Assisted Living Facility Roundtable Meeting
March 16,, 2005 8:30 a.m.
VDSS Conference Room 6
7 N. 8th Street
Richmond, VA 23219

Board Members Attending
Julie Christopher, Danny Brown, Maggi Luca, William Mitchell, Jean Cobbs, Nettie Simon-Owens, Marilyn Rigby

ALF Group Representation
Juanita Coles, Larry Goldman, Grant Goldman, Anna Pitt, Randy Scott, Carter Harrison, Eldon James. Dana Steger, Beverley Soble, Joani Latimer, Diana Thorpe, Yvonne Haynes, Nancy Hofheimer, Lana Wingate

Call to Order

The ALF Roundtable meeting was called to order by Chairman Julie Christopher at 8:30 a.m.

Welcome and Introductions

Ms. Christopher welcomed participants and thanked them for their willingness to educate members of the Board on this very important subject. Members, in turn, introduced themselves and identified the facility they were representing.

Lynne Williams, Assistant Director of Licensing introduced her staff and provided the group with an overview of the Auxiliary Grant Program. A copy of that handout is part of these minutes and housed at the VDSS Home Office with the official minutes.

Presentations:

Juanita Coles, Administrator
Coles Retirement Home

- Inadequately trained staff
- Low pay makes staff retention difficult
- Suggested random yearly drug testing
- Mandatory attendance for staff and administrators for all workshops and trainings
- Develop newsletter to keep the public informed of activities
- Involve local government leaders to assist with improving infrastructure
- Ensure residents are clean and neat
- Redefine and separate Assisted Living Facility and Nursing Facility rules and regulations
- There is a need for joint collaboration prior to enforcing laws
- Keep in mind that resources equal care level (i.e. cost of generator
- Ensure staff is knowledgeable of patient diagnosis
- Additional workshops and in-services are need in ALFs—encourage staff to use in-house libraries.

- Residents need to be compatible in age and mental ability to do well together—be cognizant of placement.

Grant Goldman, Representative
Virginia Adult Home Association

- Need to increase the Auxiliary Grant Rate. $909 is insufficient to cover room and board; provide 3 nutritionally balanced meals; medication management; shelter that is safe and nurturing. Gas and energy cost have significantly increased driving up food cost, deliveries of supplies, and transportations of residents. Facility repair and maintenance have also risen due to increased energy costs. Liability insurance, if obtainable, has quadrupled. The cost of training staff and paying proper wages and benefits has been increasing difficult. For auxiliary grant facilities.
- Increased staff turnover is due to low wages. Direct care staff are expected to care for residents and o proper documentation, help with housekeeping duties, assistance with dietary duties, all for minimal wages and minimal or no benefits.
- Concern with cost that is necessary to implement regulatory changes. In North Carolina, residents receive additional funding based on their needs and care level.
- Mixture of population is a problem. Proper disclosure of resident's conditions from discharge planner and caseworkers are vital for operators to ensure the new residents will be compatible with the current population in the facility.
- Additional concise training for staff is needed to help them deal with the demands of caring for residents with a multiple range of conditions. Additional state supported training would ease this burden.
- National Criminal History Checks on all new employees is costly and the process is time-consuming. It does not protect the public from caregivers from other states that come to Virginia seeking work. When this check is received in a timely manner, is can significantly reduce the liability of the operators and help provide the public with assurance that staffs are in compliance with barrier crime prohibitive.
- Operators need uniform procedures that are followed in a consistent manner. We must focus on the transition of operators to be able to smoothly incorporate changes that come about by changing the current system. Members were asked to wear the shoes of "the resident"; "the caregiver and operator", and those of the regulatory agencies that oversee the industry to ensure they all fit comfortable in order for the new system to really work the way it should.

Larry Goldman, Representative
Virginia Assisted Living Association (VALA)

- Question 1 regards regaining the public's confidence. He feels this is only a topic of discussion in the offices of DSS; as he, nor any of his area managers have been contacted about the Washington Post articles. He quoted Andrew Carle, Assistant Professor, Director of the Program in Assisted Living Administration, George Mason University who says "virtually no one knows that assisted living is statistically safer in nearly every category of significance-abuse and neglect, medication errors, falls, etc. than either living at home alone or in a nursing home.

It is consistently rated between 88-95% as "highly satisfactory" among both residents and the adult children who actually purchase and consume the product." The article reported on a dozen incidents since 1995, however it did not mention the more than 100 million resident days of resident care that had been provided in assisted living communities in Virginia over that period of time. While it mentioned that 96 Virginia communities received violations severe enough to warrant a fine between 98-03, it did not mention this would represent only 1/7% of all communities in any given year. It did not mention the more than 1000 claims for neglect or abuse for state nursing home beds during this same time period.

- Question 2 refers to a possible role in meeting needs of people with serious mental illness. Very good work is already being done by the Geriatric Restructuring Team that has been meeting for more than a year. Many of the people in this room serve on that team. There will be a role for assisted living providers to play, though likely to be limited to caring for older, stabilized persons with dementia.
- Question 4 refers to separating residents according to diagnoses. Demented residents are known to wander, to visit other rooms uninvited, to rummaging through drawers. Demented residents often ask the same questions over and over to the annoyance of their neighbors. The cognitively intact residents also ask questions of their demented neighbors who become frustrated and possibly agitated by not being able to answer. Remember that demented persons could otherwise be healthy and strong if not athletic.
- Medication Errors-there are many kinds of medication errors; some with little consequences and some with potentially disastrous results. These errors are too common among nursing home residents according to a study done by the University of Massachusetts Medical School, with nearly one in ten Nursing Home residents being the victim of medication-related injury each month. Errors can be prevented through the use of "bubble" packs that are on the market. The pharmacy decides what drug the resident is to take at each med pass.
- Some assisted living providers statewide are doing seated tai chi; rehabilitation and wellness services; independent research organizations which analyze incident accident reports; partnering with schools of pharmacy to see if our physicians need extra training in prescribing for seniors; many nurses on staff; safety committees; infection control committees; employ conservation measures like collecting rainwater to water lawns and using energy efficient lighting; furnishing carpeting with low volatile emissions; and generators in place.

Anna Pitt
Covenant Columns

- All ALFs are not bad and should not be grouped as such. She operates a facility in Henrico that is licensed for 26 residents.
- Staffing Turnover is a big problem
- There is a need for better training. She has her staff train for 30 days rather than the 40 hours required. Direct care and administrator need more training
- She has a full time activity person on staff

- Every new home owner should be certified as administrator (mandatory)
- State should develop a course for administrator training prior to them opening up a facility
- ALFs can benefit MHMR, but should be licensed separately due to the specialized training required. Mixed population is unfair.
- Auxiliary Grant is too low and should be increased.
- Too much paperwork required by VDSS for the AG funds available. Priority should be excellent resident care and not to worry if every "I" is dotted on a form.
- Certification of the administrator should help in many areas.
- ALFs provide better care for residents than Nursing Home. There is lack of activity for residents in NH, no music for them to hear, seems to think patients live longer in an ALF than NH.
- The negative press on ALFs is due to the population housed in them. When people are active, you can't keep them from walking the grounds.
- Medication errors continue. A better method of dosing is needed. Her home uses the uni-dose method.

Randy Scott, Representative
Virginia Association for Nonprofit Homes for the Aging

- Question 1-Failure to effectively implement enforcement processes: noncompliance with current regulations and statures; improper assessments or placement of residents; acceptance of residents that facilities cannot provide adequate care for; providers that do not adequately represent themselves to the public in the phone book; lack of support and direction to the licensing specialist in handling inadequate facilities; failure to effectively implement enforcement process and lack of adequate funding. Regaining public confidence can be accomplished through enforcement of licensing regulations fairly and consistently; conduct accurate resident assessments to address proper placement; implement a system of checks and balances to ensure proper placement; rapid implementation of moving a resident along the continuum of care; educate the public on assisted living facilities; provide excellent customer service to families and provide excellent care to the resident population.
- Question 2-Staff of most ALFs are not trained to deal with MI/MR residents. CNAs are not mental health techs; regulations should be drafted appropriate to meet the needs of this population; resources need to be in place to assist ALFs when MI/MR issues arise; ALFs goals are to help create an environment to help the elderly fit into the facility as a community while in MI/MR the goal is to help them fit into the community outside the facility; the care goals are different; MI/MR needs to have a different care team available to them that include social workers, psychiatric nursing, occupational therapy, psychology, rehab counseling, and psychiatry.

- Understand that we are dealing with two very different populations. This number of potential residents with MI/MR issues will grow as the next population starts to need housing in ALFS.

- Better excess to CSBs and expanded services
- Better funding to facilities that do the MI/MR so they can hire and train the necessary staff
- Understanding by DSS of the differences in needs
- Better understanding of how to meet the MI/MR population need in Long Term Services (ADLs and IADLs) not necessarily those designed by cognitive impairment measures for persons with dementia disorders.
- Need to distinguish supervisory help that is needed to handle daily life outside of a facility setting from help that may be needed to function productively in an age appropriate manner in terms of work or attending school.

Question 3

- Lack of desire to move a resident along the continuum of care
- Lack of understanding of the proper use of the UAI to determine appropriate placement
- Failure to understand the differences in facilities that are designed on the social model vs. the medical model
- Administrators demands to meet head in bed quotes vs. proper placement
- Lack of a check and balance system where the licensing specialist can check a UAI to determine if the placement is correct
- Lack of enforcement of regulations as they exist to insure that facilities are not creating a pseudo nursing home environment
- Failure to understand that when ALFs first started they were designed on a social model for those that were not ready for a nursing home. Now due to the drive to meet census the industry is attempting to evolve into a pseudo nursing home to meet the bottom line
- Improperly trained administrators
- Lack of trained staff to meet the needs of the aging population

Question 4

- Licensing needs to develop regulations specific to the types of care provided and understand that general regulations so not apply to all
- Residents with dementia have been shown to been shown to benefit from being in an environment specific to their needs
- This type of separation has been proven to be a positive step in ALFs with special care units. Why not look at these successes and determine if others can benefit from the same type of special units. We are not advocating to put everyone in an institution only to look at those groups that can benefit from specially trained staff and designed facilities to meet their needs.
- Dementia residents if mixed with MI/MR generally only get worse due to over stimulation
- We are aware of the rights established under the Olmstead Act

- Virginia needs to review national studies and be prepared to implement those proven to work. This can only be accomplished if the DSS desires to take on a role of consultation instead of adversarial towards new ideas.
- DSS needs to understand that it is difficult enough to train a staff to deal with one type of resident and then to mix them is asking for major infractions of regulations
- Those with substance abuse and MI often need strict limits and a staff trained to say no as well as knowledgeable in dealing with the manipulating nature of substance abusers. Kessler in the 1994 National Co morbidity Study showed that 45% of individuals with at least one lifetime alcohol disorder reported a co-occurring mental illness. 72% with a lifetime history of drug abuse reported mental illness and 29% of those with a mental disorder have a substance abuse problem. Most ALFs that house primarily the elderly are not set up to handle this population.
- Studies show that the population of aging abusers with MI/MR issues is rapidly increasing; we need to protect and train our staff to deal with each group.

Question 5

- Administrations understanding of the need to treat staff with respect, and value their opinion
- Front line staff should be a part of the decision making process in the care of the resident to empower them to take ownership in how care is provided
- Letting front line care givers sit in on care teams and family conferences
- Establish clear goals and expectation
- Staff take pride in knowing their job is important
- Improvements in training opportunities for direct care staff, not just the department heads that do not do the bulk of hands on care
- Improvement in teaching the front line staff communication skills and behavior management
- Establish career ladders for staff
- Develop the use of team approach within facilities
- Fairly and consistently enforce current regulations
- Require LPNs on site to supervise med techs and CAN or PCAs.

Question 6

- Fairly enforce current regulations
- Inspectors need to be consistent and look at the overall resident care
- Tax incentive for LTC insurance
- Increased staff training
- Licensing specialist to work out of a central office and not the district offices where each district administrator can set the tempo or direction of the licensing specialist. This cerates broad differences in how the regulations are interpreted across the state

- As new ideas arise in the method of care for different groups the licensing specialist must become less adversarial and more supportive and consultative of new approaches in working with facilities.

ALF Collaborative Panel Discussion
Overview of Assisted Living Collaborative and Process
Carter Harrison
Virginia Chapters of the Alzheimer's Association provided Board members with an overview of the ALF and process.

4-Point Plan to Safeguard Assisted Living Residents
Eldon James
Virginia Association of Area Agencies on Aging (V4A)
Assisted Living Facilities are a critical element in Virginia's mix of long term care services for seniors and persons with disabilities needing assistance with Activities of Daily Living and who prefer to live in a facility environment.

Virginia's strict eligibility requirements for Nursing Home admission result in heavier reliance upon ALFs than in other states. This position mandates that Virginia's requirements for minimum levels of care are strong and appropriate.

We have problems—well documented problems—and complex problems cannot be solved with simple solutions.

Insuring that Virginia's ALFs are safe and meet minimum quality care standards requires reform in all—not one or two—but all of four major areas

- Informed Consumers .Alfs must be required to provide accurate and complete information to allow prospective residents to choose the facility that best meets their needs
- Staff Training and Administration ALFs must have staff sufficiently trained for the services provided and administrators with oversight responsibilities must meet standardized levels of training and expertise, demonstrated to consumers via a new ALF Administrator Licensing. Licensing should raise the bar of minimum qualifications required for an individual to operate an ALF. In addition to increased educational requirements, candidates' overall performance records and pattern of fiscal and operational management should also be reviewed as part of assessing fitness for licensure. Implementation of these regulatory changes may allow a discrete time period for current operators to qualify for licensure; but there is no grandfathering of current operators. Require that all direct care staff in any licensed ALF be certified nursing assistants. Require ALF staff serving as medication aides to be certified nursing assistants and to receive enhanced training specific to the distribution of medications.

- Compliance with Virginia's Regulations ALFs must be held accountable when the Commonwealth established minimum safety and care requirements are not met. Establish a tiered system of enforcement tools that allow swift and appropriate consequences for failure to comply with the regulations governing the licensure of ALFs. Increase from $500 to $10,000 the maximum amount an ALF may be fined for being out of compliance with licensure requirements; establish an expedited system for suspension of licensure if imminent danger to residents exists, developed in conjunction with mechanisms to impose qualified temporary management or receivership, when appropriate to prevent the displacement of residents. Strengthen the DSS Division of Licensing by ensuring an adequate number of well-trained inspectors to provide thorough and consistent oversight and enforcement. Restructure DSS inspection teams to include persons with expertise in mental health care, dementia care, and clinical nursing for inspections of facilities providing care for populations with special care needs. Standards and enforcement should be appropriate to the populations with special needs. DSS cannot be effective in providing for ALF licensure compliance without the required number of staff and the level of expertise necessary for appropriate inspection.
- Public Funding ALFs must have sufficient funding provided when state funds are used to support the operating costs of ALFs who serve the poorest Virginians in need of ALF services. Auxiliary Grant funding must be increased above the current rates; increase the number of local LTC Ombudsmen. It is clear that the current AG rate of $28 per day is not adequate to realistically support the cost of providing quality care. Doubling the rate would bring it more in line with actual care costs. Increasing the funding for the LTC Ombudsman Program to reach the Institute of Medicine's recommended minimum standard of 1 ombudsman to every 2000 long term care beds.

Legislation Overview
Dana Steger, Virginia Association of Non-Profit Homes for the Aging
The 2005 General Assembly Session—Assisted Living Legislative Summary Includes:

- Creates the Board of Long-Term Care Administrators
- Establishes Licensure of ALF Administrators
- Requires Medication Aides to be Registered by the Board of Nursing
- Requires ALFs to Develop a Medication Management Plan
- Provides for Expedited Suspension of Licensure
- Increases Civil Penalties
- Requires ALF to Disclose to Prospective Residents and Legal Representative
- Requires Administrator/Staff Member Ensure Mental Health Evaluation is conducted
- Requires copies of provisional license to be displayed
- Requires background checks for ALF applicants
- Joint Legislative Audit and Review Commission (JLARC) Study
- A copy of the 2005 Session Virginia Acts of Assembly-Chapter as enrolled was provided to members.

Outstanding Issues
Beverley Soble, Virginia Health Care Association

- Lack of data on population being served in ALFS—only residents on public assistance are tracked (25% of population).
- Reimbursement
- Regulations that take into account facility size and acuity level of residents in the population
- Meeting the needs of MH, MR, SAS residents in facilities
- Supply and retention of qualified trained staff in the long term care workforce

Additional Consumer Perspective
Joani Latimer, State Ombudsman

- Staffing Issue-need to increase the Auxiliary Grant Rate to retain qualified staff
- Increase qualifications of administrators and staff with regard to medications
- Value and respect needs to be reinforced through providing training in ongoing fashion. Regard people as team members—they have the greatest influence on resident's care
- Create more opportunities for staff—lack of training; burn out; abusive situations are all concerns
- Need community support for MH facilities.
- Have heard from consumers they want basic protection, and autonomy of daily lives
- Important that Board reads legislation and invite all players to the table as regulations are being developed.

Roy Bryant, Independent Resident Owner
Mr. Bryant shared his concerns that he was not invited to this group meeting and felt this group was not represented on the panel.

He advised his facility falls under the same umbrellas as homes receiving funds and the additional regulations are putting them out of business. He shared his concern that their home must now become a medical facility but they are not receiving the funds for it. He advised that poor people are being discriminated against with the UAI; you can now place a person anywhere because of set rules. He felt a representative from the Department of Rights should have been present at this meeting to look after the rights of the poor person.

He advised he was not here asking from additional funds.

He stated a medication certified nurse can't work alone in a nursing home but is top staff at an ALF. He said that is someone wants to operate a nursing home, let them do it, if they want to operate an ALF, then let them do that.

Yvonne Haynes
Richmond Behavioral Authority
Question 3

- ALF industry has evolved form the tradition board and care model of placement into a necessary element of the continuum of care for persons with mental disabilities. As the population has changed, the expertise of providers on all levels has not.
- Lack of adequate staff training was well documented in the JLARC 1999 Report. The report stated that most ALF staff serving auxiliary grant recipients is poorly prepared to provide servies to mentally disabled residents. While licensing regulates specific educational requirements for both administrators and staff, there is still a knowledge deficit in terms of behavioral techniques, basic mental health needs, rehabilitative services, treatment modalities and psychotropic medications. Lack of access to required training further exacerbates this issue as administrators grapple with the challenge to motivate a person who worked the 11-7 shift to spend all in training and then show up for their regularly scheduled shift.
- The industry must decide what role to assume in the continuum of care. It can retain the traditional custodial/board and care model, or it can meet the needs of individuals diagnosed with a mental illness and/or co-occurring disorders, by being more treatment focused.
- Philosophy of homes licensed by DMHMRSAS appears to be the smaller the better. These group homes tend to be small facilities conducive to a more home-like environment which facilitates habilitation. There is also less stimulation, more consistency, a greater treatment focus, and a more appropriate resident-to-staff ratio. Conversely, the census at ALF can reach one hundred of more individuals of varying ages, levels of functioning, and cognitive abilities all residing within the same few hundred square feet of each other which gives credibility to the term of Community Asylums. Survival of the fittest is the prevailing philosophy of these ALFs where higher functioning residents tend to prey on those who function at a lower level. Management of such a diverse group of individuals becomes a problem; facilitating the abuse, neglect and horrendous tragedies that occur in such places.
- Lack of adequate funding exists within the industry. DMHMRSAS licensed group homes tend to have specific funding streams that support the services to residents. ALFs do not have this specific funding stream; they are expected to meet the needs of all the residents they serve, regardless of the severity of disability or lack of residential necessities, through one flat reimbursement rate that equals $11.96 per day.
- Summarized that the qualify of life for ALF residents improved by providing intensive Mental Health services for identified adults with serious mental illness to promote psychiatric/emotional stability and successful continuity of community placement; collaborative programming for ALF residents designed to improve levels of functioning; specialized mental health training for ALF administrators and staff; and funding that supported these additional services and training opportunities.

- Consistent criticism of the ALF industry is that in many instances, the staff functions at only a slightly higher level than the residents or that it is sometimes impossible to tell the difference in appearance and behavior. Given the nature of these service positions, individuals tend to be extremely transient; longevity in these positions is less than six months at best unless the employee is related to or has a relationship with the owner of the facility.
- The finding of the ACR Project clearly delineated the deficits in competence and the knowledge base of individuals employed in ALFs. Currently, direct care staff, under the supervision of the Administrator, must complete at least 12 hours of training focusing on the resident who is mentally or physically impaired. However, the expectations are that the training will be completed outside of one's regular work shift. Due to low wages, employees also take second jobs. This second job can deter meeting the required training.
- Staff incentives offered for participating in training should be considered. Perhaps this may be made more attractive if it can be credited toward CEUs, CNA, or LPN training or Adult Care Certification.
- Salary and benefits commensurate to the job are mandatory for staff commitment and retention. This will necessitate collaboration between the industry professionals and the General Assembly members to determine some threshold of reimbursement for these wage earners.

Diana Thorpe
Dept. of Medical Assistance Services
Question 2

- The Centers for Medicare and Medicaid Services will not allow ALFs to be group homes for the Mental Retardation Waiver. In order to have an approved MR Waiver, group homes for people with mental retardation must be licensed by the state mental retardation agency DMHMRSAS. If they do not need group home settings, people with mental retardation can live in ALFs and receive other waiver services, such as daily support, from DMHMRSAS licensed providers.
- Institution for Mental Disease Exclusion-Medicaid cannot get federal funds for services provided to individuals under age 65 who are patients in IMDs unless they are under the age of 22 and receiving inpatient psychiatric services. People that are age 22 through age 64 who reside in IMDs are not eligible for Medicaid.
- IMD is a hospital; nursing facility; other institution; more than 16 beds; that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease, including medical attention, nursing care and related services.
- If an AKF had more than 16 beds and provided mental health services it would be more than likely be considered an IMD and the people that resided in the facility would not be eligible for Medicaid.
- Some services such as psychosocial rehab and day treatment/partial hospitalization are available off-site to people who reside in ALFs. \
- Mental Health Support Services can be provided in the residence and Medicaid will pay for them if these services are not required to be provided by the facility based on facility licensure. Providers licensed by DMHMRSAS to into the ALF to provide the services.

- Mental Health Support Services enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Provides training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources, assistance with medication management; and monitoring of health, nutrition, and physical condition.
- If ALF regulations were to be changed to require that ALFs provide these services, Medicaid could not pay for them under current Medicaid regulations.

Nancy Hofheimer
Virginia Health Department
Question 3

- Doesn't believe that ALFs are the facility to house severe health problems. Health services are delivered on a medical model. It is dangerous without the safeguards of Nursing Homes. All services in Nursing Homes are under the care of a physician and licensed staff on grounds at all times.
- In a Nursing Home over 70% of the residents are public pay with 20+% private pay.
- Dept. of Health has state minimum regulations. Nursing Homes are regulated by State Public Need Certificate (COPN). The state evaluates the request for a nursing home-looks at the occupancy rate—and looks at whether beds have been approved in facility not yet built.
- Data about NH residents has be accessed quarterly electronically. Can see outcomes of services provided and focus on any issues coming to their attention.

Lana Wingate
Virginia Nurses Association

- Underlying causes for problems include poorly trained staff working with a variety of elderly with different problems
- No supervision; no follow up with problems and no accountability
- Need to train staff; need more nursing supervision and only admit elderly that care can be given without calling in community resources.
- Not enough mental health workers
- ALR are not trained or have the community resources for MT/MR
- Mentally ill are often abusive or societal challenged
- Mentally retarded are sometimes loving, considerate and work well as a group-there should be no interchange of the two.
- Direct Care Staff need education—cultural education
- More criteria for employment—health knowledge and management
- Support from management needed
- Need to feel like a team member, listen to what they have to say about the residents
- More money for staff and less profit for the homes
- Be better prepared, expect proper concise services
- Have more challenging activities such as trips; cruises

- Higher degree of technology to keep people independent longer