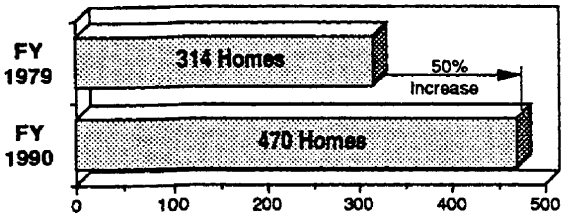
A number of instances of wandering or missing persons involving adult home residents are reported each year. For example, one adult home visited by JLARC staff cared for about 33 residents, the majority of whom were mentally disabled. One resident, a chronic schizophrenic, wandered from the home and could not be located for almost two days. Staff did not provide adequate supervision to prevent this, despite knowing the resident was confused and had wandered from the home three times on the day of the incident. Fortunately, the resident was not seriously injured, though she was dehydrated, cut, and bruised. At the time of the incident, only two staff members were on duty to care for the 32 residents present in the home.

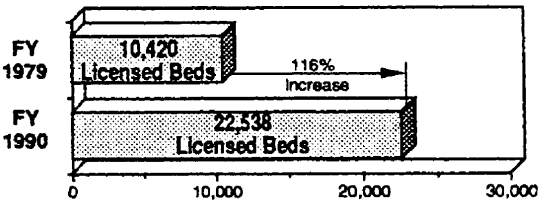
ber of licensed beds has increased from 10,420 to 22,538 beds, and the number of residents has grown from 8,800 to about 18,000. In addition, the number of mentally disabled residents in adult homes has almost tripled to 5,200 since 1979.

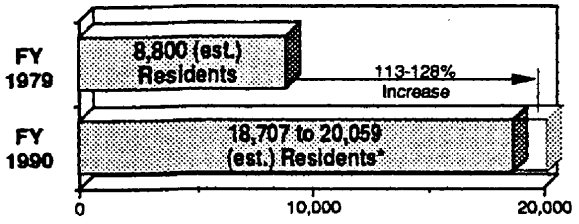
Most of the recommendations in this report focus on improving the regulatory and funding systems to accommodate the evolving role of adult homes in providing care to mentally and physically disabled populations. However, before these changes can be successful, modifications will be needed to the current placement and needs assessment processes for adult home residents.

While some of the proposed changes will not require substantial effort or the infusion of additional State resources, some will require additional funding. And, although current fiscal constraints may not allow for immediate implementation of these changes, planning for the system can begin with gradual implementation over the

Increases in the Number and Capacity of Homes for Adults, FY 1979 to FY 1990







* Estimated from data gathered by the Department of Social Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services for the 1988 report, *Aftercare Needs of Mentally Disabled Clients in Adult Homes*, and data from FY 1990 adult home cost reporting forms.

Source: *Homes for Adults in Virginia*, JLARC 1979; *Aftercare Needs of Mentally Disabled Clients in Adult Homes*, DMHMRSAS and DSS, 1988; and JLARC staff analysis of DSS Division of Licensing licensed adult home caseload data, July 10, 1990.

next few years as resources become available. This will ensure that residents are adequately protected and their needs are appropriately met in adult homes.

This report summary briefly references study findings and recommendations. Full statements of specific recommendations and supporting details are contained in the text of this report.

System-Wide Changes Are Necessary to Address the Changing Role of Adult Homes in Providing Care to Diverse Groups

Reports on the adult home system have repeatedly questioned whether adult homes are appropriate settings for the mentally disabled as well as some physically disabled adults. Regardless of one's position on this question, it is important to realize that, in fact, adult homes have become a primary source of long-term care for these populations. The statutory and regulatory framework for the system does not adequately recognize this changing role of adult homes. Consequently, significant system-wide changes are necessary to address the problems facing the current adult home system of care.

The adult home system was originally designed to provide only basic services to residents, such as room and board, general supervision, and personal care. For the mentally disabled, adult homes have adapted to provide the first level of care for clients released from State mental health or mental retardation facilities. Approximately one quarter of the residents in adult homes have some type of mental disability. Yet the provision of services to this population has been cited as deficient by JLARC reports in 1979 and 1986; an Ernst & Whinney report in 1985; and a report by DSS and the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) in 1988. Recommendations to improve the needs assessments and services provided to this group have not been implemented, partly due to funding limitations.

Adult homes are also increasingly providing care to physically disabled elderly with more intensive needs for care than the system was originally intended to

provide. Homes may be providing medical services to residents who do not progress to institutional settings that provide higher levels of care. Current adult home licensing standards and licensing staff in DSS are unable to provide adequate guidance and oversight to ensure these residents needs are appropriately met.

System-wide changes are needed to ensure that the changing role of the adult home system of care is recognized and regulated accordingly. First, changes are necessary to ensure residents are properly placed in adult homes that can provide adequate care. Next, the regulatory framework needs to be redesigned to recognize varying levels of care provided to residents. This will allow for more thorough protection and oversight of adult home residents. In addition, modifications to specific licensing standards and the enforcement process are needed to better protect home residents. Finally, changes should be made to ensure the Auxiliary Grants Program is properly administered and recognizes varying levels of care needed by residents.

Measures Are Needed to Ensure Appropriate Client Placement

Currently, there is no State policy to ensure that adult home placements, particularly for residents who receive State auxiliary grants, are appropriate and cost effective. This means that State funds paid to residents who receive adult home care may not be used in the most effective manner to ensure the delivery of an appropriate level and type of care.

If residents are inappropriately placed in adult homes, problems can arise. For example, more rapid physical and/or mental deterioration could occur if resident needs are not adequately met by adult homes. This could result in a need for treatment and care in a substantially more costly nursing facility or psychiatric hospital. Premature institutional care could negatively impact State resources because auxiliary grant recipients would be eligible for medicaid-funded, long-term care, which is more expensive to provide.

Some savings might be realized if needs assessments completed during the placement process identified that a resident's needs could be met in a less restrictive setting. For example, some community-based services could address needs by delivering care such as meals, medical care, or chore services in a client's home. Generally, community-based services such as these are less costly than 24-hour care in an adult home.

Proper placement of clients in homes for adults has long been considered a necessary element for appropriate care. A structured placement process ensures that the needs of the client are identified, and that a link exists between the needs assessment and the provision of services to clients in an appropriate care-giving setting.

The General Assembly has recognized the importance of systematic assessment and management of care of clients. During the 1990 legislative session, the General Assembly appropriated $3 million to implement a case management system currently being developed in several localities by the Long-Term Care Council for elderly Virginians. As a result of budget cuts, funding has been reduced to $2 million.

Without such a system to ensure proper placement, it is impossible to determine if adult home care is the most cost effective and appropriate setting for auxiliary grant recipients. To address concerns about the placement process, the following recommendation is made:

The Secretary of Health and Human Resources should pursue the development of a client needs assessment instrument and process for use in placing and monitoring auxiliary grant recipients in adult homes.

The Regulatory System Should Be Modified to Address Levels of Care

The current regulatory system for adult homes does not reflect changes in resident populations and the role these homes play in caring for residents. Adult home licensing standards and enforcement activities continue to focus on the provision of basic domiciliary and supervisory care for mildly impaired populations. Consequently, they do not adequately protect more seriously impaired residents.

One of the primary problems with the current regulatory system is that one set of licensing standards applies to all homes regardless of the services provided or the functional level of the residents. Licensing standards do not delineate the medical conditions of residents who may be cared for within an adult home; the number, qualifications, and training required of staff in homes caring for more seriously impaired populations; or many of the "specialized" services needed by impaired residents.

At least three distinct resident populations reside in homes for adults: residents who are moderately impaired with a need for supervision, residents who suffer from significant mental disabilities, and residents with physical disabilities requiring medical care and treatment. Standards should be established to accommodate at least these three resident populations now living in adult homes. Therefore, the following recommendation is made:

The Commission on Health Care for All Virginians should consider directing the Secretary of Health and Human Resources to develop a plan to comprehensively revise the statutory and regulatory framework of the adult home system to incorporate standards for several levels of care.

Licensing Standards and Enforcement Activities Need to Be Modified

Through regulation or the enforcement of mandated standards and requirements, the Department of Social Services seeks to protect the physical and emotional well-being of adult home residents. This protection is particularly important since regulatory authorities may be the only outside entity concerned with resident care who enters the adult homes on a regular basis. The effectiveness of DSS' enforcement is determined largely by the ability of licensing staff to identify problems and require corrective action. Deficiencies in the current licensing standards and in enforcement activities, however, limit the effectiveness of DSS' regulation. To enhance the protection of residents and the enforcement capabilities of licensing staff, the following recommendations are made:

The State Board of Social Services should promulgate additional standards regarding qualifications and training for administrators and staff of adult homes, staffing guidelines, medical procedures, medication management, and facility design.

The Commissioner of Social Services should ensure that fees assessed adult home licensees are used to provide training for adult home staff as intended by the General Assembly.

The Department of Social Services should enhance enforcement by:

- modifying existing standards to specify a minimum staff age, requiring physicians' orders be followed, and clarifying food service requirements;
- training and overseeing regional licensing staff to promote consistency;
- employing a certified dietitian to supplement enforcement of nutrition and food services; and

- using Supplemental Security Income data to assist in obtaining search warrants for illegally operating homes.

The General Assembly may wish to amend the *Code of Virginia* to require unannounced annual renewal inspections of homes for adults and authorize the use of intermediate sanctions by the Commissioner of Social Services.

Relocating the Licensing Function Will Not Solve Current Problems

Appropriate placement of the adult home licensing function within the Department of Social Services was assessed during this review. The General Assembly considered moving responsibility for licensing homes for adults from the Department of Social Services to the Virginia Department of Health during the 1990 legislative session. This review indicates that there is no compelling reason to move the responsibility from DSS at this time.

Retaining licensing within DSS would support the type of care provided in most homes, facilitate coordination between licensing and auxiliary grant administration, and be more cost effective than moving the responsibility to the Department of Health. In addition, the regional structure of DSS enhances oversight of adult homes. Licensing specialists are located closer to the homes they investigate and license, so they can respond quickly when problems arise. If recommended changes to the

Deficiencies in Licensing Standards and Enforcement Activities

Description of Deficiency	Problems Identified with: Standards	Enforcement
Qualifications/training required of home administrators and staff are minimal	●	
Staffing ratios or guidelines are lacking	●	
Medical procedures are not addressed	●	
Medication management and control is inadequate	●	
Some facility design requirements are not specified	●	
A minimum age for staff is not required	●	
Food service standards are vague	●	
A requirement that physicians' orders be followed is missing	●	
Training of licensing staff is limited		●
Oversight of regional licensing activities is weak		●
Annual renewal inspections are not made on an unannounced basis		●
Special diets and menus are not reviewed by a dietitian		●
Intermediate sanctions are not available		●
Allegations of illegally operating homes cannot always be effectively investigated.		●

Source: JLARC staff analysis of DSS adult facility licensing standards and enforcement activities.

current licensing program are not made however, the General Assembly may wish to reconsider transferring the licensing function. The following recommendation is made:

Responsibility for licensing homes for adults should remain within the Department of Social Services.

Numerous Problems Continue to Affect State Funding for Residents

Previous reviews of homes for adults, including the 1985 Ernst & Whinney report, have documented numerous problems with the State funding system for eligible adult home residents through the Auxiliary Grants Program. This review revealed that almost no improvements have been made to address weaknesses in the administration of the program, although expenditures have significantly increased to $15.5 million. Problems continue to affect the program's adult home cost reporting and rate setting processes. These problems have resulted in questions about the validity of adult home auxiliary grant rates.

Failure to correct these problems has resulted in a State funding system that does not reflect the various types of adult homes and the diverse needs of their residents. As a result, adult homes generally receive the same auxiliary grant rate regardless of the type and intensity of services they provide their residents.

Cost Reporting Process. The current cost reporting process is inadequate. The validity of the reported adult home costs collected from adult homes through the cost reporting process cannot be determined. Cases were identified that cast considerable doubt on the validity of the cost data. Adequate policies and procedures do not exist to guide DSS staff in reviewing and evaluating the cost data. This results in inconsistent evaluation of the costs reported by adult homes and inequitable treatment of some home owners.

The current cost reporting cycle does not allow sufficient time for DSS staff to appropriately review more than 300 cost reporting packets. Such a short time period leads to inadequate review of the forms by DSS staff and limits the amount of follow-up conducted on identified problems.

Rate Setting Process. The adequacy of the maximum monthly rate for adult homes ($602) has been constantly debated. Cost data submitted to DSS for a FY 1991 grant rate indicates this maximum rate may be inadequate. The median monthly cost of operating an adult home statewide is about $663, which is ten percent higher than the current maximum rate. Yet, the need for a higher rate cannot be substantiated because the cost data on which this figure is based are not audited or verified. Lack of valid cost data may result in the improper use of State funds. In addition, the rate setting process does not provide an adequate interim auxiliary grant rate for newly licensed homes; nor does it clearly articulate what services are to be provided through the auxiliary grant benefit.

To improve the ability of the current Auxiliary Grants Program to meet the needs of eligible adult home residents, the following recommendations are made:

The Department of Social Services should establish an effective cost reporting process by:

- developing guidelines for certain cost items;
- establishing clear policies, procedures, and standards for the cost reporting process;
- conducting financial audits of reported costs;
- adjusting the cost reporting period and revising the forms;
- providing an adequate interim auxiliary grant rate; and
- consolidating agency facility rate setting functions.

The Secretary of Health and Human Resources should develop a proposal for regulatory changes governing charges for services received by auxiliary grant recipients. Once regulations are established, DSS should evaluate the adequacy of the monthly personal allowance.

The Adult Home Funding System Should Be Redesigned

In its present form, the Auxiliary Grants Program is unable to differentiate adult home rates based on the varying types and amounts of services provided by adult homes. Correcting identified problems with the cost reporting/rate setting process will certainly contribute to increasing the effectiveness of the program. However, for the Auxiliary Grants Program to better meet the needs of all recipients, the funding system could be linked to the proposed regulatory structure to recognize variations in the level of care provided by adult homes. This would improve the effectiveness of the State's Auxiliary Grants Program by providing adequate funding to eligible residents needing more intensive levels of care.

Funding the proposed tiered regulatory system can only take place after DSS has formally categorized and licensed all adult homes based on the care they provide. DSS would have to collect facility cost data and determine what costs would be allowed. A maximum monthly auxiliary grant rate could then be established for each licensed level of care. This maximum rate could be based on the average or median cost of care which could become the maximum amount homes could charge auxiliary grant recipients. Preliminary estimates using program costs for FY 1990 demonstrate the cost for the proposed funding system to be about $22 million. This represents an increase of more than $6 million over actual FY 1990 Auxiliary Grants Program expenditures.

The following recommendation is made:

The Secretary of Health and Human Resources should develop a proposal to link auxiliary grant funding to the proposed regulatory framework that recognizes the different levels of care to be provided by homes for adults.

Estimated FY 1990 Cost of Funding the Auxiliary Grants Program Based on Different Levels of Care Received

	Total Estimated Cost
Auxiliary Grant Funding For Level 1 Care	$5,636,695
Auxiliary Grant Funding For Level 2 Care	14,399,499
Auxiliary Grant Funding For Level 3 Care	1,939,561
Total Auxiliary Grant Funding	$21,975,755

Source: JLARC staff analysis of FY 1990 cost data reported by adult home operators.

Table of Contents

I. Introduction

Homes for adults, as defined in §63.1-172 of the *Code of Virginia*, provide a basic level of residential care (room, board, and general supervision) to four or more aged, infirm, or disabled persons. These homes have been continuing objects of study and review over the last decade. Concerns have been raised repeatedly about (1) the quality of resident care, (2) the adequacy and reasonableness of adult home licensure and monitoring, and (3) the adequacy of State funding for residents through the Auxiliary Grants Program.

In 1979, the Joint Legislative Audit and Review Commission (JLARC) conducted an in-depth evaluation of the adult home system in Virginia. That report primarily addressed basic issues related to the health and safety of residents. It identified numerous problems in these areas.

This report is a follow-up to the study completed by JLARC in 1979. As part of the follow-up, JLARC staff revisited all those homes still in operation which were selected for field visits in 1979. JLARC staff observed that some of the conditions identified as deficient in 1979 were not evident in 1990. Serious problems with food service, nutrition, and sanitation were not observed in the homes visited in 1990. In addition, fire safety inspections no longer appear to be inadequate.

While basic health and safety measures to protect residents appear to be improved in adult homes, the current regulatory framework does not adequately protect residents who have serious mental health or medical needs. Some examples of these shortcomings are provided in Exhibit 1.

There has been a notable change in the nature of adult home care from 1979 to 1990. Adult homes now appear to be caring for a more diverse population of mentally and physically impaired adults. In addition, mental and physical impairments of adult home residents seem to be more severe now than they were in 1979. Some residents are receiving medical-type treatment to care for their impairments. Ten years ago this care would have been available only in a nursing home. These changes have resulted in increased pressure on the regulatory and funding systems for adult homes.

In addition, some of the concerns raised in the 1979 JLARC report, and subsequent studies of the adult home system, are still evident to some degree. Concerns regarding whether or not the mental health needs of some adult home residents are being met appear to be valid. Weaknesses in the licensing standards and enforcement process still exist. Finally, the rate-setting and cost reporting processes for the Auxiliary Grants Program are no better now than they were in 1979, despite a 272 percent increase in auxiliary grant expenditures. Stricter fiscal oversight is needed to ensure that funds are properly used for residents' needs.

This chapter briefly describes the major findings and recommendations from the 1979 JLARC study of homes for adults and describes actions taken in response to the recommendations. An overview of the 1990 JLARC review is presented with a brief description of the study mandate and research activities. The final section of this chapter describes how the report is organized.

Exhibit 1

The Current Regulatory System Does Not Adequately Protect Residents

Adult home licensing standards do not require homes to employ certified nurse's aides, licensed practical nurses, or registered nurses. In addition, no ratios or guidelines for staffing are provided through the licensing standards. Standards to address the quality of medical care provided residents are also lacking. The examples below are typical of problems facing the adult home system.

One adult home visited by JLARC staff cared for 53 residents with a variety of mental and physical impairments. Some residents suffered from Alzheimer's disease; some had colostomies, serious bedsores, or catheters. DSS files on the home included several complaints from health care professionals on the adequacy of care provided residents.

Three staff from home health care agencies reported problems with improper training of direct care staff to care for residents receiving home health care services, improper dispensing of medication, and failure to isolate one resident with a contagious condition. A director of a nearby rescue squad complained about the excessive number of calls his personnel had to make to the home. He felt that the home's residents were receiving inadequate supervision. A review of the squad's calls indicated that it had made 20 calls to the home during a one-year period for instances of residents falling and being injured.

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A number of instances of wandering or missing persons involving adult home residents are reported each year. For example, one adult home visited by JLARC staff cared for about 33 residents, the majority of whom were mentally disabled. One resident, a chronic schizophrenic, wandered from the home and could not be located for almost two days. Staff did not provide adequate supervision to prevent this, despite knowing the resident was confused and had wandered from the home three times on the day of the incident. Fortunately, the resident was not seriously injured, though she was dehydrated, cut, and bruised. At the time of the incident, only two staff members were on duty to care for the 32 residents present in the home.

1979 JLARC REVIEW OF HOMES FOR ADULTS

The 1979 JLARC review documented significant shortcomings in the health and safety of residents, the licensure of adult homes, and the administration of the Auxiliary Grants Program. Specific problems were noted with food service and sanitation, fire safety inspections, adult home licensing inspections, and rate setting for the Auxiliary Grants Program. To address these problems and improve the ability of the adult home system to provide appropriate services to its residents, the 1979 JLARC report issued several recommendations.

Many of the recommendations issued in the 1979 report have been implemented at least partially (Table 1). Implementation of these recommendations has resulted in a noticeable improvement in many of the areas of adult home operation such as sanitation, food service, and fire safety. Many of these recommendations were implemented through statutory changes by the General Assembly. However, some of the proposed recommendations have not been implemented or require additional action. This has resulted in continued and additional deficiencies in the adult home system of care.

1979 Study Findings

The 1979 JLARC study concluded that health and safety problems in adult homes were the result of deficiencies in the licensure and enforcement processes at the Department of Welfare. In addition, effective administration of the Auxiliary Grants Program was lacking. The report stated, "there is no clear focus of responsibility in the Department of Welfare [now the Department of Social Services] for planning, coordination, and implementation of adult home activities."

Weaknesses in the department's licensure and enforcement process were identified in the following areas: compliance inspections, use of sanctions, uniformity of enforcement activities, and licensing staff training. Compliance inspections conducted by licensing specialists were found to be of limited value. Licensing sanctions failed to correct violations of licensing standards, and intermediate sanctions were not available to enforce less serious violations. Central office staff in the Division of Licensing were not able to ensure uniform enforcement of licensing standards by regional office staff. In addition, the report noted several areas related to resident health and safety in which licensing staff needed training.

Several weaknesses were identified in the administration of the Auxiliary Grants Program. The Department of Social Services (DSS) lacked a systematic approach to auxiliary grant rate setting based on reliable cost data. At that time, auxiliary grant rates and payments were being made without data that accurately reflected the cost of operating an adult home. The report also recommended that further coordination between the Auxiliary Grants Program and adult home licensing was necessary to prevent potential abuse of auxiliary grant benefits.

Table 1

Status of Major Recommendations from the 1979 JLARC Homes for Adults Study

Recommendations	Currently Implemented	Additional Action Required
Inspections and training related to food services should be improved	✓	Yes
State Fire Marshal should inspect all licensed homes for adults	✔	No
Aftercare services should be available to deinstitutionalized clients	✓	Yes
Medication administration should be documented and training should be provided	✓	Yes
Services to be provided by the auxiliary grant should be specified	✘	Yes
All compliance inspections should be conducted on an unannounced basis	✓	Yes
Provisional licenses should be issued for a limited, nonrenewable period of time	✔	No
Intermediate sanctions should be established	✘	Yes
Illegally operating homes should be pursued	✓	Yes
DSS should ensure greater uniformity in the enforcement of standards	✓	Yes
DSS should improve its basis for setting monthly rates for homes for adults	✘	Yes
Cost reporting policies for homes for adults should be strengthened	✘	Yes
Cost reporting forms should be clarified	✓	Yes

Key: ✔ Generally Implemented ✓ Partially Implemented ✘ Not Implemented

Source: Analysis of statutory changes to Chapter 9, Title 1, *Code of Virginia*, and DSS' May 21, 1990 response regarding the status of actions taken on the 1979 JLARC report.

Actions Taken Since the 1979 Report

The JLARC follow-up of the 1979 study recommendations indicates that actions to correct some of the deficiencies were initiated. For example, statutory authority was granted to the State Fire Marshal to inspect all licensed homes for adults. The *Code of Virginia* was also amended to require at least one unannounced monitoring visit to each home annually. Language was inserted in the *Code of Virginia* to assess adult home licensing fees to provide for the development and delivery of training to adult home owners and administrators.

Deficiencies in licensing staff training were also corrected. The Department of Social Services has sponsored training for licensing staff covering areas such as nutrition, basic needs and medical assessments of residents, medication administration, and evaluating adult home compliance with licensing standards. Finally, the recent reorganization of DSS provided the Division of Licensing with direct authority over the licensing staff in the regional offices.

Immediately after the 1979 report, the Auxiliary Grants Program received greater scrutiny. A staff person with an accounting background was assigned to the program. Audits were conducted of adult home cost data. According to DSS staff, auxiliary grant rates were reduced in some instances as a result of these audits. However, this level of oversight was discontinued and has not been carried out for at least the past five years despite significant increases in auxiliary grant expenditures since 1979.

In general, the recommendations implemented from the 1979 study have produced improvements in the homes for adults system. However, many of the recommendations not implemented from the 1979 report still have merit. Additional actions regarding the homes for adults system are needed.

1990 JLARC REVIEW OF HOMES FOR ADULTS

This JLARC review was structured as a follow-up to the 1979 JLARC report on homes for adults. As part of that follow-up, the review was designed to address areas of concern regarding the quality of resident care in adult homes, the licensure of adult homes, and funding of the Auxiliary Grants Program. The review was also structured to address additional concerns resulting from the expansion and evolution of the adult home system.

The appropriate placement of the licensing function was also examined. Concerns regarding the problems facing the adult home system and the perceived lack of responsiveness on the part of DSS have led to suggestions that the licensing function is inappropriately placed in DSS and would be improved if placed within the Virginia Department of Health (VDH). During the 1990 session of the General Assembly, legislation was introduced to transfer this function to VDH. However, the bill was carried over to the 1991 session.

Study Mandate

Item 545 of the 1990 Appropriations Act directed JLARC to conduct a follow-up study to the 1979 JLARC Report on *Homes for Adults in Virginia*. The impetus for the follow-up study came from recommendations made by the Joint Subcommittee on Health Care for All Virginians during 1989. As part of its study on health care, the Joint Subcommittee examined long-term care needs in Virginia. Homes for adults were identified as a part of the delivery system for long-term care. The subcommittee was concerned about the quality of care provided to residents of homes for adults and acknowledged that this has been an ongoing concern of several past reports.

The subcommittee's report noted that, "how to restructure the licensure and reimbursement systems to address client needs has been a source of debate." The report noted that although the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and DSS had jointly completed a report in 1988 on how to address the mental health needs of adult home residents, "how to restructure the system to meet the health needs of the elderly" was still unresolved. The subcommittee's recommendation for a follow-up to JLARC's 1979 report included language to have JLARC assess:

- current licensing and monitoring systems,
- reimbursement under the Auxiliary Grants Program, and
- the health and mental health needs of homes for adults residents.

Study Activities

A number of activities were undertaken during this study to collect and analyze information about the adult home system. These research activities included: (1) document reviews, (2) structured interviews, (3) field visits, (4) file reviews, and (5) an analysis of adult home financial cost reports.

Document Reviews. JLARC staff examined studies on the adult home system in Virginia that were completed between 1979 and 1990. These included the following reports:

- JLARC report on *Homes for Adults in Virginia*, December 1979;
- *Final Report: Auxiliary Grants Program Study*, Commonwealth of Virginia, Department of Social Services, Ernst & Whinney, July 1985;
- JLARC report on *Deinstitutionalization and Community Services*, October 1986;
- House Document No. 30, *Report of the Joint Subcommittee Studying Long-Term Care*, 1987;
- House Document No. 17, *Report of the DMHMRSAS and the DSS on After-care Needs of Mentally Disabled Clients in Adult Homes*, 1988; and

- Senate Document No. 35, *Interim Report of the Joint Subcommittee on Health Care for All Virginians*, 1990.

These reports addressed similar issues and problems affecting the adult home system. Table 2 outlines the major issues discussed in these reports. JLARC staff conducted an analysis of recommendations made in the reports and the actions taken on these recommendations.

Additional reports were examined from the U.S. General Accounting Office and the Health Care Financing Administration. Reports by the Urban Institute on long-term care of the elderly, needs of the elderly, and needs of individuals with serious mental illness were also reviewed. Model licensing standards developed by the American Bar Association were examined. Written policies and procedures on how the auxiliary grant rate is established were reviewed along with the policies and procedures guiding the adult home licensing and monitoring process. Finally, DSS adult facilities' licensing standards were reviewed and analyzed.

Structured Interviews. Numerous structured interviews were conducted during the course of this review. Interviews were conducted with: (1) adult home owners/administrators in 33 adult homes; (2) DSS staff in the Divisions of Financial Management, Benefit Programs, and Service Programs; (3) licensing staff in DSS, VDH and DMHMRSAS; (4) selected staff in the Department for the Aging, the Department of Medical Assistance Services, the VDH Division of Sanitarian Services, local social service agencies, local community services boards, and area agencies on aging; and (5) the State Fire Marshal.

Field Visits. JLARC staff conducted field visits to 44 adult homes throughout the State. As part of that effort, an attempt was made to revisit the 29 homes selected for field visits in 1979. However, only 20 of the homes visited during the 1979 JLARC review still exist. A sample of homes was selected using these 20 homes plus ten additional homes to obtain a more diverse view of the adult home system. One home from the 1979 review was in the process of being closed, so another home was selected to replace it in the overall sample.

The selection of the ten additional homes was based on size, location, and whether or not the home accepted auxiliary grant recipients. The purpose of this was twofold: (1) to determine whether problems identified in the 1979 JLARC report were still evident and (2) to identify any changes in the adult home system since 1979. Table 3 compares the characteristics of the 30 sampled adult homes visited during the course of the follow-up study to the characteristics of the total number of licensed adult homes.

Field visits were also made to six homes to pretest data collection instruments and to five other homes that DSS licensing staff and local community services boards' staff identified as model facilities. These additional homes were identified as such because of their ability to provide specialized services and a high level of care to their residents. Finally, two additional homes were visited with DSS licensing staff on complaint investigations.

Table 2

Major Issue Areas Addressed in Studies of the Adult Home System

Major Issues/Proposals	1979 JLARC Report	1985 Ernst & Whinney	1986 JLARC Report	1987 House Doc. 30	1988 House Doc. 17	1990 Senate Doc. 35
Reconsideration of the role of adult homes		●		●	●	
Preadmission assessments for adult home placements		●		●	●	●
Case management of auxiliary grant recipients		●		●	●	●
Development of standards for quality and levels of care				●		
Aftercare services for mentally disabled individuals	●		●	●	●	
Requirements for trained staff in adult homes caring for mentally disabled residents			●	●	●	
Use of intermediate sanctions	●	●	●			
Transfer licensing from DSS to VDH						●
Link auxiliary grant rate to levels of adult home care				●		
Increase in the maximum auxiliary grant rate		●		●	●	
Allocation of additional funds for some impaired adult home residents		●		●	●	
Improvements to the facilty cost reporting process	●	●		●		
Improvements to the rate determination process	●	●		●		
Delineation of services to be paid by the auxiliary grant	●	●				

Source: Analysis of *Homes for Adults in Virginia*, JLARC, December 1979; *Final Report: Auxiliary Grants Program Study*, Ernst & Whinney, July 1985; *Deinstitutionalization and Community Services*, JLARC, October 1986; *Report of the Joint Subcommittee Studying Long-Term Care*, H.D. 30, 1987; *Report of the DMHMRSAS and DSS on Aftercare Needs of Mentally Disabled Clients in Adult Homes*, H.D. 17, 1988; and *Interim Report of the Joint Subcommittee on Health Care for All Virginians*, S.D. 35, 1990.

Table 3

Comparison of Characteristics of a Sample of Homes Visited in 1990 to Statewide Data on all Licensed Adult Homes

Comparison of Adult Home Sizes by Licensed Capacity

Licensed Capacity	Sample Homes		Statewide[1]	
	Number	Percent	Number	Percent
4 - 24	14	47%	234	50%
25 - 49	6	20	103	22
50 - 74	7	23	61	13
75 - 99	2	7	24	5
100 +	1	3	48	10
TOTAL	30	100%	470	100%

Comparison of the Regional Distribution of Homes

Region	Sample Homes		Statewide[1]	
	Number	Percent	Number	Percent
Lynchburg	3	10%	54	11%
Richmond	6	20	104	22
Roanoke	4	13	57	12
Northern Virginia	4	13	61	13
Southwest	3	10	43	9
Tidewater	5	17	86	18
Valley	5	17	65	14
TOTAL	30	100%	470	99%[2]

Comparison of the Number of Homes with Auxiliary Grant Recipients By Capacity

Licensed Capacity	Sample Homes[3]		Statewide[4]	
	Number	Percent	Number	Percent
4 - 24	12	52%	165	53%
25 - 49	5	22	69	22
50 - 99	5	22	56	18
100 +	1	4	22	7
TOTAL	23	100%	312	100%

[1]The total number of licensed adult homes was 470 as of June 30, 1990.

[2]Figures do not total 100 percent due to rounding.

[3]Twenty-three of the 30 sample homes had auxiliary grant recipients.

[4]The total number of licensed adult homes housing auxiliary grant recipients is 312. This is based on 1989 data on the Auxiliary Grants Program. This was the most recent data available for comparison.

Source: DSS Division of Licensing Licensed Caseload File Data, July 10, 1990 and DSS Division of Benefit Programs' analysis of the number of auxiliary grant recipients, July 1989.

File Reviews. The study team reviewed a sample of client records in 33 adult homes visited. In addition, adult home records kept by DSS regional offices were reviewed. Finally, complaint files in each DSS region were reviewed for the homes visited.

Financial Cost Analysis. Financial cost data were reviewed for the 332 homes which submitted information to obtain an auxiliary grant rate for FY 1991. A comparison of the costs reported by adult homes was made with the current maximum auxiliary grant rate. In addition, the median monthly cost of care was calculated for the 332 adult homes.

Report Organization

Chapter II presents an overview of the adult home system, and discusses the role of adult homes in providing care for the mentally and physically disabled resident populations. Chapter III discusses the adult home regulatory system and how it could be structured to meet the evolving role of adult homes in providing long-term care. In addition, it provides specific recommendations which could be implemented to address immediate concerns affecting the adult home regulatory system. Chapter IV focuses on how the funding system can be improved. It discusses immediate steps that should be taken to improve the administration and oversight of the system. Finally, it provides an analysis of how the funding system could be structured to reflect proposed changes to the regulatory system.

The report was organized in this manner for several reasons. The adult home system has had a number of problems affecting the quality of care, licensing, and funding for more than ten years, yet many of the recommendations from previous reports have not been implemented. The pervasive nature of the problems affecting the system over the last ten years indicates that some structural changes to the regulatory and funding systems may be needed. However, it is necessary to first understand the evolution of the role of homes for adults in providing long-term care to the mentally and physically impaired populations and how the systems currently operate.

It is important to consider changes to the regulatory system next, because major structural changes to the regulatory system may impact how funding is used to pay for adult home services. The discussion of specific problems and solutions affecting adult home regulation is then presented. Finally, the specific problems affecting the funding system are described and linked to a discussion of how the funding system can be adapted to parallel the recommended changes to the regulatory system. While some of the proposed changes may require additional resources or the reallocation of resources, it is important to consider that they will provide the system with adequate safeguards to accommodate the increased demands affecting the system of care now and in the future.

II. The Adult Home System of Care

Since the 1979 JLARC report, the adult home system has grown and changed significantly. The capacity of the adult home system has more than doubled, and there has been a notable change in the nature of adult home care. While many adult homes continue to provide basic services to residents (room, board, and general supervision), some homes are now providing more specialized services to residents who have more severe physical and mental impairments.

Although the role of adult homes in providing care has evolved over the past ten years, the regulatory and funding systems for adult homes and their residents remain largely unchanged. While some improvements have been made to the regulatory process, significant changes are still necessary to ensure the regulatory and funding systems adequately address the changing role of homes for adults in delivering care to mentally and physically disabled adults.

This chapter provides an overview of the current adult home system. In addition, it discusses the role of adult homes in providing care for mentally and physically disabled adults. Finally, it discusses changes that are needed for the system to address the evolving role of adult homes in providing long-term care.

Some of the proposed changes for the adult home system will not require substantial effort or the infusion of additional State resources. Other changes, however, will require additional funding which may not be possible given the State's current fiscal outlook. The General Assembly needs to determine which actions can be made now and which may be necessary to implement gradually over the next few years as resources become available.

In reconsidering the adult home system, one important caveat should be made. Adult homes make up only one part of the overall long-term care system for the mentally and physically disabled. Therefore, changes to the adult home system alone may not ensure the most efficient and effective use of State resources. It is essential that the State examine other programs which could provide less costly care for these target populations. For example, services are available for the elderly through the Department for the Aging to assist them with care in their homes. The goal of these services is to help the elderly function independently for as long as possible.

OVERVIEW OF THE HOMES FOR ADULTS SYSTEM

Homes for adults are residential facilities that provide maintenance and care to four or more aged, infirm, or disabled persons. Maintenance and care is defined by §63.1-172B of the *Code of Virginia* as "the protection, general supervision and over-

sight of the physical and mental well-being of the...individual." Homes for adults have been regulated in Virginia since 1954. Regulation of adult homes is the responsibility of the Department of Social Services (DSS) through licensure, inspection, and monitoring of the homes. Currently, there are about 470 licensed homes for adults in Virginia.

Licensure involves granting permission to operate, so facilities which meet the statutory definition of homes for adults are prohibited from operating unless a license has been granted. The only exceptions to this requirement are facilities licensed by the Virginia Department of Health (VDH) or the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); facilities licensed as child-caring institutions by DSS; and homes caring for less than four adults or those caring exclusively for individuals who are related by blood or marriage to the home operator.

Requirements for the licensing of homes for adults are specified in Title 63, Chapter 9 of the *Code of Virginia*. This chapter sets out general parameters for adult home building and staff requirements and for licensing requirements and procedures. It also establishes the State Board of Social Services as the authority for promulgating adult home licensing standards. Licensing standards cover the following areas:

- record-keeping;
- resident services;
- buildings and grounds;
- management and personnel;
- housekeeping and maintenance;
- fire and emergency protection;
- admission and discharge policies; and
- furnishings, equipment, and supplies.

Licensed adult homes are to comply with licensing standards and meet all applicable building code, sanitation, and fire safety requirements.

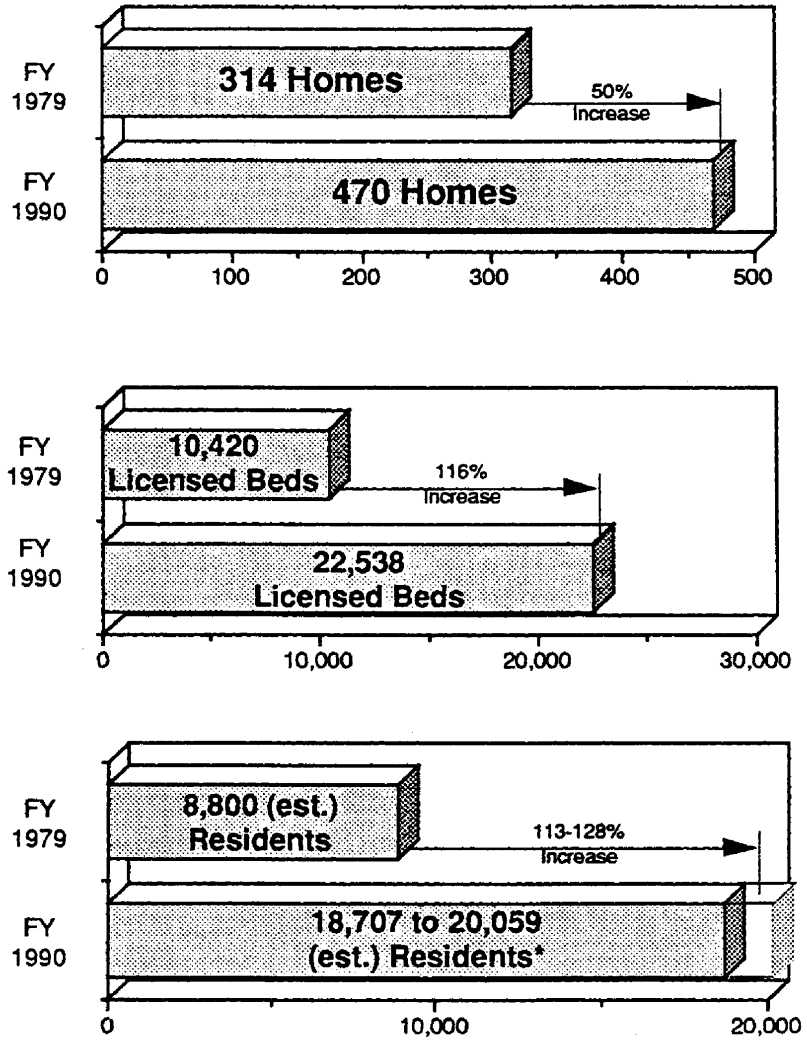
Many adult home residents with low incomes receive State funds to pay for their care in adult homes. State funding is available through the Auxiliary Grants Program. This supplements the income residents may receive from other sources such as federal programs like Supplemental Security Income (SSI) or Social Security.

Growth of the Adult Home System

The adult home system has grown significantly over the last ten years. The capacity of the system and the resident population have more than doubled (Figure 1). Current estimates place the number of adult home residents between 18,000 and 20,000. Approximately, 25 percent of this population are mentally disabled post-hospitalized clients (deinstitutionalized from State mental health and mental retardation facilities and sometimes referred to as aftercare clients). Estimates of the number

Figure 1

Increases in the Number and Capacity of Homes for Adults FY 1979 to FY 1990



* Estimated from data gathered by the Department of Social Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services for the 1988 report, *Aftercare Needs of Mentally Disabled Clients in Adult Homes*, and data from FY 1990 adult home cost reporting forms.

Source: *Homes for Adults in Virginia*, JLARC 1979; *Aftercare Needs of Mentally Disabled Clients in Adult Homes*, DMHMRSAS and DSS, 1988; JLARC staff analysis of DSS Division of Licensing licensed adult home caseload data, July 10, 1990; and FY 1990 adult home cost reporting forms.

of these residents has almost tripled from 1979 levels to 5,200 (Table 4). Auxiliary grant recipients make up about one-third of the total adult home resident population. The number of these residents has increased to more than two and one-half times the 1979 level.

If the number of adult home residents in the next ten years increases at a rate comparable to the adult home system's growth over the last ten years (113 to 128 percent), the number of adult home residents could increase to between 40,000 and 46,000 individuals by the year 2000. This growth can be attributed to several factors: (1) federal and State policies regarding deinstitutionalization of the mentally disabled population, (2) federal and State policies regarding nursing home admissions, and (3) growth in the elderly population.

First, federal and State policies to discharge mentally disabled clients from mental health and mental retardation facilities to community-based settings has resulted in increases in the number of these clients in adult homes. In 1979, JLARC reported that an estimated 1,700 to 2,000 residents in adult homes were post-hospitalized (or aftercare) clients. This represented about one-fifth of the 8,800 residents in adult homes at that time. By 1988, estimates of these clients totaled almost 5,200, accounting for about one-quarter of the estimated number of residents in adult homes. It is possible this number may continue to grow as the federal government and the State continue to seek additional ways to decrease reliance on institutional care for the mentally disabled.

Table 4

Increases in the Number of Auxiliary Grant Recipients and Mentally Disabled Aftercare Clients in Adult Homes FY 1979 to FY 1990

	FY 1979	FY 1990	Percentage Increase
Auxiliary Grant Recipients	2,281	5,761	153%
Mentally Disabled Aftercare Clients	1,700-2,000	5,190*	160-205%

*Estimated from data gathered by DMHMRSAS and DSS for the 1988 report, *Aftercare Needs of Mentally Disabled Clients in Adult Homes.*

Source: *Homes for Adults in Virginia*, JLARC 1979; *Aftercare Needs of Mentally Disabled Clients in Adult Homes*, DMHMRSAS and DSS 1988; and DSS Division of Financial Management, Auxiliary Grants Program Cases/Expenditures Report, FY 1990.

Second, the adult home system has grown as a result of continued federal and State efforts to reduce the costs associated with medicaid-funded placements in nursing homes. Stricter pre-admission screening requirements have been implemented to ensure that medicaid placements in nursing homes are appropriate.

More recently, increases in the elderly population and their need for long-term care have also contributed to the growth of adult homes. The Joint Subcommittee on Health Care for All Virginians estimated in their 1990 report that about 677,000 Virginians are over the age of 65. The report estimated that about 22 percent of this group are impaired to some degree, and about five percent of the impaired group live in adult homes.

The Joint Subcommittee's report further suggests that the demand on the adult home industry to serve the impaired elderly will increase. An increase of 40 percent in the number of elderly Virginians is expected during the next 20 years. And, according to the Center for Gerontology at Virginia Polytechnic Institute and State University, the number of impaired elderly will increase by about 49 percent during that time.

Characteristics of the Adult Home System

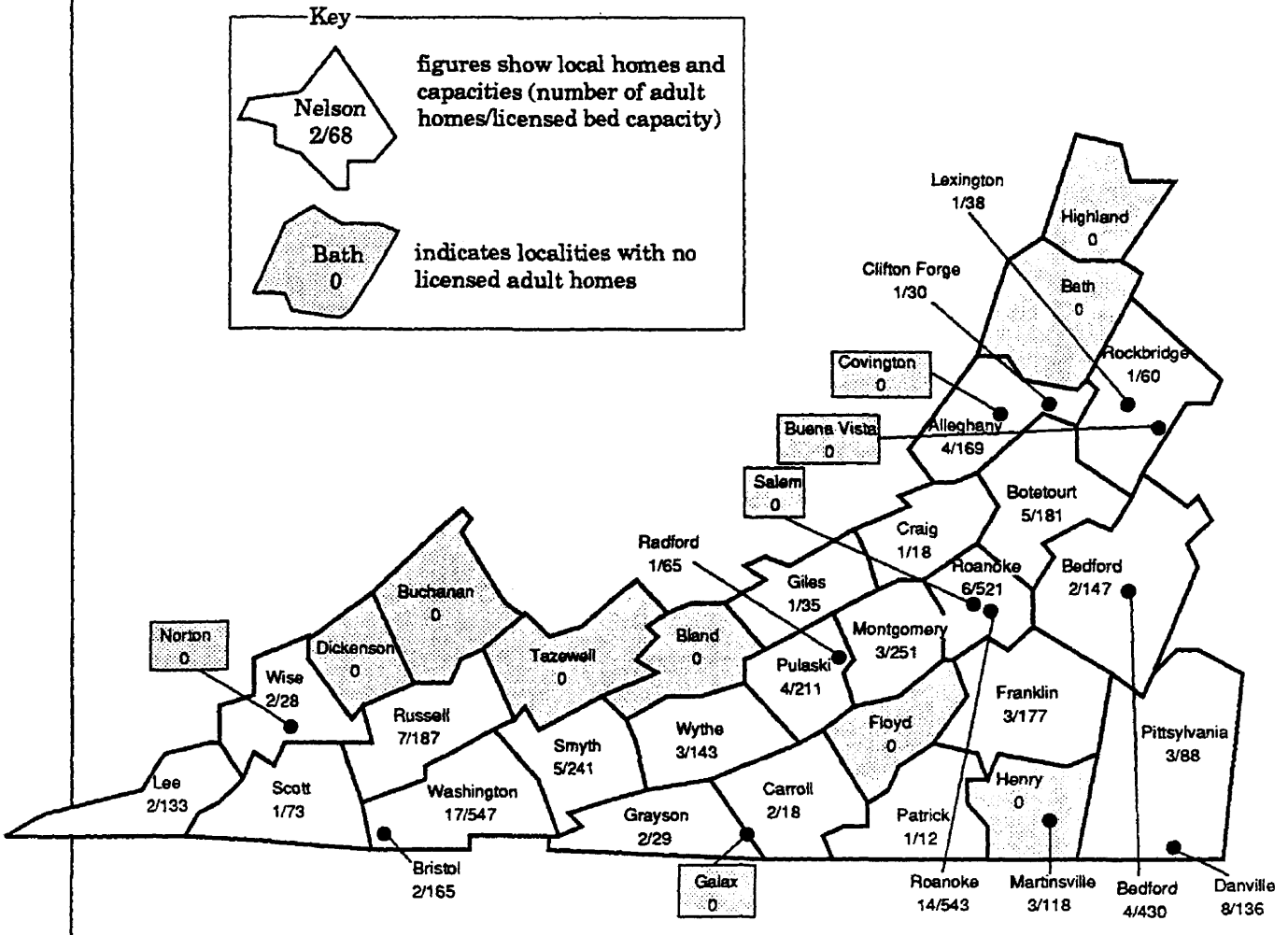
In FY 1990, 470 licensed adult homes provided care to adults across Virginia (Figure 2). These adult homes provide a diverse system of care to their residents. This diversity is partially due to the broad nature of the current statutory definition of adult homes. Homes for adults are defined by §63.1-162 of the *Code of Virginia* as "any place, establishment, or institution, public or private, including any day-care center for adults, operated or maintained for the maintenance or care of four or more adults who are aged, infirm, or disabled." Although the current definition of an adult home includes adult day care centers, the Department of Social Services has developed separate licensing standards to regulate these centers. This broad definition of adult homes has resulted in a wide range of facilities (Exhibit 2).

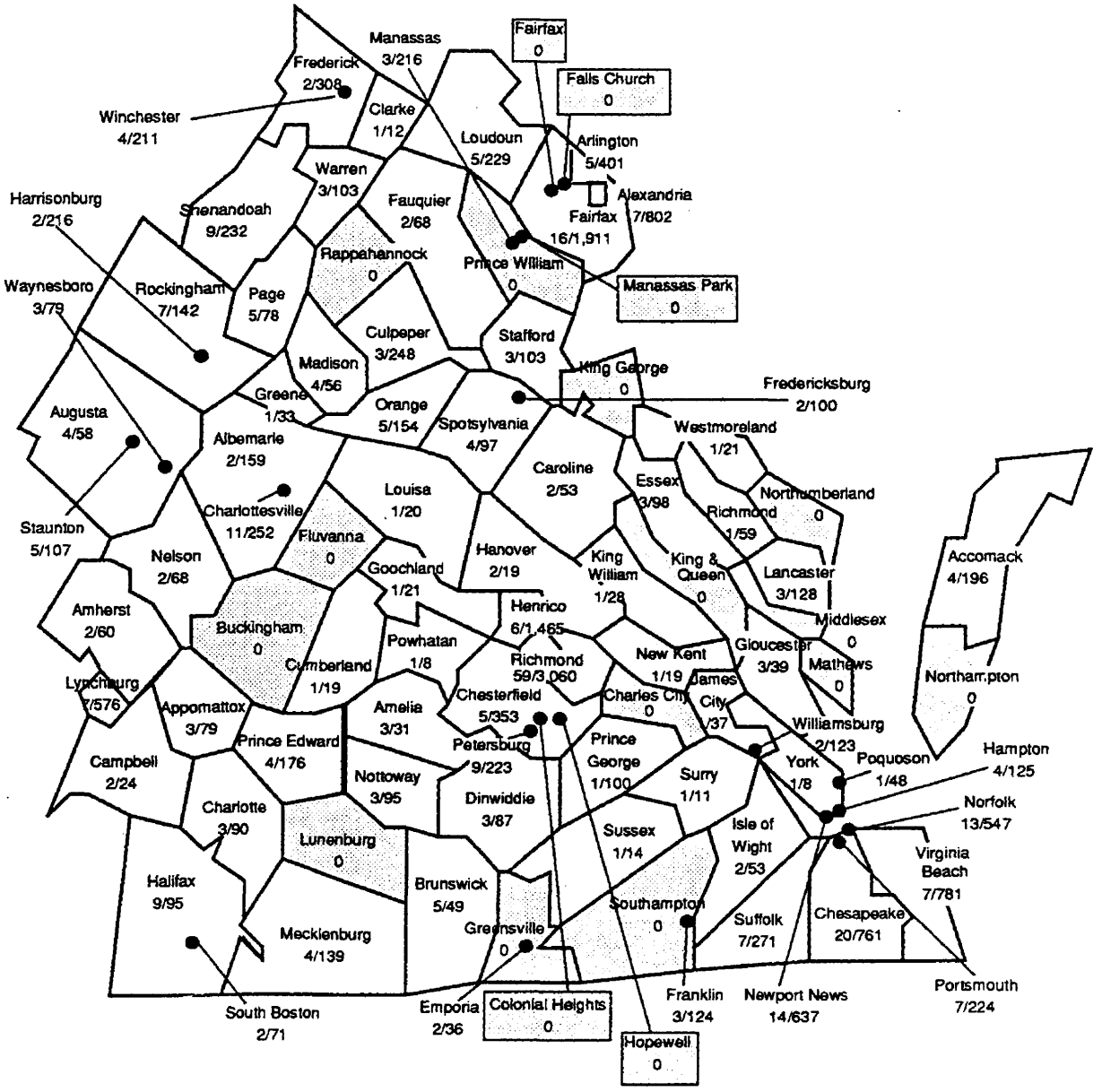
Variation in adult homes is evident in the size of the homes, types of residents admitted, services provided, and staff employed in the homes. About one-half of the licensed adult homes have a capacity of less than 50 beds. Some of these facilities are small and provide a very homelike environment for residents who need only basic supervision and assistance. In some cases, these adult homes are the primary residence of the owner, who lives in a portion of the facility and is also the primary provider of care for the residents.

During the last ten years the industry has witnessed growth in the number of homes with more than 50 beds. Some of these homes provide more intensive and specialized services to individuals suffering from a wide range of medical or mental impairments. In addition, some of these homes employ staff that are highly trained, skilled professionals.

Figure 2

Location, Capacity, and Number of Adult Homes in Virginia





Source: DSS Division of Licensing, Licensed Caseload File, July 10, 1990.

These larger, newer facilities may be specially constructed or renovated to accommodate the special needs of residents. Some of these facilities, observed during JLARC site visits, had alarms on the doors to alert staff to resident movements, centrally located nurses' stations, sophisticated call systems for residents to use in notifying staff of the need for assistance, and state-of-the-art fire protection systems including alarms and sprinklers.

A diverse group of residents are cared for in adult homes. Residents may be mentally or physically impaired, young or old, and come from any number of ethnic or racial backgrounds. Approximately 5,200 residents are post-hospitalized (deinstitutionalized) clients. About 5,700 residents received State auxiliary grant benefits in FY 1990 to help pay for their care in adult homes. This diversity was evident in field visits to adult homes during the spring and summer of 1990.

One adult home had 47 residents, who ranged in age from 25 to 77. Several received auxiliary grants and had been recently discharged from mental health and mental retardation facilities. One 32-year-

Exhibit 2

Profile of Licensed Homes for Adults

- **470 licensed homes statewide**
- **total licensed bed capacity statewide is 22,538**
- **range in size from 4 to 635 beds**
- **average size is 48 beds**
- **337 homes have a licensed capacity of 49 beds or less**
- **occupancy rate is approximately 83%**
- **332 homes have an approved auxiliary grant rate**

Source: DSS Division of Licensing, *Licensing Statistical Report, Licensed Caseload File,* July 10, 1990, and Division of Financial Management data from adult home cost reporting forms, June 25, 1990.

old male resident was mentally retarded and was diagnosed as a schizophrenic. He received an auxiliary grant to pay for domiciliary care services.

* * *

Male and female residents in one small adult home were mentally retarded and ranged in age from 27 to 31. At the time of the field visit, none of the residents received auxiliary grants to pay for their domiciliary care. All residents worked during the day at a local training center and paid for part of their domiciliary care with their earnings.

* * *

One adult home had 97 impaired elderly residents. These residents ranged in age from 62 to 98. One female resident was 70 years old. She had had a stroke and also had several other physical impairments including hypertension and diabetes.

Adult Home Resident Placement Process

Placement in an adult home may be due to a need for assistance with activities of daily living such as walking, climbing stairs, medication management, or dressing. Often, adult home placement for the mentally disabled is the result of the need for supervised housing. Individuals are referred to adult homes for placement by a variety of sources, such as families, doctors, State mental health and mental retardation facilities, local social service agencies, and local community services boards (CSBs).

The placement process begins with an individual's physical examination, which is required by licensing standards prior to acceptance into an adult home. This serves as an initial assessment of the physical needs of the individual to ensure appropriate placement. Placement is also contingent on meeting DSS-established admission criteria, individual needs assessments, and continuous monitoring of an individual's needs.

When auxiliary grant recipients are placed in adult homes, local social service agencies do not assess the appropriateness of placement or whether client needs can be met in the home. Often these clients are already residing in homes, because a grant cannot be approved unless the client is a resident of a home for adults.

Resident Admission Criteria for Adult Homes. Admission criteria for residence in adult homes are primarily outlined in DSS adult home licensing standards. In order to be admitted into an adult home, the individual must meet the following criteria:

- be at least 18 years of age,
- not be bedfast at the time of admission,
- be free from tuberculosis in a communicable form, and
- not be in need of nursing care at the time of admission.

In addition, the adult home must be able to meet the individual's needs.

Nonambulatory and semi-mobile persons may be admitted into adult homes if licensing standards are met. In addition, adult homes must meet the building requirements necessary to house nonambulatory or semi-mobile residents before they can be admitted. According to DSS licensing standards,

> "Semi-mobile" means the condition of a person who is:
>
> 1. Mentally and physically capable in an emergency of always exiting within three minutes from any area of the home available to semi-mobile residents with the help of a wheelchair, walker, cane, prosthetic device, or with the aid of [sic] single verbal command; and
>
> 2. Able to ascend and descend stairs (if present) in any necessary exit path from areas available to semi-mobile residents.

Nonambulatory is defined by the DSS standards as "the condition of a person who, because of physical or mental impairment, requires an assisted exit from the building in an emergency."

Existing homes which admit nonambulatory residents currently are not required to have automatic sprinkler systems. Regulations effective October 1, 1990 require newly constructed adult homes to have automatic sprinkler systems if the facility will care for more than five residents. Proposed regulations requiring existing adult homes to retrospectively install sprinklers are pending due to concerns about the financial impact on homes primarily caring for auxiliary grant recipients. In addition, the regulations require adult homes to have smoke detectors, fire protective signaling systems, and automatic fire detection systems by August 1, 1994.

Persons who are bedfast cannot be admitted into adult homes. However, if a person becomes bedfast after being admitted into an adult home, he or she may continue to reside in the home if certain conditions are met. Bedfast is defined as "the condition of a person, as certified by a physician, who is confined or restricted to bed for a prolonged or indefinite period of time." Residents who become bedfast after they have been admitted to an adult home may continue to reside in the home if:

- a physician determines that nursing care is not needed,

- the resident's needs can continue to be met in the home,

- physician progress notes are obtained every 90 days,

- qualified staff are on duty 24 hours a day to meet the needs of the bedfast resident, and

- building requirements for housing nonambulatory residents are met.

DSS has also set forth standards guiding the admission of post-hospitalized persons. Adult home licensing standards define a post-hospitalized individual as any person who is an "aged, infirm, or disabled adult who is being discharged from a state program for the mentally ill or mentally retarded and for whom direct placement is sought in a home for adults...."

DSS licensing standards require homes admitting persons from a State program for the mentally ill or mentally retarded to enter into written agreements with the local CSBs, or with private mental health or mental retardation service providers, to make services available to these residents. Adult homes are currently not required to have staff with specialized training or experience in dealing with the mentally ill or mentally retarded in order to admit these types of residents.

Adult Home Resident Needs Assessment and Monitoring. Adult home licensees are required to assess the service needs of prospective residents prior to admission and to monitor the changing needs of residents. This initial needs assessment is required for several reasons. First, the adult home owner or administrator must assess whether the prospective resident's needs can be met by the home. If the identified needs cannot be met by the home, the individual cannot be admitted. Second, the assessment is used to develop individual service plans for residents upon admission. Finally, the assessment provides a baseline for reassessing resident needs and redetermining whether or not the adult home can continue to meet those needs.

Adult homes are required to reassess residents' needs and reevaluate their service plans on a continuous basis. This is required so adult homes can monitor the changing condition of residents and ensure that their needs are met. At a minimum, licensing standards require homes to update the needs assessments and service plans at least once a year from the date of an individual's admission to the home.

The process to assess and monitor residents' needs has been criticized in the past. Ernst & Whinney concluded in 1985 that the "ongoing assessment rests primarily with the licensee who 1) may not be skilled in recognizing the needs of the elderly and/or disabled and 2) has financial incentives which may conflict with the client's best interest." In addition, the report also stated that the DSS licensing specialist may also lack the skills needed to evaluate whether the resident needs assessments, and whether service plans are appropriate for the individual. The 1988 DMHMRSAS/DSS report also noted that some mentally disabled residents were not receiving needed services in adult homes.

Measures Are Needed to Ensure Appropriate Client Placement

The service delivery system needs to be strengthened by the implementation of specific measures to ensure appropriate client placements and to ensure the needs of residents are met. Proper placement ensures that the needs of adult home residents are identified, and that a link exists between the needs assessment, service provision, and the auxiliary grant payment process. Placement of residents into adult homes has been a continuing source of debate since 1979.

Several reports over the last ten years have recommended improvements in the placement process, especially for residents receiving auxiliary grants. In 1985, Ernst & Whinney concluded that increased controls were needed in the placement process to ensure residents' "needs are met in the most appropriate setting." Concerns were raised in the 1985 report because "a relevant, useful plan of care may not have been outlined by the physician..." and the adult home operator may not be qualified to assess appropriate placement. In addition, the report noted that an adult home operator's financial interest may conflict with the individual client's need for appropriate care. The 1987 Report on Long-Term Care recommended that auxiliary grants "be contingent on preadmission assessments and assignment of a case manager."

Client Placement Continues To Be Uncontrolled. Currently there is no DSS policy to ensure adult home placements are appropriate and cost effective. When local social service agencies make adult home placements, the only assessment that is made is to determine financial eligibility for the auxiliary grant. Several reports in the last ten years have discussed the importance of controlling the placement process for adult home residents.

Currently placements and needs assessments are determined for many public assistance recipients by adult homes, whose staff may not have the expertise to make these assessments. Interviews with adult home operators and DSS licensing staff revealed that confusion exists regarding the use of resident needs assessments and the development of service plans. While recognizing the importance of this process, many admitted that the process used now is little more than an attempt to satisfy documentation requirements of the licensing standards.

Ernst & Whinney cited the need for a comprehensive coordinated placement process in 1985. They proposed: (1) the development and use of a community-based assessment tool to assess client needs, (2) the development of guidelines for auxiliary grant recipient placements, and (3) more detailed admissions criteria for adult homes. In their 1988 study of aftercare needs of adult home residents, DMHMRSAS and DSS also proposed the use of an assessment or screening procedure to use in making appropriate placements. This was also proposed as one method to ensure that the ongoing needs of adult home residents are met by the homes.

DSS Efforts to Address Client Placement Problems. DSS has been involved recently with the Long-Term Care Council in developing the policy and implementation guidelines for a statewide case management system for elderly Virginians. The

General Assembly appropriated $3 million to support this development in FY 1992 in four localities. As a result of budget reductions, $2 million will be used to develop the case management system, and the pilot project will be tested in three localities instead of four. The case management system will include the development of a uniform assessment process for clients. This process will use a standardized assessment instrument to identify a client's total needs and match the client with appropriate services in the community.

DSS developed regulations for an assessment process to be used in local social services agencies. These were published in the *Virginia Register of Regulations* in April 1990. The regulations contained provisions that local social service agencies use a standardized assessment instrument for the initial needs assessment and reassessment process for applicants/recipients of adult services and adult protective services. Use of the assessment instrument for auxiliary grant recipients in adult homes was to be optional.

These regulations were rescinded by the State Board of Social Services in July 1990 due to fiscal constraints in developing the assessment instrument and the potential cost impact of establishing the assessment process. DSS staff estimated that implementation of the process would require an additional 100 service workers in local agencies statewide.

DSS hopes to continue with the development of a standardized assessment instrument if funds are available. If the instrument can be developed, the department is proposing to test it in localities selected as pilot projects for the case management system which the Long-Term Care Council is developing.

Changes Are Still Necessary for Adult Home Placements. The assessment of client needs and development of appropriate service plans are critical in the adult home placement process to ensure that State funds are spent appropriately for auxiliary grant recipients. Changes are necessary for the adult home system to appropriately provide needed services to residents who need adult home care and specific services while in the adult home setting. While changes in the regulatory and funding systems (which are discussed in detail in Chapters III and IV) will help, the first step needed is the implementation of a comprehensive client placement process.

The placement process could have two steps. The first step should be an assessment of a client's need for adult home care during the auxiliary grant application process by local social service agencies. Currently, only financial and some categorical eligibility requirements are assessed at the time of the application and during annual reassessments. It may be necessary to involve more than one local agency in assessing the client's needs. Local social service agencies, local departments of health, and CSBs could be involved.

If placement in an adult home is determined to be appropriate, the second step would then be to determine whether the type of care needed can be met in an adult home regulated to deliver a specific level of care. This second step would ensure that

the needs of the client are assessed by an independent third party and appropriate care is provided to the individual.

Recommendation (1). **The Secretary of Health and Human Resources should pursue the development of a client needs assessment instrument and process for use in placing and monitoring auxiliary grant recipients in adult homes. This could be incorporated into the pilot project currently being developed by the Long-Term Care Council for use with elderly Virginians. The Department of Social Services,the Department of Health, and the Department of Mental Health, Mental Retardation and Substance Abuse Services should be involved in this development.**

RECONSIDERING THE ROLE OF HOMES FOR ADULTS

The appropriateness of the role of homes for adults in providing maintenance and care to aged, infirm, or disabled populations has been a source of concern to many in the past ten years. Studies of the adult home system since the JLARC report have focused on the structure of the overall adult home system and its relationship to the quality of resident care. Questions have surfaced on: (1) how the adult home system fits into the structure for providing a continuum of care to the mentally disabled and impaired elderly and (2) how the structure and service delivery system can ensure that the needs of residents are met.

It is clear that the role of adult homes has changed since 1979 to provide care to residents with more serious mental and physical impairments. However, the regulatory and funding systems have not kept pace with these changes. As a result, system-wide changes are necessary to ensure all adult home residents have adequate protection and care.

Role of Adult Homes in Providing A Continuum of Care

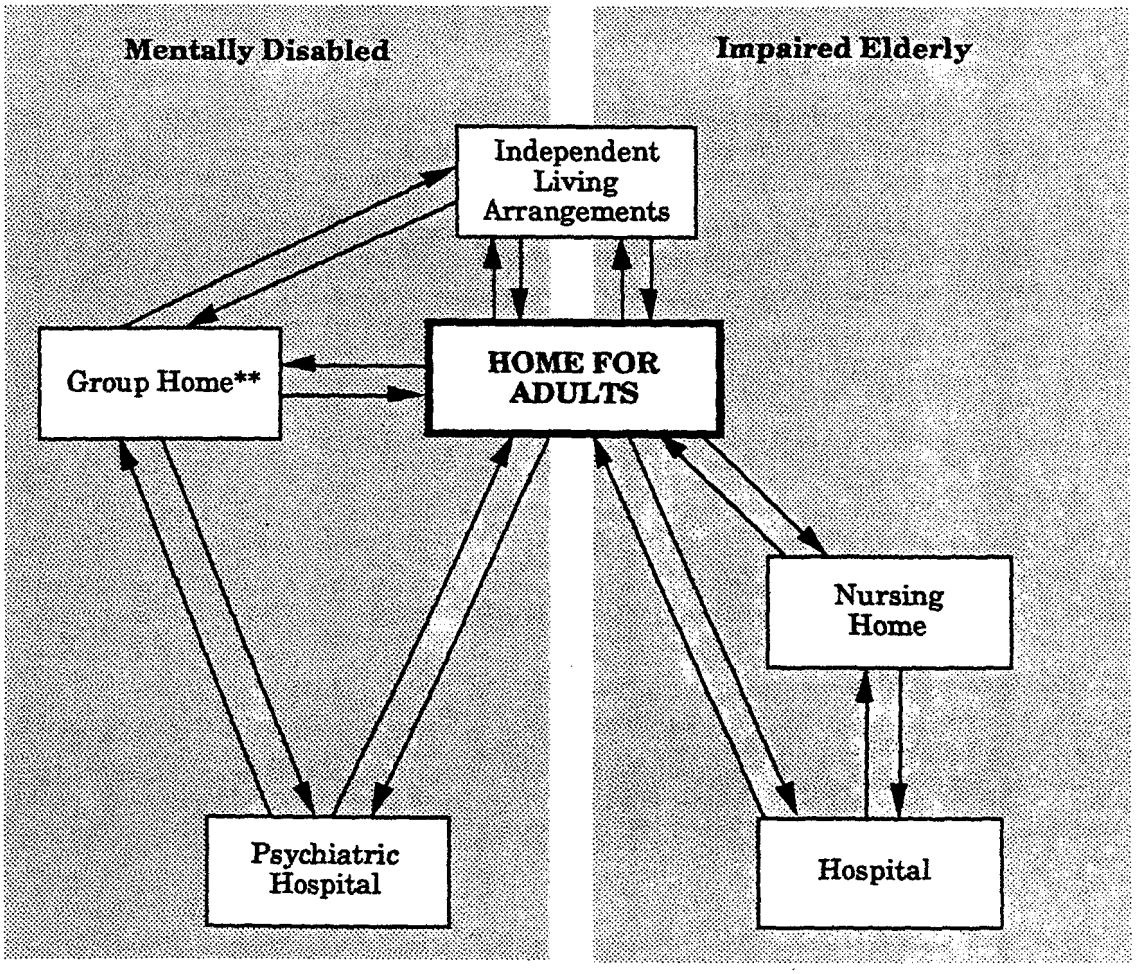
The adult home system can be thought of as one alternative setting for providing care to the mentally disabled and impaired elderly. The least restrictive setting for providing care to these populations would be their own homes and the most restrictive would be an institution such as a hospital or nursing home. Figure 3 illustrates how adult homes currently fit into the continuum of care for the mentally disabled and impaired elderly populations.

The concept of a continuum of care within the community is not a new one. The 1986 JLARC report on *Deinstitutionalization and Community Services* defined a continuum of care as:

> the availability of a range of alternative services to meet the treatment needs of different populations and the changing treatment

Figure 3

Placement of Adult Homes in the Continuum of Care for the Mentally Disabled and Impaired Elerly



*Continuum of care refers to the range of alternative settings available to allow individuals to receive needed care in the least restrictive environment. Individuals may move between settings depending on their need for treatment and care.

**Group homes for the mentally disabled are generally operated by Community Services Boards and may provide extensive mental health services for their residents.

Source: JLARC staff graphic.

needs of clients. The continuum of care should make available to each client the appropriate treatment, training, and care in the least restrictive environment.

In the past, homes for adults have served as a first level of care for many elderly individuals no longer able to live in their own homes. For the mentally disabled, adult homes often have served as the first level of care for clients released from State mental health or mental retardation facilities. Originally only basic services such as room and board, general supervision, and personal care were provided within these homes. In response to changes in the needs of residents, the adult home service delivery system has diversified. Some adult homes now provide additional services to meet the specialized needs of residents.

More recently, questions have been raised about how adult homes are functioning as part of the continuum of care. The continuum of care concept implies that appropriate treatment is available at each level to meet client needs. Homes for adults, however, are charged with providing maintenance and care which may not be construed as treatment. Maintaining an individual's well-being and providing treatment and/or rehabilitation may not be viewed as similar charges.

This problem could be further exacerbated because many residents do not move on to a different level of care after they establish residence in an adult home. Many homes see their role as long-term care providers to residents as they age. This has led to questions about the adequacy of adult home care as the health care needs of some residents become more complex and severe. In addition, some professionals in the mental health field believe that mentally disabled residents are not linked with the necessary rehabilitative/treatment services by adult homes to enable them to eventually transition to a less restrictive setting in the community.

The role adult homes play in the care for the mentally and physically disabled has never been formally established. Instead the system has grown without formal planning to determine how it should fit into the overall system of long-term care. As a result, the regulatory system has been unresponsive to changing needs of the adult home system and the funding system is under increasing pressure to provide more resources for services to eligible residents.

The Role of Adult Homes in Caring for the Mentally Disabled. Adult homes have become a primary provider of long-term care for many mentally disabled adults upon discharge from a State mental health or mental retardation institution. Mentally disabled post-hospitalized clients make up about one-quarter of all adult home residents. Nevertheless, the provision of services to this group in adult homes has been cited as deficient by JLARC in 1979 and 1986, Ernst & Whinney in 1985, and DSS and DMHMRSAS in their 1988 report on aftercare needs of adult home residents.

Several recommendations have been presented over the last ten years to improve services to this group of adult home residents. Ernst & Whinney recommended two alternatives to address the needs of mentally disabled individuals. One

alternative was to narrowly circumscribe the role of adult homes by restricting admissions while making funds available for this group to be used in other residential treatment programs. Another alternative was to continue to allow adult homes to serve a diverse population by developing a structure to ensure that providers deliver appropriate services and that they are regulated and compensated accordingly.

In 1988, DMHMRSAS and DSS recommended a voluntary certification process for homes serving the mentally disabled. Certification would require the provision of a higher level of services. In return, providers would be compensated through the establishment of an aftercare grant for each mentally disabled resident served. In addition, they recommended stronger linkages to the community mental health system through supplemental service plans developed by the adult homes and CSBs.

Some of these recommendations have not been implemented due to a lack of available funding. Services to this resident population continue to present problems. JLARC staff observed several homes during 1990 which appeared to be "mini-institutions" for the mentally disabled. However, these facilities lacked specialized staff and programs to address the needs of these residents. In addition, service linkages between the homes and local CSBs were weak.

> *One adult home visited by JLARC staff cared primarily for mentally disabled residents. The home had a capacity of 16 residents. The home had a census of 16 residents at the time of the visit. All were auxiliary grant recipients.*
>
> *The home employed two full-time staff and one part-time staff person. These staff had not received any formal training or education in the care of mentally ill or mentally retarded persons. At the time of the visit, the staff member on duty was in another part of the home cooking his meal. Rat poison was also observed in open containers on the floor of an open office.*
>
> *Several months after the JLARC visit, an argument between two residents resulted in one resident being stabbed and the other being badly beaten during the night. The staff person present in the home was not required to be awake during the night since the home had a licensed capacity of less than 20. DSS regional licensing staff determined that the call system in the home was not working so the staff member who was sleeping was not alerted to the problem.*

The Role of Adult Homes in Caring for the Physically Impaired Elderly. Adult homes are also a primary provider of long-term care for the physically impaired elderly. Adult homes were originally designed to provide care for those who need a general level of services, such as room, board, supervision, and assistance with daily living activities. Increasingly, however, they are providing more extensive medical-type services to residents who do not progress to facilities providing higher levels of

care. Many adult home operators stated in interviews that they are beginning to admit and care for older and more frail clients.

Data collected from three adult home associations representing about 40 percent of the industry illustrate the role of adult homes in providing care to the physically impaired population. Approximately 47 percent of these associations' members reported serving about 575 residents who were either nonambulatory or bedfast. In addition, about 42 percent of these homes housed more than 200 residents who required the use of bedrails, supportive restraints, feeding tubes, oxygen, or catheters.

System-Wide Changes Are Necessary to Address the Role of Adult Homes

Reports on the adult home system have repeatedly questioned whether adult homes are appropriate settings for mentally disabled individuals as well as some physically disabled adults. Regardless of one's position on this question, it is important to realize that, in fact, adult homes have become a primary source of long-term care for these groups. The statutory and regulatory framework for the system does not recognize this changing role of adult homes, however. Consequently, system-wide changes are necessary to address the problems facing the current adult home system of care.

The following chapters lay out specific methods to recognize the changing role of adult homes by restructuring the regulatory and funding systems. Chapter III describes how the current regulatory system can be modified into a tiered system to address the current role of adult homes in providing care to various impaired groups. In addition, specific proposals are set forth on how current regulatory deficiencies can be addressed by restructuring the system.

Chapter IV describes weaknesses in the adult home funding system. Recommendations are outlined on how the funding system can be improved to better serve adult home residents. It also provides a description of how the current funding system can be linked to changes in the regulatory system to address varying levels of care provided to adult home residents.

III. Regulation of Homes for Adults

The State has regulated homes for adults since 1954. Since that time, regulation has been the responsibility of the Department of Social Services (DSS) or its predecessor agencies. The goal of licensing and monitoring homes for adults is to protect the health, safety, and well-being of their residents. This protection is particularly important for adult homes since regulatory authorities may be the only outside entity concerned with resident care that enters the homes on a routine basis.

An assessment of the regulation of homes for adults indicates that the licensing structure has failed to adequately address the increasingly debilitated condition of residents within adult homes and to establish the requirements needed to safeguard all resident populations. DSS should institute significant changes to ensure that all types of resident populations are properly protected through licensure. The needs of diverse adult home populations must be better recognized by a tiered system of licensure which addresses distinct levels of care. In terms of regulating adult homes, this will require major restructuring of the State's licensing framework.

In addition, existing standards will need to be strengthened to provide a sound basis for structuring the tiered system. This will require comprehensively revising licensing requirements and strengthening enforcement capabilities. With these improvements, the licensing function can be retained within the Department of Social Services.

REGULATION IS CURRENTLY INADEQUATE FOR ADULT HOMES

The deinstitutionalization of mentally disabled clients and restrictions on placements in nursing homes have resulted in a significant number of individuals returning to or remaining in the community. Suitable housing alternatives for many of these mentally and physically impaired individuals have been limited. Over time, the adult home industry has expanded to fill this gap for a significant number of these impaired groups. This expansion has occurred with little planning or direction, however. Many homes that have accepted deinstitutionalized clients or the physically impaired elderly have been ill-prepared to care for their new residents. The 1985 study by Ernst & Whinney on the Auxiliary Grants Program made the following observation regarding the care of mentally disabled in homes for adults:

> Some homes are already specialized into quasi-psychiatric facilities without benefit of special regulatory protection, adequate funding for special services, special staffing or the programming that this population needs. There are gaps in the State's present system of residential services which Homes for Adults are attempting to fill.

Despite the changing nature of care required for many adult home residents and the expanding role of some adult homes, licensing standards have remained relatively unchanged. Standards, which were generally designed to regulate the provision of basic domiciliary and supervisory care for mildly impaired residents, have not been revised to account for the increasingly debilitated condition of residents. Licensing standards do not address the conditions of the residents that may be cared for in adult homes; the numbers, qualifications, or training required of staff in homes caring for more seriously impaired populations; or many of the "specialized" services needed by impaired residents. An example of some of the problems which occur as a result of inadequate licensing standards is the following:

> *A home health care nurse found that a resident she visited in one adult home had to be cleaned of fecal matter on six of the seven days she visited to change his catheter bag. The nurse also found that the bag had leaked because it had not been changed properly and that a buildup of mucous was present.*

If current trends continue, the adult home system will experience substantial growth and the current problems could worsen. In the future, additional demands may be placed on the system as (1) mental health needs of individuals with serious mental illnesses increase and overshadow growth in housing and treatment options, (2) demographic changes result in an increasing number of impaired elderly who have growing needs for long-term care, and (3) health care costs increase, necessitating cheaper long-term care alternatives. If the current regulatory system does not address changes affecting the care of residents in adult homes, the State will be left with a system of care that is even more inadequate and uncontrolled.

The Regulatory System Should Recognize Different Levels of Care

Currently the most critical problem facing the adult home system is the provision of care to residents with significant mental health or medical needs. One set of licensing standards applies to all homes for adults regardless of the services provided or the level of resident functioning. These standards do not adequately address quality of care issues for residents who may have physical disabilities requiring the use of oxygen, catheters, feeding tubes, or complicated medication management. In addition, the standards do not adequately address the service needs of mentally disabled residents. Consequently, the primary goal for regulating homes for adults — the protection of adults in care — is not adequately addressed by current licensing standards.

Changes in the licensing function are needed to protect adult home residents, particularly those with significant mental health or physical problems. This could be accomplished by establishing several regulatory tiers that reflect the different levels of care being provided and by strengthening standards to provide increased protection for all residents.

DSS first needs to determine which mental health and medical conditions may be properly cared for within an adult home. This should be determined with assistance from the Virginia Department of Health (VDH) and the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). Once the allowable conditions have been determined, the State Board of Social Services will need to promulgate separate licensing standards that will provide adequate protection for mentally and physically impaired residents. In addition, the standards that apply to all adult homes need to be comprehensively reviewed to enhance the protection afforded all home residents.

The Need for Additional Standards for Some Impaired Residents Is Recognized. DSS is beginning to recognize the limitations associated with having one set of standards to license all adult homes. The 1988 report on *Aftercare Needs of Mentally Disabled Clients in Adult Homes*, conducted by DMHMRSAS and DSS, recommended the development and use of voluntary certification requirements for adult homes serving mentally disabled residents. More recently, a DSS policy paper, "The Changing Role of Homes for Adults in Virginia's Evolving Long-Term Care System," stated:

> the statues [sic] need to be updated so that the services essential to support the philosophy of "aging in place" can be appropriately regulated within the various types of adult care facilities.

DSS has also begun developing a list of medical conditions which could preclude the placement of some physically disabled persons in adult homes. While DSS has taken some preliminary steps to address the problems associated with meeting the needs of mentally and physically impaired residents in adult homes, additional levels of licensing standards should be established.

House Joint Resolution 70 passed during the 1986 General Assembly session, directed DMHMRSAS and DSS to develop a model that would improve the services provided to mentally disabled residents of adult homes. These agencies recommended a model to provide better coordination between community services boards (CSBs) and adult homes, supplemental funding of approximately $1,800 for each mentally disabled resident, and voluntary certification of adult homes caring for mentally disabled residents. Although the supplemental funding was not approved, the two agencies have continued to develop a proposal for voluntary certification of homes caring for the mentally disabled. Preliminary standards for voluntary certification have been developed and address four broad areas: planning, administration and training, collaboration, and client advocacy. However, the certification process has not yet been implemented.

To evaluate the medical needs of current adult home residents, DSS staff are currently refining a nursing care indicator list. This list was developed in collaboration with representatives of VDH. The list outlines medical conditions which should not be cared for within an adult home. Exhibit 3 includes excerpts from a preliminary draft of the conditions being considered. A more final draft is expected to be presented

Exhibit 3

Preliminary Draft of Conditions Covered by the DSS Nursing Care Indicator List

Problems/Medical Procedures	Conditions that Would Be Permitted	Conditions that Would Not Be Permitted
Oxygen	• self administered, facility staff capable of monitoring for safe environment	• requires assistance, facility staff not trained to monitor for safety
Ostomy Care	• well healed, self care	• still requires post surgical care • requires assistance with care
Bowel Management	• intermittent self care or administered by a licensed, skilled medical professional	• requires assistance for regularly scheduled bowel management by skilled medical professional
Bladder Management	• intermittent self care or administered by a licensed, skilled medical professional	• requires assistance for daily management
Incontinence	• self care or requires assistance with application of incontinence pad	• requires bladder/bowel retraining • evidence of rash or redness secondary to incontinence
Contractures	• does not prevent or prohibit assistance with activities of daily living or mobility	• prevents performance of activities of daily living or mobility
Injections	• intermittent self care or administered by a licensed, skilled medical professional	• if required for daily management (exception - insulin) • injections directly into vein or intravenous drip
Wound Care	• self care or requires skilled medical care once a day or less	• requires 24-hour nursing care • exhibiting signs of infection or deterioration
Mobility	• independent in ambulation and mobility including use of assistive devices	• requires assistance with turning in bed, transfers, or to manage assistive devices
Communicable Disease	• inactive stages (no longer transmittable) • no threat to others	• active stage and presents a threat to others
Infections	• can be treated with self administered oral or topical medications	• requires intravenous antibiotics or monitoring by a skilled medical person > once a day • requires precautions or isolation measures
Physical Conditions	• medical stability • self care with medication	• requires frequent/recurrent hospitalizations resulting from medical instability
Behavior	• unacceptable behavior that responds to redirection • behaviors that do not prohibit performance of self care tasks (e.g. mildly confused)	• behaviors requiring behavioral restraints • behavior that infringes on the rights of other residents and impedes the ability of the home to provide a safe environment

Source: Quoted or paraphrased excerpts from July 1990 draft of Nursing Care Indicator List developed by DSS.

to the State Board of Social Services. The Board may mandate use of this or a modified list to exclude certain care from being provided in a home for adults.

While standards for voluntary certification and the preclusion of residents who are too seriously impaired to receive care in an adult home are good first steps, they do not go far enough. Additional sets of standards should be promulgated; one set of standards should apply to homes providing care to the mentally disabled and a second set should apply to homes caring for seriously physically impaired residents.

Other States Regulate Levels of Care. Several states regulate varying levels of care provided to the impaired elderly and the mentally disabled population. North Carolina and Maryland have regulations which address the differences in care provided to disabled residents of their domiciliary care facilities. Florida's regulatory system also recognizes differences in the level of care provided in domiciliary care facilities.

Three Levels of Care Could Be Regulated

Adult homes could be regulated through standards which recognize the delivery of at least three distinct levels of care. In visiting adult homes, three broad categories of resident populations were observed. These populations included residents who were mildly impaired, residents who suffered from significant mental disabilities, and residents with medical conditions requiring care and treatment.

The first level could be designated for facilities providing a basic level of care such as room, board, supervision, and assistance to residents with activities of daily living. The second level could be designated for facilities providing mental health and/or mental retardation services to mentally disabled residents and care for residents suffering from extensive confusion, memory loss, and/or dementia. The third level could be designated for facilities providing medical-type care to residents suffering from specific physical disabilities or impairments.

Regulating the Lowest Level of Care. The first level of care could continue to be regulated by licensure based on the current adult home standards with some modifications to address current weaknesses. These standards would be designated as the minimum, or core, requirements that all adult homes would be required to meet. This would ensure that the safety and well-being of the residents are protected and an adequate level of care is provided.

As with the current requirements, potential residents would have to undergo a physical examination prior to admission to determine whether their needs could be met in a home licensed under the standards for this first level of care. Current residents' needs would have to be reexamined. This could be done in conjunction with the implementation of the proposed placement and needs assessment process.

Regulating the Second Level of Care. The second level of care could be regulated by licensure based on the lowest level of care (or core) standards plus

additional standards that govern the care of those with mental disabilities. A second level of regulation for this care is necessary because these residents have special needs for supervision and services. Additional standards for the mentally disabled are also necessary because they may be particularly vulnerable due to the nature of their disability. For example:

> *One 43-year old male had a history of paranoid schizophrenia and had been discharged from a State psychiatric facility into an adult home. This home transferred him to another adult home in June of 1989 because he had a tendency to break things and wander. Since his transfer and admission to the second adult home, the resident wandered off several times to places such as Norfolk and Washington D.C.*
>
> *At the time of the JLARC site visit, the resident's sister had complained to DSS licensing staff that the facility lacked appropriate supervision to prevent her brother from wandering. He had been missing from the home for about three weeks before being found in a hospital in Baltimore where he had been hospitalized after spending five days in an emergency shelter there. Less than one week after returning to the home, the resident wandered off again. He showed up at another adult home two days later.*

Numerous instances of wandering by mentally disabled and other adult home residents are reported each year. Periods away from the home can be injurious to mentally disabled residents, as well as other residents, because they may go without necessary medication to manage their impairments. In addition, adult home residents could be subject to abuse while on the streets or exposed to severe weather conditions.

Mental health professionals and DSS licensing specialists have expressed concerns regarding the housing of the mentally disabled in adult homes and the need for additional safeguards for the care of these residents. These concerns include staff to resident ratios; mental health services provided; the adequacy of supervision over those who tend to wander; staff training regarding mental illness, mental retardation, and substance abuse; and medication management and control. Some mental health professionals believe that adult homes can provide adequate care to the mentally disabled if the licensing standards ensure that concerns regarding care are addressed. The owners and administrators of many adult homes also contend that they can provide adequate and cost effective care to this population.

Standards for this second level of care could incorporate requirements to address the needs of several types of mentally disabled residents, such as the mentally ill and mentally retarded, those residents who may be dually diagnosed, or residents who suffer from extensive confusion, memory loss, and/or dementia. According to the 1988 report of DSS and DMHMRSAS "the patterns of similarity among the mentally disabled HFA [home for adults] resident population suggest that differential levels of care may not be necessary to meet service needs." This suggests that a single set of standards addressing the care needs of the mentally disabled population could be

sufficient to regulate care provided to the mentally ill as well as the mentally retarded. The standards could be oriented more towards the need for adequate and appropriate levels of service, staffing, and training to assist these adult home residents. The voluntary certification requirements developed by DSS and DMHMRSAS for adult homes providing care to the mentally disabled could provide the basis for the additional standards.

Standards for this second level of care could also expand the current definition of who would be provided services. Current adult home standards define "post-hospitalized" residents as those who have been recently released from a State institution. CSBs are required to provide follow-up or aftercare services only to this group. The 1986 JLARC report on *Deinstitutionalization and Community Services* recommended expanding this definition. This definition should be expanded to include anyone with a history of mental disability within the previous five years. This would help to ensure that residents needing services and care receive them.

Licensing the Highest Level of Care. The highest level of care could be regulated by licensure based on the "core" standards plus additional standards. These added standards could address the quality of health care provided residents who have additional physical health needs requiring medical-type services.

Regulations guiding a higher level of care are necessary for several reasons. First, a number of adult homes provide medical-type services to their residents already. DSS regional licensing staff have identified 33 adult homes statewide that provide a higher level of care to their physically impaired residents. The care needed by these residents may be quite extensive due to their medical conditions, although not extensive enough to qualify the residents for nursing home care. For example:

> *One 91-year old woman residing in an adult home visited by JLARC staff had experienced a stroke. She was unable to walk and had also been diagnosed as having hypertension, coronary artery disease, an aortic valve block, and very mild dementia. Her condition warranted the use of bedrails which were authorized by her physician.*
>
> * * *
>
> *At another adult home, one resident had suffered a hip fracture and was unable to walk. The resident also was diagnosed with dementia and hypothyroidism. This resident's physician had authorized the home's use of supportive restraints to help the resident sit upright in a chair due to her physical condition.*

Many of these homes employ registered nurses, licensed practical nurses, and certified nurse's aides to provide the necessary medical care to their residents.

Another reason regulation is needed for this level of care is to ensure that standards and/or procedures are in place to determine at what point care in an adult

home is inappropriate and should not be allowed. Currently, as long as the resident's physician checks a statement on the medical examination form stating the resident's needs can be met in an adult home, care is allowed.

The standards could be developed with assistance from VDH to determine what would be included in licensing standards for this level of care. The conditions covered would not include those which require care from a skilled nursing facility or intermediate care facility (both commonly referred to as nursing homes and licensed by VDH). This would ensure there is no duplication in services provided by nursing homes and homes for adults. These standards could contain criteria outlining the types of disabilities which would require a higher level of care as well as criteria for determining when the level of care provided is inappropriate for the facility. The standards could address staff experience and training, staff to resident ratios, and conditions under which the care would be provided.

As mentioned earlier, DSS has already enlisted the help of VDH in developing a list of medical conditions which would preclude placement and care in an adult home. While the list is not final, it could be used as the basis for determining what services would be allowed in homes licensed to provide medical-type care. With additional standards for care, it is possible that the list could be expanded to allow the presence of certain medical conditions that DSS is currently considering to exclude from adult homes.

As with the first and second level of care, the physical examination along with the proposed placement and needs assessment process could be used to determine the resident's health and service needs. In addition, annual check-ups and needs assessments could be used for ongoing monitoring of the level of care needed by the individual.

In order to effectively enforce the standards, DSS will need assistance from VDH to assess quality of care. DSS licensing specialists currently do not have the expertise needed to evaluate quality of care for medical conditions. During JLARC field visits, licensing staff expressed reservations about their ability to make this type of assessment.

DSS could implement an interagency agreement with VDH for their licensing staff to assess the quality of medical care provided in homes licensed under standards for this higher level of care. This would be similar to the agreement DSS has with VDH for food service inspections. DSS licensing staff would continue to enforce the core standards and those standards not directly related to the quality of medical care provided by the facility. VDH would enforce the standards addressing the quality of medical care provided by the facility.

Redesigning the Licensing Standards. Several steps will be necessary to redesign the licensing standards to address the different levels of care provided in adult homes. First, standards will need to be drafted for each level. For higher levels of care DSS will need to collaborate with other agencies, such as DMHMRSAS and

VDH, in developing the standards. The State Board of Social Services will then need to promulgate the new standards.

Given the populations currently served by adult homes, at least three levels of standards appear appropriate. The first set of standards should cover the minimum or core licensing standards required for all homes for adults to operate in Virginia. These homes could be designated as adult residential care facilities to reflect the lower level of care provided to residents.

The second set of standards should cover a higher level of care to be provided to mentally disabled residents. These standards should specifically define mentally disabled residents as those individuals who have had a history of mental disability within the last five years. The voluntary certification standards developed by DMHMRSAS should be used as the basis for these standards. In addition, DSS and DMHMRSAS staff should collaborate in any further modifications to the standards. DMHMRSAS staff should provide training for DSS staff on how to evaluate the care provided to mentally disabled residents. These homes could be designated as specialized residential care facilities to reflect the higher level of care provided to residents.

The third set of standards should cover medical-type care provided to some physically disabled adult home residents. These standards should delineate the medical conditions that can be cared for in adult homes. DSS and VDH should collaborate in the development of these standards. They should establish an interagency agreement to have VDH staff evaluate the quality of the medical care provided residents in homes licensed under these standards. These homes could be designated as medically supervised residential care facilities to reflect the more intensive health care services provided to residents.

Recommendation (2). **The Commission on Health Care for All Virginians should consider directing the Secretary of Health and Human Resources to develop a plan to comprehensively revise the statutory and regulatory framework for the adult home system. This plan should include the development of adult home licensing standards by the Department of Social Services for the different levels of care provided by adult homes. The plan should be presented to the Commission on Health Care for All Virginians prior to the 1992 session and should contain specific proposals for statutory and regulatory changes.**

Assessing the Cost to Regulate Three Levels of Care

There should be relatively few additional costs involved in regulating three distinct levels of care since DSS' procedures for licensing adult homes would not be significantly changed. There may be some increased costs due to the additional requirement for VDH inspectors to assess the quality of medical care in some adult homes, however.

DSS already has the structure and staff to implement and enforce licensing standards within its Division of Licensing. DSS is currently consolidating its regional structure from seven to five regions. This consolidation should allow DSS to redistribute its adult home caseload and reduce some adult facility staff costs. JLARC staff estimate the department's cost to regulate adult homes in FY 1991 to be about $824,000 with the implementation of this regional consolidation and subsequent cost-cutting measures.

DSS currently collaborates with DMHMRSAS and VDH in developing guidelines for standards of care and in conducting training seminars for adult facility licensing staff and adult home owners and administrators. These activities would need to continue and could be intensified for the period of time that the standards are being developed and during the first year of implementation. The cost to continue these activities should be negligible.

DSS licensing staff have estimated that 33 adult homes are currently providing medical-type services to residents. If a VDH inspector were to assess the quality of care in these facilities, one full-time position would be needed to make these assessments. This is based on an estimate by VDH. The estimated annual cost of the inspector position, including salary and fringe benefits, would be between $35,800 and $54,660.

For an adult home caring for about 50 physically impaired residents, the VDH licensing director indicated that it could take a week for an inspector to complete the initial evaluation depending on the quality of records and documentation. Assuming a worst-case situation, the initial evaluation of the 33 homes would require 33 weeks of the inspector's time during the first year. If the population of the homes remains fairly stable, however, the time required to make subsequent evaluations would be reduced. This time commitment (33 weeks) should decrease significantly in subsequent years.

The director estimated that a follow-up evaluation of a 50-bed home would take about 1.5 days (including time for travel and report writing) if established procedures were followed. A problem facility might require two days for a follow-up evaluation.

Standards To Protect Residents Should Be Strengthened

In promulgating new standards for different levels of care, the State Board of Social Services should seek to better protect residents in all proposed levels. The current standards for homes for adults became effective January 1, 1980. Although these standards have been revised five times since that date, they continue to only minimally protect adult home residents. This shortcoming was noted in interviews with DSS licensing staff, staff in local CSBs, and staff in other local agencies. Areas that should receive particular attention during the revision include the qualifications and training for home staff, staffing ratios or guidelines, medical services, medication

management, and facility design. The need for higher standards in these areas was expressed by a number of licensing staff during the study.

Additional Requirements for Qualifications and Training of Adult Home Staff Are Needed. The qualifications and training required for adult home administrators and staff are fairly minimal. There are no requirements for education or experience related to the types of residents for whom care is provided. Adult home staff are not even required to be literate.

The home administrator is required to be at least 18 years of age and to have a high school diploma, a general education development certificate, or one year of experience in caring for adults in a group setting. Twelve hours of training are required each year and must be related to the home's operation or its residents.

No specific educational or experiential requirements are made for adult home staff. Instead, general abilities that are required of staff are noted. For example, §2.10-2 of DSS licensing standards states that staff must be "physically and mentally capable of carrying out assigned responsibilities." Training for home staff includes specific areas that are to be covered but does not include a minimum number of hours to be completed.

A number of DSS licensing specialists believe that qualifications and training required for administrators and adult home staff are inadequate. In a survey conducted by DSS, the specialists suggested requiring administrators to be knowledgeable of and have prior experience with the elderly or disabled. The specialists also suggested that all direct care staff be required to be literate to ensure that medication is given to the appropriate resident at the proper time and that emergency procedures can be read. Specialists also noted that training of home staff should be the responsibility of the home administrator and should "become a planned part of the facilities' program."

Homes which care for mentally and physically impaired residents should be required to meet a higher level of educational, experiential, and training requirements. These requirements should ensure that administrators and staff are at least minimally qualified to care for these impaired populations. DSS standards for the directors of adult day care centers are much more stringent even though these adults are in care for only a portion of the day. The standards require that directors "shall have completed at least 48 semester hours or 72 quarter hours of post secondary education from an accredited college or institution, and shall have completed at least two years of experience working with elderly or handicapped people." In addition, preliminary standards developed by DMHMRSAS and DSS for voluntary certification of homes caring for mentally disabled residents require administrators to complete a certification program. This program involves completing specified courses related to the care of the mentally disabled.

Standards for different levels of care should require that adult home staff have educational or experiential qualifications which relate directly to the resident

population. At a minimum, a specific number of hours of training which is directly related to resident needs should be mandated for staff providing these higher levels of care. The voluntary certification standards developed by DMHMRSAS and DSS require staff training every six months with at least one session a year devoted to the needs of the mentally disabled.

Additional training needs could be supported through licensing fees charged to adult home owners. Adult home owners currently pay a licensing fee which is based on the capacity of their homes. At a minimum, DSS could provide some of the additional training at little extra cost to adult home staff by simply ensuring adult home licensing fees are used for training sessions.

Section 63.1-174.01 of the *Code of Virginia* states that it is the intent of the General Assembly that these funds be used to develop and provide training for adult home staff and operators. However, the trend in the last two fiscal years has been to not fully expend licensing fees for training purposes. DSS should ensure that the licensing fees collected from homes for adults are used to provide training for adult home staff on a biennial basis.

If additional funding for DSS-sponsored training is needed, it could be collected by altering the current fee structure. Currently the annual fees range from $25 for four to 24 residents to $100 for 75 or more residents (Table 5). The current licensing fee structure could be altered to provide more funding for DSS-sponsored training. Considering that 19 homes have capacities of more than 200 residents with the largest capacity being 635, the fee structure could be altered to continue the graduated fees above the current cut-off of 75 residents. Homes which provide the higher levels of care could also be charged higher licensing fees to cover additional training related to caring for mentally and physically impaired populations.

Recommendation (3). **The State Board of Social Services should promulgate additional standards regarding adult home administrator and**

Table 5

Adult Home Licensing Fee Schedule

Licensed Capacity	Licensing Fee
4-24 beds	$ 25.00
25-49 beds	50.00
50-74 beds	75.00
75+ beds	100.00

Source: DSS General Procedures and Information for Licensure, July 1, 1989.

staff training. All adult home staff with direct care responsibility should be required to be literate. Administrator education and experience requirements should be strengthened for standards developed for care above the lowest level. In addition, additional hours of training should be required for care of special populations.

The Commissioner of Social Services should ensure that fees assessed for adult home licenses are used to provide training for adult home staff as intended by the General Assembly.

Staffing Ratios or Guidelines. There are no staffing ratios or specific staffing guidelines included in the licensing standards. Licensing specialists are expected to determine the need for staffing based on the home's ability to comply with standards; the number, capabilities, and needs of residents; the physical plant; and the abilities of the staff. Homes are also required to have enough staff "to implement the emergency fire plan" (§2.9 *Standards and Regulations for Licensed Homes for Adults,* DSS, April 20, 1989).

Licensing specialists in five regions noted that it is difficult to force a home to increase staffing when the standards are so vague. One specialist commented that the current baseline for staffing is one staff person, regardless of the number of residents or their level of functioning. A second specialist explained that the lack of staffing ratios means the staffing baseline of one is contingent on having relatively mildly impaired residents. Unfortunately, many homes have residents with varying levels of disability. The lack of staffing requirements, especially for the care of mentally disabled residents, results in inadequate supervision to protect residents from dangerous situations. For example:

> *One home that cares for mentally and medically impaired residents has been cited for a number of problems regarding the adequate protection of the residents. Nine separate complaints were made during the three year period of July 1, 1987 through July 1, 1990 about residents leaving this home and wandering, causing problems for nearby merchants and their customers.*
>
> *One complaint alleged that a resident confronted a disabled customer exiting a local restaurant and demanded money. The complaint further alleged that the resident grabbed the woman's walker from her and the resident had to be chased off by bystanders.*

The requirement for enough staff to implement the emergency fire plan was noted as being of little help in most cases. The standards do not contain guidelines for this requirement and it is very difficult to determine the minimum number of staff needed for all possible emergency situations. Most local fire departments will not certify or recommend a staffing requirement as part of their review of emergency fire plans, and licensing specialists feel they are not qualified to recommend a number that cannot be certified by a fire safety professional.

Management within the Division of Licensing is reluctant to institute staffing ratios given the difficulty of devising ratios that can simultaneously consider the needs of the residents, the abilities of the staff, and the layout of the facility. Division management has also been reluctant because some other states have found that the staffing ratios they set have become the maximum number of staff a home will employ.

Under the proposed regulatory system discussed earlier in this chapter, some problems in setting staffing requirements should be alleviated. Homes would be licensed to provide certain levels of care. Therefore, the standards or guidelines could be more easily developed and used because resident needs in each level would be more homogeneous. Proposed standards for voluntary certification of homes caring for the mentally disabled include a staff ratio of one staff person for every ten residents.

Recommendation (4). **The State Board of Social Services should promulgate staffing guidelines for licensing specialists to use in enforcing adult home standards. Staffing standards should be developed for homes providing the second level of care to mentally disabled residents. Standards should also be developed for homes providing the highest level of care.**

Medical Procedures. Current standards for licensing homes for adults do not address the medical procedures provided within homes. Considering the complexity of the medical procedures that are conducted in some homes, this is a dangerous situation. DSS should develop standards to govern the medical procedures provided and require homes to employ staff who are qualified to perform the procedures. For example, licensing standards for nursing homes include provisions for physicians' services, restorative patient care, specialized rehabilitative services, and the employment of nurses on a 24-hour basis. DSS could employ some similar standards.

Recommendation (5). **The State Board of Social Services, in consultation with the State Board of Health, should promulgate specific standards guiding medical procedures in adult homes. Standards should address staff qualifications to perform procedures, policies for restorative care, and procedures for providing specialized rehabilitative services.**

Medication Management. One of the services provided in the majority of homes for adults is the management of medication, particularly for residents who are incapable of administering their own medication. Adult homes frequently store the medication in a central location and dispense it at designated times throughout the day. DSS licensing standards do not adequately control the administration of medication and this places residents at risk. There are no requirements regarding how medication is to be separated and distributed, what training staff who administer medication should receive, or how the receipt, dispensing, and destruction of medication should be documented. This problem has been cited in both previous JLARC reports dealing with the adult home system.

The methods used by a number of homes to separate and distribute medication allow for mistakes that could be fatal. Many homes separate medication into

small paper or plastic cups to be given to the residents. During site visits, the practice of stacking the cups was observed. When the home's staff separated one of the cups, several pills stuck to the bottom of the cup above them. If this had not been noticed, it could have resulted in one resident receiving a medication he was not prescribed and another resident failing to receive needed medication. The consequences of such an event could be life-threatening.

A second major problem related to medication management is the use of a written authorization to allow non-medical personnel to administer medication. Medical practitioners, including physicians, registered and licensed practical nurses, and physician's assistants are allowed by State law to administer medication. Section 54.1-3408 of the *Code of Virginia* also authorizes "an agent authorized in writing by the physician to administer drugs ... when the drugs administered would be normally self-administered by ... a resident of any home for adults which is licensed by the Department of Social Services...."

Both licensing staff and home operators noted problems with the use of this authorization. In many cases the physicians who signed the medication authorizations were unfamiliar with the qualifications of the staff they were approving. These authorizations, therefore, represented paper compliance while providing no assurance that the staff were capable of properly administering medication. Administration of medication is particularly important when residents are taking a number of different medications that may result in an unanticipated reaction.

> *One 56-year-old woman in an adult home was prescribed Mellaril and Valium. It is possible that combinations of these drugs could result in the following adverse reactions: unconsciousness, severe drowsiness, severe weakness, shortness of breath or troubled breathing, staggering, or an unusually slow heartbeat. Adult home staff are not required to have training regarding adverse reactions associated with particular medications.*

The Division of Licensing has also recognized problems with the distribution of medication and the medication authorizations. Recommended changes to the standards have been drafted for the State Board of Social Services' review. However, these changes have not yet been approved.

The proposed changes to the standards involve the use of unit dosages and required training for staff who administer medication. Unit dose medication utilizes plastic, sealed compartments in which a pharmacist places all of the medication to be taken by a resident at a given time during the day. Unit dose cards show the date and time that each medication is to be given, which assists staff in knowing whether a resident has been given that day's medication. Requiring staff who administer medication to complete training that is approved by the State Board of Pharmacy and/or the Board of Nursing would also provide more protection to home residents than the medication authorization requirement. Mandating the use of unit dose and requiring training in medication management should be approved as soon as possible.

Problems with documentation of the receipt, administration, and destruction of prescription drugs were also identified in the 1979 JLARC report. Little has been done to specifically address these concerns. Homes are not required to document the receipt or destruction of controlled substances despite the fact that many maintain a sizable stock of these substances. There is also no requirement for homes to document the dispensing of medication.

Recommendation (6). **The State Board of Social Services, in consultation with the State Board of Health, should promulgate additional standards regarding medication management within homes for adults. These standards should include the following provisions: (1) unit dose packaging for all medications dispensed by adult home staff; (2) Board of Pharmacy and/or Board of Nursing approved medication administration training of all non-medical staff who administer medication; (3) maintenance of a log of all medications received, dispensed, and destroyed by the home; and (4) notations whenever medication is dispensed, which include the initials of the administering staff member, the date and time of the dispensing, the name of the medication, the dosage, and any significant reactions that occur.**

Facility Design and Equipment. Current licensing standards include very few special requirements for homes with mentally or physically impaired residents. For nonambulatory residents, requirements do exist for wheelchair ramps and large doorways, handrails and grab bars in bathrooms, and signaling devices in bedrooms (or adjoining baths). Some additional design and equipment requirements should be established, however, for homes that care for mentally confused residents.

Homes with mentally confused residents should be required to have electronic alarms on outside doors. Mentally confused residents such as those suffering from dementia may be physically sound and quite capable of walking out of the home. Once outside the home however, they may be oblivious to dangerous situations or may wander off. Numerous examples of residents leaving homes and being unable to care for themselves or find their way back can be found in adult home files. In one case a resident died of exposure after leaving a home without being observed.

Facility design requirements should be modified to include a standard for a maximum hot water temperature. This is particularly dangerous in homes with residents who are physically or mentally impaired. At least one home resident has died as the result of burns sustained after being pushed by another resident into scalding hot water. Four regions currently check water temperature in adult homes and require it to be lowered, if it feels too hot to the touch. Enforcement would be strengthened by having a specified maximum temperature to be verified by thermometer.

Recommendation (7). **The State Board of Social Services should promulgate additional standards addressing facility design and equipment. For example, homes providing care to mentally disabled residents should be required to have electronic alarms on all fire, emergency, and exit doors.**

Standards regarding maximum hot water temperatures should be developed for the core or minimum standards.

Standards Should Be Clarified to Facilitate Enforcement

Two main problems need to be addressed to facilitate licensing specialists' enforcement of adult home licensing standards. First, a number of the current standards are vague and should be clarified. Many of the current standards for homes for adults are not specific in nature. The ambiguity of these standards hinders the ability of licensing staff to enforce them. Some of the areas in which standards should be more clearly articulated include: (1) specifying a minimum age for adult home staff, (2) requiring staff to follow physicians orders, and (3) strengthening food service standards. Second, improvements in training and oversight of licensing specialists would promote accuracy and consistency in the enforcement of the standards and assist in ensuring that adult homes are treated equitably.

A Minimum Age for Adult Home Staff Should Be Mandated. Current licensing standards do not specify a minimum age for staff of homes for adults. Staff in the Division of Licensing indicated that this omission was an unintentional oversight on their part. Division staff further noted in a memo to JLARC staff "that our staff is unaware of regular employees in H.F.A.s [homes for adults] under the age of 18. There may be some instances where the owner's/operator's children may assist for short periods of time." In examining complaint records for homes that were visited, it was found that one home had used teenaged staff to supplement staffing on the weekends.

> *A DSS complaint investigation of a home in the Tidewater region found that teenaged grandchildren were being used to supplement staffing on the weekend. At the time that the licensing specialist arrived, three teenagers, two who were 15 and one who was 17 years of age, were assisting a 19- and a 20-year-old.*
>
> *The practice was also investigated by the Department of Labor, since child labor laws were being violated. The Department of Labor investigator noted that the care of adults is a prohibited occupation for anyone under 16 years of age. While the Labor Department would not have objected to the 17-year-old caring for adults if she had an employment certificate, the teenager did not have a certificate. The home owner stated she did not realize a certificate would be needed since the teenager was her granddaughter.*

Licensing standards should specify 18 as the minimum age for a staff member of a home for adults. Although the standards do require an adult staff member to be present and responsible for care, this does not adequately protect adult home residents. Staffing requirements are designed with the assumption that an adult will be providing care. Consequently it should be clear in the standards that minors cannot substitute for adult staff members.

Standards Should Require that Physicians Orders Be Followed. There is no standard requiring adult home staff to follow physicians' orders in providing care for residents. One licensing specialist noted that she tries to obtain compliance by citing licensing standard §2.6-2, which directs home administrators to "protect the safety and physical, mental and emotional health of residents." This specialist had recently determined that two residents were not provided special diets despite diagnoses of having diabetes and physicians' orders to control the diabetes through special diets. A standard should be added specifying that physicians' orders are to be followed unless the resident, who has not been found to be incompetent, refuses the care, diet, treatment, or medication.

Standards on Food Services Could Be Strengthened. Several food service standards were noted by licensing staff as being vague. While §4.49.F-3 of the licensing standards requires additional servings of food to be provided upon request, it does not specify that the home operator is prohibited from charging for these servings. Similarly, §4.49.C requires menus to be posted but does not specify that they must be posted where residents can read them. Both of these standards should be clarified to ensure their intent can be enforced.

Recommendation (8). **The State Board of Social Services should modify current licensing standards to: (1) specify that all adult home staff must be at least 18 years of age; (2) require that physician's orders must be followed unless the resident, who has not been found to be incompetent, refuses the care, diet, treatment, or medication; and (3) clarify requirements related to food services.**

Training and Oversight Should Be Strengthened to Enhance Consistency

Although it is not possible to have complete consistency in enforcing standards, confusion exists among licensing specialists regarding the interpretation and enforcement of standards. This confusion could lead to inconsistent enforcement of adult home standards, resulting in unfair treatment of home operators as they try to care for residents. Better communication, increased training, and stronger oversight of licensing specialists' decisions could ensure consistent enforcement of the standards.

Some inconsistencies result from a lack of effective communication regarding the rationale for the standards and how they should be enforced. Specialists in six regions indicated in interviews that they do not receive clear explanations of changes to or new interpretations of adult home standards. Changes to standards are typically explained in written Internal Procedures Memoranda (IPMs). However, specialists believe these are not the most effective means of communicating standards, since specialists are unable to ask questions about the standards or benefit from hearing the questions of their peers. These specialists believe they need training by central office staff familiar with the rationale for the standards and the philosophy on how they should be enforced. Most of the specialists interviewed could recall only two instances of this sort of training by central office staff in the last ten years.

Inconsistencies also result from inadequate oversight of enforcement by central office. The 1979 JLARC report on homes for adults recommended that central office staff complete case audits of licensing actions including on-site verification of reported conditions. The Department acknowledged that case audits have not been completed by the central office as recommended, and reviews of samples of licensing decisions have been discontinued since a decision-making process was initiated and DSS was reorganized. The decision-making process is used by licensing specialists to summarize their findings regarding a particular adult home. The process assists licensing specialists in determining how to make decisions concerning a particular adult home, but it does not evaluate consistency in enforcement activities across homes or among specialists. Therefore the decision-making process should not be considered a substitute for oversight.

With the reorganization of the agency into two districts with authority over the regions, DSS anticipates that the district office staff will monitor program operations and conduct random audits and on-site verification as needed. These actions could improve oversight of regional activities. The Division of Licensing will need to be careful, however, to ensure that district staff provide consistent oversight to prevent two distinct methods of enforcement from evolving.

Recommendation (9). **Training by central office staff familiar with the rationale for the standards revision should be held as early as possible after changes are finalized. Minor revisions could be communicated in writing, as they are now, and discussed during annual conferences.**

Recommendation (10). **District office staff should monitor the decisions made by licensing specialists for correctness and consistency. Monitoring activities should incorporate case audits which include on-site verification of reported conditions. The Division of Licensing should oversee monitoring activities to ensure consistency between the two district offices. If the district offices are abolished due to budget cuts, central office staff will need to assume the districts' monitoring responsibilities.**

DSS ENFORCEMENT ACTIVITIES COULD BE STRENGTHENED

Through regulation or the enforcement of mandated standards and requirements for homes for adults, the Department of Social Services seeks to protect the physical and emotional well-being of adult home residents. The effectiveness of this enforcement is determined largely by the ability of licensing staff to identify problems and to require corrective action. DSS could improve enforcement in both areas by implementing four recommendations from previous studies which relate to renewal inspections, the inspections of food services, intermediate sanctions, and illegally operating adult homes.

Unannounced Renewal Inspections Are Needed

The 1979 JLARC study noted that one significant weakness in DSS' enforcement of licensing standards was that home operators were usually informed of impending visits and inspections. Consequently, licensing specialists might not get an accurate picture of the home's operation because operators are given time to correct or conceal deficiencies. The General Assembly amended §63.1-177 of the *Code of Virginia* to require licensing staff "to make at least one unannounced inspection of each licensed facility each year."

Currently, monitoring visits, which are made at least once a year to check on the home's operation, are made on an unannounced basis. For the annual renewal inspection, however, home operators are given from 48 hours to one week's notice that the visit will be made. Findings resulting from the renewal inspection determine the type of license the home will receive and the category the home will be assigned. This categorical assignment determines the number of monitoring visits the home will receive during the following year.

The advance notice given for renewal inspections could compromise the accuracy of the impression the licensing specialist gets during the most important review of the year. One licensing specialist illustrated the problem by citing the following example:

> *In one home that cares for incontinent residents, the licensing specialist would find very different circumstances during unannounced monitoring visits and announced renewal inspections. During the unannounced visits the specialist would typically find that beds had been made with filthy, wet sheets still on them. During announced inspections however, the sheets were always very clean. Because the findings of the renewal inspection were the primary determinant of the home's categorical rank, the home was rated as a "1" (the best category) even though the specialist felt the rating was not deserved.*

Management personnel within the Division of Licensing contend that advance notice of the renewal inspection is necessary to ensure that the home administrator is available to provide access to all records and to discuss the compliance plan. When asked about unannounced renewal inspections, licensing specialists generally indicated that the effectiveness of the unannounced renewal inspection outweighs any inconvenience it might cause. Several specialists noted that one licensing standard requires that someone with access to the records be on duty at all times, so access should not be a problem with an unannounced inspection. Failure to provide access to the specialist would be a violation of licensing standards.

Recommendation (11). **The General Assembly may wish to amend §63.1-177 of the *Code of Virginia* to require that annual licensing renewal inspections of homes for adults be made on an unannounced basis.**

Inspections Should Be Supplemented by a Certified Dietitian

Serious problems in food services were noted during site visits completed for the 1979 JLARC study. JLARC staff recommended that DSS employ a professional nutritionist or dietitian to supplement some licensing inspections. While significantly fewer problems were noted in terms of adequate food supply during this study, nutritional problems may remain.

The most serious concerns about food services relate to the adequacy of the prescribed special diets that are served. Physicians seldom send the homes specific instructions on what a special diet should include. Several licensing specialists noted that despite the training they had received in nutrition, it was difficult for them to evaluate the adequacy of special diets or to assist homes in improving their diets.

In addition, specialists noted they are not well-equipped to evaluate home menus for nutritional content and variety. One specialist noted he considered the standards to be of little help since the nutritional requirements could be met in one meal a day.

DSS staff have stated that they use Virginia Polytechnic Institute and State University (VPISU) extension services to provide training and consultation to adult home staff on nutrition and meal planning. In addition, menu analysis is available from VPISU; however, DSS has no formal, contractual arrangement with VPISU to provide this service. Licensing staff in only one DSS region indicated that they use these services, and only then on a case by case basis.

Recommendation (12). **The Department of Social Services should employ or contract for the services of a certified dietitian to review the menus of all licensed homes. Special diets should receive particular scrutiny. A dietitian should also be available to assist in investigating complaints related to nutrition and food services.**

Intermediate Sanctions Are Needed

Currently, the only sanctions available to licensing specialists are the issuance of a provisional license or the denial or revocation of a license. As noted in previous studies and in recent interviews with licensing specialists, the provisional license is not an effective deterrent to noncompliance. Since the provisional license must be followed by an annual license or revocation of the license, some operators will make only minor changes, knowing that their license will not be revoked.

In addition, violations are typically not dangerous enough to deny or revoke a license, although they may be serious and need to be corrected. Licenses are only denied or revoked on the basis of violations that threaten the life, safety, or well-being of home residents. Typically the denial or revocation will be contested by the home

operator, resulting in a lengthy adversarial process. Only 11 licenses have been denied or revoked since July 1, 1986.

Licensing specialists have little leverage over home operators, who know their license will not be revoked due to standards' violations that are not life-threatening. Specialists in all seven regions stated that current enforcement measures are not effective and that intermediate sanctions would be useful tools for enforcing compliance with standards. The use of intermediate sanctions would ensure that violations would not be ignored, because reasonable penalties could be assessed to correspond with the seriousness of the noncompliance.

The need for intermediate sanctions has been documented in the past in both the 1979 JLARC report and the 1985 study by Ernst & Whinney. The sanctions that have been recommended in the past have included imposing fines, suspending home admissions, and transferring home residents. The following response was given by DSS to a JLARC staff request for information on the status of implementing intermediate sanctions:

> Enforcement of standards is considered a positive activity of the Department of Social Services. Our activity is designed to encourage and facilitate compliance with the requirements.
>
> Suspension of admissions and imposing fines would be considered negative enforcement and should be authorized by law. Current law and standards do not allow for these activities.

The response goes on to say that reducing a home's licensed capacity may be a better approach than suspending admissions since suspending "admission[s] would have a different impact on homes with low and high turnover in residents." Because DSS lacks the authority to implement some intermediate sanctions, the General Assembly may wish to amend the *Code of Virginia* to grant the Commissioner of Social Services this authority.

Authority to impose intermediate sanctions on institutions violating licensing standards is provided to some State agencies. The Virginia Department of Health, for example, is granted authority in §32.1-135 of the *Code of Virginia* to restrict admissions, to petition the court to levy a fine or place nursing facilities in receivership, and to revoke a facility's certification or license. Restricting new admissions has been the primary sanction used because fines and receivership were not authorized until July 1989.

DSS should consider implementing several sanctions that can be adjusted to respond to a number of different situations. At least one intermediate sanction is needed that is more effective than placing a home on a provisional license but less extreme than denying or revoking a license. Reducing a home's licensed capacity, for example, could provide DSS licensing staff needed flexibility in enforcing adult home

standards. Other sanctions, such as court-ordered fines, could be reserved for more serious problems.

Recommendation (13). **The General Assembly may wish to amend §63.1-179 of the *Code of Virginia* to authorize the Commissioner of Social Services to reduce the licensed capacity of any home for adults, to restrict or prohibit new admissions to any home for adults, to petition the court to impose civil penalties against any home for adults, or to transfer a resident from any home for adults for violations of any provision of Chapter 9, Article 1.**

Illegal Operations Should Be Aggressively Pursued

To effectively investigate allegations of illegally operating adult homes, licensing specialists must be able to inspect the alleged homes to determine the number and condition of individuals in care. Specialists are not always allowed to do this, however. When licensing specialists are denied entry to investigate an allegation and a search warrant is required, the specialist may need to have the names of the suspected residents. The 1979 JLARC report suggested using the Supplemental Security Income (SSI) recipient rolls to identify illegal operations. Although DSS did not find using the rolls to be an effective means of identifying illegal operations, the rolls could be used to determine the names of residents receiving their SSI payment checks in illegally operating homes.

Three regions reported at least one instance of being denied entry into a home since July 1, 1986. One region reported being denied entry to 16 homes. In some of the 16 cases reported, a licensing specialist was never allowed to enter the home. In other cases, a specialist was allowed into the home at a scheduled date and time, or was admitted, but not allowed to walk through the home to verify the number of residents in the home. Other examples of problems encountered by licensing specialists when dealing with unlicensed homes include the following:

> *During the investigation of one home, a licensing administrator and a police officer found residents were being taken out the back door while the licensing specialist was knocking on the front door. Some of the residents had intravenous tubes that were still attached as they were being moved.*
>
> * * *
>
> *In one home that had been a long-term problem, licensing staff were granted a search warrant after they observed four residents in the home. During the search, the specialist found 14 individuals were being cared for in the home. Seven individuals had been brought in for the day while seven were residents of the home. The seven*

residents occupied second floor bedrooms even though some were bedfast or used walkers.

* * *

Licensing staff were unable to investigate a complaint that one home was caring for five residents who were bedfast. The home operator has refused to allow entry into her home and licensing staff have been unable to gather sufficient evidence for a search warrant.

When licensing staff are denied entry to investigate an allegation, the facts of the case are presented to staff of the Attorney General's Office. A letter is written to the home owner explaining the complaint and DSS' authority to investigate. If the home owner continues to deny entry to the home after receiving the letter, licensing staff must determine whether sufficient evidence is available to request a search warrant. It is very difficult to obtain a search warrant because credible evidence demonstrating that four or more individuals are in care must be presented to justify entering a private home.

One possible source of evidence is the listing of SSI recipients the Department receives. The listing could be checked to determine the number of SSI checks that are mailed to the address in question. DSS has not used the SSI listing for this purpose in the past. Considering the danger some residents may be facing in unlicensed homes, every practical means of investigating allegations should be employed.

Recommendation (14). **The Department of Social Services should obtain Supplemental Security Income data from the Social Security Administration to use in routinely determining the name and number of recipients receiving checks in homes alleged to be operating illegally. This information should be used to assist the Department in obtaining search warrants to investigate homes that may be operating illegally.**

THE LICENSING FUNCTION SHOULD REMAIN IN DSS

Consideration has been given to moving responsibility for licensing homes for adults from the Department of Social Services to the Virginia Department of Health. The primary reasons for proposing the move appear to have been (1) the failure of DSS to implement previous recommendations regarding its licensing activities and (2) an attempt to achieve some savings by consolidating licensing of adult homes and nursing homes in one agency. House Bill 1113, introduced during the 1990 General Assembly session, would have granted VDH responsibility for licensing homes for adults. The bill was continued to the 1991 session and will be reconsidered at that time.

This review of the placement of the licensing function indicates that homes for adults should continue to be licensed by DSS. Although significant changes in the

implementation of the licensing function are needed, there is no compelling reason to move the responsibility from DSS at this time. Retaining licensing within DSS would support the type of care provided in most homes, facilitate coordination between adult home licensing and auxiliary grant administration, and be more cost effective than moving the responsibility to VDH. If recommended changes to the current licensing program are not made however, the General Assembly may wish to reconsider transferring the licensing function.

Focus of DSS Licensing Approach Supports Adult Home Regulation

Licensing by DSS is consistent with the social focus of the care provided by most adult homes. The majority of homes for adults still provide basic room, board, and supervision for their residents. According to DSS:

> For many functionally impaired adults, care in the home or in an HFA [home for adults] may require the following types of services sporadically or on a long-term basis:
>
> - personal care to assist with activities such as dressing, bathing, feeding, and transferring;
>
> - medication management to remind the adult when to take prescribed medicines;
>
> - companionship to provide social interaction; and
>
> - assistance with instrumental activities of daily living such as shopping, transportation, or money management.

DSS regulation is tailored to evaluating this basic level of care provided by most adult homes.

In contrast, the focus of VDH licensing is on the care provided in medical facilities. Nursing homes, for example are defined as facilities "in which health services ... for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition" are provided (§32.1-102.1 *Code of Virginia).* Licensing personnel within VDH are generally nurses or skilled professionals who have been trained in evaluating medical care.

The number of homes providing medical services, while increasing, is still a very small minority of all homes. According to DSS licensing staff, only 33 homes provide medical care for the majority of their residents. In addition, the level of care provided in these homes may not be comparable to that provided in nursing homes. Considering the limited number of homes for adults which follow the medical model of care and the small proportion of adult home residents who require additional medical

services, moving the entire licensing function on this basis does not appear to be appropriate at this time.

Retaining DSS Licensing Promotes Coordination With Adult Home Funding

Another reason to retain the licensing function in DSS is to continue coordination and information sharing with the Auxiliary Grants Program. DSS administers the Auxiliary Grants Program through local departments of social services. Auxiliary grant payments were established in 1973. These payments supplement the funds of SSI recipients who need the care and supervision provided by a home for adults. Administration of the Auxiliary Grants Program involves determining rates for homes accepting auxiliary grant recipients, determining eligibility for the auxiliary grant benefit, and providing case management for grant recipients. As noted by DSS:

> Planning, policy development and coordination, essential elements needed to ensure the array of services needed by persons in HFAs [homes for adults], can most effectively occur when licensing, rate determination, eligibility determination for AG [Auxiliary Grants] and provision of social services occur within the same agency.
>
> HFA activities are inter-related and require strong coordination. Such coordination is most effectively carried out when all activities are under the same administrative roof. DSS currently has policy making responsibilities in all of the key areas related to HFAs.

As noted, keeping responsibility for licensing and payment of the auxiliary grant in one agency allows for the coordination of both functions. Although this review noted some deficiencies in the sharing of information between the Divisions of Licensing and Financial Management which sets the auxiliary grant rate, these problems primarily concern the accessibility to adult home licensing data.

Retaining the Licensing Function in DSS Is Cost Effective

It appears that it would be more cost effective to retain the licensing function in DSS. The estimated cost for DSS to license homes for adults and adult day care facilities during FY 1991 is about $824,00 if some cost savings, resulting from a redistribution of workload, are implemented. Transfer of this function to VDH would result in costs of about $831,000 without including the additional costs to move staff and the licensing data base. (See Appendix B for a description of how these costs were estimated.)

The DSS estimated cost also includes the cost for a regional structure which enhances the responsiveness of licensing staff to adult home problems and complaints. Licensing staff are able to more promptly investigate complaints against licensed

facilities as a result of the regional approach. The VDH estimated cost does not include the cost for a regional structure. VDH does not have regional offices which could be used to facilitate licensing investigations or adult home monitoring visits.

Recommendation (15). **At the present time, responsibility for licensing homes for adults should remain within the Department of Social Services. DSS should continue to emphasize coordination and information sharing between the Divisions of Licensing and Financial Management to ensure both the regulatory program and the Auxiliary Grants Program operate efficiently and effectively.**

IV. State Funding of Homes for Adults

State funding for eligible adult home residents is available through the Auxiliary Grants Program. The Department of Social Services (DSS) is the agency responsible for administering the Auxiliary Grants Program. Since 1979, the Auxiliary Grants Program has been reviewed numerous times, as part of studies on the adult home system. Each report issued recommendations to enhance the funding system and improve its ability to provide adequate funding for eligible adult home residents. Many of the recommendations have not been implemented or have been implemented for only a short time.

Many shortcomings of the funding system for adult home residents, documented in earlier studies, still appear to be evident. These problems continue to limit the ability of the program to meet the needs of eligible adult home residents. These problems are exacerbated by the growing number of individuals residing in adult homes who are eligible for State funding and have diverse needs. The Auxiliary Grants Program is currently unable to:

- differentiate adult home rates based on services provided to residents,
- ensure that State funds are not being misused,
- provide adequate funding to newly opened adult homes during the first few months of operation, and
- provide valid data to determine the adequacy of the current maximum rate.

Changes in the adult home funding system are necessary to ensure adult home residents receiving auxiliary grant benefits are able to acquire appropriate and adequate adult home care. First, DSS should implement changes that ensure that the documented problems of the current Auxiliary Grants Program are corrected. Then, when the regulatory system recognizing three levels of care is in place, DSS should redesign the Auxiliary Grants Program to link State funding to the new adult home regulatory structure. By linking funding to a regulatory structure that recognizes levels of care, the State can ensure that eligible residents are provided appropriate care and adult home providers are compensated fairly for providing the care.

OVERVIEW OF THE AUXILIARY GRANTS PROGRAM

The Auxiliary Grants Program was established in 1973 to supplement income for recipients of Supplemental Security Income (SSI) and certain other individuals under Title XVI of the Social Security Act of 1972. It was intended to ensure that

recipients would be able to maintain a standard of living which met a basic level of need. The basic level of need is defined by the State Board of Social Services as the cost of providing domiciliary care in an adult home. The auxiliary grant is also available to individuals who meet all of the qualifications for SSI but whose incomes are in excess of the SSI allowance. According to the policy set by the State Board of Social Services, the auxiliary grant can only be used to provide financial support for financially eligible residents who are already residing in licensed adult homes and approved adult family care homes.

In FY 1990, the Auxiliary Grants Program totaled $15,527,136. The State share of funding for the program in FY 1990 was $12,421,709. Localities provided the remaining $3,105,427. This represents a growth of about 272 percent from FY 1979 expenditure levels. The number of auxiliary grant recipients has shown an increase of more than 152 percent since 1979 (Figure 4).

A number of procedures must be implemented before an individual can receive an auxiliary grant and home operators can accept auxiliary grant recipients. First, an auxiliary grant rate must be established for the adult home. Next, the resident's eligibility for the auxiliary grant must be determined. Once these two steps are accomplished, the benefit payment can be processed.

Auxiliary Grant Eligibility Requirements

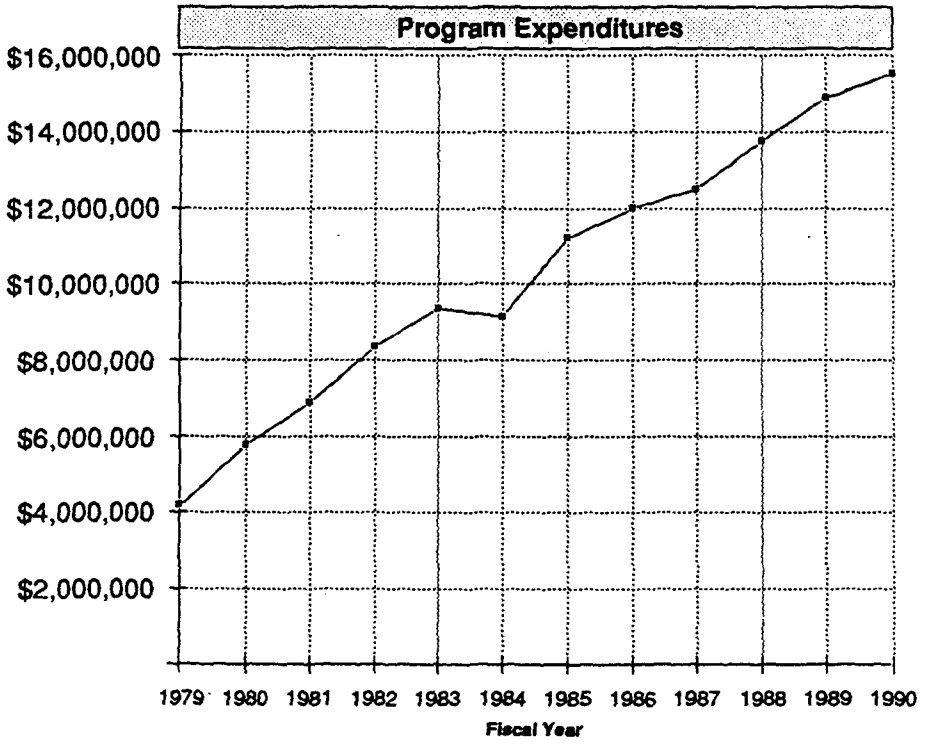
Program eligibility is determined at the local social services agency where the application for the auxiliary grant benefit is processed. Eligibility workers in the local office are charged with determining if the individual meets both non-financial and financial criteria. At the present time, there is no requirement to administer a needs assessment to ensure that placement in an adult home is appropriate. According to DSS policy, each individual applying for auxiliary grant benefits is to be personally interviewed by local social service agency staff. The interview can be conducted either in person or by telephone. Program eligibility is also reassessed annually by local social services agencies. After program eligibility is determined, the amount of the individual's benefit is calculated.

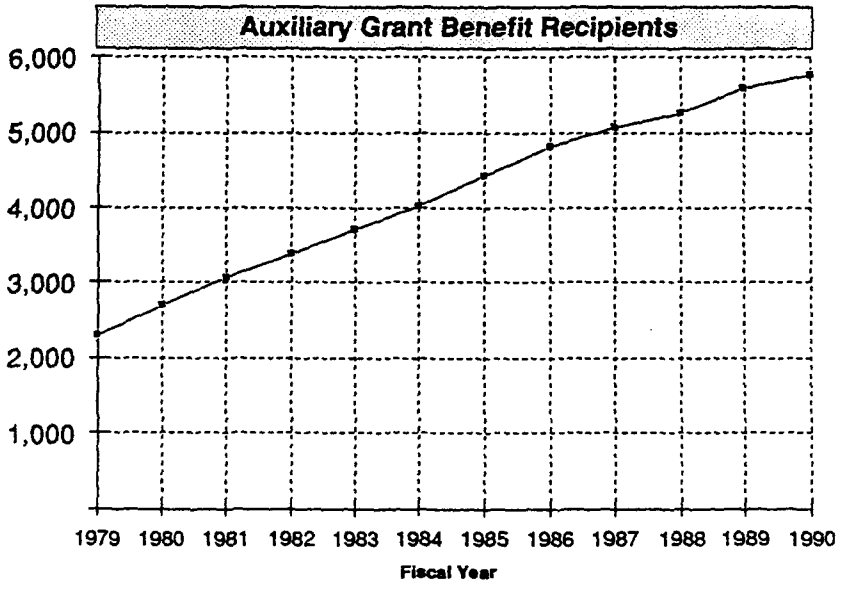
To meet non-financial guidelines, an individual applying for an auxiliary grant must prove that he or she is:

- residing in a home for adults that has been authorized to operate by the Department of Social Services or an approved adult family care home;
- a resident of the locality where auxiliary grant eligibility is being determined;
- aged, blind, or disabled (categorical requirements); and
- a citizen of the United States or an alien lawfully admitted for permanent residence.

Figure 4

Increases in Auxiliary Grants Program Expenditures and Auxiliary Grant Recipients from FY 1979 to FY 1990





Source: *Final Report: Auxiliary Grants Program Study*, Ernst & Whinney, 1985 and August 1990 Department of Social Services auxiliary grant reimbursement data.

In addition to meeting the non-financial criteria, an individual applying for the auxiliary grant must be receiving SSI benefits or meet all of the SSI guidelines except the income limitations. If an individual is receiving SSI, financial criteria have already been verified by the Social Security Administration. In these cases, local eligibility workers simply use SSI reports to verify the SSI benefit amount and other countable income. When the individual has income in excess of SSI guidelines, eligibility workers then determine if the individual's income and assets are within allowable limits for an auxiliary grant.

An individual who is receiving or is eligible for SSI benefits will have met the categorical and citizenship criteria. The requirements to reside in a licensed home for adults and locality residence are policies of the State Board of Social Services. Once the financial and non-financial criteria have been met, the individual is eligible to receive auxiliary grant benefits.

After an individual is found eligible for auxiliary grant benefits, the benefit amount is determined. The method used to determine the amount depends on whether the individual is SSI eligible. If the individual is SSI eligible, caseworkers simply take the approved adult home rate and subtract the SSI benefit and any other countable income from "total need" to obtain the auxiliary grant benefit amount. "Total need" is defined as the approved monthly rate of the adult home plus a $35 personal allowance.

If the individual is not SSI eligible, the total income that the individual has available, minus an "income disregard," is subtracted from the total need (Exhibit 4). An "income disregard" is income excluded from total monthly income when determining the total need. Generally, the maximum auxiliary grant payment is $251, including the $35 personal allowance (effective July 1, 1990).

Adult Home Auxiliary Grant Rate

Adult homes that accept auxiliary grant recipients must have a grant rate established by DSS. The grant rate is based on costs reported annually by adult homes to DSS. The maximum monthly auxiliary grant rate is set in the Appropriations Act. Currently the rate for adult homes is set at $602 per month ($692 for Planning District 8 which includes the cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park, and the counties of Arlington, Fairfax, Loudoun, and Prince William). The rate is increased annually by the percentage increase in the salary structure adjustment for State employees. The majority of the homes applying for an auxiliary grant rate (330 of 332 homes) have been approved to receive the maximum rate allowed for FY 1991.

Since FY 1979, the maximum monthly rate for adult homes has increased from $336 to the current $602 per month, an increase of more than 79 percent (Figure 5). Over the same time period, the maximum SSI payment has increased by more than 103 percent, the individual auxiliary grant payment by more than 47 percent, and the monthly personal allowance by 40 percent.

Exhibit 4

Computing the Monthly Auxiliary Grant Benefit for Residents of an Adult Home With a $602 Adult Home Rate

SSI Eligible

Step 1: [Monthly Adult Home Rate] + [Personal Allowance] = [Total Need]*

$602 + $35 = $637

Step 2: [Total Need]* - [SSI Benefit] = [Monthly Auxiliary Grant]

$637 - $386 = $251

Non-SSI Eligible

Step 1: [Monthly Income] - [Income Disregard]** = [Available Monthly Income]

$450 - $20 = $430

Step 2: [Total Need]* - [Available Monthly Income] = [Monthly Auxiliary Grant]

$637 - $430 = $207

*Total need is the approved monthly rate of an adult home plus the $35 personal allowance.

**Income disregard is income excluded from total monthly income when determining total need.

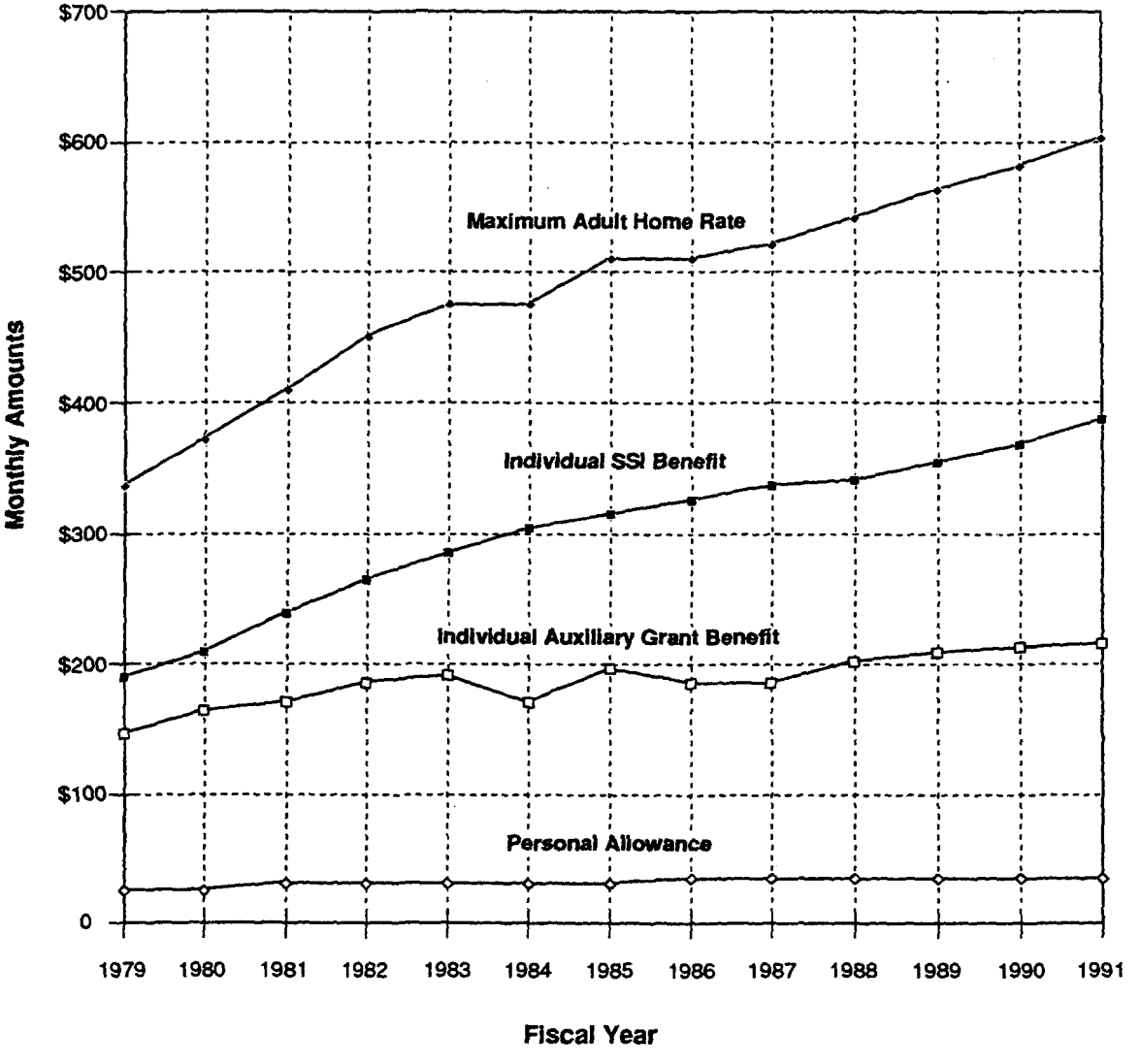
Source: JLARC staff presentation of DSS data on the Auxiliary Grants Program.

Auxiliary Grant Payment Process

Auxiliary grant benefits are paid by the locality in which residency for the recipient has been established. Checks are mailed directly to the recipient, who must pay the adult home for services provided. Each locality that pays auxiliary grant benefits submits a warrant register to DSS monthly for verification. After verification, the State reimburses localities for 80 percent of their total auxiliary grant expenditures.

Figure 5

Growth in Adult Home Auxiliary Grant Rate, Individual SSI and Auxiliary Grant Benefits, and Personal Allowance



Source: *JLARC staff analysis of Department of Social Services and Appropriations Act data.*

NUMEROUS PROBLEMS CONTINUE TO AFFECT THE AUXILIARY GRANTS PROGRAM

While the number of individuals participating in the Auxiliary Grants Program since 1979 has steadily increased, use of the auxiliary grant to provide anything more than basic, custodial care has not occurred. The role of some adult homes has changed to meet the increasing demand for enhanced services from residents; however, the State's adult home funding system has not changed to reflect the diverse needs of residents and the various types of adult homes currently operating in Virginia.

Several problems affect the Auxiliary Grants Program's ability to meet the needs of Virginia's adult home residents. Many of these same problems were identified in both the 1979 JLARC and 1985 Ernst & Whinney reports. Review of the FY 1990 cost data submitted by adult home operators indicates that the current maximum rate of $602 may be inadequate. However, the actual adequacy of the maximum rate cannot be substantiated because the cost data used to determine auxiliary grant rates may not be valid. Cost data are currently not verified or audited. In addition, the cost reporting process lacks the policies, procedures, and guidelines which would ensure that cost data are consistently reported and accurate.

The Adult Home Cost Reporting Process Is Inadequate

The operating costs reported by an adult home are the basis for calculating that home's auxiliary grant rate. Over the last ten years, numerous problems have been identified with the cost reporting process. However, little has been done to improve this important area of the Auxiliary Grants Program. Recommendations have been made to address problems related to the validity of reported costs; the lack of clear policies, procedures, and guidelines for use by personnel involved in the cost reporting process; and the design of the cost reporting form. Based on this review, these areas continue to lack sound oversight and administration. This lack of oversight could also lead to instances in which State funds are improperly used.

Validity of Reported Costs Cannot Be Determined. To compute a home's monthly auxiliary grant rate, cost data are collected on an annual basis from each adult home desiring to house auxiliary grant recipients. Cost reporting forms are currently mailed to each adult home in mid-March of each year. Homes choosing to participate in the program are instructed to return the completed forms to the appropriate DSS regional office by May 15. After a brief review in the regional office, the forms are forwarded to the Division of Financial Management in DSS' central office for further review and rate calculation.

In both the 1979 JLARC and 1985 Ernst & Whinney studies, numerous problems were documented that cast doubt on the validity of the adult home reported costs. Unfortunately, many of the same problems are evident today. Responses by

DSS staff and adult home operators to questions about the current cost reporting process raise questions about the validity of the cost data. For example:

> *During one interview, an adult home operator admitted to being confused by the cost reporting process. She stated in submitting the form, she simply copied the previous year's form and changed the applicable dates.*
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> * * *
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> *One home with a licensed capacity of five residents reported spending $19,600 on food in one year. The previous year, the home had reported spending no money on food supplies. A DSS staff person in the regional office reported he did not look at this category on the home's cost reporting form because the costs reported were from the right time period, the time frame for turning it in to central office was tight, and he was not instructed to look closely at the forms.*

In addition, it is unclear whether income derived from resident charges for certain services is being properly accounted for on the cost reporting forms. Of the 30 homes selected for follow-up visits by JLARC staff, nine reported charging residents for laundry services. However, five of the nine homes still listed laundry expenses on the cost reporting form. It is unclear whether this revenue was properly accounted for in the reported costs. DSS regional office staff also reported concerns about the accountability of the revenue received from resident charges and whether home operators were fully accounting for it by reducing reported expenses.

Methods are available to assist in improving the reliability of the cost data collected. For instance, numerous DSS staff have cited the difficulty in judging the appropriateness of home administrators' salaries. DSS, at one time, recognized this as a problem because DSS staff developed preliminary salary guidelines for adult home administrators. Such administrative salary guidelines are currently used by the Department of Medical Assistance Services (DMAS) when evaluating nursing home cost reporting forms.

In addition, other related information may be beneficial and can be collected through the cost reporting system. In 1985, Ernst & Whinney noted that restrictions and fuller disclosures of certain expenses would "improve reporting consistency and facilitate analysis." For instance, more detailed information on the fringe benefits provided by the adult home and which employees receive them could be collected. This information would be beneficial in evaluating the appropriateness of the cost of fringe benefits reported by adult homes.

Additional information concerning the homes' real property could also be collected. This information could include whether the property was leased or owned, copies of the lease, whether owners of the property are related parties, the insured value of the building, and the name of the party or financial institution holding the

mortgage. Such detailed information is currently collected through the cost reporting process for children's facilities seeking State reimbursement.

Recommendation (16). **The Department of Social Services should develop an effective adult home cost reporting process. Guidelines should be established for the eligibility of certain costs such as adult home owner and administrator salaries. Also, the Department should consider collecting additional information related to the operation of adult homes through the cost reporting process. This information should include greater background concerning fringe benefits and real property.**

Cost Reporting Policies and Procedures are Lacking. DSS personnel in both the regional and central office are involved in the cost reporting process. Their involvement ranges from answering questions about the cost reporting process to reviewing and evaluating the adult home cost data. However, policies and procedures to guide them in their work with the cost forms are not sufficient. As a result, there is a general lack of knowledge about how to review the forms, what data items are to be checked, and how to evaluate the appropriateness of the data.

DSS staff in the Division of Financial Management stated that their review of the cost reporting forms included a check of the owner-reported licensing information to ensure it matches DSS licensing data. The use of correct licensing data directly affects the ability of DSS to properly calculate a home's auxiliary grant rate. However, interviews with DSS staff and examinations of selected adult home cost forms revealed that even this rudimentary information is not reviewed thoroughly or reconciled with current licensing data. For example:

> *One adult home reported its licensed capacity as 55. However, DSS licensing records indicated the home always had a licensed capacity of 66. The home's assistant administrator also confirmed that the DSS license certificate specified a licensed capacity of 66 rather than 55. DSS staff in the Division of Financial Management did not check the licensing data and consequently computed an auxiliary grant rate based on an operator-reported capacity of 55 residents. Since the computed rate was based on the lower capacity, a higher-than-substantiated computed rate was calculated.*
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> * * *
>
> *Another adult home listed on its cost reporting form a license type of "ICF" (intermediate care facility) issued by the Virginia Department of Health for a capacity of 30. DSS licensing records indicated that the adult home had a licensed capacity of 50. DSS staff computed an auxiliary grant rate based on the licensed capacity of the intermediate care facility, not the home for adults' licensed capacity.*

Interviews with regional office staff indicated that standardized policies and procedures to guide their work with the cost reporting forms were lacking. Several regional office staff pointed out that, to their knowledge, the only policy and procedures available were included in the memorandum sent to home operators with the cost reporting packets. Because there are no standardized policies and procedures, regional office staff are not consistent in their review and evaluation of the cost reporting forms. This, in turn, results in adult home rates that are not based on consistently reported and evaluated cost data and in inequitable treatment of adult homes in the cost reporting process. For example:

> *Regional office staff voiced concern with home operator reported salaries. In addition to concern that some may be too high, they were also concerned that some were too low. One said that if the reported salaries were "ridiculously low," he would ask the home operator to set them to a more realistic level to ensure their efforts are accurately accounted for. According to this staff person, there are no written policies and procedures to judge the adequacy of salaries or whether reported salaries should be raised.*
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> * * *
>
> *In another DSS regional office, the responsible staff person only reviews the form "lightly" to verify that it is an original copy, has been signed and dated, and that the cost data are from the appropriate time period. He does not check for reasonableness or applicability of the cost data. He said he would like to do more, but he has never been supplied with policies and procedures that instruct him on what to check and how to judge the reasonableness of the data. As a result, he said he does not question any reported costs on the forms sent to him for review.*

Some regional office staff reported that they felt their role in the cost reporting process was mainly a clerical function. Involvement of the regional office staff in the cost reporting process is beneficial because regional office staff are more familiar with the adult homes in their region and are often more knowledgeable of the homes' operations than staff in the Division of Financial Management. Clear policies and procedures would enhance the role of regional office staff in this process.

Recommendation (17). **The Department of Social Services should develop clear policies, procedures, and standards for use by all individuals involved in the cost reporting process. The policies, procedures, and standards should address the roles of the Department's regional office and Division of Financial Management staff in the central office for completing, reviewing, and evaluating the cost reporting forms to ensure cost data used in the rate calculation are properly accounted for, consistent, and appropriate.**

The Cost Reporting Cycle Needs Adjusting. According to the 1979 JLARC report, 171 adult homes submitted cost reporting packets to DSS for the establishment of an approved monthly rate for FY 1979. As of July 1990, 332 homes had submitted cost reporting packets for a FY 1991 approved rate. This is an increase of more than 93 percent since 1979. Yet, the amount of time available to DSS staff to review the cost reporting forms is, in some cases, less than six weeks. This is a very limited amount of time considering the number of packets that must be reviewed.

Currently, adult home cost reports must be submitted to DSS regional offices by May 15 each year. Many of the forms are not received at the regional offices until the May 15 deadline. There are also several cases in which the forms must be returned to the operator to make corrections or provide additional information. Since the rates must be calculated by July 1, there is often very little time for adequate review by staff in either the regional office or in the Division of Financial Management, especially given the increasing number of cost reporting forms.

Recommendation (18). **The Department of Social Services should consider moving the current cost reporting period from the two-month period beginning in mid-March to a two-month period beginning in January. This would provide Department staff up to eight additional weeks to review the reported adult home cost data.**

Cost Reporting Forms Need Improvement. The 1979 JLARC report cited problems with the adult home cost reporting forms. According to DSS, the cost reporting forms have been recently revised. However, problems with the forms still appear to exist which could affect the quality of the adult home cost data collected. For example:

> *One home operator stated she had difficulty determining the total number of residents (total bed days used) that her home cared for each year. The instructions with the cost reporting form provide little guidance on how to collect and calculate this figure, even though this figure is an significant component of the home's rate calculation.*
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> * * *
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> *The revised cost reporting forms sent to home operators in 1990 contained instructions from the previous year that did not match the categories in the new forms.*
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> * * *
>
> *The general appearance of the cost reporting packet is poor. The quality of the copies make reading and understanding what is being requested difficult. One DSS regional office staff member stated he finds it difficult to believe home operators take the whole process seriously when the package looks terrible and is difficult to read.*

The process used to revise the cost reporting forms is also in need of improvement. Revisions to the 1990 cost reporting forms were made primarily by staff from an adult home advocacy group. According to staff from DSS' Division of Financial Management, no input or guidance was provided by DSS staff involved in the adult home cost reporting/rate setting process. As a result, DSS staff were unaware of the reason certain data and information were requested from adult home owners on the cost forms.

Recommendation (19). **The Department of Social Services should revise the cost reporting forms to provide clear instructions about each line item to be reported. The instructions should provide examples for items that are difficult for adult home owners to understand. The instructions should also provide space for collecting and calculating data such as bed days used. Revisions to the forms should involve Department staff involved in the adult home cost reporting/rate setting process, adult home operators, and the Homes for Adults Advisory Group.**

The Adult Home Rate Setting Process Is Deficient

The number of auxiliary grant recipients and total expenditures for the program have increased dramatically since 1979. In addition, the approved rate for homes accepting auxiliary grant recipients has also exhibited a steady increase. Nevertheless, DSS has not made appropriate fiscal management of the program a priority. The 1979 JLARC and 1985 Ernst & Whinney reports criticized DSS for accepting unaudited or unverified cost forms as the basis for adult home rates. With the exception of a brief period in the early-to-mid 1980's, DSS has not established adult home rates based on verified or audited data. By DSS' own admission, the current rate setting procedure is mainly a clerical function.

The adequacy of the current maximum auxiliary grant rate is a point of continuing debate. The adult home cost data submitted to DSS indicates the current maximum of $602 may be inadequate. Based on adult home owner reported costs submitted for a rate effective July 1, 1990, total program costs would need to increase by more than $6 million to provide a rate commensurate with the reported data. However, the need for a higher rate cannot be substantiated because the validity of the cost data used in the rate setting process is questionable. In addition, substantial errors with the cost data were identified during this review.

As a result, DSS can neither provide valid data to policymakers concerning the cost of operating an adult home nor accurately determine the adequacy of the State's maximum auxiliary grant rate for adult homes. In addition, the current rate setting process does not provide an interim auxiliary grant rate that reflects changes in the maximum rate. Finally, consistent staffing and oversight of the rate setting process is lacking, which could lead to misuse of State funds.

Adequacy of the Adult Home Auxiliary Grant Rate is Difficult to Determine. For a licensed adult home currently operating, a monthly auxiliary grant rate is calculated based on operator reported costs and allowable depreciation expenses from the facility's previous year of operation. For a home that is not newly licensed, the rate will either be the lower of the computed monthly rate or the maximum monthly rate.

As of July 1990, 330 of 332 homes with approved rates for FY 1991 received the maximum monthly rate. In 1985, Ernst & Whinney stated that the high number of homes receiving the maximum auxiliary grant rate

> suggests that either a) the maximum rate is too low...or b) unreliable cost information and the acceptance by the Department of reported costs without further verification enables virtually all HFAs [adult homes] to receive the maximum rate....Further analysis of the cost reporting process will support the hypothesis that cost data submitted by Homes for Adults is unreliable.

The lack of valid adult home operating cost data hinders policymakers when making decisions about the adequacy of the maximum monthly adult home rate. Difficulty in determining the adequacy of the current maximum rate is further highlighted by statements made by DSS staff and a review of actual cost data submitted by adult home operators. For example:

> *One DSS staff person involved in the adult home rate setting process stated that homes that do not get the maximum rate the first year will get the maximum the next year by simply increasing the reported administrative salaries enough to justify the maximum rate.*
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> * * *
>
> *Another regional office staff person reported that he checks the data to ensure there are enough costs on which to base a maximum rate. If not, he will carefully review the form to see where some data may have possibly been excluded. He will then call the home operator back to ensure that all of the available expenses have been included. He says he does this because the home will "raise the devil" if it does not get the maximum rate and, in the end, the rate will eventually be raised to the maximum.*
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> * * *
>
> *One home with a licensed capacity of 12 residents reported depreciation expenses associated with buildings as $535,000. However, the depreciation schedule in the packet indicated that the building was acquired in 1979 at a cost of $52,500. The home operator confirmed that the depreciation figure was incorrect and should have been $5,350. Yet, DSS included this incorrect figure of $535,000 in the*

home's total expenses. This resulted in the home having a computed rate based on a total cost of $660,628 instead of $130,978. As a result, the computed monthly rate for this home was more than five times higher than it should have been.

During JLARC staff site visits, most operators stated that the maximum auxiliary grant rate in effect at the time ($581 per month) was insufficient. While home operators reported they believed a more equitable rate would be anywhere from $600 to $1,500 per month, valid cost data are not available to fully substantiate their claims. Using costs reported in FY 1990, the median cost of care for an auxiliary grant recipient in an adult home statewide was about $663 per resident per month (Table 6). It is important to note that the data are self-reported by home operators and neither audited nor verified.

For homes located in both Planning District 8 (Northern Virginia) and elsewhere throughout the State, there is a distinct economy-of-scale effect for homes with a rated capacity of between 25 and 49 residents. Smaller homes have higher costs per resident because there are fewer residents to absorb the fixed costs associated with operating the home. The economy-of-scale effect lessens in the larger two groups of homes as costs associated with staff, supplies, and capital expenditures increase at a higher rate relative to the number of residents.

Table 6

Estimated Median Monthly per Resident Net Cost of Adult Home Operation*

Licensed Capacity of Adult Home	Homes Not Located in Planning District 8**	Homes Located in Planning District 8**	All Homes Statewide
4-24	$659	$1989	$665
25-49	628	1191	629
50-74	634	1395	645
75 +	711	1150	759
All Homes	$653	$1414	$663

* The estimated median monthly costs were based on operating costs reported in FY 1990 by adult homes.

** Planning District 8 includes the cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park, and the counties of Arlington, Fairfax, Loudoun, and Prince William.

Source: JLARC staff analysis of adult home costs reported in FY 1990.

It is also interesting to note that the median monthly cost of operating an adult home located in Planning District 8 is significantly higher than homes located in other areas of the State. This could indicate that homes that do accept auxiliary grant recipients are subsidizing their care through charges to private-pay residents or through charitable means. However, an important caveat must be made. The higher costs may also be a reflection of inefficient operations or indicate serious problems with the current cost reporting/rate setting process.

For example, the daily cost of operating an adult home in Planning District 8 with a licensed capacity of between 4 and 24 beds is about $66 per day. This is more than an intermediate care facility (ICF) in that region would receive from the State's medicaid program. As of March 1990, ICFs in Northern Virginia received about $60 per day for operating costs associated with caring for medicaid eligible patients.

If adult home auxiliary grant rates were increased using the median monthly rate calculated for homes located in Planning District 8 and elsewhere throughout the State (see Table 6), the total FY 1990 program cost would have increased by $6 million to more than $21 million. This estimate assumes that each auxiliary grant recipient received the maximum SSI benefit. Of this total, about $17.5 million would be the State's responsibility and about $4 million would be the responsibility of local governments.

Any decisions concerning the adequacy of the auxiliary grant rate should depend on the collection of valid cost data by DSS. Adult home cost data will need to be consistently reviewed and verified, or audited periodically to ensure calculated rates are based on actual costs. Adequacy of the maximum rate should not be evaluated until a minimum of one year of cost data have been verified and audited. After initial rates are established, cost reports can continue to be collected from adult homes annually. When audits are conducted, the audit scope should include cost data from the most recent two-year time period. In addition, DSS should establish criteria to identify homes whose cost data should be subject to further verification or audits.

Recommendation (20). **The Department of Social Services should develop and implement procedures that include financial reviews and audits of cost data reported by adult home operators. Once audits and financial reviews have been completed, the Department should calculate the median monthly cost of operating adult homes. Separate calculations should be made of costs for homes located in Planning District 8, homes located outside of Planning District 8, as well as, homes on a statewide basis.**

Current Process Does not Provide an Adequate Interim Adult Home Rate. Newly licensed homes requesting an approved auxiliary grant rate are supposed to be assigned, by DSS policy, the minimum adult home rate ($175) until 90 days of actual cost data are collected. The 1985 Ernst & Whinney report and DSS central office staff have expressed concern with this rate. The minimum rate of $175 has been in effect since 1974 when the maximum home rate was $200 per month. The minimum

monthly rate, if adjusted to match the increase in the maximum monthly rate since 1974, would be $527 per month.

At the present time, eligibility workers for residents of newly licensed adult homes usually delay the processing of auxiliary grant benefit applications until a rate other than the minimum is approved. At that time, retroactive auxiliary grant payments are made to the individual. Two problems are often encountered by delaying the processing of the application until an approved rate is assigned. First, the delay jeopardizes the medicaid benefits of auxiliary grant eligible individuals who are not SSI eligible. Second, it denies the home operator needed financial resources during the start-up phase of the business.

Eligibility for the auxiliary grants program automatically qualifies non-SSI eligible individuals for medicaid benefits. By delaying the auxiliary grant application until a rate other than the minimum is approved, the individual's eligibility for medicaid benefits is also delayed. Although the medicaid benefits are also retroactive for those found eligible, lack of initial coverage could hinder the acquisition of needed health care services.

For the newly licensed home operator, the start-up phase of the new business often has a large amount of fixed costs. During this phase, consistent financing is critical. In addition, the extremely low rate may reduce a home operator's willingness to accept auxiliary grant recipients during this period.

An adequate interim rate for newly licensed adult homes is necessary. This interim rate should provide newly licensed adult homes more adequate financing during the initial phase of operation and reduce the need to delay processing of auxiliary grant benefit applications. The current minimum rate would still apply to adult homes that do not meet the adult home rate application deadlines or requirements. A monthly interim rate of $527 for newly licensed homes should be considered.

Recommendation (21). **The Department of Social Services should adjust the minimum monthly adult home rate for newly licensed adult homes to reflect the historical increase in the maximum monthly adult home rate. This interim rate for newly licensed adult homes should reduce the need to delay processing of auxiliary grant applications.**

Cost Reporting/Rate Setting Functions Should be Consolidated

Another mechanism to improve the Auxiliary Grants Program would be to consolidate the cost reporting/rate setting function of children's and adult home facilities. Currently, the rate setting function for children's facilities is located in DSS' Division of Service Programs. Rate setting for adult homes is located in the Division of Financial Management. Both functions should be located in the Division of Financial Management to increase efficiencies and address overall problems affecting the adult home rate setting function.

Currently, the rates for 129 children's facilities are determined by one staff person in the Division of Service Programs. Consolidating both this function and the staff position into the Division of Financial Management has several advantages. First, the adult home and children's facilities rate setting functions are somewhat similar. The staff person currently assigned to rate setting for the children's facilities has extensive experience in the area of rate setting for residential care facilities. Consolidating this position in the Division of Financial Management should allow this staff person to assist in the adult home rate setting process.

In addition, the children's facilities' cost reporting process is quite formalized and collects good supplemental information. Some of the procedures used for the children's facilities cost reporting may be applicable to the adult home cost reporting process. Having both functions in the same division could facilitate an exchange of ideas on how to improve the quality of adult home data collected and the subsequent quality of the data used to base the monthly adult home auxiliary grant rate. Finally, consolidating both functions in one division should facilitate information sharing and problem solving concerning reimbursement matters for residential facilities.

In the future, if DSS is unable to properly administer the cost reporting/rate setting function of the Auxiliary Grants Program, consideration should be given to specifying in statute the duties of DSS in this area. This would ensure that the Auxiliary Grants Program's cost reporting/rate setting function is properly administered.

Recommendation (22). **The Department of Social Services should consolidate agency facility rate setting functions for children's and adult facilities in the Division of Financial Management to strengthen the adult home cost reporting/rate setting function. The Secretary of Health and Human Resources should report the status of changes made to the auxiliary grant cost reporting/rate setting function to the Commission on Health Care for All Virginians prior to the 1992 session. Should management and oversight of the adult home rate setting process not improve by this time period, the General Assembly may wish to specify by statute the responsibilities of the Department with regard to the Auxiliary Grants Program's cost reporting/rate setting function.**

Auxiliary Grant Coverage of Specific Services is Unclear

At the present time, it is unclear which services the auxiliary grant payment is intended to purchase. According to a policy paper prepared by DSS on the adult home system, all service costs that can be included on the cost reporting form should be covered by the home's approved rate. However, a number of homes charge residents for laundry, transportation, and even special diets. Charging residents for services included on the cost reporting form has many undesirable results. First and foremost, it reduces the unencumbered money available to auxiliary grant recipients through the monthly $35 personal allowance. This makes it more difficult for them to purchase

clothing, toiletries, over-the-counter medications, and to pay for the prescription drug co-payments required by medicaid.

Resident charges also make it difficult to evaluate the adequacy of the personal allowance. In addition, these charges could put the State in the position of paying for adult home services twice; once through the auxiliary grant payment and once through the personal allowance. Finally, it makes it difficult to assess the adequacy of the adult home's monthly rate if these additional revenues are not properly accounted for in the costs.

Currently, there is no mechanism for ensuring that residents are not charged for services included in the adult home cost reporting/rate setting process. According to DSS,

> there is little linkage between the rate setting process and assurance that the rate established for the [adult home] will purchase specific services, such as laundry or transportation, for the [auxiliary grant] recipient.

The Department agrees that specific services should be included under the auxiliary grant payment. In fact, the Department is currently in the process of developing draft regulations that would specify the services covered by the auxiliary grant payment. However, this process was first begun in 1988 and never completed due to resource constraints. It is unclear whether the current steps to develop and promulgate these regulations will be completed.

Recommendation (23). **As part of the comprehensive plan for the adult home system, the Secretary of Health and Human Resources should include a proposal for regulatory changes governing charges for services received by auxiliary grant recipients. The regulations should ensure that auxiliary grant recipients are not levied charges for specified services. Some of the services which should be covered through the basic auxiliary grant payment are basic laundry services, some special diets, and extra portions of food at mealtime. For example, the auxiliary grant payment to home operators could cover seven changes of underclothes and two changes of outerclothes per week for residents. Any additional items of laundry and all dry cleaning could then be assessed an additional charge.**

Current Personal Allowance May Be Inadequate

The amount of the monthly personal allowance, which is stipulated in the Appropriations Act, has increased from $25 to $35 since 1979. This is an increase of 40 percent. Over that same period, the maximum adult home rate has increased 79 percent. The ability of the $35 monthly personal allowance to meet the basic needs of the residents is questionable.

The personal allowance is an important component of the State's funding system for eligible adult home residents. It allows auxiliary grant recipients to purchase goods and services not covered by the benefit, which can directly affect their quality of life. These goods and services can include clothing, transportation, over-the-counter medications, and prescription medication co-payments.

During JLARC staff visits to adult homes, home operators were asked about the adequacy of the $35 personal allowance. Ninety percent of the operators reported that the current monthly $35 personal allowance was insufficient. These home operators indicated that a personal allowance of slightly more than $55 per month was appropriate. Examples of the difficulty in covering the cost of personal items and services through the current $35 personal allowance include the following:

> *An adult home operator reported that an auxiliary grant recipient in her home spends $12 each month for dues at the local senior citizens center. This leaves only $23 available for expenses like non-prescription medication, prescription medication co-payments, toiletries, and clothing.*
>
> * * *
>
> *Another home operator reported to JLARC staff that one auxiliary grant recipient owed the adult home $373.40 for goods and services paid for by the home because the resident did not have sufficient financial resources. For the 12-month period beginning July 1, 1989, this resident's expenses at the local pharmacy for adult diapers and prescription co-payments alone averaged $34 each month. In addition, the resident had other expenses such as transportation, a charge for additional laundry above the amount the home supplied free to all residents, and a small amount of spending money the home gave to the resident. The home operator reported she was going to ask the home's board of directors to waive this resident's debt.*

Because of the home's willingness and ability to ignore this resident's $373 debt, the resident was able to acquire the necessary personal care items and have about seven dollars each month in spending money. Many home operators reported they had residents that owed the home money because the operator would purchase items the resident needed when the resident did not have money. Most stated they would not, in all probability, ever recover this money.

Based on the monthly average of 5,761 auxiliary grant recipients in adult homes during FY 1990, a $10 per month increase in the personal allowance would increase total auxiliary grants program costs by more than $691,000. Of this amount, more than $552,000 would be the State's responsibility. The remaining $138,000 would be the responsibility of local governments.

Recommendation (24). **The Department of Social Services should evaluate the necessity of increasing the personal allowance provided to auxiliary grant recipients. The necessity and amount of the increase should not be determined until after regulations addressing the services to be included in the basic auxiliary grant benefit payment are adopted. This information should be presented to the General Assembly for consideration in adjusting the personal allowance received by auxiliary grant recipients.**

REDESIGNING THE ADULT HOME FUNDING SYSTEM

The current funding system for adult home care, as noted earlier in the report, has several deficiencies. Corrective action on the part of DSS will certainly improve the current system's ability to more adequately meet the needs of adult home residents and ensure a better accounting of State funds. Yet, additional changes and enhancements to this system will be necessary to provide adequate funding for residents in the proposed tiered regulatory system presented earlier in the report.

In its present form, the Auxiliary Grants Program is unable to differentiate adult home rates based on the varying types and amounts of services provided by adult homes. Currently, almost all homes accepting auxiliary grant recipients receive the maximum monthly rate of $602. Certainly, problems previously identified with the Auxiliary Grants Program contribute to this large number of homes receiving the same auxiliary grant rate. However, the fact that so many homes receive similar auxiliary grant rates is, in part, the result of a regulatory system that currently recognizes only one level of adult home care.

Under the proposed regulatory system, adult homes would be classified into one of three regulatory levels according to the level of care they provide their residents. In order for State funding to be sufficient to meet the needs of residents in each level of care, the funding system must be able to differentiate financial assistance for eligible individuals based on the level of care they receive from the adult home. This section presents (1) the framework for redesigning the funding system to address the proposed changes in the regulation of adult homes and (2) the possible financial impact of implementing the proposed regulatory changes. Finally, it discusses expanding the use of the auxiliary grant for other housing options for eligible mentally disabled adults.

Auxiliary Grant Funding Should be Linked to Levels of Care

Once the regulatory system is redesigned to address variations in the level of care provided to adult home residents, the funding system should be linked to the licensed level of care provided. This is necessary to ensure eligible adult home residents are able to purchase the necessary services and adult home operators are able to provide appropriate care to their residents. Unlike the current system, the

supplemental funding that many adult home residents receive could be based on the level of care provided by the adult home. This would improve the effectiveness of the State's Auxiliary Grants Program by providing more funding to eligible residents needing more intensive levels of care than to residents requiring only a basic level of care.

Currently, several other states recognize differences in levels of care provided through their supplemental funding systems. Virginia's neighbors, Maryland and North Carolina, provide different funding levels based on levels of care provided to domiciliary care residents. In addition, Florida recognizes differences in levels of care through its state supplemental funding program.

Process for Financing Levels of Care

Funding the three levels of care can only take place after DSS has formally licensed all adult home facilities according to the level of care these facilities provide their residents. Once the regulatory system is in place and facilities operate under the system for several months, facility cost data can be collected and analyzed by DSS. This data can be used to establish an appropriate monthly home rate based on the cost of care required by the regulatory standards in each of the three proposed levels of care.

For each level of care, DSS could collect the facility cost data and determine what costs would be allowed. Once this is completed, the cost of care should be calculated for each home within the first, second, and third regulatory levels. A maximum monthly auxiliary grant rate could be established for each licensed level of care. This rate could be the maximum amount homes would be allowed to charge auxiliary grant recipients. The maximum could be based on the average or median cost of care for each level. This process is similar to the one the State uses to establish medicaid reimbursement rates for nursing homes.

Assessing the Financial Impact of Funding Different Levels of Care

At first glance, the potential financial impact of varying reimbursement rates according to the level of care may appear costly. However, the increased cost to finance a higher level of care may be offset by savings which may be achieved by (1) reassessing the financing of the lowest level of care and (2) providing a regulatory system which ensures that appropriate care is provided to adult home residents who need more intense care. Without assurances that adequate care is provided to these residents, they could deteriorate faster, which could result in increased placements in more costly nursing home beds. If the individual is indigent, this could result in even higher costs to the State because his or her care would likely be subsidized through the medicaid program.

Preliminary estimates of the cost of funding the Auxiliary Grants Program based on the proposed tiered regulatory system using FY 1990 data total about $22 million (Table 7). The State's share of program funding would be approximately $17.5 million, and the local share is estimated to be $4.4 million. The estimate for the total program cost exceeds actual FY 1990 Auxiliary Grants Program expenditures by about $6.4 million.

These estimates of the total program cost were obtained by estimating the median monthly cost of care in each of the three proposed levels of care. Totals for each level were calculated using the estimated number of FY 1990 auxiliary grant recipients residing in each level of care and the median monthly cost for each level. The median monthly auxiliary grant benefit for each level was calculated by subtracting the average FY 1990 maximum SSI benefit from the median monthly cost of care in each home. The monthly cost of the program was calculated by multiplying the number of recipients by the median monthly auxiliary grant benefit for each regulatory level. The monthly program costs were then aggregated to reflect an entire year, which equals the estimated annual program cost.

Table 7

Estimated Cost of Funding the Auxiliary Grants Program Based on Different Levels of Care*

	Estimated Total Cost	Estimated State Share	Estimated Local Share
Auxiliary Grant Funding For Level 1 Care	$ 5,636,695	$ 4,509,356	$1,127,339
Auxiliary Grant Funding For Level 2 Care	14,399,499	11,519,599	2,879,900
Auxiliary Grant Funding For Level 3 Care	1,939,561	1,551,649	387,912
Total Auxiliary Grant Funding	$21,975,755	$17,580,604	$4,395,151

*Figures are based on costs submitted by adult homes in FY 1990.

Source: JLARC staff analysis of adult home costs reported in FY 1990 to the DSS Division of Financial Management for a FY 1991 auxiliary grant rate.

The data appear to indicate that the estimated cost of providing funding to adult home residents based on levels of care is not much greater than the estimated cost of the current program based on the median cost of care presented earlier in the chapter ($663). However, there are some important points which need to be considered. First, the increased regulatory standards that have been proposed for the second and third level of care are not yet in effect. Regulation for homes in these two levels could result in higher costs, if the standards require homes to employ additional or specialized personnel or to purchase specialized services.

In addition, cost estimates were based on the assumption that all residents would receive the estimated median auxiliary grant amount. Some auxiliary grant recipients will likely have income in excess of SSI levels, which would result in the payment of a lower auxiliary grant benefit than used in the cost estimate.

Estimating the Median Home Rate for the Lowest Level of Care. The estimated median monthly rate for the lowest level of care is estimated to be $658 per resident. This would result in an average monthly auxiliary grant rate of $316, and would include a monthly personal allowance of $35 (Table 8). Using this estimate, the total annual cost to the State and localities to provide auxiliary grant benefits to residents residing in the lowest level adult homes would be about $5.6 million.

The estimated cost was based on data from 245 adult homes. The calculation separated out facilities the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) identified as housing mentally disabled residents and facilities identified by DSS licensing staff as providing medical-type services to residents.

Table 8

Estimated Median Monthly Adult Home Rate and Auxiliary Grant Benefit by Level of Care*

Adult Home Licensed Level of Care	Median Monthly Adult Home Rate**	Median Monthly Auxiliary Grant Benefit**
Level One	$658	$316
Level Two	653	311
Level Three	731	389

* Figures are based on costs submitted by adult homes in FY 1990.

** Includes a monthly personal allowance of $35. The State funds 80 percent of the auxiliary grant benefit and localities fund 20 percent.

Source: JLARC staff analysis of adult home reported costs for FY 1990 to the DSS Division of Financial Management for a FY 1991 auxiliary grant rate.

Estimating the Median Home Rate for the Second Level of Care. The median monthly cost of providing care to residents of homes in the second level of care was estimated using data from 51 of 89 homes which DMHMRSAS identified as housing mentally disabled residents in 1988. The median monthly cost of care for these 51 homes was estimated to be approximately $653 per resident (Table 8). The estimated monthly auxiliary grant payment including the $35 personal allowance is $311. Using this estimate, the total annual cost to the State and localities to provide auxiliary grant benefits to residents residing in licensed facilities providing the second level of care would be about $14.4 million.

The estimated monthly cost of care in this type of home is unexpectedly lower than the cost of care for a home in the lowest level. This may be due to several factors. First, as cited earlier, the cost estimate is based on 51 of the 89 adult homes providing care to mentally disabled residents that submitted cost data to DSS. Data were not available to comprehensively identify homes serving this population. Second, it assumes that these homes are currently providing services at the level that would be required under the proposed regulatory standards for the second level of care. This is doubtful given the interview responses of mental health professionals and DSS licensing staff.

Finally, the estimated cost of providing adult home care in the second regulatory level appears to reflect an economy-of-scale effect for the homes identified as providing this level of care. Homes used to estimate the median cost of the second level of care had an average licensed capacity of 60 beds. Homes used to estimate the median cost of providing the lowest level of care had an average licensed capacity of slightly more than 31 beds. As noted earlier in this chapter, homes with fewer licensed beds will often have higher costs per resident because there are fewer residents to absorb the fixed costs associated with operating the adult home.

Although there may be additional service requirements for homes licensed to provide the second level of care, the increase in cost may not be substantial. Homes providing this level of care could meet many of these additional requirements by accessing existing services offered through local community services boards.

Estimating the Median Home Rate for the Highest Level of Care. The median cost of providing care to residents of adult homes licensed as providers of the highest level of care was estimated using cost data from adult homes identified by DSS regional licensing staff as providing medical-type care to a majority of their residents. Of the 33 homes identified, 14 submitted cost data to DSS for a FY 1991 auxiliary grant rate. The current monthly estimate to provide care to residents of these 14 homes is about $731 per resident. The estimated monthly auxiliary grant payment including the $35 personal allowance is $389. Using this estimate, the total annual cost to the State and localities to provide auxiliary grant benefits to residents residing in licensed adult homes providing the highest level of care would be about $1.9 million.

The estimated cost of care in a level three home is about $138 per month higher than the current maximum monthly auxiliary grant rate of $602. It is possible

that with licensing standards that require more sophisticated resident care, the cost estimate may increase. However, as with both the first and second level of care, the true cost to the State and local governments for funding this program cannot be assessed until the regulatory system is in place, homes are categorized according to the level of care provided residents, and accurate cost of care data are collected by DSS.

Recommendation (25). **As part of the comprehensive plan for regulating homes for adults, the Secretary of Health and Human Resources should include a proposal to link auxiliary grant funding to the proposed regulatory framework that recognizes the different levels of care provided by homes for adults. Use of the median cost of care for each level as the maximum established auxiliary grant rate for homes licensed under each level of care should be considered.**

Once the standards for the proposed regulatory system have been promulgated, the Department of Social Services should collect cost data from adult homes licensed in each level of care. This cost data should be verified and audited as necessary, then used to calculate the cost of care provided for each level.

Auxiliary Grant Benefits Could Be Used for Other Housing Options

The Auxiliary Grants Program was originally available for eligible residents of DSS licensed homes for adults. In 1982, eligibility guidelines were changed to allow financially eligible aged, blind, or disabled individuals residing in adult family care homes to receive auxiliary grant benefits. (Adult family care homes house three or fewer residents.) There has been no expansion of the Auxiliary Grants Program for use with other housing options since that time, although some changes were discussed in two previous reports on the adult home system.

In 1986, JLARC staff recommended in a report on deinstitutionalization that the General Assembly consider expanding auxiliary grant funding for residents of other housing arrangements. One alternative discussed in that report was CSB-operated residential facilities which house mentally disabled adults. Most CSB-operated residential facilities are licensed by DMHMRSAS. DMHMRSAS favors the use of auxiliary grant funding for eligible residents in CSB-operated facilities.

CSB-operated facilities provide specific services and programs for the mentally ill and mentally retarded. These facilities are able to link residents directly with CSB services and trained staff. CSB-operated facilities observed during 1990 JLARC field visits were generally providing higher levels and more intensive services to their residents than those provided by more traditional DSS-licensed adult homes. Often the primary goal of these operations is to provide the individual resident with the necessary skills and support to move from the CSB residential facility to a less restrictive residential setting.

Expanding the Auxiliary Grants Program to eligible residents (primarily SSI recipients) of CSB-operated facilities would allow CSBs to reallocate some funds used for housing into direct services for clients, including mentally disabled adult home residents. However, the total number of SSI recipients (or auxiliary grant eligible adults) currently residing in CSB-operated facilities is unknown. Consequently, the financial impact of using auxiliary grant benefits to provide housing in these facilities is unavailable.

DSS examined expanding the Auxiliary Grants Program in a report to the General Assembly in 1987 (Senate Document No. 9). The report stated that "while the number of SSI recipients and individuals with too much income for SSI which reside in group homes [licensed by DMHMRSAS] is unknown, the cost of such expansion is estimated to be minimal." The report did not provide any estimated costs regarding expansion of the program, however.

Prior to expanding program funding, the Secretary of Health and Human Resources should determine the financial impact of providing auxiliary grant funding to eligible residents of CSB-operated residential facilities. Once this is determined, the Secretary should provide the information to the General Assembly for consideration in expanding the Auxiliary Grants Program.

Appendixes

Appendix A

Study Mandate

Appropriations Act
Chapter 972 -- Approved April 18,1990

Item 545. REGULATION OF PUBLIC FACILITIES AND SERVICES

"The Joint Legislative and Audit Review Commission [sic] shall conduct a follow-up study on the 1979 Homes [sic] for Adult Study. The Commission shall report to the SJR 118-Health Care for All Virginians Commission prior to the 1991 Session, and shall submit periodic progress reports to the Commission during the year. The Departments of Social Services and Health shall cooperate with JLARC on this study."

Appendix B

Estimating The Cost of Adult Home Regulation

To help assess whether the responsibility for licensing adult homes should remain in the Department of Social Services (DSS), JLARC staff assessed the cost for DSS to regulate homes for adults. This cost estimate was then compared to the estimated cost for the Virginia Department of Health (VDH) to regulate adult homes. This comparison revealed that the cost for DSS to regulate adult homes is less than the cost of regulation by VDH. The cost of adult home regulation by DSS is estimated at $824,000, compared to $831,000 for regulation by VDH.

The cost for DSS regulation was estimated using information from DSS' Division of Licensing for FY 1990. The cost for VDH regulation was based on information obtained from VDH for FY 1990. JLARC staff modified both cost estimates to account for State employee salary adjustments for FY 1991 and actual fringe benefit costs for FY 1991. Some additional adjustments were made to each estimate, which are described in the following sections.

Estimating the Cost of DSS Adult Home Licensure

JLARC staff estimated the cost of DSS adult home licensure to be about $824,000 (Table B-1). This estimate includes the costs for 19 salaried positions with responsibility for adult home licensing, fringe benefit costs, and other administrative support costs. This estimate varies from the estimate made by DSS in FY 1990 because JLARC staff anticipate that by consolidating DSS regions and balancing workloads of adult home licensing specialists, DSS should be able to eliminate two licensing specialist positions. This assumes that all adult licensing specialists will have a caseload of 30 adult homes, as recommended by a 1987 study conducted by the Department of Planning and Budget (DPB).

Estimating the Number of Positions for Adult Home Licensure. DSS estimated that 22 positions have primary responsibility for adult home licensure. These include: 19 field licensing staff, two central office staff, and one technical support staff position (Table B-1). In projecting cost savings anticipated by the consolidation, JLARC staff eliminated the two licensing specialist positions which were the lowest grades and steps. The DSS estimate included one technical support staff position. However, the JLARC staff estimate does not include this position in the cost, as the position does not have primary responsibility for adult home licensure.

Estimating Salaries, Fringe Benefits, and Support Costs. The cost of salaries was based on DSS FY 1991 salary estimates for licensing positions with responsibility for adult home licensure. Fringe benefits estimates were adjusted by increases in FICA and VRS, effective July 1, 1990. Support costs were based on DSS estimates using guidelines they obtained from DPB for agencies to use in estimating support costs.

Table B-1

JLARC Revised Cost Estimate for DSS Adult Home Regulation

Number of Positions by Grade and Step	FY 1991 Salary	Total Salaries
2 grade 11, step 8	$34,409	$ 68,818
1 grade 11, step 3	27,538	27,538
9 grade 10, step 8	31,476	283,284
2 grade 10, step 8*	34,409	68,818
1 grade 10, step 7	30,105	30,105
1 grade 10, step 6	28,793	28,793
2 grade 10, step 5	27,538	55,076
1 grade 10, step 4	26,339	26,339
Total FY 1991 Salaries		$588,771
Fringe Benefits		
FICA @ 7.65%		45,041
Virginia Retirement System (VRS) @ 14.52%		85,490
Group Life Insurance @ 1.008%		5,935
Group Health Insurance @ $1270 per position		24,130
Total Fringe Benefits		$160,596
Support Costs		
Telephone Services @ $1200 per position		22,800
Travel @ $2100 per position		39,900
Supplies @ $400 per position		7,600
Rent @ $230 per position		4,370
Total Support Costs		$ 74,670
TOTAL COST TO REGULATE		$824,037

*These two positions receive a pay differential for Northern Virginia employees.

Source: JLARC analysis of DSS Division of Licensing estimated costs to regulate adult homes, September 1990.

Estimating the Cost of VDH Adult Home Licensure

JLARC staff estimated the cost of VDH adult home licensure to be about $831,000 (Table B-2). This estimate includes the costs for about 22 salaried positions with responsibility for adult home licensing (two of these positions would not be full-time), fringe benefit costs, and other administrative support costs. This estimate varies from the estimate made by VDH in FY 1990 because VDH inadvertently estimated licensing specialists employed at a grade 9 instead of grade 10.

Some additional modifications were made to the original VDH cost estimate. VDH had estimated the total salary cost less an anticipated three percent turnover rate. This was not included to allow for a parallel comparison to the DSS cost estimate. In addition, it is likely that turnover may be reduced due to position reductions and hiring freezes which may occur in FY 1991 and FY 1992.

Another modification to the VDH cost estimate involved fringe benefit costs. VDH staff had estimated the cost of fringe benefits as 20 percent. Because the actual cost of fringe benefits is closer to 30 percent, JLARC staff used actual percentages for FICA, VRS, and group life insurance to estimate fringe benefits. Group health insurance was estimated at $1270 per position, similar to the DSS estimate.

Table B-2

JLARC Revised Cost Estimate for VDH Adult Home Regulation

Number of Positions by Grade and Step	FY 1991 Salary	Total Salaries
13 licensing specialists grade 10, step 5	$27,538	$357,994
2 licensing supervisors grade 11, step 5	30,105	60,210
1 licensing manager grade 12, step 5	32,910	32,910
2 office services specialists grade 5, step 5	17,639	35,278
1 fiscal technician grade 6, step 5	19,283	19,283
1 office services supervisor grade 6, step 5	19,283	19,283
Portion of VDH architect	9,835	9,835
Portion of VDH development specialist	9,032	9,032
Total FY 1991 Salaries		$543,825
Fringe Benefits		
FICA @ 7.65%		41,603
VRS @ 14.52%		78,963
Group Life Insurance @ 1.008%		5,482
Group Health Insurance @ $1270 per position		25,400
Total Fringe Benefits		$151,448
Support Costs		
Communications		14,056
Employee Development		1,536
Management Information		140
Repair and Maintenance		525
Technical Services		12,326
Transportation (travel)		86,889
Administrative Supplies		1,574
Specific Use Supplies		210
Oper. Lease Payments		15,099
Insurance		3,255
Total Support Costs		$135,610
TOTAL COST TO REGULATE		$830,883

Source: JLARC analysis of VDH estimated costs to regulate adult homes, January 1990.

Appendix C

Agency Reponses

As part of JLARC's data validation process, each State agency involved in an assessment effort is given the opportunity to comment on an exposure draft of the report.

Appropriate technical corrections resulting from the written comments have been made in this version of the report. Page references in the agency responses relate to an earlier exposure draft and may not correspond to page numbers in this version of the report.

Included in this appendix are the following responses:

- Department of Mental Health, Mental Retardation and Substance Abuse Services
- Department of Social Services
- Department of Health

COMMONWEALTH of VIRGINIA
DEPARTMENT OF
Mental Health, Mental Retardation and Substance Abuse Services

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October 9, 1990

Philip A. Leone, Director
Joint Legislative Audit and
Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, VA 23219

Dear Mr. Leone:

I am writing in response to your September 18 letter requesting comments on the exposure draft of the report entitled, Follow-up Review of Homes for Adults in Virginia. I want to thank you for affording us the opportunity to examine this report before it is presented to the Commission. We do have several comments, both general and specific, which are presented below:

General Comments

1. DMHMRSAS is very pleased that the report acknowledges the special needs of persons with mental disabilities and that Homes for Adults, as presently structured, often experience difficulties with this population. We are supportive of recommendations to establish a differential level of care, new licensing requirements and intermediate sanctions for Homes for Adults serving mentally disabled residents.

2. We are also pleased to note that JLARC has recognized and given this agency or its local affiliates (Community Services Boards) an appropriate role in developing regulations, training agency and HFA staff, and collaborating with the Department of Social Services around those issues. We look forward to continuing many of the projects already underway in these areas.

3. We are disappointed that the report did not include an analysis of options to expand the use of Auxiliary Grants to help support persons in licensed residential settings other than Homes for Adults, such as group homes and supervised apartments. The question raised on page 39 regarding the role and function of HFA's within a rehabilitation-oriented

continuum of care is pertinent to this issue and should be explored further by JLARC.

4. We are extremely concerned about the report language, which seems to portray persons with mental disabilities as a homogenous group of chronically low-functioning and disoriented individuals. For example, the statement that, "Adult home residents who are mentally disabled may be particularly susceptible to problems associated with wandering episodes "(page 54) attributes to all mentally disabled persons a behavioral characteristic that only applies to a small portion of that group. The impression conveyed by this and similar generalizations will only exacerbate misperceptions about mental illness, mental retardation, Alzheimer's and other dementias, organic brain disorders, and other conditions which are very different from each other in terms of their etiology, symptomology, prognosis, and treatment. We strongly recommend that the report language be revised to address the above issue.

Specific Comments

1. (page 36, line 11) The "local agencies" referred to here should include Community Services Boards and state hospital staff in every case in which a mentally disabled applicant is being considered and should be specifically referenced here.

2. (page 39, paragraph 2). The potential conflict between a "maintenance" approach to care and a "rehabilitation/ treatment" focus could be made more explicit.

3. (page 47, line 8). The term "chronically mentally ill" should be replaced by "persons with serious mental illness" both here and elsewhere in the report.

4. (page 48, paragraph 3). It may be difficult to define the specific mental health "conditions" allowable for HFA placement, since persons with identical diagnoses will frequently exhibit vastly different symptoms and functional abilities, and will require different supports.

5. (page 54). We question whether an individual who travels to Norfolk and Washington, D.C. should be described as "wandering" to these places. Secondly, the general theme underlying the statements at the bottom of this page reflect a belief that persons with mental illness are helpless and need constant supervision, which is untrue. The statements here may be more descriptive of the service system than of persons with mental illness.

6. (page 97, last paragraph). We presume the term "auxiliary grant rate" should be "adult home rate" in line one of this paragraph.

In summary, we believe the report recommends positive changes in the types of care provided, rate structures, and licensing regulations and sanctions. This, combined with a continued collaborative process between DSS and this agency will result in significant improvements in care to mentally disabled HFA residents. We hope the above comments will be helpful in this regard.

Again, thank you for giving us an opportunity to comment on the report.

Sincerely,

King E. Davis, Ph.D.
Commissioner

cc: James C. Bumpas

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LARRY D. JACKSON
COMMISSIONER

COMMONWEALTH of VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

October 4, 1990

Mr. Phillip Leone, Director
Joint Legisative Audit and Review Commission
General Assembly Building
Suite 1100
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

First I would like to commend JLARC staff on the exposure draft report of The Follow-Up Review of Homes for Adults in Virginia. It appears that there has been a thorough and valid review of the comprehensive issues related to Homes for Adults and the draft report makes recommendations on how to integrate this industry with the long term care of the citizens of the Commonwealth. The recommendations are presented in a logical format and they are reasonable expectations for protection of the population in these facilities.

The Department of Social Services finds the recommendations sound and realistic. I will look forward to their implementation based upon the directions and efforts JLARC proposes to the Secretary of Health and Human Resources and ultimately to the General Assembly. The Department does not take strong exception to any of the recommendations and the enclosed comments detail issues of fact or problems addressing implementation.

If you or your staff have any questions or concerns regarding our comments, please feel free to contact the Division of Licensing Programs. If the basic recommendations of the report can be

implemented, including any necessary additional resources, Virginia will have the opportunity to bring our regulatory functions in Homes for Adults to the forefront. Thank you for the quality and depth of the report. As in the JLARC review of Child Day Care, I pledge my support to achieve a greatly improved and modern program for Virginia.

Cordially,

Larry D. Jackson
Commissioner

/bmw

Enclosure

Copy: The Honorable Howard Cullum, Secretary of Human Resources
Ray C. Goodwin, Deputy Commissioner for Local Programs
Carolynne H. Stevens, Director
Division of Licensing Programs

ENCLOSURES

Exposure Draft of
Follow-Up Review of Homes for Adults in Virginia

Generic:

Staff were gratified at the emphasis on the need for extensive statutory revisions. We will bring a number of additional issues and details to the attention of The Secretary and others when statutory revision begins.

The correct title for the Auxiliary Grants Program should be used throughout the document.

The Division of Fiscal Management was recently changed to Division of Financial Management.

Page 10

The section Structured Interviews does not mention staff in the Division of Benefit Programs and the Division of Financial Management.

Page 24

The Department of Social Services (DSS) proposes a stronger statement regarding the increased reliance on adult homes to provide long term care for the impaired elderly. Placement in Homes for Adults by private paying citizens requires no screening process regarding this level of care.

Page 28

Second paragraph, second sentence states "because eligibility... ....adults." Since a determination of ineligibility can be made, it is suggested "eligibility for a grant cannot be determined unless..." be changed to "a grant cannot be approved unless..."

Page 30

First sentence, first paragraph "Homes which admit nonambulatory residents currently do not have to have sprinkler systems unless they are classified as I 2 buildings..."

This implies all I 2 buildings have sprinkler systems and this is not our understanding. There are I 2 buildings that do not have sprinkler systems.

Page 38

There should be an arrow between Hospital and H.F.A. as these types of placement are often made.

Page 41

First paragraph add to "These recommendations have not been implemented" due to funding.

Pages 50-51

The proposed regulations being prepared for the State Board of Social Services have not changed in regard to the intent to discriminate between health care permitted and not permitted in Homes for Adults. The current version does, however, differ significantly from what is presented in Exhibit #2. Accordingly, it might be preferable to delete the exhibit and amend page 50 to explain the concept. This recommendation should be revised to reflect the fact that the intended changes cannot be accomplished by amending only Chapter 9 of Title 63.1. Sections of the Code pertaining to facility definitions and licensure responsibilities under the purview of DMHMRSAS and DOH, and the Boards of Nursing and Pharmacy, as well as responsibilities of DHCD and perhaps DMAS would need to be reconciled. Whether such extensive changes could be handled outside a Code Commission needs to be addressed by JLARC in the recommendation.

Page 59

Recommendation (2)

Many protections cannot be adopted as regulations under current law. An example is unit dose medication. The Department of Social Services believes that revisions of the Code's regulatory frame-work is the prerequisite in accomplishing a sound program. Next to last sentence - delete convalescent, substitute medically supervised. National literature utilizes medically supervised rather than convalescent.

Page 65 Table 5

There are major differences in this expenditure data and the data would probably change the comments by JLARC.

Provider Training

The collection amounts are correct.

Expenditures for 86, 89 and 90 FY's are correct.

We have no end of year final statement for 87 FY. The last quarter of expenditures is not included.

The expenditures stated for 88 FY are for the month of June only. The CARS expenditure for the FY is $42,367.00 or when this correction is made, the unexpended funds for the entire five year period are $9,025.00. If we could reconstruct April - June, 1987, the unexpended funds would be less.

See attached revised table.

Page 69

Last paragraph, first sentence

Suggest change to read - A second major problem related to medication management is the use of.....

A pharmacy will dispense.

Page 71

First paragraph, third sentence

After State Board of Pharmacy, add: and/or Board of Nursing.

Also Recommendation #6 item 2, after Board of Pharmacy add: and/or Board of Nursing.

Page 79

Case example

"Since the findings of the renewal inspection were the primary determinant...."

The Department does not train or endorse this concept. It appears that we have a training or interpretation error with at least one specialist regarding this issue.

Page 85

Third paragraph and Recommendation (14)

This SSI list is limited to the source of income and has not been an effective tool in the identification of illegal operations; however, the Department will continue to utilize this information. Given the problem in the data, we are not certain that use of the SSI list would be acceptable as a basis for obtaining a search warrant.

Page 88 (and also Page 92)

The third sentence of the first full paragraph reads "Auxiliary grant payments...home for adults." The program was established to be in compliance with federal law and regulations which required that assistance from State funds be provided to certain individuals who received Supplemental Security Income (SSI) or were ineligible for SSI because of excess income. The purpose of the program as stated in Section 63.1-25.1 of the Code of Virginia is "to provide assistance to certain individuals ineligible for benefits under Title XVI of the Social Security Act and to certain other individuals for whom benefits provided under Title XVI of the Social Security Act are not sufficient to maintain the minimum standards of need established by the Board." Title XVI is the Supplemental Security Income Program (SSI). In 1974 and for several years afterwards some individuals who did not reside in homes for adults were eligible for the program.

Eventually, because of increases in SSI or other income, these individuals were no longer eligible for the Auxiliary Grants Program (AG) and only people residing in homes for adults were potentially eligible.

Page 89

First paragraph second sentence, change to read

"Although... licensing division and the division of financial management, which sets the auxiliary grant rate, these problems..."

Fiscal Management, now Financial Management, does not administer the auxiliary grant program.

Page 92

The auxiliary grant program was not established specifically to supplement the income of SSI recipients.

Page 93

It is suggested that first the rate be established and next the resident's eligibility. Resident eligibility cannot be determined unless a rate is established for the facility.

Page 95

Last paragraph, first sentence

It is suggested that "In most cases" be deleted.

Page 96

Second paragraph, last sentence

Add: for an individual not residing in Planning District 8.

Page 97 Exhibit #3

Step 2 should be changed to [total need] - [SSI Benefit] - [countable income] = Monthly Auxiliary Grant

Page 102

Paragraph two, third sentence

Change "staff assigned to the auxiliary grant program" to committee. Not all staff involved in the project were auxiliary grant staff.

Page 103

Recommendation (18) Should this be (16) and then a renumbering of the following recommendations as there is no 16 or 17?

Page 110

First paragraph, first sentence

After $602 add: "except for Planning District 8"

Page 117

Third sentence

delete "paying" to read "responsible for auxiliary grant reports" The Division of Financial Management does not issue auxiliary grant checks.

Table 5

COMPARISON OF ADULT HOME LICENSING FEES COLLECTED
TO TRAINING EXPENDITURES FOR ADULT HOME STAFF

Fis. Year	Licensing Fees Collected	Training Expenditures	Unexpended Fees
1986	$ 19,061	$13,466 (OK)	$ 5,595
1987	19,130	8,681 (thru 3/87 mos)	10,449 (-20,182)
1988	22,185	~~8,892~~ 42,367 (6/88 mos)	~~13,293~~
1989	20,740	17,374 (OK)	3,366
1990	28,668	$18,871 (OK)	9,797 9,025
TOTAL	$109,784	~~$67,284~~ ~~101,026~~ 100,759	~~$42,500~~

Source: JLARC Analysis of DSS Division of Fiscal Management Data.

COMMONWEALTH of VIRGINIA

C. M. G. BUTTERY, M.D., M.P.H.
STATE HEALTH COMMISSIONER

Department of Health
Richmond, Virginia 23219

October 9, 1990

Philip A. Leone, PhD
Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, VA 23219

Dear Dr. Leone:

I appreciated the chance to talk with you this afternoon following your review of my memorandum to you and Secretary Cullum, after my review of the JLARC study on Homes for Adults in Virginia.

In summary, I agree with and support the concept of at least three tiers or levels of care. The highest tier, as I understand it, being for people admitted to homes for the aged who have aged in place and now need some nursing services, but not enough to require admission to an intermediate care facility.

Based on my experience over the last two to three years with the DSS and our joint attempt to enforce the Health Department standards within homes for the aged, I believe that a higher level of care can be provided in a home for adults. However, because such care requires medical and nursing skills to protect the health of the occupant such care can ONLY be rendered if the individual affected occupied a room meeting the life/safety standards of a nursing home. The level of care could well be less. We could work out an agreement with DSS on the conditions and skills necessary for such care.

To do this, and enforce acceptable standards, I believe it essential that the Department of Health have the statutory authority to inspect and license a subset of the beds in that HFA. This is similar to our licensing subsets of beds in nursing homes in the past for skilled care as opposed to intermediate care.

Given the authority, I believe we could do the same for a subset of HFA beds located in a wing or separate section where the life safety and nursing standards could be enforced and to which we would give a separate license. These beds could also be licensed as HFA beds in case no one needed the higher level of care, thus, they would be dual licensed. This would allow, for instance, a husband and wife to occupy the same room without leaving a facility, when one becomes too frail to manage by themself.

The crucial issue is our ability to license a subset of beds to the higher standard to protect the life and health of the occupant. I do not believe this can be done simply by a memorandum of agreement.

Thank you for your willingness to bring my concerns to the committee. I am sorry the Virginia Health Planning Board is meeting concurrently with your committee or I would have been present to make the point. Possibly I can come to a later meeting.

Sincerely yours,

C. M. G. Buttery, MD, MPH
State Health Commissioner

pc: The Honorable Howard M. Cullum

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