

**REPORT OF THE
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION**

**Status Report: Impact of
Assisted Living Facility Regulations**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



HOUSE DOCUMENT NO. 41

**COMMONWEALTH OF VIRGINIA
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2006**

In Brief

Status Report: Impact of Assisted Living Facility Regulations

The Appropriation Act requires JLARC to report on the impact of new regulations adopted pursuant to major 2005 legislation on assisted living facilities (ALFs).

This JLARC review provides a "snapshot" of the assisted living industry early in the implementation of the new law and regulations, which phase in between 2005 and 2008.

This review found that 82 percent of the 588 ALFs have no recent history of compliance problems, and 64 percent have no recent verified complaints about care or services. Twenty-three percent of all ALFs, however, have a history of either compliance problems or an above-average number of verified complaints.

While the new law and regulations will improve important elements of quality care such as medication administration and staff training, the problems that low-income residents have in accessing mental health services will not necessarily improve.

New costs also stem from the new law and regulations. These costs will be a particular issue for the estimated 117 ALFs that serve mostly low-income residents because the State auxiliary grant rate is low. These facilities will be challenged by implementation of the new law and regulations.

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COMMONWEALTH of VIRGINIA

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June 20, 2006

The Honorable Thomas K. Norment, Jr.
Chairman
Joint Legislative Audit and Review Commission
General Assembly Building
Richmond, Virginia 23219

Dear Senator Norment:

Item 21F of the 2004-2006 Appropriation Act, as amended by the 2005 General Assembly, requires JLARC to report on the impact of new regulations adopted pursuant to major legislation affecting assisted living facilities. Staff were directed to report on the impact of these regulations on the cost of providing services, residents' access to providers and other services, and tangible improvements in the quality of care delivered. An interim report was produced in November 2005; this status report includes the findings of the most recent JLARC review. A final report is due by June 1, 2007, under language included in the 2006-2008 Appropriation Act.

On behalf of the Commission staff, I would like to thank the staff at the Departments of Social Services; Health Professions; Mental Health, Mental Retardation and Substance Abuse Services; and Medical Assistance Services for their assistance during this study.

Sincerely,

A handwritten signature in black ink that reads 'Philip A. Leone'.

Philip A. Leone
Director

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JLARC Report Summary:

Status Report: Impact of Assisted Living Facility Regulations

Key Findings

- Implementation of legislation affecting assisted living is generally on schedule. (Chapters 1 and 2)
- Most assisted living facilities (ALFs) in Virginia have no recent history of compliance problems, and have no recent verified complaints about care or services. There are 137 ALFs—23 percent of the total—with a recent history of either compliance problems or an above-average number of verified complaints. (Chapter 3)
- The new law and regulations likely will improve important elements of quality care, such as medication administration, adequacy of staffing, and access to mental health services, although problems remain. (Chapters 4 and 5)
- Legislative and regulatory changes include requirements that will increase costs. The rate for the State's auxiliary grant program, which pays for the care of 6,500 low-income assisted living residents, is well below the current market price and is below what three neighboring states pay for similar services. (Chapter 6)

The 2004-2006 Appropriation Act requires JLARC to report on the impact of new regulations adopted pursuant to major legislation affecting assisted living facilities. The 588 assisted living facilities (ALFs) in Virginia provide assistance and care for four or more adults who have limited functional capabilities, including the aged and disabled. ALFs are growing in size. In 1997, total capacity was 27,537 and the average size was 45. Today, the total capacity statewide is 32,958, and the average size is 56.

The residents of assisted living are also changing. More residents need help with the activities of daily living, such as administering medications. Data for low-income residents shows a trend toward more dependency and more mental disabilities.

This report provides a "snapshot" of the ALF industry early in the implementation of the new law and regulations. Future reports may then identify changes in the cost, quality, and availability of care that can be attributed to the new law and regulations.

LEGISLATION PHASES IN OVER THREE YEARS

The 2005 General Assembly passed major legislation affecting ALFs. The new law gave the Department of Social Services (DSS) new enforcement authority, directed the Department of Health

Professions (DHP) to license facility administrators and register medication aides, and increased the auxiliary grant rate. DSS and DHP are required to implement the law over three years, from 2005 to 2008.

DHP is currently developing regulations for the licensing and registration provisions in the law. New training requirements for ALF administrators, managers, and medication aides will be critical to licensure.

DSS implemented emergency regulations in December 2005, and permanent regulations are currently under review. These permanent regulations must be implemented by December 28, 2006, or provisions in the emergency regulations will expire and the prior regulations will come back into effect.

Although DSS accomplished a major regulatory overhaul in a short period of time, implementation of the emergency regulations had shortcomings. DSS did not adequately train ALF administrators or its field inspectors, and some regulatory provisions may be unworkable. These shortcomings should be addressed in the permanent regulations currently under review within the executive branch.

A MINORITY OF ALFS HAVE QUALITY CONCERNS

Quality of care is a key concern in assisted living, yet it is difficult to measure. No definition of quality care is found in the *Code of Virginia* or in DSS licensing standards.

As proxies for quality of care, JLARC staff used measures of facilities' compliance with standards and verified complaints. Of the 588 licensed ALFs, 82 percent have no recent history of compliance problems, and 64 percent have no recent verified complaints.

There are 137 ALFs of concern (23 percent of all ALFs), however, that do have compliance problems or an above-average number of verified complaints. ALFs in this group tend to be larger and are more likely to have auxiliary grant residents. Future JLARC studies may monitor the performance of these ALFs of concern to determine whether, as the new law and regulations phase in, these problems diminish.

Medication administration and staffing are two keys to quality care in assisted living. Medication administration was the most frequent verified complaint and health and safety violation in ALFs in 2005. Prior JLARC reports identified medication administration as a concern. The new law addresses problems with medication administration by requiring the registration of medication

aides and improved documentation. However, the impact of these regulations likely will not be seen until enforcement begins in July 2008.

Staffing problems are also prevalent, particularly in the ALFs of concern. These problems include the recruitment and retention of quality staff, the number of on-duty staff, and staff training. Recruitment and retention appear to be statewide concerns, while the number of on-duty staff and staff training are problems primarily for the ALFs of concern. Increased training hours and first aid and CPR training for more staff were included in the emergency regulations.

Problems accessing assisted living services in Virginia appear confined largely to the State's auxiliary grant residents. While private pay residents may face waiting lists to get into the facility of their choice, and there are some mostly rural localities with no ALFs, auxiliary grant residents can experience difficulty finding open ALF beds in their community. Limited access to auxiliary grant beds and mental health services could weaken the impact of key provisions in the 2005 legislation. Shortages of auxiliary grant beds in some areas may also inhibit DSS from adequately enforcing State regulations and improving the quality of care in marginal ALFs.

Access to mental health services has improved in recent years although some auxiliary grant residents with mental disabilities appear to experience ongoing problems accessing needed mental health services, either from the local community services board (CSB) or from their ALF. Problems with ALF staff and CSB services may limit the impact of new DSS regulations affecting mental health services.

NEW LAW AND REGULATIONS WILL IMPACT COSTS

Recent changes to the law and regulations on assisted living will impose new costs on ALF employees and on the facilities themselves. Although specific training requirements, for example, are not yet finalized, compliance with other draft requirements could cost \$1,800 or more for each ALF. Additional requirements, such as for emergency electrical connections, will also have a cost impact.

These costs will be a particular issue for the estimated 117 ALFs that serve mostly public pay residents because the auxiliary grant rates have not kept up with these requirements. The auxiliary grant is the primary means of paying for low-income assisted living residents although the State also pays higher rates for about a quarter of low-income residents. The grant rate of \$982 per month

represents 33 to 59 percent of the current average price (which ranges from \$1,674 to \$2,940, depending on the data source) for assisted living in Virginia.

As if acknowledging the inadequacy of the auxiliary grant rate, another State agency (the Department of Medical Assistance Services) uses State general funds to pay supplements of up to \$180 per month to 1,742 low-income ALF residents, 27 percent of all auxiliary grant recipients. Even with the highest supplement (\$982 + \$180 or \$1,162 per month for 140 of these residents), Virginia's payment remains below market prices.

Special circumstances, such as staff who draw below-market wages or receipt of significant outside revenue, help explain how some facilities can afford to meet standards. Special circumstances should not be a requisite for quality care in ALFs that choose to serve low-income residents.

At Virginia's current auxiliary grant rate, facilities serving low-income residents will be challenged by implementation of the new law and standards.

Assisted Living in Virginia

In Summary

The 2004-2006 Appropriation Act requires JLARC to report on the impact of new regulations adopted pursuant to major legislation affecting assisted living facilities (ALFs). The 588 ALFs in Virginia provide assistance and care for four or more adults who have limited functional capabilities, including the aged and disabled. ALFs are growing in size, with a total capacity statewide of 32,958. More residents need help with activities of daily living, such as administering medications. Data for low-income residents show a trend toward more dependency and more mental disabilities. This report provides a "snapshot" of the ALF industry early in the implementation of the new law and regulations. Future reports may then identify changes in the cost, quality, and availability of care that can be attributed to the new law and regulations.

Item 21F in the 2004-2006 Appropriation Act requires the Joint Legislative Audit and Review Commission (JLARC) to report on the impact of new regulations adopted pursuant to major legislation affecting assisted living facilities (see Appendix A for a copy of the mandate). This is the second JLARC report completed in response to this mandate. An interim report was published in November 2005.

Assisted living facilities (ALFs) provide assistance and care for four or more adults who have limited functional capabilities, including the aged and disabled. These facilities are typically operated by private providers and receive funding from residents and their families as well as from federal, State, and local sources. The facilities are licensed by the Department of Social Services (DSS). As of January 2006, there were 588 ALFs in Virginia with a total capacity of 32,958.

In 2004, a series of articles in the *Washington Post* called attention to serious problems in some of Virginia's ALFs, documenting cases of neglect, abuse, and violence, as well as questioning the State's licensing function. The series seemed to indict the assisted living industry, stating that:

Across the state and in all types of homes, many disabled and vulnerable adults have been abandoned to poor care and failed supervisionViolations of State regulations are varied and widespread and have been found by inspectors in roughly half the homes since 1998 Many residents are never visited by family or friends. They might see inspec-

tors only twice a year. Their mental impairments make them poor witnesses. And there is no requirement that case managers be assigned to monitor residents' care, advocates noted. State officials have been left in the dark about abuse and neglect because agency records are often incomplete. In many cases, facilities do not report incidents to the state.

The Secretary of Health and Human Resources responded to the *Post* series by convening a task force aimed at revising the statutory framework for licensing assisted living. A number of bills were introduced during the 2005 General Assembly, which responded by adopting SB 1183 / HB 2512.

This major legislation increased the education and training requirements for key ALF staff, strengthened sanctions and enforcement mechanisms available to DSS, provided additional licensing staff to DSS, and increased the auxiliary grant (a State subsidy for low-income ALF residents), along with mandating other improvements. The General Assembly also directed JLARC to undertake this review.

THE ASSISTED LIVING INDUSTRY IS GROWING AND CHANGING

The role of the assisted living facility has evolved away from a board-and-care model of the traditional "rest home" toward that of serving persons with diverse medical needs and problems. Some ALFs continue to provide small, home-like environments, while others are larger, housing up to 595 residents in the largest facilities.

The ALF Population Is Diverse and Increasing

ALF residents range from 18 to more than 100 years of age. Typically, residents cannot live independently but do not need full-time nursing care. This includes the frail elderly, residents with mental disabilities such as schizophrenia or Alzheimer's, and adults of any age who need help with routine activities.

ALFs provide services to a wide range of people. The common characteristic of ALF residents is disability of some type, including physical and/or mental disabilities.

The number of persons residing in Virginia's assisted living facilities has increased significantly over the years. Since 1979, for example, licensed capacity has more than tripled, from 10,420 to 32,958 (Table 1). This 217 percent growth rate greatly exceeds the

Table 1: Assisted Living Is a Growth Industry in Virginia

Fiscal Year	Number of Licensed Facilities	Bed Capacity	Average Size
1979	314	10,420	33
1990	470	22,538	48
1997	612	27,537	45
2001	679	34,696	51
2006 ¹	588	32,958	56
Percent Growth	88%	217%	70%

¹As of January 2006.

Source: Prior JLARC reports; DSS caseload data.

42 percent growth of Virginia's overall population between 1980 and 2005.

The population eligible for assisted living may continue to grow. Older Virginians represent one of the fastest growing segments of the population and are a key population served in assisted living. The proportion of Virginians over 85 years of age, for example, will more than double between 2000 and 2030, according to the Census Bureau, increasing from 87,000 to about 250,000 persons.

As noted in the 2005 JLARC report *Impact of an Aging Population on State Agencies*, the rate of disability increases with age. Based on self-reported data from the 2000 Census, 74 percent of Virginians aged 85 or over have one or more disabilities. Projections prepared by the Virginia Department for the Aging indicate that the number of persons with Alzheimer's, for example, will double between 2000 and 2030, from 2.6 to 4.3 percent of the State's population.

Facilities Are Fewer in Number, Larger, and Provide More Assistance

ALFs are housed in a variety of physical structures, including former motels, hotels, and nursing homes; older houses originally used as personal residences; and newly opened, specially designed buildings. Figure 1 illustrates the diversity of structures currently licensed for assisted living.

Some ALFs provide a "rest home" model of care, others are integrated into "life care communities" which may provide a range of living options, from independent living through full-time nursing care. Some offer short-term stays, and others look after people for many years. Most residents pay for their care from their personal

Figure 1: Assisted Living Facilities Can Be Converted Nursing Homes, Hotels (This Page), Converted Former Residences (Page 5), or Newer, Specially Designed Buildings (Page 6)







Source: JLARC staff photographs of ALFs throughout Virginia, December 2005-April 2006.

financial resources; the State- and local-funded auxiliary grant program pays for the care of about 19 percent of all residents.

The number of licensed facilities nearly doubled from 314 in 1979 to 612 in 1997 and then decreased to 588 by January 2006. Their overall capacity has declined from the peak in 2001 of 679 facilities with 34,696 beds (Table 1). The average size of a facility has grown 70 percent over the longer period, from an average of 33 beds in 1979 to 56 beds in 2006.

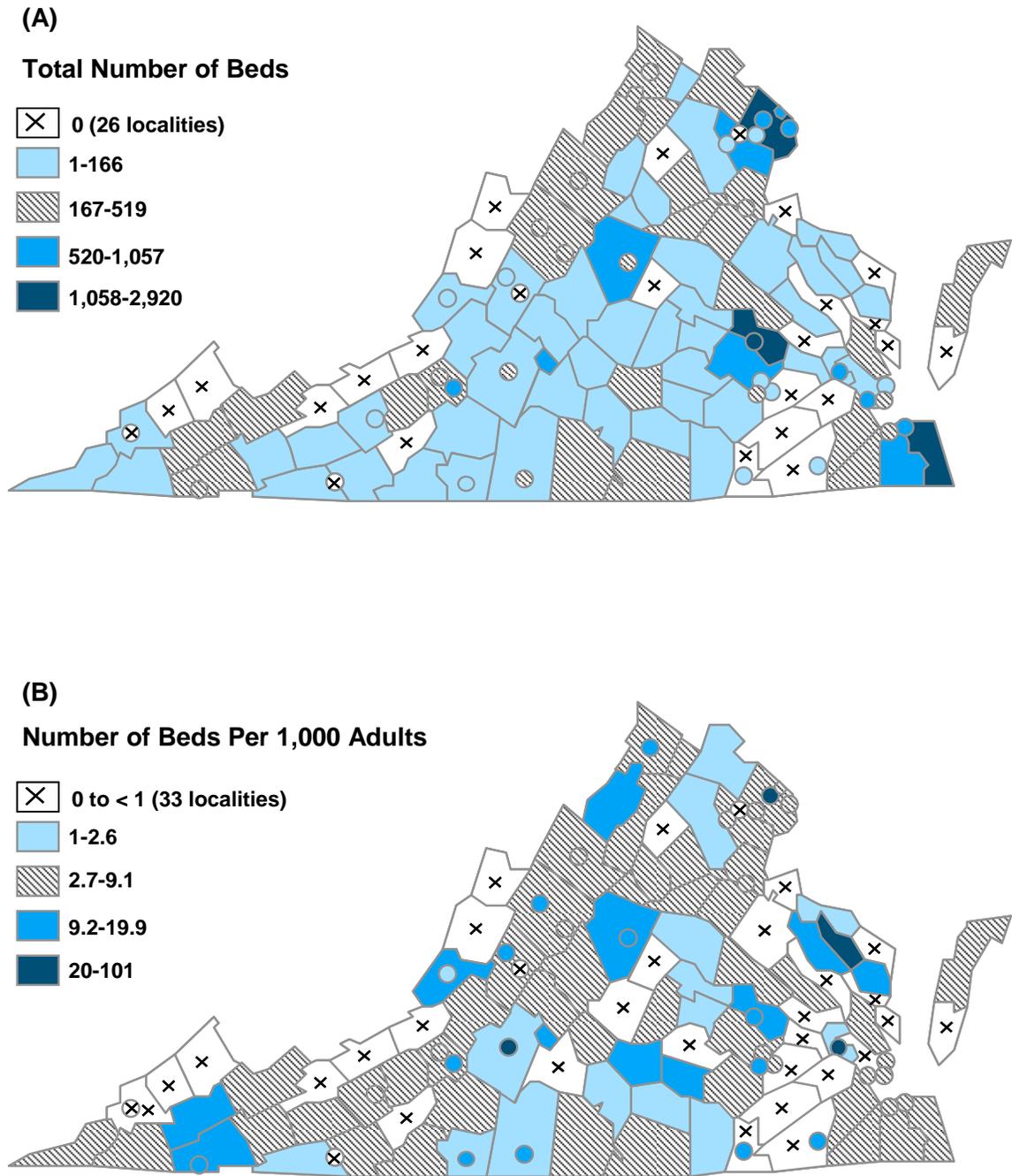
The slightly downward trend in the number of facilities, together with increased size, can be at least partly explained several ways. DSS staff indicate a trend in ownership of ALFs, away from the "mom and pop" rest home operations of the past as many owner/operators age out of the business. Larger corporate owners are entering the assisted living market, some expanding into assisted living from businesses such as hotel management and real estate development. Publicly traded and specialized assisted living corporations are also entering the Virginia market.

Assisted living is not available in all Virginia localities. As the map illustrates (Figure 2A), 26 cities and counties have no ALFs. Most of the unserved localities are smaller, rural counties. Although ALFs are located in most localities, they are concentrated—ten localities account for 42 percent of all ALF beds. Three localities each have more than 2,000 assisted living beds: Fairfax County has 2,920, Henrico County has 2,270, and Richmond City has 2,094.

When compared to the population over age 18, a different pattern of concentration emerges. In addition to the 26 localities with no ALFs, seven localities have less than one assisted living bed per 1,000 people over 18 years of age (Figure 2B). Nine of the ten localities with the highest ratios of assisted living beds per 1,000 adults are cities, including larger cities such as Richmond and Roanoke, but also including smaller cities such as Bedford (at 101, with the highest ratio of beds per 1,000 adults in the State), Falls Church (72 beds per 1,000), and Williamsburg (54 beds per 1,000).

Another trend in recent years has been towards providing a higher level of care. For example, the 1998 JLARC study found 120 or 19 percent of all adult care residences (as they were then called) licensed to provide residential living—meaning that the facility may provide only "minimal" assistance with the activities of daily living (ADLs, including eating, bathing, and dressing). In 2006, just 59 facilities or ten percent were licensed for this level of care. At the same time, the number of facilities licensed to provide assisted living, which indicates the capability to provide a moderate level of

Figure 2: Assisted Living Is Not Available in 26 Virginia Localities (A), and A Higher Number of Localities Have Less Than One Bed Per 1,000 Adults (B)



Source: JLARC analysis of DSS licensing data and 2004 U.S. census population estimates.

assistance with ADLs, increased from 484 or 80 percent in 1997 to 529 or 90 percent of all licensed facilities in 2006.

Needs Are Changing for Key Population Served by ALFs

ALFs serve a population with more diverse needs than nursing homes. Residents range in age from 18 to over 100. Many residents have no mental problems but need help with ADLs. While persons who need such assistance are generally older, a significant number of younger and middle-aged residents with mental disabilities often require some help with daily activities that require a higher level of cognitive functioning and physical ability, such as meal preparation, housekeeping, and transportation.

Although there is no data available to describe all 33,000 ALF residents, data is available on the 19 percent of the ALF population whose care is paid for through the State auxiliary grant program. Data is collected on each auxiliary grant resident in the 24-page Uniform Assessment Instrument (UAI). The UAI is completed by personnel who are independent of the ALF (typically social services caseworkers or case managers with a local community services board), and the data is maintained by the Department of Medical Assistance Services. The 1998 JLARC review also used this data source, so trends over the past seven years can be observed.

The UAI data indicates that the median age (the mid-point) of 66 is almost the same as the 65 years noted in the 1998 JLARC report. More than half of the low-income residents of ALFs are female, as shown in Table 2. The UAI data shows that a key trend among auxiliary grant residents of ALFs is the increasing number with mental disabilities. The 1998 JLARC report found that 47 percent of all auxiliary grant recipients also had mental disabilities. Using data from 2003 to 2005, 65 percent of auxiliary grant recipients now have diagnosed mental disabilities.

The increasing number of auxiliary grant recipients with mental disabilities illustrates a point made in the 1998 JLARC report: that the State has in effect encouraged the development of the ALF industry as a major, though unplanned, component of housing and treatment for persons with mental disabilities. That report found that ALFs were a major placement option for Virginia's State-operated mental health facilities, with 508 or seven percent of persons discharged from State facilities being placed in ALFs in fiscal year (FY) 1996. The comparable figure for FY 2005 was 437 or 8.5 percent of all persons discharged from State facilities.

Two other trends are shown in Table 2. The percentage of auxiliary grant residents who depend on others for help with medica-

Table 2: Characteristics of Public Pay ALF Residents

	1997 ¹	2003-2005
% Female	54%	53%
% Needing Help With		
Bathing	55	56
Dressing	33	36
Bladder	20	18
Toileting	18	15
Transferring	14	9
Bowel Function	12	8
Eating	9	11
Dependent on Others for Medication Assistance	80	94
Mental Health Diagnosis		
Schizophrenia	17	15
Mental Retardation	11	10
Other	4	14
Bipolar/Personality Disorder	3	5
Dementia	3	7
Alzheimer's	2	4
Epileptic/Other Neurological	1	9
Anxiety Disorders	1	2
Total With Mental Health Diagnosis	47	65
Total Number	4,812	8,310

¹Data from Table 6 of the 1998 JLARC report *Services for Mentally Disabled Residents of Adult Care Residences*.

Source: JLARC staff analysis of Uniform Assessment Instrument data.

tion has increased from 80 to 94 percent. Secondly, there are increases in the percentage diagnosed with dementia, Alzheimer's, and epilepsy and other neurological disorders.

Prior JLARC Studies Found Growth and Problems in the Industry

JLARC has reviewed the licensing, funding, and operation of assisted living facilities in three prior reports, beginning in 1979 with *Homes for Adults in Virginia*. In 1990, a follow-up report was issued, and a 1998 report focused on services for adult care residents with mental disabilities. Action has been taken on many recommendations made by these reports, as noted in Exhibit 1.

Several themes recur in the reports. One theme is the growth of the industry, stemming in the past from the deinstitutionalization of people with mental disabilities as well as from demographic trends. All three reports also found some facilities that exceeded State standards and others that struggled to meet them. The reports identified concerns about the health and safety of the residents, the effectiveness of State licensing and monitoring, and the adequacy of State funding through the auxiliary grant program.

Exhibit 1: Most Prior JLARC Recommendations Have Been At Least Partially Implemented

Recommendation (Date of JLARC Report)	Current Implementation Status	Additional Action Necessary
DSS should make unannounced license renewal inspections (1979, 1990)	✓	No
Staff should be at least 18 and literate, and should follow physicians' orders (1990)	✓	No
The fire marshal should have authority to inspect all licensed ALFs (1979)	✓	No
Stronger DSS enforcement of standards is needed (1979, 1990, 1998)	○	Yes
Administrator education and experience requirements should be strengthened (1979, 1990, 1998)	○	Yes
Certified dietician should review menus in licensed facilities; special diets should receive particular scrutiny (1979, 1990)	✗	Yes
Statutory authority is needed for staffing standards in assisted living (1979, 1990, 1998)	✗	Yes
Standards should be established for levels of care that match the types of residents in assisted living (1990, 1998)	○	Yes
More than one person per facility should be trained in medication administration (1998)	○	Yes
Staff should have more training in caring for mentally disabled residents (1979, 1990, 1998)	○	Yes
Each community services board (CSB) with a minimum number of clients in ALFs should be funded for additional staff positions to focus on services for these clients (1998)	✗	Yes
Statutes should require CSB staff to help ALF staff develop individualized service plans and to monitor and visit their clients in ALFs (1998)	○	Yes
The auxiliary grant monthly rate should be increased and linked to services provided (1990, 1998)	○	Yes
Additional funding should be provided to promulgate best practices (1998)	✗	Yes
The personal allowance for auxiliary grant recipients should be increased and limits placed on how facilities may use it (1998)	○	Yes

Key: ✓ = Generally Implemented ○ = Partially Implemented ✗ = Not Implemented

Source: JLARC staff analysis of statutory and regulatory changes.

The current study was triggered by some of the same factors at work in the mid-1990s: major legislative changes, including increased funding and additional State licensing staff, and impending revisions to the assisted living regulations.

ASSISTED LIVING IS REGULATED BY THE STATE

Regulation of assisted living is primarily a state function, and states utilize distinct frameworks to ensure the protection of assisted living residents. A key difference is whether the state uses a medical model and regulates assisted living through the state health department (for example, Tennessee and Maryland) or whether the state views ALFs as a "social" community-based program, regulating them through the state social services or welfare department (Virginia). States also differ in how assisted living is regulated. Missouri, for example, sets staffing ratios (one staff person on the day shift for every 15 residents) for facilities that provide personal care assistance. Maryland and West Virginia authorize the regulatory agency to prescribe staffing patterns for specific facilities when conditions warrant.

The federal government plays a minimal role in regulating the assisted living industry. Unlike for nursing homes, few federal regulations have been established for ALFs. Federal agencies' roles are typically limited to funding certain programs related to assisted living such as Medicaid reimbursement for health care and the long-term care ombudsman program.

In Virginia, ALFs are licensed by the Department of Social Services (DSS). According to the *Code of Virginia* §63.2-1732, the State Board of Social Services has "the authority to adopt and enforce regulations ... to protect the health, safety, welfare and individual rights of residents of assisted living facilities and to promote their highest level of functioning." DSS is responsible for establishing standards, monitoring facilities' compliance through regular inspections, enforcing compliance, sanctioning non-compliant ALFs, and administering the auxiliary grant program, a financial assistance program for low-income residents of assisted living.

Additional State agencies are involved in regulating other aspects of ALFs. The Department of Health is responsible for licensing and monitoring the kitchens and food service. Local health departments conduct a minimum of one inspection annually. The local fire marshal is responsible for inspecting and enforcing the local fire codes. Local officials also enforce building code requirements. The Department of Health Professions will now be responsible for licensing ALF administrators and registering medication aides, a result of the 2005 legislation.

Other State agencies involved in providing services for ALF residents are the Department of Medical Assistance Services (DMAS) and the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). DMAS is responsible for the UAI used to determine the types of assistance required by residents and handles Medicaid reimbursements for medical and mental health services. DMHMRSAS is responsible for services for the mentally ill, mentally retarded, and substance abusers, and is the umbrella organization for 40 local community services boards (CSBs) throughout Virginia.

JLARC IS CONDUCTING A MULTI-YEAR STUDY

The study mandate directs JLARC to report on the impact of the new regulations on cost of services, access to services, and tangible improvements to the quality of care. An interim report, issued in November 2005, recapped the statutory and regulatory changes, and provided background on assisted living in Virginia. The report recommended that the General Assembly extend the deadline for the final report because key provisions of the new law do not take effect until after June 2006. Key aspects of the new regulations take effect over the next two years.

This report provides a "snapshot" of conditions in the ALF industry early in the implementation of the new law and regulations. Baseline measures of cost, quality and access to services are established, providing a basis of comparison for future studies, which may then identify changes that can be attributed to the new law and regulations.

The study approach was to identify ALFs that have a recent history of compliance problems and verified complaints. Future studies will then be able to observe how the new law and regulations affect these facilities over time. Research activities and methods are discussed in more detail in Appendix B. DSS has divided the State into eight regions for purposes of administering licensing programs (Appendix C). A glossary of acronyms is included in Appendix D.

New Law and Its Implementation

In Summary

The 2005 General Assembly passed major legislation affecting assisted living facilities. The new law gave the Department of Social Services (DSS) new enforcement authority, directed the Department of Health Professions (DHP) to license facility administrators and register medication aides, and increased the auxiliary grant rate. DSS and DHP are required to implement these changes over three years, from 2005 to 2008. DHP is currently developing regulations for the licensing and registration provisions in the law. DSS implemented emergency regulations in December 2005, and permanent regulations are currently being developed. These permanent regulations must be implemented by December 28, 2006, or provisions in the emergency regulations will expire and the prior regulations will come back into effect. Although DSS accomplished a major regulatory overhaul in a short period of time, implementation of the emergency regulations had shortcomings. DSS did not adequately train ALF administrators or its field inspectors, and some regulatory provisions may be unworkable. These shortcomings should be addressed in the permanent regulations currently being developed.

The 2005 legislation required the Department of Social Services (DSS) and Department of Health Professions (DHP) to develop substantial new regulations over several years. These agencies generally appear to be on schedule. DHP is currently developing regulations for ALF administrators and medication aides to be implemented in 2007. DSS implemented emergency regulations in December 2005, and permanent regulations that will replace the emergency regulations in December 2006 are under review. These permanent regulations are needed to ensure that prior regulations for ALFs do not come back into effect.

LEGISLATION PHASES IN OVER THREE YEARS

In 2005 the General Assembly enacted major legislation (SB 1183 / HB 2512) affecting assisted living facilities. The legislation was designed to improve the quality of care provided by ALFs and to strengthen the State's regulatory framework in relation to these facilities. The new law, developed with input from a variety of stakeholders, passed both chambers of the General Assembly unanimously and was signed into law by the Governor. The law's provisions phase in over three years, from 2005 to 2008.

The legislation gives DSS enhanced enforcement powers, directs DHP to license facility administrators and register medication

aides, and requires facilities to provide consumers with basic information about their services and costs. Several provisions also address problems related to the care of residents with mental health, mental retardation, and substance abuse issues. The major elements of the legislation are detailed below.

Enhanced DSS Enforcement Authority

In an effort to improve the regulation of ALFs in the Commonwealth, the General Assembly strengthened the enforcement authority available to DSS. The department will now have greater enforcement powers and more flexibility in responding to facilities with a history of regulatory violations.

Maximum Fine Increased to \$10,000. The legislation allows DSS to assess civil penalties for each day a facility is out of compliance with its license and the health, safety, and welfare of its residents are threatened. The aggregate amount of financial penalties for a facility is limited to \$10,000 over any two-year period. The previous maximum fine was \$500 per facility inspection.

The State Board of Social Services (SBSS) is required to develop criteria for the use of penalties based on four factors: the severity, pervasiveness, duration, and degree of risk of a violation. DSS also has the authority to accept a plan of correction from the facility and adjust the penalty amount if the plan is met. The proceeds from civil penalties will be directed to a special non-reverting fund and used for training ALF staff statewide and providing facilities with technical assistance.

License Suspension Process Is Streamlined. DSS now has the authority to issue a summary suspension of a facility's license when the health, safety, and welfare of its residents are threatened. Although DSS already had authority to revoke a facility's license for a variety of offenses, the summary suspension provision was included to improve the department's ability to close facilities in a timely fashion.

The new legislation authorizes DSS to suspend a portion of a facility's operating license. DSS already had the authority to reduce a facility's licensed capacity or prohibit new admissions to protect the health and safety of residents. However, a growing number of ALFs are jointly owned and operated alongside adult day care centers, nursing homes, and other long-term care settings within a single "continuous care" facility. In addition, some ALFs may include different wings that provide different service levels to specific populations, such as mental health or Alzheimer's patients. The new provision gives DSS the flexibility to suspend a portion of a facility's license while leaving its remaining operations intact.

Strengthened Staff Licensing and Training Requirements

The 2005 legislation included several provisions to improve the qualifications of ALF staff, including new licensing, registration, and training requirements. Prior to the legislation, standards for facility administrators, medication aides, and other direct care staff were addressed primarily through regulatory provisions.

ALF Administrators Must Be Licensed. The legislation builds on existing regulations of ALF administrators by requiring that they receive and maintain a license from the Board of Long-Term Care Administrators (BLTCA) beginning in July 2007. Facility administrators providing only the residential level of care will not have to hold a license, according to the new legislation. This would exclude facilities that provide only minimal or limited assistance with residents' activities of daily living, according to *Code of Virginia* §63.2-100. Under the new legislation, the SBSS will determine more precise criteria for this exemption.

The new law reconstituted the Board of Nursing Home Administrators and renamed it the BLTCA. The board is charged with developing curriculum standards and licensure criteria. The new law specifically allows individuals to serve as the administrator of record for more than one facility. The SBSS is to determine the number of facilities one administrator can oversee.

Managers Can Relieve Administrators in Smaller ALFs. The emergency regulations adopted by the SBSS require the administrator to be present at the ALF at least 40 hours each week, except in smaller ALFs (19 or fewer residents) where the administrator may serve other facilities. In these smaller ALFs, the regulations permit the administrator to be absent from a facility a portion of the 40 hours, provided there is a person designated as "manager" who serves when the administrator is not present at the facility.

The regulations also require managers to meet minimum training levels. ALF managers must have at least one year of administrative or supervisory experience in caring for adults in a group care facility plus either 30 hours of college courses or completion of a DSS-approved training course and additional training related to operation of a residential facility for adults. When adults with mental impairments reside in the facility, the regulations specify that "at least four hours of training shall focus on residents who are mentally impaired."

Medication Aides Must Register With Board of Nursing. One of the most common personal care services ALFs provide is administering medication to residents. In recent years, the medication needs of ALF residents have grown increasingly complex, making a

skilled staff critical to a facility's operation. In addition, 2004 DSS licensing data indicated that the largest number of standards violations was in the area of medication.

The General Assembly responded by mandating that facility staff responsible for administering medication be registered by the Board of Nursing, beginning in July 2007. The legislation requires the board to develop regulations governing the registration process, including a training curriculum, continuing education requirements, competency evaluations, and professional conduct standards.

Direct Care Staff Must Meet New Training and Qualifications Requirements. An additional provision related to facility staff requires the SBSS to develop training and qualifications standards for all direct care employees. Direct care staff help residents with daily living activities such as bathing, eating, and walking. Staff affected by this provision include aides, assistants, and supervisors.

More Information Must Be Provided to Consumers

The General Assembly also took steps to help consumers make better informed decisions about assisted living facilities. Prior to the legislation, there were few requirements that administrators publish information about their facilities or post notices of regulatory violations.

ALFs Must Provide Disclosure Forms to Prospective Residents. ALFs are now required to provide consumers, upon request, with basic information about the facility. Under the new law, facilities will use a standardized disclosure form developed by DSS to list key information that consumers need to evaluate their long-term care options, including

- the circumstances in which residents can be admitted, transferred, or discharged,
- basic and supplemental services and fees,
- information about facility staff and their qualifications,
- recreational activities provided for residents, and
- ownership structure of the facility.

ALFs Must Post Provisional Licenses at Public Entrances. DSS already had the authority to issue provisional licenses, effective for six months, to facilities temporarily unable to meet all regulatory requirements. Under the new law, an ALF operating under a provisional license is required to post a copy of that license at each

public entrance to the building. The notice also must state that a description of the facility's violations of State standards is available in writing or on its website. In addition, facilities are now required to post notices when DSS attempts to revoke or deny the renewal of its operating license. Prior to the legislation, these posting requirements were left to the discretion of the department.

Medication and Mental Health Requirements Are Improved

As discussed earlier, the personal care needs of many ALF residents have grown increasingly complex in recent years. The General Assembly included two additional provisions aimed at addressing this trend, one designed to improve the screening of mental health needs, the other to better manage the medication needs of residents.

Mental Health Screenings Are Required for Some Residents. Since 1993, State law has required ALFs to ensure that residents' needs are assessed with the UAI prior to admission. The UAI is the primary tool used to identify mental health and behavioral needs of ALF residents. However, the 1998 JLARC report *Services for Mentally Disabled Residents of Adult Care Residences* found deficiencies in the UAI's ability to detect such needs.

The legislation addressed these concerns by requiring facilities to ensure that residents whose behavior is suggestive of mental illness, mental retardation, or substance abuse are evaluated by a qualified mental health professional. If further mental health services are needed, the facility must notify the resident's legal representative and the local community services board (CSB). CSBs are local agencies that use public funds to provide mental health, mental retardation, and substance abuse services for the community.

ALFs Must Develop Medication Management Plans. In addition to mandating the registration of medication aides, the General Assembly also took steps to improve the delivery of medication in ALFs. The legislation requires facilities to write management plans describing their procedures for administering medication to residents. Plans are to demonstrate an understanding of the responsibilities involved in managing medications and must be approved by DSS. The new law identifies the required elements of medication management plans, including

- standard operating procedures,
- record-keeping procedures for documenting the medications delivered each day, and
- staff responsible for administering medication and their qualifications.

Facilities are also responsible for developing procedures to monitor their compliance with their medication management plan.

Three Additional Legislative Changes Affect ALFs

Legislation passed by the General Assembly in 2004 requires that, by July 1, 2007, ALFs with six or more residents be able to connect to a "temporary emergency electrical power source for the provision of electricity during an interruption of the normal electric power supply" (*Code of Virginia* §63.2-1732D). This provision was designed to ensure that individuals in ALFs, including the most vulnerable residents with disabilities and medical needs, have a stable and reliable source of electricity during an extended power outage.

Additional legislation from the 2006 General Assembly session will require ALFs (and all other facilities providing services to children, the elderly, or the disabled) to conduct national criminal background checks for all employees and volunteers. ALFs were already required to have State criminal background checks for employees, but this legislation (SB 421) extends the requirement to *national* criminal checks and to volunteers as well as employees. These background checks cost \$15 apiece and are handled through the Department of State Police.

In 2006, the General Assembly also approved amendments to the 2004-2006 Appropriation Act that will temporarily suspend three provisions of the emergency regulations. These changes, in HB 5012, will

- limit to 40 hours the department-approved training course for managers in small ALFs,
- reinstate a provision allowing staff in small facilities (19 or fewer residents) to sleep during overnight shifts if they remain accessible to residents, and
- nullify provisions in the *Virginia Administrative Code* (VAC) requiring ALFs to intervene when residents display certain "high-risk" behaviors.

Because HB 5012 completes spending for the fiscal year ending June 30, 2006, these suspended provisions would be restored unless budget legislation for the 2006-2008 biennium includes similar language.

IMPLEMENTATION OF LEGISLATION IS PROGRESSING, BUT CRITICAL MILESTONES REMAIN

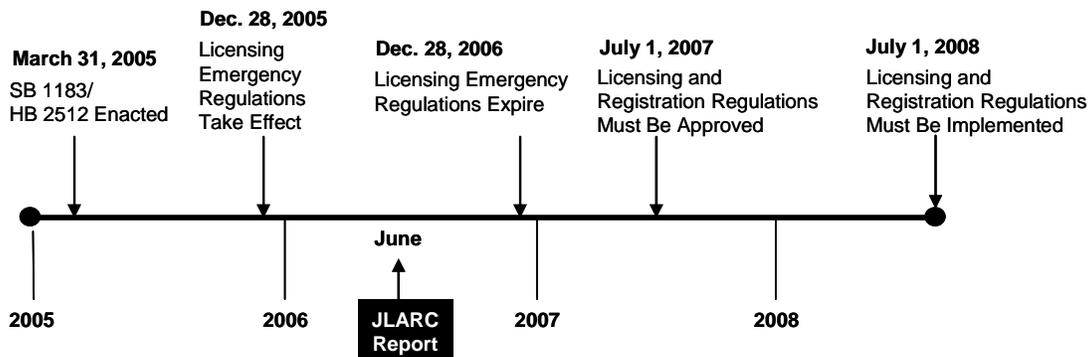
DSS and DHP are primarily responsible for implementing the provisions of the 2005 legislation. DSS is responsible for various provisions in enforcement, public information, and quality improvement, as discussed above. DHP is responsible for registration of medication aides and administrator licensure. Significant implementation dates remain (Figure 2).

The Administrative Process Act (*Code of Virginia* §2.2-4000 and following) governs the development of regulations in Virginia by State agencies. Agencies must notify the public of an intended regulatory action through the *Virginia Register*, provide for 30 days of public comment before publishing proposed regulations, and ensure a minimum of 60 days for comments following publication of proposed language. Agencies have the option to hold public hearings on a set of regulations, and the Act allows interested parties to force public hearings if the agency initially declines to hold them. These requirements generally apply when agencies are developing new or revising existing regulations.

Under certain circumstances, the Act allows State agencies to bypass these requirements and expeditiously implement new regulations. These circumstances include situations where regulations are needed to address an "imminent threat to public health or safety" or where State or federal law requires new regulations within 280 days of a law's enactment. Once these emergency regulations are in place, agencies have 12 months to develop permanent regulations or allow the emergency regulations to expire.

As noted previously, the 2005 legislation required DSS to adopt the new ALF regulations on an emergency basis. The department

Figure 2: Milestones in the Implementation of the 2005 Legislation Remain



Source: JLARC staff analysis.

is currently developing permanent regulations to replace the emergency regulations. DSS staff have characterized these permanent regulations as a broad overhaul of existing regulations that will include the emergency regulations and additional revisions.

DSS Implemented Emergency Regulations in December 2005

An enactment clause in the 2005 legislation required the SBSS to promulgate new regulations within 280 days of the legislation's enactment, permitting the adoption of emergency regulations. The SBSS approved emergency regulations in August 2005, and these regulations took effect December 28, 2005.

The emergency regulations revised sections 22 VAC 40-71-10 through 22 VAC 40-71-700 of the *Virginia Administrative Code*. Many of these changes are required by the 2005 legislation, although some are not.

DSS Is Hiring and Training 11 New Staff. The 2005 Appropriation Act allocated funding for 11 new ALF licensing staff at DSS. As of May 2006, the department had filled eight of these 11 positions, including six new licensing inspectors, a nurse consultant, and an information specialist. DSS indicated that three inspector positions remain unfilled, in part due to a lack of qualified candidates.

As required by the legislation, DSS provided training on the expiring regulations in August and September 2005. DSS also developed a training module on the emergency regulations and statutes and presented them to all licensing inspectors in the fall of 2005. ALF inspectors also attended training sessions on the UAI, individualized service plans (ISPs) for ALF residents, and mandated reporter sessions through adult protective services.

DSS Permanent Regulations Are Currently Under Review. Under the Administrative Process Act, emergency regulations can remain in effect no longer than 12 months. At the end of one year, State agencies must implement permanent regulations or allow the previous regulations to be renewed. As a result, DSS must implement permanent regulations by December 28, 2006, if the new regulatory provisions are to remain in effect.

It appears possible that permanent regulations will not be implemented before the December 28, 2006, deadline, allowing regulations in effect before the 2005 legislation to be revived. In an effort to forestall this possibility, the SBSS adopted proposed permanent regulations alongside the emergency regulations at its August 2005 meeting. These proposed regulations are currently undergoing executive branch review and must be followed by a 60-day pub-

lic comment period, a public hearing, and an economic impact analysis by the Department of Planning and Budget. DSS staff are concerned about meeting the December 28 deadline, and changes to the proposed regulations could significantly delay the implementation process.

Department of Health Professions Must Implement New Regulations by 2007

The Board of Nursing (BON) and the Board of Long-Term Care Administrators (BLTCA), both within the Department of Health Professions, are responsible for the licensing and registration provisions contained in the 2005 legislation. The boards must adopt final regulations on or before July 1, 2007. However, regulations for ALF administrators and medication aides cannot be enforced for 12 months, or not before July 1, 2008.

Proposed Regulations for Medication Aides Would Require 68 Hours of Training. The BON established a task force to develop criteria for the certification of medication aides in July 2005. As required by statute, a Notice of Intended Regulatory Action (NOIRA) was published in July, and the public comment period closed in August 2005. Proposed regulations were adopted in November and are currently undergoing executive branch review. A 60-day public comment period and a public hearing will follow.

The proposed regulations adopted by the BON would require medication aides to meet DSS training requirements for direct care staff, pass a competency exam approved by the board, and complete a 68-hour course in an approved program. The training course would include 40 hours of classroom instruction, 20 hours of supervised skills practice, and eight hours on the administration of insulin. Individuals with one year of experience working as a medication aide in an ALF can substitute an eight-hour review course for the 68-hour training course. Registered aides would be required to renew their registration every two years and complete four hours of continuing education training each year.

These regulations remain in draft form and could change as a result of executive branch review, the public comment period, or public hearings.

BLTCA Adopted Proposed Regulations for Licensing ALF Administrators in January 2006. The BLTCA was newly established to administer and regulate the licensure of ALF administrators. The first meeting was held in August 2005 when a task force was appointed to develop the curriculum and criteria for licensure. A NOIRA was published in July 2005 and a public comment period closed in November.

The task force met five times during the fall and winter of 2005. Proposed regulations were adopted by the full BLTCA on January 10, 2006, and were submitted for executive branch review in March. Following executive branch approval, the board expects to publish the proposed regulations during the summer of 2006. A 60-day comment period and public hearing will follow.

In their current form, the proposed regulations would require all ALF administrators to complete a minimum of 30 semester hours at a college or university and pass a State examination approved by the board. As summarized in Table 3, various combinations of education and training are required to qualify for the examination. Importantly, until July 1, 2009, the regulations allow applicants to bypass these education and training requirements if they have served full-time as the head or assistant administrator in a licensed ALF for two of the three years between 2005 and 2008. The State examination would still be required. Finally, administrators would be required annually to complete 20 hours of continuing education and renew their license.

Like proposed regulations for registering medication aides, the licensure regulations remain in draft form and may change as a result of executive branch review, the public comment period, or public hearings.

Table 3: Proposed Regulations for Licensing ALF Administrators Offer Applicants Four Paths to the State Exam

Track	Proposed Education Requirement	Proposed Training Requirement
Degree Program	Baccalaureate or higher degree in health care related field; coursework must meet prescribed content areas ¹	320-hour internship
Certificate Program	Baccalaureate or higher degree in field unrelated to health care; 21 semester hours in prescribed content areas ¹	320-hour internship
Administrator-in-Training Program	30 semester hours in prescribed content areas ¹	500-hour internship
Administrator-in-Training Program	30 semester hours in any subject	1,000-hour internship

¹ Prescribed content areas are resident/client services management; human resource management; financial management; physical environment management; and leadership and governance.

Source: Board of Long-Term Care Administrators proposed regulations.

IMPLEMENTATION OF THE DSS EMERGENCY REGULATIONS HAD SHORTCOMINGS

As the primary State agency responsible for regulating ALFs in Virginia, DSS was tasked with implementing key provisions of the 2005 legislation. Legislation required DSS to implement provisions of the law within 280 days of the legislation's enactment. For this reason, DSS bypassed the standard regulatory process and developed new regulations in an expedited fashion. Emergency regulations took effect December 28, 2005, and will expire on December 28, 2006. As noted earlier, proposed permanent regulations to replace these emergency regulations are currently under review.

Although DSS accomplished a significant regulatory overhaul in a short period of time, the department's implementation of the 2005 legislation had shortcomings. Three problems became apparent.

First, DSS training did not adequately prepare ALF administrators or regional licensing inspectors for the new regulations before they took effect December 28. While the department has made an effort in recent months to offer administrators and inspectors additional guidance, further steps are needed if the 2005 legislation is to be implemented properly.

Second, key provisions of the emergency regulations appear vague or impractical. Regulations aimed at improving ALF residents' access to mental health services have generated confusion among ALF administrators, and provisions involving medication administration and staff training may be unworkable. Unless addressed in the permanent regulations currently being developed, these limitations have the potential to limit the impact of the 2005 legislation.

Third, a controversial provision in the emergency regulations was not mandated by the 2005 legislation. The emergency regulations approved by the SBSS repealed an important exemption to a staffing requirement that applied to ALFs housing fewer than 19 residents. The new requirement may impose additional costs on smaller ALFs and could drive operators from the industry.

DSS Did Not Adequately Prepare ALF Administrators or Its Own Inspectors for the New Regulations

As the main regulatory agency responsible for implementing key provisions in the 2005 legislation, DSS developed a training program on the new regulations for ALF administrators and licensing inspectors. DSS staff conducted training sessions throughout the State during the months of October, November, and December 2005. These sessions were aimed at helping ALF administrators

understand how to comply with the new standards and teaching inspectors how to enforce them.

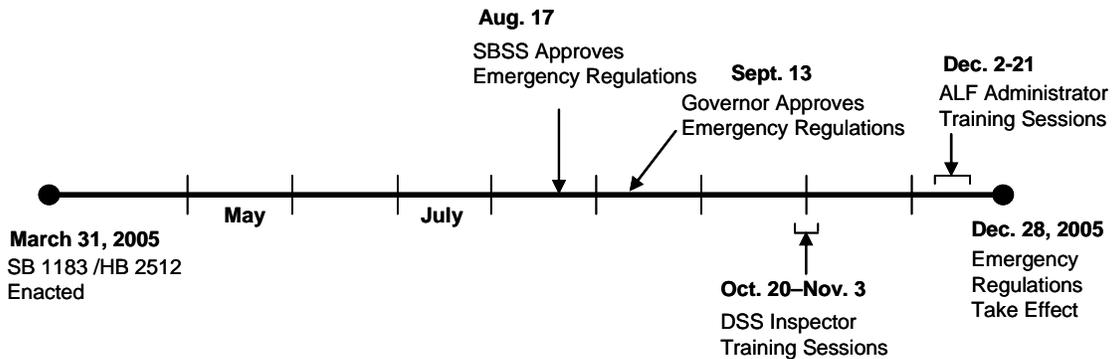
An effective training program for ALF administrators was critical to implementing the 2005 legislation. The emergency regulations developed by the SBSS required ALFs to make key changes in their operations. These regulations were designed to improve the quality of care in ALFs, and involve services for residents with mental disabilities, medication administration, and staff qualifications.

Training for licensing inspectors was also important to implementing the new legislation. The General Assembly designed the 2005 law in part to strengthen the enforcement tools available to DSS for noncompliant facilities. Making full use of these enforcement tools requires that licensing inspectors are trained to apply the new regulations in a correct and consistent manner.

Although the emergency regulatory process is several months shorter than the standard process, it appears that DSS had adequate time to prepare a training program for ALF administrators. The 2005 legislation was signed into law on March 31 and the SBSS approved emergency regulations on August 17. Regulations were approved by the Governor on September 13. Nonetheless, training sessions for ALF administrators were not conducted until December, approximately five months after regulations were approved by the SBSS (Figure 3).

Although DSS was developing the emergency regulations in a shortened time frame, the department's training program had shortcomings that could have been prevented. One problem was that DSS had not resolved issues involving specific regulations before it trained ALF administrators and licensing inspectors, so

Figure 3: Training for ALF Administrators Was Conducted Five Months After Emergency Regulations Were Developed



Source: JLARC staff analysis.

DSS staff was not prepared to answer questions from inspectors. Staff did not adequately address similar questions from ALF administrators one to two months later.

As a result, administrators were ill-equipped to comply with the new regulations when they took effect December 28, and inspectors were not fully prepared to enforce them. Despite these problems, licensing inspectors were instructed to cite facilities for violating the new standards immediately after the December 28 effective date.

Training for ALF Administrators Was Held Less Than One Month Before New Regulations Took Effect. One serious problem with the training program developed by DSS was that ALF administrators did not have adequate time to prepare for the new regulations.

All training sessions were conducted less than one month before the new regulations took effect; five sessions were held within two weeks of the December 28 deadline (Table 4). For example, the western licensing region conducted its sole training session on December 14. The central region held its two sessions less than ten days before the regulations took effect.

The department held 11 administrator training sessions for the 588 licensed ALFs in the State. One session was held in each of the eight regional licensing offices, with three regions each providing an additional training session. Sessions generally lasted five to six hours, and included a summary of the 2005 legislation and the new regulations.

Table 4: Administrator Trainings Were Held Two to Three Weeks Before New Regulations Took Effect on December 28, 2005

2005 Training Date	DSS Licensing Region
December 2	Verona
December 6	Virginia Beach
December 7	Peninsula
December 8	Virginia Beach
December 8	Piedmont
December 12	Piedmont
December 14	Western
December 15	Fairfax
December 15	Northern
December 19	Central
December 21	Central

Note: See Appendix C for map of DSS ALF licensing regions.

Source: DSS Division of Licensing Programs.

The late dates of the ALF administrator training hampered providers' efforts to prepare for the new standards. Administrators in every licensing region complained to JLARC staff that they did not have enough time to learn the new regulations and make needed changes in their day-to-day operations. As a result, administrators were still working to meet the new standards when they took effect on December 28.

DSS Did Not Provide Administrators Needed Technical Guidance on Difficult Regulations. The department's training program also failed to provide ALF administrators needed guidance for complying with the new regulations. Written guidance on critical provisions was not provided in a timely manner. Moreover, trainers (who also were the DSS inspectors) were unable to address providers' questions during the sessions. Administrators were told to contact their licensing inspectors with questions, but inspectors were not always able to answer these questions.

A major flaw in the training program was that DSS did not provide administrators with written technical assistance or model forms until months after the regulations took effect. Model forms for a medication management plan and public disclosure materials were still under development on December 28, 2005. DSS staff said there were efforts to address administrators' questions individually during and after the training sessions. However, the department did not issue a guidance document addressing these questions until April 10, 2006, more than three months after the new regulations became effective.

In addition, DSS staff did not adequately address questions raised by administrators at the training sessions. One ALF administrator interviewed for this study complained that DSS trainers at their session rushed through the material and did not elaborate on confusing provisions regarding mental health services and medication administration. Another ALF administrator told JLARC staff their session was held during a snowstorm and some administrators left early to pick up children from school. DSS did not provide a makeup session, in a neighboring region, until February 2006.

Regional Licensing Inspectors Did Not Receive Sufficient Guidance on the New Regulations. Similar to its training for ALF administrators, the department's training program for licensing inspectors had shortcomings. Although inspectors were tasked with helping administrators understand and comply with the new regulations, training sessions did not address critical questions previously raised by inspectors. As a result, licensing inspectors were not prepared to answer these questions when raised by ALF administrators.

DSS conducted a total of three day-long training sessions for its ALF licensing inspectors. The sessions were held in late October and early November in Williamsburg, Fredericksburg, and Roanoke. Inspectors were asked to review the emergency regulations and provide the department with questions or concerns before the sessions.

One inspector told JLARC staff that DSS trainers discouraged questions at her session and would not provide immediate answers. Instead, staff promised to provide written answers at a later date. However, no guidance document had been issued to inspectors by the time the department began training ALF administrators. This was problematic because, as mentioned earlier, DSS trainers told ALF administrators to contact their inspector with questions about the new regulations.

Five Provisions of the Emergency Regulations May Be Unworkable

Virginia's assisted living population includes a growing number of individuals with complex medical needs. In recent decades, assisted living has become a common source of long-term care for the frail elderly as well as younger individuals with serious mental health and developmental disorders. As data from recent UAI assessments indicates, ALF residents often require several medications to manage medical conditions that may include schizophrenia, Alzheimer's, diabetes, and heart disease. Some facilities have struggled to meet the needs of their sickest residents.

Key provisions in the emergency regulations were aimed at improving the quality of care ALFs provide for residents with serious medical needs. DSS developed new regulations to address problems with medication administration, record-keeping, and staff training. The department also revised its regulations for ALFs that serve individuals with mental disabilities.

However, during the course of this study, JLARC staff heard complaints from ALF administrators, industry advocates, and licensing inspectors that five provisions in the emergency regulations are vague or impractical. ALF administrators from every licensing region voiced concerns with these provisions. Although the provisions involving high-risk behavior and CSB assistance may be temporarily suspended by the General Assembly, these provisions could emerge again in the permanent regulations currently under review. All five provisions have the potential to weaken the impact of the 2005 legislation if they are not addressed in the permanent regulations.

Definition of "High-Risk Behavior" Is Vague. The emergency regulations include new requirements that ALFs seek emergency assistance and develop intervention plans when residents with mental disabilities engage in high-risk behavior. Recent budget legislation passed by the General Assembly would invalidate these requirements if signed into law.

Section 22 40-71-(1)-10 of the *Virginia Administrative Code* defines "high-risk behavior" as "...any behavior, including an expressed intent, that exposes, or has the potential to expose, the person exhibiting the behavior, or those being exposed to the behavior, to harm."

The definition also provides examples of high-risk behavior, such as

- physically assaulting others or gesturing,
- destroying property that exposes self or others to harm,
- wandering in or outside of the facility,
- being intrusive in the personal space of others, and
- increased physical activity such as floor-pacing that might indicate anxiety or stress.

ALF administrators complained to JLARC staff that this definition is vague and difficult to apply. One administrator said the language encompasses the typical behavior of Alzheimer's or dementia patients. An operator who owns multiple facilities and specializes in elderly residents with cognitive deficits instructed his staff to ignore the new provisions involving high-risk behavior because the definition is unworkable. Staff with DMHMRSAS agreed that some examples in the definition are common among Alzheimer's and dementia patients.

A guidance document for ALF administrators, developed by DSS and issued April 10, 2006, acknowledged that some behaviors listed in the definition are common among residents with dementia or Alzheimer's. However, the document noted that ALFs need not react to every instance of a high-risk behavior. The document also emphasized that closely monitoring residents' behavior will help ALFs distinguish between high-risk behaviors that require emergency assistance and less threatening behavior common to Alzheimer's and dementia patients. Similarly, DMHMRSAS staff said that ALF staff should be familiar with their residents' behavior and track it through daily behavioral logs.

The monitoring and record-keeping practices recommended by DSS and DMHMRSAS may alleviate some of the confusion sur-

rounding the definition of high-risk behavior. However, ALFs may need additional direct care staff and training to adopt these practices. DMHMRSAS officials said staff ratios of 10-15 residents per ALF staff, common in many ALFs, are too high for staff to adequately monitor each resident's behavior. Behavioral monitoring may be particularly difficult in ALFs with high staff turnover or where staff have other duties in addition to caring for residents.

As noted previously, permanent regulations to replace the emergency regulations are currently under executive branch review. The department should use this process to redefine high-risk behavior to focus on residents with mental disabilities. Mental health professionals from the DMHRMRSAS and private practitioners could potentially provide assistance.

Requirement That ALFs Seek CSB Assistance Is Problematic. One provision in the emergency regulations, 22 VAC 40-71-(4)-485-A, requires ALFs to seek emergency assistance from their CSB when a resident engages in high-risk behavior that results in a crisis situation. These regulations, which would be suspended under recent legislation passed by the General Assembly, further require ALF and CSB staff to consider adopting an intervention plan that describes the resident's problematic behavior and the prescribed response to this behavior. If the CSB does not provide requested emergency assistance, the ALF must document how it plans to meet the needs of the resident.

Requiring ALFs to seek emergency assistance from their CSB is problematic for two reasons. First, according to a JLARC survey of ALF administrators, 18 percent of facilities reported difficulty accessing mental health services from CSBs. These difficulties may stem in part from disagreements between ALF staff and CSB staff over what constitutes an emergency. For example, the administrator of a facility in Richmond that primarily serves residents with mental disabilities said that CSB staff often decline to provide requested assistance because they do not believe an incident is an emergency. Another administrator serving a similar population in the Tidewater region reported that the CSB intervenes only when the situation has become extreme.

To date, DSS has not taken adequate steps to address this problem. The department's guidance document on the new regulations clarifies for ALF administrators when they must seek emergency assistance from CSBs. However, the department cannot compel CSBs to provide assistance to ALFs. The *Code of Virginia* requires only that CSBs provide emergency assistance, and ALFs and CSBs often disagree on what constitutes an emergency. Further, DSS has not developed interagency agreements with DMHMRSAS or CSBs that might clarify this confusion. If the department wishes to

require that ALFs seek CSB assistance, it should pursue inter-agency agreements that define when and how CSBs will provide this assistance.

A second problem with this provision is that compliance will be difficult for ALFs that receive mental health services from private providers rather than a CSB. The department required facilities to seek CSB assistance because CSBs play a central role in providing emergency mental health services for Medicaid recipients, including temporary detention orders for individuals in need of immediate treatment. However, ALFs that contract with a private mental health service report having little or no relationship with their CSB. As a result, these facilities may not receive immediate assistance from the CSB.

There is no requirement in the *Code of Virginia* that ALFs receive services from only their CSB. Some facilities have contracted with private psychiatrists for Medicaid-funded services such as case management, medication oversight, and emergency assistance. Some of these contracts reflect dissatisfaction with the level of assistance being provided by the CSB. One ALF administrator said she began contracting with a private psychiatrist almost ten years ago because CSB staff were not responsive to calls for assistance.

ALFs' Ability to Contract With Mental Health Professionals May Be Hindered. As noted earlier, under certain circumstances ALFs are now required to arrange a mental health evaluation for current or prospective residents. The emergency regulations require that such evaluations be completed by a qualified mental health professional with training and experience in treating psychiatric conditions. The regulations also include a "conflict-of-interest" clause prohibiting qualified mental health professionals who do the evaluations from maintaining a financial interest in the ALF.

There is concern that this conflict-of-interest clause may prevent ALFs from contracting with mental health professionals to conduct resident evaluations. Some ALF administrators said the clause, in its current wording, appears to encompass independent contractors. DSS staff confirmed that the clause prohibits mental health professionals from doing the evaluations if they contract with ALFs to provide ongoing services. This may be problematic because some ALFs rely on mental health professionals to provide resident evaluations on a contract basis.

DSS should use the permanent regulations to accommodate facilities that contract with private mental health providers for resident evaluations. The conflict-of-interest clause was designed to ensure that mental health professionals conduct objective evaluations of individuals' mental health needs. While that objectivity can be

compromised when an evaluator owns or invests in a facility, not all independent contractors will have a substantial financial interest in an ALF. The department could relax the conflict-of-interest clause to permit evaluations by independent contractors who do not appear to have a substantial financial interest in a facility.

Requirement To Accompany Residents on Offsite Events May Be Unworkable. Provisions in the emergency regulations require at least one ALF staff to accompany residents on offsite activities sponsored by the facility or when a resident is being transported. DSS added these provisions to ensure that emergency assistance remains available when residents leave the facility.

There are indications that this provision may impose a substantial new responsibility on ALFs with auxiliary grant residents. Some ALF administrators voiced concern that direct care staff may be required to accompany residents on trips to and from the doctor. Many facilities rely on private contractors through the State Medicaid program for medical transportation. However, these contractors may not satisfy the first aid and CPR requirements contained in the emergency regulations. DSS staff indicated that, in these cases, ALFs may be responsible for accompanying the resident on medical trips.

ALFs May Have Difficulty Meeting Requirement That Residents' Prescriptions Include a Diagnosis. The new regulations include a requirement that ALFs ensure all physician orders for medications include the resident's diagnosis or condition. This requirement appears to include both prescription and over-the-counter medications. If a prescription does not list a formal diagnosis or medical condition, ALFs are responsible for contacting the doctor and obtaining one. Under this requirement, ALFs may be penalized when a doctor fails to provide a diagnosis or condition.

Although requiring a written diagnosis or condition may help reduce medication errors in ALFs, some facilities may have difficulty complying with the provision. One administrator with experience in clinical settings noted that doctors often omit diagnoses and conditions from written prescriptions and may be unresponsive to requests from ALFs that they be added.

Further, DSS does not have the statutory authority to require that physicians include formal diagnoses or conditions on written prescriptions. The Drug Control Act (*Code of Virginia* §54.1-3400 and following) gives the Board of Pharmacy authority to regulate the dispensing of prescription drugs in Virginia. In addition, neither the Drug Control Act nor the regulations and guidance documents issued by the board require formal diagnoses or conditions on prescriptions.

Controversial Provision of the Emergency Regulations Was Not Required by the 2005 Law

ALF administrators and industry advocates reported that DSS used the emergency regulatory process to bypass the Administrative Process Act requirements and develop a new staffing requirement not included in the 2005 legislation. This regulatory change repealed an exemption allowing overnight staff in ALFs housing 19 or fewer residents to sleep during their shift as long as they remained available to residents. Several administrators affected by this change told JLARC staff it will require additional nighttime staff and will increase their operating costs (the cost of services is discussed in Chapter 6). Some administrators said that these costs will force them to close their facility.

DSS may have been within its legal authority to repeal this provision, but the change was not explicitly required under the 2005 legislation. The department construed the term "appropriate" staff to encompass this requirement. By including a controversial and potentially costly new staffing requirement in its emergency regulations, the department has created the perception that it deliberately sought to avoid public input on the matter. While legislation passed by the General Assembly may temporarily restore the overnight exemption for small facilities, the department may choose to include the staffing requirement in its permanent regulations. In this case, the SBSS should receive public comment on the new requirement and consider any proposed revisions.

Assisted Living Facilities of Concern

In Summary

Quality of care is a key concern in assisted living, yet it is subjective and difficult to measure. No definition of quality care is found in the *Code of Virginia* or in DSS licensing standards. As proxies for quality of care, JLARC staff used measures of facilities' compliance with standards and verified complaints. Of the 588 licensed ALFs, 82 percent have no recent history of compliance problems and 64 percent have no recent verified complaints about care or services. A minority of ALFs (23 percent) do have compliance problems and/or an above-average number of verified complaints. These ALFs of concern tend to be larger and are more likely to have auxiliary grant residents. Future JLARC reports may monitor the performance of ALFs of concern to determine the effect of the new law and regulations.

The study mandate directs JLARC staff to report on "tangible improvements in the quality of care" resulting from the 2005 legislation, which was aimed at improving the quality of care in ALFs. The principal strategy for this study is to observe how key characteristics of ALFs change over several years as the new law and regulations take effect. This report describes the "baseline" of care in assisted living prior to the implementation of the emergency regulations. As provisions of the 2005 legislation take effect, subsequent reports will discuss the impact of the new regulations and licensing provisions.

Three keys to quality care were identified by analyzing ALFs with a recent history of verified complaints and compliance problems. The keys to quality include medication administration, staffing, and access to mental health resources. As the new law and regulations take effect, ALFs statewide and particularly ALFs of concern will be observed for changing patterns of verified complaints and violations of core health and safety standards. For subsequent reports, ALFs of concern will be monitored for changes as the new law and regulations take effect. For a more detailed explanation of study methodology, see Appendix B.

DEFINING QUALITY CARE IS SUBJECTIVE

No explicit definition of quality of care is found in the *Code of Virginia* or the *Virginia Administrative Code (VAC)*. The *Code of Virginia* states that the State Board of Social Services has "the authority to adopt and enforce regulations to...protect the health,

safety, welfare, and individual rights of residents...and to promote their highest level of functioning." The VAC defines minimum standards for ALFs with no clear definition of quality care. Consequently, licensing staff and ALF administrators offered various definitions of quality care:

- providing a safe setting with staff who care;
- using the five senses test including noise level, cleanliness of residents and ALF, meaningful interaction between staff and residents, good food, timely and correct medication administration, resident interaction with the community, and respect for individuality;
- observing clean, odor-free residents who have good food, comfortable rooms, activities, safety, and security;
- maintaining proper diet, activities, nursing, management, staff interaction with residents, housekeeping, maintenance and fulfilling residents' needs;
- meeting the residents' needs and having staff who show dignity and respect for all residents;
- providing for residents who are well taken care of, happy, and clean;
- offering good food, appropriate physical plant design, care for activities of daily living, and engaging activities; and
- ensuring the psychosocial well-being of residents including physical, mental, and emotional, and providing good food; having compassionate staff.

Licensing staff and administrators acknowledge that quality care is not always measurable, pointing, for example, to subjective factors such as "compassion," "happiness," and "good food." ALF licensure is contingent upon the facility's ability to meet and/or exceed the standards. And the role of licensing inspectors is to evaluate compliance with standards, not to apply subjective measures of quality.

Instead of subjective measures, JLARC staff used compliance with standards and verified complaints as indicators of quality care. Compliance with standards is monitored by the Department of Social Services Division of Licensing Programs (DOLP) through facility inspections. Any violation of standards is recorded in inspection reports. The frequency of licensing inspections is determined by the type of license. In the event of repeated non-compliance, DSS may use corrective measures such as an adverse enforcement action against the facility.

The type of license issued to a facility indicates its compliance with licensing standards. The license type dictates (1) the duration of the license, which may be, one, two, or three years; and (2) the frequency of mandated inspections. Regional licensing inspectors assign a license based on the ALF's compliance with standards at the time of renewal. In determining license type, inspectors consider the number and nature of violations, adverse enforcement actions, and the quality of the ALF's established policy and procedures. Licensing staff cautioned that the type of license alone does not necessarily indicate problems in a facility or reflect the quality of care provided by the facility. The five license types, frequency of mandated inspections, and the number of ALFs with each type of license in January 2006 are shown in Table 5.

JLARC staff also examined verified complaints against ALFs. Complaints can be reported by residents, family members, employees, visitors, or anyone else, and may be filed with any of at least three different offices: the Department of Social Services DOLP or Adult Protective Services (APS), or the Office of the State Long-Term Care Ombudsman. The respective agency then investigates the complaint and determines its validity.

Table 5: ALF Licenses Indicate Levels of Compliance and Inspections by DSS

License Type	Level of Compliance	Inspections Required	Number of ALFs	Percent of total
Provisional (6-month)	Temporarily unable to comply with licensing standards.	1 every other month	15	3%
1-year	Substantially complies with minimum standards. While there may be violation of one or more standards that pose little risk, compliance exists for nearly all standards.	3 per year	289	49
2-year	Complies on a sustained basis with minimum standards.	2 per year	171	29
3-year	Routinely exceeds basic care, programs, and services required by the minimum standards.	1 per year	93	16
Conditional (6-month)	Issued to new ALFs during the first six months of operation. Allows new ALFs to demonstrate compliance.	2 in 6 months	<u>18</u>	<u>3</u>
Totals			586 ¹	100%

¹License type not available for two facilities.

Source: JLARC staff analysis of licensing data and DSS Division of Licensing Programs standard operating procedures 202 and 301.

QUANTITATIVE DATA USED TO IDENTIFY ALFS OF CONCERN

Because the intent of the new law was to improve the quality of care and services in certain ALFs, JLARC staff reviewed licensing and complaint data. Of 588 licensed ALFs, JLARC staff identified 137 ALFs of concern, or 23 percent of ALFs statewide. The remaining 77 percent of licensed facilities have no reported compliance problems over the past two years, and a below-average number (four or fewer) of verified complaints over the past two years.

JLARC staff used data on verified complaints and licensing compliance to ensure objectivity in identifying ALFs with quality of care concerns (Table 6).

Most ALFs Had No Verified Complaints

In 2004 and 2005 there were 374 facilities, or 64 percent of all licensed facilities, that had no verified complaints from any of the three sources. For ALFs with complaints, the average number of verified complaints (using data from all three sources) was five. Twenty-six percent, or 153 facilities, had less than five verified complaints, and 10 percent, or 61 ALFs, had five or more verified complaints. These 61 facilities with an above-average number of verified complaints were considered "ALFs of concern." Nine facilities had more than 20 verified complaints in 2004 and 2005 combined.

Complaints concerning non-compliance with standards and abuse, neglect, or exploitation of resident, are made to the DSS licensing division. Licensing inspectors investigate complaints and determine their validity. For cases involving abuse or neglect, the inspector conducts a joint investigation with APS. There are 24 categories of licensing complaints including abuse and neglect, food and nutrition, medication, staffing, records, and physical plant.

APS investigates complaints of abuse, neglect, and exploitation of adults age 60 and older, and incapacitated adults age 18 and older, and provides services for persons in need. Each of the 120 local departments of social services receives complaints and conducts the investigations. A determination is made as to the validity of the complaint within 45 days.

The ombudsman program is a federally mandated program which responds to complaints made by individuals who may have no one to advocate on their behalf, and who receive long-term care services in facilities and the community. There are five complaint categories: resident rights, resident care, quality of life,

Table 6: ALFs of Concern Were Identified Using Two Types of Data

Verified Complaints	Description	Time Frame
DSS Division of Licensing Programs	Accusation that an ALF is not in compliance with standards or that adults are being abused, neglected, or exploited	Calendar Year 2005
DSS Adult Protective Services	Complaints of abuse, neglect, and exploitation	June-Dec. 2005
Office of the State Long-Term Care Ombudsman	Complaints made by or on behalf of individuals receiving long-term care services	FYs 2004, 2005

Licensing Compliance¹	Description	Time Frame
Provisional License	License issued to an ALF for six months when the facility is temporarily unable to comply with licensing standards	April 2004-Dec. 2005
Adverse Enforcement Action	A sanction against an ALF that violates regulations in ways that negatively impact the health, safety, or welfare of residents	Nov. 2003-Oct. 2005
Enforcement Watch	A monitoring tool used to identify and document monitoring activities and actions taken on an ALF that has failed to maintain substantial compliance with standards	Calendar Year 2005
High-Risk Health & Safety Standards	A subset of 90 licensing standards identified by JLARC staff as "high-risk" health and safety standards	Five inspections prior to Dec. 28, 2005

¹Licensing compliance data is from the DSS Division of Licensing Programs.

Source: DSS Division of Licensing Programs, DSS Adult Protective Services, and Office of the State Long-Term Care Ombudsman.

administration, and complaints not against facility. The 2005 JLARC report *Impact of an Aging Population on State Agencies* discusses the role of the ombudsman program in providing services to older Virginians.

The following three case studies illustrate typical complaints at three different facilities.

Case Studies

Residents complained to an inspector that they were being served small portions of food and not allowed to have seconds. Residents had discussed the situation with the administrator during resident council meetings, but nothing changed. When the inspector investigated, she discovered that at least one resident was not being served a special diet, as ordered by the doctor. A verified complaint resulted. Subsequent inspection reports indicate that residents continue to complain about the food.

* * *

An anonymous complaint alleged an unclean and odorous facility. The inspector discovered torn, dirty carpet throughout the facility and a foul odor in the hallways. A verified complaint resulted. The administrator directed staff to immediately clean to remove the foul odor and reported that the carpet would be replaced. Inspection reports from four months after the verified complaint indicate that the carpet had not yet been replaced.

* * *

The administrator of an ALF housing cognitively impaired residents self-reported a complaint of insufficient staffing that resulted in a resident wandering out of the facility. Two staff were providing care to more than 20 cognitively impaired residents. A third employee was late and another called in sick. A resident exited the facility unnoticed, was found one mile from the facility, and was returned by an off-duty staff person within the hour. The result was a verified complaint. The administrator agreed to retrain all staff on procedures for appropriate staff coverage.

Licensing Data Identified Facilities With a Recent History of Non-Compliance With Standards

JLARC staff examined each ALF's recent status using DOLP data that identifies non-compliant facilities:

- provisional license (discussed above),
- adverse enforcement actions,
- enforcement watch, or
- above average high-risk health and safety violations.

Eighteen percent, or 105 ALFs, were found non-compliant by at least one of these methods, and is considered an ALF of concern. The remaining 82 percent of ALFs statewide do not have a recent history of compliance problems.

An adverse enforcement action is a sanction imposed on an ALF by DSS for serious or repeated violations of standards. DSS management personnel review requests for adverse enforcement actions from the regional licensing offices, and make a determination about imposition. Adverse actions include license revocation, denial of licensure application, probation (intermediate sanction for substantial non-compliance), reduction of capacity, prohibition on

new admissions, mandated training, a civil penalty, and termination of public funding.

Enforcement watch is a monitoring tool used by the licensing division to identify and monitor facilities that have failed to maintain substantial compliance with licensing standards. According to a department procedure issued in March 2006, facilities on enforcement watch are monitored through increased licensing inspections for six to 12 months. Licensing staff meet monthly to discuss the ALF's progress.

A report developed by the licensing division identified 529 licensing standards and statutes from the *Code of Virginia* pertaining to the health and safety of ALF residents. Each facility's violations over the five most recent inspections conducted prior to the implementation of the emergency regulations are included in the report. To identify the ALFs with serious concerns, JLARC staff selected the 90 highest risk standards and *Code* sections to analyze. The report identified 522 ALFs with one or more violations of the high-risk health and safety standards. High-risk standards selected were those most critical to residents' health and safety including resident care, staffing, medications, food and nutrition, building and fire safety, and resident rights.

137 ALFs Have a Recent History of Complaints or Compliance Problems

JLARC staff identified 137 ALFs with a recent history of verified complaints or compliance problems using the data sources displayed in Table 6. No one indicator had more weight in identifying ALFs of concern. Instead, ALFs of concern had one or more of the following indicators during 2003-2005, as detailed in Table 7:

- a provisional license, an adverse enforcement action, or placement by DSS on its enforcement watch list,
- seven or more violations of the 90 highest-risk health and safety violations across the most recent five inspections (seven is two standard deviations above the average number of such violations), or
- an above-average number (five or more) of total verified complaints across all three sources.

To enhance the data analysis, JLARC staff used additional methods to collect information on ALFs including site visits to 29 facilities. Eleven ALFs were visited preliminarily to familiarize JLARC staff with assisted living generally. An additional 18 ALFs of concern were chosen for site visits based in part on geographical rep-

Table 7: Criteria for Identification of ALFs of Concern

Indicator	Standard for Inclusion¹	Number of ALFs Identified	Percent of all ALFs
Total Verified Complaints	5 or more	61	10%
Provisional License	1	39	7
Adverse Enforcement Action	1	40	7
Enforcement Watch	1	49 ²	8
Violation of High-Risk Health & Safety Standards	7 or more	29	5

¹Time frames are shown in Table 6.

²In 2005, 57 ALFs were on enforcement watch; 8 of those ALFs were closed by January 2006.

Source: JLARC staff analysis of data from DSS Division of Licensing Programs, DSS Adult Protective Services, and Office of the State Long-Term Care Ombudsman.

resentation. During these visits, JLARC staff interviewed the administrator and licensing inspector, and toured each facility.

Use of Quantitative Data to Assess Quality of Care Has Limitations

Using complaints and compliance data as indicators of quality of care presents study limitations. Because quality of care cannot be measured directly, ALFs that provide poor quality care but have a good compliance record and few complaints may not be identified as of concern. On the other hand, ALFs that are so identified may provide quality care but also may have experienced a one-time problem due to, for example, disgruntled employees who were subsequently dismissed (as JLARC staff confirmed in one case).

Data sources used by JLARC staff in this analysis may also have one or more of the following limitations:

- Residents, especially auxiliary grant residents, may not have advocates or family members to file a complaint. As a result, the number of verified complaints for ALFs housing primarily auxiliary grant residents may be lower.
- Residents may fear retribution and may not report incidents to authorities. The Virginia Office for Protection and Advocacy (VOPA) noted cases where ALF staff threatened residents with removal from the facility for reporting problems. Certain ALFs may have fewer or no verified complaints if retribution occurs.
- Errors exist in licensing caseload data. In some cases, the license type is incorrect in the database. For example, licensing staff told JLARC staff about ALFs on a provisional license that were not identified as such in caseload data. Other

facilities on a provisional license may not have been correctly identified. According to DOLP data management personnel, these are data entry errors by regional licensing inspectors.

- The APS complaint database is incomplete and covers only six months, from June to December 2005. The database was made available to all APS personnel statewide in October 2005. Many APS staff apparently fail to enter the name of the ALF in which the incident occurred. State data personnel indicated that the APS staff require additional training on using the database.
- Occasional or isolated incidents may occur in ALFs that generally have no complaints or compliance issues. In these cases, DSS licensing inspectors indicate that higher quality ALFs respond quickly and appropriately by notifying officials, including police, licensing staff, and family members, and by dismissing negligent staff.
- ALFs with previous complaints or compliance concerns may improve due to a new administrator, technical assistance from licensing staff, or other factors. For example, ALFs on enforcement watch receive additional visits and technical assistance from licensing staff, which may improve compliance with standards.

This method of identifying non-compliant ALFs also assumes no systemic bias in the inspection process. Anecdotal evidence, however, suggests that some licensing inspectors may regulate ALFs that house primarily auxiliary grant residents differently and be either more or less strict with these facilities. However, DSS management personnel state that when there are serious compliance issues with an ALF, they consider adverse enforcement actions equally for auxiliary grant and private pay facilities.

CHARACTERISTICS OF ALFS OF CONCERN

After identifying ALFs with verified complaints and compliance problems, JLARC staff looked for common characteristics among these ALFs. Problems with medication administration and staffing were found frequently in ALFs of concern. The size of the ALF and location may also be factors among ALFs of concern. The pay status (auxiliary grant or private pay) and the age of the physical facility itself do not appear to be characteristic of ALFs of concern.

Problems With Medication Administration and Staffing

Important assistance provided by assisted living facilities involves medication administration and help with the activities of daily life, help provided by the facility's employees. Several sources of data

show that most ALFs do not have problems meeting standards in these areas, although ALFs of concern are more likely to have trouble with these functions.

Medication issues are the most frequent source of verified complaints in all ALFs, followed by issues of staff quality and training (Table 8). A review of enforcement watch also flagged medication and staffing as topping the list of most frequently violated standards. Analysis of health and safety violations identified as "high-risk" also reveals medication administration as a serious concern in certain facilities.

Table 8: Most Frequent Verified Licensing Complaints in 2005

Complaint Area	Verified Complaints	
	Number	Percent
Medication/Medical Issues	86	22%
Staff Quality/Training	50	13
Records	38	10
Supervision (of Residents)	29	7
Physical Plant	28	7
Structured Program	28	7
Physical Abuse/Neglect	23	6
Admission/Discharge	20	5
Other	95	24
Total	397	100%¹

¹ Numbers do not total to 100 due to rounding.

Source: JLARC staff analysis of 2005 licensing complaints from DSS Division of Licensing Programs.

In 2005, 57 facilities were on enforcement watch for failure to maintain substantial compliance with standards in one or more areas. Medication violations occurred in 21 of these ALFs, and staffing violations were noted in 20. Along with physical plant violations, these problems are of particular concern to licensing staff because they tend to be recurring violations.

Size, Location, and Staff Turnover Are Factors in ALFs of Concern

ALFs with a range of bed capacities are identified as having a recent history of verified complaints or compliance problems, although larger ALFs (those with 20 or more residents) may be more likely to have complaints or compliance problems. Large facilities constitute 69 percent of all ALFs; however, they make up 77 percent of ALFs of concern. Smaller ALFs represent 31 percent of ALFs in Virginia, and only 23 percent of ALFs of concern.

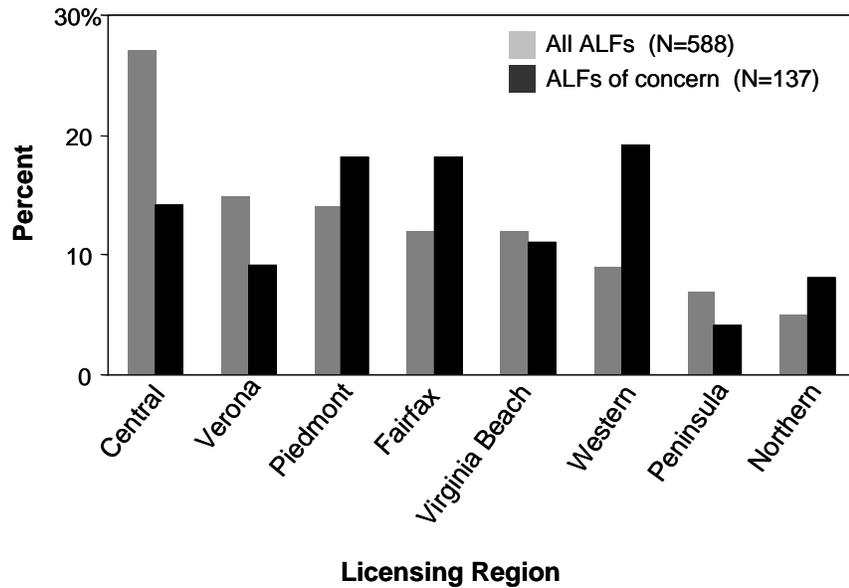
ALFs of concern are found in all regions across the State. ALFs of concern are found disproportionately greater in four regions (Piedmont, Fairfax, Western, and Northern), and disproportionately fewer in the other four regions compared to the overall statewide distribution (Figure 4). The western region has nine percent of ALFs and 19 percent of ALFs of concern. Conversely, the central region has 27 percent of ALFs and 14 percent of ALFs of concern.

Staff turnover is higher in ALFs of concern. According to responses from administrators in the JLARC survey, on average 29 percent of the direct-care staff had been hired in the last six months in ALFs of concern. For all ALFs, the comparable turnover figure was 20 percent. Facilities may have more difficulty with compliance and complaints in part because they also have newer staff with less training and experience.

Pay Status Is Not a Factor in ALFs of Concern

ALFs of concern serve both private pay and auxiliary grant residents; pay status does not appear to be a factor in ALFs of concern. JLARC staff estimated that 27 percent of ALFs statewide house primarily auxiliary grant residents, and 29 percent of ALFs of concern house primarily auxiliary grant residents. For example, one ALF on enforcement watch for medication violations houses more

Figure 4: ALFs of Concern Are Located Throughout the State



Source: JLARC staff analysis of data from DSS Division of Licensing Programs, DSS Adult Protective Services, and Office of the State Long-Term Care Ombudsman.

than 50 private pay residents, charging approximately \$2,000 per resident per month. Another ALF on enforcement watch for medication violations in the same licensing region houses 20 auxiliary grant residents at the current grant rate of \$982 per month.

Age of Building Is Less Important Than Administrator's Initiative

No data exists to show the age or type of buildings used as ALFs. During site visits, however, JLARC staff observed that the age of the physical structure does not indicate the likelihood of compliance problems. Of the 18 site visits, those housed in older buildings had only slightly greater numbers of physical plant violations. The administrator's initiative and willingness to correct violations appears to be a more relevant factor, as illustrated by these examples:

Case Studies

A facility built as an ALF in the late 1980s has ongoing physical plant concerns such as rusty vents and light fixtures, broken floor tiles and furniture, dirty tubs and toilets, broken lamps and light covers, and a missing kitchen cabinet door. Inspection reports frequently note repeat violations because, the report says, the administrator has not fixed problems, in one case for five months.

* * *

An ALF that was originally a motel in the 1960s had violations such as dirty showers, loose electrical wires, broken furniture, a rotting wood door frame, and trash in the yard. The inspector cited ongoing physical plant concerns. However, the inspector noted that a new administrator is more responsive to correcting problems, and the physical plant is improving.

* * *

A corporate facility built within the last few years had physical plant violations such as urine stained sheets in one resident room, cracked floor tiles, stained ceiling, a leak in the kitchen ceiling, damage to walls and door jams with chips and missing paint, brown stains on the carpet, and fruit flies throughout the facility. The administrator wrote a plan of action to clean, paint, and correct the violations. During a subsequent inspection two months later, licensing personnel observed that the violations had been corrected, except for stained ceiling tiles in the hallway and cracks in the kitchen floor tiles.

Medication Management and Staffing Problems

In Summary

Effective medication administration and adequate staffing are key factors in quality care in assisted living. Medication administration topped the list of both verified complaints and health and safety violations in ALFs in 2005. Prior JLARC reports identified medication administration as a concern, and it remains a problem for the ALFs of concern. The new law addresses problems with medication administration by requiring the registration of medication aides. However, the impact of these regulations will not necessarily be seen until enforcement begins in July 2008. Staffing problems are also prevalent, particularly in ALFs of concern. Staffing problems include the recruitment and retention of quality staff, the number of on-duty staff, and staff training. Recruitment and retention appear to be statewide problems, while the number of on-duty staff and staff training are primarily problems for the ALFs of concern. Increased training hours and first aid and CPR training for more staff were included in the emergency regulations.

Through analysis of ALFs with a recent history of verified complaints and compliance problems, JLARC staff identified medication administration and staffing as key factors in quality care in assisted living. JLARC reports on assisted living in 1979, 1990, and 1998 also identified both medication administration and staffing as problematic. The reports included recommendations to address these concerns. While some of the recommendations have been implemented, problems in these areas remain.

Medication administration or staffing appear to be problematic primarily in ALFs of concern, 23 percent of ALFs statewide. Observed medication problems primarily involve failure to follow physicians' prescriptions and orders for administration, inadequate documentation, and inadequate staff training in medication administration. The 2005 legislation addressed medication concerns by requiring training, testing, and registration of medication aides.

Problems with staffing include recruitment and retention, the quantity of on-duty staff, and staff training. Staffing problems are exacerbated by low wages and difficult working conditions. The emergency regulations partially addressed staffing issues by increasing direct-care staff training hours, increasing CPR and first aid training requirements, and requiring that ALF administrators be licensed.

MEDICATION ADMINISTRATION REMAINS A QUALITY OF CARE CONCERN

Medication administration in ALFs has frequently been cited as problematic. Deficiencies in medication administration were noted in the 1979 JLARC report *Homes for Adults in Virginia*, which recommended documentation and staff training in medication administration. The 1990 report *Follow-up Review of Homes for Adults in Virginia* found that few of the recommendations from 1979 with regard to medication administration had been implemented. JLARC staff again recommended documentation of medication administration and staff training.

The 1998 report *Services for Mentally Disabled Residents of Adult Care Residences* noted that a medication training program had been implemented by the Board of Nursing. However, in many cases, JLARC staff found ALFs with only one employee certified to administer medications and recommended that regulations provide for more than one staff person to be trained. The report also noted problems including staff with a lack of basic knowledge about medication management, improper medication administration, failure to follow protocol for certain medications, and inadequate documentation of medication administration.

While 77 percent of ALFs have no recent history of medication concerns, medication administration continues to be a frequent complaint and compliance issue for ALFs of concern. Of all verified licensing complaints, medication and medical issues were the most prevalent, comprising 22 percent of all complaints in 2005 (Table 8). Of the 57 ALFs on enforcement watch in 2005, 21 had repeated medication violations.

Observed medication violations primarily involve failure to follow physicians' prescriptions and orders for administration, inadequate documentation, and inadequate staff training in medication administration. Eight of the ten most frequently cited high-risk health and safety violations were related to medication administration in 2005 (Table 9). These ten represent 51 percent of the 4,971 critical health and safety violations across all ALFs most recent five inspections prior to the implementation of the emergency regulations.

Table 9: Medication Standards Are the Most Frequently Violated Critical Standards

Description of Standard	Number of Violations
Medication, diet, medical procedure or treatment should not be started, changed or discontinued without a physician's order.	372
Medications shall be administered according to doctor's instructions.	342
Date, time given, and staff initials shall document medication administration.	300
For each employee there shall be an original criminal background check.	270
Name and initials of all staff administering medications shall be documented.	268
Medication errors or omissions shall be documented.	264
A complete first aid kit shall be on hand.	261
A resident may store medications in his/her room if the uniform assessment instrument indicates that he/she is capable of self-administration.	166
Staff who administer medications shall complete an approved medication training program.	153
Portion of the ALF subject to health department inspections shall comply with those regulations.	141

Source: JLARC analysis of DSS Division of Licensing Programs health and safety records.

The following examples illustrate medication administration in ALFs of concern which resulted in adverse enforcement actions by the licensing division:

Case Studies

A regional licensing inspector's review of resident records revealed that a resident had been discharged from the hospital after being treated for deep vein thrombosis (a blood clot in her leg). According to the records, ALF staff failed to administer Coumadin (a blood thinner) for two days after her release from the hospital. In addition, ALF staff applied Silvadene to her wound, although the physician did not prescribe this medication. The medications were corrected the following day and the administrator said that the med techs would receive refresher training within the next 6 months.

* * *

A licensing inspector conducted a complaint investigation regarding medication administration. Records indicated that medication aides had been administering a resident's prescription eye drops to treat glaucoma. However, the phar-

macy confirmed that the prescription had not been filled for 13 months. The medication's manufacturer confirmed that one bottle contains a 30- to 40-day supply of eye drops. The licensing inspector determined that the resident had not received the prescription for nine months and the medication administration records had been falsified. The result was a rise in intraocular pressure (which eventually causes blindness), as measured by the resident's eye doctor. The facility was fined \$500.

* * *

During an inspection, a regional licensing inspector found that ALF staff did not administer prescribed medications to 27 residents for up to one month. Documentation stated that medications were "out," and the physician was not contacted regarding missed medications. The licensing inspector also observed a staff member toss a resident's medications in a trash can when the resident refused the medications. The same staff member informed a resident that she was planning to throw away the evening medications because the resident would be at a doctor's appointment. The facility was placed on probation and fined \$500. Several months later the licensing inspector found that staff did not administer prescribed medications to at least 21 residents for two or more days. Several of the residents were insulin-dependent and required daily monitoring. There was no documentation indicating that the insulin levels were monitored or the insulin administered. The licensing division sent a license revocation letter on November 18, 2004; however, this facility is still in operation.

The fact that many assisted living residents take multiple medications daily underscores both the importance of accurate medication administration and the complexity of ensuring proper medication is consistently administered. One-quarter of auxiliary grant residents take nine or more medications a day. Some medications may be administered three times daily, during meals; others may be administered once or twice a day. The need to appropriately manage these complex schedules for an average-sized facility of 56 residents, for example, underscores the increasing importance of medication administration in ALFs.

Registration of Medication Aides Aims To Improve Medication Administration

The new law includes three provisions aimed at improving medication administration in ALFs: the registration of medication aides, development of medication management plans, and increasing

medication review requirements. During JLARC staff's site visits, most ALF administrators agreed that registration of medication aides along with additional required training is a good idea and may improve the quality of care. Medication aides will now be held accountable for following administration guidelines. In addition, ALFs will be able to help verify whether medication aides are registered with the Board of Nursing.

ALF STAFFING REMAINS A QUALITY OF CARE CONCERN

Typical staffing in ALFs consists of an administrator and direct-care staff. The administrator is the licensee or individual designated by the licensee who oversees the day-to-day operations of the facility, including compliance with all ALF regulations. Direct-care staff include supervisors, assistants, aides, or others who assist residents in their daily living activities. According to the ALF administrator survey, the average number of direct-care staff is 20. Depending on the size of the facility, an ALF may also employ a cook, an activities director, and other support personnel.

Staffing is fundamental to quality care and a problem in the ALFs of concern. Licensing staff, ALF administrators, and other professionals consistently cite staffing as problematic. In addition, licensing complaints and compliance data indicate that ALFs of concern have problems with staffing. Staffing concerns include

- the recruitment and retention of qualified direct-care staff,
- maintaining a sufficient number of staff to meet residents' needs,
- ensuring adequate staff training, and
- supervision of staff.

Recruitment and Retention of Quality Staff Is a Challenge

The recruitment and retention of quality staff is a serious problem in assisted living. According to national research, it is a long-standing problem in long-term care for several years with providers nationwide reporting vacancies and high turnover rates for nurses and direct-care staff. Low wages, lack of health insurance and other benefits, and difficult working conditions contribute to these issues. Similar conditions have been identified in Virginia.

Difficulties in recruiting and retaining quality staff may lead to problems in ALFs. The second most frequent verified licensing complaint in 2005 was staff quality and training. Furthermore, there were 23 verified cases of resident abuse or neglect by ALF staff in 2005 (Table 8).

Recruiting qualified staff is a challenge for administrators of ALFs statewide and in ALFs of concern. During site visits to ALFs of concern, nearly half of the 18 administrators interviewed said that finding qualified direct-care staff is a problem. Licensing staff and resident advocates confirm a problem as well. The administrator of one private pay ALF with a three-year license and licensed capacity of almost 500 residents indicated it is constantly trading qualified staff with similarly sized facilities.

The retention of qualified staff is challenging as well, and turnover rates are high. According to the JLARC survey of ALF administrators, the average number of direct-care staff is 20 and an average of four of those staff were hired in the last six months. This is a turnover rate of 40 percent for one year. One administrator noted an extremely high rate of 93 percent in the previous year: 25 of the 27 staff were newly hired.

Administrators note the negative impact of poor staff retention on residents. Residents come to depend on particular staff and build relationships. High staff turnover negatively impacts these relationships. Training costs also increase with increased numbers of staff needing initial training hours, which are greater than annual refresher training hours.

Other factors including low wages, difficult working conditions, and employees who have limited English language skills contribute to problems with recruitment and retention of staff in ALFs. Low wages are an obstacle to hiring and maintaining quality staff. In ALFs of concern, the typical starting salary for direct-care staff varied by region and facility, but ranges from \$5.15 to \$10.00 per hour. ALFs often compete for direct-care staff with other low-wage employers such as fast food restaurants and national retail stores, according to administrators. Difficult working conditions further exacerbate the problem because employees may prefer an "easier" job for the same pay.

Concerns about low wages for direct-care staff may be greater in certain regions of the State. Administrators and licensing staff in the Fairfax region consistently noted that direct-care staff work full-time at two ALFs, due to the high cost of living. In Fairfax, one national retailer starts employees at \$12 an hour, several dollars more than area ALFs, which start direct-care staff at \$8-\$10 an hour.

Difficulties with employees who have limited English language skills is an increasing problem, particularly in the Fairfax region. Licensing staff and administrators note that an increasing immigrant workforce has resulted in many direct-care staff who are non-native English speakers. The language barrier creates a prob-

lem with certain populations, particularly the cognitively impaired, for whom clear and understandable speech is a priority. Although immigrant staff may have relevant education and training, difficulties with language skills may still result in miscommunications regarding medications or other health and safety issues.

Difficult working conditions also contribute to recruitment problems and high staff turnover. Administrators, licensing staff, and resident advocates noted that the work in ALFs is often difficult and physically demanding. Particularly when other low-wage jobs are less demanding, the nature of the work may lead to recruitment and retention problems. One administrator noted that once the staff realize the nature of the work, they often leave the facility to work at retail stores and earn comparable wages.

Neither current standards nor the emergency regulations specify minimum educational or experiential requirements for direct-care staff. Standards require that direct-care staff be 18 years or older, pass the State criminal background check, be of good character, and be able to read, write, and speak English. Direct-care staff at the assisted living level of care are required to complete at minimum a 40-hour training.

ALFs are not required to employ licensed health care professionals. However, in the JLARC survey, administrators reported having three to 13 certified nurse aides (CNAs) on staff. ALFs of concern appear to employ fewer CNAs on average. Education and experience levels of direct-care staff may relate to the incidence of verified complaints and compliance problems.

Some ALFs Continue To Have Inadequate Numbers of Staff on Duty

DSS has not implemented staffing guidelines or ratios although these were recommended in the 1990 and 1998 JLARC reports. Only ALFs with cognitively impaired residents are required to have a minimum of two direct-care staff during all shifts, regardless of the number of residents. The proposed regulations include a requirement that each ALF have a "mechanism for demonstrating how staffing is determined."

Current standards require ALFs to have adequate staff to maintain the physical, mental, and psychosocial well-being of residents. Licensing staff determine adequate staffing based on a standard which requires "sufficient staff...to implement the approved fire plan." Consequently, an ALF may meet the standard yet provide inadequate service to residents.

Licensing inspectors cite cases where, in their opinion, the staffing level required to implement the fire plan is inadequate to provide quality care. Standards provide no basis for requiring an ALF to increase staffing. One inspector described an ALF in which one direct-care staff member covered three floors with 60 residents. The inspector felt this level of staffing was inadequate yet also believed the standards were vague enough to permit it.

Licensing staff and complaints data indicate that some ALFs of concern have inadequate staffing levels. Verified complaints related to staff supervision of residents was the fourth most frequent verified complaint in 2005. Licensing staff indicate that insufficient supervision is generally related to the lack of enough staff for the number of residents. For example, of the 57 facilities on enforcement watch in 2005, 20 were on watch for repeated staffing problems, including inadequate staff supervision and inadequate numbers of staff.

Insufficient staffing may also be a problem when an employee is sick or does not show up for work. In these case studies, the facilities faced adverse enforcement actions as a consequence of staffing problems:

Case Studies

Local emergency services personnel responded to a call from an ALF licensed for more than 100 residents. When fire and rescue personnel arrived, they were unable to locate staff on the first or second floors. They discovered two residents in distress, one having fallen out of bed and unable to get up. When the single direct-care staff on duty was located, he admitted to having been asleep, a violation of standards. A second staff member had not shown up for work, creating a staffing shortage.

*** * ***

A facility serving nearly 40 cognitively impaired residents had two staff on duty, and a third employee absent when a resident was discovered missing. One-and-a-half hours later facility staff called emergency personnel. The resident was found by the local search-and-rescue team, taken to the hospital, and treated for a large bruise on the head and hypothermia. Licensing records cite insufficient staffing to care for the number of cognitively impaired residents housed by the facility.

Staff Training and Training Costs Are a Concern

Staff training is a key to quality care and is a compliance problem in some ALFs of concern. During site visits, ALF administrators and licensing staff cited training for direct-care employees as fundamental to providing quality care to residents. In 2005, staff quality and training was the second most frequent verified licensing complaint (13 percent of complaints). In addition, the 2005 General Assembly recognized the need for additional staff training when it required the SBSS to adopt regulations on direct-care staff qualifications and training.

The emergency regulations increased the annual training hours, the number of first aid and CPR certified staff, and shortened the time frame for completion of training. Hours for direct-care staff at the assisted living level of care increased from 12 to 16 hours. The regulations added the requirement that each direct-care staff be certified in first aid and CPR, instead of one staff per shift. Finally, the training for new staff must be completed within two months instead of four.

Licensing standards define training requirements for direct-care staff. Initial training for direct-care staff in facilities that provide residential care only requires general knowledge of aged, infirm, or disabled adults and of overall facility policy and procedures. Eight hours of refresher training is also required annually.

Training hours for direct-care staff in assisted living level facilities are more substantial. Initially, direct-care staff are required to complete an approved educational curriculum for nursing or geriatric assistants, home health, or personal care aide programs or the 40-hour direct-care staff training, approved by the DSS licensing division. Further training requirements are for 16 hours annually, which should focus on the population in care.

ALFs meet training requirements for direct-care staff in a variety of ways. ALFs may have trainers on staff and utilize training provided by regional DSS licensing staff. ALFs sometimes use local churches, pharmacies, or other ALF-sponsored training.

The quality of some training may be questionable. Licensing inspectors in two regions questioned the standards and the effectiveness of selected staff training. DSS provides guidance for determining which training is creditable, and a variety of activities appear to qualify as training. Some examples noted by JLARC staff would seem to be of marginal value. For example, one ALF invited a doctor to speak informally to staff over lunch. Some employees left to attend to residents' needs and heard perhaps five minutes of the discussion, according to an inspector. Another ad-

administrator gave direct-care staff a self-study manual to read and let them take chapter tests.

With the increased training requirements, administrators are concerned about the financial impact. In response to a survey question regarding additional costs stemming from the new regulations, training (including CPR and first aid) was the most frequently mentioned concern among ALF administrators. More than half of the administrators interviewed during site visits mentioned the cost of increased training hours as a concern.

Administrators Are Responsible for Staffing the Facility

The administrator is the licensee or individual designated by the licensee who oversees the day-to-day operations of the facility, including compliance with all regulations. The 1990 JLARC report *Follow-up Review of Homes for Adults in Virginia* recommended strengthening educational and experiential standards for administrators and requiring additional administrator training for care of special populations.

Current licensing standards for ALF administrators require a high school diploma or GED, two years of post-secondary education in a related field, and one year of experience caring for adults with mental or physical impairments, as appropriate for the population in care. Administrators employed before February 1996 need not fulfill the post-secondary education requirement.

The 2005 legislation requires licensure of ALF administrators. DSS and Department of Health Professions personnel noted that licensure may have a significant impact on current administrators and that the intention was to ensure a higher level of competency.

Based on the ALF administrator survey, the average education level of administrators appears to be similar between ALFs statewide and those with a recent history of verified complaints and compliance problems. Unrelated to ALFs of concern, however, there is a negative correlation between the administrator's education level and the number of auxiliary grant residents in the facility. Facilities that house primarily auxiliary grant residents tend to have administrators with less formal education, and ALFs with mostly private pay residents tend to have administrators with higher levels of education.

There appear to be some problems related to administrators' responsibilities in ALFs. Among the most frequent verified complaints are record-keeping (38), physical plant (28), and admission/discharge (20). These areas are among the primary responsibilities of the administrator.

Limited Access to Assisted Living Services

In Summary

Access to assisted living services in Virginia is problematic primarily for the State's auxiliary grant residents. While private pay residents may face waiting lists to get into the facility of their choice, auxiliary grant residents can experience difficulty finding open ALF beds in their community. Access to mental health services has improved in recent years although some auxiliary grant residents with mental disabilities experience ongoing problems accessing needed mental health services, either from the local community services board (CSB) or from their ALF. Limited access to auxiliary grant beds and mental health services could weaken the impact of key provisions in the 2005 legislation. Shortages of auxiliary grant beds in some areas may inhibit DSS from adequately enforcing State regulations and improving the quality of care in marginal ALFs. Similarly, problems with ALF staff and CSB services may limit the impact of new mental health regulations.

The study mandate directed JLARC to address residents' access to assisted living providers and services, including mental health and other Medicaid-funded services for ALF residents receiving the auxiliary grant. This report provides a description of the current availability of ALF beds and services in Virginia. Future reports may evaluate the impact of the new law and regulations on access to assisted living care.

Assisted living is a critical source of long-term care in Virginia. Access to assisted living services includes access to vacant beds for prospective residents and access to mental health services for residents with mental disabilities. A shortage of available beds in a locality may force individuals in need of assisted living care to remain in inadequate care settings or move to a different part of the State where beds are available. Similarly, lack of access to mental health services can prevent ALF residents from functioning at their highest level and may lead to acute psychiatric episodes that include harm to self or others.

Access to assisted living services appears to be a problem primarily for the State's auxiliary grant recipients. There are no indications that individuals with the financial resources to purchase long-term care face significant barriers to assisted living care. Although there are waiting lists for private-pay residents, these waiting lists may reflect strong demand for popular facilities. Generally, the market appears responsive to increases in demand for private as-

sisted living services, with corporate owners from the hotel and real estate industries expanding into assisted living.

ACCESS TO AUXILIARY GRANT BEDS IS LIMITED IN SOME PARTS OF VIRGINIA

The State's auxiliary grant program is an important source of housing for low-income people with disabilities who need moderate assistance with their activities of daily living but cannot afford private assisted living care. These individuals rely on auxiliary grant funds to access long-term care services outside a nursing home setting. Elderly recipients of the auxiliary grant often enter an ALF when they can no longer care for themselves and may remain in a facility until they require nursing home care or they pass away.

Auxiliary grant funding also provides housing for individuals with mental health or mental retardation diagnoses. As noted in the 1998 JLARC report *Services for Mentally Disabled Residents of Adult Care Residences*, assisted living has emerged as a significant, though unplanned, component of the State's mental health care system. Virginia has made a concerted effort in recent decades to move individuals with mental disabilities out of State-run hospitals and into the community. According to DMHMRSAS staff, approximately eight percent of persons discharged from State-run hospitals annually are placed directly in ALFs. More than 4,300 of these discharges have occurred since 1996 (Table 10). Other ALF residents may have bypassed State-run hospitals altogether, moving directly to a community-based setting from the home.

Both low-income seniors and low-income individuals with mental health or mental retardation issues can experience problems accessing assisted living services through the auxiliary grant program. Auxiliary grant recipients may have trouble finding ALFs in their community that accept public-pay residents. In addition, ALF residents with mental disabilities may have difficulty receiving the services they need to manage their condition.

Certain Regions Lack Needed ALF Beds for Auxiliary Grant Recipients

Data is not available as to which ALFs accept auxiliary grant recipients, but there are indications that the State lacks an adequate number of auxiliary grant beds to meet the current demand for publicly financed assisted living care. Approximately 26 localities have no ALF beds, and seven other localities have less than one

Table 10: More Than 4,300 Individuals Have Been Discharged From State Hospitals to ALFs Since 1996

Fiscal Year	Persons Discharged to ALFs
1996	508
1997	507
1998	457
1999	414
2000	424
2001	307
2002	387
2003	484
2004	467
2005	437
Total	4,392

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

bed per 1,000 persons more than 18 years of age. (Statewide maps of licensed ALF beds are provided in Chapter 1.) The number of auxiliary grant recipients fell ten percent from FY 1997 to FY 2005, from approximately 6,950 beds to 6,250. Auxiliary grant beds as a percentage of total licensed capacity fell over the same period from 25 to 19 percent.

Results from the JLARC survey suggest that the shortage of auxiliary grant beds is a common problem for CSB case managers. Thirty-nine percent of the 360 responding case managers report experiencing problems finding open ALF beds for their auxiliary grant clients. A higher percentage—49 percent—report difficulty finding an ALF that can meet the specific care needs of their clients.

The shortage of auxiliary grant beds may be most pronounced in certain areas of the State. Based on survey results, case managers who experience ongoing problems placing auxiliary grant clients were clustered in Northern Virginia, Eastern (Tidewater) Virginia, and Central Virginia.

Comments from ALF administrators and DSS staff also suggest that auxiliary grant beds are limited in these regions. Licensing inspectors from all three regions expressed concern that publicly financed assisted living care is scarce in these regions. In addition, ALF administrators in other parts of the State said that they serve auxiliary grant residents originally from these regions.

It also appears that ALFs with high concentrations of auxiliary grant recipients have higher occupancy rates than ALFs with relatively few auxiliary grant residents. According to the JLARC sur-

vey of ALF administrators, facilities in which more than 75 percent of residents receive auxiliary grant funding have a median occupancy rate of 93 percent. Twenty-nine percent of these facilities—or 25 ALFs—are at full capacity. By contrast, facilities in which less than 25 percent of the residents receive the auxiliary grant have a median occupancy rate of 80 percent. Figure 5 compares these occupancy rates to the statewide median occupancy rate of 84 percent.

One result of local shortages of auxiliary grant beds is that some low-income individuals in need of assisted living may relocate to a different region of the State to find available beds. Unlike private-pay individuals, who often can plan for assisted living care in advance and access alternative services when necessary, housing needs for auxiliary grant recipients are generally more immediate. As a result, CSB case managers may be forced to place their clients in ALFs in a different region of the State. This can pose significant problems for individuals with ties to their community.

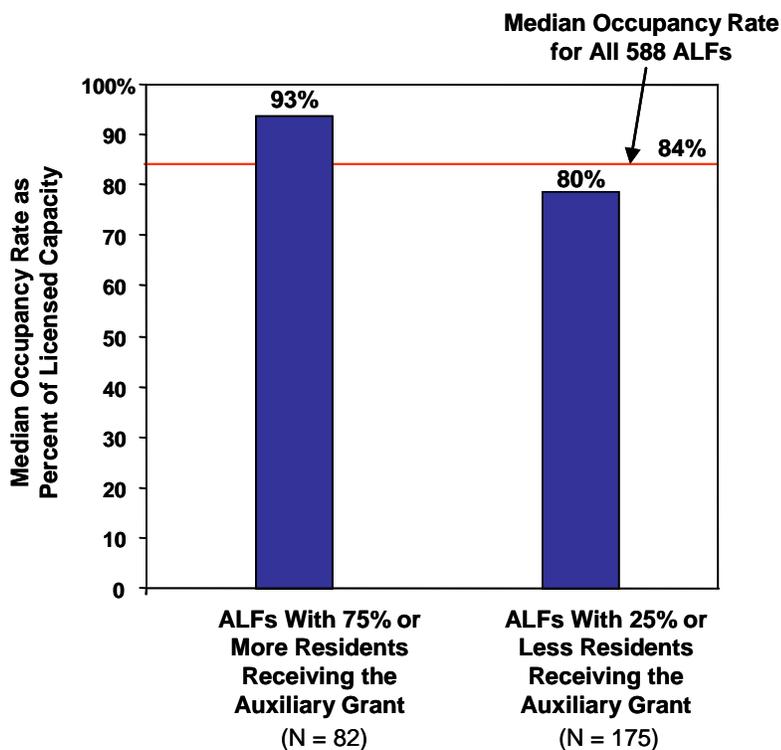
Current Shortage of Auxiliary Grant Beds Could Weaken the Impact of the 2005 Legislation

The current shortage of auxiliary grant beds could weaken the impact of provisions in the new law aimed at improving quality. For example, a lack of beds for auxiliary grant recipients may inhibit DSS from taking adverse enforcement measures with facilities that serve public-pay residents. As a result, DSS may be forced to tolerate marginal ALFs in order to maintain access to auxiliary grant beds.

In some cases, enforcement actions or punitive measures such as imposing a civil penalty may cause an auxiliary grant facility to close. The loss of such a facility could substantially reduce access to auxiliary grant care in an area if few other ALFs serve public-pay residents.

There are indications that the availability of auxiliary grant beds factors into the use of adverse enforcement actions with some facilities that serve public-pay residents. DSS staff said the department will close a facility when necessary. However, three licensing inspectors who inspect ALFs serving auxiliary grant residents told JLARC staff that access to public-pay care should also be a factor in the department's enforcement decisions. One inspector said that while the 2005 legislation may have been aimed at ALFs with compliance problems, closing facilities that serve auxiliary grant residents is not feasible when auxiliary grant beds are already scarce.

Figure 5: ALFs Serving Primarily Auxiliary Grant Recipients Have Higher Occupancy Rates Than Private Pay ALFs



Source: JLARC survey of ALF administrators.

The concern is that some inspectors may adopt a less stringent regulatory approach in regions with high concentrations of auxiliary grant recipients. This could mean overlooking certain violations or recommending adverse enforcement steps only as a last resort. One inspector noted that DSS staff in regions with large numbers of auxiliary grant recipients may be more inclined to help noncompliant facilities come into compliance rather than use punitive measures.

PROBLEMS ACCESSING MENTAL HEALTH SERVICES APPEAR TO BE LIMITED TO A FRACTION OF ALFS

A substantial number of individuals with mental disabilities reside in ALFs. UAI data from FY 2003 to FY 2005 indicates that more than half of ALF residents receiving the auxiliary grant have a diagnosed cognitive impairment that requires ongoing treatment. These impairments include serious mental illness, mental retardation, and conditions such as dementia and Alzheimer's. The in-

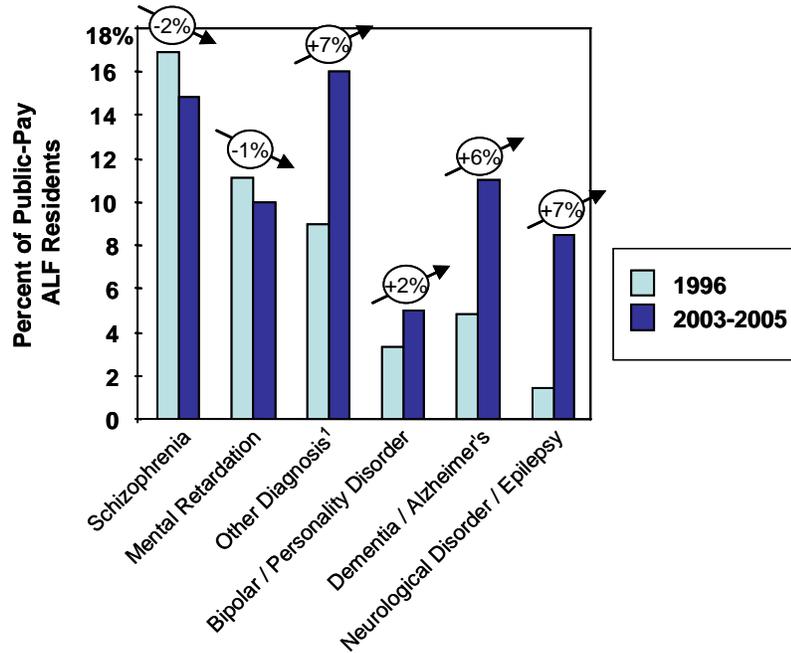
crease in public-pay ALF residents with diagnosed cognitive impairments since 1996 is shown in Figure 6.

Data from recent UAI assessments also indicates that diagnoses of mental retardation or mental illness account for 70 percent of cognitive impairments in ALFs. Individuals with these diagnoses are younger and require greater assistance than public-pay residents as a whole. As indicated in Table 11, they also take more medications and are more likely to have behavioral problems that pose a threat to other residents. The potential for aggressive or disruptive behavior is consistent with diagnoses such as schizophrenia, bipolar disorder, and mental retardation.

Residents With Mental Disabilities Rely on ALFs and Mental Health Professionals for Needed Services

Access to mental health services is critical to managing residents' mental disabilities. Symptoms of depression, schizophrenia, bipolar disorder, and other conditions often can be controlled with the

Figure 6: Percentage of Public-Pay ALF Residents With Cognitive Impairments Has Increased Since 1996



¹Includes major depression and anxiety disorder.

Source: JLARC analysis of Uniform Assessment Instruments administered to auxiliary grant recipients in FY 2003-2005.

Table 11: Residents With Mental Disabilities Are Younger and Have Greater Care Needs Than Auxiliary Grant Recipients Overall

Characteristic	Number/Percent	
	Auxiliary Grant Recipients With MH/MR Diagnosis	All Auxiliary Grant Recipients
Median Age	59	66
Median Number of Medications	7	4
Abusive/Aggressive/Disruptive Behavior (Less Than Weekly)	13%	8%
Abusive/Aggressive/Disruptive Behavior (Weekly or More)	11%	6%

Source: JLARC analysis of Uniform Assessment Instruments data from FY 2003-2005.

proper treatment regimen. However, these conditions can become difficult to manage when prescribed medications are not administered or needed services are not available. The potential for violence is a special concern in facilities that mix younger individuals with mental disabilities with frail elderly residents and other vulnerable members of the community.

While ALF administrators and staff are not licensed mental health providers, they play an important role in helping residents with mental disabilities achieve their highest level of functioning. ALFs are responsible for ensuring that residents receive prescribed medication and other needed services. In addition, ALF staff are in a position to identify high-risk behavior among residents and intervene before a crisis emerges. This intervention may involve direct staff efforts to de-escalate a crisis or requests for assistance from a CSB.

ALFs that care for individuals with mental disabilities also rely heavily on medical professionals outside the facility to provide mental health services. Because auxiliary grant recipients in Virginia are eligible for Medicaid, services for residents with mental disabilities generally are provided by one of 40 CSBs around the State. ALFs that serve auxiliary grant residents may also contract with private practitioners to provide mental health services.

Individuals with mental disabilities may require several mental health services while living in ALFs. Services such as emergency assistance, case management, and outpatient or day support programs are provided by mental health professionals. Other services such as medication administration, behavioral supervision, and structured activities are provided by ALF direct-care staff. Table 12 summarizes these services.

Table 12: Mental Health Services for ALF Residents With Mental Disabilities

Mental Health Service	Provider	Description
Emergency Assistance	CSB or other mental health professional	Crisis intervention to stabilize situation when resident's behavior becomes threatening or unmanageable; may include immediate counseling, jail, or hospitalization.
Case Management	CSB or other mental health professional	Assessment of the resident's mental health needs and coordination of services.
Outpatient and Day Support Services	CSB or other mental health professional	Outpatient psychotherapy and psychiatric services, psychosocial rehabilitation skills.
Medication Administration	ALF	Assistance with daily medications to manage medical conditions and control side effects.
Behavioral Supervision	ALF	Assistance with activities of daily living, monitoring residents for medical conditions or side effects, and ensuring residents' safety.
Structured Activities	ALF	A minimum of 11 hours per week of structured activities tailored to residents' needs.

Source: JLARC staff analysis.

Most Auxiliary Grant Recipients Appear to Have Access to Adequate Mental Health Services

Access to mental health services remains a critical issue for auxiliary grant recipients with mental disabilities. Past JLARC reviews of assisted living in 1979, 1990, and 1998 found that the mental health needs of some residents were not being met. The 1998 review concluded that inadequate staff supervision in ALFs and poor relations between ALFs and CSBs were leaving some residents with mental disabilities without critical mental health services. While some of these problems remain, there are indications that access to mental health services has improved.

Most ALFs Can Readily Access Mental Health Services From CSBs.

Results from a JLARC survey of ALF administrators suggest that most facilities do not experience problems accessing mental health services from CSBs. A majority of survey respondents—57 percent—said that their CSB is usually or almost always responsive to calls for assistance with residents exhibiting high-risk behavior. Seventy-four percent of responding ALFs said mental health services are available to residents with mental disabilities in their area.

A smaller number of ALFs experience ongoing difficulties with CSB services. Approximately 18 percent of survey respondents expressed dissatisfaction with the level of assistance from their CSB, including emergency and other referrals. Among facilities that sought emergency assistance from a CSB in the past year, 36 percent said services were never or rarely provided in a timely manner. Forty-six percent of these respondents said their CSB was never or only sometimes responsive to calls for assistance.

As in past studies of assisted living, JLARC staff heard complaints from several ALF administrators regarding CSBs. Administrators complained that emergency assistance is often not available, and noted that CSBs will require ALF staff to bring a resident to the CSB for assistance. ALF administrators said that transporting a disruptive and potentially violent resident generally is not a practical option.

Complaints about CSB services may have arisen from the following factors:

- **Poor ALF-CSB Relations.** Some ALFs that serve residents with mental disabilities maintain little or no ongoing communication with their CSB. In other cases, the relationship may be marred by personality conflicts. For example, the inspector for one ALF that serves residents with mental disabilities told JLARC staff that the administrator has a history of disputes with the local CSB.
- **Inadequate CSB Resources.** There are indications that some CSBs lack the resources to meet the current demand for mental health services. DMHMRSAS officials reported that CSBs generally have trouble providing needed services for ALFs, nursing homes, group homes, and other facilities for individuals with mental disabilities. DMHMRSAS staff also indicated that some CSBs are understaffed and cannot respond to calls for assistance from ALFs, especially during overnight shifts.
- **Differing Definitions of "Emergency."** Some ALFs and CSBs appear to use differing definitions of what constitutes an emergency. ALF staff that lack experience with individuals with mental disabilities may be more inclined to seek CSB assistance rather than directly addressing a situation. Officials with DMHMRSAS told JLARC staff that ALFs often want a resident removed from the facility when they seek CSB assistance.

Case Management Services for ALF Residents Have Improved. The 1998 JLARC review of assisted living found that case managers were not spending adequate time with their clients in ALFs, either

due to heavy caseloads or because ALFs were not allowing them access. The report found a median caseload of 41 for case managers statewide and noted that 31 percent of case managers reported visiting their clients less than once per month.

Case management services for ALF residents with mental disabilities have improved since 1997. It appears that ALF administrators generally are not denying CSB case managers access to residents, an improvement that may reflect a change to the *Code of Virginia* requiring ALFs to admit CSB personnel. In the current JLARC survey of CSB case managers, 95 percent of respondents said they have adequate access to their clients in ALFs. A majority of case managers responding to the survey—70 percent—reported receiving adequate assistance from ALFs toward managing their clients' mental health needs.

CSB case managers also may be spending more time with clients who reside in ALFs. The survey of case managers found that the median caseload had fallen by five clients, to 36. In addition, only nine percent of survey respondents reported visiting their ALF clients less than once per month; by contrast, more than 80 percent of case managers said they visited at least once per month. However, 46 percent of ALF administrators responding to the JLARC survey said CSB case managers visit clients in their facility less than monthly.

CSB Case Managers Have Concerns With Mental Health Services in Some ALFs. Evaluations from case managers of ALFs offer a more mixed picture of the mental health services available to ALF residents with mental disabilities. Most ALFs that serve individuals with mental disabilities appear to meet the basic needs of these residents. More than 80 percent of case managers responding to the JLARC survey said their clients in ALFs appear to be receiving their medication as prescribed, and 77 percent of respondents indicated that ALFs generally meet their clients' basic needs.

Case managers appear to be more concerned with the quality of structured activities in ALFs that serve individuals with mental disabilities. Only 40 percent of case managers believe ALFs provide their clients structured activities that help them reach their highest level of functioning. Almost as many case managers—38 percent—believe ALFs do not provide their clients with such activities. Written comments from case managers illustrate these concerns:

My clients typically are engaged in very little activity that stimulates cognitive or physical functioning. Most are generally in bed and rarely out of their rooms except to eat dinner or smoke.

Clients at [this ALF] have nothing to do during the day. There are no programs and little interaction between staff and clients. If they do not go to [the CSB "clubhouse"] they are left to watch TV, sleep, or talk with other residents. [This] does little for the mental health of the clients.

Case managers also expressed concern with the quality of direct-care staff in ALFs. Only 41 percent of case managers reported that ALF staff have adequate training and experience to work with their residents with mental disabilities. Approximately 32 percent of survey respondents do not believe ALF staff have adequate training and experience. The quality of ALF staff was identified as an issue in the 1998 JLARC review, and staff quality remains a concern in assisted living facilities today.

Meeting the Needs of Individuals With Mental Disabilities Depends on Several Factors

Five factors appear to influence the ability of ALFs and CSBs to meet the needs of ALF residents with mental disabilities. Factors such as medication management, ALF-CSB relations, and mental health evaluations were addressed directly in the new law and emergency regulations. Other factors, such as the level of CSB assistance and the mental health qualifications of ALF staff, were indirectly addressed or not addressed in the new regulations.

- **Medication Management.** Medication management is a key factor in managing ALF residents' mental disabilities. Failure to take prescribed medications is a common cause of hospitalization for individuals with psychiatric conditions. Without proper medication, individuals with schizophrenia, depression, and other conditions may become a danger to themselves or others. The 2005 legislation requires DHP to register medication aides serving in ALFs. The new law also requires ALFs to develop medication management plans.
- **ALF-CSB Relations.** DMHMRSAS officials believe the mental health needs of ALF residents are best met when ALFs and CSBs collaborate to coordinate their care efforts. Such a relationship helps ensure that CSB staff are familiar with an ALF's residents and can provide appropriate mental health services. Collaboration may include periodic training sessions by CSB staff, which can provide important guidance for ALF staff who lack experience working with a mental health population. It may also involve regular dialogue between ALF and CSB staff to review changes to residents'

conditions. New DSS regulations that require ALFs to seek CSB assistance were designed in part to promote such collaboration.

- **UAI, ISPs, and Mental Health Evaluations.** UAIs, individualized service plans (ISPs), and mental health evaluations play an important role in identifying the needs of individuals with mental disabilities and designing a treatment plan to meet those needs. The *Code of Virginia* requires a UAI for every ALF resident in order to identify care needs, including assistance with the activities of daily living (ADLs). Similarly, State regulations require ALFs to complete an ISP for each resident that explains how the facility will meet the care needs identified in the UAI. Mental health evaluations were a critical part of the emergency regulations. Under certain circumstances, ALFs must now ensure that current and prospective residents receive a mental health evaluation.
- **ALF Staff.** Caring for residents with mental disabilities requires an adequate number of staff with the training to work with a mental health population. These residents generally require greater behavioral supervision and monitoring than ALF residents with less debilitating conditions. Training from mental health professionals can help ALF staff ensure that disabled individuals follow their treatment regimen and achieve their highest level of functioning. Regular training sessions can also help ALF staff recognize potentially threatening behavior and intervene before that behavior becomes unmanageable.
- **CSB Resources.** CSBs that lack adequate resources may have difficulty meeting the needs of ALF residents with mental disabilities. Inadequate staff can hamper a CSB's ability to provide emergency assistance to ALFs, particularly during off-peak times such as overnight. Funding shortfalls may limit ALF residents' access to psychosocial rehabilitation and other day treatment programs. Similarly, large caseloads may prevent case managers from providing adequate attention to individual residents.

Model Programs and Best Practices Involve Close Partnership Between ALFs and CSBs.

In recent years, the General Assembly has funded pilot projects designed to enhance CSB services for ALFs that serve residents with mental disabilities by providing additional case management services and staff at ALFs. The projects, intended for areas with high concentrations of ALFs, were conducted in Richmond and localities in western and southwestern Virginia. A DMHMRSAS review of the projects found decreased hospitalization rates and improvements in residents' behavior, level of functioning, and quality of life.

The value of a collaborative relationship between an ALF and its CSB is apparent in an ALF currently involved in a similar pilot project:

Case Study

A facility located in Richmond partners with the Richmond Behavioral Health Authority (RBHA) to meet residents' mental health needs. The facility serves 11 individuals with mental disabilities that include schizophrenia and major depression. In addition to auxiliary grant funding, the ALF receives funding from RBHA to hire additional direct-care staff. ALF and RBHA staff work closely to meet residents' mental health needs. A licensed clinical social worker acts as a liaison between the facility and RBHA, providing case management and other services to the residents. A psychiatrist and clinical nurse also visit the ALF weekly. In addition, RBHA provides daily activities and community events designed to improve residents' interpersonal and living skills. The clinical social worker indicated that hospitalizations have fallen under the pilot project.

Other best practices to meeting the mental health needs of ALF residents may not require additional funding. JLARC staff visited one ALF that serves a substantial number of seniors receiving the auxiliary grant, some of whom have mental health concerns. The facility employs two care strategies that could be adopted in other ALFs without additional funding:

Case Study

The ALF administrator and senior direct-care staff hold monthly sessions with case managers from the local CSB to coordinate their care efforts and address emerging issues with residents. The administrator also meets weekly with senior ALF staff to identify and resolve resident concerns. Decisions from both meetings are communicated to ALF staff that interact directly with residents. The administrator said that both practices are critical to meeting the needs of residents with mental disabilities at the facility.

Impact of the New Mental Health Regulations Depends on Adequate ALF Staff and CSB Assistance. Adequate ALF staff and CSB resources will likely play key roles in determining the impact of the new regulations on the quality of mental health services in ALFs. Key provisions in the emergency regulations depend on adequate direct-care staff in ALFs and adequate assistance from CSBs. The behavioral monitoring of ALF residents envisioned by DSS may be difficult for facilities that lack adequate numbers of qualified staff. Similarly, provisions aimed at promoting more collaboration be-

tween ALFs and CSBs may not succeed in areas where CSBs lack the resources to meet the current demand for mental health services.

Cost Impact of the New Law and Regulations

In Summary

Recent changes to the law and regulations on assisted living will impose new costs on ALF employees and on the facilities themselves. Although specific training requirements, for example, are not yet finalized, compliance with other draft requirements could cost \$1,800 or more for each ALF. Other new requirements, such as for emergency electrical connections, will also be costly. These costs will be a particular issue for the estimated 117 ALFs that serve mostly public pay residents because the rates have not kept up with these requirements. The auxiliary grant is the primary means of paying for low-income assisted living residents although the State pays higher rates for about a quarter of low-income residents. The grant rate of \$982 per month represents 33 to 59 percent of current average prices for assisted living, well below the market price. At the current auxiliary grant rate, these facilities will be challenged by the cost of implementing the new standards.

The study mandate directs JLARC to consider the impact of the new regulations on the cost of services in assisted living facilities. Several new requirements will add to the cost of operating these facilities. The cost of compliance in many cases is likely to increase the cost of assisted living in Virginia.

The majority of assisted living residents—81 percent of the licensed capacity, or about 27,200 residents—pays for their care with their own financial resources, which may include Social Security and other sources of income. The State auxiliary grant program, along with the federal Supplemental Security Income (SSI), paid for the care of an average monthly caseload of 6,250 low-income residents, representing about 19 percent of the licensed capacity of assisted living facilities in FY 2005. The current monthly auxiliary grant rate is \$982.

NEW LAW AND REGULATIONS WILL AFFECT COSTS

Recent statutory changes as well as the emergency regulations that took effect in December 2005 contain several new requirements that will directly affect the cost of operating an assisted living facility. Some of these costs, such as training, licensing, and certification requirements, may be paid by individuals seeking employment in ALFs. But other costs pertaining to staffing patterns and facility requirements will likely be paid by the facilities to assure compliance with the new requirements.

Staff and Training Requirements Will Increase Costs

Several new requirements pertain to the qualifications of ALF employees. The employees themselves bear the responsibility to be trained and licensed or certified, and the licenses and certification pertain to the individual, not to the facility. Costs stemming from these requirements are likely to be borne by the prospective employees, although several ALF administrators told JLARC staff that, at least initially, their facilities would cover training and licensing costs for current staff. These administrators indicated that this practice may be necessary to assure the availability of qualified staff.

Some of these costs are not yet known because training requirements and curricula, for example, have not yet been finalized or approved. This analysis references costs of related training programs although in most cases these existing programs are not strictly comparable.

Administrators Must Be Licensed. The 2005 legislation requires annual State licensing of ALF administrators, except for those at ALFs providing only the residential level of care. There are currently 59 ALFs licensed only for the residential level of services; the remaining 529 provide assisted living and would require licensed administrators.

The Board of Long Term Care Administrators (BLTCA) has developed draft regulations which contain education and testing requirements for the position. Under the draft regulations, persons already serving full-time as an ALF administrator or assistant administrator would be exempt from the education requirements although all applicants must pass a State examination. The draft education standard for new ALF administrators requires either

- a four-year college degree in a health-care related field that meets Board-specified content requirements and a 320-hour internship, or
- completion of a certificate program which in turn requires the degree plus an internship under supervision of a registered "preceptor," or
- completion of 30 semester hours in certain content areas and a minimum of 500 hours in an administrator-in-training program, or 30 hours in any area plus 1,000 hours in an administrator-in-training program.

Under the draft regulations, an annual 20-hour continuing education requirement would also be required for license renewal.

Because the regulations are still in draft status, education and training requirements are subject to change. Until the regulations are final, there is unlikely to be an assisted living administrator curriculum established within, for example, the Virginia Community College System. There is also a question as to whether, after the initial wave of ALF administrators are licensed, student enrollment would be sufficient to warrant community or other college curriculum development. As an illustration of the potential cost, however, J. Sergeant Reynolds Community College in Richmond currently charges \$80.50 per credit hour, which would result in a tuition cost of \$2,417 for a 30 semester hour requirement. Other training and education venues with different costs may be available in the future.

The BLTCA has also proposed fees for testing and licensing. If adopted, the application fee would be \$200 and the annual renewal would cost \$225. The draft regulations exempt from initial training requirements (but not from the initial testing requirement) persons who have served as an ALF administrator or assistant administrator for two of the prior three years.

The draft requirement for 20 hours per year of continuing education to maintain licensure could vary widely in cost. Continuing education requirements in a variety of professions can typically be satisfied in a variety of ways, including online courses, conference-based seminars and self-study. Costs are likely to vary significantly based on the particular venue and method.

Managers Must Be Present in Smaller ALFs. The emergency regulations adopted by the Board of Social Services requires the administrator to be present at the facility at least 40 hours each week, except in smaller ALFs (19 or fewer residents), where the administrator may serve other facilities. In these smaller ALFs, of which there are 184 (31 percent of the total 588), regulations permit the administrator to be absent from a facility a portion of the 40 hours provided that a person is designated as "manager" to serve when the administrator is not present.

The emergency regulations specify training requirements for these ALF managers, including at least one year of administrative or supervisory experience in caring for adults in a group care facility plus either 30 hours of college courses or completion of a Department-approved training course and additional training related to operation of a residential facility for adults. When adults with mental impairments reside in the facility, the regulations specify that "at least four hours of training shall focus on residents who are mentally impaired."

As with administrators, there is not yet an approved curriculum or training course for ALF managers, so any cost estimate would be tentative. Costs are likely to vary significantly based on the particular training venue and method.

Medication Aides Must Be Registered. The 2005 legislation requires that persons who administer drugs in ALFs must be registered with the Board of Nursing. The Board's draft regulations require 68 hours of training: 40 hours of classroom instruction, 20 hours of supervised skills practice in medication administration, and an eight-hour training module in administering and assisting with the administration of insulin. Additionally, the draft regulations require a \$75 initial application fee with a \$50 biennial renewal fee.

It could be expected that the cost of medication aide training will be less than the certified nurse aide (CNA) certification and training program. More training is required to become a CNA—120 hours—than is being considered for medication aides. For CNAs, at least 40 of these 120 hours must consist of hands-on clinical practice in a nursing home—the clinical practice cannot be in an ALF.

J. Sergeant Reynolds Community College offers a CNA training program which, although it exceeds these minimum requirements, costs \$403 plus another \$75 for books and materials, according to the program director. Costs for medication aides may be different as other training and education venues with different costs may be available in the future.

CPR and First Aid Training and Certification Are Required. The emergency regulations require that each ALF have at least one staff member on the premises at all times with current certifications in adult first aid and cardiopulmonary resuscitation (CPR). There is also a requirement that facilities licensed for more than 100 residents have at least one additional employee with these certifications for every 100 residents. A further requirement is for staff driving residents to and from activities and appointments to be certified in both adult first aid and CPR.

The cost of CPR and first aid training was the most frequently cited concern of ALF administrators responding to the JLARC survey. CPR along with adult first aid training and certification programs typically costs \$40-\$65 per person. Based on the survey, ALFs have an average of 20 direct-care employees (both full- and part-time). Consequently, costs will run \$800-\$1,300 for initial training. The high turnover among staff at many ALFs means that much of this cost may be incurred annually although CPR and first aid certification is valid for one to three years.

National Criminal History Checks Will Be Required. The 2006 General Assembly adopted SB 421, requiring all businesses and organizations that provide care to children, the elderly, or disabled to request a national criminal background check of all employees and volunteers. The bill contained a reenactment clause requiring both appropriate funding (for the Department of State Police, who administer background checks) as well as a requirement that the bill be adopted again by the 2007 General Assembly. Assuming that these conditions are met, the requirement will take effect in July 2007.

The Department of State Police indicates that these national criminal background checks cost \$15 apiece. The JLARC survey of ALF administrators found that, on average, ALFs retain 20 direct care employees (full- and part-time), as noted above. ALFs have additional staff such as cooks, activities staff, and an administrator. Thus, on average, 23 staff will need background checks.

The initial cost of conducting these 23 national criminal history checks will therefore be \$345 for the "average" ALF, and will vary depending on the number of employees. Volunteers as well as new employees may be required to self-pay for background checks, although it is less clear whether existing employees will be required to pay.

Total Employee Costs. These employee-related costs are likely to average about \$1,800-\$1,900 per ALF initially (Table 13). Although in most cases they represent new expenses, these costs represent a small proportion (averaging less than one percent) of annual revenue for the "average" ALF, based on cost reports voluntarily filed with DSS by 354 ALFs. For smaller ALFs serving primarily auxiliary grant recipients, however, these may be significant new costs.

As noted earlier, in some cases individual employees may pay the costs of background checks, training, registration, certification and licensure. Additional costs imposed on low-wage workers may reduce the availability of qualified staff, as employees shift to less-demanding work with similar pay. Due to the difficult labor market in many areas of the State, ALF administrators have suggested that the facilities may bear some or all of these costs in order to assure the availability of qualified staff.

Table 13: New Law and Draft Regulations Would Impose Costs on ALF Employees

	Proposed Costs per Employee		Minimum Number of Employees Affected	Initial Cost per "Average" ALF
	Initial	Renewal		
Administrator Licensing	\$200	\$225 annually	1	\$200
Medication Aide Registration	\$75	\$50 biennially	2	\$150
CPR Certification	\$40-\$65	\$40-\$65 biennially	1 per shift	\$120-\$195
First Aid Certification	\$40-\$65 ¹	\$0-\$50 every 3 years	All direct-care staff	\$1,000
National Criminal Background Check	\$15 ²	None	All employees	\$345
Total				\$1,815-\$1,890

Note: An "average" ALF is here considered to have 23 employees (including full- and part-time staff, as found in the JLARC survey of ALF administrators): 20 in direct care, one administrator, one food service, and one activities director. Training costs for administrators and medication aides will be in addition to costs shown.

¹ May be combined with CPR certification costs.

² Required only upon initial employment.

Source: JLARC staff analysis of statutes and DSS regulations and JLARC survey of ALF administrators.

Facility Requirements Will Also Be Costly

Two recent statutory and regulatory changes apply to ALF operations, the cost of which would most likely be borne by the facility. These include a requirement for emergency electrical generators and, for smaller ALFs, for night-shift personnel to remain awake.

Emergency Electrical Connections Will Be Required. A statutory change adopted in 2004 requires that ALFs with six or more residents be able to connect, by July 1, 2007, to a "temporary emergency electrical power source for the provision of electricity during an interruption of the normal electric power supply" (*Code of Virginia* §63.2-1732D). This provision was adopted after 2003's Hurricane Isabel knocked out power to wide swaths of Virginia for more than a week. Because ALFs provide residential care for persons with disabilities and medical needs, they clearly have an increased need for a stable and reliable source of electricity. This population would be especially vulnerable during extremes of temperature, such as an extended power outage caused by an ice storm.

As of January 2006, 558 of the 588 ALFs or 95 percent had licensed capacities of six or more. During fieldwork for this study, JLARC staff found that some ALFs have emergency generators already installed. As of spring 2006, however, the majority of ALFs have not yet complied with this requirement.

The statute mandates only the ability to connect to a temporary electrical power source, which may cost upwards of \$500, depend-

ing on facility size and other factors. While a generator is not mandated, additional arrangements may be necessary to ensure access to a generator should one be needed. Dominion Virginia Power installs 12-kilowatt emergency generators at prices starting around \$6,000. Larger ALFs may require substantially higher capacity generators at proportionately higher costs. Ongoing maintenance and operation costs may also be significant.

"Awake at Night" Requirement for Smaller ALFs. Previous Board of Social Services regulations required at least one staff member to be awake and on duty in each ALF building when at least one resident is present. The regulations permitted an exception for ALFs with 19 or fewer residents, allowing the staff member on the night shift to sleep, provided no resident required the staff member to be awake at night. DSS licensing inspectors indicate that a signal system to allow residents to awaken the staff member was considered sufficient to comply with the requirement in these smaller ALFs.

The emergency regulations eliminate this exception for smaller ALFs. Under the emergency regulations, these ALFs are required to have a staff member awake and available to respond to residents. The General Assembly has adopted language suspending this regulation, however, in amendments to the 2004-2006 budget.

Several administrator/owners of these smaller ALFs indicated to JLARC staff that this would be a costly requirement, requiring them to add an employee on the night shift. If an additional employee is necessary to comply with this requirement, the cost—for facilities serving primarily auxiliary grant recipients—will generally exceed the additional revenue available through the increase in the auxiliary grant. This is partly because under the old regulations, the employee (often the administrator/owner) could sleep at the facility during the night shift and be available to residents via a signaling or alarm mechanism, thus complying with the prior standard, as in the following example:

Case Study

The owner/administrator of an ALF licensed for fewer than 15 beds, who also exclusively served auxiliary grant residents, told JLARC staff that prior to the emergency regulations she was the main staff person available to residents day or night. Being allowed to sleep yet be "available" through an alarm system was one of the ways her facility could remain open and exclusively serve auxiliary grant recipients. She indicated it would probably cost \$2,500-\$3,000 per month to hire staff to meet this "awake at night" requirement. As a result of recent increases in the auxiliary grant rate, this facility saw a total increase in revenue of

\$1,056 per month (the difference between 12 residents at \$894 per month in FY 2005 and 12 residents at \$982 per month in FY 2006).

The average hourly wage for entry-level direct care staff was reported by administrators during JLARC fieldwork to be between \$5.15 and \$10. Adding the employees necessary to work an additional eight-hour shift seven days per week would cost from \$1,253 to \$2,433 per month in wages alone. Housing additional auxiliary grant recipients to generate the additional revenue may be an option for a few ALFs although the facility is, of course, also expected to provide 24-hour care, including meals and other services. In addition, many smaller facilities have limited space and lack the flexibility to accommodate additional residents.

Facility Requirements Will Increase Costs

The cost impact of these new requirements on a typical ALF will be significant, as shown in Table 14. The impact of the "awake at night" requirement may be especially costly for the smaller ALFs. The General Assembly suspended this requirement in amendments to the 2004-2006 Appropriation Act.

Table 14: New Law and Regulations Impose Costs on ALFs

Requirement	Estimated Costs per ALF
"Awake at Night" Requirement for Smaller ALFs ¹	\$1,253-\$2,433/month
Emergency Electrical Connection	\$500 or more ²

¹The enforcement of this requirement was suspended in amendments to the 2004-2006 Appropriation Act (HB 5012).

²Depending on size of facility and other factors, plus annual maintenance.

Source: JLARC staff analysis of statutes and regulations.

INCREASES IN THE AUXILIARY GRANT RATE DID NOT ACCOUNT FOR THE COST OF NEW REQUIREMENTS

The above discussion identifies ten types of cost increases required by recent statutory and regulatory changes. Most ALFs serve residents who are paying from their own private financial resources, so these ALFs may be able to pass the increased costs on to these residents in the form of higher prices. JLARC staff found that 90 percent or more of the residents in at least 260 ALFs are paying for their care with private resources (Table 15).

Table 15: Some ALFs Depend On Auxiliary Grant Funding

Percentage of Auxiliary Grant Residents	Number of ALFs	% of All ALFs
Less Than 10% (More Than 90% Private Pay)	260	44%
10%-50%	54	9
50% or More	117	20
Unknown	157	27
Total	588	100%

Source: DSS data; JLARC survey of ALF Administrators.

There are, however, at least 117 ALFs with 50 percent or more auxiliary grant residents, and an additional 54 ALFs with between ten and 50 percent auxiliary grant recipients. These 171 facilities are partly dependent, and many are almost completely dependent, upon auxiliary grant revenue to remain in business. JLARC staff were unable to determine the payment status of residents in the remaining 157 ALFs.

Although the auxiliary grant rate has increased several times in recent years, the increases were not tied to the increased costs imposed under the statutes and regulations. Instead, the increases have been either a result of cost of living adjustments made by the federal SSI program or have been set by the General Assembly and DSS. For example, for the January 2006 increase from \$944 to \$982 per month, \$24 of the \$38 increase was due to the federal cost of living adjustment in the SSI program and the remaining \$14 was accomplished through use of certain programmatic surpluses within DSS. It also appears that special circumstances may be required for some facilities to remain in business using the auxiliary grant as the sole source of revenue. In effect, these special circumstances allow the rate to remain low in those facilities.

The current auxiliary grant rate of \$982 per month is not linked to the current cost of care in assisted living. Instead, it has incremented over the years from a base that was originally calculated from cost reports submitted by ALFs to DSS. Prior to 1998, the Appropriation Act set a maximum rate, with the intent that many facilities would operate below the maximum. DSS managed a rate-setting process intended to help control the costs to the State.

All three prior JLARC reports on ALFs found major problems with the use of unaudited cost reports from ALFs and with the DSS rate-setting process, which is no longer used. The rate is now set in the Appropriation Act and is uniform for all facilities.

Grant Rate Has Generally Outpaced Inflation

The adequacy of the monthly rate has always been in question. In the first several years of the program, for example, the rate increased faster than inflation, according to the 1979 JLARC report on homes for adults. First established in 1974, the auxiliary grant program was intended to cover the cost of assisted living in facilities then licensed as homes for adults, as documented by cost reports submitted to the State by the facilities.

Although the auxiliary grant rate has never been widely viewed as adequate, the rate has either kept up with or exceeded the rate of inflation, depending on the base year chosen for comparison. The rate paid in the early years of the program—in 1979 the rate was \$372 per month, for instance, and adjusted for inflation it would now be \$1,001—is close to the current rate of \$982 per month, taking inflation into account.

Choosing a more recent year as the basis for comparison, on the other hand, indicates that increases in the auxiliary grant have exceeded inflation. Adjusting the 1997 rate of \$695 for inflation, for example, would result in a rate of \$846. The current \$982 per month is significantly higher. These findings on inflation do not take into account the changes noted above in the law and regulations.

Grant Rate Is Well Below Market Prices

Although the auxiliary grant has outpaced recent inflation, it remains well below market prices, as illustrated in Figure 10. JLARC staff identified market prices for assisted living in several ways:

- Although filing cost reports is now optional and the data is unaudited, the 354 reports submitted to DSS by ALFs in 2005 indicated an average cost of \$1,674 per month with a median of \$1,255 (these figures include profit and inflation factors, as calculated by DSS). The auxiliary grant is 59 percent of this reported average and 78 percent of this reported median.
- The average monthly rate charged, as reported by 277 administrators on the JLARC survey, was \$2,172 with a median (the mid-point, with 50 percent above and 50 percent below) of \$2,000. The \$982 auxiliary grant rate is 45 percent of the reported average and 49 percent of the reported median.
- In early 2006, Genworth Financial, Inc., surveyed assisted living costs nationwide, contacting at least ten percent of all licensed facilities in each state. The report found that for

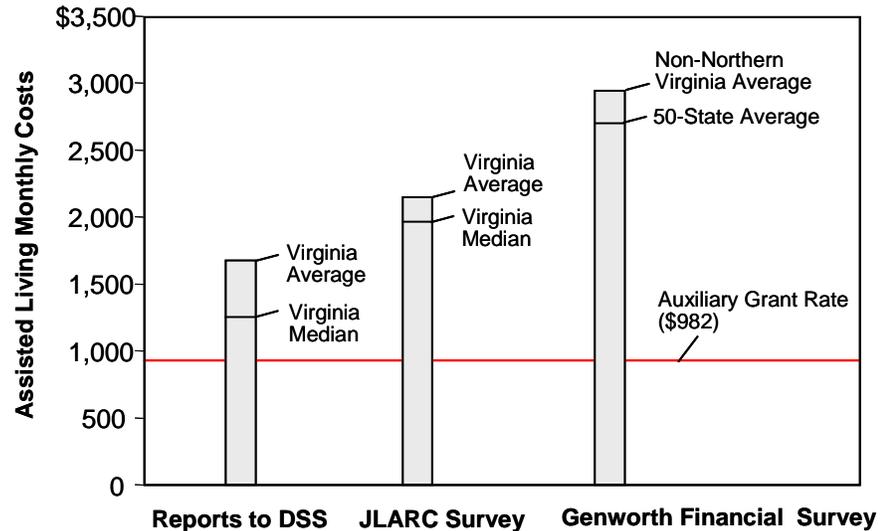
non-northern Virginia facilities, the average monthly cost of a private one-bedroom unit was \$2,940. The nationwide monthly average was reported as \$2,691. The auxiliary grant is 33 percent of the reported non-northern Virginia average and 36 percent of the national average.

- In an opinion question, 88 percent or 214 of 244 ALF administrators responding in the JLARC survey said they did not agree that the current rate is adequate. Only 7 of the 246 respondents "agreed" or "strongly agreed" that the current rate is adequate (23 had no opinion).

Because the auxiliary grant rate is well below the market price, it is not surprising that some facilities find other sources of revenue or rely upon other special circumstances to stay in business.

Three Neighboring States Pay More. According to the Genworth Financial report, the national average cost of assisted living is well above the rate of Virginia's auxiliary grant rate. Three neighboring states—Maryland, North Carolina, and West Virginia—also set a higher rate of payment for their low-income residents in assisted living programs. Maryland and North Carolina use Medicaid's home and community-based waiver program to pay for some assisted living services for low-income residents.

Figure 10: The Auxiliary Grant Rate Is Below Market Prices



Source: JLARC staff analysis of 2005 data from cost reports submitted to DSS, a 2006 JLARC survey of ALF administrators in Virginia, and a 2006 Genworth Financial survey of ALFs nationwide.

Although there are differences between the states in how assisted living is defined and how standards are enforced, the difference in payments in three neighboring states is striking.

Like Virginia, North Carolina pays a supplement to an individual's SSI payment if he or she resides in a licensed ALF. The combined basic payment is \$1,118 per month. According to North Carolina licensing staff, most of these residents also qualify for Medicaid-funded services: up to \$577 per month (tied to facility size) for personal care services and additional amounts for other services: up to \$325 per month if the resident needs assistance with eating, for example. A typical ALF above 31 beds in size may thus be receiving a combined \$1,695 or more per month for each low-income resident—73 percent above Virginia's auxiliary grant rate.

Maryland pays for assisted living for low-income residents through the Medicaid home and community-based waiver program. This program requires participants first to be found eligible for nursing home services. Consequently, Maryland beneficiaries may be "sicker" and require more assistance than Virginia's auxiliary grant recipients although many Virginia ALF administrators have stated that 10 or 20 years ago, their residents would also have been in nursing homes. For assisted living, Maryland's Medicaid program pays up to \$1,737 per month and requires the resident to pay an additional \$420 for room and board (Medicaid does not pay room and board costs). Assisted living programs thus typically receive a total of \$2,157 per month, 120 percent higher than Virginia's monthly auxiliary grant rate.

West Virginia has a limited SSI supplemental funding program, which in 2004 covered 319 residents. It supplemented the individual's SSI payment to provide a current (2006) maximum of \$1,028 per month. Tennessee provides no state funding for low-income residents of assisted living and does not participate in the Medicaid waiver program. (This is one reason ALFs in southwestern Virginia receive a high number of Tennessee citizens.)

A summary of SSI supplemental payments made by states for assisted living is included in Appendix D. Virginia's auxiliary grant is one such program.

Special Circumstances Often Help Explain Compliance

Special circumstances that reduce costs or supplement a facility's revenue stream help explain how some ALFs that are dependent on auxiliary grant revenue can stay in operation. In some cases, administrators have sought additional resources to supplement auxiliary grant revenue. Through resident attendance at CSB "clubhouses" and other programs, many ALFs serving persons

with mental disabilities in effect receive the benefit of additional funding. In other instances, persons serving as ALF staff are receiving below-market wages or no wages at all.

Case Studies

At two facilities visited by JLARC staff, several of the "employees" were in fact family members of the owner who may not have been drawing a competitive wage or salary and who may be working at the facilities out of family loyalty. One facility was licensed for more than 45 and served only auxiliary grant recipients with mental disabilities. The second ALF was licensed for more than 30, all of whom received the auxiliary grant.

* * *

At another facility, the owner/administrator indicated that neither he nor his wife, who served as the facility's nurse, draw a salary from the facility. This ALF was licensed for more than 70, all of whom received the auxiliary grant.

* * *

Another ALF with more than 100 residents, most of whom receive the auxiliary grant, receives a substantial annual subsidy from the Area Agency on Aging.

* * *

At another facility serving about a dozen auxiliary grant residents with mental disabilities, the local CSB provides some funding and assigns a clinical social worker to assist the facility's residents.

The CSB funding in the last case study stems from State funds appropriated to DMHMRSAS for "pilot projects in areas that have high concentrations of adult care residences" (Chapter 951, Item 334I). In effect, this funding pass-through represents acknowledgement by the State that ALFs serving residents with mental disabilities require more funding than the auxiliary grant provides.

Auxiliary Grant Rate Should Be Sufficient for Compliance

Special circumstances that reduce costs or provide additional funding should not be a requisite for quality care in ALFs that choose to serve low-income residents. Instead, the auxiliary grant rate should be sufficient to ensure compliance with State law and regulations. It is clear that the grant rate is well below market prices.

As if acknowledging the inadequacy of the auxiliary grant rate, another State agency (DMAS) provides a supplement for residents determined to need "intensive" services although it also supplements certain persons deemed to need less intense services.

Virginia Pays More in Certain "Holdover" Cases. The State pays more than the auxiliary grant rate for the care of 1,742 residents of assisted living, 27 percent of all auxiliary grant recipients. This practice is a holdover from a program in effect prior to 2000 and is fully funded with State general funds.

Virginia used Medicaid funding for certain persons in ALFs during the late 1990s. From 1996 through 2000, an additional \$90 per month available through a federal Medicaid waiver program was provided for "assisted living," and an additional \$180 per month was provided for "intensive assisted living." The additional funding was tied to an assessment of the individual's need for care and was based on an additional half-hour to hour per day of personal care for the resident.

According to DMAS staff, this use of federal waiver funds was terminated by the Centers for Medicare and Medicaid Services following an audit in 2000 that found a higher level of service was not required under State standards. The 1998 JLARC report also noted that there was no requirement in State standards for additional care to be provided, as expected under the federal program.

DMAS is no longer admitting new individuals into the program but is authorized under the 2004-2006 Appropriation Act (Items 326D and 328) to continue paying the \$180 per month (without the federal match) for 140 ALF residents who qualified prior to 2000 and the \$90 per month supplement for 1,602 residents qualified prior to 2000. Funding for these "holdovers" totaled approximately \$2 million in State general funds in FY 2006. These 1,742 ALF residents represent 27 percent of all auxiliary grant recipients.

The residents receiving these additional "holdover" payments are required to have annual assessments showing they continue to warrant a higher level of service. However, DSS continues to have no standards or regulations that require a higher service level for these individuals.

Virginia Has Three Rates of Pay for Low-Income ALF Residents. The continuation of these payments despite the lack of a requirement for any higher level of service suggests that DMAS recognizes the need for additional funding in ALFs. In effect, Virginia has three monthly rates of public funding:

- \$982 for most auxiliary grant recipients, including all newly qualifying recipients;
- \$982 + \$90 or \$1,072 for the 1,602 "holdover" regular assisted living residents; and
- \$982 + \$180 or \$1,162 for the 140 "holdover" intensive assisted living residents.

Because the auxiliary grant is well below market prices, even for "holdover" residents, ALFs serving predominantly auxiliary grant residents will be challenged by the emergency regulations and the new State law.

CONCLUSIONS

This is the first in a series of planned status reports on the impact of the 2005 law and the subsequent regulations affecting assisted living facilities. Several State boards and agencies are implementing the changes and are generally on schedule. It appears possible that permanent regulations may not be implemented before the December 28, 2006, deadline, thus allowing regulations in effect prior to the new law to be revived.

As the new law and regulations phase in, the number of ALFs of concern (that have a recent history of compliance problems and an above-average number of verified complaints) should decrease. Problems with administering medications should also diminish. These outcomes will be at least in part due to the increased training and licensure required for administrators and the training and registration required for medication aides. Enhanced penalty provisions and strengthened DSS enforcement should also play a role.

Case management services for public pay, mentally disabled residents of ALFs appear to have improved since previous JLARC reports. Caseloads have decreased for CSB staff assigned to these clients. CSB staff also report spending more time with their ALF clients than in the past but continue to be concerned about the qualifications of ALF staff in dealing with residents who have mental disabilities. Improved relations with CSB staff and increased assistance for ALFs should be addressed between DSS and DMHMRSAS.

Finally, while the new law and regulations impose some costs on ALFs and ALF staff, matching adjustments to the auxiliary grant rate have not been made. The grant rate is well below market prices and below rates paid in three neighboring states. ALFs serving predominantly auxiliary grant residents will be challenged to comply with the new law and regulations.

Study Mandate

Chapter 951, 2005 Acts of the General Assembly

Item 21 F. The Joint Legislative Audit and Review Commission (JLARC) shall report on the impact of new assisted living regulations on the cost of providing services, residents' access to providers and other services, including Medicaid-funded mental health and other services, and tangible improvements in the quality of care delivered. The Department of Social Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Medical Assistance Services shall cooperate fully as requested by JLARC and its staff. JLARC shall submit an interim report by November 1, 2005 and a final report by June 30, 2006.

Research Activities and Methods

JLARC staff used several methods to conduct this study. The intent of this study is to develop a “baseline” about licensure, services, and funding in assisted living facilities, and then observe how they change over the coming years in response to the new law and regulations. To assure a relatively complete understanding of assisted living, JLARC staff

- surveyed and interviewed several groups of people with special knowledge of ALFs,
- reviewed extensive data on ALFs’ compliance with licensing standards and on complaints filed with both DSS and with the Office of the Long-Term Care Ombudsman (LTCO),
- reviewed financial data submitted by 354 ALFs to DSS,
- analyzed data collected on the uniform assessment instrument (UAI) and maintained by DMAS, and
- visited a sample of ALFs, touring each facility and interviewing the administrator and the licensing inspector.

Specific methods used for this study included a survey of ALF administrators; a survey of CSB case managers; identification of ALFs with a recent history of compliance problems and verified complaints; interviews with a variety of personnel; and field visits to 29 ALFs.

SURVEY OF ALF ADMINISTRATORS

To learn the views of the current assisted living administrators, who may also be owners and operators, JLARC staff conducted a written survey. Questions were developed that assessed demographics of the resident population, the types of structured activities provided, mental health services for residents, satisfaction with licensing processes, interaction with the local Community Services Board, staffing patterns, and opinions about the emergency regulations. A copy of the administrator survey is available from JLARC staff.

Using DSS’s January 2006 active licensing caseload files, JLARC staff mailed the survey to all 588 ALFs. Two follow-up postcards were also mailed to non-respondents over the subsequent month.

This effort generated 342 responses, for a response rate of 58 percent. However, 21 surveys were excluded for a variety of reasons such as significant amounts of missing data. There was no significant difference between survey respondents and non-respondents with regard to their licensed capacity or the number of founded complaints or violations. Responses were received from ALFs in 92 of the 107 localities with ALFs. An analysis indicated no geographic pattern of non-response.

SURVEY OF CSB CASE MANAGERS

Many (but not all) case managers employed by the 40 community services boards (CSBs) have frequent contact with clients who reside in assisted living facilities. JLARC staff surveyed these case managers to get their views on services available to their clients and other aspects of assisted living. The online, Web-based survey was conducted in two parts. In part one, case managers were asked about their caseload, case management activities, and ability to secure adequate ALF placement for a client. In part two, case managers were asked to identify a maximum of three ALFs in which they have clients residing. For each ALF, the case manager was asked about their clients' individual services plans, access to services, adequacy of care.

Because many case managers do not have clients in ALFs, JLARC staff asked each CSB director to identify which of their case managers should respond to a JLARC survey. Of the 40 CSBs, 29 responded indicating a total of 368 case managers who work with clients in ALFs. The directors were asked to forward a special password to case managers with clients in ALFs. This password allowed access to both parts of the online JLARC survey. For part one, JLARC staff received 250 completed surveys from case managers in 36 CSBs, representing 85 percent of all CSBs. For part two, there were 366 responses about 145 unique ALFs (approximately 25 percent of all ALFs).

IDENTIFICATION OF ALFS WITH A RECENT HISTORY OF VERIFIED COMPLAINTS OR COMPLIANCE PROBLEMS

JLARC staff collected available data on all 588 ALFs (Chapter 3, Table 6) for 2003-2005 from the following:

- Department of Social Services Division of Licensing Programs,
- Department of Social Services Adult Protective Services, and
- Office of the State Long-Term Care Ombudsman program.

This data was used to develop a profile of each ALF.

The Licensing Division Provided a Variety of Data

The licensing division provided JLARC staff with a variety of data. The various sources helped to characterize facilities throughout the State and identify those that have been compliant with standards from 2003-2005. Analyzing five types of licensing data strengthened and added reliability to the study:

- Caseload data on all licensed facilities from April 2004 to January 2006,
- Notices of adverse enforcement action taken from November 2003 to October 2005,
- Enforcement watch lists for calendar year 2005,
- Violations of health and safety standards for the five most recent inspections prior to December 28, 2005, and
- Verified complaints for calendar year 2005.

Monthly Caseload Reports. The licensing division produces two ALF caseload reports each month which include the facility name, file number, administrator's name, licensing region and inspector, license type and expiration date, bed capacity, location, and contact information. Caseload reports were used to calculate the statewide distribution of ALFs, inspector caseloads, and frequency of license types. Contact information was also used to mail the administrator survey.

JLARC staff identified two problems with the caseload reports. First, data on 12 facilities was found to be duplicated. Initially, there appeared to be 600 ALFs statewide in January 2006. After the eliminating 12 duplicate entries, 588 licensed ALFs were identified.

Second, there were two data fields in the caseload report that indicated an ALF's license type. In some cases, the license type for the same ALF was different. According to DSS data management personnel, one of the two fields is not used by data management personnel and errors are due to regional licensing inspector data entry. However, in a few cases regional licensing staff indicated that the license type found in one field was not the correct license type, and the license type in the second field was correct.

This may mean incorrect information is provided to the public. According to DSS data management personnel, the first field is used to post the ALFs' license type on the public website, which provides licensing information to long-term care consumers and fam-

ily members. The public could thus be misinformed as to the type of license that a facility currently holds.

Adverse Enforcement Actions. The licensing division provided JLARC staff with copies of all adverse enforcement action letters sent between November 2003 and October 2005. These letters indicate sanctions imposed on an ALF for serious or repeated violations of standards. Types of adverse actions include license revocation, denial of licensure application, probation, reduction of capacity, prohibition on new admissions, mandated training, a civil penalty, and termination of public funding.

The information is automated; however, licensing staff found errors in the dataset. Consequently, licensing staff provided JLARC staff with copies of all letters mailed during this period.

Enforcement Watch. Enforcement watch is a monitoring tool used by the licensing division to identify and monitor facilities that have failed to maintain substantial compliance with licensing standards. Statewide watch lists for calendar year 2005 were used. The standard operating procedure was issued in March, 2006.

There may be inconsistent use of enforcement watch. The licensing division's standard operating procedure provides guidelines for placing ALFs on enforcement watch. Procedure states that the licensing supervisor shall place all facilities that have been issued a sanction on watch. One licensing region did not place a single ALF on watch throughout 2005; although, adverse enforcement action letters from 2005 indicate that this region issued sanctions to at least two facilities in 2005.

Health and Safety Violations. A report developed by the licensing division identified 529 licensing standards and statutes from the *Code of Virginia* pertaining to the health and safety of ALF residents. Each facility's violations over the five most recent inspections conducted prior to the implementation of the emergency regulations are included in the report. JLARC staff selected the 90 highest-risk standards and *Code* sections to analyze. For example, standards were selected which relate to medication administration, nutrition, background checks, adequate staff, abuse and neglect, resident rights, facility cleanliness, adequate heat and air conditioning, and fire safety, among others.

Licensing staff expedited the report's completion and requested that JLARC staff use it in identifying ALFs with health and safety violations. One week after the receipt of the data, an email from State licensing staff notified JLARC staff that

Unfortunately we have found at least one inspector that has failed to enter approximately 20 inspections. We believe there are others who have failed to enter a substantial number of their inspections in [the database]. We are frantically trying to determine which inspectors are/were negligent in entering some inspections and how many inspections have not been entered.

JLARC staff requested that an updated version of the report be sent once corrected; however, data was received on June 2, 2006, too late to be used for this report. As a result, facilities with serious health and safety violations may not have been identified.

Licensing Complaints. Complaints concerning non-compliance with standards and abuse, neglect, or exploitation of residents, are made to the licensing division. There are 24 categories of licensing complaints including abuse and neglect, food and nutrition, medication, staffing, records, and physical plant. Licensing inspectors investigate complaints and determine their validity.

DSS licensing management informed JLARC staff of inaccuracies in the complaint data. One problem is that inspectors may not enter the reports properly into the system. For example, DSS staff explained that only "closed" complaints have been finalized by the inspector and the validity determined. However, analysis of "open" complaints revealed that a closed date and determination of validity had been entered into the system for a dozen or more complaints. JLARC staff determined that complaints with a closed date and determination of validity were in fact closed, and therefore used them in the analysis.

Adult Protective Services Provided Limited Complaints Data

Adult Protective Services (APS) investigates complaints of abuse, neglect, and exploitation of adults age 60 and older, and incapacitated adults age 18 and older, and provides services when persons are determined to be in need. APS staff in the 120 local departments of social services receive and investigate complaints, and enter information into the State database. State APS staff maintain the database and provided JLARC staff with limited data on verified complaints from June to December 2005.

APS staff enter complaint information into a new database, which became available in October 2005. Some local department staff did not begin using the database until a later date, so data provided to JLARC staff does not include information from all 120 local departments. Staff are asked to enter complaint information, includ-

ing where the incident took place. If the incident occurred in an ALF, the database provides space for the facility's name.

Unfortunately, many APS staff do not enter the name of the facility. For example, from June to November 2005, there were 56 verified complaints in ALFs. However, only 15 were identified by name. The remaining 41 were left blank. Therefore, JLARC staff were unable to identify the location of 41 verified incidents of abuse, neglect, or exploration that occurred in ALFs in summer and fall 2005.

State APS staff informed JLARC staff of problems with the database and data entry. Local department APS staff were being trained on use of the database when the complaints dataset was provided to JLARC staff.

Office of Long-Term Care Ombudsman Provided Complaints Data for FYs 2004 and 2005

The ombudsman program is a federally mandated program which responds to complaints made by individuals receiving long-term care services in facilities and the community who may have no one to advocate on their behalf. There are five complaint categories: resident rights, resident care, quality of life, administration, and complaints not against facility. The ombudsman's office provided JLARC staff a report of complaints against ALFs in fiscal years 2004 and 2005, including the verification status. Because the data did not include an explanation of the category or type of complaint, JLARC staff only know there was a verified complaint, not the nature or type of complaint.

Identification of ALFs With Complaints and Compliance Problems

To identify facilities with a recent history of verified complaints and compliance problems, JLARC staff considered the following:

- whether DSS issued a provisional license from April 2004 through December 2005,
- whether DSS imposed an adverse enforcement action between November 2003 and October 2005,
- whether DSS placed the facility on “enforcement watch” during calendar year 2005,
- the number of health and safety violations in each facility’s five most recent licensing inspections prior to the implementation of the emergency regulations,

- the number of verified complaints filed with the Office of the Long-Term Care Ombudsman in FY 2004 and FY 2005,
- the number of verified complaints filed with DSS's Adult Protective Services from June to December 2005, and
- the number of verified complaints filed with DSS's Division of Licensing Programs in calendar year 2005.

These factors were used to identify a subset of 137 ALFs with a recent history of verified complaints and compliance problems. No one indicator was key to inclusion in the subset. ALFs in the subset had one or more of the following characteristics during 2003-2005 (Chapter 3, Table 7):

- a provisional license, an adverse enforcement action, or placement by DSS on its enforcement watch list,
- seven or more violations per inspection of the 80 highest-risk health and safety violations across the most recent five inspections (seven is two standard deviations above the average violations), or
- five or more verified complaints across all three sources. The average of 4.7 complaints was calculated using all ALFs with verified complaints. Those ALFs with zero complaints were not included in the analysis.

The overall approach for identifying the subset was to select facilities with sufficient performance issues to warrant additional attention, and that may be the most likely to change as a result of the new law and regulations. Facilities with a provisional license, an adverse action, or that were on the enforcement watch list have demonstrated problems sufficient to compel DSS staff to pay increased attention. To this list, JLARC staff added "outlier" facilities that had a number of health and safety violations that was at least two standard deviations above the mean (seven or more), and an above-average number (five or more) of total verified complaints.

SITE VISITS TO 29 ALFS

JLARC staff visited 29 ALFs during the course of this study, including 18 ALFs with compliance problems and/or complaints, as described above. Eleven initial facility visits were for the purpose of generally familiarizing JLARC staff with assisted living. An additional 18 ALFs from the ALFs with compliance problems and/or complaints were chosen for site visits based in part on geographical representation (Table 1). During these visits, JLARC staff interviewed the administrator and the DSS licensing specialist, and toured each facility.

Table 1: Setting the Site Visit Sample Size

Region	ALFs statewide		Site Visit Sample	
	#	%	#	%
Central	157	27	4	22
Verona	87	15	3	17
Fairfax	71	12	3	17
Piedmont	80	14	2	11
Western	51	9	2	11
Virginia Beach	71	12	2	11
Northern	27	5	1	6
Peninsula	44	7	1	6
Total	588	100%¹	18	100%¹

¹Does not total 100 percent due to rounding.

Source: January 2006 caseload from DOLP.

DATA ANALYSIS

During the course of this study, JLARC staff analyzed data from a variety of sources.

UAI Data

JLARC staff analyzed data from recent Uniform Assessment Instrument (UAI) assessments to review the care needs and medical diagnoses of ALF residents receiving the auxiliary grant. The Department of Medical Assistance Services (DMAS) provided UAI assessments conducted in FY 2003-05 for public-pay residents of ALFs. These records included initial assessments for individuals entering an ALF and reassessments for continuing ALF residents. JLARC staff analyzed the most recent assessment for 8,310 unique individuals.

Although all ALF residents must undergo a UAI assessment prior to entering a facility and annual assessments thereafter, DMAS only collects UAI assessments for auxiliary grant recipients. Assessments for private-pay residents of ALFs are generally conducted by ALF staff and are not maintained in a central location. As a result, JLARC staff could not use UAI data to characterize the more than 27,000 ALF residents who use private resources to purchase assisted living care.

Auxiliary Grant Financial Reports

For many years, assisted living facilities were required to submit financial reports to DSS to qualify for an auxiliary grant rate. This requirement was repealed in 1998; however, in 2005, 354 facilities

voluntarily submitted financial reports, covering either calendar year 2004 or a more recent 12-month period. The reports include data on the facility's revenue and expenditures. DSS provided JLARC staff with this data.

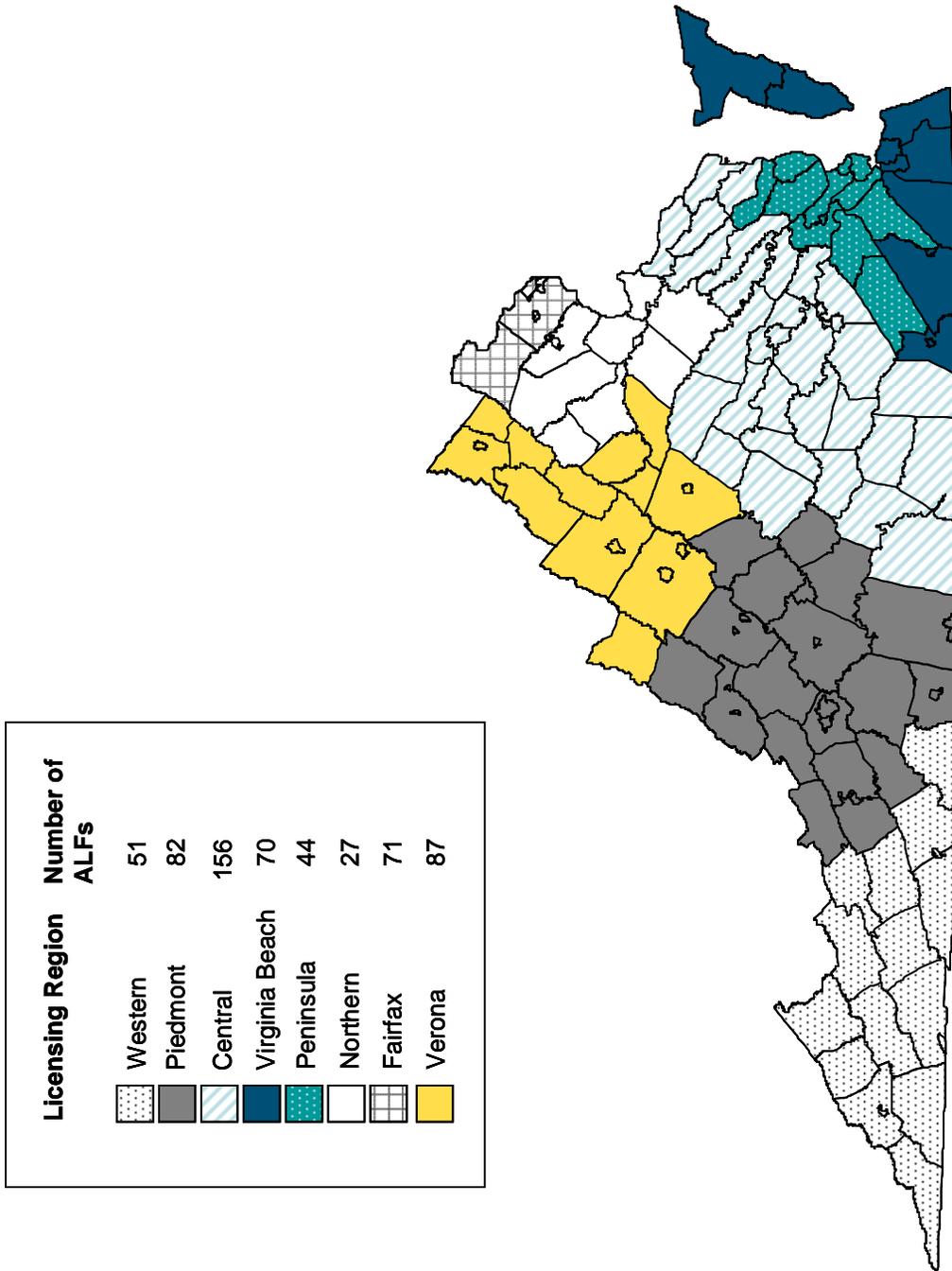
STRUCTURED INTERVIEWS AND MEETINGS

During the course of this study JLARC staff interviewed more than 100 persons with knowledge of assisted living. Persons interviewed included

- DSS licensing staff,
- ALF administrators and other employees,
- CSB directors and staff of the CSB Directors' Association,
- interest groups such as the Virginia Association of Homes for Adults (VAHA), the Virginia Association of Nonprofit Homes for the Aging (VANHA), the Virginia Assisted Living Association (VALA), the Virginia Health Care Association (VHCA), and the Southwest Assisted Living Association (SALA),
- staff with other State agencies including the Department of Health Professions, the Virginia Office for Protection and Advocacy, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Medical Assistance Services,

JLARC staff also attended numerous meetings, including meetings of the Board of Nursing and the Board of Long Term Care Administrators and their respective advisory committees working on registration and licensing standards, and DSS sponsored training on the emergency regulations for both licensing inspectors and ALF administrators.

DSS Licensing Regions



Appendix **D**

Glossary of Acronyms

ADL	Activities of daily living
ALF	Assisted living facility
APS	Adult Protective Services
BLTCA	Board of Long-Term Care Administrators
BON	Board of Nursing
CNA	Certified Nurse Aide
CPR	Cardiopulmonary resuscitation
CSB	Community Services Board
DHP	Department of Health Professions
DMAS	Department of Medical Assistance Services
DMHMRSAS	Department of Mental Health, Mental Retardation and Substance Abuse Services
DOLP	Division of Licensing Programs
DSS	Department of Social Services
ISP	Individualized Service Plan
NOIRA	Notice of Intended Regulatory Action
RBHA	Richmond Behavioral Health Authority
SBSS	State Board of Social Services
SOP	Standard Operating Procedure
SSI	Supplemental Security Income
UAI	Uniform Assessment Instrument
VAC	Virginia Administrative Code
VOPA	Virginia Office for Protection and Advocacy

State Supplements to SSI for Assisted Living, 2005

State	Monthly Amount (Combined Federal and State)	Number of Recipients
Alabama	\$635-\$639	432
Alaska	\$679	794
California	\$979	58,149
Connecticut	\$579	4,833
Delaware	\$719	708
District of Columbia	50 beds or less: \$916 Over 50 beds: \$1,036	760
Florida	\$657	8,499
Hawaii	6 beds or more: \$1,209	74
Idaho	\$918-\$1,053	6
Illinois	N/A: Based on individual needs	575
Indiana	\$1,197	1,594
Iowa	\$777	2,369
Kentucky	\$1,019	3,335
Maine	\$796-\$813 (boarding home)	52
Maryland	Minimal Supervision: \$515 Moderate Supervision: \$2,365	Minimal: 515 Moderate: 2,365
Massachusetts	\$1,033	1,239
Michigan	Domiciliary care: \$666 Personal Care: \$737 Home for Aged: \$758	Domiciliary: 36 Personal: 12,966 Home for Aged: 649
Minnesota	\$1,153	N/A
Missouri	\$735-\$871	7,472
Montana	\$673	114
Nebraska	\$1,017	908
Nevada	\$929	377
New Hampshire	\$786	129
New Jersey	\$729	6,478
New Mexico	\$679	478
New York	\$845-\$1,014, tied to region & care	216,524
North Carolina	\$1,130	23,456
North Dakota	\$878	476
Ohio	\$1,135	634
Oregon	\$581	1,111
Pennsylvania	\$968-\$973	12,662
Rhode Island	\$1,154	741
South Carolina	\$927	2,960
South Dakota	\$1,110	219
Vermont	\$803	137
Virginia	\$944	6,367
Washington	\$605	4,610
West Virginia ¹	\$1,028	319
Wisconsin	\$759	23,544

¹Based on JLARC staff interview.

Note: The table shows the total amount provided for residents, which includes federal Supplemental Security Income (SSI) together with any state-provided supplement to SSI. Does not include amounts paid by Medicaid. No supplement for assisted living provided in Arizona, Arkansas, Colorado, Georgia, Kansas, Louisiana, Mississippi, Oklahoma, Tennessee, Texas, Utah, Wyoming. Residents in these states received only the federal SSI, which was \$579 in 2005.

Source: Social Security Administration, *State Assistance Programs for SSI Recipients*, January 2005.

Agency Responses

As a part of the extensive validation process, State agencies and other entities involved in a JLARC assessment effort are given the opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from comments provided by these entities have been made in this version of the report. This appendix includes written responses from the Department of Social Services and the Department of Health Professions.



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

Office of the Commissioner

Anthony Conyers, Jr.
COMMISSIONER

June 6, 2006

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

Dear Mr. Leone:

Thank you for the opportunity to comment on the exposure draft of the Joint Legislative Audit and Review Commission's (JLARC's) staff entitled, Impact of Assisted Living Facilities Regulations: Status Report. We want to commend your staff for the work done on this report on the implementation of laws and regulations that affect Assisted Living Facilities (ALF's) and the benefits we believe the longitudinal study will yield for this very complex industry and its regulation. We recognize the difficulties that the JLARC staff faces in responding to its charge at a time when so many significant changes are taking place and when certain key criteria have not been identified or clarified. The Department of Social Services (VDSS) will, of course, use the staff report to correct and strengthen current practices. As your study proceeds, we expect to improve regulatory methods, in part by continuing to improve the quality of the management information reports from our automated systems, which should be useful to your staff as the study continues.

An example of where criteria need to be developed and/or clarified is the concept of "quality." Both VDSS and JLARC staff agree that quality is a critical attribute with, as yet, no commonly accepted definition, and we hope that we can work together to develop a measurable definition of quality, much as is occurring in child care in many states. In the absence of a definition, JLARC staff has necessarily taken a limited view of quality indicators at this time. We believe that both VDSS and JLARC staff agree that quality is more than the absence of complaints and violations of standards that are essential to life, health and safety. Those standards, unfortunately, lack a level of attention to issues that otherwise would heavily contribute to ALF residents' quality of life. Many of the latter types of indicators were suggested by VDSS staff and ALF Administrators and were included in the JLARC report. To develop the kinds of rating systems currently being used in child care and extending similar indicators to adult care, however, will require more work, more attention to metrics, and more attention to how the various indicators operate holistically rather than separately.

Providing a satisfying quality of life and the enhancement and preservation of residents' capabilities will require relationships, activities, and support across the several domains of human experience to occur concurrently, e.g., care-giving staffs that can and do spend quality time with residents so that reassuring and constructive social relationships develop within the facility; programs and activities that promote benefits to the cognitive and emotional dimensions of life; services and activities that support wellness and delay dependency; surroundings that provide a comfortable sense of belonging and privacy; access to constructive interaction with the external community; etc. Using child care quality rating systems as examples, we can illustrate that it is possible to measure enough indicators to help guide providers and others in the assessment and improvement of quality. A few examples are: observing the amount and nature of staffs' verbal and non-verbal interactions, such as touching and eye-contact with residents; the modal response time when a resident needs assistance; the extent to which direct care staffs know their assigned residents and are active participants in the use of service plans; the extent to which residents are encouraged to have reasonable choices and autonomy; evidence of management strategies that not only maintain high compliance but also promote the principles of person-centered care, manage workforce issues in ways that professionalize staffs, promote stability and bonding; etc. A great deal of work remains to be done to conceptualize the criteria and the metrics, but we believe that we should be heading in that general direction.

VDSS Recommendations

With that general direction in mind, we respectfully offer three recommendations to the Commission:

1. Consideration should be given to extending the study of ALFs well beyond the scope, purpose and duration established for the current project.
 - As an extension of this study, VDSS recommends a periodic review of the status of assisted living at two to three year intervals over at least a decade to track progress and to provide *comprehensive* information to guide policymakers and the involved agencies in their programmatic, regulatory and policy roles.
 - As this and previous JLARC studies clearly indicate, the assisted living industry has been in a state of constant growth and change in its clientele and purpose for at least three decades. This is expected to continue in response to the demographic, social and economic forces acting on Virginia and the nation. Moreover, funding issues have created pressure to keep the regulatory requirements below the safety levels desirable in current and evolving market conditions.
2. Ongoing research should focus on the issue of how best to regulate "small" facilities.
 - Some interested parties have expressed a desire for less-stringent standards for "small" facilities. The VDSS has little latitude to reduce regulatory requirements without jeopardizing consumer safety by using size alone as a measure because the acuity variable cannot be ignored. Additionally, there is no consensus on a definition of "small," with opinions ranging from eight to seventy-five beds.
 - There is value in finding ways to preserve small operations that some consumers prefer but that are financially precarious, often lack the business management and service resources to meet today's service needs safely, and do not enjoy the economies of scale that benefit larger or chain operations.

- This issue also raises questions about whether or not the licensing threshold should be set at one, as it is in children’s residential regulation, and how to encourage the development of the adult foster family model that is available in some but not all localities.
 - Also included in these questions is whether or not a different and more viable business and regulatory model would be useful and attractive to licensees, such as creating options for “co-op” or system business models. Such models might permit small operations to engage in formal collaboratives to share specialized management, service resources and oversight responsibilities. They might also assist providers to gain some reduction in insurance costs related to liability and worker benefits.
 - Given the market pressures on small operations, it would be helpful for legislative and policy recommendations in these areas to be developed within the next year or two.
3. Continuing study should include the question of how to develop and expand a quality workforce and, specifically, how to bring more training and educational resources to the aid of the industry.
- All human care is labor-intensive. Despite increasing recognition of its social and economic importance, human care remains caught in intense competition for workers, e.g., with retail and fast-food firms.
 - Human care is demanding and stressful, especially to workers who do not realize and/or appreciate the intrinsic rewards in the work – leading to harmful turnover rates and severe impediments to quality.
 - Unlike the child care industry, where federal funds have been supporting workforce development for more than a decade, the adult care industries have only VDSS’ training funds from licensing fees and fines and, more recently, a relatively small “pass through” appropriation for training in dementia care. Adult care has also attracted little in the way of private contributions and industry participation as compared to child care.
 - Workforce development is a critical aspect of quality care aspirations. Without a more robust and reliable demand for competent and competitively available workers, however, the state’s colleges and private training firms cannot be expected to develop the array of educational supports that the industry needs in today’s market.

Specific Responses to the Exposure Draft Report

We were impressed with the amount and accuracy of information covered in the report and identified few factual errors. There were some areas where we felt additional information would help readers to put the report’s findings into context, and we offer those comments here.

Prior JLARC Recommendations That Have Not Been Implemented

The report provided the status of recommendations from previous JLARC reports. The following are our comments related to certain recommendations that the JLARC staff indicated had not been implemented:

- Certified dietitian should review menus in licensed facilities; special diets should receive particular scrutiny. The report notes that this was not implemented and additional action is necessary. The *proposed* ALF replacement regulations contain a requirement for on-site quarterly oversight of special diets by a dietitian or nutritionist, each of whom must meet the requirements of the *Code of Virginia* and regulations for dietitians and nutritionists. The oversight is to include a review of the physician's order and the preparation and delivery of the special diet for each resident who has such a diet. The quarterly oversight also must include an evaluation of the adequacy of each resident's special diet and the resident's acceptance of the diet. VDSS considered proposing that a dietitian or nutritionist review menus, but concluded that this would be unnecessarily expensive for ALFs since there are resources available on the Internet, in the library, and as specified in the standards themselves that relate to menus.
- Statutory authority is needed for staffing standards in assisted living. Within provisions of current law, the issue of staffing standards is addressed in depth in the *proposed* replacement regulations, which were drafted for the review process and submitted at the same time as the emergency regulations. Nationwide experience suggests that the diversity in size, populations in care, and physical plants in ALFs does not lend itself to setting mandated ratios. VDSS has proposed that each facility "have a mechanism for demonstrating how staffing requirements are determined. At a minimum this mechanism will specify day-to-day routine direct care needs and any identified special needs for the residents in care as well as any non-direct care tasks routinely required of the staff." Meanwhile, VDSS is developing an acuity-based assessment tool for inspectors' use in evaluating the staffing needs based on resident specific care needs, which can be used in conjunction with existing or revised regulations.
- Standards should be established for levels of care that match the types of residents in assisted living. The report also indicates that a recommendation to establish levels of care that match the types of residents has not been implemented and that additional action is necessary. The ALF standards provide for the two levels of care specified in the *Code of Virginia*. The ALF standards also include requirements to ensure that special needs of residents with medical conditions or mental disabilities are met and promote interaction with community mental health resources.

Other JLARC staff comments in the report that VDSS believes need clarification are as follows:

Legislation Required Training for Inspectors on Current Regulations and Code

The report states that, "As required by the legislation, DSS developed a training module on the emergency as well as existing regulations and statutes and presented it to all licensing inspectors in the fall of 2005. ALF inspectors also attended training sessions on the UAI, individualized service plans (ISPs) for ALF residents, and mandated reporter sessions through adult protective services."

VDSS suggests that the legislative mandate was solely to deliver staff training on the *then expiring* (pre-emergency) ALF regulations, not the emergency regulations, although it is agency practice to train both staffs and providers when regulations are significantly revised. Two-day training sessions on regulations and statutes were delivered in August and September, 2005, via videoconference to all adult program inspectors, their licensing administrators and select central office staff. Two separate sessions using videoconference and web-based software were conducted. The training was conducted while the emergency regulation was still in administrative review status. The workshop content included final interactive exercises, additional handout materials including interpretive advice, and individual written tests before training credit was given. Modules covered ALF issues and trends, general procedures, related regulations (including auxiliary grant and assessment regulations), regulations related to mental health, social health, medical health, safety of the physical environment, standards related to management (including policies, training and background checks), and statutes.

Training on the Emergency Regulations was not Adequate

VDSS had an abbreviated amount of time to properly prepare providers and inspectors for the emergency regulations. The regulations were not finalized and approved by the Governor until September 13, 2005, leaving three and a half months, rather than the five months stated in the report. The regulatory process typically includes changes, additions or retractions prior to implementation. VDSS could not anticipate with certainty the final form that regulations would take prior to the Governor's approval.

Immediately following the mandated training on the expiring regulations, work began on developing curriculum to train staff on emergency regulations for ALFs and general procedures. The day-long staff training workshops for inspectors, select central office staff and licensing administrators were delivered in the field in three separate sessions on Oct. 13, 20 and 27, 2005, i.e., beginning one month after the regulations were signed and concluding two months before the implementation date. Content covered ALF issues, changes to general procedures (summary suspension procedures), mental health regulations, medical health regulations, general procedures (civil penalties), and a question and answer session. In addition to developing content, curriculum developers also created draft forms and handouts, developed responses to inspectors' questions, produced accompanying participant workbooks and slides, and coordinated logistics.

Provider training was held during December, giving central office and field office staffs only three full work weeks to revise curriculum to reflect additional material produced as a result of inspectors' questions during and after their training. In all, 597 facilities were represented at the statewide training workshops for providers on emergency regulations during December 2005, including some still in the application process but not including attendees to additional training sessions offered by the field offices after implementation.

VDSS Didn't Provide Technical Guidance in a Timely Manner (p.27-28)

The report notes that a guidance document was issued more than three months after the effective date of the new regulations. It is important to understand that many questions were answered during and after training sessions with the licensing staffs and providers, on the phone and by

Mr. Philip A. Leone

June 6, 2006

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email. Many of these answers, as well as responses to additional questions, were included in the guidance document issued in April 2006.

Regrettably, issuance of the formal guidance document and model forms was delayed because of competing priorities. In addition, despite the best efforts of content experts at central office and inspectors, all questions arise in the context of nearly 600 facilities' unique programs and can never be fully identified and resolved before new regulations are implemented. This was a larger issue in this case because some of the new regulations involved complex legal, mental health and medical health regulatory changes and new regulations that needed to be resolved after further research and consultation within and across agency lines.

Mental Health Provisions Are Vague or Impractical

Concerns were raised about high risk behaviors and private mental health providers and a Memorandum of Understanding (MOU) with Community Service Boards (CSBs) was suggested.

Although it is not entirely clear in the JLARC exposure draft which regulation(s) raised concerns regarding access to mental health services, all residents, public and private-pay, generally have the option to seek mental health services from the public and private sectors. There are only two situations where restrictions are imposed. First, when a resident is seeking admission into an ALF, Standard 150.P.3(c) requires that the qualified mental health professional conducting the admission evaluation not have a direct or indirect financial interest in the facility for which the resident is being considered. The intent is to avoid a biased decision for financial gain. The Department concurs that this requirement may pose special hardship in some rural localities where there may be few mental health professionals and intends to revise the language before the proposed replacement regulation is finalized. In the meantime, the VDSS will approve an allowable variance request that establishes a balance between avoiding conflicts of interest and the need to access mental health services.

The other restriction that may limit whom a facility or resident may use to access mental health services specifically deals with a crisis where a mentally disturbed resident is believed to be at risk of harming self or others. The standard that relates to this situation is Standard 485, specifically Standard 485. A. While the Department will reword the standard for greater clarity before the replacement regulation is finalized, it is VDSS' belief that the intent is consistent with § 37.2-809 of the *Code of Virginia*. That section provides that if a mentally disturbed resident is believed to be at risk of harming self or others or is believed to be unable to care for self as a result of a mental illness, the local community services board would need to be called to conduct an evaluation to determine the need for hospitalization. In the event that hospitalization is needed and the resident in crisis is unwilling to be admitted, an involuntary commitment to a hospital can *only* be obtained by the sworn petition of an employee or designee of the local community services board (§ 37.2-809 (B) & (D)). If, however, the resident in crisis is willing to be admitted voluntarily, then the coordination of admission to the hospital can be arranged by the resident's own private physician or mental health professional. Therefore, other than having a situation that is described in and meets the *Code* requirements of § 37.2-809, the facility and/or resident is free to use a mental health care professional of choice, public or private.

- High risk behaviors. Some behaviors can unquestionably be viewed as high risk, such as a person known to be depressed stating he wants to commit suicide. Other behaviors may be as clear only if the observer(s) know more about the context in which that behavior has been observed. For example, if someone who is known to pace the floor at a certain frequency or time begins to significantly increase the pacing, that may be a warning sign of heightened anxiety or waning self-control. The intended point for providers regarding high risk behaviors is the need to become very familiar with the behavioral repertoire of their residents in order to anticipate and effectively manage potential risks for harm. This is the thinking also expressed by the Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS). By doing so, staff will be better able to distinguish between a behavior that for one resident might be a trigger that could lead to a harmful event while benign for a different resident.
- Memorandum of Understanding (MOU). Currently, one of the requirements of a service agreement (Standard 670.A) between the assisted living facility and a public or private mental health clinic or provider is the need for the mental health clinic or provider to respond to the emergency mental health needs of the residents. However, no criteria are included to attempt to explain what constitutes an emergency. To some degree, the perception of being in an emergency will always be both somewhat subjective and heavily influenced by an individual's knowledge level and experience when an event occurs. It is understandable that under-trained staffs may, as compared to trained clinicians, over-estimate the danger, which may be safer than if they were to under-estimate the danger. VDSS believes that the problem is not that criteria need to be established to determine when an emergency exists. Instead, the Department believes that this problem will be best addressed by (1) helping ALF staffs to better understand and to safely and effectively manage disturbing symptoms of mental health disabilities; (2) promoting more communication between ALFs and CSBs; and (3) providing more emergency clinicians to the CSBs.

Accompanying Residents Offsite is Unworkable

Providers were instructed during training sessions that "Mall trips or other functions where residents are able to leave the vehicle at the curbside, shop or participate independently and return independently to the van at a specified time would not require that trained staff accompany the residents on the activity."

With the exception of true medical transport, State Medicaid transportation providers are not responsible for supervising or assisting residents into, during, and out of appointments. If an individual is physically or mentally incapable of self-management during transport and while at the appointment site, the ALF is responsible for ensuring that someone accompanies to provide the needed assistance. When that escort is a facility employee, he or she must be appropriately trained/certified.

Difficulty with Requirement that Prescriptions Include Diagnosis

Regulation **22 VAC 40-71-400.D** references physician's orders. These are not prescriptions that the pharmacy fills (subject to the Drug Control Act) but the orders that permit the ALF medication management staff to administer the prescribed medications.

Additionally, the standard does not specify that the order must contain a diagnosis but rather that the physician's orders contain "the diagnosis, condition or specific indications for administering each drug." Feedback from several providers indicates that this has not been an overwhelming task except in those extreme circumstances where they had not obtained any such information on any residents in the past. To date, VDSS is finding that to be the exception rather than the rule, and even in those cases, the majority of physicians were responsive once they understood the safety issues and the enhanced protections the standard provides against mis-medication or lack of sufficient information to question what might have been an error in the orders. It should be noted that over-the-counter medications routinely provide indications for use.

The basis and authority for the standard is in documents other than VDSS regulations. In the [Regulations Governing the Practice of Medicine, Osteopathy, Podiatry and Chiropractic - 2-8-2006](#) at **18VAC85-20-28**. Practitioner-patient communication; termination of relationship. **A. 2.** A practitioner shall present information relating to the patient's care to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care. The Board of Nursing's approved curriculum, "A Resource Guide for Medication Management for Persons Authorized Under the Drug Control Act," requires that medication aides assisting with administration of prescribed medications ensure that the residents and/or a responsible party understand what medications are being taken by the resident and for what conditions those medications are being taken.

Controversial Provision Was Not Required by the 2005 Law

While issuing the emergency regulation with a standard repealing the previous permission for certain facilities with less than 20 beds to have night staff asleep may have been controversial, it is a logical interpretation of the 2005 law. The single, broad term "appropriate" was added to § 63.2-1803(B) of the *Code of Virginia*, which, at (ii), details one staff responsibility as to provide "the physical safety of the residents on the premises." In trying to assign meaning to the added term, the Department considered the statutory definition of an ALF (§ 63.2-100), which includes ". . . 24-hour supervision, and assistance (scheduled and unscheduled) . . ." as well as rising acuity and incidents where residents had been unable to summon staffs who were sleeping (unauthorized) at night. Although sleeping families supervise young or impaired family members at night, the usual intent of "appropriate" commercial care supervision is to be awake or, at minimum, that exceptions be granted only after careful scrutiny by the agency.

The report also raises concern about the expense to small facilities if staffs are not permitted to sleep at night. VDSS is sympathetic to this concern; however, it is also concerned about the potential for impaired care and protection of residents when staffs are sleeping. Providers have been told that they may request an allowable variance to the standard if residents in the facility do not have needs that require a staff to be awake at night. The allowable variance process allows the Department to ensure that protections are in place for residents based on individual facility characteristics, including floor design, rather than granting a "blanket" exception as was

done in the previous regulation. The volume of variance requests for sleeping staffs has not been high. To date, eight providers requested and have been granted an allowable variance to continue the practice of allowing staffs to sleep.

Inspectors Treat Facilities Differently that have Auxiliary Grant (AG) Recipients

VDSS acknowledges that some inspectors may not recommend sanctions as readily for AG facilities and is working to ensure a consistent approach at the field level. The concern is, “Where will the residents go if we close the facility?” Management direction, however, is that residents cannot be allowed to live in substandard conditions, and enforcement sanctions are handled consistently, once received by central office, regardless of whether the facility is public or private pay.

VDSS Has Not Implemented Staffing Guidelines

As mentioned earlier in this letter, the issue of staffing standards is addressed in depth in the *proposed* replacement regulations, which were drafted for the review process and submitted at the same time as the emergency regulations. Nationwide experience suggests that the diversity in size, populations in care, and physical plants in ALFs does not lend itself to setting mandated ratios. VDSS has proposed that each facility “have a mechanism for demonstrating how staffing requirements are determined. At a minimum this mechanism will specify day-to-day routine direct care needs and any identified special needs for the residents in care as well as any non-direct care tasks routinely required of the staff.” Meanwhile, VDSS is developing an acuity-based assessment tool for inspectors’ use in evaluating the staffing needs based on resident specific care needs, which can be used in conjunction with existing or revised regulations

Quality and Relevance of Training ALF Staff Attend

The exposure draft states, “The quality of some training may be questionable. Licensing inspectors in two regions questioned the standards and the effectiveness of selected staff training. VDSS provides guidance for determining which training is creditable, so a variety of activities appear to qualify as training. Some examples noted by JLARC staff would seem to be of marginal value. For example, one ALF invited a doctor to speak informally to staff over lunch. Some employees left to attend to residents’ needs and heard perhaps five minutes of the discussion, according to an inspector. Another administrator gave direct-care staff a self-study manual to read and let them take chapter tests.”

The Department’s guidance document, “Criteria for Provider Training,” which is posted on the Town Hall website at http://www.townhall.state.va.us/GuidanceDoc/ViewGuidanceDoc.cfm?Guidance_Document_ID=994, provides criteria for determining which provider training should be counted toward meeting the requirements as set out in the programmatic regulations. In reference to the first example cited in the report, the training criteria guidance document includes a requirement that “at a minimum, there should be a demonstration of knowledge and when appropriate a demonstration of competency in performing the skills presented in the training.” The licensing inspector should have credited training time only to those facility staffs that were actually present during the training and should have asked what kind of final knowledge check was implemented. In the second example, the ALF is permitted to use a self-study book for training “under the

supervision of a facilitator with verified expertise in the course topic who can provide guidance as needed.” The inspector should have asked for an explanation of how discussion was facilitated and by whom, and verified the credentials of the facilitator. If training does not meet DSS criteria, it should not be accepted as meeting the programmatic regulations. The Department will direct field offices to review this guidance document to ensure that inspectors are clear about compliance determination in crediting in-service training.

The Department is responsible for the quality of its formal provider training program for adult care facilities. Since July 1995, VDSS has had an interagency agreement with the Virginia Geriatric Education Center (VGEC) of Virginia Commonwealth University to present training to adult care providers. This training is required in § 63.1-194.3 of the *Code of Virginia* and the *Appropriations Act* which requires that licensing fees paid by assisted living facilities and adult day care centers be used for provider training. In addition, training is offered to ALF staff by the Alzheimer’s Association on an ongoing basis.

Each year VGEC develops a training needs assessment which is sent to licensed adult facilities and Licensing staffs to identify possible training topic areas. VDSS maintains final approval on training topics, curricula, and related training matters. The trainings are designed for all levels of staff including direct care staffs, supervisors and administrators.

Training topics offered in FY ’06 included: Developing and Implementing Individualized Services Plans; Managing Aggressive Behavior; Caring for Others, Helping Yourself: Mental Illness; Essential Skills for Caregivers: Observe, Document, and Report; Avoiding Burnout: Caring for Others by Caring for Ourselves; Food! Glorious Food! Nutritional Needs of Elderly and Disabled Adults; and, Person Centered Caring: Leadership. Sessions planned for FY ’07 include: Person Centered Caring: Leadership Series (phase 2); Developing and Implementing Individualized Service Plans; Activities for the Cognitively Impaired; Adverse Medication Reactions/Residents’ Rights; Safety and Preparedness; Grief, Transfer Trauma, and Dying; Train-the-Trainer, Individualized Service Plans.

Licensing field offices also offer training both directly and through outside sources during their provider meetings. Licensing personnel are the sole trainers for mandatory new provider training; this service includes pre-application, application, and refresher training.

Problems Exist with the Data Field for License Type

The report expressed concern about two data fields and whether they could result in mis-informing members of the public that consult the Department’s website.

There are two fields in the database that hold similar, but not necessarily identical, information. The first field holds information about the type of license issued, while the second field holds information about the facility’s performance profile or category. These should be identical at the time of license issuance, but a facility’s performance may decline during the licensure period. For example, at the time a two-year license is issued, field one would show that a two-year license had been issued, while the second field would show that the facility’s performance level was also “two.” The inspection schedule is tied by both statute and policy to the facility’s level

of compliance with regulations. When the inspector returns to perform a monitoring inspection, he/she may find that there have been changes in the facility's performance that warrant more frequent monitoring. This could be reflected by a change in the facility's category designation in the database. Because the license is a legal document, the terms of the license, including the duration of the license, cannot be changed except by legal proceeding. If this is not warranted, the end result could be a license duration of two years, but a category of "one" or even "provisional." Only the license type is posted on the public VDSS website, while the category information is used as an internal management tool. (VDSS proposed language for the 2005 legislation that would have granted authority to shorten the duration of a license without appeal if performance dropped below the level for which the license was issued, but this part of the package was not adopted.)

Inconsistent Use of Enforcement Watch

VDSS acknowledges that enforcement watch has been used inconsistently by the field offices. A new standard operating procedure was issued a few months ago and, although that document clearly outlines procedures for placing a facility on enforcement watch, some offices have not completed implementation. Changes are also being considered that will increase the use of enforcement watch and aid in consistency.

Data Entry Errors and Failure to Submit Corrections

The Division of Licensing Programs Help and Information System (DOLPHIN) serves three purposes – to manage data, manage program performance, and conduct research. Since the development of DOLPHIN, the Division of Licensing Programs and its staff have been steadily becoming more proficient in using DOLPHIN for each of these areas. We are still in the phase of developing reports. Our first attempt at pulling together a detailed report of all the inspections for a certain facility type during a specified time frame was for JLARC in March, 2006. Although the report worked, we then discovered data entry omissions that have taken considerable time and effort to analyze, repair and verify. Data entry accountability has been addressed with staffs and some related software issues were addressed with the contract vendor. Belatedly, and with apologies for the delay, the JLARC team was provided with a replacement spreadsheet on June 2.

The Department has completed four phases of its reports development project, gradually building a repertoire of reports that will serve it, and its stakeholders, well in terms of fundamental information needs, such as basic work data, detecting data entry problems, and macro-tracking facility compliance for general trends. Future report development will focus on targeting more detailed problems with data entry and facility compliance, such as identifying patterns in citations, flagging facilities with repeat violations, etc. As the capability to report more detailed information increases, so will the capacity for quality improvement and research.

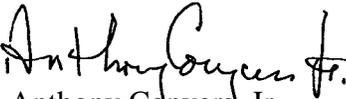
Mr. Philip A. Leone

June 6, 2006

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Again, I thank the JLARC staff for its diligence and professionalism in preparing this report and for the opportunity to respond on behalf of VDSS. If you have questions concerning our response, I am available to discuss them with you at your convenience.

Sincerely,



Anthony Conyers, Jr.

c: The Honorable Marilyn B. Tavenner
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JUN - 5 2006

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Philip A. Leone, Director
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Richmond, Virginia 23219

Dear Mr. ^{Phil} Leone:

Thank you for forwarding to me the exposure draft of Impact of Assisted Facilities Regulations: Status Report.

Relevant to the report, this agency is primarily concerned with the implementation of new provisions of law regulating medication aides by the Board of Nursing and administrators of assisted living facilities by the Board of Long Term Care Administrators. The report accurately reflects the status of our efforts and activities in these areas. As noted, the regulations required to implement the programs mandated by the 2005 Session of the General Assembly will not be fully implemented until rules are finalized and individuals have the opportunity to comply.

This report provides valuable information about the nature, scope, funding and performance of assisted living care in this Commonwealth, as well as regulatory activities that are intended to improve the quality of care and services to residents. We appreciate the opportunity to continue working with JLARC, other agencies and stakeholders in the future, as we strive to meet the mandates of law.

Again, thank you for the exposure draft.

Sincerely,

Robert A. Nebiker

Cc: The Honorable Marilyn Tavenner
Sandra Reen
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