Code of Virginia § 30-168.
The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

Joint Commission on Health Care Membership
Chair
The Honorable Charles W. Carrico, Sr.

Vice-Chair
The Honorable Rosalyn R. Dance

Senate of Virginia
Senator George L. Barker
Senator Siobhan S. Dunnnavant
Senator John S. Edwards
Senator L. Louise Lucas
Senator Glen H. Sturtevant, Jr.
Senator David R. Sueterlein

Virginia House of Delegates
Delegate David L. Bulova
Delegate Benjamin L. Cline
Delegate T. Scott Garrett
Delegate Patrick A. Hope
Delegate Riley E. Ingram
Delegate Kaye Kory
Delegate John M. O’Bannon III
Delegate Christopher K. Peace
Delegate Christopher P. Stolle
Delegate Roslyn C. Tyler

Commission Staff
Michele L. Chesser, Ph.D.
Executive Director
Paula R. Margolis, Ph.D., MPH
Senior Health Policy Analyst
Andrew D. Mitchell, Sc.D.
Senior Health Policy Analyst
Stephen G. Weiss, M.P.A.
Senior Health Policy Analyst
Agnes Dymora
Executive Assistant/Office Manager
Preface

Passed during the 2017 General Assembly session, Senate Joint Resolution 266 (Senator Dance) instructed the Joint Commission on Health Care (JCHC) to study the current staff-to-resident ratio requirements for assisted living facilities and special care units.

Virginia requires that ALFs have a sufficient number of staff on duty to safely operate the facility. ALFs need the flexibility to adjust staffing to meet frequently changing resident needs. Increasing labor costs could result in the closing of beds for individuals with low income who receive the Auxiliary Grant (public funds that contribute to ALF care) as ALFs are unable to increase rates charged to these individuals which are established by the Legislature. In addition, the DSS does not have the information technology capability to generate standard reports on ALF inspection results. In February 2018, a new regulation package updating the rules for ALFs took effect, and operators, industry groups and state agency staff expressed the preference for allowing time to implement the new rules before deciding whether or not to set specific staffing ratios.

At the November 2017 JCHC Decision Matrix meeting, members approved an option to introduce a budget amendment to raise Auxiliary Grant rates and an option to request, by letter of the JCHC Chair, that the Secretary of Health and Human Resources direct the DSS to field a Request for Information (RFI) for enhancing data reporting capabilities.

The Joint Commission members and staff would like to acknowledge and thank those who assisted in the study, including: Tara D. Ragland, MSA, LNHA, Director of Adult Programs and Deborah A. Lloyd, RN, Operations Consultant, Virginia DSS; Lisa Wooten, MPH, BSN, RN, Injury and Violence Prevention Program Supervisor, Virginia Department of Health (VDH); Kate Marshall, LCSW, Regional Consultant, Adult Community Behavioral Health Services, Department of Behavioral Health and Developmental Services; Judy Hackler, Executive Director and April R. Payne, LNHA Vice President of Quality Improvement Director, Virginia Association for Assisted Living; Bryan L. Porter, Office of the Commonwealth’s Attorney; Derrick Kendall, Chief Executive Officer, Lucy Corr; Dana Parsons, Vice President, LeadingAge Virginia; Bruch M. Slough, Executive Director and Jeffrey J. McInnis, Administrator, Saint Francis Home; Ed Corbeil, Vice President of Operations, Commonwealth Senior Living; Jennifer G. Fidura, Virginia Network of Private Providers, Inc.; Mike Mallon, MPH, Community Health Program Specialist, Department of Health (VDH); James Rothrock, Commissioner, Paige L. McCleary, MSW, Director, Adult Protective Services Division, Tishau Harris Ugworji, Program Manager and Shelley Henley, Auxiliary Grant Program Consultant, Department of Aging and Rehabilitative Services (DARS); Terry A. Smith, Director, Division of Aging and Disability Services, Cindy Olson, Director, Eligibility and Enrollment Services Division, and Steve Ankiel, Program Manager, Division of Aging and Disability Services, Department of Medical Assistance Services (DMAS); Matt Mansell, Vice

---

1 The National Center for Assisted Living. Assisted Living 2016 State Regulatory Review; October 2016.
President of Government and Regulatory Affairs, Virginia Health Care Association - Virginia Center for Assisted Living; Joan Thomas, Birmingham Green; Randy Scott, Saint Mary’s Woods; Julia Ciarlo Hammond, Eckert Seamans Cherin & Mellott, LLC.

This study and report was assigned to, and completed by, Paula R. Margolis, Ph.D., M.P.H., Senior Health Policy Analyst at the JCHC. She may be contacted at pmargolis@jchc.virginia.gov.
# Table of Contents

**Executive Summary**.......................................................................................... V

**Background**......................................................................................................... 1

**Current Virginia ALF Regulation** ................................................................. 2

**Staffing and Salaries** ......................................................................................... 3

**Monitoring Limitations** .................................................................................... 3

**Costs and Reimbursement** ................................................................................. 3

**Recent Developments** ....................................................................................... 4

**Review of Literature and Other States** ......................................................... 4

**Policy Options** ................................................................................................... 5

  **Public Comments** .............................................................................................. 5

    **Public Comment Excerpts** ............................................................................. 5

**Joint Commission on Health Care Actions** .................................................. 6

**Legislative Action** .............................................................................................. 6

**JCHC Staff for This Report** ................................................................................. 6

**Attachment- Staffing Ratios in Assisted Living Presentation**
**Executive Summary**

Passed during the 2017 General Assembly session, Senate Joint Resolution 266 (Senator Dance) instructed the Joint Commission on Health Care (JCHC) to study the current staff-to-resident ratio requirements for assisted living facilities and special care units. The resolution was passed by indefinitely in Senate Rules committee with the understanding that JCHC would conduct the study.

The JCHC study included site visits to five ALFs in the Central Virginia region which entailed tours of the facilities and interviews with ALF operators, staff members and residents. In addition, input was solicited and received from advocates, industry groups, and employees of several state agencies that are responsible for various ALF licensing, oversight, and payment issues. Lastly, a literature review provided information regarding staffing ratio policies in other states, ALF labor adequacy, salary information, staff turnover rates, and information on the projected cost of ALF care. The literature review revealed that very few states require specific staffing ratios; rather, they have rules that are similar to those in Virginia that require a sufficient number of staff members in order to safely operate the facility. ALF operators, industry groups and state agency staff expressed the view that implementing specific staff-to-resident ratios would be very difficult, due to the variety of facility configurations, the differing and frequently changing mix of resident level-of-need in each facility, and the commitment to provide person-centered care, which may result in the need for different staff levels at various times of day (e.g., many residents need assistance bathing and prefer to bathe before breakfast). In addition, both the literature review and ALF operator interviews revealed that there is high turnover of direct care staff. ALF operators reported that after training staff at their expense, staff frequently leave the facility after a few months to work in home-based care.

Persons meeting low income and other eligibility requirements may qualify for funding to pay for ALF stays from the Auxiliary Grant (AG), (which provides state and local funds that contribute to ALF costs). The AG rate is set by the Virginia Legislature, and the current rate covers approximately one-third to one-half of the cost of providing ALF care. Over the last several years, a number of ALFs serving persons who receive the AG have closed or reduced the number of beds allocated to AG recipients. ALF operators expressed concern that increasing labor requirements would be costly and could result in increasing the rates to private-pay residents and/or reducing the number of AG recipients they are able to serve, as they are unable to adjust charges to AG recipients. In February 2018, a new, wide-ranging regulation package updating the rules for ALFs took effect, and operators, industry groups and state agency staff expressed the preference for allowing time to implement the new rules before deciding whether or not to set specific staffing ratios. Also, ALFs are required by the Department of Social Services (DSS) to use a staffing tool when setting staff levels. DSS monitors their use of the tool during inspections. Currently, DSS, in conjunction with facility operators, is developing a new

---

3 The National Center of Assisted Living 2013 Survey
tool that can be used by ALFs to better determine their staffing needs. The new tool will be pilot-tested and should be completed in 2018. Another issue that was highlighted during talks with industry groups and state agency staff was the fact that the DSS does not have the information technology capability to generate standard reports on ALF inspection results. Creating monitoring reports is currently a manual process, requiring data drawn from several different systems, is time consuming and relies upon institutional knowledge and outside industry groups who gather information from their member facilities. JCHC members were presented with four policy options. At the November 2017 JCHC Decision Matrix meeting, members voted to proceed with policy option three: to introduce a budget amendment to raise Auxiliary Grant rates (amount to be determined), and policy option four: by letter of the JCHC Chair, request that the Secretary of Health and Human Resources direct the DSS to field a Request for Information (RFI) for enhancing data reporting capabilities.
STAFFING RATIOS IN ASSISTED LIVING

Passed during the 2017 General Assembly session, Senate Joint Resolution 266 (Senator Dance) instructed the Joint Commission on Health Care (JCHC) to study the current staff-to-resident ratio requirements for assisted living facilities and special care units. Specifically, it was requested that the JCHC:

1. Identify and analyze current staff-to-resident ratio requirements for assisted living facilities (ALF) and special care units
2. Make recommendations for changes to such ratio requirements that would lead to better care and quality of life for residents, including recommendations regarding the total number and type of staff that:
   a. are required to meet the routine and special needs of all residents
   b. must be awake and on duty during night shifts
   c. should accompany residents on trips away from the assisted living facility or special care unit

The resolution was passed by indefinitely in Senate Rules committee with the understanding that JCHC would conduct the study.

Background

Assisted living facilities (ALF) are congregate home-like settings housing four or more adults who are aged, infirmed or disabled. They provide 24/7 supervision and oversight of the physical and mental well-being of an individual, housekeeping, meals, medication management, transportation, and other services. ALFs may not admit individuals whose care needs are greater than the ALF’s ability to safely serve. No ALF in Virginia may admit individuals who are ventilator dependent, have some stage III and IV dermal ulcers, pose an imminent physical threat to themselves or to others, need continuous licensed nursing care, or have physical/mental health needs that cannot be met, as determined by the facility.

ALFs are varied in type and may be for-profit or not-for-profit; have various numbers of beds; may be affiliated with a faith-based organization; may be small, stand-alone operations, or they may be part of a local or national chain. ALFs may serve mixed populations (needing different levels of care) in the same unit, or they may be continuing care communities having several separate units providing different levels of care that residents may move through as their needs change (e.g., independent living, residential care, assisted living, memory care and skilled nursing).

Federal regulations prohibit Medicare and Medicaid from paying for ALF room and board costs. Most of the ALFs in Virginia serve residents who are private pay, while some also serve individuals who receive Auxiliary Grant (AG) funds. The AG is a state- and locally-funded grant program (80% state and 20% local funds) that contributes to room and board costs for individuals who meet income and other eligibility criteria. In addition to the AG, Virginia Medicaid pays a per diem rate of $49.50 (approximately $1,485 per month) to help pay for direct care services for
persons living in ALFs who are enrolled in the Medicaid Alzheimer’s Assisted Living Waiver. The Waiver will expire the end of June 2018 with no plans for renewal.

Individuals in the Alzheimer’s Assisted Living Waiver will be moved to other Medicaid Home and Community-Based Services Waivers (such as the Elderly and Disabled with Consumer Direction Waiver), but ALFs will no longer receive the Medicaid direct care services per diem payment for these individuals. According to DMAS, this change effects approximately twenty individuals. DMAS staff reports that some ALFs have agreed to continue to serve Medicaid recipients with Alzheimer’s Disease, despite the cessation of the per diem payment.

**Current Virginia ALF Regulation**

The Department of Social Services (DSS) inspects and licenses ALFs, and inspections occur at least annually. Licenses may be granted for one to three years based on inspection results, and there is also a provisional, six-month license for ALFs with significant issues which need to be addressed immediately.

Each ALF resident must have an individualized service plan that is based on their needs and must be updated at least every 12 months. Current Virginia law does not mandate a staff-to-resident ratio in most instances, but it does specify the minimum number of staff that must be on duty overnight and in units that serve residents with special needs, such as memory care. In addition:

- facilities must have a written staffing plan that specifies the number and type of staff required to meet the direct care needs of their residents
- ALFs must have written back-up plans for when regular staffing plans cannot be met
- ALFs must report safety incidents to DSS within a day of occurrence
- Virginia regulations specify the training required of individuals who provide direct care services
- Virginia regulations require that each room have a call signal system for residents to use when they need immediate attention
- Residents may wear remote signaling devices when they are not in their rooms in ALFs without call buttons, staff must check on each resident at least once per hour overnight and keep a log documenting when checks were made

Virginia requires that ALFs specify a method to determine and document staffing needs but does not specify the method – each ALF may develop their own method for determining and documenting staffing needs. Documentation based on the method is reviewed when DSS performs inspections and responds to complaints. Several ALF administrators expressed that staffing needs in ALFs can change frequently, depending on changing resident needs and turnover in resident populations. They stressed that requiring a fixed staff-to-resident ratio would be inefficient, result in over-staffing and under-staffing at times due to needs based on patient-centered care plans (e.g., many residents need assistance with bathing and desire to bathe around the same time of day) and could lack the flexibility needed to provide adequate care.
**Staffing and Salaries**

The 2013 National Center of Assisted Living survey reported that over half of ALF employees consisted of nursing staff. Certified Nurse Assistants (CNAs) represented a third of all nursing staff, and 27% were resident caregivers or non-certified nursing assistants. The turnover rate among nursing staff was 24% overall, and 206 of the responding ALFs reported that they had a combined total of over 1,000 nursing staff vacancies.

According to the Bureau of Labor Statistics, the nationwide mean hourly wage for nursing assistants in 2016 was $13.29. In Virginia, the mean hourly wage was $12.52 ($0.77 below national mean), and in the District of Columbia it was $16.05. Staff turnover is a constant challenge. One Virginia ALF administrator reported that, although they provide free on-site CNA training, many CNA staff members leave the facility after several months to work for individuals in their homes. Another Virginia ALF administrator reported that adding 3 more staff would raise costs by $2,490 per resident per year.

**Monitoring Limitations**

DSS does not currently have automated reporting capabilities to track inspection results and violations. Creating reports to monitor performance is currently a manual process that draws on data from several separate files, is time consuming and dependent on institutional knowledge. In fact, LeadingAge (a statewide organization representing not-for-profit ALFs) creates summary reports of their member facilities’ inspection findings which they provide to DSS. Additional resources for DSS are needed in order to create reports that can be easily produced on a regular basis to help identify problems and track trends over time and persist despite agency staff turnover.

**Costs and Reimbursement**

Genworth Financial estimated that in 2019, the median cost of assisted living in Virginia will be approximately $4,300 per month. The current AG monthly rate (approximately $1,220) covers about 28% of the projected 2019 monthly cost. Resident SSI income (except for a small monthly personal needs allowance) goes towards the monthly ALF payment, and the AG pays the difference between the amount that the resident pays and the AG rate. ALF administrators report that they must carefully manage their mix of AG to private paid residents, mix of level of need, and mix of unit types, in order to ensure adequate cash flow to remain viable. One non-profit ALF that serves a majority of residents whose fee is paid through the AG reported that they generally end each year with an operating deficit of approximately $400,000 to $500,000. The religious organization with which they are affiliated fills the funding gap. According to DSS staff, ALFs serving AG recipients have closed due to inadequate funding, and small ALFs are particularly vulnerable. Further, they report that placing individuals receiving the AG has become increasingly difficult, resulting in individuals being placed further away from their families.

---

iv Ibid.
Recent Developments

An ALF stakeholder workgroup led by DSS is in the process of developing a new tool to help ALFs better determine staffing requirements. The tool is modeled on one used in Oregon modified to reflect Virginia needs. The tool will be pilot-tested in Virginia facilities that range in size, acuity mix, affiliation status and region. Results from the pilot tool will be compared to those determined by the current tools to help determine efficacy. It is expected that the new tool will be available in 2018 but its use will be voluntary; ALFs may still choose their current method to determine and document staffing needs.

In addition, DSS led a multi-year effort of stakeholders to update Virginia regulations dealing with ALFs. The new regulation package was signed by Governor McAuliffe in the summer of 2017 and included revised language increasing staff training on cognitive impairment, increased supervision of medication aides, increased administrator staffing, fall risk ratings for all residents, increased incentives for employment of full-time licensed health care professionals, and additional requirements for signaling devices and awake overnight staff. DSS staff and ALF administrators expressed the preference for allowing time for the new regulations to be implemented and their results evaluated before considering changes mandating staffing ratios.

Review of Literature and Other States

According to the 2016 National Center for Assisted Living Regulatory Review, ten states specify staff-to-resident ratios in ALFs (Georgia, Idaho, Indiana, Maine, Mississippi, Missouri, Michigan, New Mexico, North Carolina, and South Carolina). Two of these states (Nevada and North Carolina) only specify ratios in special care units. In states that do not specify staff ratios, staff levels must be sufficient to meet resident needs and ensure safety, and the ALF must have a written staffing plan and demonstrate how their staffing system works. This is similar to Virginia’s requirements.

The literature review findings suggest that specifying staffing ratios may result in a loss of staffing flexibility with increased costs but little or no gain in quality, due to the frequent changes in need at facilities. As noted above, resident turnover results in differing staffing needs, based upon the current mix of resident’s needs and their desire for the timing of activities requiring assistance during the day. Some hours may be more staff-intensive (e.g., due to the need for assistance with bathing, toileting, dressing) than other times of the day despite the same number of residents. Set staff-to-resident ratios could result in both overstaffing and understaffing at times. Findings also included that increasing direct care staff may result in a reduction of other categories of staff (e.g., housekeeping) with no increase in quality.
Policy Options

The JCHC policy analyst staff offered four policy options to the JCHC members:

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>Take no action</td>
</tr>
<tr>
<td>Option 2</td>
<td>Direct the Department of Social Services to further determine explicit minimum staffing ratio requirements for day, evening and overnight shifts</td>
</tr>
<tr>
<td>Option 3</td>
<td>Raise Auxiliary Grant rates</td>
</tr>
<tr>
<td>Option 4</td>
<td>Request that the Secretary of Health and Human Services direct DSS to field a Request for Information for enhancing data reporting capabilities</td>
</tr>
</tbody>
</table>

Public Comments

The JCHC received comments from the following stakeholders: The Virginia Assisted Living Association, The Virginia Health Care Association – Virginia Center for Assisted Living, LeadingAge Virginia, and a member of the Arlington County Commission of Aging/Long-Term Care Residences Committee. None of the commenters were in support of Option 1. Three commenters were in support of Options 2 – 4. One commenter was opposed to Option 2.

Public Comment Excerpts

“The Virginia Assisted Living Association (VALA) - highly recommends the JCHC support the policy options 3 and 4 that were recommended in the report to introduce a budget amendment to raise the Auxiliary Grant (AG) rate and to request the Secretary of Health and Human Resources to direct the Department of Social Services (VDSS) to field a Request for Information (RFI) for enhancing data reporting capabilities. VALA has been informed by several assisted living (AL) providers they would be able to admit and to retain residents who qualify for the AG rate if the AG rate were increased. Many AL communities do not accept new admissions of residents who qualify for the AG rate due to it being significantly underfunded, which then forces many of those residents to acquire housing at nursing home facilities at a significantly higher rate to the government…Increase of the AG rate helps to stabilize accurate placement of residents into long term care communities based on their acuity needs instead of on their financial resources. VALA does not support option 2 of requesting VDSS to determine explicit minimum staffing ratio requirements for day, evening and overnight shifts. VDSS is currently in the process of completing the Comprehensive Revision of the Standards for Licensed Assisted Living Facilities that is expected to have an effective date of February 1, 2018. This comprehensive revision is the result of many years of thoroughly reviewing the current requirements and taking into considerations current resident populations, service practices, available and pending technology, and comments from many stakeholders including VALA, the Alzheimer’s Association, local Ombudsmen, family members, several Virginia agencies, and several other industry specific associations.”

Virginia Health Care Association – Virginia Center for Assisted Living: “…Option 2: We believe that this option is duplicative and unnecessary in light of the pending overhaul of assisted living regulations that have a target effective date of February 1, 2018…We think these regulations and their more stringent approach to staffing should be allowed to move forward and take effect before consideration of additional requirements is considered. Option 3: We strongly support additional funding for Auxiliary Grants (AG)…the current rate is not sufficient to allow for facilities to serve
many AG recipients if any at all. A higher rate that is closer to the cost of care for these individuals would serve as a strong incentive to get them the best care possible. Option 4: We support providing additional resources to DSS to better track and provide data to policymakers and providers across the Commonwealth. Better data will lead to better health care outcomes and help guide all assisted living providers across the Commonwealth to embrace best practices and approaches to the provision of resident-centered care.”

LeadingAge Virginia: “New comprehensive assisted living regulations will become effective on February 1, 2018, and they provide for increased levels of staffing within special care units and overall enhanced resident care. Generally, we feel that the best approach is to allow these regulations to be implemented to determine their effectiveness before moving forward with the development of staffing standards…We strongly support the introduction of a budget amendment to increase the auxiliary grant rate because the current rate is too low and does not provide adequate funding to care for many of the complex medical needs of residents…We strongly support the ability for DSS to have enhanced reporting capabilities.”

Arlington County Commission of Aging/Long-Term Care Residences Committee: “We recommend Option 2: By letter of JCHC Chair request that the Department of Social Services (DSS) determine explicit minimum staffing ratio requirements for day, evening and overnight shifts. We must ensure safe staff to resident ratios.”

**Joint Commission on Health Care Actions**

At the JCHC Decision Matrix meeting held in November 2017, the members voted to support Policy Option 3 – Raise Auxiliary Grant Rates, and Policy Option 4 - Request that the Secretary of Health and Human Resources direct the Department of Social Services to field a request for information to enhance data reporting capabilities. The Deputy Commissioner of Health and Human Resources was present at the meeting, and the JCHC Chair obtained his agreement to act on this request.

**Legislative Action**

During the 2018 General Assembly session, Senator Rosalyn Dance introduced a budget amendment, Senate Bill 30 Item 343 #1s, to increase the Auxiliary Grant rate by $50 per month (for a total request of $2,280,000) in the first year of the biennium and an additional $100 per month in the second year (for a total request of $4,560,000), and Delegate Roslyn C. Tyler introduced a companion bill (House Bill 30 Item 343 #1h). The Senate Committee and Floor approved $0 in the first year and $1,000,000 in the second year of the Budget. At the time of the writing of this report, a final budget has not been passed. The Legislature failed to pass a Budget at the end of the regular 2018 session and a special session was scheduled for April 8, 2018 and the reconvened session was scheduled for April 18, 2018.

**JCHC Staff for this Report**

Paula R. Margolis, Ph.D., M.P.H.
Senior Health Policy Analyst
Study Mandate SJR 266 - Senator Dance

- Identify and analyze current staff-to-resident ratio requirements for assisted living facilities (ALF) and special care units

- Make recommendations for changes to such ratio requirements that would lead to better care and quality of life for residents, including recommendations regarding the total number and type of staff that:
  - Are required to meet the routine and special needs of all residents
  - Must be awake and on duty during night shifts
  - Should accompany residents on trips away from the assisted living facility or special care unit
Virginia Assisted Living

• A congregate home-like setting housing four or more adults who are aged, infirm or disabled
• Provide 24/7 supervision and oversight of the physical and mental well-being of an individual, housekeeping, meals, medication management, transportation, and other services

- ALFs may be:
  • For-profit and not-for-profit
  • Affiliated with a faith-based organization
  • Small, stand alone or part of a large, national chain
  • Serve mixed populations in the same unit (with additional staffing and training; security monitoring system; secured outdoor area or close staff supervision)
- Continuing care retirement communities (CCRC), (sometimes referred to as life plan communities) that can serve individuals in various levels of care as their needs change (independent living, residential care, assisted living, skilled nursing)
  • May serve residents who are private pay, Auxiliary Grant paid, or a mix (the majority serve predominantly or solely private pay)

Assisted Living Facilities May Not Admit Individuals Whose Level of Need is Beyond their Capability to Serve

No individual may be admitted or retained:
• Who requires a level of care/service, or type of service, the facility does not provide
• If the facility does not have appropriate type and numbers of staff

Individuals who may not be admitted include those:
• Who are ventilator dependent
• Have some stage III and stage IV dermal ulcers
• Pose an imminent physical threat to self or others
• Need continuous licensed nursing care
• Have physical/mental health needs that cannot be met as determined by the facility
Residential living:
- Minimal assistance with ADLs/medication administration
- And/or dependent in one ADL or one or more instrumental activities of daily living (IADL) and are able to maintain themselves independently

Assisted Living:
- Moderate assistance - dependent in two or more activities of daily living (ADL)
- And/or dependent in behavior patterns (abusive, aggressive, disruptive)

Nursing Facility:
- Dependent in two to four ADLs
- Or semi-dependent or dependent in behavior pattern and orientation
- And semi-dependent in joint motion
- Or dependent in medication administration

ADLs:
- Bathing
- Dressing
- Toileting
- Transferring
- Eating
- Ambulating

IADLs:
- Managing finances
- Handling transportation (driving/public transit)
- Shopping
- Preparing meals
- Using the phone and other communication devices
- Managing medications
- Housework and basic home maintenance

The Uniform Assessment Instrument (UAI) is Used to Determine Levels of Service

ALs can house residents with various levels of need within one building or section, and the levels of need can frequently change, based on changes in residents’ condition and/or turnover

Activities of Daily Living

62% need help with bathing
47% need help with dressing
39% need help with toileting
20% need help with eating
30% need help with bed transfer

Common Conditions ALs Help Residents Manage

40% have Alzheimer’s disease or dementia
46% have cardiovascular disease
23% have depression
17% have diabetes

Specialized dementia care services
Memory care is an increasing component of assisted living.
- 12% have a unit, wing or floor designated
- 10% only serving adults with dementia

Activities and Services

Typical services
- 24-hour supervision and assistance
- Exercise, health, and wellness programs
- Housekeeping and maintenance
- Meals and dining services
- Medication management or assistance
- Personal care services such as ADLs
- Transportation

Coordinated services
- Assisted living does not directly provide certain health care services, but consistently works with other providers to offer these services.
- Dental
- Depression screening
- Hospice
- Mental health or counseling
- Pharmacy/Pharmacist
- Podiatry
- Skilled nursing
- Therapy (physical, occupational or speech)
### Virginia Assisted Living Regulation Summary

- The Department of Social Services licenses and inspects ALFs at least annually.
- Licenses may be for one to three years based on inspection results, and there is a provisional, six-month license for those with significant issues which need to be addressed immediately.
- Each resident must have an individualized service plan that is based on their needs which must be updated at least every 12 months.
- Current Virginia law does not mandate a staff to resident ratio in most instances.
- It does specify the minimum number of staff that must be on duty over night and for units that serve residents with special needs, such as memory care.
- Facilities must have a written staffing plan that specifies the number and staff required to meet the direct care needs of their residents.
- They must have written back up plans for when regular staffing plans cannot be met.
- They must report safety incidents to DSS within a day of occurrence.
- Virginia specifies the training required of individuals who provide direct care.
- Virginia regulations require that each room have a call signal system for residents to use when they need immediate attention.
- Residents may also wear remote signaling devices to use when needed when they are not in their rooms.
- In ALFs without call buttons, staff must check on each resident at least once per hour overnight and keep a log documenting when checks were made.

---

### Virginia Auxiliary Grant Program (AG) Administered by the Department of Aging and Rehabilitation Services

- The AG program is an outgrowth of the federally-mandated State SSI Supplementation Program when SSI replaced Old Age Assistance.
- States were required to supplement the SSI payments of those who would have been negatively impacted by the change or the states would lose Federal Medicaid funding.

AG covered services include:

- Room and board (furnished room, meals, housekeeping and linen service)
- Maintenance and care, including:
  - Minimal assistance with personal hygiene
  - Medication administration
  - Provision of personal toiletries
- AG covered services include minimal assistance with:
  - Care of personal possessions
  - Care of funds
  - Use of the telephone
  - Arranging transportation
  - Obtaining necessary personal items and clothing
  - Making/keeping appointments, assisting with correspondence
  - Securing health care and transportation for treatment
  - Providing appropriate social and recreational activities
  - General supervision for safety

See Appendix IV for details.

[http://www.dss.virginia.gov/family/as/auxgrant.cgi](http://www.dss.virginia.gov/family/as/auxgrant.cgi)
Auxiliary Grants (AG) Eligibility Criteria and Payment

AG eligibility criteria require that individuals:
• Receive Supplemental Security Income (SSI) and/or are aged, blind or disabled and meet income limits
• Must be a US citizen or a non-citizen who meets specified criteria*
• Have countable income less than the combined AG rate plus the personal needs allowance (PNA) of $81 per month
• Have non-exempt resources of less than $2,000 for one person or $3,000 for a couple

The current AG AL rate is set at $1,221 per month outside of NVA and $1,402 per month in NVA
• AG rates are set by the General Assembly and adjusted based on Social Security cost of living adjustments
• The maximum monthly SSI payment is $735 and depends on how much the person earned while working
• The AG pays the difference between residents’ SSI payment (minus the PNA) and the AG AL rate

Example: Current AG Rate = $1,221 per month

Resident payment: ($735 SSI – $81 PNA) = $656
Auxiliary Grant payment: ($1,221 - $656) = $565

*Eligibility for non-citizens is limited to those defined by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act

Auxiliary Grant Spending in Virginia and Monthly Payment Rates Compared to Costs

State General Funds Allocated for Auxiliary Grants

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY 2011</td>
<td>$23,152,956</td>
</tr>
<tr>
<td>SFY 2012</td>
<td>$20,739,804</td>
</tr>
<tr>
<td>SFY 2016</td>
<td>$21,898,969</td>
</tr>
<tr>
<td>SFY 2017</td>
<td>$21,398,969</td>
</tr>
</tbody>
</table>

Monthly Auxiliary Grant Rate

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY 2012</td>
<td>$1,112</td>
</tr>
<tr>
<td>SFY 2017</td>
<td>$1,221</td>
</tr>
</tbody>
</table>

Average Monthly Enrollment

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY 2013</td>
<td>4,669²</td>
</tr>
<tr>
<td>SFY 2016</td>
<td>4,138¹</td>
</tr>
</tbody>
</table>

Genworth Financial Median Monthly Assisted Living Costs³

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$3,950</td>
</tr>
<tr>
<td>2019 Projected</td>
<td>$4,316</td>
</tr>
</tbody>
</table>

¹ Department for Aging and Rehabilitation Services Annual Report 2016
² Department for Aging and Rehabilitation Services Annual Report 2013

The current AG monthly rate equals about 28% of the Genworth projected 2019 median monthly cost

• ALFs must carefully manage their mix of AG to private pay residents and levels of needs
• Several ALFs serving AG recipients have closed due to inadequate funding - small ALFS are particularly vulnerable
• DSS has had difficulty placing individuals receiving the AG resulting in individuals being placed further away from their families
Medicaid Recipients in Assisted Living in Virginia

- **Virginia Medicaid pays $49.50 per day for Medicaid recipients enrolled in the Alzheimer’s Assisted Living Waiver (AAL) living in ALFs**
  - This is in addition to the AG payment and does not pay for room and board
  - There are also individuals who in Medicaid that are not in the AAL waiver who receive assisted living
    - **ALFs do not receive the per diem Medicaid payment for individuals who receive Medicaid but are not enrolled in the AAL Waiver**
  - The AAL Waiver will expire this year; DMAS’ current plans are to not renew the waiver; although, DMAS staff has indicated that plans may not yet be final

- **Other Payer sources: savings, long term care insurance and employee sponsored benefits**
  - About 8% of the U.S. population has private long term care insurance
  - Individuals using their own funds may “spend down” to meet Auxiliary Grant financial eligibility

Primarily Private and Auxiliary Grant Paid Assisted Living – Observations from Site Visits

- Staff members at all sites were very dedicated to their residents, and residents expressed high levels of satisfaction
- Administrators at ALFs with all or mostly privately paid residents reported slim but positive operating margins
- An administrator at an ALF with a majority of AG paid residents reported operating losses of about $500K per year; the gap is filled by an affiliated religious organization
- Majority AG-funded AL characteristics included:
  - AG funded residents lived in double-occupancy rooms with a shared water closet (private pay residents had private rooms and bathrooms)
  - Showers are in halls and shared by multiple residents
  - Most food is donated from local grocers – food is near its ‘use by’ date and must be culled prior to use; $1.71 per resident per day is spent on non-donated foodstuffs
  - Fewer observed organized activities
  - Does not accept residents with high needs due to staffing limitations
Findings from the National Center of Assisted Living 2013 Survey

In 2013, the median turnover rate among nursing staff was 24.2%

<table>
<thead>
<tr>
<th>Median Turnover Rates</th>
<th>Turnover</th>
<th>Vacant Positions</th>
<th>Number</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>24.2%</td>
<td>Total</td>
<td>1,021</td>
<td>100%</td>
</tr>
<tr>
<td>Nursing</td>
<td>25.0%</td>
<td>Nursing</td>
<td>615</td>
<td>60%</td>
</tr>
<tr>
<td>CNAs</td>
<td>13.6%</td>
<td>CNAs</td>
<td>213</td>
<td>21%</td>
</tr>
<tr>
<td>Resident Caregivers</td>
<td>36.4%</td>
<td>Resident Caregivers</td>
<td>193</td>
<td>19%</td>
</tr>
</tbody>
</table>

206 facilities reported they had a total of 1,021 vacant positions

2016 National Center for Assisted Living
Regulatory Review of Assisted Living Requirements

- Ten states mandate specific staffing ratios
- In states that do not, staff levels must be sufficient to meet resident needs and ensure safety
- And/or the ALF must have a written staffing plan and demonstrate how their staffing system works
- States that do mandate ratios include: Georgia, Idaho, Indiana, Maine, Mississippi, Missouri, Michigan, New Mexico, North Carolina, and South Carolina\(^1\)

- One Virginia ALF reported that their direct care staff compensation equals $14.54 (wages and benefits) per hour with total staffing costs of $465,745 per year
- Adding 3 more staff would raise costs by $2,490 per resident per year
- They opined that increased ratios may put smaller companies and those serving a high proportion of residents receiving AG funding out of business

\(^1\) See Appendix I for details
Residential Care Communities Staffing Levels
National Health Statistics Report 2016 (2014 Data)

Registered Nurses (RN)
• RN staffing levels ranged from 2 minutes (0.04 of 1 hour per resident per day) in Louisiana to 1.03 hours in South Dakota
• RN staffing levels were significantly higher than the national ratio (16 minutes or 0.27 of 1 hour) in 10 states (Hawaii, Iowa, Kansas, Maryland, Minnesota, Montana, South Dakota, Vermont, West Virginia, and Wyoming)
• RN staffing levels were significantly lower than the national ratio (16 minutes or 0.27 of 1 hour) in 13 states (Alabama, Arkansas, California, Colorado, Delaware, Louisiana, Mississippi, Nevada, New York, Pennsylvania, Rhode Island, Tennessee, and Virginia)

Aides
• Aide staffing levels ranged from 1.18 hours per resident per day (1 hour 11 minutes) in Indiana to 3.94 hours (3 hours 56 minutes) in Wisconsin
• Aide staffing levels were significantly higher than the national ratio (2.37 hours or 2 hours 22 minutes) in 7 states (Alaska, Kansas, Minnesota, New Mexico, South Dakota, West Virginia, and Wisconsin)
• The Virginia ratio of 1.94 was lower than the national average of 2.37 hours per day
LPN/VN staffing levels ranged from 1 minute (0.02 of 1 hour per resident per day) in Nevada to 1.26 hours in Iowa.

LPN/VN staffing levels were significantly higher than the national ratio (12 minutes or 0.20 of 1 hour) in 20 states (Alabama, Delaware, D.C., Illinois, Indiana, Iowa, Kansas, Kentucky, Mississippi, Nebraska, New Hampshire, New Jersey, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Virginia, and West Virginia).

LPN/VN staffing levels were significantly lower than the national ratio (12 minutes or 0.20 of 1 hour) in 11 states (Alaska, California, Colorado, Connecticut, Idaho, Louisiana, Maine, New Mexico, Nevada, Rhode Island, and Utah).

CNAs are often trained by ALFs.

As people live longer in their homes, CNAs are migrating to home health after several months.

They can earn higher wages that are paid directly by consumers.
Policy implications from Literature Review¹

- There is a heightened need for training, as the mix of physically frail and cognitively impaired elderly and residents with mental illness and developmental disabilities increase.

- Minimum direct care staff requirements may lead to the substitution of indirect care staff (e.g., food workers, janitors) for direct care staff (nurses, nurse assistants, and medication aides).

- All types of healthcare professionals are needed in the right proportion for better outcomes.

¹ See Appendix II for details.

The Department of Social Services is Leading the Effort to Create a New Staffing Tool

- Virginia requires a method to determine and document staffing needs.
- Documentation based on the method is used when DSS performs inspections and responds to complaints.
- A workgroup lead by DSS is developing a new tool to help better determine staffing needs.
- The tool is modeled on one used in Oregon modified to reflect Virginia needs.
- The tool will be pilot tested in Virginia facilities that range in size, acuity mix, affiliation status, and regions.
- Results will be compared to those determined by use of the current form.

Use of this tool will be voluntary (regulations do not mandate the use of a specific tool).
- Once complete DSS will:
  - Make the tool available on its website for download.
  - Update its presentation for training.
  - Explore contracting for webinar training of the revised tool.
  - Consider options for creating online data entry capacity.
The Department of Social Services Must Manually Create Reports

- Data compilation for monitoring currently requires that DSS staff manually combine data from several system components which is time-consuming and dependent on institutional knowledge
- DSS does not have staff to write programs to create standardized, automated reports on measures and trends
- DSS is receiving reports compiled by LeadingAge Virginia (a statewide organization representing not-for-profit ALFs) which include data on their members only

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Number of Violations</th>
<th>Number of Inspections</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1: 22VAC40-72-440-C Individualized service plans</td>
<td>58</td>
<td>355</td>
</tr>
<tr>
<td>#2: 22VAC40-72-670-C Administration of Medications and Related Provisions</td>
<td>46</td>
<td>355</td>
</tr>
<tr>
<td>#3: 22VAC40-72-290-C Staff records and health requirements</td>
<td>40</td>
<td>355</td>
</tr>
<tr>
<td>#4: 22VAC40-72-670-H Staff records and related provisions</td>
<td>35</td>
<td>355</td>
</tr>
<tr>
<td>#5: 22VAC40-72-850-A Maintenance of buildings and grounds.</td>
<td>34</td>
<td>355</td>
</tr>
<tr>
<td>#6: 22VAC40-72-550-F Resident rights</td>
<td>26</td>
<td>355</td>
</tr>
<tr>
<td>#7: 22VAC40-72-630-A Medication management plan and reference materials</td>
<td>26</td>
<td>355</td>
</tr>
<tr>
<td>#8: 22VAC40-72-440-E Individualized service plans</td>
<td>20</td>
<td>355</td>
</tr>
<tr>
<td>#9: 22VAC40-72-840-I General requirements</td>
<td>20</td>
<td>355</td>
</tr>
<tr>
<td>#10: 22VAC40-72-850-F Maintenance of buildings and grounds</td>
<td>18</td>
<td>355</td>
</tr>
</tbody>
</table>

A Request For Information (RFI) process could be used, at no expense, to collect information from vendors on possible solutions and costs for upgrading data reporting capabilities

- **DSS could then:**
  - Identify funds and/or seek a budget request
  - Publish a Request for Proposals (RFP) in order to contract with a vendor to create a solution
The Department of Social Services has lead a multiple-year effort to update Virginia assisted living regulations. Updating regulations involved a multiple-year effort that included stakeholders from all aspects of the senior living industry, including: assisted living providers, Alzheimer’s Association representatives, the long-term care ombudsman, resident advocacy groups and various State Departments and Agencies.

New regulations recently signed by the Governor include requirements for:

- Increased training of direct care staff on cognitive impairment
- Increased supervision of medication aides
- Increased administrator staffing
- Fall risk ratings for all residents
- Increased incentives for employment of full-time licensed health care professionals
- Requirements for signaling devices and awake overnight staff

1See Appendix V

Policy Options

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>Take no action</td>
</tr>
<tr>
<td>Option 2</td>
<td>By letter of the JCHC chair, request that the Department of Social Services determine explicit minimum staffing ratio requirements for day, evening and overnight shifts</td>
</tr>
<tr>
<td>Option 3</td>
<td>Introduce a budget amendment to raise Auxiliary Grant rates (amount to be determined)</td>
</tr>
<tr>
<td>Option 4</td>
<td>By letter of the JCHC Chair, request that the Secretary of Health and Human Resources direct the Department of Social Services to field a Request for Information (RFI) for enhancing data reporting capabilities</td>
</tr>
</tbody>
</table>
Written public comments on the proposed options may be submitted to JCHC by close of business on Thursday October 12, 2017.

Comments may be submitted via:
- E-mail: jchcpubliccomments@jchc.virginia.gov
- Fax: 804-786-5538
- Mail: Joint Commission on Health Care
  P.O. Box 1322
  Richmond, Virginia  23218

Full comments will be provided to Commission members and summarized during the JCHC’s November 21st decision matrix meeting.

(All public comments are subject to FOIA release of records)

Appendix I
States that Specify Staffing Levels in AL
NCAL 2016 Assisted Living State Regulatory Review

Georgia
- Staff ratios of 1:15 during the day and 1:25 during night
- At least one administrator, on-site manager, or responsible staff person, all of whom must be at least 21 years of age, and must be on the premises 24 hours a day
- There should be a minimum of one on-site staff person per 15 residents during awake hours and one staff person per 25 residents during sleeping hours
- Additionally, there must be sufficient staff to meet residents' needs
- The ALF must develop and maintain accurate staffing plans that take into account the specific needs of the residents
<table>
<thead>
<tr>
<th>State</th>
<th>Staffing Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maine</td>
<td>• An on-site administrator must be employed by the facility</td>
</tr>
<tr>
<td></td>
<td>• There are no staffing ratios, except as described below for Level IV residential care facilities</td>
</tr>
<tr>
<td></td>
<td>• Level IV ratio requirements - 1 staff to 12 residents</td>
</tr>
<tr>
<td>Missouri</td>
<td>• ALFs must have an adequate number and type of personnel for the proper care of residents, the residents’ social well-being, protective oversight of residents, and upkeep of the facility</td>
</tr>
<tr>
<td></td>
<td>• At a minimum, the staffing pattern for fire safety and care of residents shall be:</td>
</tr>
<tr>
<td></td>
<td>• One staff person for every 15 residents or major fraction of 15 during the day shift</td>
</tr>
<tr>
<td></td>
<td>• One person for every 20 residents or major fraction of 20 during the evening shift</td>
</tr>
<tr>
<td></td>
<td>• One person for every 25 residents or major fraction of 25 during the night shift</td>
</tr>
<tr>
<td>North Carolina</td>
<td>• At all times there must be one supervisor/administrator-in-charge who is directly responsible for ensuring that required duties are carried out and residents are never left alone</td>
</tr>
<tr>
<td></td>
<td>• The facility must have a designated activity director</td>
</tr>
<tr>
<td></td>
<td>• Regulations specify staffing requirements, qualifications for various positions, and detailed staffing ratios for the type of staff (aide, supervisor, and administrator or administrator in charge), first, second or third shift, and the number of residents</td>
</tr>
<tr>
<td></td>
<td>• Regulations specify different management requirements for facilities based on size from 7-30 residents, 31-80 residents, and 81 or more residents</td>
</tr>
<tr>
<td></td>
<td>• Staffing ratios in special care units = 1:8 during the day; 1:10 during the night; 0.8 for each resident over 10</td>
</tr>
<tr>
<td>South Dakota</td>
<td>• Each facility must have a designated administrator responsible for the daily overall management of the facility</td>
</tr>
<tr>
<td></td>
<td>• There must be a sufficient number of qualified personnel to provide effective care, with a minimum of 0.8 hours of direct resident care for each resident for each 24-hour period</td>
</tr>
<tr>
<td></td>
<td>• At least one staff person must be on duty at all times, and those staff on duty must be awake at all times</td>
</tr>
<tr>
<td></td>
<td>• South Dakota legislation has additional staffing ratio requirements for health care facilities, from which assisted living centers may request an exception by completing a state form</td>
</tr>
</tbody>
</table>
Assisted Living Staffing Requirements in Select States

Arkansas: On-site staff/resident ratios

<table>
<thead>
<tr>
<th>No. Residents</th>
<th>Day</th>
<th>Evening</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 16</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>17 - 32</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>33 - 49</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>50 - 66</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>67 - 83</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>84 Plus</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Florida: Minimum staff hours per week

<table>
<thead>
<tr>
<th>No. Residents</th>
<th>Hours/Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5</td>
<td>168</td>
</tr>
<tr>
<td>6 - 15</td>
<td>212</td>
</tr>
<tr>
<td>16 - 25</td>
<td>253</td>
</tr>
<tr>
<td>26 - 35</td>
<td>294</td>
</tr>
<tr>
<td>36 - 45</td>
<td>335</td>
</tr>
<tr>
<td>46 - 55</td>
<td>375</td>
</tr>
<tr>
<td>56 - 65</td>
<td>416</td>
</tr>
<tr>
<td>66 - 75</td>
<td>457</td>
</tr>
<tr>
<td>76 - 85</td>
<td>498</td>
</tr>
<tr>
<td>86 - 95</td>
<td>539</td>
</tr>
<tr>
<td>For each additional 20</td>
<td>Add 42</td>
</tr>
</tbody>
</table>

Appendix II: Literature Review Details

- Literature search from 1990 to 2017 using PubMed, ProQuest, Ovid Medline, and CINAHL
- Searched citations of final articles
- Search strategy – “building block”, MeSH associated with keywords that reflected Assisted Living Staffing Ratios and Quality of Care
- Keywords included – “nursing staffing ratios” AND “quality”; “nursing homes” AND “staffing”; “assisted living staffing ratios” AND “staffing” and “quality”
- Inclusion criteria – English language, peer reviewed articles, quantitative and qualitative articles, date range 1990-2017
- Exclusion criteria – case studies, non-English language, conceptual papers, editorials and reviews
Appendix II: Literature Review Details

Literature Review – ALF Staffing Ratios and Quality of Care

<table>
<thead>
<tr>
<th>Year of Publication and Country</th>
<th>Author</th>
<th>Title</th>
<th>Journal</th>
<th>Objective</th>
<th>Data source &amp; Methodology</th>
<th>Sample Size</th>
<th>Results</th>
<th>Policy Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995, USA</td>
<td>Phillips, C., et al</td>
<td>Report on the Effects of Regulation on Quality of Care in Board and Care Homes</td>
<td>U.S. DHHS Assistant Secretary for Planning and Evaluation/Office of Disability, Aging and Long-Term Care Policy</td>
<td>To document the characteristics of board and care homes and residents, to assess the quality of care received by board and care residents and examine the effects of State regulation on the quality of such care.</td>
<td>Data source: Survey of Board and Care Facilities in 30 states. Interviews in 88 licensed and 126 unlicensed homes with 512 operators, and 1,138 facility staff, and 3,257 facility residents.</td>
<td>Positive effects of regulation on quality of care and life in board and care homes. States with extensive regulatory systems had a significantly smaller proportion of unlicensed impaired elderly, and residents with mental illness and developmental disabilities created caregiving challenges. A wide range of services, staffing patterns, staff training and knowledge were needed to meet residents' needs. The need for training requirements to be clearly specified. Highlighted the need for board and home care industry to work closely with the state government to improve quality of care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 2011, USA                     | Bowblis, J.R. | Staffing Ratios and Quality: An Analysis of Minimum Direct Care Staffing Requirements for Nursing Homes | Health Services Research | To identify the impact of minimum direct care staffing requirements on quality of care. | Data source: Online Survey Certification and Reporting System (OSCAR) System | 17,952 nursing facilities | First analysis: relationship between MDCS requirements and staffing levels (overall reliance - reliance on Medicaid not considered). Higher MDCS increased the total number of staff. Second analysis (assume reliance on Medicaid): Total staffing increased for all nursing homes but nursing homes with more reliance on nursing homes that are more reliant on Medicaid. MDCS have mixed effects on care practices but are generally associated with improved resident outcomes and meeting regulatory standards. | Higher MDCS requirements increase the total number of staff employed in nursing homes. The effect is larger the higher the level of staffing mandated by the MDCS requirement and for nursing homes that are more reliant on Medicaid. High Medicaid reliant nursing homes did not change licensed staff composition but hired more RNs instead of LPNs to keep skill mix similar to levels before the increase in MDCS requirements. Non-Medicaid reliant nursing homes hired CNAs to keep the proportion of RNs staff constant. Higher staffing is associated with higher quality, but skill mix of staffing matters (Bowblis, J.R., p. 1514). Nursing homes choose labor and material intensive care practices in response to MDCS requirements and the substitution effect resulting from MDCS requirements leads to mixed results for increases in quality measures (Bowblis, J.R., 2011, p. 1514). | |

| 2011, USA                     | Bowblis, J.R. | Literature Review – ALF Staffing Ratios and Quality of Care | Nursing Homes | Requirements for Care Staffing | Minimum Direct Staffing | Quality mixture of frail elderly, cognitively impaired elderly, and residents with mental illness and developmental disabilities created caregiving challenges. A wide range of services, staffing patterns, staff training and knowledge were needed to meet residents' needs. The need for training requirements to be clearly specified. Highlighted the need for board and home care industry to work closely with the state government to improve quality of care. | | | | |
## Literature Review – ALF Staffing Ratios and Quality of Care

<table>
<thead>
<tr>
<th>Year of Publication and Country</th>
<th>Author</th>
<th>Title</th>
<th>Objective</th>
<th>Data source &amp; Methodology</th>
<th>Sample Size</th>
<th>Results</th>
<th>Policy Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007, USA</td>
<td>Stearns, S.C., et al</td>
<td>Determinants and Effect of Nurse Staffing Intensity and Skill Mix in Residential Care/Assisted Living Settings</td>
<td>To provide an analysis of the intensity and skill mix of nursing staff using data from a four state study and their relationship to outcomes.</td>
<td>Longitudinal data from the Collaborative Studies of Long-Term Care (CS- LTC) Methodology: Descriptive statistics used to assessed the levels of direct care staff (RNs, LPNs, and personal care aides) and regression analyses to evaluate the relationship between intensity, measured as care hours per resident, and skill mix, measured as the percentage of total care hours by licensed nurses, facility characteristics, and four health outcomes.</td>
<td>LBRH residents of 170 residential care/assisted living facilities</td>
<td>For very small facilities, care hours per resident decreased with facility size and increased with dementia prevalence (case-mixed effect). Licensed staff accounted for a greater proportion of total hours in nonprofit settings. Health outcomes did not vary by total care hours per resident, but hospitalization rates were significantly lower in facilities with higher proportions of skilled staff hours. The effect was stronger as dementia cases mix increased. The health outcomes measured included mortality, care hours, hospitalization, and incident morbidity.</td>
<td>RC/AL facilities have lower staffing needs compared to nursing homes due to the residents high level of functional ability. However, the need for aging in place may increase demand to nursing homes levels. Analysis showed no evidence of benefits from increased hours of care per resident. Study found RNs and LPNs to be close substitutes in RC/AL settings. Greater proportion of direct care hours was protective against hospitalization, though affect varied with facility case mix. Nonprofit facilities had greater levels of skill mix than for-profit facilities.</td>
</tr>
</tbody>
</table>

### Methodology
- **Data source & Methodology:**These data were collected from the Collaborative Studies of Long-Term Care (CS-LTC) questionnaires, which include measures of facility characteristics, nurse and aide staffing, and resident health outcomes. The study used a longitudinal design to assess the relationship between staffing and health outcomes over time. Descriptive statistics were used to describe the levels of direct care staff (RNs, LPNs, and personal care aides) and regression analyses were conducted to evaluate the relationship between intensity of care, measured as care hours per resident, and skill mix, measured as the percentage of total care hours by licensed nurses, facility characteristics, and four health outcomes. The study found that facilities with higher proportions of skilled staff hours had better health outcomes, particularly for residents with dementia. The results were consistent across different facility types, with nonprofit facilities having higher levels of skill mix than for-profit facilities. This suggests that staffing levels may have a positive impact on health outcomes, especially in facilities with higher proportions of skilled staff hours. However, the need for aging in place may increase demand to nursing homes levels. Further research is needed to explore the impact of staffing levels on other outcomes and to understand the implications for policy and practice.
### Literature Review – ALF Staffing Ratios and Quality of Care

<table>
<thead>
<tr>
<th>Year of Publication and Country</th>
<th>Author</th>
<th>Title</th>
<th>Journal</th>
<th>Objective</th>
<th>Data source &amp; Methodology</th>
<th>Sample Size</th>
<th>Results</th>
<th>Policy Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009, USA</td>
<td>Alexander, G. L.</td>
<td>An Analysis of Nursing Home Quality Measures and Staffing</td>
<td>Journal of Gerontology: Social Sciences</td>
<td>To examine the extent to which nursing home staffing levels and compliance with a state’s minimum staffing standard are associated with total deficiencies, QoC deficiencies, and severe deficiencies</td>
<td>Annual cost report data submitted to the California Office of Statewide Health Planning and Development (COSHPD), OSCAR, Automated Certification and Licensing Administrative Information and Management System, US Bureau of Economic Analysis. Methodology: Panel data analysis of random-effect models. Dependent variable: Nursing home deficiencies categorized into total deficiencies, QoC deficiencies, and severe deficiencies. Explanatory variables: three sets of nursing staffing levels-total nursing hours per resident day (HPRD), meeting the state minimum nursing home staffing standard, and nursing HPRD by type of personnel (RN, LPN, CNA). Control variables such as number of beds measured by categorical groups, profit status, three payer mix, and occupancy rate.</td>
<td>4,933 yearly observations of 1,099 Medicare and/or Medicaid certified, skilled nursing homes in California between 1999 and 2003</td>
<td>Higher total nursing staffing level were negatively related to deficiencies. Higher RN staffing levels were negatively related to total and QoC deficiencies but not related serious deficiencies. Meeting California’s staffing standard was negatively related to deficiencies partially. Meeting staffing standard was associated with a lower number of total deficiencies and QoC deficiencies but not with the probability of receiving serious deficiencies.</td>
<td>Even though California nursing home staffing standard of 3.2 total nursing HPRD is more than several other states’ requirements, it is below CMS recommendation of 4.1 total nursing HPRD that can decrease serious harm or jeopardy to residents. Nursing homes with higher RN staffing levels received significantly fewer total and QoC deficiencies. Higher RN LPN levels had no relationship with or a positive relationship with the deficiencies. The effect of LPN staffing on quality were inconclusive. Substitution of LPN for RN staffing may decrease quality rather than increase quality. RN and NA staffing levels were negatively associated with all the three types of deficiencies.</td>
</tr>
</tbody>
</table>

**Missouri nursing homes (N=510)** Statistical measures in nearly half of the nursing QM evaluated revealed significant differences between the mean percentages of residents with a nursing homes. Strategies for quality concern in facilities with contrasting staffing levels, QMs beyond the basic regulatory approach.
<table>
<thead>
<tr>
<th>Year of Publication and Country</th>
<th>Author</th>
<th>Title</th>
<th>Journal</th>
<th>Objective</th>
<th>Data source &amp; Methodology</th>
<th>Sample Size</th>
<th>Results</th>
<th>Policy Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014, USA</td>
<td>Beeber, A.S., et al</td>
<td>Licensed Nurse Staffing and Health Service Availability in Residential Care and Assisted Living</td>
<td>Journal of the American Geriatrics Society</td>
<td>To create a data-driven typologies of licensed nurse staffing and health services in residential care and assisted living facilities</td>
<td>Data source: Convenient sampling of administrators and supervisors from 89 RC/AL communities. Variations Across</td>
<td>89 RC/AL communities</td>
<td>The analysis showed staff clusters of (i) no or minimal hours worked by licensed nurses (i.e., hours, primarily LPNs or RNs (ii) high hours (iii) high mix of RNs and LPNs. Basic services were performed by 89% of own staff, 7% of contract staff, and not available in 4%. Technically complex services were performed by 64% of own staff, 18% of contract staff, and not available in 18%. Wound care, and therapies were performed by 45% of own staff, 37% of contract staff, and not available in 29%. Gastrostomy and intravenous medications were performed by 38% of own staff, 27% of contract staff, and were not available in 55%. Testing and specialty services were performed by 12% of own staff, 73% of contract staff, and not available in 15%. The no or minimal hours staffing cluster had a significantly lower service availability score. Testing and specialty services were high in the mix of RNs and LPNs. Basic services; Technically complex services; Assessment, Wound care, and Therapies availability were related to the presence or absence of licensed nurses rather than the type or number of nurses on staff.</td>
<td>Majority had licensed nurses in some capacity with implications for care outcomes. 24% of communities had no or minimal hours worked by licensed nurses. Stearns SC, et al. (2007) found an negative association between RN staffing and hospitalization rates and explained that RNs could better identify and manage acute medical problems and decreased hospitalization rates. Communities with high hours and a mix of RNs and LPNs provided testing and specialty services. Implying that larger communities may attempt to manage residents with complex healthcare needs by employing more nurses and providing more overall services to support aging in place (Stone &amp; Reinhard, 2007). The study did not directly relate nursing presence to outcomes and did not cover CNAs who constitute the bulk of the RC/AL workforce.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year of Publication and Country</th>
<th>Author</th>
<th>Title</th>
<th>Journal</th>
<th>Objective</th>
<th>Data source &amp; Methodology</th>
<th>Sample Size</th>
<th>Results</th>
<th>Policy Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017, USA</td>
<td>Han, K., et al</td>
<td>Variations Across U.S. Assisted Living Facilities: Admissions, Resident Care Needs, and Staffing</td>
<td>Journal of Nursing Scholarship</td>
<td>To examine ALFs' admission policies, resident care needs, and staffing characteristics.</td>
<td>Data source: 2010 National Survey of Residential Care Facilities. Methodology: Used a cross-sectional secondary data analysis from 2010 National Survey of Residential Care Facilities to measure nine admission policy items, seven items on the proportion of residents with selected conditions or care needs, and six staffing characteristics. ALFs were classified into small, medium, and large. The measurements were then propped to the national US estimates.</td>
<td>2,301</td>
<td>ALF admitted residents with considerable healthcare needs and served populations requiring nursing care. Staffing was mostly composed of patient care aides, with fewer than half of ALFs using licensed care providers (RNs and LPNs). Smaller facilities had more inclusive admission policies and residents with more complex care needs and less access to licensed nurses than larger facilities.</td>
<td>Potential overlap with nursing home populations. However, ALF's regulations lag far behind those in effect for nursing homes. Measurement criteria of care outcomes critically needed to ensure appropriate ALF care quality, for oversight and monitoring of care quality.</td>
</tr>
</tbody>
</table>
Appendix III: The Ten Top Safety Hazards in Assisted Living

- Lack of Safety Alert System
- Poor Lighting in Living Areas
- Improper Administration of Medications
- Obstructed Walkways
- Chairs Without Armrests
- Carpets/Floors in Poor Condition
- Resident Abuse
- Infections
- Poor Security

A study involving over US 2,000 ALFs found:
- Residents in smaller ALFs had greater complex care needs, fewer licensed nursing staff and less in-service training for personal care aides compared to mid-sized or large facilities
- Residents in these ALFs were more likely to be minority, male and younger than in large ALFs

Han, RN, PhD, Trinkoff, RN, ScD, FAAN, et. al. Variation Across U.S. Assisted Living Facilities: Admissions, Resident Care Needs, and Staffing. Journal of Nursing Scholarship. 2017; 49:1, 24-32

Appendix IV

22 VAC 40-80-100 - Duration of Licensure

- The Virginia Department of Social Services (DSS) licenses AL
- Each license and renewal may be issued for up to three successive years
- The criteria for determining the periods of licensure are based on the activities, services, management, and compliance history of the facility and are the same for both for-and not-for-profit facilities
  - A three-year license may be issued when a facility routinely substantially exceeds the minimum standards
  - A two-year license may be issued when a facility maintains compliance with minimum standards and may exceed on a sustained basis in some areas
  - An annual license may be issued when a facility demonstrates an inconsistent level of compliance but substantial compliance is reached. Some reinforcement and guidance are needed in order for the facility to meet or maintain minimum requirements
  - Provisional license may be issued (for up to six months) when a regular license expires and the applicant is temporarily unable to comply with the requirements of the regulations
  - ALFs are inspected at least one time per twelve-month period
The Individualized service plan must address the immediate needs of the resident.
The comprehensive plan shall include a description of identified needs based upon the,
  - Uniform Assessment Instrument
  - Admission physical examination
  - Interview with resident
  - Assessment of psychological, behavioral and emotional functioning,
  - A written description of what services will be provided and by whom
  - When and where the services will be provided
  - The expected outcome and date of attaining the expected outcome

ISPs shall be reviewed and updated at least every 12 months and as needed as the condition of the resident changes.

A. The AFL shall have staff adequate in knowledge, skills, and abilities and sufficient in numbers to provide services to attain and maintain the physical, mental and psychosocial well-being, as determined assessments and individualized service plans...

B. The ALF shall maintain a written plan that specifies the number and type of direct care staff required to meet the day-to-day, routine direct care needs and any identified special needs for the residents in care...directly related to actual resident acuity levels and individualized care needs

C. There shall be an adequate number of staff persons on the premises at all times to implement the approved fire and emergency evacuation plan

D. There shall be at least one direct care staff member awake and on duty at all times in each building when at least one resident is present

EXCEPTION: In buildings that house 19 or fewer residents, the staff member on duty does not have to be awake during the night if none of the residents require a staff member awake and on duty at night

E. Written work schedules shall be maintained and shall indicate the names and job classifications of all staff working each shift
Virginia Regulations

22 VAC 40-72-460 - Health care services:

• The facility shall have a written back-up plan to ensure that a person who is qualified is available if the direct care staff member who usually provides the care is absent

22 VAC 40-72-100 - Incident reports:

• Each facility shall report to the regional licensing office by the next working day any major incident that has negatively affected or that threatens the life, health, safety or welfare of any resident

22 VAC 40-72-250 - Direct care staff qualifications:

• Graduation from a Virginia Board of Nursing-approved educational curriculum from a Virginia Board of Nursing accredited institution for nursing assistant, geriatric assistant or home health aide

• Graduation from a personal care aide training program approved by the Virginia Department of Medical Assistance Services

• Graduation from a educational curriculum for nursing assistant, geriatric assistant or home health aide approved by the Board of Nursing

22 VAC 40-72-910 - provisions for signaling/call systems

• Signaling/call systems permit staff to determine the origin of the signal or is audible and visible in a manner that permits staff to determine the origin of the signal

• In buildings licensed to care for 20 or more residents under one roof, there shall be a signaling device that terminates at a central location that is continuously staffed

• In buildings licensed to care for 19 or fewer residents under one roof, if the signaling device does not permit staff to determine the origin of the signal as specified, direct care staff shall make rounds at least once each hour

• Rounds shall begin when the majority of the residents have gone to bed and shall terminate when the majority of the residents have arisen

• A written log shall be maintained showing the date and time rounds were made - logs for the past two years shall be retained
### Appendix V: Select Updated Virginia Regulations

- **22VAC40-73-160** – Adds to administrator training requirements that administrators who supervise medication aides, but are not registered medication aides themselves, must have annual training in medication administration.

- **22VAC40-73-170** - Adds that an unlicensed shared administrator for smaller residential living care facilities must be at each facility for six hours during the day shift of the 10 required hours a week.

- **22VAC40-73-210** – Increases the annual training hours for direct care staff.

- **22VAC40-73-220** – Adds requirements regarding private duty personnel.

- **22VAC40-73-260** – Adds requirement that at least one person with first aid certification and at least one person with cardiopulmonary resuscitation (CPR) certification must be in each building, rather than on the premises.

- **22VAC40-73-280** – Changes an exception (allowing staff to sleep at night under certain circumstances) to one of the staffing requirements to limit its application to facilities licensed for residential living care only.

- **22VAC40-73-325** – Adds a requirement for a fall risk rating for residents who meet the criteria for assisted living care.

---

### Appendix V: Select Updated Virginia Regulations

- **22VAC40-73-490** – Reduces the number of times annually required for health care oversight when a facility employs a full-time licensed health care professional; adds a requirement that all residents be included annually in the health care oversight, adds to the oversight evaluating the ability of residents who self-administer medications to continue to safely do so, adds additional requirements for oversight of restrained residents.

- **22VAC40-73-930** – Adds to the provision for signaling/call systems that for a resident with an inability to use the signaling device, this must be included on his individualized service plan with frequency of rounds indicated, with a minimum of rounds every two hours when the resident has gone to bed at night, with an exception permitted under specific circumstances.

- **22VAC40-73-1010** – Removes the exception (for facilities licensed for 10 or fewer with no more than three with serious cognitive impairment) that applied to all requirements for mixed population.

- **22VAC40-73-1030** – Increases the training required in cognitive impairment for direct care staff, and except for administrator, other staff.

- **22VAC40-73-1130** – Adds requirement that when there are 20 or fewer residents present in a special care unit, there must be at least two direct care staff members awake and on duty in the unit, and for every additional 10 residents, or portion thereof, there must be at least one more direct care staff member awake and on duty in the unit, rather than two direct care staff in each unit.

- **22VAC40-73-1140** - Increases the number of hours of training in cognitive impairment for the administrator and changes the time period in which the training must be received for both the administrator and for direct care staff who work in a special care unit, also increases training in cognitive impairment for others who have contact with residents in a special care unit.