REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

ASSISTED LIVING AND SERVICES FOR VULNERABLE ADULTS ISSUES IN LONG-TERM CARE PURSUANT TO HJR 689, HJR 751, SJR 485 AND SJR 486

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 98

COMMONWEALTH OF VIRGINIA
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Preface

Bills and resolutions approved during the 1999 General Assembly directed the Joint Commission Health Care to study a number of long-term care related issues. These included issues related to adult care residences, adult foster care, and services for vulnerable adults. These study mandates included HJR 689, HJR 751, SJR 485, and SJR 486.

HJR 689 directed the Joint Commission on Health Care to (i) review the settings and delivery of care to vulnerable adults in Virginia; (ii) enlist the input of the agencies providing services to vulnerable adults and those agencies licensing or otherwise regulating facilities and individuals providing care; (iii) review other states' laws and regulations concerning personal care services, home health care, hospice, and personal attendants; (iv) seek advice from Virginia's vulnerable adults and their families; (v) evaluate any administrative or court cases which may be reviewed without breach of confidentiality; and (vi) review such reports and academic studies of the issues as may be available.

HJR 751 directed the Joint Commission on Health Care to "study and make recommendations relating to the issue of flexibility in the Board of Social Services regulations to meet changing consumer needs as the Board initiates its regular three-year review of the regulations of adult care residences. Specifically, the Commission shall identify ways in which such regulations can be adapted to ensure that core services can be made available to persons as they 'age in place' at their current residences."

SJR 485 directed the Joint Commission on Health Care to examine the effectiveness of adult foster care programs and to include "such recommendations as may be appropriate to encourage and promote the availability of adult foster care programs in the Commonwealth and other related issues as the Commission may deem appropriate."

SJR 486 directed the Joint Commission on Health Care to "undertake a comparative review of services provided in assisted living facilities, including payment rate and waiver option approaches utilized in other jurisdictions."

Based on our research and analysis during this review, we concluded the following:

- "Adult care residence" (ACR) is a term used in Virginia to encompass a wide variety of care settings. This expansive definition potentially limits the ability of elderly and disabled persons to age in place, because a facility that

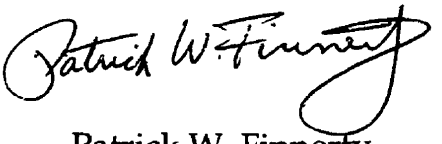
provides even minimal services becomes subject to full-scale licensure as an ACR.

- The wide variety of settings and types of care provided in ACRs make staffing guidelines difficult to establish.
- A 1997 JLARC study found that 47 percent of the public pay residents in ACRs had a behavioral health diagnosis.
- DSS indicated that most of the 23 recommendations made in the JLARC report have not been implemented. Many of these recommendations require actions on the part of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS).
- In response to a JCHC survey, 66 percent of community services board (CSB) respondents disagreed or strongly disagreed with the statement that Virginia's regulations for ACRs are adequate to protect the health and safety of mentally disabled residents. Seventy-four percent of CSB respondents disagreed or strongly disagreed with the statement that DSS enforcement of ACR regulations is adequate to protect the health and safety of mentally disabled residents. Moreover, 83 percent of respondents agreed or strongly agreed with the statement that DMHMRSAS should have a role in the licensure of ACRs that serve the mentally disabled.
- In terms of public pay rates for 24 hour long-term care, the lowest reimbursement level is for adult foster care ($508 per month for most of the state and $584 for Northern Virginia).
- Of the 32 states which have an adult/family foster care program, 22 require mandatory licensure and eight (including Virginia) rely on voluntary certification. At least one on-site inspection is required each year by 24 states. (Virginia requires an inspection once every two years.)
- There is no single, toll-free telephone number for residents of long-term care facilities or their families to call to request adult protective services or ombudsman services or to register a complaint about a long-term care provider (regardless of the type of complaint).

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 43-45.

The Long-Term Care Subcommittee held three meetings at which testimony was received from interested parties. The staff briefing on these issues comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments regarding the report. The public comments (attached at Appendix B) provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services; the Department of Social Services; the Virginia Housing Study Commission; the Department of Housing and Community Development; the Virginia Housing Development Authority; the Virginia Association of Community Services Boards; the Virginia League of Social Services Executives; the Virginia Association of Area Agencies on Aging; the Virginia Health Care Association; the Virginia Hospital and Healthcare Association; the Virginia Association of Nonprofit Homes for the Aging; and the Virginia Adult Home Association for their cooperation and assistance during this study.



Patrick W. Finnerty
Executive Director

December, 1999

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I.
Authority for the Study

Bills and resolutions approved during the 1999 General Assembly direct the Joint Commission Health Care to study a number of long-term care related issues. These include issues related to adult care residences, adult foster care, and services for vulnerable adults. These study mandates include HJR 689, HJR 751, SJR 485, and SJR 486.

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> HJR 751 directs the Joint Commission on Health Care to: study and make recommendations relating to the issue of flexibility in the Board of Social Services regulations to meet changing consumer needs as the Board initiates its regular three-year review of the regulations of adult care residences. Specifically, the Commission shall identify ways in which such regulations can be adapted to ensure that core services can be made available to persons as they "age in place" at their current residences.

> SJR 485 directs the Joint Commission on Health Care to study: the effectiveness of adult foster care programs in Virginia and other jurisdictions [and to include] such recommendations as may be appropriate to encourage and promote the availability of adult foster care programs in the Commonwealth and other related issues as the Commission may deem appropriate.

SJR 486 directs the Joint Commission on Health Care to "undertake a comparative review of services provided in assisted living facilities, including payment rate and waiver option approaches utilized in other jurisdictions." Specifically, the resolution directs that:

such review should address payment schedules for programs funded by the Department of Medical Assistance Services (DMAS), the Auxiliary Grant, and the care managers funded by the Department of Social Services (DSS). In addition, such review should consider benefit packages, in addition to salary, [that are] available to service providers. To determine the consistency of the DSS Adult Protective Services function statewide, such review also should include funding available for oversight responsibilities for the same. Finally, such review should include such other related issues as may seem appropriate.

This report is the second of two reports to be prepared by Joint Commission on Health Care staff during 1999. A report presented at the June 29, 1999 Joint Commission on Health Care meeting addressed SB 1172, SB 1173, and HJR 527.

II.
Financing and Licensure of Adult Care Residences in Virginia

Adult Care Residences Are Licensed by the Department of Social Services

The Department of Social Services licenses adult care residences (ACRs), adult day care centers, and district homes for the aged. Regulation and licensure of adult care residences and adult day care centers is a responsibility of state government, as there is no federal regulation of these types of facilities. Section 63.1-174, of the *Code of Virginia* states, "The State Board [of Social Services] shall have the authority to promulgate and enforce regulations to carry out the provisions of this article and to protect the health, safety, welfare, and individual rights of residents of adult care residences and promote their highest level of functioning." Adult care residences in Virginia were previously referred to as "homes for adults."

In Virginia, the term "adult care residence" is defined by Section 63.1-172 of the *Code of Virginia* as "any place, establishment, or institution, public or private, operated or maintained for the maintenance or care of four or more persons who are aged, infirm, or disabled and who are cared for in a primarily residential setting." This definition potentially encompasses a number of care settings. These include: independent living wings of continuing care retirement communities (CCRC), assisted living components of CCRCs, residential care facilities (in some states termed "board and care facilities"), dedicated assisted living facilities, and independent living apartment complexes where the management entity brokers or arranges for services (for example a Section 8 housing project serving the low-income elderly that arranges for or provides housekeeping, personal care services, and home health services).

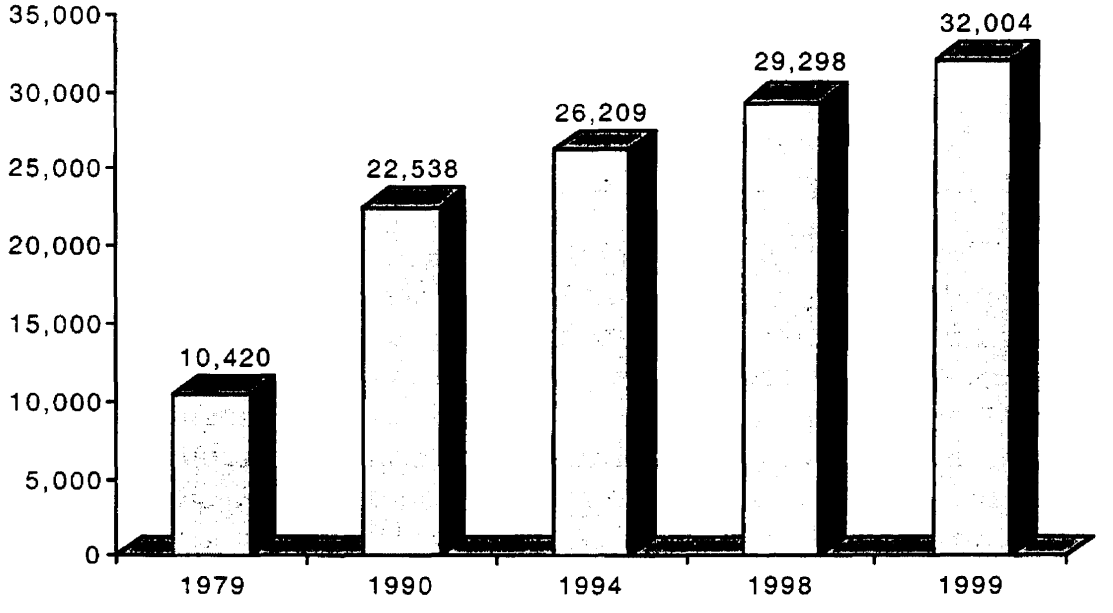
As can be seen from Figure 1, the number of ACR beds has increased dramatically between 1979 and 1999.

Auxiliary Grants Help Fund Care for Public Pay ACR Residents

An auxiliary grant is a state government funding source for public pay residents of adult care residences. Adult care residences, once known in Virginia as homes for adults, provide maintenance and care for four or more adults who may be aged, infirm, or disabled. An auxiliary grant supplements resident income for those qualifying for the program; the

resident income is typically provided through Supplemental Security Income (SSI). As of June 1999, there were 6,706 auxiliary grant recipients in Virginia. The average auxiliary grant received in 1998 was $261, though this will increase somewhat during the current fiscal year, due to the increase in the auxiliary grant rate approved by the 1999 General Assembly. The maximum auxiliary grant that can be received is $775 for most of Virginia and $891 for Northern Virginia.

Figure 1
Number of ACR Licensed Beds, 1979-1999 (includes pending and new applications for 1999)



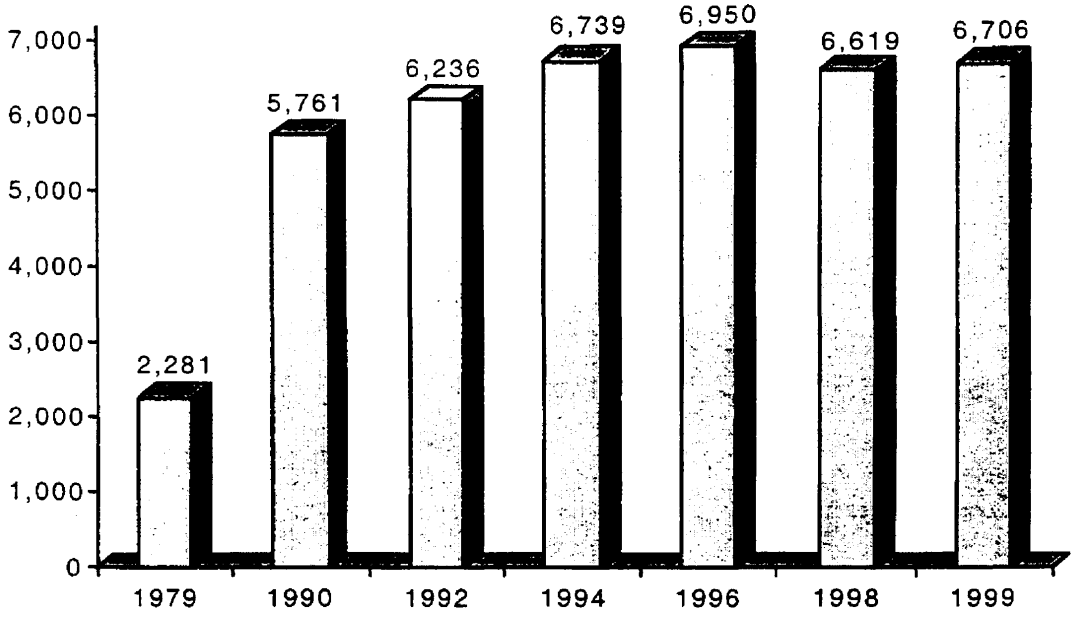
Source: Virginia Department of Social Services

It is important to note that auxiliary grant recipients also qualify for Medicaid. During the 1999 session of the General Assembly, the Department of Medical Assistance Services estimated that, on average, the costs to the Virginia Medicaid program were $8,756 per auxiliary grant recipient.

While the number of ACR beds has been steadily increasing, the number of public pay clients has remained flat during the 1990s. Figure 2 shows the number of public pay clients in adult care residences from 1979

to 1999. As Figure 2 reflects, the number of public pay clients in ACRs (auxiliary grant recipients) has actually decreased since the mid-1990's.

Figure 2
Number of Auxiliary Grant Recipients, 1979-1999



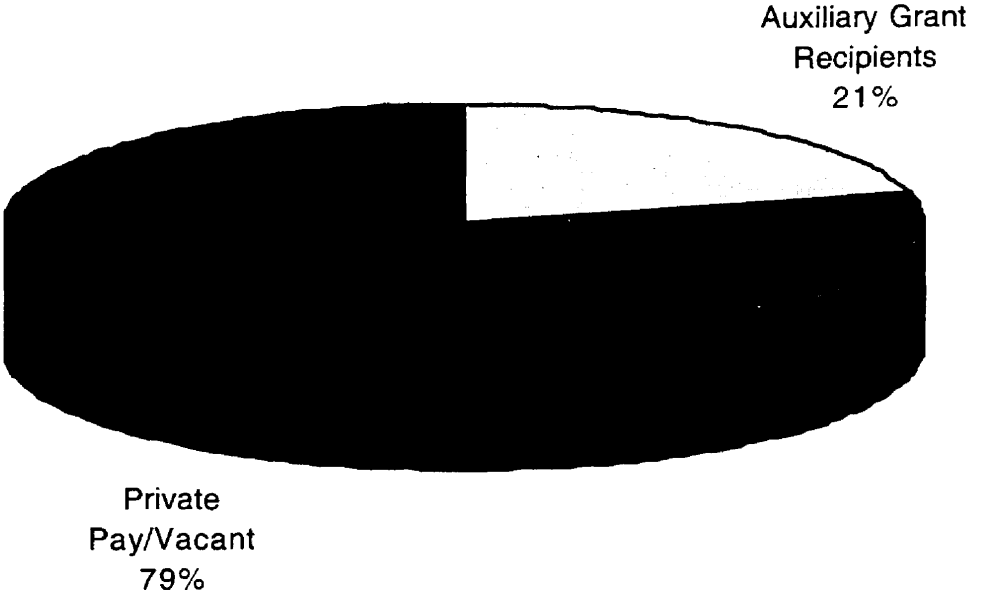
Source: Virginia Department of Social Services

As the number of ACR beds has increased while the number of public pay clients has remained flat or actually decreased, auxiliary grant recipients are a decreasing percentage of the overall population of ACR residents. As Figure 3 reflects, auxiliary grant recipients currently occupy only 21 percent of the total number of licensed ACR beds in Virginia.

In most cases, an ACR either has very few auxiliary grant recipients or a large number of them. While the ACR industry is regulated and treated in statute as one industry, there are in fact several different types of ACRs which have as many differences as they do similarities. There is a segment of the ACR industry that is heavily dependent on auxiliary grants. JLARC's 1997 report found that 35 percent of all auxiliary grant recipients live in five localities: Richmond, Washington County, Roanoke, Roanoke County, and Petersburg. On the other hand, there are almost no auxiliary grant beds in the most heavily populated part of the state,

Northern Virginia, though there is a growing number of licensed adult care residences.

Figure 3
Public Pay Residents in ACRs



Source: Virginia Department of Social Services, JCHC staff analysis.

Auxiliary Grant Expenditures Are Split Between the State and Local Governments

The uneven distribution of auxiliary grant recipients is problematic, because local governments are required to fund 20 percent of the cost of auxiliary grants. The heavy concentration of auxiliary grant recipients in a small number of localities has a disproportionate impact on those localities. This impact includes the direct cost of funding auxiliary grants and the indirect costs of additional CSB services and other related costs. While the "home" locality of an auxiliary grant recipient will fund the 20 percent share of a person's auxiliary grant even if the person is being cared for in another locality, in many cases, such as discharges from state mental health facilities, there is no identifiable responsible locality and the locality in which the receiving ACR is located absorbs the cost of the local

share of the auxiliary grant. This is why localities near major state mental health facilities, such as Washington County or Smyth County, are paying far more for auxiliary grant recipients than would be expected given their proportion of the state's population. For example, Washington County, which has approximately 56,000 residents, expended $750,544 on the auxiliary grant program in FY 1998. This compares with $530,329 expended by Fairfax County for the auxiliary grant program in FY 1998. Fairfax has approximately 928,000 residents, or 16 times Washington County's population.

Maximum Auxiliary Grant Rate is Currently $775/Month for Most of the State

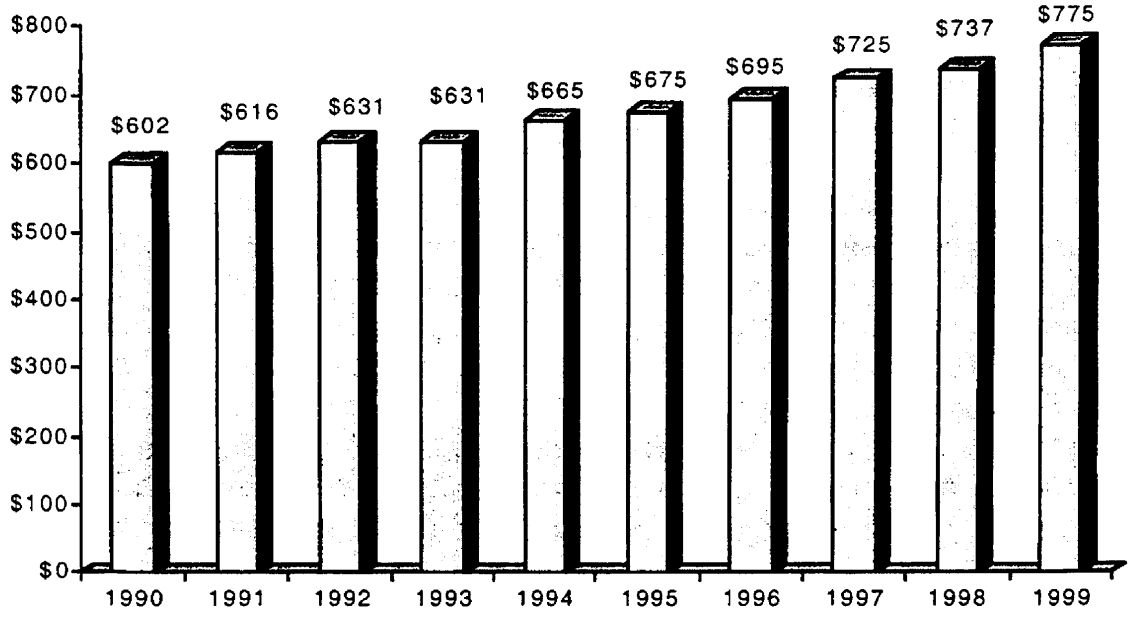
Virginia's auxiliary grant rate has risen in the past decade, driven partly by the federal "maintenance of effort" requirement that state auxiliary grant spending keep pace as a proportion of the auxiliary grant program with the proportion provided by Supplemental Security Income. Therefore, increases in the SSI rate can drive a corresponding increase in the state auxiliary grant rate. Figure 4 reflects the maximum auxiliary grant rate for most of the state (except Northern Virginia) from 1990 to present. As noted earlier, the maximum rate for Northern Virginia in any given year is fifteen percent above the rate for the remainder of the state.

Differential for Assisted Living Care Is Not Tied To Services Provided To Residents

Based on interviews with state agency staff, as well as JLARC's findings from its 1997 report, the reimbursement levels for regular assisted living care and intensive assisted living care were arrived at in a somewhat arbitrary fashion. These reimbursement figures need to be more closely tied to the services that are expected to be delivered at each level of care. In particular, it appears that the reimbursement level for intensive assisted living services may be too low given the relatively high level of effort required to provide round the clock care to someone dependent in four ADLs. For example, Virginia Medicaid currently reimburses personal care at a rate of $9.50 per hour (a rate it is noted that the home care industry feels is too low). By comparison, Medicaid provides ACRs an additional $180 per month to provide intensive assisted living care reimbursed at $6.00 per hour with a limit of 30 hours per month. This is not to say personal care rates are too high, only that Medicaid intensive assisted living care does not appear to be adequately reimbursed. In particular, the 30 hour per month limit appears to be

driven more by fiscal concerns than careful analysis of resident conditions and needs.

Figure 4
Maximum Auxiliary Grant Rate, 1990-1998
(Does Not Reflect the 15 Percent Northern Virginia Differential)



Source: Virginia Department of Social Services.

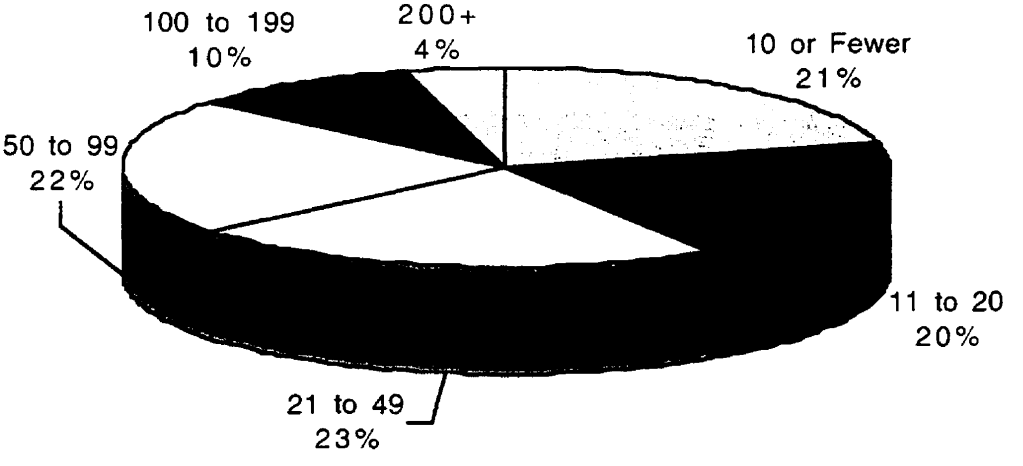
Small ACRS

Of the total number of licensed adult care residences in Virginia as of July 1, 1999 (617), a significant percentage have fewer than 50 beds in terms of licensed capacity (Figure 5). There has been considerable discussion in recent years about adapting adult care residence regulations to meet the needs of smaller ACRs. However, there is not an agreed upon definition of what constitutes a small ACR. The Virginia Adult Home Association (VAHA) views a small adult care residence as one with fewer than 50 beds. As Figure 5 illustrates, nearly two-thirds of all licensed ACRs (64 percent) have fewer than 50 beds. Forty-one percent of licensed ACRs have 20 or fewer beds.

When asked about meeting the needs of small ACRs, Department of Social Services licensing staff have asked which, if any, regulatory requirements should be loosened or eliminated for small adult care

residences and what about being a smaller facility makes health and safety requirements less appropriate.

Figure 5
Size of Licensed ACRs (by Licensed Bed Capacity)



Source: Virginia Department of Social Services.

With these concerns of DSS staff in mind, it may be appropriate to consider small homes as an additional category of licensure, with regulations tailored to meet the needs of these homes. It should be noted that this is not to say that such homes should have more lax or less protective regulations, only that they should have regulations better tailored to meet their needs.

Housing for Seniors and the Disabled and Aging in Place

Given the broad definition of adult care residence currently used in the *Code of Virginia,* there has been an ongoing issue regarding whether housing that is otherwise deemed to be independent living is subject to licensure as an ACR. These types of independent living arrangements include, but are not limited to, the independent living components of continuing care retirement communities and subsidized senior housing

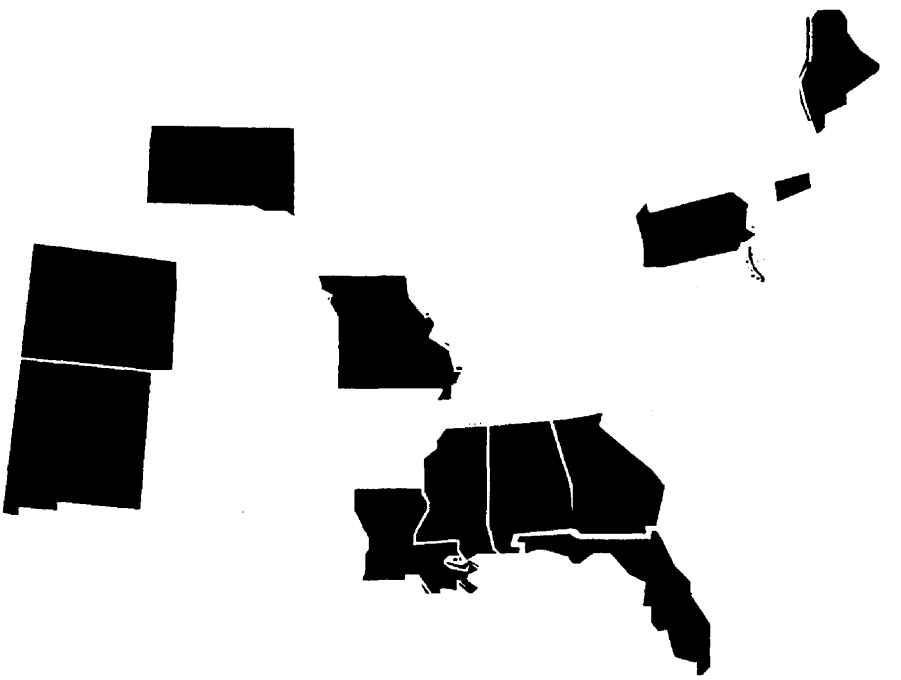
such as Section 8 housing. In providing services for seniors, there has been an increasing emphasis on "aging in place," that is to say providing services to persons as they become older to allow them to remain in their homes, rather than requiring a person to move each time they require additional services. At present, the expansive definition of ACR in Virginia state law potentially limits the ability of elderly and disabled persons to age in place, because a facility that provides even minimal services becomes subject to full-scale licensure as an adult care residence.

Options for addressing this concern include tightening the definition of adult care residence in state law and creating a statutory definition of independent living that would explicitly allow management entities for senior and disabled housing communities to offer optional services such as housekeeping, money management, transportation, and in-home care without being subject to state licensure.

Staffing Guidelines for Other States

HJR 527 directed the Joint Commission on Health Care to examine the need for additional staffing guidelines for adult care residences. As was noted in last month's issue brief, other states do not use the term adult care residence. Therefore, JCHC staff conducted a telephone survey of other states regarding the staffing guidelines in place for assisted living in those states. Responses to the survey were received from 29 states. JCHC staff also examined secondary data on assisted living in other states compiled by the National Academy of State Health Policy and the American Association of Homes and Services for the Aging. Based on this research, JCHC staff were able to identify 13 states that have specific staffing requirements for direct-care staff in assisted living facilities beyond a general requirement that such facilities have sufficient staff to meet resident needs. It is noted that one state (Texas) formerly had such requirements and has discontinued them in favor of requiring facilities to disclose their staffing levels. Figure 6 shows the states with staffing requirements for assisted living. These requirements are summarized state by state in Figure 7.

Figure 6
States With Assisted Living Staffing Guidelines More Specific than the Requirement for "Sufficient Staff" (States Shaded in Black Indicated Having More Specific Guidelines)



Source: JCHC telephone survey of state long-term care ombudsman.

Figure 7
Specific Provisions for States Reporting Assisted Living Staffing Guidelines for Direct-Care Staff Beyond a General Requirement for "Sufficient Staff"

State	Staffing Guideline
Alabama	1 staff member per six residents per 24 hours
Colorado	minimum 1/10 staff to resident ratio for day shift; 1/15 ratio for night shift.
Connecticut	specific requirements for R.N. supervision based on number of direct-care staff

State	Staffing Guideline
Delaware	required ratios for direct care staff, licensed nurses, and nursing supervisors (varies by shift)
Florida	Minimum number of full-time equivalent staff per 24 hour period based on the number of residents in the facility (for example 9 FTE staff per 24 hour period for facilities with 76-85 residents)
Georgia	one staff person per 15 residents during working hours; 1 per 25 residents during non-working hours
Louisiana	Excluding the director and cook (required for 10 or more residents), the number of required staff is determined by dividing the number of residents by 3, then dividing again by 1.6 to determine the number of staff required per 24 hour period.
Maine	Specific staffing to resident ratios of 1/12 for day shift, 1/18 for evening shift, and 1/30 for night shift.
Mississippi	One attendant per 10 residents from 7:00 a.m. to 6:00 p.m.; sufficient staff to meet residents needs at other times
Missouri	minimum staff to resident ratios of 1/15 to 1/25 depending on shift
New Mexico	1 direct care staff to 15 residents when residents are awake; minimum of one staff member for facilities with less than 15 residents or two staff members for facilities with more than 15 residents while residents are sleeping
Pennsylvania	Direct care staffing ratios depending on the size of the facility and mobility of residents
South Dakota	.8 hours direct care personnel per resident per 24 hour period

Source: JCHC staff survey, review of secondary data.

III.
Mentally Disabled Residents of Adult Care Residences

Many Auxiliary Grant Recipients Have A Behavioral Health Care Diagnosis

JLARC's 1997 study of adult care residences found that 47 percent of auxiliary grant recipients analyzed had a behavioral health care diagnosis. The type of behavior health care diagnosis varied. The most common diagnoses were schizophrenia and mental retardation. Figure 8 shows the mental health diagnoses of public pay ACR residents, based on 1996 data from the Uniform Assessment Instrument (UAI).

Figure 8
Mental Health Diagnoses of Public Pay ACR Residents

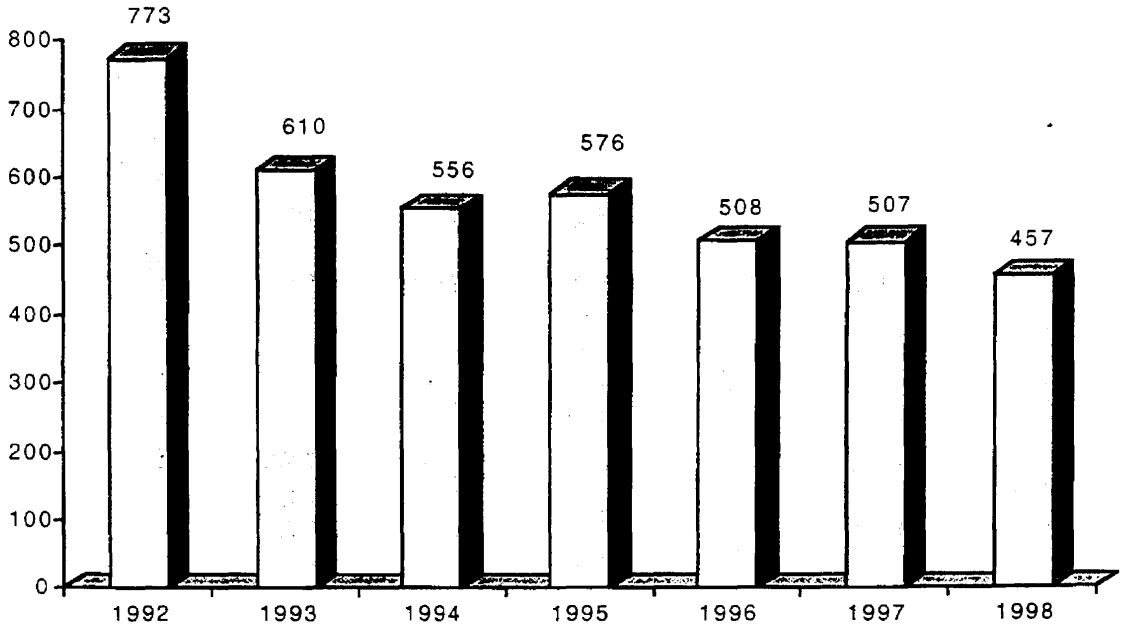
Diagnosis	Percentage
Schizophrenia	16.9%
Mental Retardation	11.1%
Other Psychiatric	4.4%
Bipolar and Personality Disorder	3.3%
Major Depression	3.2%
Non-Alzheimer's Dementia	2.8%
Alzheimer's	2.0%
Anxiety Disorders	1.4%
Epilepsy/Other Neurological	1.4%
Total	46.5%

Source: Joint Legislative Audit and Review Commission, *Services for Mentally Disabled Residents of Adult Care Residences* (HD 4, 1998).

Indeed, since the 1970s, ACRs have been a *de facto* part of Virginia's mental health care system. For example, between 1992 and 1998, there were 3,987 persons discharged from state mental health and mental retardation facilities who were directly placed in ACRs (Figure 9). This figure represents between 6 percent and 8 percent of total discharges from state facilities in any given year. However, this figure does not capture

persons who may be discharged to another care setting (such as a parent's home) who later end up in an ACR.

Figure 9
Discharges from State Mental Health and Mental Retardation Facilities Directly Into an Adult Care Residence: FY 1992-1998

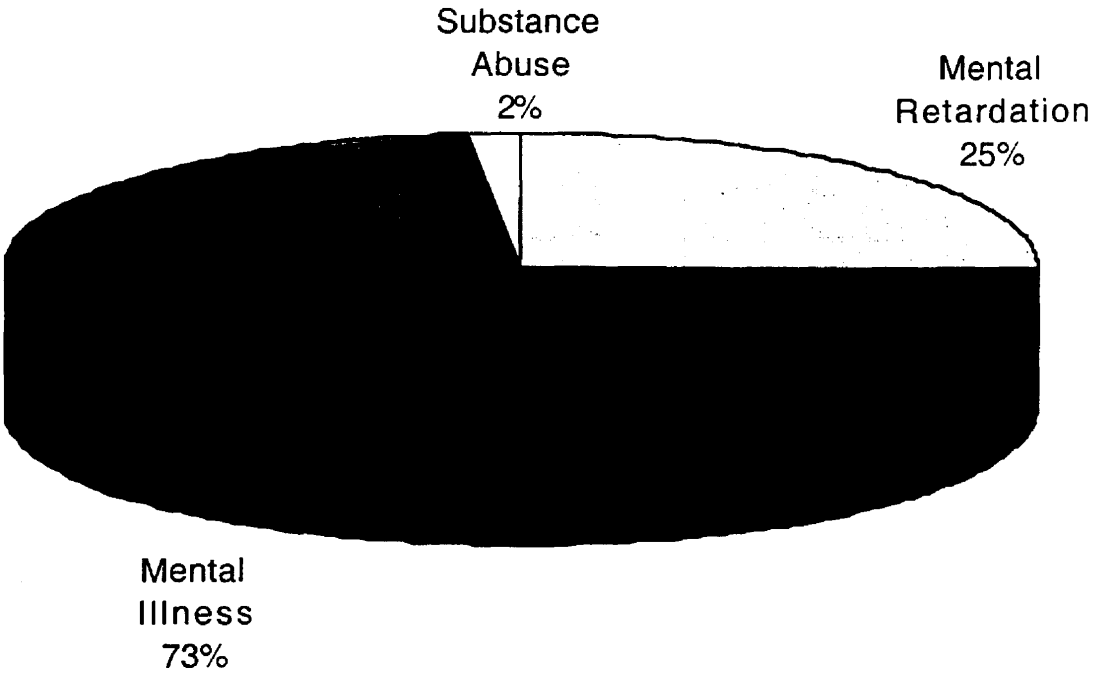


Source: Department of Mental Health, Mental Retardation and Substance Abuse Services.

Survey of Community Services Boards

To further quantify the degree to which persons with mental disabilities are being served in adult care residences, JCHC staff conducted a survey of all 40 Community Services Boards (CSBs). Thirty-one responses were received for a response rate of 77 percent. Thirty of the thirty-one CSBs responding to the survey indicated that they had clients that they served who resided in an adult care residence. The thirty CSBs with clients in an ACR reported serving between six clients and 373 clients, for a total of 2,660 clients for the thirty CSBs. The average number of clients served by a CSB in an ACR was 89. Figure 10 shows the breakdown of these clients by primary diagnosis in terms of mental illness, mental retardation, or substance abuse.

Figure 10
CSB Clients Residing in an ACR (Total=2,660)
for the 31 CSBs Responding to the Survey



Source: JCHC Survey of Community Services Boards.

1997 JLARC Recommendations

JLARC's 1997 study *Services for Mentally Disabled Residents of Adult Care Residences* made 23 recommendations to improve the services delivered to mentally disabled residents of adult care residences. These recommendations are summarized below (the full text of most recommendations is not included in the interest of space):

- increasing use by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) of UAI data;

- training by DMHMRSAS for local agency personnel on assessing the mentally ill;

- revising the UAI to better assess the needs of the mentally disabled;

- improving communication between DMHMRSAS, community services boards, and ACRs to ensure that placement policies are followed;

- require that CSBs participate in the development of individual services plans for mentally disabled residents of ACRs;

- improving medication management within ACRs;

- revising DSS regulations for ACRs to require specific training of direct care staff on meeting the needs of the mentally disabled;

- requiring CSBs to routinely offer training to ACR staff;

- development of a staffing standard to ensure adequate supervision and care of ACR residents;

- requiring CSBs to ensure that adequate staff are available to provide emergency services within their service areas;

- amending the *Code of Virginia* to require ACRs accepting auxiliary grant recipients to allow community services board staff into the ACR to assist residents;

- requiring DSS and DMHMRSAS to develop standards for staffing and programming in ACRs that have significant populations of residents with substance abuse problems;

- providing sufficient funds for CSBs with a threshold number of clients in ACRs to have a staff position focused on ensuring services are provided to CSB clients in ACRs;

- revising DSS standards to more clearly define the differences in services to residents between residential living, assisted living, and intensive assisted living;

- improving DSS enforcement and giving the department authority to levy financial penalties;

- amending the Practitioner Self-Referral Act to make its provisions applicable to physicians and psychiatrists who refer

patients for care in any ACR in which they have a financial interest;

- identifying other state agencies to develop modules of specific adult care residence standards, such as care for the mentally ill, mentally retarded, and substance abuse residents;

- abolishing the current rate setting process and cost reporting forms used to set auxiliary grant rates;

- collecting appropriate financial data for prospective rate setting for assisted living services;

- adjusting licensing standards to reflect the need for additional personal assistance in the assisted living level of care;

- amending the *Code of Virginia* to authorize DMAS to reduce, withhold, or suspend assisted living and intensive assisted living payments to ACRs with provisional licenses;

- developing a medical reimbursement account for auxiliary grant recipients in ACRs;

- adjusting the personal needs allowance.

The 1998 General Assembly approved Senate Joint Resolution (SJR) 119, directing DSS to report to the Joint Commission on Health Care by October 1, 1998 regarding its implementation of these recommendations. DSS provided this report to the Joint Commission on Health Care in late 1998. The DSS report indicated that several of the JLARC recommendations had been implemented. The personal needs allowance for auxiliary grant recipients was increased from $40 to $54 per month by the 1998 General Assembly. The 1998 General Assembly also approved House Bill 780, a Joint Commission on Health Care initiative, which allows DSS to levy financial penalties and other intermediate sanctions for certain violations of adult care residence regulations. DMAS and DSS jointly conducted audits on a sample of ACR providers. The General Assembly allocated funds for pilot projects in Richmond and Washington County/Bristol for identifying and providing appropriate services for mentally disabled residents of ACRs. The Secretary of Health and Human Resources established an inter-agency task force to improve use of the

UAI. DMHMRSAS prepared a training program for all pre-admission screening evaluators.

While several JLARC recommendations have been implemented, most have not yet been acted upon. While a number of the recommendations relate to actions by executive agencies, there are several which can be addressed through legislative action. These are discussed in the next several sections.

Application of the Practitioner Self-Referral Act to Health Care Providers with an Interest in ACRs

JLARC recommended amending the Practitioner Self-Referral Act to prevent physicians from referring residents to ACRs in which they have an ownership interest. Specifically, JLARC recommended that "The General Assembly may wish to amend the Practitioner Self-Referral Act to make its provisions applicable to physicians and psychiatrists who refer patients for care in any adult care residence in which they have a financial interest." The JLARC report stated:

> The Practitioner Self-Referral Act prohibits a health care practitioner from referring a patient for health services to any entity outside the practitioner's office or group practice if the practitioner or any of the practitioner's immediate family members is an investor in such entity. However, practitioners who make such referrals and are subsequently involved with the provision of care to the referred patients are exempted. In the case of ACRs, where many residents (especially those who are mentally disabled) have little or no family or outside person to check on them, this can lead to concern about care and patient choice.

JLARC cited a case it identified in which the administrator of a psychiatrist-owned ACR refused to allow CSB staff into the facility and stated this case "points to a concern about health care practitioners' potential conflict of interest in referring patients to an ACR for which they are the sole medical provider."

DSS regulations currently address this issue to some extent by stating that the psychiatric/psychological exam, when required, "shall have been completed by a person having no financial interest in the adult care residence, directly or indirectly as an owner, officer, employee, or as an independent contractor with the residence" (22VAC40-71-660). A

similar provision exists for completion of the UAI. However, these requirements do not relate to referrals to the facility or ongoing treatment.

JCHC staff discussed this JLARC recommendation with the president and president-elect of the Psychiatric Society of Virginia. Neither expressed opposition to this recommendation, though the suggestion was made to reword the recommendation to refer to all health care practitioners, which would seem to be consistent with the wording of the Act generally.

Ensuring Access by CSB Staff to Adult Care Residences

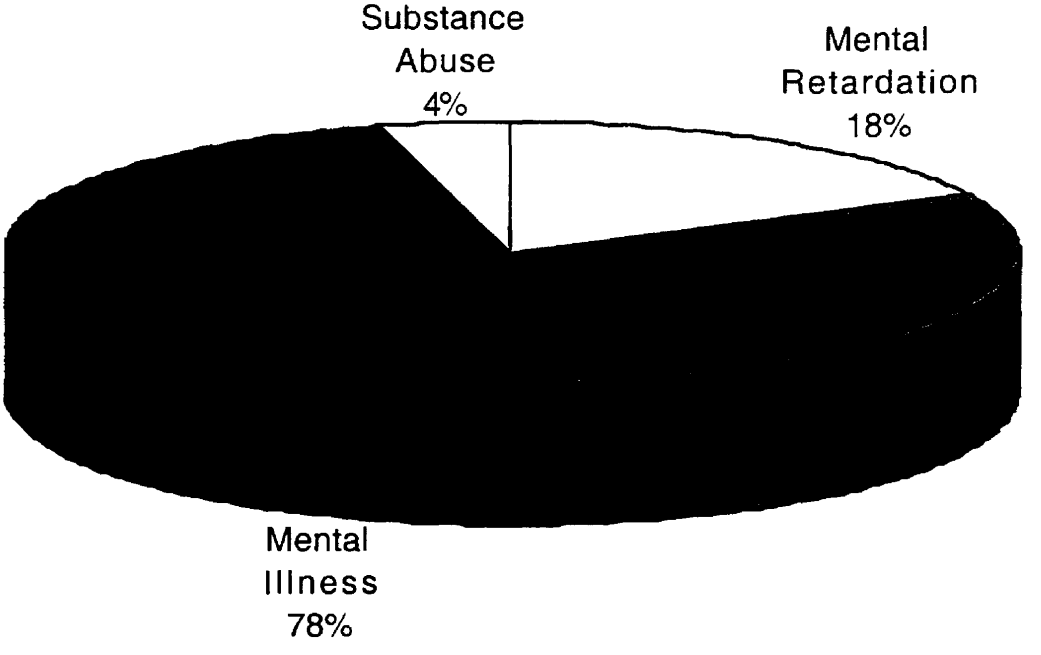
The JLARC report noted a concern about CSB access to clients in ACRs, in certain circumstances. To assess whether or not this was still a concern, the JCHC survey of CSBs included an item which asked "In the past year, has your staff experienced any difficulty in entering an adult care residence to provide services to clients residing there." Thirty responses were received to this item. Of these, four indicated "yes," and 26 indicated "no." One response of "no" added the comment that "but we have in the past." While this problem does not appear to be pervasive, it does not appear to have been eliminated.

Addressing Funding Shortages for CSB Case Management of ACR Residents

The JCHC survey also asked CSBs whether there were any mentally disabled residents in ACRs within the CSBs service area that were in need of services from the CSB but not receiving such services due to funding shortages. CSBs were fairly evenly spilt on this question. Fifteen CSBs responded "no" to this item. Thirteen CSBs responded "yes" to this item. Two CSBs responded "no" but added a note indicating that additional services were needed for some of the clients currently receiving services. The thirteen CSBs that indicated having potential additional clients living in ACRs needing services indicated that a total of 353 clients needed additional services. Figure 11 shows the breakdown for this total among mental illness, mental retardation, and substance abuse.

In addition, the Richmond Behavioral Health Care Authority stated that it estimated 750 mentally ill persons living in ACRs within its service area were not receiving services, though the CSB was unable to determine how much of this was due to lack of funds.

Figure 11
Persons in Need of CSB Services Not Receiving Such Services Due to Lack of Funding (Total=353, does not include data from Richmond City)

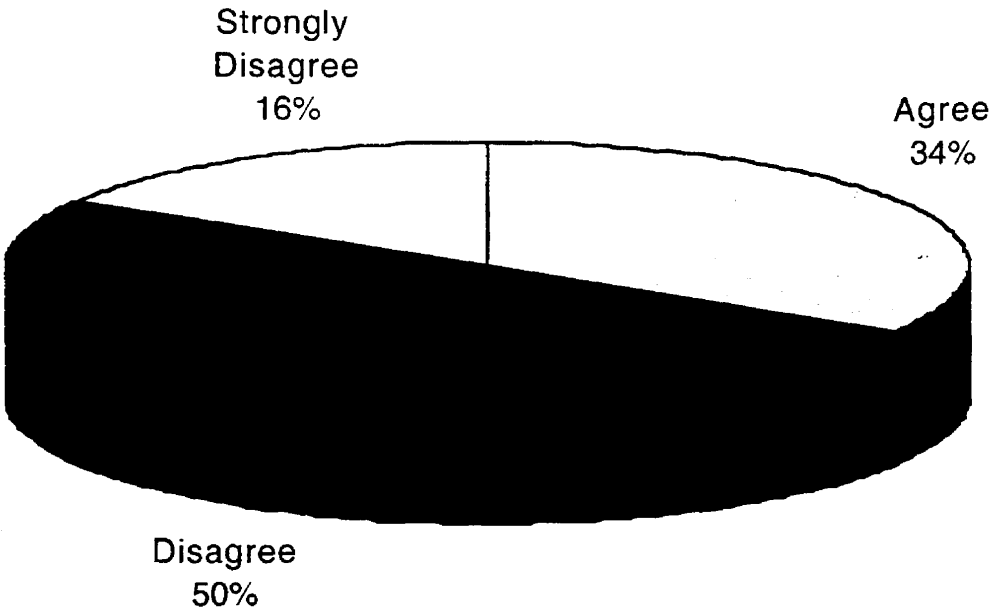


Source: JCHC Survey of Community Services Boards.

Development of Additional Regulations Related to Special Populations Within ACRs

JLARC recommended that appropriate state agencies (including presumably DMHMRSAS) develop modules for the ACR regulations to address the needs of special populations such as the mentally ill or the mentally retarded. This recommendation conceivably could also apply to the Department of Rehabilitative Services with regard to the physically disabled. With regard to Alzheimer's Disease and other forms of dementia, it is not clear which state agency this recommendation would apply to. To determine the viewpoint of CSBs with regard to the adequacy of current ACR regulations for meeting the needs of mentally disabled residents, CSBs responding to the JCHC survey were asked to agree or disagree with the following statement: "State regulations for Adult Care Residences are adequate to protect the health and safety of mentally disabled residents of ACRs." Figure 12 shows responses to this item.

Figure 12
CSB Responses to the Statement: *State regulations for Adult Care Residences are adequate to protect the health and safety of mentally disabled residents of ACRs.*



Source: JCHC Survey of Community Services Boards.

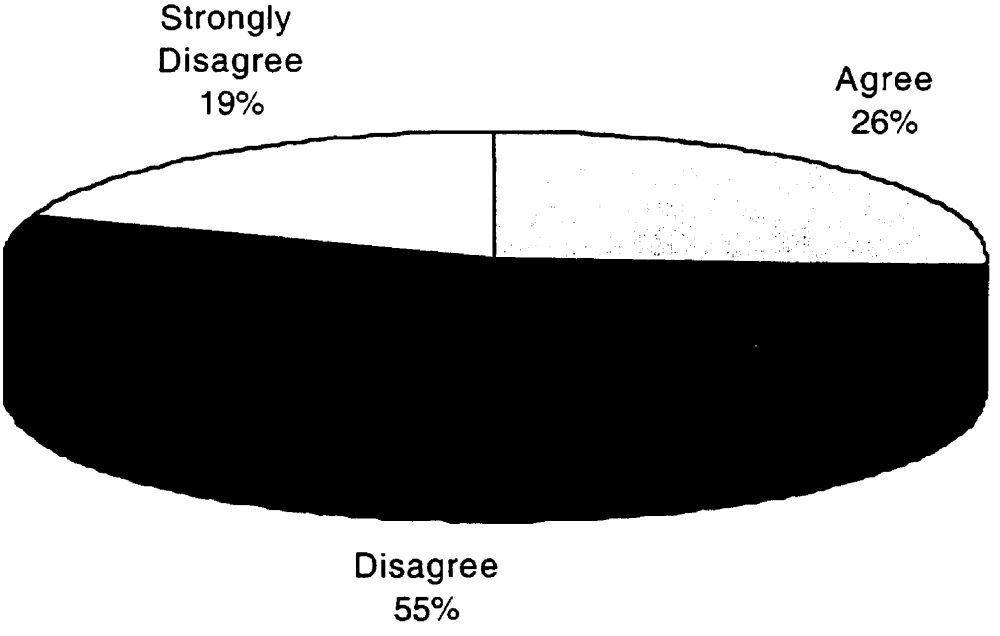
As can be seen from Figure 12, 66 percent of CSBs responding to the survey disagreed or strongly disagreed with this statement.

JLARC also recommended a team approach to licensure, where staff from a number of agencies would become involved in ACR licensure. These agencies conceivably include DMHMRSAS, the Department for the Aging, and the Department of Rehabilitative Services. The experience of state agencies in this type of joint regulatory venture is at best mixed. A number of state agency staff interviewed during this review pointed to coordination problems involved in the enforcement of children's residential (CORE) standards. However, the agency that was most frequently mentioned in terms of a role in licensure of ACRs was DMHMRSAS.

The survey of CSBs asked respondents to agree or disagree with the statement that "State enforcement (by the Department of Social Services) of adult care residence regulations is adequate to protect the health and

safety of mentally disabled residents of ACRs." Figure 13 shows responses to this item. As can be seen from Figure 13, 74 percent of respondents disagreed or strongly disagreed with this statement.

Figure 13
CSB Responses to the Statement: *State enforcement (by the Department of Social Services) of adult care residence regulations is adequate to protect the health and safety of mentally disabled residents of ACRs.*

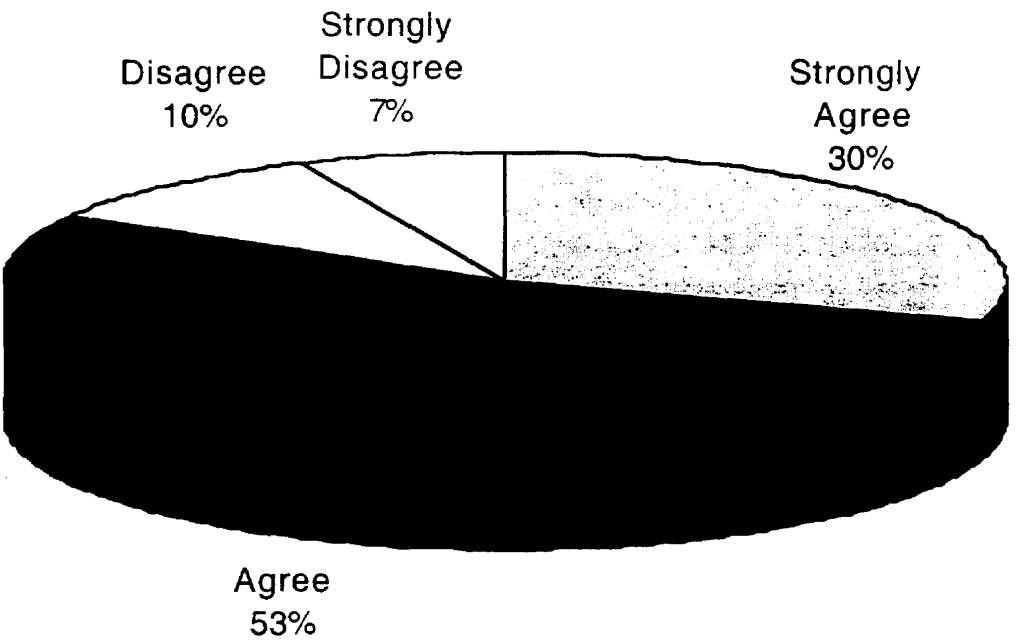


Source: JCHC Survey of Community Services Boards.

Role of DMHMRSAS in Oversight of Adult Care Residences

The appropriate role of DMHMRSAS in oversight of adult care residences has been discussed in various state government reports for a number of years. As part of the survey of CSBs, respondents were asked to agree or disagree with the statement "The Department of Mental Health, Mental Retardation, and Substance Abuse Services should have a role in licensure of adult care residences serving the mentally disabled." Figure 14 shows responses to this item. As can be seen from Figure 14, 83 percent of respondents agreed or strongly agreed with this statement.

Figure 14
CSB Responses to the Statement: *The Department of Mental Health, Mental Retardation, and Substance Abuse Services should have a role in licensure of adult care residences serving the mentally disabled.*

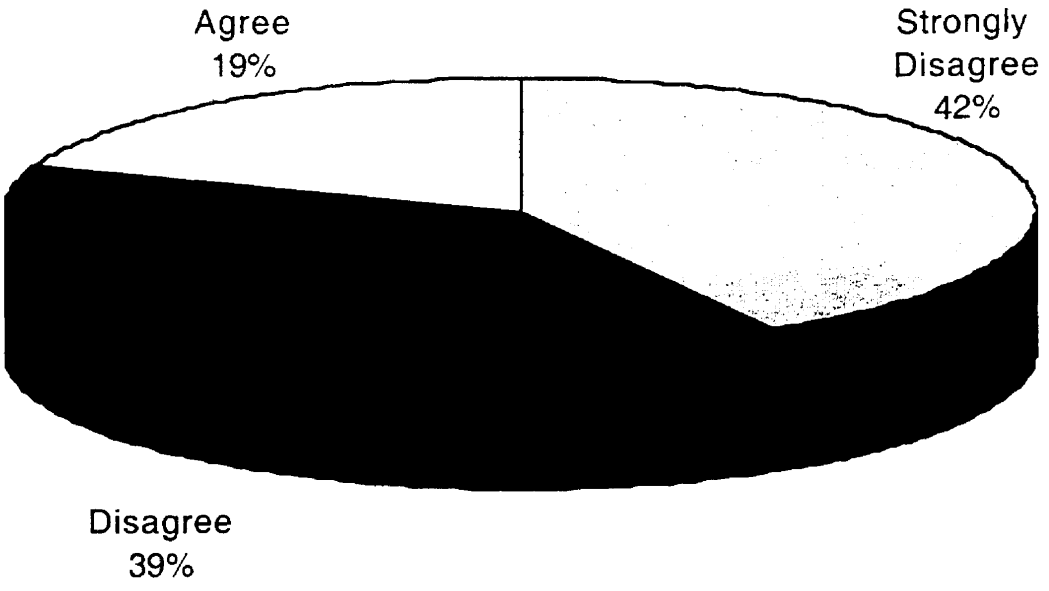


Source: JCHC Survey of Community Services Boards.

Increasing Public Funding for Mentally Disabled Residents of ACRs

One potential role for DMHMRSAS with respect to adult care residences could be to administer funds targeted at increasing reimbursement to facilities that accept auxiliary grant recipients discharged from state mental health or mental retardation facilities. There is a widely held perception that the current auxiliary grant rate is not adequate to meet the needs of mentally disabled residents of ACRs. CSBs responding to the JCHC survey were asked to agree or disagree with the statement that "the current auxiliary grant rate is adequate to meet the needs of mentally disabled residents of ACRs." Figure 15 shows responses to this item. As can be seen from Figure 15, 81 percent of respondents disagreed or strongly disagreed with this statement.

Figure 15
CSB Responses to the Statement: *the current auxiliary grant rate is adequate to meet the needs of mentally disabled residents of ACRs*



Source: JCHC Survey of Community Services Boards.

One current problem in targeting funds to facilities with mental disabilities is that a mentally ill person or person with substance abuse problems is unlikely to have sufficient impairment medically or in terms of activities of daily living to qualify for the Medicaid Intensive Assisted Living waiver. However, increases in the auxiliary grant rate have the effect of both increasing the number of people eligible for the grant and making all of these additional recipients eligible for Medicaid. One option to address this problem would be to have DMHMRSAS administer a general fund supplement to the auxiliary grant for persons discharged from a state mental health or mental retardation facility into an adult care residence. This supplement could be paired with additional requirements for the facility to meet to ensure that the facility is able to meet the needs of the mentally disabled resident. While DSS might well remain responsible for enforcing compliance with these standards, DMHMRSAS could assist DSS in development of these standards.

This option would require the addition of substantial additional staff to DSS's licensing division. Alternatively, DSS could continue to

license all ACRs, while DMHMRSAS could certify ACRs for participation in the behavioral health care supplement to the auxiliary grant.

It is worth noting that eight CSBs indicated that they currently operate ACRs. These eight CSBs reported average monthly costs ranging from $1,600 per month to $5,135 per month. This compares with the current maximum auxiliary grant of $775/month for most of state and $891 for Northern Virginia. The CSB that reported its monthly costs as $1,600 commented that "Adult Care Residences are not designed nor funded to provide care for persons with MI or MR disabilities. Our own experience as an ACR operator shows that double the auxiliary grant funding is barely adequate to meet needs."

Allowing the Auxiliary Grant to be Used in Settings Other Than an ACR

At present, the auxiliary grant is only allowed to be used in a licensed adult care residence. In some cases, care for the mentally disabled may be appropriately provided in other settings such as adult foster care, group homes, or other congregate housing. One option for increasing access to housing for the mentally disabled would be to allow the auxiliary grant to be used in settings outside of an ACR. One role for DMHMRSAS might be to approve such facilities or homes, in cooperation with DSS, for receipt of the auxiliary grant.

IV.
Adult Foster Care

Adult Foster Care Reimbursement Currently Lags Significantly Behind ACR Reimbursement

In terms of public pay rates for 24 hour long-term care, the lowest reimbursement level is for adult family foster care, more commonly known as adult foster care. Adult foster care involves the placement of aged or disabled individuals in private homes for care. Adult foster homes cannot care for more than three adults without being subject to licensure as an adult care residence.

Adult foster homes are often referred to as unregulated. In actuality, oversight of these homes is provided by local departments of social services, though such oversight is admittedly minimal in some cases. The maximum reimbursement rate for this program is currently $508 per month for most of the state and $584 for Northern Virginia. This translates to a daily payment rate of $16.70 for most of the state ($19.20 for Northern Virginia). Funding for the program, like most social services programs, consists of 80 percent state funds (general funds) and 20 percent local funds. In a limited number of cases, adult foster homes may receive additional reimbursement from community services boards. In fact, many if not most public pay residents of adult foster homes have been placed there after discharge from a state behavioral health facility.

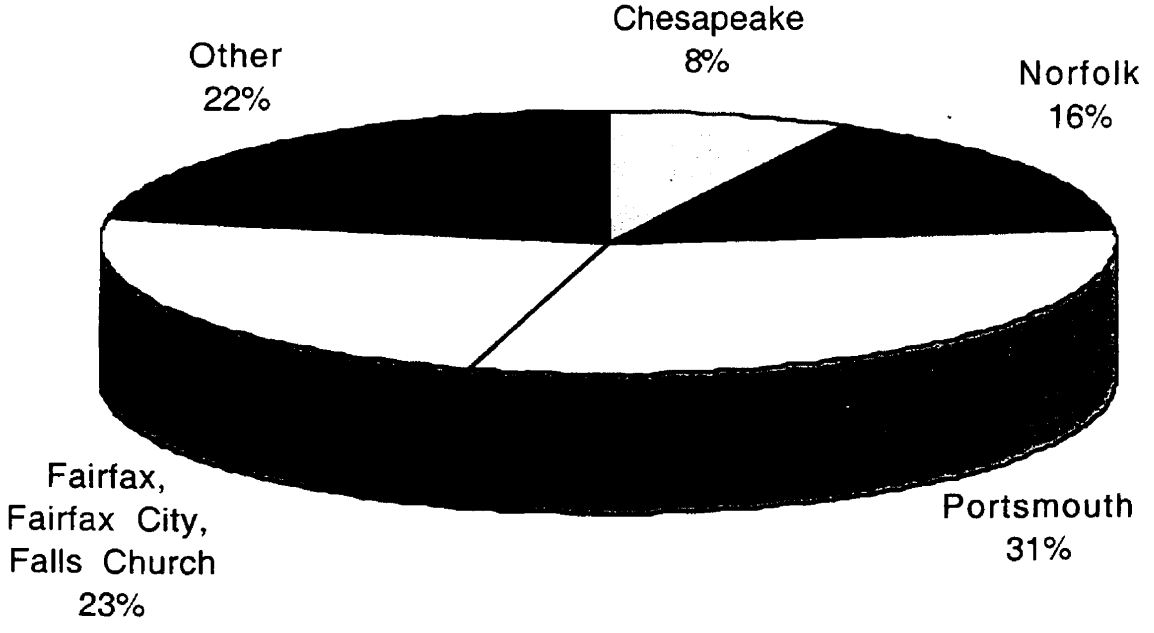
While the auxiliary grant rate is increased somewhat each year as a result of the SSI maintenance of effort requirement, there is no such requirement for adult foster care. Therefore, increases in the rate paid for this care are more infrequent and the rate for adult foster care is significantly less than is the case for the auxiliary grant rate. One option for addressing the low level of payment for adult foster care would be to allow the auxiliary grant rate to be used in the adult foster care setting, if the home were approved by the Department of Social Services.

Adult Foster Care Is Not Currently a Mandated Service

At present, only 22 of Virginia's 122 local departments of social services have an adult foster care program (also referred to as adult family care). There are currently 110 authorized adult foster care/adult family care homes serving 103 total adults (not all approved homes currently are

being utilized). While there are 22 localities participating in the program, four localities account for the significant majority of placements. Figure 16 shows this information. As can be seen from Figure 16, Portsmouth alone accounts for nearly a third of the adult foster care placements in Virginia.

Figure 16
Adult Foster Care Placements in Virginia by Locality



Source: JCHC Survey of Community Services Boards.

Other States' Regulatory Requirements for Adult Family/Foster Care

Currently, there are no national standards for adult/family foster care. In order to determine individual states' regulatory frameworks, a telephone survey was conducted in July 1999 by a Virginia Commonwealth University faculty member, who in turn contracted with the JCHC to write this section of the report. The survey updated findings from a 1996 national study[1] on the status of adult/family foster care to include the most current information on each state's program. Results of the survey are summarized in Figures 17 through 21.

[1]Folkemer, D., Jensen, A., Lipson, L. Stauffer, M. & Fox-Grage, W. (1996). Adult Foster Care for the Elderly: A Review of State Regulatory and Funding Strategies. Washington, DC: American Association of Retired Persons Public Policy Institute.

States With Family Foster Care Programs

At least thirty-two states have an adult/family foster care program as part of the state administered social service system (Figure 17). Varying terminology is used, including "adult family care home," "family rest care homes," and "domiciliary care services," to describe a service defined by several common factors:

- SIZE: A distinguishing characteristic of adult/family foster homes is their small size, ranging in the number of residents from one to eight (with the exception of Delaware which allows a maximum of 16 residents in a setting). Virginia allows a maximum of three residents; in excess of that number constitutes an adult care residence.

- FAMILY ATMOSPHERE: Attaining a family-like environment is a central goal of all the programs. The program is generally associated with small family-operated homes--the sole type of provider in the majority of states with this program (18). However, there are indications that the trend, as exemplified by the experience in Washington, Oregon, and Minnesota, is to move toward licensing of private business concerns.

- TARGET POPULATION: All states with this program focus on serving adults with mental and/or physical disabilities. The target population generally consists of older persons, persons with mental illness, and persons with developmental disabilities. However, program participants tend to be targeted by need as opposed to age. Defining functional eligibility is an ongoing issue. In addition, 26 states maintain specific conditions for exclusion of admission or for transfer.

- TYPE OF SERVICES: Adult/family care homes provide supervision and personal care services (medication management is common) in addition to room and meals.

- SERVICE USAGE: The number of "active" homes range from a minimum of 52 (Colorado) to a maximum of 2,160 (Minnesota). The number of residents ranges from a low of 90 in New Jersey, to a high of 4,354 in Minnesota. Virginia currently has 110 certified homes with 106 residents.

- PUBLIC FUNDING: Each state uses public resources to subsidize

part, or all, of the cost of care. Five states--Alabama, Colorado, Delaware, Iowa and Delaware--maintain adult/family foster care solely for publicly supported residents. In Virginia, residents are supported through the Department of Social Services Auxiliary Grant Program.

Twenty-two States Employ Either Licensure or Voluntary Certification Standards

Of the 32 states with adult/family foster care, 69% (22) maintain a system of mandatory state licensure for all providers (Figure 18). Three states (Alaska, Texas, Wisconsin) do not require smaller homes, as defined by each state, to meet minimum licensing requirements. Depending upon the size of the home, goals of the program, and eligibility requirements of providers and residents, licensing standards can be complex and demanding. Common regulations, above general inspection, staffing, and training requirements are listed in Figure 19.

Eight states, including Virginia, elect not to employ a formal licensing process, but instead rely upon a system of voluntary certification for homes that want to be approved as providers and receive public funding. Generally, either the state social service or aging agency takes on this role. Those homes that elect not to participate in the certification process can legally accept private pay clients.

Twenty-five States Require At Least Annual Inspections

A common defining factor of all homes that maintain a system of licensure or certification is ongoing contact between providers and the regulatory agency (Figure 20). On-site inspections are required at least annually in the majority of states. Virginia requires inspections every two years.

Eighteen States Require Both Residency and 24-Hour Supervision

Figure 21 shows that all states with this program have either a provider residency or 24-hour supervision requirement (which does not require the provider to stay awake); 56% (18) require both. Three states do not require full-time 24-hour supervision (Delaware, Idaho, Maryland), yet still maintain specific requirements for certain types of residents under certain conditions.

Twenty-seven States Maintain Orientation, Training or Certification Requirements for Providers

Apart from supervision, training and orientation is an important facet of state oversight of adult foster/family care. Twenty-seven of 32 states with this program require some degree of orientation and training. The most common scenario (10 of 32 states) is for initial orientation and training to be required without mandatory annual training. Virginia maintains a less stringent requirement, allowing the local department of social services to determine all training requirements.

Examples of common training topics include: physical care-giving, medication management, nutritional needs, conflict resolution, cognitive disabilities, emergency evacuation, communication skills, first aid and cardiopulmonary resuscitation, and behavior management.

Figure 17
States Reporting on Adult/Family Foster Care Programs

REPORTED ON AFC PROGRAMS SERVING THE ELDERLY	REPORTED PROGRAM OR FUNDING INITIATIVE	NO AFC PROGRAM	NO RESPONSE
AK	AR	CA	ME
AL	NH	DC	NM
AZ		GA	SC
CO		IL	VT
CT		IN	
DE		KS	
FL		LA	
HI		MO	
ID		MS	
IA		OK	
KY		RI	
MA		TN	
MD		WY	
MI			
MN			
MT			
ND			
NE			
NJ			
NV			
NY			
NC			
OH			
OR			
PA			
SD			
TX			
UT			
VA			
WA			
WI			
WV			

Source: Survey administered by Ann Kiser, Ph.D., Virginia Commonwealth University.

Figure 18
Type of State Regulation of Adult/Family Foster Care

State	Licensure	Certification	Other
Alaska	X (FOR 3 OR MORE BEDS)	X (FOR MEDICAID CLIENTS)	
Alabama			APPROVAL STANDARDS
Arizona	X	X	
Colorado	X	X	
Connecticut			
Delaware	X		
Florida	X		
Hawaii	X		
Idaho		X	
Iowa		X	
Kentucky	X		
Maryland		X	
Massachusetts		X	
Michigan	X		
Minnesota	X		
Montana	X		
Nebraska		X	
Nevada	X		
New Jersey	X		
New York	X		
North Carolina	X		
North Dakota	X		
Ohio	X (AFH)	X (CFH)	
Oregon	X		
Pennsylvania		X	
South Dakota	X (FOR PUBLIC-PAY CLIENTS ONLY)		
Texas	X		IF 2 OR FEWER BEDS, NO LICENSURE; MINIMUM STANDARDS SET INSTEAD.
Utah	X		
Virginia		X	
Washington	X		
West Virginia		X	
Wisconsin	X (3-4 BEDS)	X (1-2 BEDS)	

Source: Survey administered by Ann Kiser, Ph.D., Virginia Commonwealth University.

Figure 19

COMMON LICENSING REQUIREMENTS

Safety/fire code standards

Provider plan for evacuation

Physician statement regarding ability to provide care

Background check, records, immunization record, demonstration of assets to maintain home

Written plan of operation including use of substitute caregivers

Maintenance of client medical and medication records

Meal preparation standards

Submission of periodic health status reports

Infection control standards

Documentation of vehicle and homeowner insurance

Admission procedures

Source: Survey administered by Ann Kiser, Ph.D., Virginia Commonwealth University.

Figure 20
Required Minimum Frequency of On-Site Home Inspections

every 6 months	annually	every 2 years	no response
AL	AK	MI	DE
ID	AZ	MN	IA
MD	CO	VA***	
NC*	FL	WA****	
ND**	HI		
NJ	KY		
NY	MA		
WV	MT		
	NE		
	NV		
	OH		
	OR		
	PA		
	SD		
	TX		
	WI		

* NORTH CAROLINA REPORTED INSPECTIONS EVERY TWO MONTHS.
** NORTH DAKOTA REPORTED INSPECTIONS AT A MINIMUM TWO TIMES PER YEAR; ADDITIONAL INSPECTIONS MAY BE CONDUCTED AT ANY TIME.
*** IN VIRGINIA, PROVIDERS MUST BE APPROVED EVERY TWO YEARS.
**** WASHINGTON REPORTED INSPECTIONS EVERY 18 MONTHS.

Source: Survey administered by Ann Kiser, Ph.D., Virginia Commonwealth University.

Figure 21
Staffing Requirements in Adult Foster Care

STATE	PROVIDER MUST LIVE IN HOME	24-HOUR SUPERVISION (NOT AWAKE)	NOTES AND EXCEPTIONS
AK		X	
AL	X	X	
AZ	X	X	
CO		X	
CT			
DE			FULL-TIME SUPERVISION REQUIRED. REGULATIONS STATE THAT PROVIDER WILL NOT LEAVE THE PREMISES FOR MORE THAN 12 HOURS WITHOUT DELEGATING NECESSARY DUTIES TO A RESPONSIBLE ADULT WHOSE NAME IS ON FILE WITH THE DIVISION OF PUBLIC HEALTH.
FL	X	X	
HI	X	X	
ID	X		24-HOUR AWAKE SUPERVISION REQUIRED ONLY FOR RESIDENTS IN THE HIGHEST CARE CATEGORY.
IA	NO RESPONSE	NO RESPONSE	
KY	X	X	
MD			24-HOUR SUPERVISION (NOT AWAKE) IS REQUIRED IF IT IS DETERMINED NECESSARY AS PART OF THE INDIVIDUAL'S CARE PLAN.
MA	X	X	
MI	X	X	
MN		X	
MT	X	X	
ND	X	X	
NE	X	X	
NJ	X	X	
NV		X	
NY	X	X	
NC	X	X	
OH		X	
OR		X	
PA	X	X	
SD	X	X	

TX		X	
UT		X	
VA		X	
WA	X	X	FULL-TIME, 24-HOUR SUPERVISION (NOT AWAKE) IS REQUIRED , EXCEPT FOR SHORT PERIODS (E.G., SHOPPING, ERRANDS).
WV	X	X	
WI	X	X	

Source: Survey administered by Ann Kiser, Ph.D., Virginia Commonwealth University.

V.
Vulnerable Adults and Adult Protective Services

Adult Protective Services at the Local Level Must Be Primarily Funded From Other Budget Line Items

The adult protective services program, overseen by the state Department of Social Services and implemented by all 122 local departments of social services, responds to reports of abuse, neglect, or exploitation of adults. At present, local social service departments must pay for most of the cost of adult protective services programs by using funds for other programs. The 1999 General Assembly, for the first time appropriated money for adult protective services, responding to a budget amendment introduced as part of the Joint Commission on Health Care's legislative package. The cost of fully funding adult protective services would be significant ($6 million GF). This would involve $5.7 million for local agencies and $300,000 for oversight and training by the Virginia Department of Social Services. Full funding of adult protective services would be one of the key steps that could be taken for meeting the needs of vulnerable adults.

Creation of an Adult Protective Services Central Registry

During the 1999 Session of the General Assembly, legislation was introduced (House Bill 2449) that would have created an adult protective services central registry, similar in concept to the child protective services central registry. One of the goals of the legislation was to try to prevent instances where a person who is fired from a position at one long-term care facility for abuse or neglect of patients or residents is able to secure employment at another facility. As part of this study, the JCHC was asked by the House Committee on Health, Welfare, and Institutions to examine this concept.

Local social services agencies are generally opposed to the concept of an adult protective services registry administered through local departments of social services and the Virginia Department of Social Services. Local agencies expressed concern about the staffing requirements for maintaining a central registry and about the way this would shift the focus of adult protective services from identifying adults in need of services to identifying wrong-doing. Similarly, the Virginia Department of Social Services expressed concern about the creation of an adult protective services registry in terms of the staff resources it would

require, the potential uses of the registry, and the difficulty in identifying responsible individuals when abuse or neglect occurs in an institutional setting.

This opposition by social services agencies suggests that administering such a program through local departments of social services would not be feasible. However, HB 2449 addresses a legitimate gap in protections for vulnerable adults, the lack of a centralized repository of complaints regarding long-term care providers and the lack of any single point of contact for consumers to lodge long-term care related complaints. Options for addressing this gap will be discussed in the next section.

Need for a Centralized Information System/Single Point of Contact for Long-Term Care Related Complaints

At present, residents of long-term care facilities or their family members must call one of several different local or state agencies, depending on the circumstances involved. These include, but are not limited to:

- contacting the Department of Health for complaints about nursing facilities or home health agencies;

- contacting the Virginia Department of Social Services for concerns about adult care residences or adult day care centers;

- contacting the local department of social services to seek adult protective services;

- contacting the office of the state long-term care ombudsman or the local long-term care ombudsman to seek the services of a long-term care ombudsman;

- contacting the Department of Medical Assistance Services for concerns about personal care providers or other Medicaid waiver services providers.

Service to citizens of the Commonwealth would be improved by establishing a single, toll-free number that citizens could call to request adult protective services or ombudsman services or to register a complaint against a long-term care provider (regardless of type). One option would be to establish a toll-free hotline, with appropriate staff and equipment,

within the Office of the Long-Term Care Ombudsman. This office could "triage" calls, collect the needed information, and then direct the information to the appropriate agency without the citizen needing to make additional calls. The office could also act as a central repository of complaints against all types of long-term care facilities. This would allow for better tracking and trending of patterns and needed improvements in different types of long-term care settings.

VI.
Policy Options for Phase II

Policy Options

The following policy options are offered for the Joint Commission on Health Care regarding the long-term care topics discussed in this issue brief. It is noted that, for the most part, these policy options are not mutually exclusive. The Joint Commission on Health Care may choose to pursue two or more of these options.

Policy Options

Option I: **Take no action.**

Option II: **Introduce legislation revising the statutory definition of adult care residences to include categories for assisted living, independent living, and small adult care residences (fewer than 10 residents). Explicitly state that independent living facilities (such as Section 8 housing) may offer or make available certain services to allow residents to age in place (such as housekeeping, assistance with money management, and home health care) without being subject to state licensure. Include an enactment clause directing the Department of Social Services to promulgate regulations for small adult care residences. Distinguish in statute between board and care facilities (which would continue to be called an adult care residence) and assisted living facilities. Direct the Board of Social Services, with staff support from the Departments of Social Services; Department of Medical Assistance Services; Department of Mental Health, Mental Retardation, and Substance Abuse Services; Department of Health, and Department of Rehabilitative Services to develop a new set of regulations for assisted living that clearly distinguish assisted living care from board and care services.**

Option III: **Introduce legislation establishing a minimum direct care staff to resident ratio for assisted living care in the Commonwealth.**

Option IV: Introduce legislation requiring mandatory disclosure of staffing levels or ratios for all licensed adult care residences and assisted living facilities.

Option V: Introduce legislation and companion budget amendments (including FTE and funding for the administration of the program) giving the Department of Mental Health, Mental Retardation, and Substance Abuse Services authority to administer a general fund supplement to the auxiliary grant for persons discharged from state mental health facilities into an adult care residence. The level of this supplement should be, at a minimum, the same amount as the current maximum auxiliary grant ($775/month). Include an enactment clause directing the Board of Mental Health, Mental Retardation, and Substance Abuse Services to promulgate regulations within 280 days to certify facilities for participation in this supplemental program. Costs could be capped for this program by limiting participation in the budget language and directing the Department to direct the funding to the most impaired individuals.

Option VI: Introduce a budget amendment (language) directing the Department of Mental Health, Mental Retardation, and Substance Abuse Services, with the assistance of Virginia's community services boards and the Virginia Association of Community Services Boards, to develop a budget proposal for implementing all applicable outstanding recommendations made by the Joint Legislative Audit and Review Commission's 1997 report *Services for Mentally Disabled Residents of Adult Care Residences.*

Option VII: Introduce legislation requiring any adult care residence, assisted living facility, or adult foster care home receiving an auxiliary grant payment to provide access to community services boards staff for the purpose of case management or assistance for CSB clients residing in the facility.

Option VIII: Introduce a budget amendment providing 12 FTE and $480,000 (GF) to the Department of Social Services to increase its oversight of services for mentally disabled residents of adult care residences.

Option IX: Introduce legislation amending the Practitioner Self Referral Act (Section 54.1-2410 et seq. of the *Code of Virginia*) to make its provisions applicable to health care providers who refer patients for care in any adult care residence in which they have a financial interest.

Option X: Introduce legislation and a companion budget amendment allowing the auxiliary grant to be used for care in any adult care residence, assisted living facility, adult foster care home, or independent living facility approved by the Department of Social Services and/or the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

Option XI: Introduce a budget amendment (language and $60,000 GF for a staff position and associated expenses) directing the Virginia Department of Social Services to develop statewide standards, based on best practices in other states, for the adult foster care.

Option XII: Introduce a budget amendment providing $6 million (GF) for full funding of adult protective services in the Commonwealth. Of this amount, $300,000 is for program development, oversight, and training at the state level and $5.7 million is for services at the local level.

Option XIII: Introduce legislation and a budget amendment (cost estimate to be developed) charging the Office of the State Ombudsman with establishment of a state-wide, toll-free hotline for any long-term care related complaints or concerns, tracking and trending of such complaints, and referrals for appropriate services.

Option XIV: Introduce a budget amendment funding necessary changes to the assisted living waiver after review of the recommendations of the Department of Medical Assistance Services, pursuant to the study the department is conducting at the direction of the 1999 Appropriation Act.

APPENDIX A

HOUSE JOINT RESOLUTION NO. 689

Directing the Joint Commission on Health Care to study the efficacy of providing additional protections for vulnerable adults.

Agreed to by the House of Delegates, February 1, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, in generations past, vulnerable adults were fewer and families were available and willing to care for these adults most of the time; and

WHEREAS, as we approach the millennium, news reports and health industry newsletters indicate that our population of vulnerable adults is dramatically increasing; and

WHEREAS, in response to the growing need for long-term care service for this expanding population, small businesses and entrepreneurs will respond to provide care in various settings, including various institutions and the home; and

WHEREAS, Virginia has laws relating to undue influence in the context of various wills and trusts, adult protective services, criminal records checks of persons who work in certain health care facilities, and regulation of health professionals and facilities; and

WHEREAS, in recent years, scams and cons to steal the resources of vulnerable adults have taken on many guises, using telephone and computer communications and sophisticated sales techniques as well as the age-old ploy of undue influence and harassment; and

WHEREAS, the Commonwealth's laws provide vulnerable adults with protection from some actions of unscrupulous people, however, such mechanisms may not prove to be effective in protecting this population in this age of technology and information explosion; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study the efficacy of providing additional protections for vulnerable adults. In conducting this study, the Joint Commission shall (i) review the settings and delivery of care to vulnerable adults in Virginia; (ii) enlist the input of the agencies providing services to vulnerable adults and those agencies licensing or otherwise regulating facilities and individuals providing care; (iii) review other states' laws and regulations concerning personal care services, home health care, hospice, and personal attendants; (iv) seek advice from Virginia's vulnerable adults and their families; (v) evaluate any administrative or court cases which may be reviewed without breach of confidentiality; and (vi) review such reports and academic studies of the issues as may be available.

All agencies of the Commonwealth shall provide assistance to the Joint Commission for this study, upon request.

The Joint Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 751

Directing the Joint Commission on Health Care, with the assistance of the Virginia Housing Study Commission, the Department of Housing and Community Development, the Virginia Housing Development Authority, and the Department of Social Services to study and make recommendations relating to the issue of flexibility in the Board of Social Services regulations to meet changing consumer needs as the Board initiates its regular three-year review of the regulations of adult care residences.

Agreed to by the House of Delegates, February 23, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, nationally and in the Commonwealth, the concept of assisted living has emerged in recent years as an important link in the continuum of care for the elderly; and

WHEREAS, although numerous assisted living facilities are operating in the Commonwealth, particularly in urban areas, and many more are in the planning and construction phases, the cost of residency in most of these facilities lies beyond the reach of a majority of seniors; and

WHEREAS, the number of seniors in the Commonwealth is increasing significantly; and

WHEREAS, the population of our nation, our Commonwealth, and our neighborhoods has "aged in place," that is, grown older and more frail in both single family and multifamily residences, condominiums, and publicly funded housing; and

WHEREAS, as the need for supportive services begins, the individual needing these services is faced with the choice of moving to a facility that provides care, obtaining care in his or her own residence, or going without care; and

WHEREAS, funding for these services can be tied to a certain type of facility, which may link eligibility criteria to age, level of frailty, and economic status of the person in need; and

WHEREAS, owners and managers of certain housing complexes in the Commonwealth may, due to regulatory requirements, be faced with the choice of providing services or coordinating them for senior residents or seeing these residents go without needed assistance; and

WHEREAS, it is desirable that those in need of appropriate services receive these services while not being unreasonably exposed to risks to their health, safety, or welfare; and

WHEREAS, the unintended outcome of certain state regulations is that increasing numbers of Virginia's seniors may not receive the care they need; and

WHEREAS, in December 1998 the Virginia Housing Study Commission concluded a two-year study of affordable assisted living options for seniors; and

WHEREAS, the Commission study identified the need for additional affordable assisted living options for seniors in the Commonwealth together with the interest of the Commonwealth in fostering the development of these options; and

WHEREAS, the development and operation of these facilities as well as the provision of assisted living services for seniors "aging in place" in the Commonwealth is extremely challenging, given the complexity of financing restraints, revenue concerns, staffing recruitment and retention needs, and regulatory issues; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, with the assistance of the Virginia Housing Study Commission, the Department of Housing and Community Development, the Virginia Housing Development Authority, and the Department of Social Services be directed to study and make recommendations relating to the issue of flexibility in the Board of Social Services regulations to meet changing consumer needs as the Board initiates its regular three-year review of the regulations of adult care residences. Specifically, the Commission shall identify ways in which such regulations can be adapted to ensure that core services can be made available to persons as they "age in place" at their current residences.

All agencies of the Commonwealth shall provide assistance to the Joint Commission for this study, upon request.

The Joint Commission shall complete its work in time to submit its findings and report on its progress to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 485

Directing the Joint Commission on Health Care to study the effectiveness of adult foster care programs in Virginia and other jurisdictions.

Agreed to by the Senate, February 4, 1999
Agreed to by the House of Delegates, February 15, 1999

WHEREAS, the number of seniors in the Commonwealth is increasing significantly; and

WHEREAS, the population of our nation, our Commonwealth, and our neighborhoods has grown older and more frail, whether housed in single family or multifamily residences, assisted living facilities, or other types of living arrangements; and

WHEREAS, as the need for supportive services begins, an individual needing such services is faced with the choice of moving to a facility that provides care, obtaining care in his or her own residence, or going without care; and

WHEREAS, adult foster care may present an increasingly viable option for providing such services; and

WHEREAS, the Virginia Housing Study Commission, in December 1998, concluded a two-year study of affordable assisted living options for seniors; and

WHEREAS, in the course of the study, Commission members were advised that less than 150 Virginians are currently served by adult foster care programs; and

WHEREAS, additional Virginians could potentially be served by such programs; and

WHEREAS, the Joint Commission on Health Care has formed a Subcommittee on Long-Term Care; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study the effectiveness of adult foster care programs in Virginia and other jurisdictions.

In conducting its study, the Joint Commission on Health Care shall include such recommendations as may be appropriate to encourage and promote the availability of adult foster care programs in the Commonwealth and other related issues as the Commission may deem appropriate.

All agencies of the Commonwealth shall provide assistance to the Commission for this study, upon request.

The Commission shall complete its work in time to submit its findings and report on its progress to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 486

Directing the Joint Commission on Health Care to undertake a comparative review of services provided in assisted living facilities.

Agreed to by the Senate, February 4, 1999
Agreed to by the House of Delegates, Februray 15, 1999

WHEREAS, nationally and in the Commonwealth, the concept of assisted living has emerged in recent years as an important link in the continuum of care for the elderly; and

WHEREAS, although numerous assisted living facilities are operating in the Commonwealth (particularly in urban areas) and many more are in the planning and construction phases, the cost of residency in most such facilities lies beyond the reach of a majority of seniors; and

WHEREAS, the number of seniors in the Commonwealth is increasing significantly; and

WHEREAS, the population of our nation, our Commonwealth, and our neighborhoods has grown older and more frail, whether in single family or multifamily residences, assisted living facilities, and other types of living arrangements; and

WHEREAS, as the need for supportive services begins, the individual needing the same is faced with the choice of moving to a facility that provides care, obtaining care in his or her own residence, or going without care; and

WHEREAS, seniors in need of care receive the same from a variety of individuals, including family, friends, certified nursing assistants, licensed practical nurses, registered nurses, registered nurses certified in geriatrics, therapists, and physicians, with different levels of training and expertise; and

WHEREAS, the most intimate and consistent such care is often provided by individuals who are at the entry level of the long-term care profession and who receive the least financial compensation; and

WHEREAS, the Virginia Housing Study Commission in December 1998 concluded a two-year study of affordable assisted living options for seniors; and

WHEREAS, due to such factors as the difficult nature of providing such intimate care, the low unemployment rate in the Commonwealth, and the relatively low pay scale for certified nursing assistants and case managers, such Commission study found that individuals, agencies, and facilities statewide are challenged in

attracting and retaining well-trained, dependable, and compassionate caregivers; and

WHEREAS, such study recognized the possibility that more competitive compensation packages for such caregivers will likely enhance opportunities of assisted living facilities and providers to attract and retain the best qualified, most dependable, and most compassionate staff; and

WHEREAS, the Joint Commission on Health Care has formed a Subcommittee on Long-Term Care; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care is directed to undertake a comparative review of services provided in assisted living facilities, including payment rate and waiver option approaches utilized in other jurisdictions. Such review should address payment schedules for programs funded by the Department of Medical Assistance Services (DMAS), the Auxiliary Grant, and the care managers funded by the Department of Social Services (DSS). In addition, such review should consider benefit packages, in addition to salary, available to service providers. To determine the consistency of the DSS Adult Protective Services function statewide, such review also should include funding available for oversight responsibilities for the same. Finally, such review should include such other related issues as may seem appropriate. The Commission is requested to consult with the Virginia League of Social Services Executives in conducting such review.

All agencies of the Commonwealth, particularly DMAS and DSS, shall provide assistance to the Commission for this study, upon request.

The Commission shall complete its work in time to submit its findings and report on its progress to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: ASSISTED LIVING AND SERVICES FOR VULNERABLE ADULTS ISSUES IN LONG-TERM CARE (SJR 485, SJR 486, HJR 689 AND HJR 751)

Individuals/Organizations Submitting Comments

A total of 64 individuals and organizations submitted comments in response to the SJR 485, SJR 486, HJR 689 and HJR 751 report on assisted living and services for vulnerable adults issues in the long-term care study.

- AARP
- Alzheimer's Association Northern Virginia Chapter
- Betty Bowden
- Department of Social Services, Accomack County
- Department of Social Services, Campbell County
- Department of Social Services, City of Galax
- Department of Social Services, City of Newport News
- Department of Social Services, Commonwealth of Virginia
- Department of Social Services, Grayson County
- Department of Social Services, Isle of Wight County
- Department of Social Services, James City County
- Department of Social Services, Shenandoah County
- Department of Social Services, Spotsylvania County (2)
- Department of Social Services, Staunton-Augusta County
- Division of Social Services, City of Lynchburg
- Ann K. Hedgepeth
- INTERgeneration LINKS, Inc.
- James City County Attorney
- National Alliance for the Mentally Ill—Central Virginia Affiliate
- Northern Virginia Aging Network

- Northern Virginia Long-Term Care Ombudsman Program
- O'Brien Homes, Inc.
- Portsmouth Task Force On Aging
- Southern Area Agency on Aging
- Spotsylvania County Administrator
- Spotsylvania County Social Services Advisory Board
- Virginia Adult Home Association
- Virginia Alliance of Social Work Practitioners
- Virginia Association of Area Agencies on Aging
- Virginia Association of Community Services Boards
- Virginia Association of Nonprofit Homes for the Aging
- Virginia Health Care Association
- Virginia Hospital and Healthcare Association
- Virginia League of Social Services Executives
- Virginia League of Social Service Executives Adult Services Committee
- Virginia Long-Term Care Ombudsman Program
- Virginia Municipal League
- 27 Form Letters

Policy Options

Option I: Take no action.

Option II: Introduce legislation revising the statutory definition of adult care residences to include categories for assisted living, independent living, and small adult care residences (fewer than 10 residents). Explicitly state that independent living facilities (such as Section 8 housing) may offer or make available certain services to allow residents to age in place (such as housekeeping, assistance with money management, and home health care) without being subject to state licensure. Include an enactment clause directing the Department of Social Services to promulgate regulations for small adult care residences. Distinguish in statute between board and care facilities (which would continue to be called an adult care residence) and assisted living facilities. Direct the Board of Social Services, with staff support from the Departments of Social Services; Department of Medical Assistance Services; Department of Mental Health, Mental Retardation, and Substance Abuse Services; Department of Health, and Department of Rehabilitative Services to develop a new set of regulations for assisted living that clearly distinguish assisted living care from board and care services.

Option III: Introduce legislation establishing a minimum direct care staff to resident ratio for assisted living care in the Commonwealth.

Option IV: Introduce legislation requiring mandatory disclosure of staffing levels or ratios for all

licensed adult care residences and assisted living facilities.

Option V: Introduce legislation and companion budget amendments (including FTE and funding for the administration of the program) giving the Department of Mental Health, Mental Retardation, and Substance Abuse Services authority to administer a general fund supplement to the auxiliary grant for persons discharged from state mental health facilities into an adult care residence. The level of this supplement should be, at a minimum, the same amount as the current maximum auxiliary grant ($775/month). Include an enactment clause directing the Board of Mental Health, Mental Retardation, and Substance Abuse Services to promulgate regulations within 280 days to certify facilities for participation in this supplemental program. Costs could be capped for this program by limiting participation in the budget language and directing the Department to direct the funding to the most impaired individuals.

Option VI: Introduce a budget amendment (language) directing the Department of Mental Health, Mental Retardation, and Substance Abuse Services, with the assistance of Virginia's community services boards and the Virginia Association of Community Services Boards, to develop a budget proposal for implementing all applicable outstanding recommendations made by the Joint Legislative Audit and Review Commission's 1997 report *Services for Mentally Disabled Residents of Adult Care Residences*.

Option VII: Introduce legislation requiring any adult care residence, assisted living facility, or adult

foster care home receiving an auxiliary grant payment to provide access to community services boards staff for the purpose of case management or assistance for CSB clients residing in the facility.

Option VIII: Introduce a budget amendment providing 12 FTE and $480,000 (GF) to the Department of Social Services to increase its oversight of services for mentally disabled residents of adult care residences.

Option IX: Introduce legislation amending the Practitioner Self Referral Act (Section 54.1-2410 et seq. of the *Code of Virginia*) to make its provisions applicable to health care providers who refer patients for care in any adult care residence in which they have a financial interest.

Option X: Introduce legislation and a companion budget amendment allowing the auxiliary grant to be used for care in any adult care residence, assisted living facility, adult foster care home, or independent living facility approved by the Department of Social Services and/or the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

Option XI: Introduce a budget amendment (language and $60,000 GF for a staff position and associated expenses) directing the Virginia Department of Social Services to develop statewide standards, based on best practices in other states, for the adult foster care.

Option XII: Introduce a budget amendment providing $6 million (GF) for full funding of adult protective services in the Commonwealth. Of this amount, $300,000 is for program development,

oversight, and training at the state level and $5.7 million is for services at the local level.

Option XIII: Introduce legislation and a budget amendment (cost estimate to be developed) charging the Office of the State Ombudsman with establishment of a state-wide, toll-free hotline for any long-term care related complaints or concerns, tracking and trending of such complaints, and referrals for appropriate services.

Option XIV: Introduce a budget amendment funding necessary changes to the assisted living waiver after review of the recommendations of the Department of Medical Assistance Services, pursuant to the study the department is conducting at the direction of the 1999 Appropriation Act.

Overall Summary of Comments

The comments from each of the 64 respondents were generally favorable. Option XII received the greatest level of support with 56 out of 64 responding favorably. Options II-XI, XIII, and XIV received varying levels of support and opposition from the numerous commenters. None of the respondents expressed support for Option I.

Summary of Individual Comments

AARP

Norma McDonough, Chair, William L. Lukhard, Vice-Chairman, and Jack R. Hundley, Coordinator, commented in support of Options II, IV - XIII. They expressed opposition to Option III and reserved comment on Option XIV until the study being done by the Department of Medical Assistance Services is available. The AARP also suggested that the Joint Commission consider two other

initiatives. First, propose legislation to require bankers and others employed in financial institutions to report suspected financial fraud and/or abuse by in-home care providers. Second, conduct a study of any needed legislative changes and additional resources that Commonwealth Attorneys need to assist them in timely prosecution of elder abuse cases.

Alzheimer's Association Northern Virginia Chapter

Ian Niemi Kremer, Director of Public Policy, suggested that the Joint Commission support the following measures to strengthen the Commonwealth's protection of vulnerable adults: provide hands-on dementia-specific training to state licensure agency personnel; provide hands-on dementia specific training to direct care staff of licensed care facilities; expand the number of state surveys/inspections conducted during evenings and weekends; establish a zero-tolerance policy for licensed care facilities which have inadequate staff at the time of a state survey/inspection; and increase penalties and prosecution for tipping off licensed care providers about impending "unannounced" state surveys/inspections.

Betty Bowden

Ms. Bowden, a constituent, expressed support for Option XII.

Departments of Social Services

Twelve (12) Departments of Social Services expressed support for Option XII. Additionally, Terry A. Smith, Adult Services Program Manager, Commonwealth of Virginia, expressed support for Options II, IV - VIII, X, XII, and XIV. Regarding Option II, Ms. Smith said careful consideration should be given to the number of beds defining a "small" adult care residence. Regarding Option III, Ms. Smith stated that sufficient enforcement of the existing regulations would more readily ensure that residents receive the care that they require. Absolute numbers of staff do not always equate to quality of services. Regarding Option XI, Ms. Smith stated that they would prefer to strengthen adult family/foster care program policy.

Division of Social Services, City of Lynchburg

Mark C. Johnson, Director, expressed support for Option XII.

Ann K. Hedgepeth

Ann K. Hedgepeth, a constituent, endorsed Options XI - XIII.

INTERgeneration LINKS, Inc.

Constance McKenna, Ph.D., President, stated that in Option II, as there are no regulations for adult foster care, it is inappropriate to promulgate the same regulations for all small adult care residences when, in fact, they operate quite differently. They recommended that guidelines for quality care be promulgated, and not oblige families to follow regulations designed for larger facilities. Also, orientation and training should be provided and made accessible to care providers.

She stated that Option V was not clear in that it does not indicate that adult foster care homes would be eligible for the increased auxiliary grant rate if they accepted persons discharged from state mental health facilities. They believe family living in adult foster care homes should certainly be an option for the mentally disabled, and a supplement for the extra level of care and supervision required by host families should be provided.

Dr. McKenna enthusiastically agreed with allowing the auxiliary grant to be used in settings other than ACR and recommended that language be included specifically allowing for mixed populations if the mentally disabled persons do not pose a safety risk.

As the adult foster care rate is inadequate to be an incentive for attracting new families into the program, she recommended that due to somewhat lower overhead costs, payment be 15% less than the auxiliary grant rate for adult care residences with 4-10 individuals, but with legislation to provide automatic increases tied to any increase in the ACR rate.

Dr. McKenna urged that Virginia seriously consider mandating that adult foster care be a service provided in every county or incorporated city. Further, she recommended that the Commonwealth should fund a high enough level of adult foster care through auxiliary grants or some other mechanism to relieve the burden on local jurisdictions for assuring that this highly desirable and feasible option is an available choice to all dependent adults in Virginia.

James City County Attorney

Andrew H. Herrick, Assistant County Attorney, endorsed Option XII and stated its at-risk adult citizens would greatly benefit from this proposal. He expressed opposition to Option X and expressed concern that broadening the available options would likely increase the number of applicants for auxiliary grants; hence, costs would likely rise for both the state and localities alike. Further, he stated that localities should not be required to fund auxiliary grants at any level.

National Alliance for the Mentally Ill - Central Virginia Affiliate (NAMI-CVA)

Margaret G. Seiler and Mary L. Trusdell, members of NAMI-CVA, endorsed Option II, V, and IX with comments. In Option II, they stated that authorities and private citizens alike need to know precisely what various terms, like ACR and "assisted living", mean. Option V is endorsed because they believe authorities who are trained and experienced regarding the mentally disabled should have some supervisory responsibility regarding ACRs which accept such vulnerable residents.

They expressed disappointment that not <u>all</u> of the recommendations made in JLARC's 1999 study have been implemented. They endorsed improving medication management and requiring training of direct care staff on meeting the specific needs of the mentally disabled.

Lastly, they suggested possibly adding to Option VII the appropriation of a "significant sum" to enable CSBs to expand their services to mentally disabled ACR residents could be very helpful.

Northern Virginia Aging Network

Erica F. Wood, Legislative Chair, expressed support for Options II - IV, VI - VIII, and X - XIV.

Northern Virginia Long-Term Care Ombudsman Program

Rita Schumacher expressed general support for Option II except they do oppose any changes to statutory definitions that would indicate that there is some type of distinction between "assisted living" and "board and care" when there is none. According to Ms. Schumacher, "the only difference between the two is the price they charge." Also regarding Option II, they support statutory clarification that independent living facilities may make available certain services allowing residents to age in place without being subject to state licensure. She stated that in their experience, residents understand that the housing staff is simply helping them access available services; the housing facility has no financial connection to the services and has no responsibility for the services themselves. This is the key distinction between ACRs and independent facilities and this distinction needs to remain. Ms. Schumacher expressed support for Options III - V. However, while they support Option V, they urge that the funds not be restricted solely to people who are discharged from a state mental health facility. Additionally, they expressed support for Options VIII, IX, XII - XIV. Ms. Schumacher commented that they were surprised that such legislation would be necessary in Option VII.

O'Brien Homes, Inc.

Linwood S. Russell and Roy Bryant, small ACR representatives, commented that procedurally, the lack of early input and discussion of the issues by small ACR licensees "was a grave oversight and calls even the draft report into question." They stated that the Commission has the responsibility to communicate the notion that the current policies and regulatory options are not exhaustive but rather growth steps in an evolutionary process. They urged that the need for teamwork as well as commitment to and action on a community vision and common ground would be invaluable.

They indicated that on issues of financing and licensure of ACRS, the following should be included: (a) a continuous focus on ACRs as "homelike environments"; (b) regulatory reform recognizing small ACRs, fifty beds or less, as a business entity with unique industry potential and needs; (c) relief from the strain and bondage of a one-year license for professionals with three or more consecutive years of successful licensed operation; (d) a onetime equity adjustment in auxiliary grant monthly base rate from $775 to $950 with state annual cost of living adjustments/increments added thereafter; and (e) an understanding that ACR services, assisted living services and intensive assistive living services represent a continuum with increasing complexities, services and compensation. The concept of "sufficient staff" seems effective and prudent for traditional ACRs.

They believe that mentally disabled residents of ACRs as well as other placements along the continuum must adhere to professional evaluations and recommendations based on the behavioral needs of the residents, capabilities of the facilities and best practices with a view toward controlling unfair competition and/or self-interest placements.

Regarding legislation authorizing multiple agencies to provide case management and other administrative services to residents in a single facility, they believe that there must be a single or common set of regulatory standards for the ACR facility.

Lastly, they suggested that legislation and budget for expanding the services of the Office of the State Ombudsman should also include hearing and resolution of issues that beg third-party solutions between service providers and regulatory agencies.

Portsmouth Task Force on Aging

Viki Lorraine, Chairperson, expressed support for Option XI stating that it is necessary to ensure that elderly people have housing options when they need additional help with their activities of daily living. Ms. Lorraine also commented in support of Option XII stating that it is necessary to increase the quantity and quality of services available to vulnerable adults.

Southern Area Agency on Aging

Nancy Vanhoozer, RN, expressed strong support for Options III and XIV.

Spotsylvania County Administrator

L. Kimball Payne, III, County Administrator expressed support for Option XII.

Spotsylvania County Social Services Advisory Board

Janet M. Coleman, LCSW, expressed support for Option XII.

Virginia Adult Home Association

Michael Osorio, Executive Director, provided information concerning auxiliary grant funds, regulatory flexibility, ACR staffing and initiatives for state savings. Mr. Osorio did not respond directly to any of the specific policy options contained in the issue brief.

Virginia Alliance of Social Work Practitioners

Betty Hunter Bazemore expressed support for Option XII.

Virginia Association of Area Agencies on Aging

Debbie Palmer, President, expressed support for Options II - V, VII - X, and XII - XIV.

Virginia Association of Community Services Boards

Mary Ann Bergeron expressed support for Options II - IV, VI - XIV. She expressed support for Option V with the qualification that the supplement should be extended to all persons with well-documented histories of "MH, MR, and/or SA," whether they have been discharged from state facilities or not.

Virginia Association of Nonprofit Homes for the Aging (VANHA)

Marcia A. Melton, Vice President of Public Policy, supports Option II with the exception of a revised set of regulations for small adult care residences. VANHA does not support separate regulations of small homes. Additionally, VANHA supports Options V - VII, IX, and XIV. VANHA expressed opposition to Options III and IV.

Virginia Health Care Association

Mary Lynne Bailey, Vice President for Legal and Government Affairs, expressed support for Options II, VII - IX, and XI - XIV. Ms. Bailey expressed opposition to Option III and IV.

Virginia Hospital and Healthcare Association

Susan C. Ward, Vice President, expressed support for Options II, VII, XII, and XIII. Ms. Ward offered the following comment regarding Option II: VHHA believes additional discussion is needed to determine how each category of facility should be identified and defined, considering the services each provides and the populations served. Also, VHHA is not convinced that separate rules for smaller facilities are needed or appropriate. Ms. Ward expressed opposition to Options III - V.

Virginia League of Social Services Executives

Susan L. Clark, President, commented that nursing homes suffer limited penalties for failure to report abuse and suggested that an adult protective services central registry could be one solution. Ms. Clark stated that nursing homes which violate patient rights by a failure to act on behalf of the patient should be reported to the

Medicaid Fraud Control Unit of the office of the Attorney General. The League would recommend the establishment of minimum qualifications for ACR administrators. Additionally, the League feels the following actions would help protect adults: (1) education and training regarding what is abuse and neglect required for law enforcement and for facility staff both in nursing homes and adult care facilities; (2) clearer protocol for adult protective services in facilities; and (3) full funding to local departments of social services for adult protective services.

Virginia League of Social Services Executives Adult Services Committee

Nancy W. Bockes, Co-Chair, commented in support of Option XII stating that it is imperative that funding be made available to serve this vulnerable population.

Virginia Long-Term Care Ombudsman Program

Mark C. Miller, State Ombudsman, expressed support for Options II - V, VII - X, XII, and XIII. Regarding Option II, Mr. Miller noted that while the Ombudsman Program supports statutory clarification to allow independent living facilities, such as Section 8 housing, to offer supportive services to residents without being subject to licensure, they do not support any statutory delineation differentiating between "board and care" and "assisted living" facilities.

Virginia Municipal League

R. Michael Amyz, Executive Director, expressed support for Options V - VIII, XI, and XII. He expressed opposition to Option X.

JOINT COMMISSION ON HEALTH CARE

Executive Director

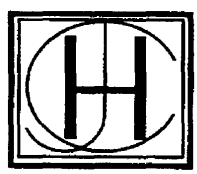
Patrick W. Finnerty

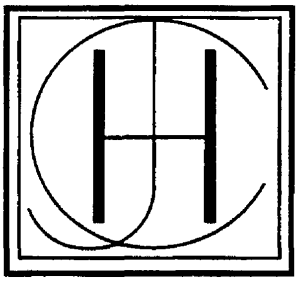
Senior Health Policy Analysts

Joseph J. Hilbert
William L. Murray, Ph.D.
E. Kim Snead

Office Manager

Mamie V. White





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